

mhGAP Intervention Guide

for mental, neurological and substance use disorders
in non-specialized health settings

Version 2.0



World Health
Organization



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mhGAP-IG 2.0 » Preface

Mental, neurological and substance use (MNS) disorders are highly prevalent, accounting for a large burden of disease and disability globally. There remains a wide gap between available health systems capacity and resources, what is urgently needed, and what is available to reduce the burden. Nearly 1 in 10 people have a mental health disorder, but only 1% of the global health workforce provides mental health care. MNS disorders interfere, in substantial ways, with the ability of children to learn and the ability of adults to function in families, at work, and in society at large.

Recognizing the imperative to provide services for people with MNS disorders and their carers, and to bridge the gap between available resources and the large need for these services, the WHO Department of Mental Health and Substance Abuse launched the Mental Health Gap Action Programme (mhGAP) in 2008. The key objectives of mhGAP are to reinforce the commitment of governments, international organizations and other stakeholders to increase the allocation of financial and human resources for care of MNS disorders and to achieve much higher coverage with key interventions in low- and middle-income countries. Through these objectives, mhGAP provides evidence-based guidance and tools to advance toward achieving the targets of the Comprehensive Mental Health Action Plan 2013-2020.

In 2010, the mhGAP Intervention Guide (mhGAP-IG) for MNS disorders for non-specialized health settings was developed to assist in implementation of mhGAP. A simple technical tool based on the mhGAP guidelines, mhGAP-IG presents integrated management of priority MNS conditions using protocols for clinical decision-making. There is a widely shared but false notion that all mental health interventions are complex and can only be delivered by highly specialized staff. Research in recent years has demonstrated the feasibility of delivery of pharmacological and psychosocial

interventions in non-specialized health-care settings. Since its release in 2010, mhGAP-IG has been widely used by a range of stakeholders including ministries of health, academic institutions, NGOs and other philanthropic foundations and researchers to scale-up mental health services. mhGAP-IG Version 1.0 is being used in more than 90 countries in all WHO regions and mhGAP materials were translated into more than 20 languages, including the six UN official languages.

Five years after the initial launch of the guide, updates to the mhGAP guidelines based on emerging literature was performed and revised mhGAP guidelines were published in 2015. We are now pleased to present mhGAP-IG Version 2.0 which not only reflects these updates but also extensive feedback from the field to enhance the guide in its clarity and usability.

It is our hope that this guide will continue to be a key technical tool to deliver care for people with MNS disorders around the world and lead us closer to achieving the goal of Universal Health Coverage.

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INTRODUCTION

Mental Health Gap Action Programme (mhGAP) – Background

According to WHO Mental Health Atlas 2014, more than 45% of the world population lives in a country where there is less than 1 psychiatrist for every 100,000 people and there are even fewer neurologists. It is clear that relying solely on specialists to provide services for people affected by mental, neurological and substance use (MNS) disorders would prevent millions of people from accessing the services they need. Even when available, the interventions often are not evidence-based or of high quality. The Mental Health Gap Action Programme (mhGAP) was thus developed with the objective of scaling up care for MNS disorders.

The mhGAP approach consists of interventions for prevention and management of priority MNS conditions, identified on the basis of evidence about the effectiveness and feasibility of scaling up these interventions in low- and middle-income countries. Priority conditions were identified based on the criteria that they represented a high burden (in terms of mortality, morbidity and disability), resulted in large economic costs or were associated with violations of human rights. These priority conditions include depression, psychoses, self-harm/suicide, epilepsy, dementia, disorders due to substance use and mental and behavioural disorders in children and adolescents. The mhGAP-Intervention Guide (mhGAP-IG) is a resource to facilitate delivery of the mhGAP evidence-based guidelines in non-specialized health care settings.

Uptake of mhGAP-IG Version 1.0 by WHO Member States and other stakeholders has been remarkable and clearly shows the need for such a tool. mhGAP-IG Version 1.0 has been used at the country level through the following varied methods: most commonly, as a key tool in the phased approach to scale-up mental health services on a regional, national, and sub-national

level; as a capacity building tool for a wide range of health professionals and para-professionals; and as a reference guide for developing and updating undergraduate and post-graduate curricula for health professionals.

Development of mhGAP Intervention Guide – Version 2.0

The updated mhGAP guidelines and the feedback and evaluation from mhGAP-IG 1.0 users have shaped the revision and development of this updated version of mhGAP-IG. A complete update of the mhGAP guidelines following the WHO's process of guideline development methodology, including the process of evidence review, synthesis and development of recommendations through the participation of an international panel of individual experts and institutions with appropriate background experience: clinicians, researchers, programme managers, policy makers and service users, was performed and published in 2015. The detailed methods and updated recommendations can be found in the mhGAP Evidence Resource Centre. http://www.who.int/mental_health/mhgapevidence/en/.

Feedback has been received from experts in all WHO regions who used the mhGAP-IG package in the past three years to train non-specialized health care professionals and to provide MNS services at several implementation sites. A preliminary draft of mhGAP-IG 2.0, based on expert and field inputs, was then circulated among a wide group of reviewers across the world, allowing for a diversity of opinion in this intensive review process. This process incorporated feedback from a range of end-users, including non-specialist health care providers and people with MNS disorders across all WHO regions. End-user feedback was collected through a

questionnaire and locally facilitated focus group discussions were coordinated by WHO. Reviewer responses collected throughout this process have been incorporated into the mhGAP-IG 2.0.

Furthermore, several users of mhGAP-IG have highlighted the limitations of only having a paper-based format, suggesting that interactive electronic or internet-based (e-) or mobile (m-) versions of mhGAP-IG might have benefits in terms of increased ease of use, added functionality and cost savings. mhGAP-IG 2.0 has therefore, been designed and packaged with the intention to work across these multiple domains: paper, electronic, and mobile, with the e-mhGAP-IG currently under development and to be released soon.

Incorporating this extensive feedback, the updated 2015 mhGAP guidelines and the new opportunities afforded by an e-version, the key updates of mhGAP-IG 2.0 include:

- » Content update in various sections based on new evidence, feedback and recommendations from mhGAP users.
- » Use of a vertical algorithm model, allowing for a streamlined and simplified clinical assessment.
- » Inclusion of new algorithm for follow-up in all modules.
- » Inclusion of two new modules: Essential care and practice (which is an update for the chapter on General Principles of Care in version 1.0) and Implementation module.
- » A revised module for Psychoses (integrating both psychosis and bipolar disorder), Child and Adolescent Mental and Behavioural Disorders (covering Developmental, Behavioral and Emotional Disorders), and Disorders due to Substance Use (including both disorders due to alcohol and disorders due to drug use).

Use of mhGAP-IG Version 2.0

The mhGAP-IG is a model guide and it is essential that it is adapted to the unique national or local situation. Users may select a subset of the priority conditions or interventions to adapt and implement, depending on the contextual differences in prevalence and availability of resources. Adaptation is necessary to ensure that the conditions that contribute most to disease burden in a specific country are covered, and that mhGAP-IG 2.0 is appropriate for the local conditions that affect treatment of people with MNS disorders in the health care facility. The adaptation process should be used as an opportunity to develop a consensus on technical issues across disease conditions—this requires involvement of key national stakeholders. Adaptation will include language translation and ensuring that the interventions are acceptable in their sociocultural context and suitable for the local health system.

The target user group of mhGAP-IG is non-specialized health-care providers working at first- and second-level health-care facilities. These providers include primary care doctors, nurses and other members of the health-care workforce. Although mhGAP-IG 2.0 is to be implemented primarily by non-specialists, mental health care specialists may also find it useful in their work. In addition, specialists have an essential and substantial role in training, support and supervision, and mhGAP-IG 2.0 indicates where access to specialists is required for consultation or referral to improve utilization of scarce resources. Specialists would also benefit from training on public health aspects of the programme and service organization. Implementation of mhGAP-IG ideally requires coordinated action by public health experts and managers, and dedicated specialists with a background in public health. Therefore, training in the use of mhGAP-IG is best done as part of a systems approach involving health planners, managers and policy makers so that the interventions proposed are supported by necessary infrastructure/resources e.g. availability of essential medicines. mhGAP-IG training also needs to be incorporated in an ongoing manner with mechanisms in place to ensure adequate support, supervision and refresher training for the healthcare providers.

How to use the mhGAP-IG Version 2.0

The mhGAP-IG is a model guide and it is essential that it is adapted to the unique national or local situation. Users may select a subset of the priority conditions or interventions to adapt and implement, depending on the context.

- » The mhGAP-IG 2.0 begins with “Essential Care and Practice”, a set of good clinical practices and general guidelines for interactions of health care providers with people seeking mental health care. All users of the mhGAP-IG should familiarize themselves with these principles and should follow them as far as possible.
- » The mhGAP-IG includes a “Master Chart”, which provides information on common presentations of the priority conditions. This guides the clinician to the relevant modules. The most serious conditions should be managed first. mhGAP-IG 2.0 has a new addition to the Master Chart – Emergency Presentations of Priority MNS Conditions. This section has been added to help identify emergency situations and direction to management guidelines.
- » The modules, organized by individual priority conditions, are a tool for clinical decision-making and management. Each module is in a different colour to allow easy differentiation. There is an introduction at the beginning of each module that explains which condition(s) the module covers and a quick overview describing key assessment and management steps.
- » Each of the modules consists of three sections:

-  **Assessment**
-  **Management**
-  **Follow-up**

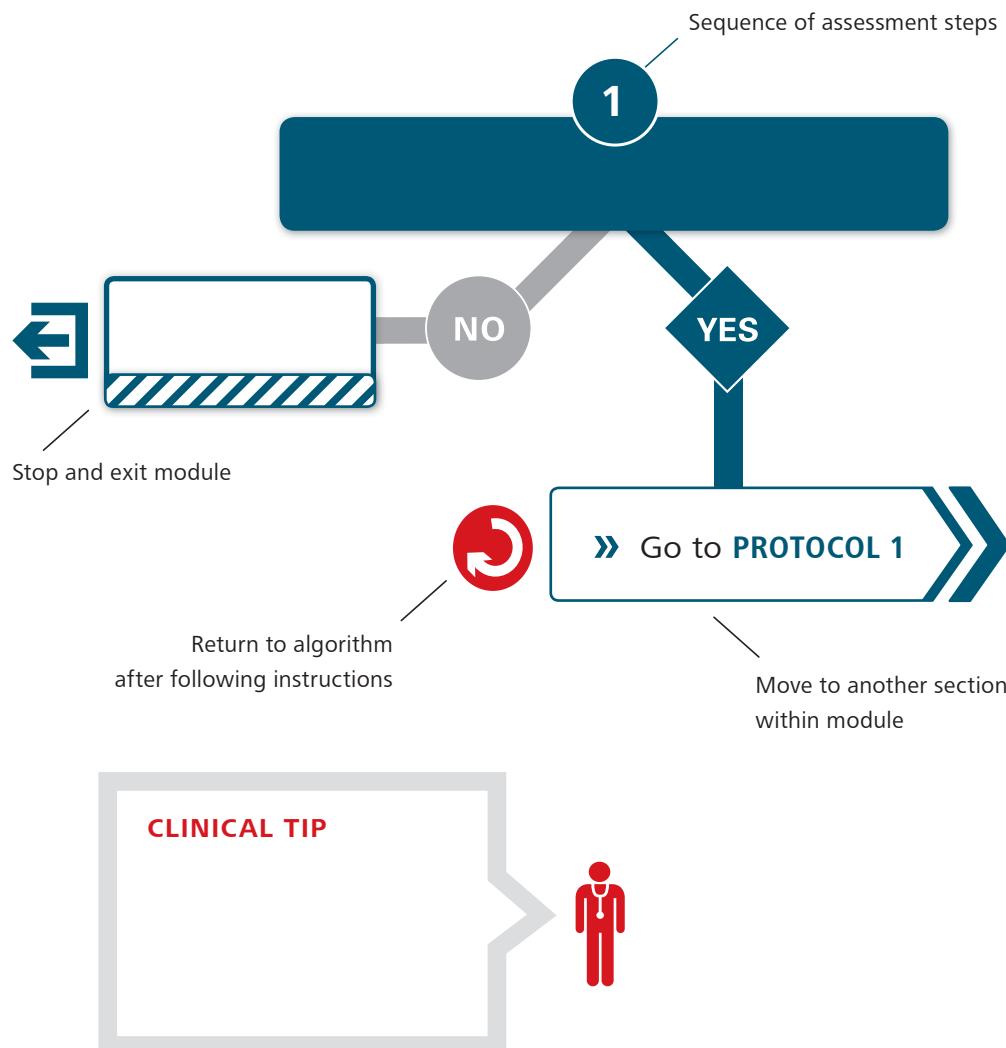
 **The Assessment section** is presented in a framework of flowcharts with multiple clinical assessment points. Each module starts with common presentations of the suspected condition, from which there are a series of clinical assessment questions one should move down answering yes or no, which directs the user to move on for further instructions to reach a final clinical assessment. It is important that users of the mhGAP-IG start at the top of the assessment and move through all the decision points to develop a comprehensive clinical assessment and management plan.

 **The Management section** consists of intervention details which provide information on how to manage the specific conditions that have been assessed. This includes more technical psychosocial and pharmacological interventions when appropriate.

 **The Follow-up section** provides detailed information on how to continue the clinical relationship and detailed instructions for follow-up management.

- » The mhGAP-IG 2.0 uses a series of symbols to highlight certain aspects within the modules. A list of the symbols and their explanation is given on the following page. Throughout the modules, important points are also highlighted as key clinical tips.
- » Also included is a module on Implementation of mhGAP-IG, which provides summary steps on how to implement mhGAP-IG.
- » At the end of the guide, a glossary of terms used in mhGAP-IG 2.0 is provided.

Visual Elements & Symbols



ESSENTIAL CARE & PRACTICE

This module outlines the principles of essential care for all people seeking health care, including those with MNS conditions, and their carers. The first section of this module covers the general principles of clinical care and aims to promote respect for the privacy of people seeking care for MNS conditions, foster good relationships between health care providers, service users and their carers, and ensure care is provided in a non-judgmental, non-stigmatizing, and supportive manner. The second section covers essentials of mental health clinical practice and aims to present healthcare providers with an overview of the assessment and management of MNS conditions in non-specialized settings.

A. GENERAL PRINCIPLES

- Use effective communication skills
- Promote respect and dignity

B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE

- Assess physical health
- Conduct a MNS assessment
- Manage MNS conditions

A. GENERAL PRINCIPLES

I. Use Effective Communication Skills

Using effective communication skills allows healthcare providers to deliver good quality care to adults, adolescents, and children with mental, neurological and substance use (MNS) conditions. Consider the following core communication skills and tips:

COMMUNICATION TIP #1

Create an environment that facilitates open communication

- » Meet the person in a private space, if possible.
- » Be welcoming and conduct introductions in a culturally appropriate manner.
- » Maintain eye contact and use body language and facial expressions that facilitate trust.
- » Explain that information discussed during the visit will be kept confidential and will not be shared without prior permission.
- » If carers are present, suggest to speak with the person alone (except for young children) and obtain consent to share clinical information.
- » When interviewing a young woman, consider having another female staff member or carer present.

COMMUNICATION TIP #2

Involve the person

- » Include the person (and with their consent, their carers and family) in all aspects of assessment and management as much as possible. This includes children, adolescents and older adults.

COMMUNICATION TIP #3

Start by listening

- » Actively listen. Be empathic and sensitive.
- » Allow the person to speak without interruption.
- » If the history is unclear, be patient and ask for clarification.
- » For children, use language that they can understand. For example, ask about their interests (toys, friends, school, etc.).
- » For adolescents, convey that you understand their feelings and situation.

COMMUNICATION TIP #4

Be friendly, respectful and non-judgemental at all times

- » Always be respectful.
- » Don't judge people by their behaviours and appearance.
- » Stay calm and patient.

COMMUNICATION TIP #5

Use good verbal communication skills

- » Use simple language. Be clear and concise.
- » Use open-ended questions, summarizing and clarifying statements.
- » Summarize and repeat key points.
- » Allow the person to ask questions about the information provided.

COMMUNICATION TIP #6

Respond with sensitivity when people disclose difficult experiences (e.g. sexual assault, violence or self-harm)

- » Show extra sensitivity with difficult topics.
- » Remind the person that what they tell you will remain confidential.
- » Acknowledge that it may have been difficult for the person to disclose the information.

II. Promote Respect and Dignity

Persons with MNS conditions should be treated with respect and dignity in a culturally appropriate manner. As a health care provider, make every effort to respect and promote the will and preference of people with MNS conditions and support and engage them and their carers in the most inclusive way. Persons with MNS conditions are often more vulnerable to human rights violations. Therefore, it is essential that in the health care setting, providers promote the rights of people with MNS conditions in line with international human rights standards, including the UN Convention on the Rights of Persons with Disability (CRPD)*.

*For more information on CRPD: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

DOs

- » Treat people with MNS conditions with respect and dignity.
- » Protect the confidentiality of people with MNS conditions.
- » Ensure privacy in the clinical setting.
- » Always provide access to information and explain the proposed treatment risks and benefits in writing, if possible.
- » Make sure the person provides consent to treatment.
- » Promote autonomy and independent living in the community.
- » Provide persons with MNS conditions with access to supported decision making options.

DON'Ts

- » Do not discriminate against people with MNS conditions.
- » Do not ignore the priorities or wishes of people with MNS conditions.
- » Do not make decisions for, on behalf of, or instead of the person with MNS conditions.
- » Do not use overly technical language in explaining proposed treatment.

B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE

I. Assess Physical Health

Persons with MNS disorders are at higher risk of premature mortality from preventable disease and therefore must always receive a physical health assessment as part of a comprehensive evaluation. Be sure to take a proper history, including both physical health and MNS history, followed by a physical health assessment to identify concurrent conditions and educate the person about preventive measures. These actions must always be undertaken with the person's informed consent.

Assessment of Physical Health

- » **Take a detailed history and ask about risk factors.**
Physical inactivity, inappropriate diet, tobacco, harmful alcohol and/or substance use, risky behaviour and chronic disease.
- » **Perform a physical examination.**
- » **Consider a differential diagnosis.**
Rule out physical conditions and underlying causes of MNS presentations by history, physical examination and basic laboratory tests as needed and available.
- » **Identify comorbidities.**
Often, a person may have more than one MNS condition at the same time. It is important to assess and manage this when it occurs.

CLINICAL TIP:

Persons with severe mental disorders are 2 to 3 times more likely to die of preventable disease like infections and cardiovascular disorders. Focus on reducing risk through education and monitoring.



Management of Physical Health

- » Treat existing comorbidities concurrently with the MNS disorder. Refer to/consult with specialists, if needed.
- » Provide education on modifiable risk factors to prevent disease and encourage a healthy lifestyle.
- » To support physical health of persons with MNS conditions, health care providers should:
 - Provide advice about the importance of physical activity and a healthy diet.
 - Educate people about harmful alcohol use.
 - Encourage cessation of tobacco and substance use.
 - Provide education about other risky behaviour (e.g. unprotected sex).
 - Conduct regular physical health checks and vaccinations.
 - Prepare people for developmental life changes, such as puberty and menopause, and provide the necessary support.
 - Discuss plans for pregnancy and contraception methods with women of childbearing age.

II. Conduct a MNS Assessment

Conducting an assessment for MNS conditions involves the following steps. First, the presenting complaint is explored, then a history is obtained including asking about past MNS issues, general health problems, family MNS history, and psychosocial history. Observe the person (Mental Status Exam), establish a differential diagnosis, and identify the MNS condition. As part of the assessment, conduct a physical examination and obtain basic laboratory tests as needed. The assessment is conducted with informed consent of the person.



HISTORY TAKING

1 Presenting Complaint

Main symptom or reason that the person is seeking care.

- » Ask when, why, and how it started.
- » It is important at this stage to gather as much information as possible about the person's symptoms and their situation.

2 Past MNS History

- » Ask about similar problems in the past, any psychiatric hospitalizations or medications prescribed for MNS conditions, and any past suicide attempts.
- » Explore tobacco, alcohol and substance use.

3 General Health History

- » Ask about physical health problems and medications.
- » Obtain a list of current medications.
- » Ask about allergies to medications.

4 Family History of MNS Conditions

- » Explore possible family history of MNS conditions and ask if anyone had similar symptoms or has received treatment for a MNS condition.

5 Psychosocial History

- » Ask about current stressors, coping methods and social support.
- » Ask about current socio-occupational functioning (how the person is functioning at home, work and in relationships).
- » Obtain basic information including where the person lives, level of education, work/employment history, marital status and number/ages of children, income, and household structure/living conditions.

For children and adolescents, ask about whether they have a carer, and the nature and quality of the relationship between them.

Suspect a priority MNS condition
and go to the relevant module(s) for
assessment



ASSESSMENT FOR MNS CONDITIONS

1 Physical Examination

- » Conduct a targeted physical examination guided by the information found during the MNS assessment.

2 Mental Status Examination (MSE)*

- » Ask about and observe the person's Appearance and Behaviour, Mood and Affect, Content of Thought, any Perceptual disturbances and Cognition. See symptom based Master Chart (MC) for details.

3 Differential Diagnosis

- » Consider the differential diagnosis and rule out conditions that have similar presenting symptoms.

4 Basic Laboratory Tests

- » Request laboratory tests when indicated and possible, especially to rule out physical causes.

5 Identify the MNS Condition

- » Identify the MNS condition using the appropriate module(s).
- » Assess for other MNS symptoms and priority conditions (see Master Chart).
- » Follow the appropriate management algorithm and treatment protocols.



CLINICAL TIP:

Once a MNS disorder is suspected,
always assess for self harm/suicide (»SUI)

***Mental Status Examination adapted for non-specialists may include:** Behavior and Appearance = symptoms and signs involving the way a person looks or acts; Mood and Affect = symptoms and signs involving the regulation and expression of emotions or feeling states; Content of Thought = symptoms and signs involving subject matter of thoughts including delusions, paranoia, suspiciousness and suicidal ideation; Perceptual Disturbance = sensory perceptions occurring in the absence of the appropriate (external) stimulus (e.g. auditory or visual hallucinations). The person may or may not have insight into the unreal nature of the perception; Cognition = symptoms, signs and clinical findings indicative of a disturbance in mental abilities and processes related to attention, memory, judgment, reasoning, problem solving, decision making, comprehension and the integration of these functions.

III. Manage MNS Conditions

Once the assessment is conducted, follow the management algorithm in mhGAP-IG to manage the MNS disorder.

Key steps in management are found in the box below.



MANAGEMENT STEPS FOR MNS CONDITIONS

Many MNS conditions are chronic and require long-term monitoring and follow-up.

Managing a MNS disorder over time involves the following steps.

- 1 Develop a treatment plan in collaboration with the person and their carer.**



CLINICAL TIP:

Written treatment plan should cover:

- Pharmacological interventions (if any)
- Psychosocial interventions
- Referrals
- Follow-up plan
- Management of any concurrent physical and/or other MNS conditions

- 2 Always offer psychosocial interventions for the person and their carers.**

- 3 Treat the MNS disorder using pharmacological interventions when indicated.**

- 4 Refer to specialists or hospital when indicated and available.**

- 5 Ensure that appropriate plan for follow-up is in place.**

- 6 Work together with carer and families** in supporting the person with the MNS disorder.

- 7 Foster strong links** with employment, education, social services (including housing) and other relevant sectors.

- 8 Modify treatment plans for special populations.**

① Treatment Planning

- » Discuss and determine treatment goals that respect the willingness and preferences for care.
- » Involve the carer after obtaining the person's agreement.
- » Encourage self-monitoring of symptoms and explain when to seek care urgently.

② Psychosocial Interventions

A. Psychoeducation

Provide information about the MNS condition to the person, including:

- » What the condition is and its expected course and outcome.
- » Available treatments for the condition and their expected benefits.
- » Duration of treatment.
- » Importance of adhering to treatment, including what the person can do (e.g. taking medication or practising relevant psychological interventions such as relaxation exercises) and what carers can do to help the person adhere to treatment.
- » Potential side-effects (short and long term) of any prescribed medication that the person (and their carers) need to monitor.
- » Potential involvement of social workers, case managers, community health workers or other trusted members in the community.
- » Refer to management section of relevant module(s) for specific information on the MNS disorder.

B. Reduce stress and strengthen social supports

Address current psychosocial stressors:

- » Identify and discuss relevant psychosocial issues that place stress on the person and/or impact their life including, but not limited to, family and relationship problems, employment/occupation/livelihood issues, housing, finances, access to basic security and services, stigma, discrimination, etc.
- » Assist the person to manage stress by discussing methods such as problem solving techniques.
- » Assess and manage any situation of maltreatment, abuse (e.g. domestic violence) and neglect (e.g. of children or the elderly). Discuss with the person possible referrals to a trusted protection agency or informal protection network. Contact legal and community resources, as appropriate.
- » Identify supportive family members and involve them as much as possible and appropriate.
- » Strengthen social supports and try to reactivate the person's social networks.
- » Identify prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychosocial support (e.g. family gatherings, visiting neighbours, community activities, religious activities, etc.).
- » Teach stress management such as relaxation techniques.

C. Promote functioning in daily activities

- » Provide the person support to continue regular social, educational and occupational activities as much as possible.
- » Facilitate inclusion in economic activities.
- » Offer life skills training, and/or social skills training if needed.

D. Psychological Treatment

Psychological treatments are interventions that typically require substantial dedicated time and tend to be provided by specialists trained in providing them. Nonetheless, they can be effectively delivered by trained and supervised non-specialized workers and through guided self-help (e.g. with use of e-mental health programmes or self-help books).

The interventions listed below are described briefly in the glossary.

<u>Example of Intervention</u>	<u>Recommended for</u>
Behavioral Activation	DEP
Relaxation Training	DEP
Problem Solving Treatment	DEP
Cognitive Behavioural Therapy (CBT)	DEP, CMH, SUB, PSY
Contingency Management Therapy	SUB
Family Counseling or Therapy	PSY, SUB
Interpersonal Therapy (IPT)	DEP
Motivational Enhancement Therapy	SUB
Parent Skills Training	CMH

3 Pharmacological Interventions

- » Follow the guidelines on psychopharmacology in each module.
- » Use pharmacological interventions when available and when indicated in the management algorithm and table provided.
- » In selecting the appropriate essential medication, consider the side effect profile of the medication (short and long term), efficacy of past treatment, drug-drug interactions or drug-disease interactions.
- » Consult the National Formulary or the WHO Formulary as needed.
- » Educate the person about risks and benefits of treatment, potential side effects, duration of treatment, and importance of adherence.
- » Exercise caution when providing medication to special groups such as older people, those with chronic disease, women who are pregnant or breastfeeding, and children/adolescents. Consult a specialist as needed.

4 Referral to specialist/hospital if needed

- » Stay alert for situations that may require referral to a specialist/hospital, for example, non-response to treatment, serious side effects with pharmacological interventions, comorbid physical and/or MNS conditions, risk of self-harm/suicide.

5 Follow-up

- » Arrange a follow-up visit after the initial assessment.
 - » After every visit, schedule a follow-up appointment and encourage attendance. Schedule the appointment at a mutually convenient time.
 - » **Schedule initial follow-up visits more frequently until the symptoms begin to respond to treatment.** Once symptoms start improving, schedule less frequent but regular appointments.
 - » **At each follow-up meeting, assess for:**
 - Response to treatment, medication side-effects, and adherence to medications and psychosocial interventions.
 - General health status (be sure to monitor physical health status regularly).
 - Self-care (e.g. diet, hygiene, clothing) and functioning in the person's own environment.
 - Psychosocial issues and/or change in living conditions that can affect management.
 - The person's and the carer's understanding and expectations of the treatment. Correct any misconceptions.
 - » **During the entire follow-up period:**
 - Acknowledge all progress towards the treatment goals and reinforce adherence.
 - Maintain regular contact with the person (and their carer, when appropriate). If available, assign a community worker or another trusted person in the community to support the person (such as a family member).
 - Explain that the person can return to the clinic at any time in between follow-up visits if needed (e.g. for side-effects of medications, etc).
 - Have a plan of action for when the person does not show up for appointments.
 - Use family and community resources to contact people who have not returned for regular follow-up.
 - Consult a specialist if the person does not improve or worsens.
 - Document key aspects of interactions with the person and the family in the case notes.
- » **Refer to the management section of relevant module(s) for disorder-specific follow-up information.**

6 Involving Carers

- » When appropriate, and with the consent of the person concerned, involve the carer or family member in the person's care.
- » Acknowledge that it can be challenging to care for people with MNS conditions.
- » Explain to the carer the importance of respecting the dignity and rights of the person with a MNS condition.
- » Identify psychosocial impact on carers.
- » Assess the carer's needs to ensure necessary support and resources for family life, employment, social activities, and health.
- » Encourage involvement in self-help and family support groups, where available.
- » With the consent of the person, keep carers informed about the person's health status, including issues related to assessment, treatment, follow-up, and any potential side-effects.

7 Links with other sectors

- » To ensure comprehensive care and based on the initial assessment, link the person to employment, education, social services (including housing) and other relevant sectors.

8 Special Populations

CHILDREN / ADOLESCENTS

- » Explore exposure to adverse factors such as violence and neglect which may affect mental health and wellbeing.
- » Assess the needs of carers.
- » Treat adolescents who may come alone for help even if not accompanied by parent or guardian. Obtain informed consent from the adolescent.
- » Allow opportunities for the child/adolescent to express concerns in private.
- » Adapt language to the child/adolescent's level of understanding.
- » Explore available resources within the family, school and community.

WOMEN WHO ARE PREGNANT OR BREAST-FEEDING

- » If the woman is of child-bearing age, ask about:
 - Breastfeeding
 - Possible pregnancy
 - Last menstrual period, if pregnant
- » Liaise with maternal health specialist to organize care.
- » Consider consultation with mental health specialist if available.
- » Exercise caution with pharmacological interventions – check toxicity to fetus and passage into breast milk. Consult a specialist as needed.

OLDER ADULTS

- » Address psychosocial stressors that are particularly relevant to the person, respecting their need for autonomy.
- » Identify and treat concurrent physical health problems and manage sensory deficits (such as low vision or poor hearing) with appropriate devices (e.g. magnifying glass, hearing aids).
- » Use lower doses of medications.
- » Anticipate increased risk of drug interactions.
- » Address needs of carers.

MASTER CHART



Overview of Priority MNS Conditions

1. These common presentations indicate the need for assessment.
2. If people present with features of more than one condition, then all relevant conditions need to be assessed.
3. All conditions apply to all ages, unless otherwise specified.
4. ! For emergency presentations, please see the table on page 18.

COMMON PRESENTATION

PRIORITY CONDITION

- » Multiple persistent physical symptoms with no clear cause
- » Low energy, fatigue, sleep problems
- » Persistent sadness or depressed mood, anxiety
- » Loss of interest or pleasure in activities that are normally pleasurable

DEPRESSION (DEP)

- » Marked behavioural changes; neglecting usual responsibilities related to work, school, domestic or social activities
- » Agitated, aggressive behavior, decreased or increased activity
- » Fixed false beliefs not shared by others in the person's culture
- » Hearing voices or seeing things that are not there
- » Lack of realization that one is having mental health problems

PSYCHOSES (PSY)

- » Convulsive movement or fits/seizures
- » During the convulsion: loss of consciousness or impaired consciousness, stiffness, rigidity, tongue bite, injury, incontinence of urine or faeces
- » After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body

EPILEPSY (EPI)

CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS (CMH)



Common presentations of emotional, behavioral and developmental disorders vary by age in children and adolescents.

Child/adolescent being seen for physical complaints or a general health assessment who has:

- » Problem with development, emotions or behaviour (e.g. inattention, over-activity, or repeated defiant, disobedient and aggressive behaviour)
- » Risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases (e.g. HIV/AIDS or history of difficult birth)

Carer with concerns about the child/adolescent's:

- » Difficulty keeping up with peers or carrying out daily activities considered normal for age

- » Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place and person)
- » Mood or behavioural problems such as apathy (appearing uninterested) or irritability
- » Loss of emotional control (easily upset, irritable or tearful)
- » Difficulties in carrying out usual work, domestic or social activities

- » Appearing affected by alcohol or other substance (e.g. smell of alcohol, slurred speech, sedated, erratic behaviour)
- » Signs and symptoms of acute behavioural effects, withdrawal features or effects of prolonged use
- » Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance)
- » Signs of chronic liver disease (abnormal liver enzymes), jaundiced (yellow) skin and eyes, palpable and tender liver edge (in early liver disease), ascites (distended abdomen is filled with fluid), spider naevi (spider-like blood vessels visible on the surface of the skin), and altered mental status (hepatic encephalopathy)
- » Problems with balance, walking, coordinated movements, and nystagmus

- » Extreme hopelessness and despair
- » Current thoughts, plan or act of self-harm/suicide, or history thereof
- » Any of the other priority conditions, chronic pain, or extreme emotional distress

- » Behaviour (e.g. too active, aggressive, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school)

Teacher with concerns about a child/adolescent

- » e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work

Community health or social services worker with concerns about a child/adolescent

- » e.g. rule- or law-breaking behaviour, physical aggression at home or in the community

DEMENTIA (DEM)



DISORDERS DUE TO SUBSTANCE USE (SUB)

All persons presenting to health care facilities should be asked about their tobacco and alcohol use.

SELF-HARM/SUICIDE (SUI)

! EMERGENCY Presentations of Priority MNS Conditions

EMERGENCY PRESENTATION	CONDITION TO CONSIDER	GO TO
<ul style="list-style-type: none"> » Act of self-harm with signs of poisoning or intoxication, bleeding from self-inflicted wound, loss of consciousness and/or extreme lethargy » Current thoughts, plan, or act of self-harm or suicide, or history of thoughts, plan, or act of self-harm or suicide in a person who is now extremely agitated, violent, distressed or lacks communication » Acute convulsion with loss of consciousness or impaired consciousness » Continuous convulsions 	MEDICALLY SERIOUS ACT OF SELF-HARM	SUI
<ul style="list-style-type: none"> » Agitated and/or aggressive behaviour 	IMMINENT RISK OF SELF-HARM/SUICIDE	
<ul style="list-style-type: none"> » Smell of alcohol on the breath, slurred speech, uninhibited behaviour; disturbance in the level of consciousness, cognition, perception, affect or behaviour » Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea, anxiety; seizure and confusion in severe cases » Unresponsive or minimally responsive, slow respiratory rate, pinpoint pupils » Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of cocaine or other stimulants, increased pulse and blood pressure, aggressive, erratic or violent behaviour 	EPILEPSY STATUS EPILEPTICUS ALCOHOL OR OTHER SEDATIVE WITHDRAWAL	EPI, SUB
	ACUTE ALCOHOL INTOXICATION ALCOHOL WITHDRAWAL ALCOHOL WITHDRAWAL DELIRIUM	DEM, PSY, SUB
	SEDATIVE OVERDOSE OR INTOXICATION	SUB
	ACUTE STIMULANT INTOXICATION OR OVERDOSE	

DEPRESSION

People with depression experience a range of symptoms including persistent depressed mood or loss of interest and pleasure for at least 2 weeks.

People with depression as described in this module have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas.

Many people with depression also suffer from anxiety symptoms and medically unexplained somatic symptoms.

Depression commonly occurs alongside other MNS conditions as well as physical conditions.

The management of symptoms not fully meeting the criteria for depression is covered within the module on Other Significant Mental Health Complaints. Go to » OTH.

DEP » Quick Overview



ASSESSMENT

- » Does the person have depression?
- » Are there other explanations for the symptoms?
 - Rule out physical conditions
 - Rule out a history of mania
 - Rule out normal reactions to recent major loss
- » Assess for other priority MNS conditions



MANAGEMENT

- » Management Protocols
 1. Depression
 2. Depressive episode in bipolar disorder
 3. Special populations
- » Psychosocial Interventions
- » Pharmacological Interventions



FOLLOW-UP



DEP 1 » Assessment

COMMON PRESENTATIONS OF DEPRESSION

- *Multiple persistent physical symptoms with no clear cause*
- *Low energy, fatigue, sleep problems*
- *Persistent sadness or depressed mood, anxiety*
- *Loss of interest or pleasure in activities that are normally pleasurable*

1

Does the person have depression?

Has the person had at least one of the following core symptoms of depression for at least 2 weeks?

- Persistent depressed mood
- Markedly diminished interest in or pleasure from activities



Depression is unlikely
» Go to » OTH

NO

YES



Depression is unlikely
» Go to » OTH



Depression is unlikely
» Go to » OTH

Has the person had several of the following additional symptoms for at least 2 weeks:

- Disturbed sleep or sleeping too much
- Significant change in appetite or weight (decrease or increase)
- Beliefs of worthlessness or excessive guilt
- Fatigue or loss of energy
- Reduced concentration
- Indecisiveness
- Observable agitation or physical restlessness
- Talking or moving more slowly than usual
- Hopelessness
- Suicidal thoughts or acts

NO

YES

Does the person have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

NO

YES

Consider DEPRESSION



CLINICAL TIP:

A person with depression may have psychotic symptoms such as delusions or hallucinations. If present, treatment for depression needs to be adapted. **CONSULT A SPECIALIST.** 

2

Are there other possible explanations
for the symptoms?

IS THIS A PHYSICAL CONDITION THAT CAN RESEMBLE OR EXACERBATE DEPRESSION?

Are there signs and symptoms suggesting anaemia, malnutrition,
hypothyroidism, mood changes from substance use and medication side-effects
(e.g. mood changes from steroids)?

» MANAGE THE
PHYSICAL CONDITION

YES

NO

Do depressive symptoms remain
after treatment?

NO

YES

No treatment
needed.

IS THERE A HISTORY OF MANIA?

Have several of the following symptoms occurred simultaneously, lasting for at least 1 week, and severely enough to interfere significantly with work and social activities or requiring hospitalization or confinement?

- Elevation of mood and/or irritability
- Decreased need for sleep
- Increased activity, feeling of increased energy, increased talkativeness or rapid speech
- Impulsive or reckless behaviours such as excessive spending, making important decisions without planning and sexual indiscretion
- Loss of normal social inhibitions resulting in inappropriate behaviours
- Being easily distracted
- Unrealistically inflated self-esteem

NO

YES

**DEPRESSIVE EPISODE
IN BIPOLAR
DISORDER is likely**

**CLINICAL TIP:**

People with depressive episode in bipolar disorder are at risk for mania. Treatment is different from depression. **Protocol 2 must be applied.**

» Go to **STEP 3** then to **PROTOCOL 2**

**HAS THERE BEEN A MAJOR LOSS (E.G. BEREAVEMENT)
WITHIN THE LAST 6 MONTHS?**

YES

NO

DEPRESSION is likely

» Go to **STEP 3** then to **PROTOCOL 1**

Are any of the following symptoms present?

- Suicidal ideation
- Beliefs of worthlessness
- Psychotic symptoms
- Talking or moving more slowly than normal

Does the person have a previous history of depression?

NO

YES

DEPRESSION is likely

Do not manage for depression.
» Go to »OTH

NO

YES

3

Are there concurrent priority MNS conditions?

! IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing. Go to »SUI.

» **Assess for concurrent MNS conditions according to the mhGAP-IG master chart. Go to »MC.**

! *People with depression are at higher risk for most other priority MNS conditions.
Assess for disorders due to substance use.*



» **Go to PROTOCOL 1**



DEP 2 » Management

PROTOCOL

1

Depression

- » Provide psychoeducation to the person and their carers. (2.1)
- » Reduce stress and strengthen social supports. (2.2)
- » Promote functioning in daily activities and community life. (2.3)
- » Consider antidepressants. (2.5)
- » If available, consider referral for one of the following brief psychological treatments: interpersonal therapy (IPT), cognitive behavioural therapy (CBT), behaviour activation and problem-solving counselling. (2.4)
- » **✗ DO NOT** manage the symptoms with ineffective treatments, e.g. vitamin injections.
- » Offer regular follow-up.

PROTOCOL

2

Depression in Bipolar Disorder

- » Consult a specialist.
- » If a specialist is not immediately available, follow treatment for depression (**PROTOCOL 1**). However, NEVER prescribe antidepressants alone without a mood stabilizer such as lithium, carbamazepine or valproate because antidepressants can lead to mania in people with bipolar disorder (Go to **» PSY**).
- » If symptoms of mania develop, tell the person and the carers to stop the antidepressant immediately and return for help.

Special populations

Note that interventions may differ for these populations



CHILD / ADOLESCENT

- » For management of depression in children/adolescents, go to **» CMH**.



WOMEN WHO ARE PREGNANT OR BREASTFEEDING

- » Follow treatment for depression (**PROTOCOL 1**) but AVOID antidepressants if possible, especially during the first trimester.
- » If no response to psychological treatment, consider using with caution the lowest effective dose of antidepressants.
- » If breastfeeding, avoid long acting medication such as fluoxetine.
- » **CONSULT A SPECIALIST**, if available.

PSYCHOSOCIAL INTERVENTIONS



2.1 Psychoeducation: key messages to the person and the carers

- » Depression is a very common condition that can happen to anybody.
- » The occurrence of depression does not mean that the person is weak or lazy.
- » Negative attitudes of others (e.g. "You should be stronger", "Pull yourself together") may be because depression is not a visible condition, unlike a fracture or a wound. There is also the misconception that people with depression can easily control their symptoms by sheer willpower.
- » People with depression tend to have unrealistically negative opinions about themselves, their life and their future. Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression improves.
- » Thoughts of **self-harm or suicide** are common. If they notice these thoughts, they should not act on them, but should tell a trusted person and come back for help immediately.

2.2 Reduce stress and strengthen social support

- » Assess for and try to reduce stressors. (Go to » **ECP**)
- » Reactivate the person's previous social network. Identify prior social activities that, if started again, may potentially provide direct or indirect psychosocial support, e.g. family gatherings, visiting neighbours, and community activities.

2.3 Promote functioning in daily activities and community life

- » Even if it is difficult, encourage the person to try to do as many of the following as possible:
 - Try to start again (or continue) activities that were previously pleasurable.
 - Try to maintain regular sleeping and waking times.
 - Try to be as physically active as possible.
 - Try to eat regularly despite changes in appetite.
 - Try to spend time with trusted friends and family.
 - Try to participate in community and other social activities as much as possible.
- » Explain to the person and carer that these activities can all help improve mood.

2.4 Brief psychological treatments for depression

- » This guide does not provide specific protocols to implement brief psychological interventions. WHO, among other agencies, has developed manuals that describe their use for depression. An example is, Problem Management Plus, (http://www.who.int/mental_health/emergencies/problem_management_plus/en/), which describes the use of behavioural activation, relaxation training, problem solving treatment and strengthening social supports. Moreover, the manual Group Interpersonal Therapy (IPT) for Depression describes group treatment of depression (http://www.who.int/mental_health/mhgap/interpersonal_therapy/en). Thinking Healthy, (http://www.who.int/mental_health/maternal-child/thinking_healthy/en), describes the use of cognitive-behavioural therapy for perinatal depression.

PHARMACOLOGICAL INTERVENTIONS

2.5 Consider antidepressants

- » Discuss with the person and decide together whether to prescribe antidepressants. Explain that:
 - Antidepressants are not addictive.
 - It is very important to take the medication every day as prescribed.
 - Some side effects may be experienced within the first few days but they usually resolve.
 - It usually takes several weeks before improvements in mood, interest or energy is noticed.
- » Consider the person's age, concurrent medical conditions, and drug side-effect profile.
- » Start with only one medication at the lowest starting dose.
- » Antidepressant medications usually need to be continued for at least 9-12 months after the resolution of symptoms..
- » Medications should never be stopped just because the person experiences some improvement. Educate the person on the recommended timeframe to take medications.

CAUTION

- » If the person develops a manic episode, stop the anti-depressant immediately; it may trigger a manic episode in untreated bipolar disorder.
- » Do not combine with other antidepressants, as this may cause serotonin syndrome.
- » Antidepressants may increase suicidal ideation, especially in adolescents and young adults.

Antidepressants in special populations

ADOLESCENTS 12 YEARS OF AGE OR OLDER

- » If symptoms persist or worsen despite psychosocial interventions, consider fluoxetine (but no other selective serotonin reuptake inhibitor (SSRI) or tricyclic antidepressant (TCA)).
- » If fluoxetine is prescribed, ask the adolescent to return weekly, for the first 4 weeks, to monitor thoughts or plans of suicide. 

WOMEN WHO ARE PREGNANT OR BREASTFEEDING

- » Avoid antidepressants, if possible.
- » Consider antidepressants at the lowest effective dose if there is no response to psychosocial interventions.
- » If the woman is breastfeeding, avoid long acting antidepressant medication such as fluoxetine.
- » Consult a specialist if available. 

OLDER ADULTS

- » Avoid amitriptyline if possible.

PEOPLE WITH CARDIOVASCULAR DISEASE

- »  Do NOT prescribe amitriptyline.

ADULTS WITH THOUGHTS OR PLANS OF SUICIDE

- » SSRIs are the first choice. Overdose of TCAs such as amitriptyline may be fatal and therefore should be avoided in this group.
- » If there is an imminent risk of self-harm or suicide (Go to » SUI), give a limited supply of antidepressants (e.g. one week supply at a time).
- » Ask the person's carers to keep and monitor medications and to follow-up frequently to prevent medication overdose.

TABLE 1: Antidepressants

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINdications / CAUTIONS
AMITRIPTYLINE <i>(a tricyclic antidepressant (TCA))</i>	<p>Start 25 mg at bedtime.</p> <p>Increase by 25-50 mg per week to 100-150 mg daily (maximum 300 mg).</p> <p>Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses.</p> <p>Elderly/Medically Ill: Start 25 mg at bedtime to 50-75 mg daily (maximum 100 mg).</p> <p> Children/Adolescents: Do not use.</p>	<p>Common: Sedation, orthostatic hypotension (risk of fall), blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction.</p> <p>Serious: ECG changes (e.g. QTc prolongation), cardiac arrhythmia, increased risk of seizure.</p>	<p>Avoid in persons with cardiac disease, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma, and bipolar disorder (can trigger mania in people with untreated bipolar disorder).</p> <p>Overdose can lead to seizures, cardiac arrhythmias, hypotension, coma, or death.</p> <p>Levels of amitriptyline may be increased by anti-malarials including quinine.</p>
FLUOXETINE <i>(a selective serotonin reuptake inhibitor (SSRI))</i>	<p>Start 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg (maximum 80 mg).</p> <p>Elderly/medically ill: preferred choice.</p> <p>Start 10 mg daily, then increase to 20 mg (maximum 40 mg).</p> <p> Adolescents</p> <p>Start 10 mg daily. Increase to 20 mg daily if no response in 6 weeks (maximum 40 mg).</p>	<p>Common: Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction.</p> <p>Serious: bleeding abnormalities in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.</p>	<p>Caution in persons with history of seizure.</p> <p>Drug-Drug interactions: Avoid combination with warfarin (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers.</p> <p>Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).</p>



DEP 3 » Follow-up

1

ASSESS FOR IMPROVEMENT

Is the person improving?

NO

YES



RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » Schedule the second appointment within 1 week.
- » Initially maintain regular contact via telephone, home visits, letters, or contact cards more frequently, e.g. monthly, for the first 3 months.

- » If not yet receiving psychological treatment, consider psychological treatment.
- » If receiving a psychological treatment, evaluate engagement in and experience of current psychological treatment.
- » If not yet on antidepressants, consider antidepressants.
- » If on antidepressants, assess:
 - Does the person take the medication as prescribed?
If not, explore reasons why and encourage adherence.
 - Are there side effects?

If yes, evaluate and weigh benefits of treatment.
If no to side effects to antidepressants, increase dose (**TABLE 1**).
Follow-up in 1-2 weeks.
- » **CAUTION WITH DOSE INCREASE.** CLOSE FOLLOW-UP NEEDED DUE TO POSSIBLE INCREASE IN SIDE EFFECTS.

- » Encourage the person to continue with their current management plan until they are *symptom free for 9-12 months*.
- » **Arrange a further follow up appointment in 1-2 weeks.**
- » Decrease contact as the person's symptoms improve, e.g. once every 3 months after the initial 3 months.

Note: follow up should continue until the person no longer has any symptoms of depression.

Are there symptoms of mania?

YES

NO

- » Discontinue antidepressant medication.
- » Treat mania and consult a specialist. 

2 MONITOR TREATMENT

At every contact:

- » Provide psychoeducation, reduce stress and strengthen social supports, promote functioning in daily activities and community life, and review, if applicable, antidepressant medication use and psychological treatment.
- » Does the person have any new symptoms of concern? Review for MNS and concurrent physical conditions.
- » Is the person a woman of childbearing age and considering pregnancy? If so, CONSULT A SPECIALIST. 
- ⚠ Assess for any IMMINENT RISK OF SUICIDE (Go to »SUI).

3

REVISE TREATMENT AS APPROPRIATE

Has the person been symptom free for 9-12 months?

NO

YES

- » Continue medication until person is symptom free for 9-12 months.

- » Discuss with the person the risks and benefits of stopping the medication.
- » Taper the dose of medication gradually, over a minimum of 4 weeks. Monitor the person for symptom recurrence.

DEPRESSION

PSYCHOSES

The psychoses module covers management of two severe mental health conditions, psychosis and bipolar disorder. People with psychosis or bipolar disorder are at high risk of exposure to stigma, discrimination and violation of their right to live with dignity.

Psychosis is characterised by distorted thoughts and perceptions, as well as disturbed emotions and behaviours. Incoherent or irrelevant speech may also be present. Symptoms such as hallucinations – hearing voices, or seeing things that are not there; delusions – fixed, false beliefs; severe abnormalities of behaviour – disorganised behaviour, agitation, excitement, inactivity, or hyperactivity; disturbances of emotion – marked apathy, or disconnect between reported emotion and observed affect, such as facial expression and body language, may also be detected.

Bipolar disorder is characterized by episodes in which the person's mood and activity levels are significantly disturbed. This disturbance consists on some occasions of an elevation of mood and increased energy and activity (mania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is complete between episodes. People who experience only manic episodes are also classified as having bipolar disorder.

PSY » Quick Overview



ASSESSMENT

» Explore other explanations for the symptoms

- EVALUATE FOR MEDICAL CONDITIONS

e.g. rule out delirium, medications and metabolic abnormalities

- EVALUATE FOR OTHER RELEVANT MNS CONDITIONS

» Assess for acute manic episode

» Evaluate if the person has psychosis



MANAGEMENT

» Management Protocols

1. Bipolar disorder – manic episode
2. Psychosis
3. Special populations: women who are pregnant or breast-feeding, adolescents, and older adults

» Psychosocial Interventions

» Pharmacological Interventions

1. Psychosis: initiation of antipsychotics
2. Manic episode: initiation of mood stabilizer or antipsychotic; avoid antidepressants



FOLLOW-UP



PSY 1 » Assessment

COMMON PRESENTATIONS OF PSYCHOSES

- *Marked behavioural changes, neglecting usual responsibilities related to work, school, domestic or social activities.*
- *Agitated, aggressive behaviour, decreased or increased activity.*
- *Fixed false beliefs not shared by others in the person's culture.*
- *Hearing voices or seeing things that are not there.*
- *Lack of realization that one is having mental health problems.*

1

Are there any other explanations for the symptoms?

» EVALUATE FOR MEDICAL CONDITIONS

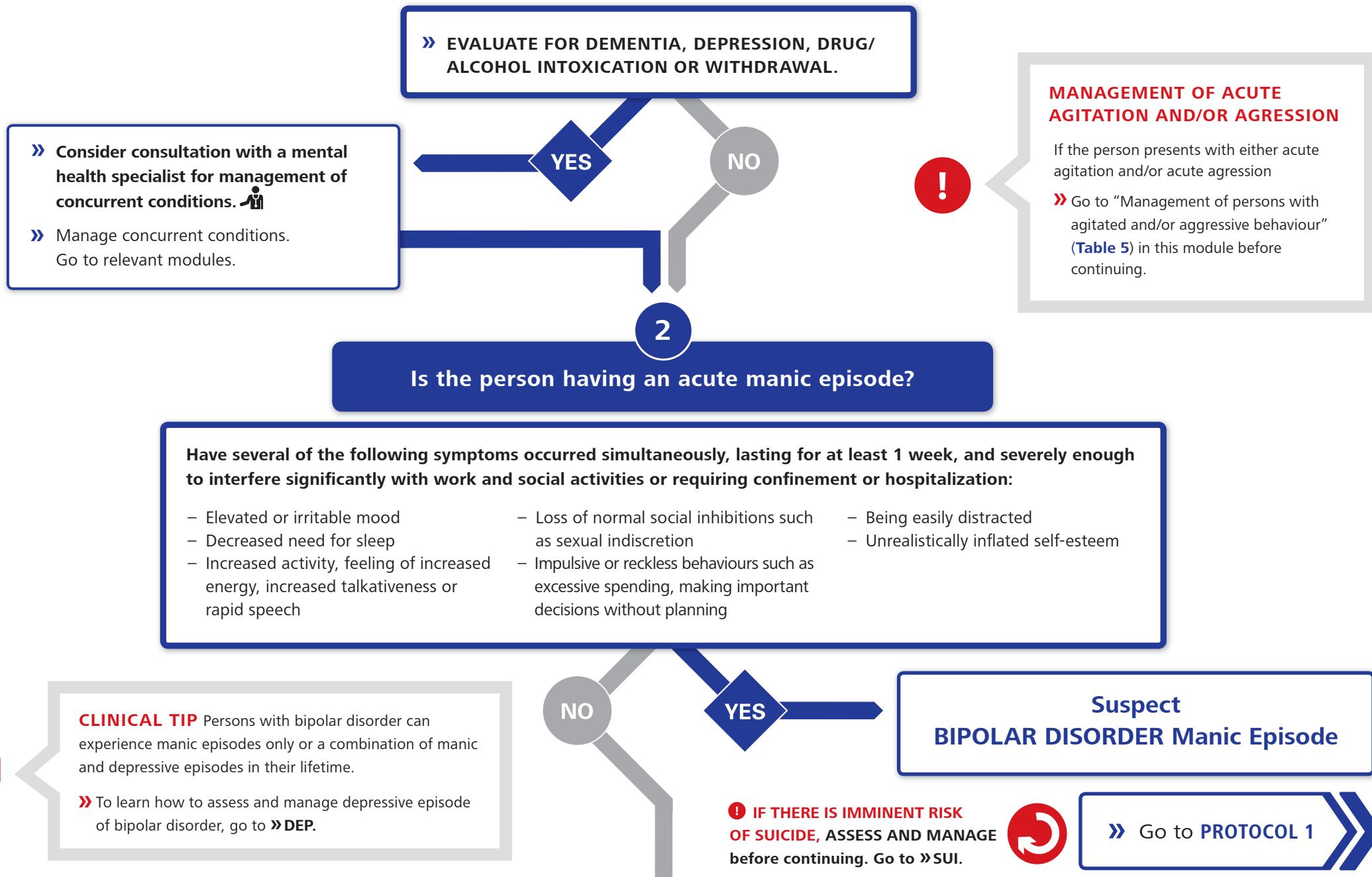
By history, clinical examination, or laboratory findings, are there signs and symptoms suggesting **delirium** due to an acute physical condition, e.g. infection, cerebral malaria, dehydration, metabolic abnormalities (such as hypoglycaemia or hyponatraemia); **or medication side effects**, e.g. due to some antimalarial medication or steroids?

» Assess and manage the acute physical condition, and refer to emergency services/specialist as needed.

» If symptoms persist after management of the acute cause, go to **STEP 2**

YES

NO



3

Does the person have psychosis?

Does the person have at least two of the following:

- Delusions, fixed false beliefs not shared by others in the person's culture
- Hallucinations, hearing voices or seeing things that are not there
- Disorganized speech and/or behaviour, e.g. incoherent/irrelevant speech such as mumbling or laughing to self, strange appearance, signs of self-neglect or appearing unkempt

NO

YES



» Consider consultation with specialist to review other possible causes of psychoses.

Suspect PSYCHOSIS

» Go to **PROTOCOL 2**

❗ IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing. Go to »SUI.





PSY 2 » Management

PROTOCOL

1

Manic Episode in Bipolar Disorder

- » Provide **psychoeducation** to the person and carers. (2.1)
- » **Pharmacological Intervention.** (2.6)
 - ❗ **If patient is on antidepressants – DISCONTINUE** to prevent further risk of mania.
 - **Begin treatment** with lithium, valproate, carbamazepine, or with antipsychotics. Consider a short term (2-4 weeks maximum) benzodiazepine for behavioural disturbance or agitation.
- » Promote functioning in daily activities. (2.3)
- » Ensure safety of the person and safety of others.
- » Provide regular follow-up.
- » Support rehabilitation in the community.
- » Reduce stress and strengthen social supports. (2.2)

PROTOCOL

2

Psychosis

- » Provide **psychoeducation** to the person and carers. (2.1)
- » **Begin antipsychotic medication.** (2.5)
 - Start with a low dose within the therapeutic range and increase slowly to the lowest effective dose, in order to reduce the risk of side-effects.
- » Promote functioning in daily activities. (2.3)
- » Ensure safety of the person and safety of others.
- » Provide regular follow-up.
- » Support rehabilitation in the community.
- » Reduce stress and strengthen social supports. (2.2)

Special populations

Note that interventions may differ for PSYCHOSES in these populations



WOMEN WHO ARE PREGNANT OR BREASTFEEDING

- » Liaise with maternal health specialists to organize care.
- » Consider consultation with mental health specialist if available.
- » Explain the risk of adverse consequences for the mother and her baby, including obstetric complications and psychotic relapses, particularly if medication stopped.
- » Consider pharmacological intervention when appropriate and available. See below.

Pharmacological Interventions

PSYCHOSIS

- » In women with psychosis who are planning a pregnancy or pregnant or breastfeeding, low-dose oral haloperidol, or chlorpromazine may be considered.
- » Anticholinergics should NOT be prescribed to women who are pregnant due to extrapyramidal side-effects of antipsychotic medications, except in cases of acute, short-term use.
- » Depot antipsychotics should not be routinely prescribed to women with psychotic disorders who are planning a pregnancy, pregnant, or breastfeeding because there is relatively little information on their safety in this population.

MANIC EPISODE IN BIPOLAR DISORDER

- » AVOID VALPROATE, LITHIUM and CARBAMAZEPINE during pregnancy and breastfeeding due to the risk of birth defects.
- » Consider low-dose haloperidol with caution and in consultation with a specialist, if available.
- » Weigh the risks and benefits of medications in women of childbearing age.
- » If a pregnant woman develops acute mania while taking mood stabilizers, consider switching to low dose haloperidol.



ADOLESCENTS

- » Consider consultation with mental health specialist.
- » In adolescents with psychotic or bipolar disorder, **risperidone** can be offered as a treatment option only under supervision of a specialist.
- » If treatment with risperidone is not feasible, **haloperidol** or **chlorpromazine** may be used only under supervision of a specialist.



OLDER ADULTS

- » Use lower doses of medication.
 - » Anticipate an increased risk of drug-drug interactions.
- ! CAUTION**
- Antipsychotics carry an increased risk of cerebrovascular events and death in older adults with dementia-related psychosis.

PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

Key messages for the person and their carers:

- » Explain that the symptoms are due to a mental health condition, that psychosis and bipolar disorders can be treated, and that the person can recover. Clarify common misconceptions about psychosis and bipolar disorder.
- »  Do not blame the person or their family or accuse them of being the cause of the symptoms.
- » Educate the person and the family that the person needs to take the prescribed medications and return for follow-up regularly.
- » Explain that return and/or worsening of symptoms are common and that it is important to recognize these early and visit to the health facility as soon as possible.
- » Plan a regular work or school schedule that **avoids sleep deprivation and stress** for both the person and the carers. Encourage the person to solicit advice about major decisions especially ones involving money or major commitments.

CLINICAL TIP

Build rapport with the person.

Mutual trust between the person and the health-care provider is critical to ensure treatment adherence and long-term outcomes.



- » Recommend **avoiding alcohol, cannabis or other non-prescription drugs**, as they can worsen the psychotic or bipolar symptoms.

- » Advise them about maintaining a healthy lifestyle, e.g. a balanced diet, physical activity, regular sleep, good personal hygiene, and no stressors. Stress can worsen psychotic symptoms. *Note: Lifestyle changes should be continued as long as needed, potentially indefinitely. These changes should be planned and developed for sustainability.*

2.2 Reduce stress and strengthen social supports

- » Coordinate with available health and social resources to meet the family's physical, social, and mental health needs.
- » Identify the person's prior social activities that, if reinitiated, would have the potential to provide direct or indirect psychological and social support, e.g. family gatherings, outings with friends, visiting neighbors, social activities at work sites, sports, and community activities. Encourage the person to resume these social activities and advise family members about this.
- » Encourage the person and carers to improve social support systems.



CLINICAL TIP

Ensure persons with psychosis are treated with respect and dignity. For further details go to »ECP.

2.3 Promote functioning in daily living activities

- » Continue regular social, educational and occupational activities as much as possible. It is best for the person to have a job or to be otherwise meaningfully occupied.
- » Facilitate inclusion in economic activities, including culturally appropriate supported employment.
- » Offer life skills training and/or social skills training to enhance independent living skills for people with psychosis and bipolar disorders and for their families and/or carers.
- » Facilitate, if available and needed, independent living and supported housing that is culturally and contextually appropriate in the community.

2.4 General advice for carers

- »  Do not try to convince the person that his or her beliefs or experiences are false or not real. Try to be neutral and supportive, even when the person shows unusual behaviour.
- »  Avoid expressing constant or severe criticism or hostility towards the person with psychosis.
- » Give the person freedom of movement. Avoid restraining the person, while also ensuring that their basic security and that of others is met.
- » In general it is better for the person to live with family or community members in a supportive environment outside of the hospital setting. Long-term hospitalization should be avoided.

PHARMACOLOGICAL INTERVENTIONS

! FOR SPECIAL POPULATIONS, (women who are pregnant or breastfeeding, children/adolescents, and older adults), see detailed recommendations.

2.5 Psychosis

- » Antipsychotics should routinely be offered to a person with psychosis.
- » **Start antipsychotic medication immediately.** See **Table 1**.
- » Prescribe one antipsychotic at a time.
- » Start at lowest dose and titrate up slowly to reduce risk of side effects.
- » Try the medication at a **typically effective dose for at least 4-6 weeks** before considering it ineffective.
- » Continue to monitor at that dose as frequently as possible and as required for the first 4-6 weeks of therapy. If there is no improvement, see **Follow-up** and **Table 4**. 
- » Monitor weight, blood pressure, fasting sugar, cholesterol and ECG for persons on antipsychotics if possible (see below).

! CAUTION!

» Side effects to look for:

- **Extrapyramidal side effects (EPS):** akathisia, acute dystonic reactions, tremor, cog-wheeling, muscular rigidity, and tardive dyskinesia. Treat with anticholinergic medications when indicated and available (see **Table 2**).
- **Metabolic changes:** weight gain, high blood pressure, increased blood sugar and cholesterol.
- **ECG changes (prolonged QT interval):** monitor ECG if possible.
- **Neuroleptic malignant syndrome (NMS):** a rare, potentially life-threatening disorder characterized by muscular rigidity, elevated temperature, and high blood pressure.

2.6 Manic Episode in Bipolar Disorder

If patient is on antidepressants:

- » **DISCONTINUE ANTIDEPRESSANTS** to prevent further risk of mania.
- » **Begin treatment with lithium, valproate, carbamazepine, or with antipsychotics** (see **Table 3**).

Lithium: consider using lithium as first line treatment of bipolar disorder only if clinical and laboratory monitoring are available, and prescribe only under specialist supervision. If laboratory examinations are not available or feasible, lithium should be avoided and valproate or carbamazepine should be considered. Erratic compliance or stopping lithium treatment suddenly may increase the risk of relapse. Do not prescribe lithium where the lithium supply may be frequently interrupted. Obtain kidney and thyroid function, complete blood count, ECG, and pregnancy tests before beginning treatment if possible.

Valproate and Carbamazepine: Consider these medications if clinical or laboratory monitoring for lithium is not available or if specialist is not available to supervise lithium prescription.

Haloperidol and risperidone: consider haloperidol and risperidone only if no clinical or laboratory monitoring is available to start lithium or valproate. Risperidone can be used as an alternative to haloperidol in individuals with bipolar mania if availability can be assured, and cost is not a constraint.

! CAUTION

! For women who are pregnant or breastfeeding, avoid valproate, lithium and carbamazepine. Use of **low-dose haloperidol is recommended with caution and under the care of a specialist, if available.**

- » **Consider a short term (2-4 weeks maximum) benzodiazepine for behavioural disturbances or agitation:**
 - Persons with mania who are experiencing agitation may benefit from short-term (2-4 weeks maximum) use of a benzodiazepine such as diazepam.
 - Benzodiazepines should be discontinued gradually as soon as symptoms improve, as tolerance can develop.
- » Continue maintenance treatment for at least 2 years after the last bipolar episode. 
 - Lithium or valproate can be offered for the maintenance treatment of bipolar disorder. *If treatment with one of these agents is not feasible, haloperidol, chlorpromazine or carbamazepine may be used. Offer maintenance treatment in primary care settings under specialist supervision.*

TABLE 1: Antipsychotic medications

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINdications/cautions
HALOPERIDOL	Start 1.5-3 mg daily. Increase as needed (maximum 20 mg daily). Route: oral (p.o.) or intramuscular (i.m.).	Common: sedation, dizziness, blurred vision, dry mouth, urinary retention, constipation. Serious: orthostatic hypotension, extrapyramidal side effects (EPS), ECG changes (prolonged QT interval), weight gain, galactorrhea, amenorrhea, Neuroleptic malignant syndrome (NMS).	Caution in patients with: kidney disease, liver disease, cardiac disease, long QT syndrome or taking QT-prolonging medications. Monitor ECG if possible.
RISPERIDONE	Start 1 mg daily. Increase to 2-6 mg daily (maximum 10 mg). Route: p.o.	Common: sedation, dizziness, tachycardia. Serious: orthostatic hypotension, metabolic effects (elevated lipids, insulin resistance, weight gain), EPS, elevated prolactin, sexual dysfunction, NMS.	Caution in patients with: cardiac disease. Drug-drug interactions: carbamazepine can reduce levels of risperidone, whereas fluoxetine can increase levels.
CHLORPROMAZINE	Start 25-50 mg daily. Increase to 75-300 mg daily (up to 1000 mg may be necessary for severe cases). Route: p.o.	Common: sedation, dizziness, blurred vision, dry mouth, urinary retention, constipation, tachycardia. Serious: orthostatic hypotension, syncope, EPS, photosensitivity, weight gain, galactorrhea, amenorrhea, sexual dysfunction, priapism, NMS, agranulocytosis, jaundice.	Contraindications: impaired consciousness, bone marrow depression, pheochromocytoma. Caution in patients with: respiratory disease, kidney disease, liver disease, glaucoma, urinary retention, cardiac disease, long QT syndrome or taking QT-prolonging medications. Monitor ECG if possible. Drug-drug interactions: <ul style="list-style-type: none">– Increases effects of blood pressure lowering medications.– Lowers blood pressure if combined with epinephrine.– Levels may be increased by antimalarials including quinine.
FLUPHENAZINE depot/long-acting	Start 12.5 mg. Use 12.5-50 mg every 2-4 weeks. Route: i.m. in gluteal region.  Avoid in women who are pregnant/breastfeeding.  Do not use in children/adolescents.	Common: sedation, dizziness, blurred vision, dry mouth, urinary retention, constipation, tachycardia. Serious: orthostatic hypotension, syncope, EPS, photosensitivity, weight gain, galactorrhea, amenorrhea, sexual dysfunction, priapism, NMS, agranulocytosis, jaundice.	Contraindications: impaired consciousness, parkinsonism. Caution in patients with: cardiac disease, kidney disease, liver disease. Use with caution in older adults. Drug-drug interactions: <ul style="list-style-type: none">– Increases effects of blood pressure lowering medications.– Can lower blood pressure if used with epinephrine.

TABLE 2: Anticholinergic medications

(for treatment of extrapyramidal side effects (EPS))  **Avoid in women who are pregnant or breastfeeding if possible.**

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINdications/CAUTIONS
BIPERIDEN	Start 1 mg twice daily. Increase to 3-12 mg daily. Route: p.o or intravenous (i.v.).	Common: sedation, confusion and memory disturbance (especially in older adults), tachycardia, dry mouth, urinary retention and constipation. Rarely, angle-closure glaucoma, myasthenia gravis and gastrointestinal obstruction.	Caution in patients with: cardiac, liver, or kidney disease. Drug-drug interactions: Caution when combining with other anticholinergic medications.
TRIHEXYPHENIDYL (Benzhexol)	Start 1 mg daily. Increase to 4-12 mg per day in 3-4 divided doses (maximum 20 mg daily). Route: p.o		

TABLE 3: Mood stabilizers **Avoid in women who are pregnant or breastfeeding if possible.**

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINdications/CAUTIONS
LITHIUM ! Use only if clinical and laboratory monitoring are available.	Start 300 mg daily. Increase gradually every 7 days until target blood level reached (maximum 600-1200 mg daily). Monitor every 2-3 months. Route: p.o Target blood levels: 0.6-1.0 mEq/liter – In acute manic episode: 0.8-1.0 mEq/liter – For maintenance treatment: 0.6-0.8 mEq/liter. <i>6 months on medication is needed to determine full effectiveness of maintenance treatment.</i>	Common: sedation, cognitive problems, tremor, impaired coordination, hypotension, leukocytosis, polyuria, polydipsia, nausea, diarrhea, weight gain, hair loss, rash. Serious: diabetes insipidus, hypothyroidism, ECG changes (arrhythmia, sick sinus syndrome, T-wave changes).	Contraindicated in patients with: severe cardiac or kidney disease. Dehydration can increase lithium levels. Drug-drug interactions: nonsteroidal anti-inflammatory drugs (NSAIDs), angiotensin-converting-enzyme inhibitor (ACE inhibitor), thiazide diuretics, metronidazole, and tetracycline can increase lithium levels. Lithium toxicity can cause seizures, delirium, coma, and death.
SODIUM VALPROATE	Start 500 mg daily. Increase slowly to 1000-2000 mg daily (maximum 60 mg/kg/day). Route: p.o HIV Preferred choice in persons living with HIV/AIDS due to drug-drug interactions.	Common: sedation, headache, tremor, ataxia, nausea, vomiting, diarrhea, weight gain, transient hair loss. Serious: impaired hepatic function, thrombocytopenia, leucopenia, drowsiness/confusion, liver failure, hemorrhagic pancreatitis.	Caution in patients with: underlying or suspected hepatic disease. Monitor liver function tests and platelets if possible. Drug-drug interactions: Valproate levels decreased by carbamazepine, increased by aspirin.
CARBAMAZEPINE	Start 200 mg daily. Increase by 200 mg weekly to 400-600 mg daily in two divided doses (maximum 1200 mg daily). Route: p.o Note: Dose may need to be adjusted after 2 weeks due to induction of its own metabolism.	Common: sedation, confusion, dizziness, ataxia, double vision, nausea, diarrhea, benign leucopenia. Serious: hepatotoxicity, cardiac conduction delay, low sodium levels, severe rash.	Contraindicated in patients with: history of blood disorders, kidney, liver, or cardiac disease. Drug-drug interactions: – May reduce the effects of hormonal birth control, immunosuppressants, antiepileptics, antipsychotics, methadone and some antiretrovirals. – Levels can be increased by certain antifungals and antibiotics.

TABLE 4: Review adherence, side effects and dosing based on clinical situation/ presentation

CLINICAL SITUATION	ACTION
The person is not tolerating antipsychotic medication, i.e. the person has extrapyramidal symptoms (EPS) or other serious side effects	<ul style="list-style-type: none"> » Reduce the dose of antipsychotic medication. » If side-effects persist, consider switching to another antipsychotic medication. » Consider adding anticholinergic medication for short-term use to treat EPS if these strategies fail or if symptoms are severe (see Table 2).
Adherence to treatment is unsatisfactory	<ul style="list-style-type: none"> » Discuss reasons for non-adherence with the person and carers. » And provide information regarding importance of medication. » Consider depot/long-acting injectable antipsychotic medication as an option after discussing possible side effects of oral versus depot preparations.
Treatment response is inadequate (i.e. symptoms persist or worsen) despite adherence to medication	<ul style="list-style-type: none"> » Verify that the person is receiving an effective dose of medication. If the dose is low, increase gradually to lowest effective dose to reduce the risk of side effects. » Enquire about alcohol or substance use and take measures to reduce this. Go to »SUB. » Enquire about recent stressful event that may have led to worsening of clinical condition and take measures to reduce stress. » Review symptoms to rule out physical and/or other priority MNS conditions. Go to »PSY 1, see STEP 1 » Consider risperidone as an alternative to haloperidol or chlorpromazine, if cost and availability are not constraints. » If the person does not respond to adequate dose and duration of more than one antipsychotic medication, using one medicine at a time, then antipsychotic combination treatment may be considered; preferably under the supervision of a specialist, with close clinical monitoring. » Consider consultation with a specialist for the use of clozapine in those who have not responded to other antipsychotic medications at adequate doses and durations. Only use clozapine under the supervision of a specialist and only if routine laboratory monitoring is available, due to the risk of life-threatening agranulocytosis.

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour !

ASSESSMENT

- » Attempt to communicate with the person.
- » Evaluate for underlying cause:
 - **Check Blood Glucose.** If low, give glucose.
 - **Check vital signs,** including temperature and oxygen saturation. Give oxygen if needed.
 - **Rule out delirium and medical causes** including poisoning.
 - **Rule out drug and alcohol use.** Specifically consider **stimulant intoxication** and/or **alcohol/sedative withdrawal.** Go to » SUB.
 - **Rule out agitation due to psychosis or manic episode in bipolar disorder.** Go to **Assessment, » PSY 1.**

COMMUNICATION

- » Safety is first!
- » Remain calm and encourage the patient to talk about his or her concerns.
- » Use a calm voice and try to address the concerns if possible.
- » Listen attentively. Devote time to the person.
- » Never laugh at the person.
- » Do not be aggressive back.
- » Try to find the source of the problem and solutions for the person.
- » Involve carers and other staff members.
- » Remove from the situation anyone who may be a trigger for the aggression.
- » If all possibilities have been exhausted and the person is still aggressive, it may be necessary to use medication (if available) to prevent injury.

SEDATION AND USE OF MEDICATION

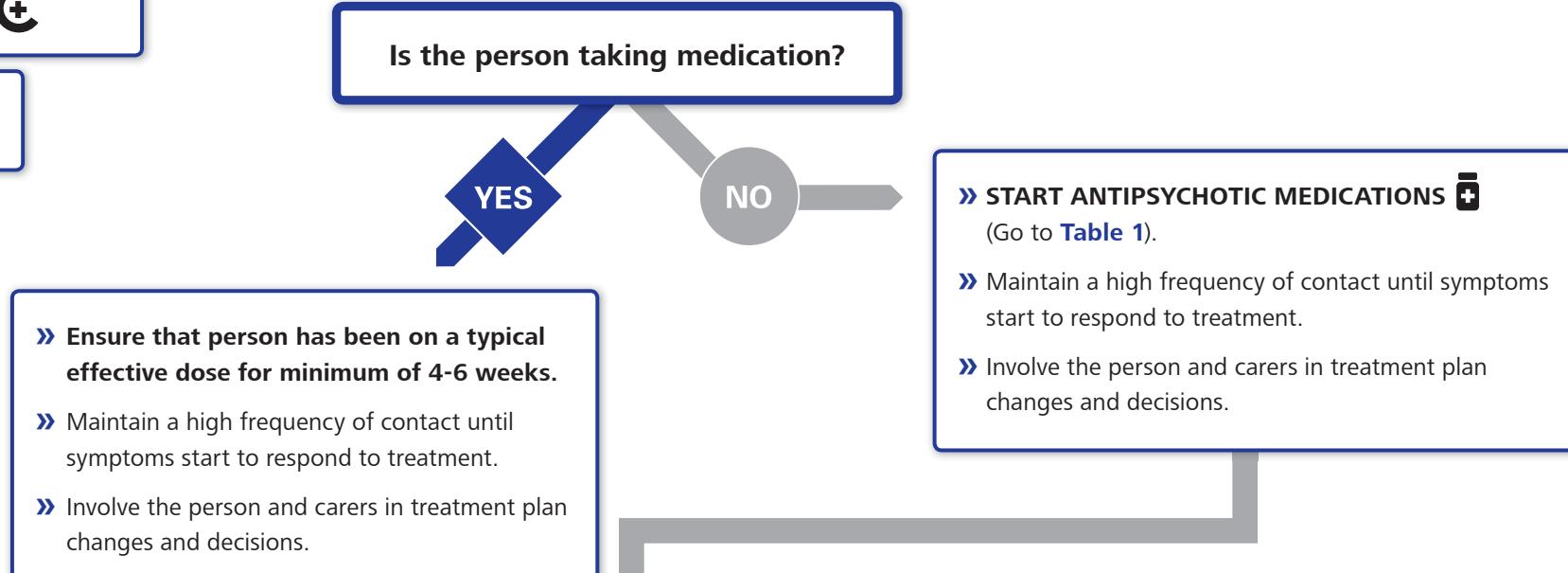
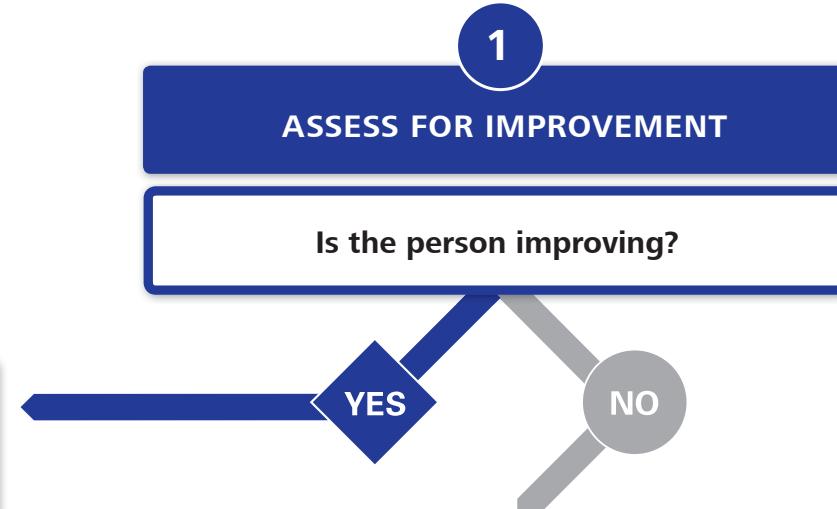
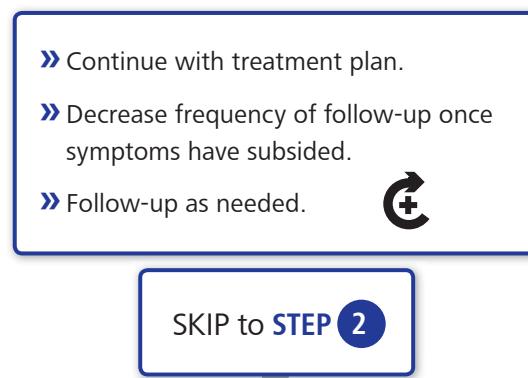
- » Sedate as appropriate to prevent injury.
- » For agitation due to psychosis or mania, consider use of haloperidol 2mg p.o./i.m. hourly up to 5 doses (maximum 10 mg).
Caution: high doses of haloperidol can cause dystonic reactions. Use biperiden to treat acute reactions.
- » For agitation due to ingestion of substances, such as alcohol/sedative withdrawal or stimulant intoxication, use diazepam 10-20 mg p.o. and repeat as needed. **Go to » SUB.**
- In cases of extreme violence**
 - Seek help from police or staff
 - Use haloperidol 5mg i.m., repeat in 15-30mins if needed (maximum 15 mg)
 - Consult a specialist. 
- » **if the person remains agitated**, recheck oxygen saturation, vital signs and glucose. Consider pain. Refer to hospital. 
- » **Once agitation subsides, refer to the master chart (MC) and select relevant modules for assessment.**

! Special Populations:

Consult a specialist for treatment. 



PSY 3 » Follow-up PSYCHOSIS



RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » Initial follow-up should be as frequent as possible, even daily, until acute symptoms respond to treatment.
- » Regular follow-up is needed. Once symptoms respond, monthly to quarterly follow-up is recommended (based on clinical need and feasibility factors such as staff availability, distance from clinic, etc.)



2

ROUTINELY MONITOR TREATMENT

- » Review psychosocial interventions.
- » If on medication, review **adherence, side effects and dosing** ([Table 4](#)).
Check weight, blood pressure, and blood glucose.
- » If the person starts to use any other medications with potential drug-drug interactions, consider reviewing the medication dose.
- » Ask regarding the onset of symptoms, prior episodes, and details of any previous or current treatment.

3

DISCONTINUE MEDICATIONS

Person with first episode, relapse, or worsening of psychosis symptoms:

- » Consider discontinuation of medications
12 MONTHS after symptoms have resolved.

Person with psychotic symptoms persisting more than 3 months:

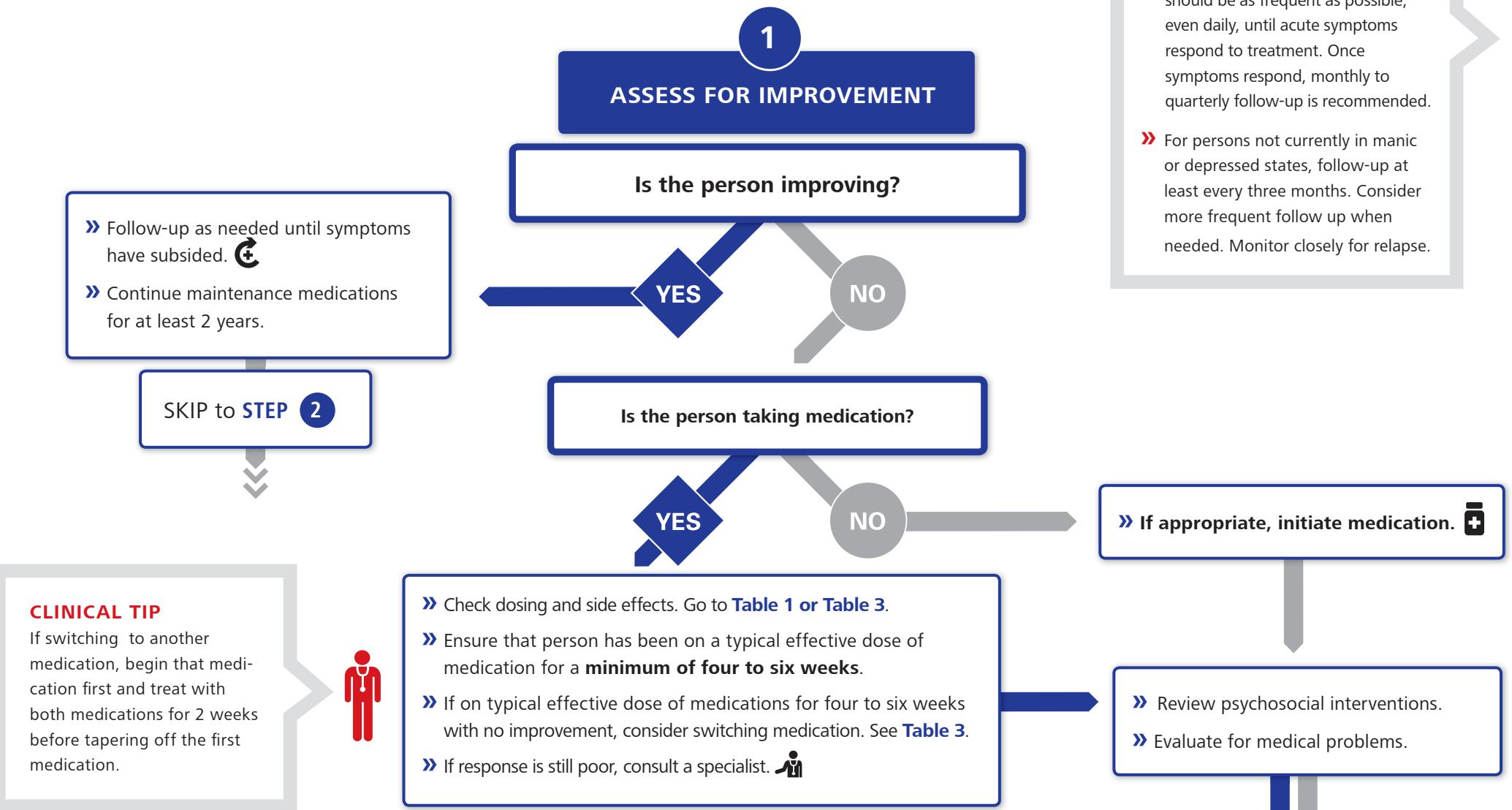
- » Consider discontinuation of medications **if person is in FULL REMISSION** of symptoms for several years.

- » Discuss risks of relapse against long-term medication side-effects with person and family.
- » If possible, consult a specialist. 
- » Gradually and slowly reduce the medication dose. When medications are withdrawn, individuals and family members need to be educated to detect early symptoms of relapse. Close clinical monitoring is recommended.



PSY 3 » Follow-up

MANIC EPISODE IN BIPOLAR DISORDER



2

ROUTINELY MONITOR TREATMENT

- » Review and provide psychosocial interventions.
- » If on medication, review **adherence, side effects and dosing**. See **Table 4**.
- » If the person starts any other medications with the potential for drug-drug interactions, consider reviewing the medication dose.

3

DISCONTINUE MEDICATIONS

Has the person been in full remission of symptoms with no episodes of bipolar disorder for *at least two years*?

» Consider discontinuation of medications

- Discuss with person/carer the risk of discontinuation.
- Consult a specialist regarding the decision to discontinue maintenance treatment after 2 years. 
- Reduce gradually over period of weeks or months.

YES

NO

» Routinely follow up and monitor treatment. 

EPILEPSY

Epilepsy is a chronic noncommunicable disorder of the brain, characterized by recurrent unprovoked seizures. Epilepsy is one of the most common neurological disorders and with proper treatment, can be well controlled in the majority of people.

Epilepsy has many causes. It may be genetic. Epilepsy may occur in people who have a past history of birth trauma, brain injury (including head trauma and strokes), or brain infections. In some people, no cause may be identified.

Seizures are caused by abnormal electrical activity in the brain and are of two types: convulsive and non-convulsive. Non-convulsive epilepsy has features such as change in mental status while convulsive epilepsy has features such as sudden abnormal movements, including stiffening and shaking of the body. The latter is associated with greater stigma and higher morbidity and mortality. This module covers only convulsive epilepsy.

EPI » Quick Overview

Acute presentation of seizures/convulsions warrants
emergency treatment & management



ASSESSMENT

- » **EMERGENCY:**
Assessment & management of acute convulsions
- » Assess if person has convulsive seizures
- » Assess for an acute cause
(e.g. neuroinfection, trauma, etc.)
- » Assess if the person has epilepsy and for any underlying causes (by history or examination)
- » Assess for concurrent priority MNS conditions



MANAGEMENT

- » **Management Protocol and Special Populations**
 1. Epilepsy
 2. Special Populations (women of childbearing age, children/adolescents, and people living with HIV)
- » **Psychosocial Interventions**
- » **Pharmacological Interventions**



FOLLOW-UP



EPI » EMERGENCY

PERSON PRESENTS WITH
CONVULSION OR IS
UNRESPONSIVE AND STIFF

CLINICAL TIP:

Assessment and management
should occur simultaneously.



1

Any sign of head or neck injury?

NO

YES

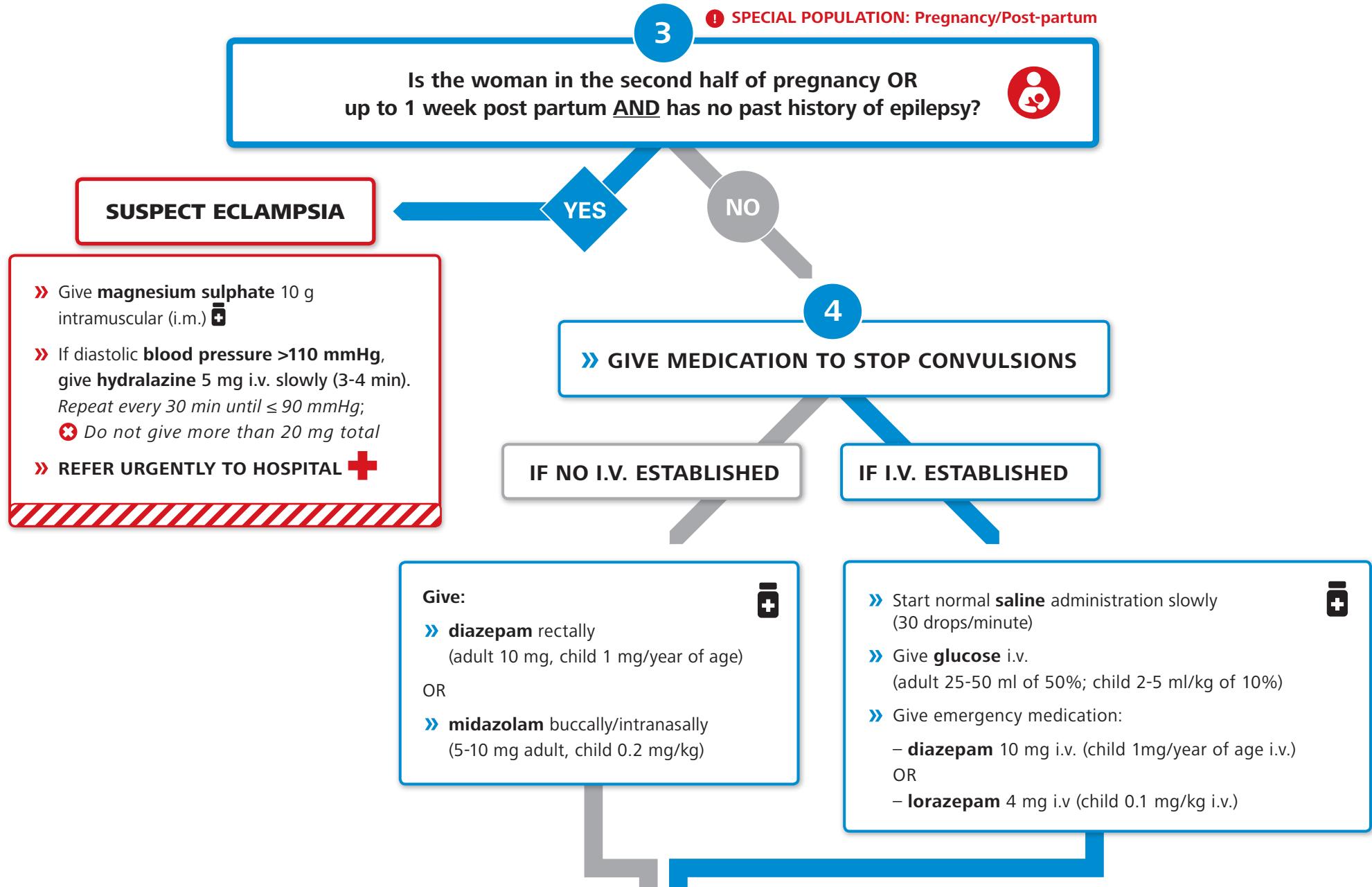
2

» KEEP HEAD AND NECK STABLE

- » Check AIRWAY, BREATHING, CIRCULATION (ABCs)
Ensure the person has nothing in their airway, is breathing well and has a stable pulse
- » Check BLOOD PRESSURE, TEMPERATURE and RESPIRATORY RATE
- » Start timing the duration of the convulsions, if possible
- » Make sure the person is in a safe place and if possible, put them down on their side to help breathing; loosen any neckties or clothing around the neck, take off eye glasses, and place something soft under the head (if available)

- » Place an intravenous (i.v.) line for medication/ fluid administration if possible
- » **✖ DO NOT LEAVE THE PERSON ALONE**
- » **✖ DO NOT PUT ANYTHING IN THE MOUTH**
- » **FOR A PERSON WITH POSSIBLE HEAD INJURY, NEUROINFECTION (FEVER) OR FOCAL DEFICITS, REFER URGENTLY TO HOSPITAL +**





5

Have the convulsions stopped within
10 minutes of 1st dose of emergency medication?

NO

YES

» Proceed to **EPI 1 (Assessment)**

» **GIVE 2nd DOSE OF EMERGENCY MEDICATION** 

6

Have the convulsions stopped?

NO

YES

» Proceed to **EPI 1 (Assessment)**

!

- » REFER URGENTLY TO HEALTH FACILITY 
- ✖ DO NOT GIVE MORE THAN 2 DOSES
OF EMERGENCY MEDICATION

7

IS THE PERSON IN STATUS EPILEPTICUS?

- » Convulsions continue after 2 doses of emergency medication, **OR**
- » No recovery in between convulsions

SKIP to STEP 10

NO

(e.g. convulsions stopped after
second dose of emergency medication
on arrival to health facility)

YES

8

**STATUS EPILEPTICUS IS LIKELY***Management should occur in health facility*

- » Continue to check AIRWAY, BREATHING, and CIRCULATION (ABCs)
- » Give oxygen
- » Monitor need for intubation/ventilation continuously

9

GIVE ONE OF THE FOLLOWING MEDICATIONS INTRAVENOUSLY **» VALPROIC ACID:**

20 mg/kg i.v. once up to maximum dose of 1 g, over 30 min

» PHENOBARBITAL:

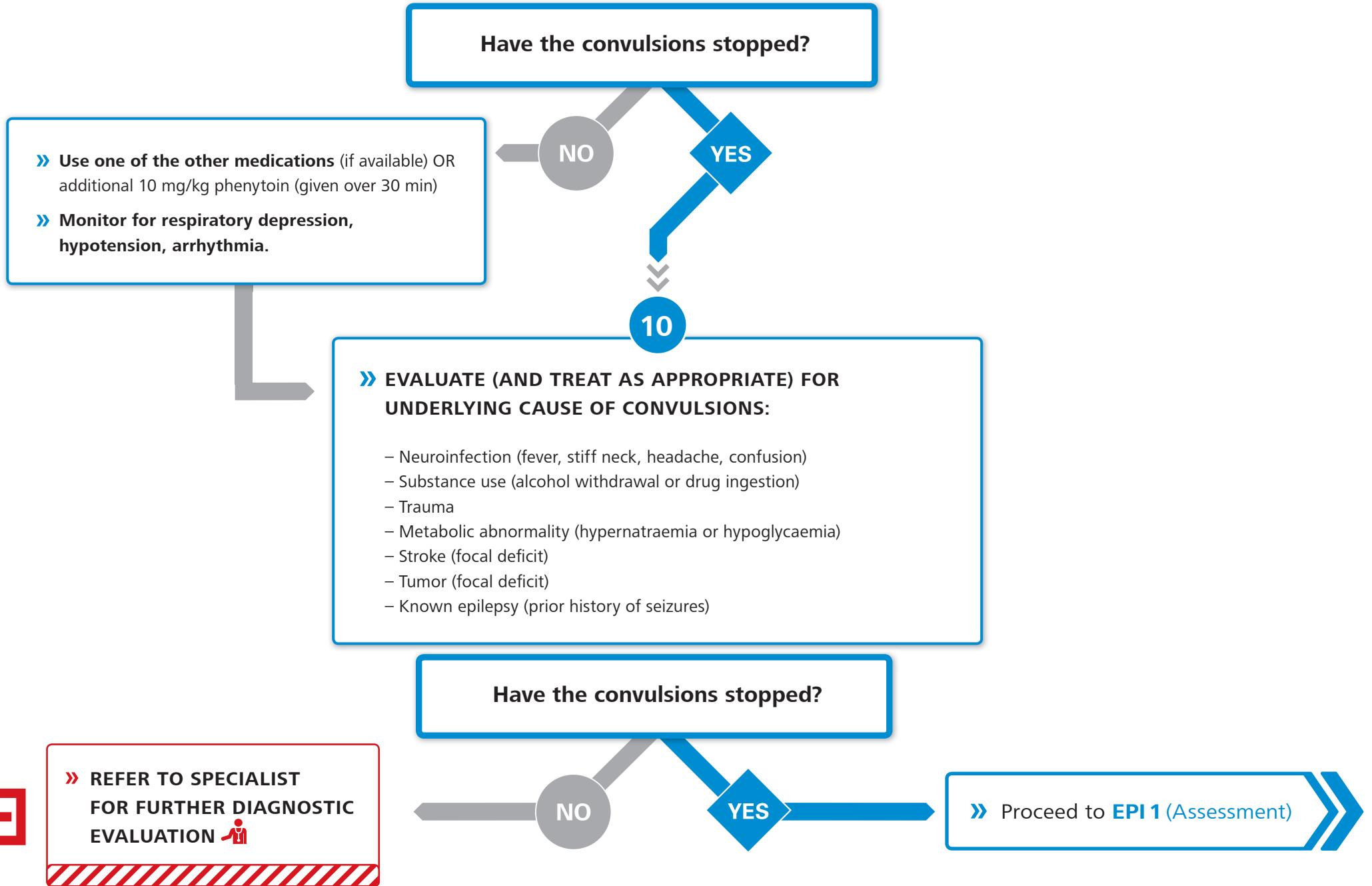
15-20 mg/kg i.v.* up to maximum dose of 1 g, over 100 mg/min

*If no i.v. access, can use i.m. phenobarbital (same dose as i.v.)

» PHENYTOIN:

15-20 mg/kg i.v. up to max dose of 1 g, over 60 min
– use second i.v. line (DIFFERENT FROM DIAZEPAM)

! **PHENYTOIN CAUSES SIGNIFICANT DAMAGE IF EXTRAVASATES, MUST HAVE GOOD I.V. LINE!**





EPI 1 » Assessment



CLINICAL TIP

Syncpe and pseudoseizures should be considered during initial evaluation and in cases of treatment failure.

» Syncopal (fainting) spells often are associated with flushing, sweating, pallor, and occasionally a feeling of vision darkening prior to an episode. Mild shaking may occur at the end.

» Pseudoseizures are typically associated with a stress trigger. Episodes are often prolonged and can involve nonrhythmic jerking of the body, eyes may be closed, and pelvic thrusting is often seen. There is typically a rapid return to baseline after the episode. If pseudoseizures are suspected, go to » OTH.

COMMON PRESENTATIONS OF EPILEPSY

- Convulsive movement or fits/seizures
 - During the convulsion:
 - Loss of consciousness or impaired consciousness
 - Stiffness, rigidity
 - Tongue bite, injury, incontinence of urine or faeces
 - After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body

1

Does the person have convulsive seizures?

Has the person had convulsive movements lasting longer than 1-2 minutes?

NO

YES

Convulsive seizures unlikely

- » Consult a specialist for recurrent episodes
- » Follow-up in 3 months



Has the person had at least 2 of the following symptoms during the episode(s)?

- Loss of consciousness or impaired consciousness
- Stiffness, rigidity
- Bitten or bruised tongue, bodily injury
- Incontinence of faeces/urine
- After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body

Convulsive seizures unlikely

- » Consult a specialist for recurrent episodes 
- » Follow-up in 3 months 

NO

YES

**Suspect
CONVULSIVE SEIZURES**

2

Is there an acute cause?

Is there neuroinfection or other possible causes of convulsions?

» Check for signs and symptoms:

- | | | | |
|-------------|---|---|--|
| – Fever | – Meningeal irritation
(e.g. stiff neck) | – Metabolic abnormality
(e.g. hypoglycemia/
hyponatremia) | – Alcohol or drug
intoxication or
withdrawal |
| – Headache | – Head injury | | |
| – Confusion | | | |

YES

NO

Suspect EPILEPSY



IS IT A CHILD 6 MONTHS TO 6 YEARS OLD WITH A FEVER?



Are the convulsions:

- Focal: Starts in one part of the body
- Prolonged: Lasts more than 15 min
- Repetitive: More than 1 episode during the current illness

NO

YES

COMPLEX FEBRILE SEIZURE
» REFER TO HOSPITAL +
FOR ADMISSION



SIMPLE FEBRILE SEIZURE

- » Look for cause (local Integrated Management of Childhood Illness (IMCI) guidelines)
- » Observe over 24 hours
- » No antiepileptic treatment needed



» EVALUATE & TREAT MEDICAL CONDITION

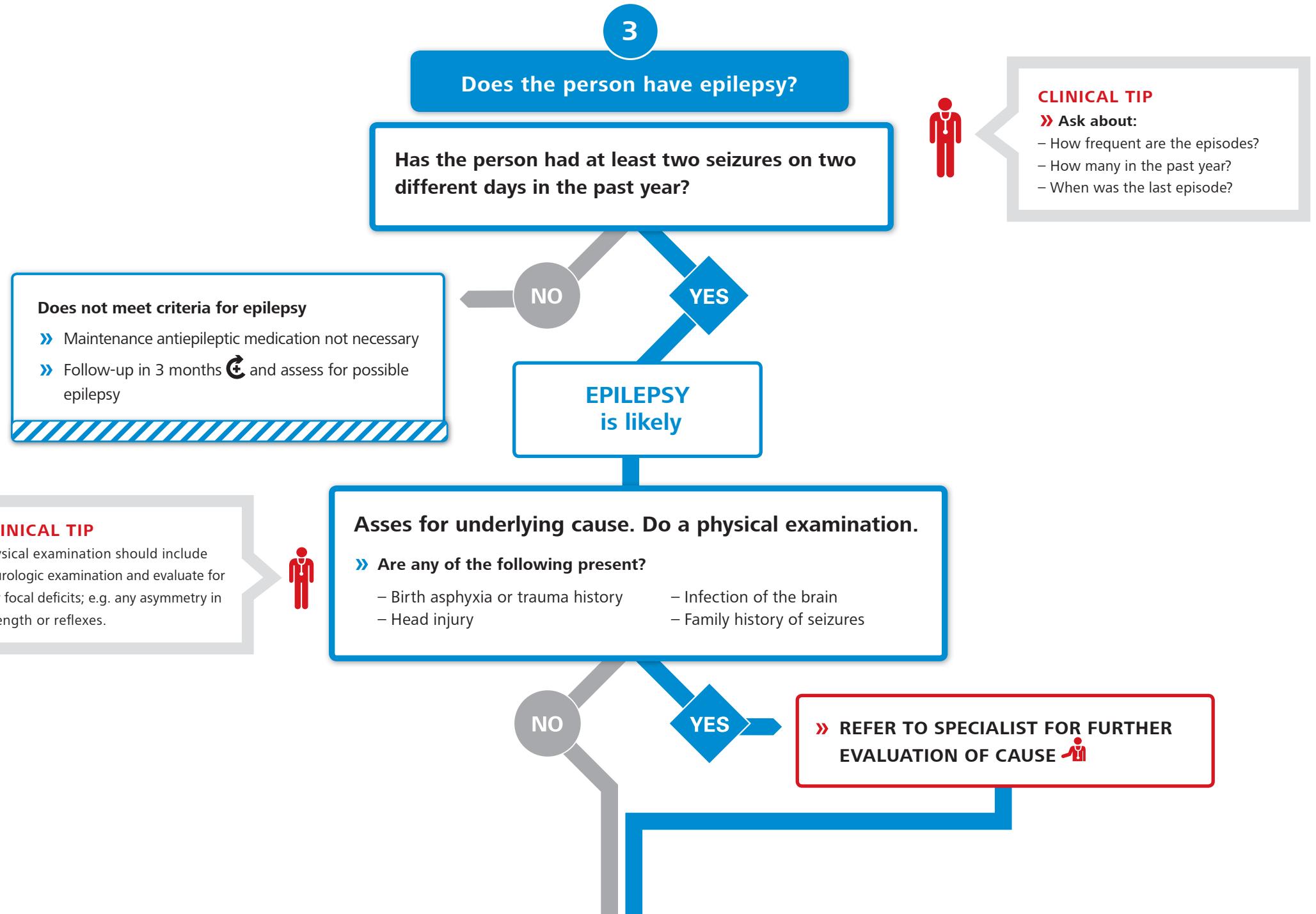
» REFER TO HOSPITAL +

IF POSSIBLE FOR HEAD INJURY,
MENINGITIS, AND METABOLIC
ABNORMALITIES

✖ ANTIEPILEPTIC MEDICATION
NOT REQUIRED

» Follow-up in 3 months to
assess for possible epilepsy 📆

SKIP to STEP 3



4

Are there concurrent MNS conditions?

» Assess for other concurrent MNS conditions according to the mhGAP-IG Master Chart (MC)



! Please note persons with EPILEPSY are at higher risk for DEPRESSION, DISORDERS DUE TO SUBSTANCE USE. CHILDREN AND ADOLESCENTS MAY HAVE ASSOCIATED MENTAL AND BEHAVIOURAL DISORDERS. SUBSTANCE USE DISORDERS

» Go to PROTOCOL 1

! IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing to Protocol. Go to » SUI.





EPI 2 » Management

PROTOCOL

1

- » Provide **psychoeducation** to the person and carers (2.1)
- » Initiate **antiepileptic medications** (2.3)
- » Promote functioning in daily activities (2.2)

Special populations

Note that interventions are different for EPILEPSY in these populations



WOMAN OF CHILDBEARING AGE

Concern: Risk of antiepileptic medication to fetus/child



CHILD / ADOLESCENT

Concern: Effect of antiepileptic medication on development and/or behavior



PERSON LIVING WITH HIV

Concern: Drug interactions between antiepileptic medications and antiretrovirals

» Advise folate (5 mg/day) to **prevent neural tube defects**, in **ALL women of childbearing age**.

» **AVOID VALPROATE.**

» **CAUTION If Pregnant:**

- Avoid polytherapy. *Multiple medications in combination increase the risk of teratogenic effects during pregnancy.*
- If medications are stopped during pregnancy, they should always be tapered.
- Advise delivery in hospital.
- At delivery, give 1 mg vitamin K i.m. to the newborn to prevent haemorrhagic disease.

» **If breastfeeding**, carbamazepine preferred to other medication.

» For those with a **developmental disorder**, manage the condition. Go to » CMH.

» For children with behavioural disorder, avoid phenobarbital if possible. Manage the condition. Go to » CMH.

» When available, refer to specific drug interactions for person's antiretroviral regimen and antiepileptic medication.

» **Valproate** is preferred due to fewer drug-drug interactions.

» **AVOID PHENYTOIN AND CARBAMAZEPINE WHEN POSSIBLE.**

PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

Provide information on: *"What is a convulsion/epilepsy" and the importance of medication.*

- » "A convulsion is caused by excess electrical activity in the brain – it is not caused by witchcraft or spirits."
- » "Epilepsy is the recurrent tendency for convulsions."
- » "It is a chronic condition, **but if you take your medicine as prescribed, in the majority of people it can be fully controlled.**"
- » The person may have several people helping them take care of their convulsions. Discuss this with the person.
- » Ask the person to let you know if they are seeing a traditional or a faith healer, showing respect for this, but emphasizing the need for being seen at a healthcare facility. The person should also be informed that medicines and herbal products can sometimes have adverse interactions, so the health care providers must know about everything they take.

CLINICAL TIP:

- » Seizures lasting greater than 5 minutes are a medical emergency – one should seek help immediately.
- » Most people with epilepsy can have normal lives with good adherence to treatment.

Provide information on: *How carers can manage convulsion at home.*

- » Lay person down, on their side, head turned to help breathing.
- ✖ DO NOT PUT ANYTHING IN THEIR MOUTH OR RESTRAIN THE PERSON.
- » Ensure the person is breathing properly.
- » Stay with person until the convulsion stops and they wake up.
- » Sometimes people with epilepsy know that a convulsion is imminent. They should lie down somewhere safe if they have that feeling.
- » Epilepsy is not contagious. You cannot catch the disorder by assisting the person experiencing convulsions.

Provide information on: *When to get medical help.* !

- » When a person with epilepsy appears to have trouble breathing during a convulsion, they need immediate medical help.
- » When a person with epilepsy has a convulsion lasting longer than 5 minutes outside of a health facility, they need to be taken to one.
- » When a person with epilepsy is not waking up after a convulsion, they need to be taken to a health facility.

2.2 Promote functioning in daily activities and community life

» Refer to Essential Care and Practice (ECP) for interventions that promote functioning in daily living and community life.

» In addition, inform carers and people with epilepsy that:

- People with epilepsy can lead normal lives. They can marry and have children.
- Parents should not remove children with epilepsy from school.
- People with epilepsy can work in most jobs. However they should avoid jobs with high risk of injury to self or others (e.g. working with heavy machinery).
- People with epilepsy should avoid cooking on open fires and swimming alone.
- People with epilepsy should avoid excessive alcohol and recreational substances, sleeping too little, or going to places with flashing lights.
- Local driving laws related to epilepsy should be observed.
- People with epilepsy may qualify for disability benefits.
- Community programs for people with epilepsy can provide assistance in jobs and support for both the person and family.

PHARMACOLOGICAL INTERVENTIONS

2.3 Initiate antiepileptic medications

- » Choose a medication that will be consistently available.
- »  If special population (children, women of childbearing age, person living with HIV), see relevant section of this module.
- » Start with only one medication at lowest starting dose.
- » Increase dose slowly until convulsions are controlled.
- » Consider monitoring blood count, blood chemistry and liver function tests, if available.

CAUTION!

- » Check for **drug-drug interactions**. *When used together, antiepileptics may increase or reduce the effect of other antiepileptics. Antiepileptics may also reduce effect of hormonal birth control, immunosuppressants, antipsychotics, methadone, and some antiretrovirals.*
- » Rarely, can cause severe bone marrow depression, hypersensitivity reactions including Stevens-Johnson Syndrome, altered Vitamin D metabolism and Vitamin K-deficient hemorrhagic disease of newborns.
- »  When possible, avoid use of sodium valproate in pregnant women due to **risk of neural tube defects**.
- » All anticonvulsant medications should be discontinued slowly as stopping them abruptly can cause seizure breakthrough.

TABLE 1: Antiepileptic medications

MEDICATION	ORAL DOSING	SIDE EFFECTS	CONTRAINDICATIONS / CAUTIONS
CARBAMAZEPINE	<p>Adults: Start 100-200 mg daily in 2-3 divided doses. Increase by 200 mg each week (max 1400mg daily).</p> <p>Children: Start 5 mg/kg daily in 2-3 divided doses. Increase by 5 mg/kg daily each week (max 40mg/kg daily OR 1400mg daily).</p> <p> Women who are pregnant or breastfeeding: Use with caution.</p>	<p>Common: Sedation, confusion, dizziness, ataxia, double vision, nausea, diarrhea, benign leukopenia.</p> <p>Serious: Hepatotoxicity, cardiac conduction delay, low sodium levels.</p>	Caution in patients with history of blood disorders, kidney, liver or cardiac disease. Dose may need to be adjusted after 2 weeks due to induction of its own metabolism.

TABLE 1: Antiepileptic medications (cont.)

MEDICATION	ORAL DOSING	SIDE EFFECTS	CONTRAINdications / CAUTIONS
PHENOBARBITAL	<p>Adults: Start 60 mg daily in 1-2 divided doses. Increase weekly by 2.5-5 mg (maximum 180 mg daily).</p> <p>Children: Start 2-3 mg/kg daily in 2 divided doses. Increase weekly by 1-2 mg/kg daily depending on tolerance (maximum 6mg daily).</p>	<p>Common: Sedation, hyperactivity in children, ataxia, nystagmus, sexual dysfunction, depression.</p> <p>Serious: Liver failure (hypersensitivity reaction), decreased bone mineral density.</p>	Contraindicated in patients with acute intermittent porphyria. Lower doses for patients with kidney or liver disease.
PHENYTOIN	<p>Adults: Start 150-200 mg daily in two divided doses. Increase by 50 mg daily every 3-4 weeks (max 400 mg daily).</p> <p>Children: Start 3-4 mg/kg daily in 2 divided doses. Increase by 5 mg/kg daily every 3-4 weeks (maximum 300 mg per day).</p> <p> Women who are pregnant or breastfeeding: Avoid</p> <p> Older adults: Use lower doses</p>	<p>Common: Sedation, confusion, dizziness, tremor, motor twitching, ataxia, double vision, nystagmus, slurred speech, nausea, vomiting, constipation.</p> <p>Serious: Hematologic abnormalities, hepatitis, polyneuropathy, gum hypertrophy, acne, lymphadenopathy, increase in suicidal ideation.</p>	Lower doses for patients with kidney or liver disease.
SODIUM VALPROATE	<p>Adults: Start 400 mg daily in 2 divided doses. Increase by 500 mg daily each week (maximum 3000 mg daily).</p> <p>Children: Start 15-20 mg/kg daily in 2-3 divided doses. Increase each week by 15 mg/kg daily (max 15-40 mg/kg daily).</p> <p> Women who are pregnant: Avoid</p> <p> Older adults: Use lower doses</p>	<p>Common: Sedation, headache, tremor, ataxia, nausea, vomiting, diarrhea, weight gain, transient hair loss.</p> <p>Serious: Impaired hepatic function, thrombocytopenia, leukopenia, drowsiness/confusion (valproate-induced hyperammonemic encephalopathy, a sign of toxicity), liver failure, hemorrhagic pancreatitis.</p>	Use with caution if underlying or suspected hepatic disease. Drug-drug interactions: Valproate levels decreased by carbamazepine, increased by aspirin.



EPI 3 ➤ Follow-up

1

REVIEW THE CURRENT CONDITION



RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » Follow up should occur every 3-6 months

Does the person have more than 50% seizure reduction in convulsion frequency?

NO

YES

IF THE PERSON IS NOT IMPROVING ON CURRENT DOSE:

- » Review adherence to medications.
- » Consider increase in medication dose as needed to maximal dose if no adverse effects.
- » If response is still poor,
 - Consider switching medication. The new medication should be at an optimum dose before slowly discontinuing the first.
- » If response is still poor,
 - Review diagnosis.
 - REFER TO SPECIALIST.
- » Follow-up more frequently.

CLINICAL TIP:

- » **ADVERSE EFFECTS** (e.g. drowsiness, nystagmus, diplopia, ataxia) are from too high doses of medication for the person.
- » **If there is an IDIOSYNCRATIC REACTION** (allergic reaction, bone marrow depression, hepatic failure), switch antiepileptic medication.



2

MONITOR TREATMENT

At every contact:

- » Evaluate side-effects of medication including adverse effects and idiosyncratic reactions (clinically and with appropriate laboratory tests when available).
- » Provide psychoeducation and review psychosocial interventions. 
- » **Is the person a woman of childbearing age and considering pregnancy?** If so, consult specialist. 
- » **Does the patient have any new symptoms of concern?** Review for any new symptoms of depression and anxiety given high risk of co-morbidity with epilepsy.
- » **Is the patient on any new medications that may have interactions?** (Many anticonvulsants have interactions with other medications). If so, consult a specialist. 

3

CONSIDER MEDICATION DISCONTINUATION WHEN APPROPRIATE

Has the person been convulsion free for several years?

NO

YES

IF THERE ARE NO PROBLEMS WITH MEDICATIONS

- » **Continue at current dose.** Correct dosing is lowest therapeutic dose for seizure control, while minimizing adverse side-effects.
- » Continue close follow-up and review for possible discontinuation of medications once seizure free for at least two years.

- » **Discuss risk of seizure occurrence with person/carer** (if epilepsy is due to head injury, stroke or neuroinfection, there is a higher risk of seizure recurrence off medication), and risks and benefits of discontinuing medications.

- » **If in agreement, gradually take the person off medication by reducing the doses over 2 months and monitoring closely for seizure recurrence.** 

CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS

This module covers assessment and management of developmental disorders, behavioural disorders, and emotional disorders in children and adolescents.

DEVELOPMENTAL DISORDER is an umbrella term covering disorders such as intellectual disability as well as autism spectrum disorders. These disorders usually have a childhood onset, impairment or delay in functions related to central nervous system maturation, and a steady course rather than the remissions and relapses that tend to characterize many other mental disorders.

BEHAVIOURAL DISORDERS is an umbrella term that includes specific disorders such as attention deficit hyperactivity disorder (ADHD) and conduct disorders. Behavioural symptoms of varying levels of severity are very common in the general population. Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioural disorders.

EMOTIONAL DISORDERS are among the leading mental health-related causes of the global burden of disease in young people. Emotional disorders are characterized by increased levels of anxiety, depression, fear, and somatic symptoms.

Children and adolescents often present with symptoms of more than one condition and sometimes the symptoms overlap. The quality of home and social educational environments influence children's and adolescents' wellbeing and functioning. Exploring and addressing psychosocial stressors along with opportunities to activate supports are critical elements of the assessment and management plan.

CMH » Quick Overview



ASSESSMENT

- » Assess for problems with development
- » Assess for problems with inattention or over-activity
- » Assess for problems with emotions. If an adolescent, evaluate for moderate to severe depression
- » Assess for repeated defiant, disobedient, and aggressive behaviour
- » Assess for presence of other priority MNS conditions
- » Assess the home environment
- » Assess the school environment



MANAGEMENT

- » Management Protocols
 1. Developmental Delay/Disorder
 2. Problems with Behaviour
 3. Attention Deficit Hyperactivity Disorder (ADHD)
 4. Conduct Disorder
 5. Problems with Emotions
 6. Emotional disorders and Moderate to Severe Depression in Adolescents
- » Psychosocial Interventions



FOLLOW-UP

TABLE 1: COMMON PRESENTATIONS OF CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS BY AGE GROUP

May be reported by carer, self-reported or observed during the assessment process.

	DEVELOPMENTAL DISORDERS	BEHAVIORAL DISORDERS	EMOTIONAL DISORDERS
Infants and Young Children (age <5)	<ul style="list-style-type: none">– Poor feeding, failure to thrive, poor motor tone, delay in meeting expected developmental milestones for appropriate age (e.g. smiling, sitting, interacting with others, sharing attention, walking, talking and toilet training)		
Middle Childhood (age 6-12)	<ul style="list-style-type: none">– Delay in reading and writing– Delay in self-care such as dressing, bathing, brushing teeth	Ages 4-18 <ul style="list-style-type: none">– Excess over-activity: excessive running around, extreme difficulties remaining seated, excessive talking or moving restlessly– Excessive inattention, absent-mindedness, repeatedly stopping tasks before completion and switching to other activities– Excessive impulsivity: frequently doing things without forethought– Repeated and continued behaviour that disturbs others (e.g. unusually frequent and severe tantrums, cruel behaviour, persistent and severe disobedience, stealing)– Sudden changes in behaviour or peer relations, including withdrawal and anger	<ul style="list-style-type: none">– Excessive crying, clinging to a carer, freezing (holding the body very still and being silent) and/or tantrums– Extreme shyness or changes in functioning (e.g. new wetting or soiling behaviour or thumb sucking)– Diminished initiation of play and social interaction– Sleep and eating difficulties
Adolescents (age 13-18)	<ul style="list-style-type: none">– Poor school performance– Difficulty understanding instructions– Difficulty in social interaction and adjusting to changes		<ul style="list-style-type: none">– Recurrent, unexplained physical symptoms (e.g. stomach ache, headache, nausea)– Reluctance or refusal to go to school– Extreme shyness or changes in functioning (e.g. new wetting or soiling behaviour or thumb sucking)
All Ages	<ul style="list-style-type: none">– Difficulty carrying out daily activities considered normal for the person's age; difficulty understanding instructions; difficulty in social interactions and adjusting to changes; difficulties or oddities in communication; restrictive/repetitive patterns of behaviours, interests and activities		<ul style="list-style-type: none">– Problems with mood, anxiety or worry (e.g. irritable, easily annoyed, frustrated or depressed mood, extreme or rapid and unexpected changes in mood, emotional outbursts), excessive distress– Changes in functioning (e.g. difficulty concentrating, poor school performance, often wanting to be alone or stay home)
			<ul style="list-style-type: none">– Excessive fear, anxiety or avoidance of specific situations or objects (e.g. separation from caregivers, social situations, certain animals or insects, heights, closed spaces, sight of blood or injury)– Changes in sleeping and eating habits– Diminished interest or participation in activities– Oppositional or attention-seeking behaviour



CMH 1 » Assessment

COMMON PRESENTATIONS OF CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS

- **Child/adolescent being seen for physical complaints or a general health assessment who has:**
 - Any of the typical presenting complaints of emotional, behavioural or developmental disorders (See **Table 1**)
 - Risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases (e.g. HIV/AIDS or history of difficult birth)
- **Carer with concerns about the child/adolescent's:**
 - Difficulty keeping up with peers or carrying out daily activities considered normal for age
 - Behaviour (e.g. too active, aggressive, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school)
- **Teacher with concerns about a child/adolescent**
 - e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work
- **Community health or social services worker with concerns about a child/adolescent**
 - e.g. rule- or law-breaking behaviour, physical aggression at home or in the community

ASSESS FOR DEVELOPMENTAL DISORDERS



CLINICAL TIP

- » Adolescents should always be offered the opportunity to be seen on their own, without carers present.
- » Clarify the confidential nature of the discussion.
- » Indicate in what circumstances parents or other adults will be given information.
- » Explore the presenting complaint with the child/adolescent and carer.

Assess all domains – motor, cognitive, social, communication, and adaptive.

» **For toddlers and young children:**

Has the child had any difficulties with age-appropriate milestones across all developmental areas?

» **For older children and adolescents:**

Are there difficulties with school (learning, reading, and writing), communicating and interacting with others, self-care, and everyday household activities?

SKIP to **STEP 2**

NO

YES

Suspect DEVELOPMENTAL DELAY/DISORDER

Are there signs/symptoms suggesting any of the following:

- Nutritional deficiency, including iodine deficiency
- Anaemia
- Malnutrition

- Acute or chronic infectious illness, including ear infection and HIV/AIDS

NO

YES

- » **Manage conditions using Integrated Management of Childhood Illness (IMCI)**
www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet or other available guidelines.

Assess the child for visual and/or hearing impairment:**For vision assessment, see if the child fails to:**

- Look at your eyes
- Follow a moving object with the head and eyes
- Grab an object
- Recognize familiar people

For hearing assessment, see if the child fails to:

- Turn head to see someone behind them when they speak
- Show reaction to loud noise
- Make a lot of different sounds (tata, dada, baba), if an infant

NO**YES****» CONSULT WITH SPECIALIST FOR EVALUATION.** **» Go to PROTOCOL 1** **2****ASSESS FOR PROBLEMS WITH INATTENTION OR HYPERACTIVITY****Is the child/adolescent:**

- Overactive?
- Unable to stay still for long?
- Easily distracted, has difficulty completing tasks?
- Moving restlessly?

YES**NO****SKIP to STEP 3** 

Are symptoms persistent, severe, and causing considerable difficulty with daily functioning?
Are ALL of the following true?

- Are symptoms present in multiple settings?
- Have they lasted at least 6 months?
- Are they inappropriate for the child/adolescent's developmental level?

- Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

YES

NO

ADHD
is unlikely

**Consider
PROBLEMS WITH BEHAVIOUR**

Consider ADHD

» Go to **PROTOCOL 2** 

SKIP to **STEP 3** 

Rule out physical conditions that can resemble ADHD.

Does the child/adolescent have any of the following:

- Thyroid diseases
- Acute or chronic infectious illness, including HIV/AIDS
- Uncontrolled pain e.g. from an ear infection, sickle cell disease

NO

YES

» **Treat the physical condition**

» Go to **PROTOCOL 3** 

3

ASSESS FOR CONDUCT DISORDER**Does the child/adolescent show repeated aggressive, disobedient, or defiant behaviour, for example:**

- Arguing with adults
- Defying or refusing to comply with their requests or rules
- Extreme irritability/anger
- Frequent and severe temper tantrums
- Difficulty getting along with others
- Provocative behaviour
- Excessive levels of fighting or bullying
- Cruelty to animals or people
- Severe destructiveness to property, fire-setting
- Stealing, repeated lying, truancy from school, running away from home

SKIP to STEP 4**CONDUCT DISORDER
is unlikely****NO****YES****CLINICAL TIP: AGE-APPROPRIATE DISRUPTIVE OR CHALLENGING BEHAVIOUR IN CHILDREN/ADOLESCENTS****Toddlers and young children
(age 18 months – 5 years)**

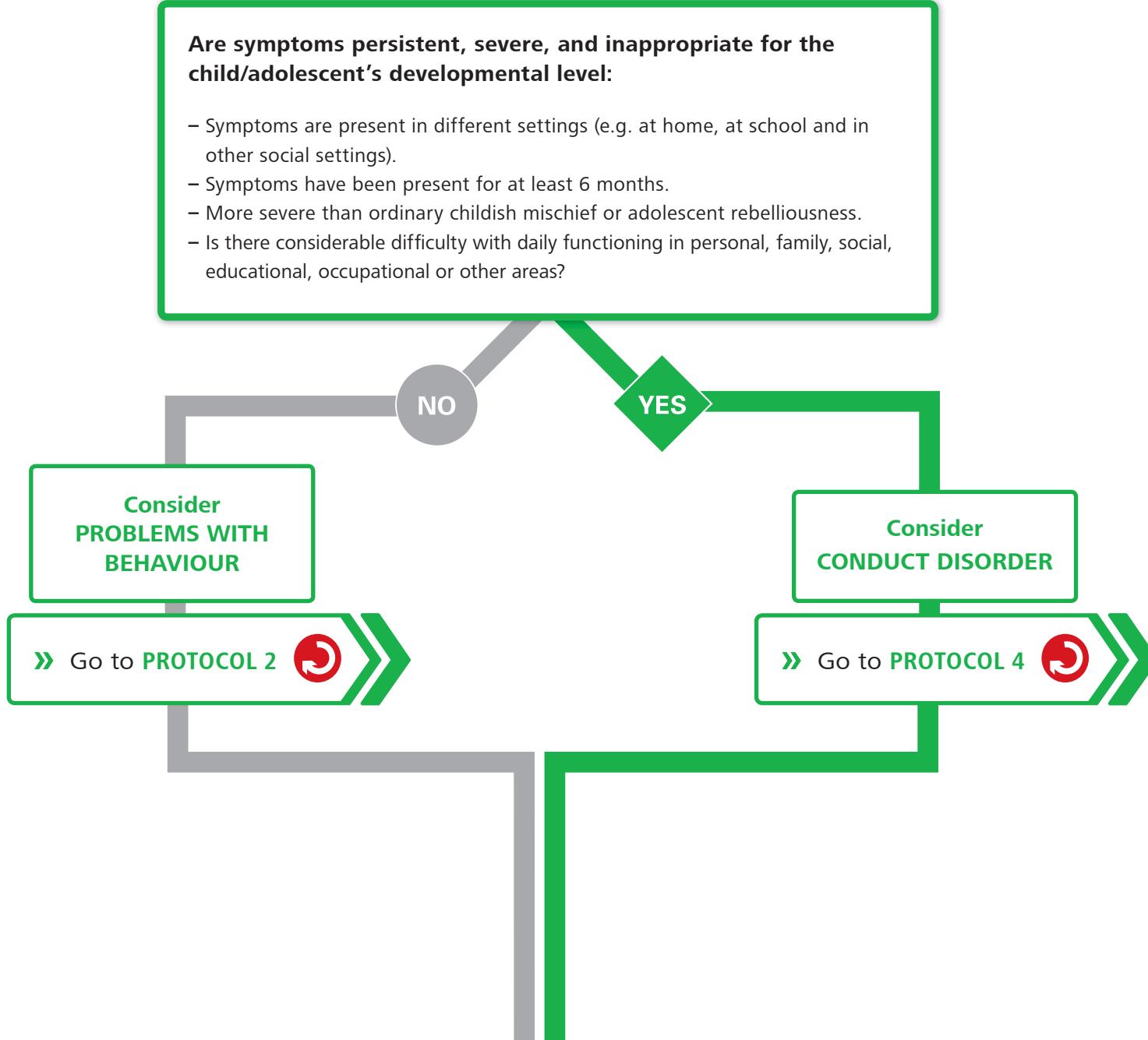
- Refusing to do what they are told, breaking rules, arguing, whining, exaggerating, saying things that aren't true, denying they did anything wrong, being physically aggressive and blaming others for their misbehaviour.
- Brief tantrums (emotional outbursts with crying, screaming, hitting, etc.), usually lasting less than 5 minutes and not longer than 25 minutes, typically occur less than 3 times per week. Developmentally typical tantrums should not result in self-injury or frequent physical aggression toward others, and the child can typically calm themselves down afterward.

**Middle Childhood
(age 6-12)**

- Avoidance of or delay in following instructions, complaining or arguing with adults or other children, occasionally losing their temper.

**Adolescents
(age 13-18)**

- Testing rules and limits, saying that rules and limits are unfair or unnecessary, occasionally being rude, dismissive, argumentative or defiant with adults.



4

ASSESS FOR EMOTIONAL DISORDERS**(prolonged, disabling distress involving sadness, fearfulness, anxiety or irritability)****Ask if the child/adolescent:**

- Is often feeling irritable, easily annoyed, down or sad?
- Has lost interest in or enjoyment of activities?
- Has many worries or often seems worried?
- Has many fears or is easily scared?
- Often complains of headaches, stomach-aches or sickness?
- Is often unhappy, down-hearted or tearful?
- Avoids or strongly dislikes certain situations (e.g. separation from carers, meeting new people, or closed spaces)?

SKIP to STEP 5**NO****YES****CLINICAL TIP: AGE-APPROPRIATE FEARS AND ANXIETIES IN CHILDREN AND ADOLESCENTS**

Babies & Toddlers (age 9 months – 2 years)	- Fear of strangers, distress when separating from caregivers
Young Children (age 2-5)	- Fear of storms, fire, water, darkness, nightmares, and animals
Middle Childhood (age 6-12)	- Fear of monsters, ghosts, germs, natural disasters, physical illness, and being badly injured - Anxiety about school or about performing in front of others
Adolescents (age 13-18)	- Fear of rejection by peers, performing in front of others, physical illness, medical procedures, catastrophes (e.g. war, terrorist attack, disasters)

Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

YES

NO

Consider
EMOTIONAL DISORDER

Consider
PROBLEMS WITH
EMOTIONS

» Go to PROTOCOL 5



SKIP to STEP 5



Rule out physical conditions that can resemble or exacerbate emotional disorders.

Are there any signs/symptoms suggesting:

- Thyroid diseases
- Infectious illness, including HIV/AIDS
- Anaemia

- Obesity
- Malnutrition
- Asthma

- Medication side-effects
(e.g. from corticosteroids or inhaled asthma medications)

» Manage the physical condition.

YES

NO

» Go to PROTOCOL 6



In adolescents, assess for moderate to severe depression.

Does the adolescent have problems with mood (feeling irritable, down or sad)
OR has lost interest in or enjoyment of activities?

YES

NO

SKIP to STEP 5

Has the adolescent had several of the following additional symptoms most days for the last 2 weeks?

- Disturbed sleep or sleeping too much
- Significant change in appetite or weight (decrease or increase)
- Beliefs of worthlessness or excessive guilt
- Fatigue or loss of energy
- Reduced concentration
- Indecisiveness
- Observable agitation or physical restlessness
- Talking or moving more slowly than usual
- Hopelessness
- Suicidal thoughts or acts

Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

YES

NO

Consider
PROBLEMS WITH
EMOTIONS

» Go to PROTOCOL 5

SKIP to STEP 5

Consider DEPRESSION

CLINICAL TIP

Delusions or hallucinations may be present. If present, treatment for depression needs to be adapted. **CONSULT A SPECIALIST** 



Rule out a history of manic episode(s) and normal reaction to recent major loss. See » DEP.

» Go to **PROTOCOL 6** 

5

ASSESS FOR OTHER PRIORITY MNS CONDITIONS

! IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing. Go to »SUI. 

Are there any other concurrent MNS conditions? Assess according to the mhGAP-IG Master Chart. See » MC.

! Do not forget to assess for disorders due to substance use. See »SUB.

! For children with developmental delay/disorders, do not forget to assess for epilepsy. See »EPI.

» ASSESS AND MANAGE concurrent MNS conditions 

YES

NO

CLINICAL TIP

- » Ask the child/adolescent directly about these exposures when developmentally appropriate and safe to do so (e.g. not in the presence of a carer who may have committed the maltreatment).
- » Adolescents should always be offered the opportunity to be seen on their own, without carers present.



6

ASSESS THE HOME ENVIRONMENT

Are the emotional, behavioural or developmental problems a reaction to or aggravated by a distressing or frightening situation?

Assess for:

- » Clinical features or any element in the clinical history that suggest maltreatment or exposure to violence (see CLINICAL TIP).
- » Any recent or ongoing severe stressors (e.g. illness or death of a family member, difficult living and financial circumstances, being bullied or harmed).

YES

NO

- » Refer to child protection services if necessary
- » Explore and manage stressors
- » Ensure child/adolescent's safety as a first priority
- » Reassure the child/adolescent that all children/adolescents need to be protected from abuse
- » Provide information about where to seek help for any ongoing abuse
- » Arrange additional support including referral to specialist
- » Contact legal and community resources, as appropriate and as mandated
- » Consider additional psychosocial interventions
- » Ensure appropriate follow-up 

CLINICAL TIP:**WARNING FEATURES OF CHILD MALTREATMENT****CLINICAL FEATURES****» Physical abuse**

- Injuries (e.g. bruises, burns, strangulation marks or marks from a belt, whip, switch or other object)
- Any serious or unusual injury without an explanation or with an unsuitable explanation

» Sexual abuse

- Genital or anal injuries or symptoms that are medically unexplained
- Sexually transmitted infections or pregnancy
- Sexualised behaviours (e.g. indication of age-inappropriate sexual knowledge)

» Neglect

- Being excessively dirty, unsuitable clothing
- Signs of malnutrition, very poor dental health

» Emotional abuse and all other forms of maltreatment

Any sudden or significant change in the behaviour or emotional state of the child/adolescent that is not better explained by another cause, such as:

- Unusual fearfulness or severe distress (e.g. inconsolable crying)
- Self-harm or social withdrawal
- Aggression or running away from home
- Indiscriminate affection seeking from adults
- Development of new soiling and wetting behaviours, thumb sucking

ASPECTS OF CARER INTERACTION WITH THE CHILD/ADOLESCENT

- » Persistently unresponsive behaviour, especially toward an infant (e.g. not offering comfort or care when the child/adolescent is scared, hurt or sick)

» Hostile or rejecting behaviour

- » Using inappropriate threats (e.g. to abandon the child/adolescent) or harsh methods of discipline

Do the carers have any priority MNS condition that could impact their ability to care for the child/adolescent?

Consider especially depression and disorders due to substance use.



CLINICAL TIP

- » Depressive disorder in carers can worsen emotional, behavioural or developmental disorders in their children/adolescents.

NO

YES

- » Assess and manage for carer MNS conditions.
- » Go to Management 2.6 (Carer support)

Is the child getting adequate opportunities for play and social interaction/communication at home?

Consider asking:

- » With whom does the child spend most of their time?
- » How do you/they play with the child? How often?
- » How do you/they communicate with the child? How often?

NO

YES

- » Provide advise on age-appropriate stimulation and parenting. Refer to Care for Child Development http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/
- » Consider need for additional support for the child including referral to child protection services where available.

7

ASSESS THE SCHOOL ENVIRONMENT**Is the child/adolescent in school?****YES****NO**

- » Provide information regarding educational services and educate carer on importance of keeping the child/adolescent in school as much as possible.

CLINICAL TIP

- » Ask the child/adolescent directly about these exposures when developmentally appropriate and safe to do so.

**Is the child/adolescent:**

- » Being bullied, picked on or made fun of?
- » Not able to participate and learn?
- » Not wanting/refusing to attend school?

NO**YES**

- » After getting consent, liaise with teachers and other school staff. Go to Management (2.7).
- » If there has been an absence from school, try to help the child/adolescent return to school as soon as possible and explore reasons for absence.

» Go to CMH 2 (Management)



CMH 2 » Management

PROTOCOL

1

Developmental Delay/Disorder

- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide psychoeducation to person and carers and parenting advice. Provide guidance on developmental disorders. (2.2 and 2.3)
- » Provide carer support. (2.6)
- » Liaise with teachers and other school staff. (2.7)
- » Link with other available resources in the community such as Community-Based Rehabilitation.
- » Offer Parent Skills Training, when available. (2.8)
- » Refer children with developmental disorders to specialist for further assessment, advice on management plan and family planning.
- » Ensure appropriate follow-up every three months or more, if needed.
- » **DO NOT** offer pharmacological treatment.

PROTOCOL

2

Problems with Behaviour

- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide guidance on improving behaviour. (2.3)
- » Assess for and manage stressors, reduce stress and strengthen social supports.
- » Liaise with teachers and other school staff. (2.7)
- » Link with other available resources in the community.
- » Offer follow-up.

PROTOCOL

3

Attention Deficit Hyperactivity Disorder (ADHD)

- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide psychoeducation to person and carers and parenting advice. Provide guidance on improving behaviour. (2.2 and 2.3)
- » Assess for and manage stressors, reduce stress and strengthen social supports.
- » Provide carer support. (2.6)
- » Liaise with teachers and other school staff. (2.7)
- » Link with other available resources in the community.
- » Consider Parent Skills Training when available. (2.8)
- » Consider behavioural interventions when available. (2.8)
- » If above treatments have failed AND the child/adolescent has a diagnosis of ADHD AND is at least 6 years old, refer to a specialist for methylphenidate treatment.
- » Ensure appropriate follow-up every three months or more, if needed.

PROTOCOL**4****Conduct Disorder**

- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide psychoeducation to person and carers and parenting advice. (2.2) 
- » Provide guidance on improving behaviour. (2.3)
- » Assess and manage stressors, reduce stress and strengthen social supports.
- » Provide carer support. (2.6)
- » Liaise with teachers and other school staff. (2.7)
- » Consider Parent Skills Training when available. (2.8)
- » Link with other available resources in the community.
- » Ensure appropriate follow-up every three months or more, if needed. 
- » Consider behavioural interventions when available. (2.8)
- » **✗ DO NOT** offer pharmacological treatment.

PROTOCOL**5****Problems with Emotions**

- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide psychoeducation to the person and carers and parenting advice. (2.2) 
- » Assess for and manage stressors, reduce stress and strengthen social supports.
- » Liaise with teachers and other school staff. (2.7)
- » Link with other available resources in the community.

PROTOCOL**6****Emotional Disorder or Depression**

- » **✗ DO NOT** consider pharmacological treatment as first line treatment.
- » **✗ DO NOT** prescribe pharmacological treatment for children younger than 12 years.
- » Provide guidance on child/adolescent well-being. (2.1)
- » Provide psychoeducation to the person and carers. (2.2 and 2.5) 
- » Provide carer support. (2.6)
- » Liaise with teachers and other school staff. (2.7)
- » Link with other available resources in the community.
- » Assess for and manage stressors, reduce stress and strengthen social supports.
- » Consider Parent Skills Training when available. (2.8)
- » Consider referral for behavioural intervention or interpersonal therapy.
- » When psychological interventions prove ineffective, consult a specialist for Fluoxetine (no other SSRIs or TCAs). Go to »DEP for medication details.
- » Ensure appropriate follow-up once a month or more, if needed. 

PSYCHOSOCIAL INTERVENTIONS



2.1 Guidance to promote child/adolescent well-being and functioning



- » Can be provided to all children, adolescents and carers even if no disorder is suspected.

ENCOURAGE THE CARER TO:

- » Spend time with their child in enjoyable activities.
Play and communicate with their child/adolescent.
http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/
- » Listen to the child/adolescent and show understanding and respect.
- » Protect them from any form of maltreatment, including bullying and exposure to violence in the home, at school, and in the community.
- » Anticipate major life changes (such as puberty, starting school, or birth of a sibling) and provide support.

ENCOURAGE AND HELP THE CHILD/ADOLESCENT TO:

- » **Get enough sleep.** Promote regular bed routines and remove TV or other electronic devices with screens from the sleeping area/bedroom.
- » **Eat regularly.** All children/adolescents need three meals (breakfast, mid-day, and evening) and some snacks each day.
- » **Be physically active.** If they are able, children and adolescents aged 5–17 should do 60 minutes or more of

physical activity each day through daily activities, play, or sports. See www.who.int/dietphysicalactivity/publications/recommendations5_17years

- » Participate in school, community, and other social activities as much as possible.
- » Spend time with trusted friends and family.
- » Avoid the use of drugs, alcohol, and nicotine.

2.2 Psychoeducation to person and carers and parenting advice

- » Explain the delay or difficulty to the carer and the child/adolescent as appropriate and help them identify strengths and resources.
- » Praise the carer and the child/adolescents for their efforts.
- » Explain to the carer that parenting a child/adolescent with an emotional, behavioural or developmental delay or disorder can be rewarding but also very challenging.
- » Explain that persons with mental disorders should not be blamed for having the disorder. Encourage carers to be kind and supportive and show love and affection.
- » Promote and protect human rights of the person and the family and be vigilant about maintaining human rights and dignity.
- » Help carers to have realistic expectations and encourage them to contact other carers of children/adolescents with similar conditions for mutual support.

» Guidance for improving behaviour can be provided to all carers who are having difficulty with their child/adolescent's behaviour even if a behavioural disorder is not suspected.

2.3 Guidance for improving behaviour

ENCOURAGE THE CARER TO:

- » Give loving attention, including playing with the child every day. Provide opportunities for the adolescents to talk to you.
- » Be consistent about what your child/adolescent is allowed and not allowed to do. Give clear, simple, and short instructions on what the child should and should not do.
- » Give the child/adolescent simple daily household tasks to do that match their ability level and praise them immediately after they do the task.
- » Praise or reward the child/adolescent when you observe good behaviour and give no reward when behaviour is problematic.
- » Find ways to avoid severe confrontations or foreseeable difficult situations.
- » Respond only to the most important problem behaviours and make punishment mild (e.g. withholding rewards and fun activities) and infrequent compared to the amount of praise.
- » Put off discussions with the child/adolescent until you are calm. Avoid using criticism, yelling, and name-calling.
- » **✗ DO NOT** use threats or physical punishment, and never physically abuse the child/adolescent. Physical punishment can harm the child-carer relationship; it does not work as well as other methods and can make behaviour problems worse.
- » Encourage age-appropriate play (e.g. sports, drawing or other hobbies) for adolescents and offer age-appropriate support in practical ways (e.g. with homework or other life skills).

2.4 Psychoeducation for developmental delay/disorder

ENCOURAGE THE CARER TO:

- » Learn what the child's strengths and weaknesses are and how they learn best, what is stressful to the child and what makes him/her happy, and what causes problem behaviours and what prevents them.
- » Learn how the child communicates and responds (using words, gestures, non-verbal expression, and behaviours).
- » Help the child develop by engaging with her/him in everyday activities and play.
- » Children learn best during activities that are fun and positive.
- » Involve them in everyday life, starting with simple tasks, one at a time. Break complex activities down into simple steps so that the child can learn and be rewarded one step at a time.
- » Make predictable daily routines by scheduling regular times for eating, playing, learning, and sleeping.
- » Keep their environment stimulating: avoid leaving the child alone for hours without someone to talk to and limit time spent watching TV and playing electronic games.
- » Keep them in the school setting for as long as possible, attending mainstream schools even if only part-time.
- » Use balanced discipline. When the child/adolescent does something good, offer a reward. Distract the child/adolescent from things they should not do.
- » **✖ DO NOT** use threats or physical punishments when the behaviour is problematic.

» Persons with developmental disorders may often have associated behavioural problems that are difficult for the carer to manage. See guidance for improving behaviours. (2.3)

» Promote and protect the human rights of the person and family and be vigilant about maintaining human rights and dignity.

- Educate carers to avoid institutionalization.
- Promote access to health information and services.
- Promote access to schooling and other forms of education.
- Promote access to occupations.
- Promote participation in family and community life.

» Make predictable routines in the morning and at bedtime. Promote regular sleep habits. Schedule the day with regular times for eating, playing, learning, and sleeping.

» For excessive and unrealistic fears:

- Praise the child/adolescent or give small rewards when they try new things or act bravely.
- Help the child practice facing the difficult situation one small step at a time (e.g. if the child is afraid of separating from the carer, help the child gradually increase the amount of time he/she plays alone while the carer is nearby).
- Acknowledge the child's feelings and worries and encourage them to confront their fears.
- Help the child/adolescent create a plan to help them cope in case a feared situation occurs.

2.5 Psychoeducation for emotional problems/disorders including depression in adolescents

- » Address any stressful situation in the family environment such as parental discord or a parent's mental disorder. With the help of teachers explore possible adverse circumstances in the school environment.
- » Provide opportunities for quality time with the carer and the family.
- » Encourage and help the child/adolescent to continue (or restart) pleasurable and social activities.
- » Encourage the child/adolescent to practice regular physical activity, gradually increasing the duration of sessions.
- » Consider training the child/adolescent and carer in breathing exercises, progressive muscle relaxation and other cultural equivalents.

» Explain that emotional disorders are common and can happen to anybody. The occurrence of emotional disorders does not mean that the person is weak or lazy.

» Emotional disorders can cause unjustified thoughts of hopelessness and worthlessness. Explain that these views are likely to improve once the emotional disorders improve.

» Make the person aware that if they notice thoughts of self-harm or suicide, they should tell a trusted person and come back for help immediately.

PSYCHOSOCIAL INTERVENTIONS (CONT.)

2.6 Carer support

- » Assess the psychosocial impact of the child/adolescent's disorders on the carers, and offer support for their personal, social, and mental health needs.
- » Promote necessary support and resources for their family life, employment, social activities, and health.
- » Arrange for respite care (trustworthy carers taking over care on a short term basis) to give primary carers a break, especially if the child has a developmental disorder.
- » Support family to handle social and familial problems and help to problem solve.

2.7 Liaise with teachers and other school staff

- » After getting consent from the child/adolescent and carer, contact the child/adolescent's teacher and provide advice/ make a plan on how to support the child with learning and participation in school activities.
- » Explain that the child/adolescent's mental disorder is affecting their learning/behaviour/social functioning and that there are things the teacher can do to help.

» Ask about any stressful situations that may have an adverse impact on the child's emotional well-being and learning. If the child is being bullied, advise the teacher on appropriate action to stop it.

» Explore strategies to help engage the child in school activities and facilitate learning, inclusion, and participation.

» Simple tips:

- Provide opportunities for the child/adolescent to use their skills and strengths.
- Ask the student to sit at the front of the class.
- Give the student extra time to understand and complete assignments.
- Divide long assignments into smaller pieces and assign one piece at a time.
- Provide extra praise for effort and rewards for achievements.
-  DO NOT use threats or physical punishments or excessive criticism.
- For students with significant difficulties in the classroom, recruit a volunteer to come to class to provide one-on-one attention or pair the student with a peer who can provide support or help with learning.
- If the child/adolescent has been out of school, help them return as soon as possible by creating a gradually increasing reintegration schedule. During the reintegration period, the student should be excused from quizzes and exams.

2.8 Brief psychological treatments

This guide does not provide specific protocols to implement brief psychological interventions, such as parent skills training, interpersonal therapy and behavioural therapy. WHO has developed Parent Skills Training package for caregivers of children with developmental delay/disorders and is available on request.



CMH 3 » Follow-up

1

ASSESS FOR IMPROVEMENT

Is the person improving?

Reassess and monitor the child/adolescent's symptoms, behaviour, and functioning at every visit.



CLINICAL TIP

» If exposure to one or more types of maltreatment was identified in the assessment, assess ongoing exposure and risks to the child/adolescent.

YES

NO

- » Continue with management plan and follow-up until symptoms cease or remit.
- » Provide additional psychoeducation and advice on parenting.
- » **If on medication**, consider gradually reducing medication dose in consultation with a specialist.
- » **If not on medication**, decrease frequency of follow up once symptoms have subsided and the child/adolescent is able to perform well in daily life.

- » Provide additional psychoeducation and advice on parenting, as appropriate.
- » Review psychosocial interventions and revise management plan as needed. Involve child/adolescent and carers in decision-making, as appropriate.
- » Offer regular follow-up.

If NO improvement in symptoms and/or functioning in 6 months:

- » Provide additional interventions if available.
- » Increase the frequency of follow-up visits as needed.
- » **REFER TO SPECIALIST** if available, for further assessment and management.

CLINICAL TIP

- » For adolescents, plan to see the adolescent separately from their parent/carer for part of the follow-up visit. Clarify the confidential nature of the health care discussion, including in what circumstances parents or other adults will be given information.



DEVELOPMENTAL DISORDERS

If no improvement, further deterioration, predicted danger to the child, or physical health is affected (such as nutritional problems),

- » REFER TO SPECIALIST for further assessment and advice on management plan.

- ✖ DO NOT consider pharmacological treatment.

ADHD

If no improvement and the child is at least 6 years old and has received psychosocial treatment for at least 6 months

- » Refer to or consult SPECIALIST for methylphenidate use.

CONDUCT DISORDERS

If no improvement or predicted danger to the adolescent

- » REFER TO SPECIALIST for further assessment and advice on management plan.

- ✖ DO NOT consider pharmacological treatment.

EMOTIONAL DISORDERS

If no improvement and the child/adolescent has received psychosocial treatment for at least 6 months

- » REFER TO SPECIALIST.

- ✖ DO NOT initiate pharmacological treatment.

DEPRESSION

If no improvement and the adolescent is 12 years or older and has received psychosocial treatment for at least 6 months

- » Refer to or consult SPECIALIST for fluoxetine (but not other SSRIs or TCAs).

2

CONDUCT ROUTINE ASSESSMENTS

At every visit:

- » For children under 5 years, monitor child development.
- » Assess for the presence of any new problem or symptom related to mood, behaviour or development/learning. For adolescents, assess for the presence of worsening mood (irritable, easily annoyed or frustrated, down or sad) or suicidal thoughts.
Go back to Assessment Step 4 for worsening mood. Go to »SUI for suicidal thoughts.
- » Explore and address psychosocial stressors in the home, school or work environment, including exposure to violence or other forms of maltreatment.
- » Assess opportunities for the child/adolescent to participate in family and social life.
- » Assess carers' needs and support available to the family.
- » Monitor attendance at school.
- » Review management plan and monitor adherence to psychosocial interventions.
- » If on medication, review adherence, side-effects, and dosing.

3

MONITOR PHARMACOLOGICAL TREATMENT AS APPLICABLE

Additional monitoring if the adolescent has been prescribed fluoxetine

- » Record prescription and administration details.
- » **Weekly for the first month, then every month:** monitor for reported side-effects and changes in mood and other symptoms.
- » Consult specialist if you identify severe medication side-effects or adverse events (e.g. new or worsening suicidal thoughts, suicidal or self-harming behaviour, agitation, irritability, anxiety or insomnia). 
- » Advise the adolescent to continue the medication even if they feel better. The medication should be continued for 9-12 months after the symptoms have resolved to reduce the risk of relapse.
- » Advise against suddenly stopping the medication.
- » **If symptoms have been resolved for 9-12 months:** Discuss with adolescent and carer risks and benefits to taper off medication. Reduce treatment gradually over minimum 4 weeks, monitor closely for symptom recurrence.

Additional monitoring if the child has been prescribed methylphenidate

- » Record prescription and administration details.
- » Monitor potential for misuse and diversion.
- » **Every three months:** monitor/record height, weight, blood pressure, reported side-effects, and changes in behaviour.
- » Consult specialist if you observe medication side-effects (e.g. failure to make expected gains in weight and height, increased blood pressure, agitation, anxiety, and severe insomnia). 
- » **After one year of treatment:** Consult specialist regarding the continuation of methylphenidate.

DEMENTIA

Dementia is a chronic and progressive syndrome due to changes in the brain. Although it can occur at any age, it is more common in older people. Dementia is a significant cause of disability and dependency among older people worldwide; it has a physical, psychological, social, and economic impact on carers, families, and society at large.

The conditions that cause dementia produce changes in a person's mental ability, personality, and behaviour. People with dementia commonly experience problems with memory and the skills needed to carry out everyday activities. Dementia is not part of normal ageing. Alzheimer's disease is the most common cause, however, dementia can be caused by a variety of diseases and injuries to the brain. People with dementia often present with forgetfulness or feeling depressed. Other common symptoms include deterioration

in emotional control, social behaviour, or motivation. People with dementia may be totally unaware of these changes and may not seek help. Family members may notice memory problems, changes in personality or behaviour, confusion, wandering, or incontinence. However some people with dementia and their carers may deny or minimize the severity of memory loss and associated problems. Dementia results in decline in cognitive functioning and usually interferes with activities of daily living, such as washing, dressing, eating, personal hygiene, and toilet activities. Although there is no cure, with early recognition and supportive treatment, the lives of people with dementia and their caregivers can be significantly improved, and the physical health, cognition, activity, and well-being of the person with dementia can be optimized.

DEM » Quick Overview



ASSESSMENT

- » Assess for signs of dementia
- » Are there any other explanations for the symptoms?
 - Rule out delirium
 - Rule out depression (pseudodementia)
- » Evaluate for other medical issues
- » Assess for behavioral or psychological symptoms
- » Rule out other MNS conditions
- » Evaluate the needs of carers



MANAGEMENT

- » Management Protocols
 1. Dementia – without behavioural/psychological symptoms
 2. Dementia – with behavioural/psychological symptoms
- » Psychosocial Interventions
- » Pharmacological Interventions



FOLLOW-UP



DEM 1 » Assessment



CLINICAL TIP:

Interview the key informant (someone who knows the person well) and ask about recent changes in thinking and reasoning, memory and orientation. Occasional memory lapses are common in older people, whereas some problems can be significant even if infrequent.

Ask, for example, whether the person often forgets where they put things. Do they sometimes forget what happened the day before? Does the person sometimes forget where they are?

Ask the informant when these problems started and whether they have been getting worse over time.

CLINICAL TIP

Assess directly by testing memory, orientation, and language skills with a general neurologic assessment, utilizing culturally adapted tools if available. See Essential Care & Practice (» ECP).

COMMON PRESENTATIONS OF DEMENTIA

- Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place, and person)
- Mood or behavioural problems such as apathy (appearing uninterested) or irritability
- Loss of emotional control-easily upset, irritable, or tearful
- Difficulties in carrying out usual work, domestic, or social activities

1



Assess for signs of dementia

Are there problems with memory and/or orientation?

(e.g. forgetting what happened the previous day or not knowing where he or she is)

NO

YES

DEMENTIA is unlikely.

» Screen for other MNS conditions.

Does the person have difficulties in performing key roles/activities?

(e.g. with daily activities such as shopping, paying bills, cooking, etc.)

NO

YES

DEMENTIA is unlikely.

» Screen for other MNS conditions.

2

Are there any other explanations for the symptoms?



Have the symptoms been present and slowly progressing for at least 6 months?

YES

NO

» Ask for ANY of the following:

- Abrupt onset
- Short duration (days to weeks)
- Disturbance at night and associated with impairment of consciousness
- Disorientation of time and place

NO

YES

Does the person have moderate to severe DEPRESSION? Go to »DEP.

YES

NO

Suspect DELIRIUM



» Manage depression. Go to »DEP.

» Once treated for depression, review criteria for dementia. Go to STEP 1

Suspect DEMENTIA

» Evaluate for possible medical causes (toxic/metabolic/infectious).

- Obtain urinalysis to evaluate for infection
- Review medications, particularly those with significant anticholinergic side effects (such as antidepressants, many antihistamines, and antipsychotics)
- Evaluate for pain
- Evaluate nutritional status, consider vitamin deficiency or electrolyte abnormality



CLINICAL TIP

Delirium: transient fluctuating mental state characterized by disturbed attention that develops over a short period of time and tends to fluctuate during the course of a day. It may result from acute organic causes such as infections, medication, metabolic abnormalities, substance intoxication, or substance withdrawal.

CLINICAL TIP

Cognitive impairment may be the result of depression – “Pseudodementia”



Evaluate for other medical issues

Does the person have ANY of the following?

- » Less than 60 years old prior to symptom onset
- » Onset of symptoms associated with head injury, stroke, or altered or loss of consciousness
- » Clinical history of goitre, slow pulse, dry skin (hypothyroidism)
- » History of sexually transmitted infection (STI), including HIV/AIDS

Unusual Features.

» Refer to specialist. 

YES

NO

Does the person have poor dietary intake, malnutrition, or anaemia?

NO

YES

- » Fortification of food and monitoring of weight is necessary.

Does the person have cardiovascular risk factors?

- Hypertension
- High cholesterol
- Diabetes
- Smoking

- Obesity
- Heart disease (chest pain, heart attack)
- Previous stroke or transient ischaemic attack (TIA)

NO

YES

- » Refer to appropriate SPECIALIST. 
- » Reduce cardiovascular risk factors:

- Advise person to stop smoking
- Treat hypertension
- Advise weight-reducing diet for obesity
- Treat diabetes

4

Evaluate the needs of the carers.**CLINICAL TIP****Determine:**

- Who are the main carers?
- Who else provides care and what care do they provide?
- What is difficult to manage?

Is the carer having difficulty coping or experiencing strain?

NO

YES

» Explore psychosocial interventions about respite care, activation of community support network, and family/individual therapy, if available.

Is the carer experiencing depressed mood?

NO

YES

» For assessment of depression in care, go to »DEP.
» Try to address strain with support and psychoeducation. Problem-solving counselling or cognitive behavioural therapy.

Is the carer facing loss of income and/or additional expenses because of the needs for care?

NO

YES

» Explore local financial support options, such as disability services.

5

Does the person have ANY of the following
BEHAVIOURAL or PSYCHOLOGICAL symptoms of dementia?

Behavioural symptoms, e.g.

- » Wandering
- » Night-time disturbance
- » Agitation
- » Aggression

Psychological symptoms, e.g.

- » Hallucinations
- » Delusions
- » Anxiety
- » Uncontrollable emotional outbursts

YES

NO

» Go to PROTOCOL 1

» Go to PROTOCOL 2

! IF THERE IS IMMINENT RISK OF SUICIDE,
ASSESS AND MANAGE before continuing
to Protocol. Go to »SUI.



IF THE PERSON HAS OTHER CONCURRENT
MNS CONDITIONS, ASSESS AND MANAGE
before continuing to Protocol





DEM 2 » Management

PROTOCOL

1

DEMENTIA – without behavioural and/or psychological symptoms

- » Provide **Psychoeducation** to person and carers. (2.1)
- » Encourage carers to conduct interventions to improve cognitive functioning. (2.4)
- » **Promote independence**, functioning, and mobility. (2.3)
- » **Provide carers with support.** (2.5)
- » Consider medications only in settings where specific diagnosis of Alzheimer's Disease can be made AND where adequate support and supervision by specialists and monitoring (for side-effects) from carers is available. (2.6)

PROTOCOL

2

DEMENTIA – with behavioural and/or psychological symptoms

Follow PROTOCOL 1



- » Manage behavioral and psychological symptoms. (2.2)

If there is imminent risk to the person or carer:

- » Consider antipsychotic medications if symptoms persist or if there is imminent risk of harm. (2.7)
- » **Refer to specialist** when available.

PSYCHOSOCIAL INTERVENTIONS



2.1 Psychoeducation

- » Ask people assessed with dementia whether they wish to know the diagnosis and with whom it should be shared.
 - Tailor the explanation of the illness so that they can understand and retain the information.
 - Give basic information. (Do not overload them with too much!)
- » Key Messages:
 - Dementia is an illness of the brain and tends to get worse over time.
 - Although there is no cure, there is much that can be done to help and support the person and the family.
 - Many specific concerns and behaviors can be managed as they arise. A lot can be done to make the person more comfortable and to make providing support less stressful for the carer.

2.2 Manage behavioral and psychological symptoms

- » Identify and treat underlying physical health problems that may affect behaviour. Look for pain, infections, etc. on physical exam (Go to »ECP). Refer to specialist if needed.
- » Identify events (e.g. shopping at busy market) or factors (e.g. going out alone) that may precede, trigger, or enhance problem behaviours. Modify these triggers if possible.

- » Consider environmental adaptations such as appropriate seating, safe wandering areas, signs (e.g. 'no exit' sign on the street door or signpost to toilet).
- » Encourage soothing, calming, or distracting strategies. Suggest an activity the person enjoys (e.g. going for a walk, listening to music, engaging in conversation), especially when feeling agitated.

2.3 Promote functioning in activities of daily living (ADLs) and community life

- » For interventions that promote functioning in ADLs and community life, go to »ECP.
- » Plan for ADL in a way that maximises independent activity, enhances function, helps to adapt and develop skills, and minimises the need for support. Facilitate functioning and participation in the community involving people and their carers in planning and implementation of these interventions. Assist in liaison with available social resources.
 - Give advice to maintain independent toileting skills, including prompting and regulation of fluid intake. (If incontinence occurs, all possible causes should be evaluated and treatments trialed before concluding it is permanent).
 - Keep the environment at home safe to reduce the risk of falling and injury.
 - Inform family members that it is important to keep the floor of the person's home without clutter to reduce the risk of falling.

- Recommend making adaptations in the person's home. It can be helpful to add hand-rails or ramps. Signs for key locations (e.g. toilet, bathroom, bedroom) can help ensure that the person does not get lost or lose orientation while home.
- Recommend physical activity and exercise to maintain mobility and reduce risk of falls.
- Advise recreational activities (tailored to stage and severity of dementia).
- Manage sensory deficits (such as low vision or poor hearing) with appropriate devices (e.g. magnifying glass, hearing aids).
- Refer for occupational therapy, if available.

2.4 Interventions to improve cognitive functioning

Encourage carers to:

- » Provide regular orientation information (e.g. day, date, time, names of people) so that the person can remain oriented.
- » Use materials such as newspapers, radio, or TV programmes, family albums and household items to promote communication, to orient them to current events, to stimulate memories, and to enable people to share and value their experiences.
- » Use simple short sentences to make verbal communication clear. Try to minimize competing noises, such as radio, TV, or other conversation. Listen carefully to what the person has to say.
- » Keep things simple, avoid changes to routine, and, as far as possible, avoid exposing the person to unfamiliar and bewildering places.

PSYCHOSOCIAL (CONT.)

2.5 Carer support

- » Assess the impact on the carer and the carer's needs to ensure necessary support and resources for their family life, employment, social activities, and health (see »DEM 1).
- » Acknowledge that it can be extremely frustrating and stressful to take care of people with dementia. **Carers need to be encouraged to respect the dignity of the person with dementia and avoid hostility towards, or neglect of, the person.**
- » Encourage the carers to seek help if they are experiencing difficulty or strain in caring for their loved one.
- » Provide information to the carer regarding dementia, keeping in mind the wishes of the person with dementia.
- » Provide training and support in specific skills, e.g. managing difficult behaviour, if necessary. To be most effective, elicit active participation, e.g. role play.
- » Consider providing practical support when feasible, e.g. home-based respite care. Another family or suitable person can supervise and care for the person with dementia to provide the main carer with a period of relief to rest or carry out other activities.
- » Explore whether the person qualifies for any disability benefits or other social/financial support (government or non-governmental).

PHARMACOLOGICAL INTERVENTIONS

2.6 For Dementia without behavioural and/or psychological symptoms

- »  Do not consider cholinesterase inhibitors (like donepezil, galantamine and rivastigmine) or memantine routinely for all cases of dementia.
- » Consider medications only in settings where specific diagnosis of Alzheimer's Disease can be made AND where adequate **support and supervision by specialists** and monitoring (for side-effects and response) from carers is available.

If appropriate:

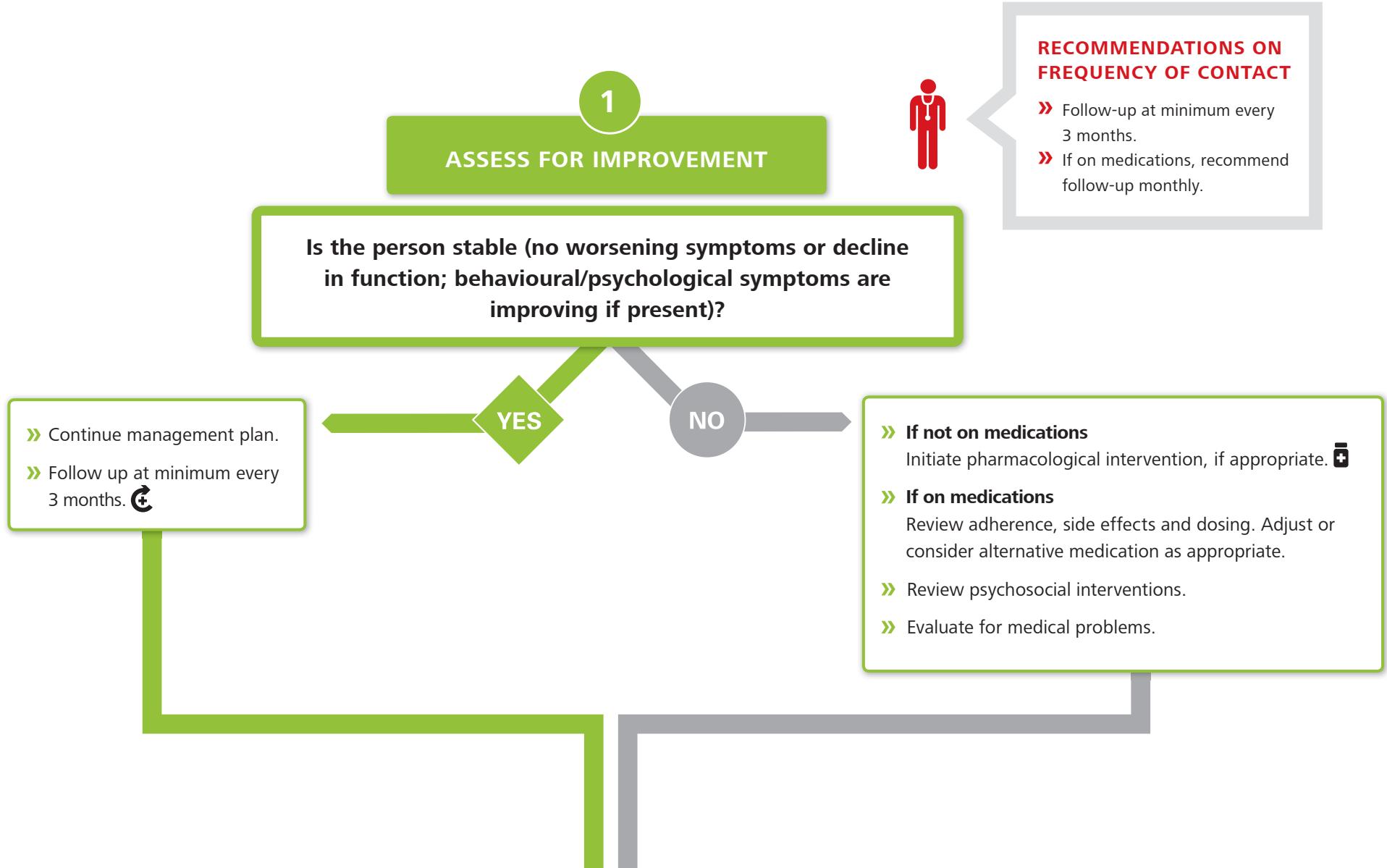
- » For dementia with suspected Alzheimer's Disease, and with CLOSE MONITORING, consider cholinesterase inhibitors (e.g. donepezil, galantamine, rivastigmine) OR memantine.
- » For dementia with associated vascular disease, consider memantine.

2.7 Antipsychotic medication for behavioural and/or psychological symptoms

- » Provide psychosocial interventions first. 
- » If there is imminent risk to person or carers, consider antipsychotic medication. Go to »PSY 2, Management for details about antipsychotic medication.
- » Follow the principles of:
 - "Start low, go slow" (titrate) and review the need regularly (at least monthly).
 - Use the lowest effective dose.
 - Monitor the person for extrapyramidal symptoms (EPS).
- »  Avoid i.v. haloperidol.
- »  Avoid diazepam.



DEM 3 » Follow-up



2

CONDUCT ROUTINE ASSESSMENTS**At each visit, routinely assess and address the following:**» **Medication side-effects**

If on antipsychotics, check for extrapyramidal symptoms
(Go to » PSY). Stop or reduce dose if present.

» **Medical and MNS co-morbidities**» **Ability to participate in activities of daily living and any needs of care**» **Safety risks** and offer appropriate behaviour modification if disease has progressed (e.g. limit driving, cooking, etc.)» **New behavioural or psychological symptoms**» **Symptoms of depression** (Go to » DEP) or imminent risk of self-harm/suicide (Go to » SUI).» **Needs of the carers**

3

PROVIDE PSYCHOSOCIAL INTERVENTIONS» **Continue to promote functioning and provide psychosocial education.** 

See » DEM 2.1-2.5 and » ECP for details.

DISORDERS DUE TO SUBSTANCE USE

Disorders due to substance use include both drug and alcohol use disorders and certain conditions including acute intoxication, overdose and withdrawal.

ACUTE INTOXICATION is a transient condition following intake of a psychoactive substance resulting in disturbances of consciousness, cognition, perception, affect, or behaviour.

OVERDOSE is the use of any drug in such an amount that acute adverse physical or mental effects are produced.

WITHDRAWAL is the experience of a set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance; it has been consumed in high enough doses and for a long enough duration for the person to be physically or mentally dependent on it. Withdrawal symptoms are, essentially, opposite to those that are produced by the psychoactive substance itself.

HARMFUL USE is a pattern of psychoactive substance use that damages health. This damage may be physical, e.g. liver disease, or mental, e.g. episodes of depressive disorder. It is often associated with social consequences, e.g. family or work problems.

DEPENDENCE is a cluster of physiological, behavioural, and cognitive phenomena in which the use of a psychoactive substance takes on a much higher priority for a given individual than other behaviours that once had greater value. It is characterized by a strong craving to use the substance and a loss of control over its use. It is often associated with high levels of substance use and the presence of a withdrawal state upon cessation.

SUB » Quick Overview



ASSESSMENT

- » **EMERGENCY ASSESSMENT:**
Is intoxication or withdrawal suspected?
 - Does the person appear sedated?
 - Does the person appear overstimulated, anxious, or agitated?
 - Does the person appear confused?
- » **Does the person use psychoactive substances?**
- » **Is there harmful use?**
- » **Does the person have substance dependence?**



MANAGEMENT

» Management Protocols

1. Harmful use
2. Dependence
3. Alcohol withdrawal
4. Opioid withdrawal
5. Opioid agonist maintenance treatment
6. Benzodiazepine withdrawal

» Psychosocial Interventions

» Pharmacological Interventions



FOLLOW-UP

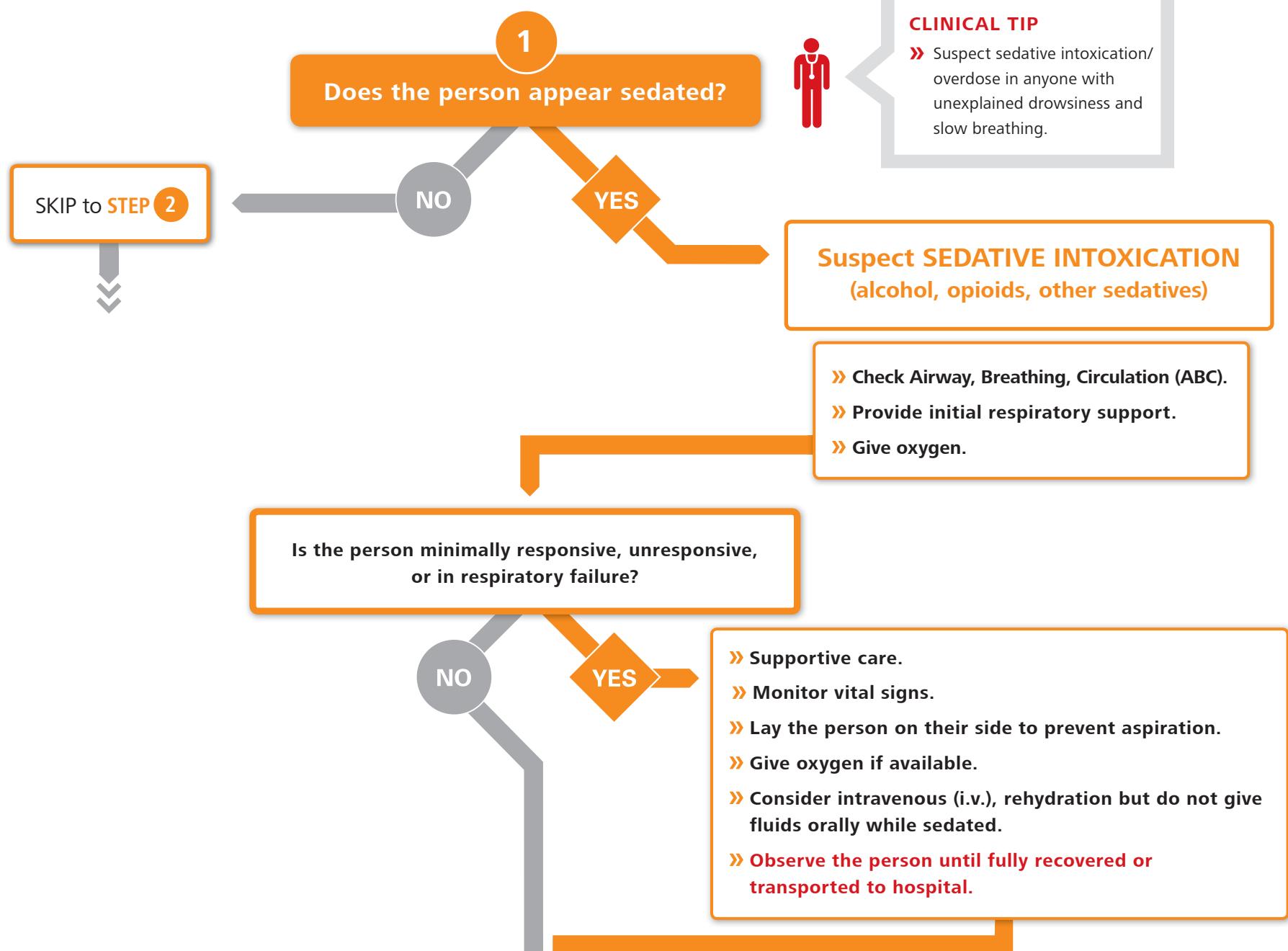
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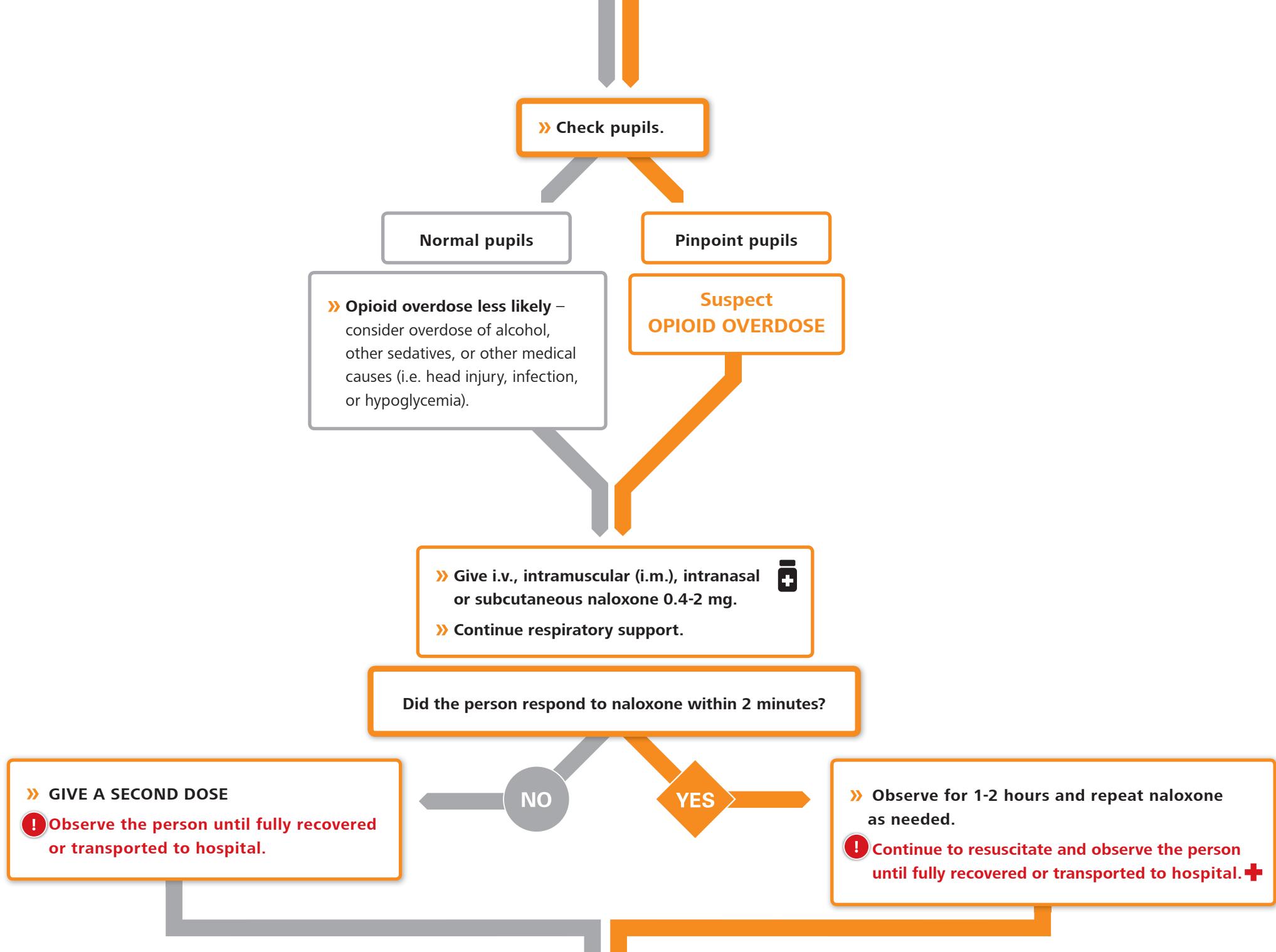
SUB » EMERGENCY

If no emergency presentation present, go to »SUB 1, Assessment.

EMERGENCY PRESENTATIONS OF DISORDERS DUE TO SUBSTANCE USE

- **Alcohol intoxication:** Smell of alcohol on the breath, slurred speech, uninhibited behaviour; disturbance in the level of consciousness, cognition, perception, affect, or behaviour
- **Opioid overdose:** Unresponsive or minimally responsive, slow respiratory rate, pinpoint pupils
- **Alcohol or other sedative withdrawal:** Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea, anxiety; seizure and confusion in severe cases
- **Stimulant intoxication:** Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of psychoactive substances, raised pulse and blood pressure, aggressive, erratic, or violent behaviour
- **Delirium associated with substance use:** Confusion, hallucination, racing thoughts, anxiety, agitation, disorientation, typically in association with either stimulant intoxication or alcohol (or other sedative) withdrawal





2

Does the person appear
overstimulated, anxious, or agitated?

YES

NO

SKIP to STEP 3

ASSESS AND MANAGE A - D

A

Person has recently stopped drinking or using sedatives and is now showing any of the following signs: Tremors, sweating, vomiting, increased blood pressure (BP) & heart rate, and agitation.

Suspect
ALCOHOL,
BENZODIAZEPINE OR
OTHER SEDATIVE
WITHDRAWAL

» MANAGE WITHDRAWAL

- If the person has tremors, sweating, or vital sign changes then give diazepam 10-20 mg orally (p.o.) and transfer to hospital or detoxification facility if possible.
- Observe and repeat doses as needed for continued signs of withdrawal (tremors, sweating, increased BP and heart rate).
- For alcohol withdrawal **only**: Give thiamine 100 mg daily for five days.

!

TRANSFER IMMEDIATELY TO A HOSPITAL
if the following are present:

- Other serious medical problems, e.g. hepatic encephalopathy, gastrointestinal bleeding, or head injury.
- Seizures: give diazepam 10-20 mg p.o., i.v. or rectum (p.r.) first.
- Delirium: give diazepam 10-20 mg p.o., i.v. or p.r. first. If severe and not responsive to diazepam, give an anti-psychotic medication such as haloperidol 1-2.5 mg p.o. or i.m. Continue to treat other signs of withdrawal (tremors, sweating, vital signs changes) with diazepam p.o., i.v. or p.r.



B

Person has recently used stimulants (cocaine, amphetamine type stimulants (ATS) or other stimulants) and is showing any of the following signs: dilated pupils, anxiety, agitation, hyper-excitable state, racing thoughts, raised pulse and blood pressure.

**Suspect
ACUTE STIMULANT
INTOXICATION**

- » Give diazepam 5-10 mg p.o., i.v., or p.r. in titrated doses until the person is calm and lightly sedated.
- » If psychotic symptoms are not responsive to diazepam, consider antipsychotic medication such as haloperidol 1-2.5 mg p.o. or i.m.. **Treat until symptoms resolve. If symptoms persist, go to »PSY.**
- » For management of persons with aggressive and/or agitated behaviour go to »PSY, Table 5.
- » **If the person has chest pain, tachyarrhythmias, or other neurological signs TRANSFER TO HOSPITAL.** 
- » During the post-intoxication phase, be alert for suicidal thoughts or actions. If suicidal thoughts are present, go to »SUI.

C

Person has recently stopped using opioids and is showing any of the following signs: dilated pupils, muscle aches, abdominal cramps, headache, nausea, vomiting, diarrhea, runny eyes and nose, anxiety, restlessness.

**Suspect
ACUTE OPIOID
WITHDRAWAL**

» MANAGE OPIOID WITHDRAWAL

- Methadone 20 mg, with a supplemental dose of 5-10 mg 4 hours later if necessary.
- Buprenorphine 4-8 mg, with a supplementary dose 12 hours later if necessary.
- If methadone or buprenorphine are not available, any opioid can be used in the acute setting, i.e. morphine sulphate 10-20 mg as an initial dose with a 10 mg extra dose if needed. Also consider an alpha adrenergic agonists, i.e. clonidine or lofexidine.

» Once stable, go to »SUB 2

D

RULE OUT OTHER MEDICAL CAUSES AND PRIORITY MNS CONDITIONS.

3

Does the person appear confused?

YES

NO

SKIP to **SUB 1 Assessment**

Are there any medical conditions which might explain the confusion, including:

- head trauma
- hypoglycaemia
- pneumonia or other infections
- hepatic encephalopathy
- cerebrovascular accidents (CVA)

NO

YES



» Manage the physical condition and refer the person to hospital.



ASSESS AND MANAGE A – C

A

Person has stopped drinking in the last week: confusion, hallucination, racing thoughts, anxiety, agitation, disorientation, typically in association with either stimulant intoxication or alcohol (or other sedative) withdrawal.

**Suspect
ALCOHOL OR
SEDATIVE
WITHDRAWAL
DELIRIUM**

- » If the person is showing other signs of alcohol or sedative withdrawal (tremors, sweating, vital signs changes)
 - Treat with diazepam 10-20 mg p.o. as needed.
 - **TRANSFER TO HOSPITAL.**
- » **Manage delirium** with antipsychotics such as haloperidol 1-2.5 mg p.o. or i.m.

B

Person has been drinking heavily in the last few days AND has any of the following signs:

- nystagmus (involuntary, rapid and repetitive movement of the eyes)
- ophthalmoplegia (weakness/paralysis of one or more of the muscles that control eye movement)
- ataxia (uncoordinated movements).

**Suspect
WERNICKE'S
ENCEPHALOPATHY**

- » Treat with thiamine 100-500 mg 2-3 times daily i.v. or i.m. for 3-5 days.
» **TRANSFER TO HOSPITAL.** 

C

Person has used stimulants in the last few days: Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of psychoactive substances, raised pulse and blood pressure, aggressive, erratic, or violent behaviour.

**Suspect
STIMULANT OR
HALLUCINOGEN
INTOXICATION**

- » Treat with diazepam 5-10 mg p.o., i.v. or p.r. until the patient is lightly sedated.
» If psychotic symptoms **do not respond to diazepam, consider an antipsychotic such as haloperidol 1-2.5 mg p.o. or i.m.**
» If psychotic symptoms **persist, go to »PSY**

CLINICAL TIP

- » Following the management of emergency presentation, GO to **»SUB 1 assessment** and **»SUB 2 management protocols 1 to 6** as appropriate.





SUB 1 » Assessment

COMMON PRESENTATIONS OF DISORDERS DUE TO SUBSTANCE USE

- *Appearing affected by alcohol or other substance (e.g. smell of alcohol, slurred speech, sedated, erratic behaviour)*
- *Signs of recent drug use (recent injection marks, skin infection)*
- *Signs and symptoms of acute behavioural effects, withdrawal features or effects of prolonged use (see Box 1)*
- *Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance)*
- *Signs of chronic liver disease (abnormal liver enzymes), jaundiced (yellow) skin and eyes, palpable and tender liver edge (in early liver disease), ascites (distended abdomen is filled with fluid), spider naevi (spider-like blood vessels visible on the surface of the skin), and altered mental status (hepatic encephalopathy)*
- *Problems with balance, walking, coordinated movements, and nystagmus*
- *Incidental findings: macrocytic anaemia, low platelet count, elevated mean corpuscular volume (MCV)*
- *Emergency presentation due to substance withdrawal overdose, or intoxication. Person may appear sedated, overstimulated, agitated, anxious or confused*
- ***Persons with disorders due to substance use may not report any problems with substance use. Look for:***
 - Recurrent requests for psychoactive medications including analgesics
 - Injuries
 - Infections associated with intravenous drug use (HIV/AIDS, Hepatitis C)



CLINICAL TIP

» Avoid stereotyping! All persons presenting to health care facilities should be asked about their tobacco and alcohol use.

BOX 1: PSYCHOACTIVE SUBSTANCES: ACUTE BEHAVIOURAL EFFECTS, WITHDRAWAL FEATURES, AND EFFECTS OF PROLONGED USE

	ACUTE BEHAVIOURAL EFFECTS	WITHDRAWAL FEATURES	EFFECTS OF PROLONGED USE
Alcohol	Smell of alcohol on breath, slurred speech, disinhibited behavior, agitation, vomiting, unsteady gait	Tremors, shaking, nausea/vomiting, increased heart rate and blood pressure, seizures, agitation, confusion, hallucinations <i>Can be life-threatening</i>	Loss of brain volume, reduction in cognitive capacity, impaired judgement, loss of balance, liver fibrosis, gastritis, anaemia, increased risk of some cancers and a range of other medical problems
Benzodiazepines	Slurred speech, disinhibited behavior, unsteady gait	Anxiety, insomnia, tremors, shaking, nausea/vomiting, increased heart rate and blood pressure, seizures, agitation, confusion, hallucinations <i>Can be life-threatening</i>	Memory impairment, increased risk of falls in the elderly, risk of fatal sedative overdose
Opioids	Pinpoint pupils, drowsiness and falling asleep, decreased awareness, slow speech	Dilated pupils, anxiety, nausea/vomiting/diarrhea, abdominal cramps, muscle aches and pains, headaches, runny eyes and nose, yawning, hair standing up on arms, increased heart rate and blood pressure	Constipation, risk of fatal sedative overdose, hypogonadism, adaptations in reward, learning and stress responses
Tobacco	Arousal, increased attention, concentration and memory; decreased anxiety and appetite; stimulant-like effects	Irritability, hostility, anxiety, dysphoria, depressed mood, increased heart rate, increased appetite	Lung disease (in tobacco smokers), cardiovascular disease, risk of cancers and other health effects
Cocaine, Methamphetamines & Amphetamine-type stimulants	Dilated pupils, increased blood pressure and heart rate, excited, euphoric, hyperactivity, rapid speech, racing thoughts, disordered thinking, paranoia, aggressive, erratic, violent	Fatigue, increased appetite, depressed, irritable mood <i>Watch out for suicidal thoughts</i>	Hypertension, increased risk of cerebrovascular accidents (CVAs), arrhythmias, heart disease, anxiety, depression
Khat	Alertness, euphoria, and mild excitation	Lethargy, depressed mood, irritability	Khat users often spend a significant portion of the day chewing khat; constipation, risk of mental health problems such as psychosis
Cannabis	Normal pupils, red conjunctivae, delayed responsiveness, euphoria, relaxation	Depressed or labile mood, anxiety, irritability, sleep disturbance (there may not be any clearly observable features)	Increased risk of mental health problems including anxiety, paranoia and psychosis, lack of motivation, difficulty in concentration, increased risk of vasospasm leading to myocardial infarction and stroke
Tramadol	Opioid effects (sedation, euphoria, etc.) followed by stimulant effects (excitation and in high doses seizures)	Predominantly opioid withdrawal effects but also some serotonin norepinephrine reuptake inhibitor (SNRI) withdrawal symptoms (depressed mood, lethargy)	Opioid dependence, risk of seizures, disturbed sleep
Volatile solvents	Dizziness, disorientation, euphoria, light-headedness, increased mood, hallucinations, delusions, incoordination, visual disturbances, anxiolysis, sedation	Increased susceptibility to seizures	Decreased cognitive function and dementia, peripheral neuropathy, other neurological sequelae, increased risk of arrhythmias causing sudden death
Hallucinogens	Increased heart rate, blood pressure, body temperature, decreased appetite, nausea, vomiting, motor incoordination, papillary dilatation, hallucinations	No evidence	Acute or chronic psychotic episodes, flashbacks or re-experiencing of drug effects long after termination of use
MDMA	Increased self-confidence, empathy, understanding, sensation of intimacy, communication, euphoria, energy	Nausea, muscle stiffness, headache, loss of appetite, blurred vision, dry mouth, insomnia, depression, anxiety, fatigue, difficulty concentrating	Neurotoxic, leads to behavioral and physiological consequences, depression

1

Does the person use substances?

Ask about use of tobacco, alcohol, and psychoactive prescription medicines. Depending on the setting and the presentation, consider asking about cannabis and other substance use.



CLINICAL TIP

While taking a history, ask:

- » How the person started using substances?
- » When they started using them?
- » What was happening in their life at that time?
- » If anyone in their family or social circle use substances?
- » If they have tried to reduce their use? Why? What happened?



- » Emphasise the health benefits of not using psychoactive substances.
- » **EXIT MODULE**

NO

YES

2

Is the substance use harmful?

For each substance used assess:

A Frequency and quantity of use. (Hint: Ask "How many days per week do you use this substance? How much do you use per day?")

B Harmful behaviours. (Hint: Ask "Does your substance use cause you any problems?")

- Injuries and accidents
- Driving while intoxicated
- Drug injection, sharing needles, reusing needles
- Relationship problems as a result of use

- Sexual activity while intoxicated that was risky or later regretted
- Legal or financial problems
- Inability to care for children responsibly

- Violence towards others
- Poor performance in education, employment roles
- Poor performance in expected social roles (e.g. parenting)

NO

YES



Remember answers for use later during assessment.

3

Is DEPENDENCE likely?

For each substance used ask about the following features of dependence:

- High levels of *frequent substance use*
- A **strong craving** or sense of compulsion to use the substance
- Difficulty **self regulating** the use of that substance despite the risks and harmful consequences
- Increasing levels of use **tolerance** and **withdrawal** symptoms on cessation

CLINICAL TIP

Patterns of substance use that suggest dependence include:

TOBACCO: several times a day, often starting in the morning.

ALCOHOL: more than 6 standard drinks at a time, and daily use.

PRESCRIPTION PILLS: taking a higher dose of medication than prescribed and lying to get prescriptions.

CANNABIS: at least 1 g of cannabis daily.

NO

YES

» Proceed to **PROTOCOL 2**

! **IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing to Protocol (Go to » SUI)**



Is the substance use harmful?

See answer in step 2, above.

NO

YES

» Proceed to **PROTOCOL 1**

! **IF THERE IS IMMINENT RISK OF SUICIDE, ASSESS AND MANAGE before continuing to Protocol (Go to » SUI)**



- » Provide psychoeducation about the risks of different levels of each substance used.
- » **EXIT MODULE**





SUB 2 » Management

PROTOCOL

1

Harmful Use

- » Provide **psychoeducation** and emphasize that the level/pattern of substance use is causing harm to health. 
- » Explore the person's motivations for substance use. Conduct **motivational interviewing**.
(See **BRIEF PSYCHOSOCIAL INTERVENTION – MOTIVATIONAL INTERVIEWING (2.2)**).
- » Advise stopping the substance completely or consuming it at a non-harmful level, if one exists.
Verbalise your intention to support the person to do this. Ask them if they are ready to make this change.
- » Explore **STRATEGIES FOR REDUCING OR STOPPING USE (2.3)** and
STRATEGIES FOR REDUCING HARM (2.5).
- » Address food, housing, and employment needs.
- » Follow up 
- » If the person is an adolescent  or a woman of child-bearing age, pregnant, or breastfeeding,
see **SPECIAL POPULATIONS**.

PROTOCOL

2

Dependence

IF THE PERSON IS DEPENDENT ON OPIOIDS:

- » Maintenance treatment is generally more effective than detoxification.
- » Assess the severity of dependence and, if appropriate, provide or refer the person for opioid agonist maintenance treatment, also known as opioid substitution therapy (OST), after detoxification. Go to **PROTOCOL 5 (Opioid Agonist Maintenance Treatment)**.
- » In the remainder of cases arrange planned detoxification, if necessary. Go to **PROTOCOL 4 (Opioid Withdrawal)**.

IF THE PERSON IS DEPENDENT ON BENZODIAZEPINES:

- » Sudden cessation can lead to seizures and delirium. Consider gradually reducing the dose of benzodiazepine with supervised dispensing or a more rapid reduction in an inpatient setting. Go to **PROTOCOL 6 (Benzodiazepine Withdrawal)**.

IF THE PERSON IS DEPENDENT ON ALCOHOL:

- » Sudden alcohol cessation can lead to seizures and delirium; however, if the person is willing to stop using alcohol, facilitate this. Determine the appropriate setting to cease alcohol use, and arrange inpatient detoxification, if necessary. Go to **PROTOCOL 3 (Alcohol Withdrawal)**.
- » Advise consumption of thiamine at a dose of 100 mg/day p.o. 
- » Consider pharmacologic intervention to prevent relapse in alcohol dependence; medications include acamprosate, naltrexone and disulfiram. Baclofen can also be used, however, its sedating effects and risk of abuse make it best reserved for specialist settings. With these medications, an effective response may include a reduction in the quantity and frequency of alcohol consumption, if not complete abstinence. Go to **Table 1**. 

FOR ALL OTHER SUBSTANCES:

- » Advise stopping the substance completely and verbalise your intention to support the person in doing so. Ask them if they are ready to do this.
- » Explore **STRATEGIES FOR REDUCING OR STOPPING USE** and **STRATEGIES FOR REDUCING HARM**.
- » Consider referral to peer help groups or rehabilitation/residential therapeutic communities, if available.
- » Address food, housing, and employment needs.
- » Assess and treat any physical or mental health co-morbidity, ideally after 2-3 weeks of abstinence, as some problems will resolve with abstinence.

IN ALL CASES:

- » Provide psychoeducation. 
- » Arrange for detoxification services if necessary or treatment in an inpatient facility where available. Treat withdrawal symptoms as needed.
- » Provide a brief intervention using motivational interviewing to encourage the person to engage in treatment of their substance dependence.
- » Consider longer-term psychosocial treatment for persons with ongoing problems related to their substance use, if they do not respond to the initial brief interventions. Evidence-based psychological therapies for disorders due to substance use include structured individual and group programmes that are run over 6-12 weeks or more, and that use techniques such as cognitive behavioural therapy, motivational enhancement therapy, contingency management therapy, community reinforcement approach, and family therapy. Evidence-based social support approaches include employment and accommodation support. 

PROTOCOL

3

Alcohol Withdrawal

- » Provide as quiet and non-stimulating an environment as possible; well-lit during the day and lit enough at night to prevent falls if the person wakes up at night.
- » Ensure adequate fluid intake and that electrolyte requirements are met, such as potassium and magnesium.
- » **ADDRESS DEHYDRATION:** Maintain adequate hydration including i.v. hydration, if needed, and encourage oral fluid intake. Be sure to give thiamine before glucose to avoid precipitating Wernicke's encephalopathy.

» Pharmacological Intervention: 

When appropriate, treat alcohol withdrawal symptoms. In the case of planned detoxification, prevent withdrawal symptoms using diazepam. The dose and duration of diazepam treatment varies according to the severity of the withdrawal.

- Administer diazepam at an initial dose of up to 40 mg daily (10 mg four times a day or 20 mg twice a day) for 3-7 days, p.o. Gradually decrease the dose and/or frequency as soon as symptoms improve. Monitor the person frequently, as each person may respond differently to this medication.
- In the **hospital setting**, diazepam can be given more frequently, (i.e. hourly), and at higher daily doses, up to 120 mg daily for the first 3 days p.o., if necessary, and based on frequent assessment of the person's withdrawal symptoms and mental status.
- In persons with **impaired hepatic metabolism**, (i.e. persons with signs of liver disease or the elderly), use a single low dose initially of 5-10 mg p.o., as benzodiazepines may have a longer duration of action in these populations. Alternatively, a shorter acting benzodiazepine such as **oxazepam may be used instead of diazepam**. See **Table 1**.
- **CAUTION**

Use caution when initiating or increasing the dose of benzodiazepines, as they can cause respiratory depression. Use caution in persons with respiratory disease and/or hepatic encephalopathy.

PREVENTING AND TREATING WERNICKE'S ENCEPHALOPATHY:

- » Chronic heavy users of alcohol are at risk for **Wernicke's encephalopathy**, a thiamine deficiency syndrome characterized by confusion, nystagmus, ophthalmoplegia (trouble with eye movements), and ataxia (uncoordinated movements).
- » **To prevent this syndrome, all persons with a history of chronic alcohol use should be given thiamine 100 mg p.o. per day. Give thiamine prior to administering glucose to avoid precipitating Wernicke's encephalopathy.**

CLINICAL TIP

For planned alcohol cessation, assess the person's risk for severe withdrawal.

Ask:

- » Have there been past episodes of severe withdrawal symptoms, including seizures or delirium?
- » Are there other significant medical or psychiatric issues?
- » Do significant withdrawal features develop within 6 hours of the person's last drink?
- » Have outpatient cessation attempts failed in the past?
- » Is the person homeless or without any social support?

If risk is high, inpatient detoxification is preferable to outpatient detoxification.



CLINICAL TIP: General principles to apply during management of any withdrawal:

- » Maintain hydration.
- » Manage specific withdrawal symptoms as they emerge, i.e. treat nausea with anti-emetics, pain with simple analgesics, and insomnia with light sedatives.
- » Allow the person to leave the treatment facility if they wish to do so.
- » Continue treatment and support after detoxification.
- » Depressive symptoms may occur in the post-intoxication period, during or after withdrawal, and/or the person may have pre-existing depression. Be alert to the risk of suicide.
- » Offer all persons continued treatment, support, and monitoring after successful detoxification, regardless of the setting in which detoxification was delivered.

PROTOCOL

4

Opioid Withdrawal

» **! CAUTION** is advised before embarking upon withdrawal from opioids, especially when there has been injection use. When a decision is made to initiate withdrawal, inform the person about what to expect, including symptoms and their duration. For example, withdrawal results in lower tolerance to opioids. This means that if the person resumes opioid use at their usual dose after withdrawal that they are at an increased risk of overdosing. Due to these risks, withdrawal is best undertaken when there is a plan for admission to a residential rehabilitation or other psychosocial support programme. Alternatively, the person may be considered for opioid substitution therapy with either methadone or buprenorphine; see the opioid agonist maintenance treatment section (see protocol 5), and select one of the following pharmacological options for management:

» **Buprenorphine:** Buprenorphine is given sublingually at a dose range of 4-16 mg per day for 3-14 days for withdrawal management. Before initiating buprenorphine treatment, it is important to wait until signs and symptoms of opioid withdrawal become evident - at least 8 hours after the last dose of heroin and 24-48 hours after the last dose of methadone; otherwise, there is a risk that buprenorphine itself will precipitate a withdrawal syndrome. Special care should be taken for individuals taking other sedating medications.

» **Methadone:** Methadone is given orally at an initial dose of 15-20 mg, increasing, if necessary, to 30 mg per day. Then gradually decrease the dose, until tapered off completely, over 3-10 days. As with buprenorphine, special care should be taken for individuals taking other sedating medications.

» **Clonidine or Lofexidine:** If opioid substitution medications are not available, clonidine or lofexidine can be used to manage some opioid withdrawal symptoms, namely hyperarousal. They are given at dose ranges of 0.1-0.15 mg 3 times daily p.o. and are dosed according to body weight. Light-headedness and sedation may result. Monitor blood pressure closely. Other symptoms of withdrawal should also be treated, i.e. nausea with anti-emetics, pain with simple analgesics, and insomnia with light sedatives.

» **Morphine sulphate:** 10-20 mg as an initial dose with 10 mg extra dose if needed. Sedation and respiratory depression which can be life threatening. Prolonged use can lead to dependence. For more details go to **Table 1**.

PROTOCOL**5****Opioid Agonist Maintenance Treatment**

- » Opioid agonist maintenance treatment requires the presence of an established and regulated national framework. It is characterized by the prescription of long-acting opioid agonists (or partial agonists), such as methadone or buprenorphine, generally on a daily, supervised basis. There is strong evidence that agonist maintenance treatment with methadone or buprenorphine effectively reduces illicit drug use, the spread of HIV, mortality, and criminality, as well as improving physical health, mental health, and social functioning.
- » **Monitoring:** Medications used for opioid agonist maintenance treatment are open to misuse and diversion, hence, programmes should use various methods of limiting the risk of diversion, including supervised consumption.
- » For more details please see **Table 1**.

PROTOCOL**6****Benzodiazepine Withdrawal**

- » Benzodiazepine withdrawal can be managed by switching to a long-acting benzodiazepine and gradually decreasing the dose, tapered over 8-12 weeks, and in conjunction with psychosocial support. More rapid tapering is possible only if the person is in an inpatient setting in a hospital or detoxification facility.
- » If severe, uncontrolled benzodiazepine withdrawal develops or occurs due to a sudden or unplanned cessation, consult a specialist or other available resource person immediately to start a high-dose benzodiazepine sedation regime and to hospitalise the person. Be cautious with unsupervised dispensing of benzodiazepines to unknown patients. 

PSYCHOSOCIAL INTERVENTIONS



2.1 Psychoeducation

- » Disorders due to substance use can often be effectively treated, and people can and do get better.
- » Discussing substance use can bring about feelings of embarrassment or shame for many people. Always use a non-judgmental approach when speaking with people about substance use. When people feel judged, they may be less open to speaking with you. Try not to express surprise at any responses given.
- » Communicate confidently that it is possible to stop or reduce hazardous or harmful alcohol use and encourage the person to come back if he or she wants to discuss the issue further.
- » A person is more likely to succeed in reducing or stopping substance use if the decision is their own.

2.2 Motivational Interviewing (Brief Intervention)

- » Brief interventions using motivational interviewing is an approach to discussing substance use in a non-judgemental way. It encourages a person to reflect on their own substance use choices. It can be used as part of a very brief encounter for addressing risks or harmful substance use. It can also be used as part of a longer discussion that takes place over several sessions that address dependent patterns of substance use; this is referred to as Motivational Enhancement Therapy.

Throughout the discussion it is important to include all parts of the process: expressing empathy and building an atmosphere of trust, while also pointing out contradictions in their narrative, and challenging false beliefs. Avoid arguing with the person. They should feel that the practitioner is there to support them and not to criticize them. If the person is unable to commit to ending their harmful pattern of substance use at this time, discuss why this is the case, rather than forcing the person to say what they think is expected.

» Techniques for more in depth discussions:

1. Provide personalised **feedback** to the person about the risks associated with their pattern of substance use, whether or not they have a pattern of HARMFUL USE or DEPENDENCE, and the specific harms they may be experiencing or causing to others.
2. Encourage the person to **take responsibility** for their substance use choices, and the choice of whether or not to seek assistance for their substance use. Do this by asking them how concerned THEY are about their substance use.
3. Ask the person the **reasons for their substance use**, including as a response to other issues such as mental health problems or specific stressors, and the perceived benefits they have from substance use, even if only in the short term.
4. Ask about their perception of both the positive and negative **consequences of their substance use** and, if necessary, challenge any overstatement of the benefits and understatement of the risks/harms.
5. Ask about the person's **personal goals**, and whether or not their substance use is helping them or preventing them from reaching these goals.

6. Have a **discussion** with the person based on the statements about their substance use, its causes, consequences and their personal goals, allowing exploration of apparent inconsistencies between the consequences of substance use and the person's stated goals.

7. **Discuss options** for change based on the choice of realistic goals and try to find a mutually agreed course of action.

8. **Support the person to enact these changes** by communicating your confidence in them to make positive changes in their life, by provide information on the next steps as needed (further review, detoxification, psycho-social support), and by providing the person with take-home materials if available.

» **Examples of questions to ask.** Non-judgmentally elicit from the person their own thoughts about their substance use by asking the following questions:

1. Reasons for their substance use. (Ask: "Have you ever thought about why you use [substance]?")
2. What they perceive as the benefits from their use. (Ask: "What does [substance] do for you? Does it cause you any problems?")
3. What they perceive as the actual and potential harms from the substance use. (Ask: "Has [substance] use caused you any harm? Can you see it causing harm in the future?")
4. What is most important to the person. (Ask: "What is most important to you in your life?")

2.3 Strategies for Reducing and Stopping Use

Steps to reducing or stopping the use of all substances:

If the person is interested in reducing their substance use, discuss the following steps with them.

- » Identify triggers for use and ways to avoid them. For example: pubs where people are drinking or areas where the person used to obtain drugs, etc.
- » Identify emotional cues for use and ways to cope with them (i.e. relationship problems, difficulties at work, etc.).
- » Encourage the person not to keep substances at home.

2.4 Mutual Help Groups

- » **Mutual help groups** such as Alcoholics Anonymous, Narcotics Anonymous, or Smart Recovery can be helpful referrals for persons with disorders due to substance use. They provide information, structured activities, and peer support in a non-judgmental environment. Find out what mutual help groups are available locally.

2.5 Strategies for Preventing Harm from Drug Use and Treating Related Conditions

- » Encourages the person to engage in less risky behaviour.
 - Advise not to drive if intoxicated.
 - If the person uses opioids, provide intramuscular or intranasal naloxone for family members, which family members can keep and use if the person has overdosed while waiting for help to arrive or *en route* to hospital.

If the person injects drugs:

- » Inform the person about the risks of intravenous drug use, which include: being at higher risk of infections such as HIV/AIDS, Hepatitis B and C, skin infections that can cause septicaemia, endocarditis, spinal abscesses, meningitis, and even death.
- » Considering that the person may not stop injecting drugs right away, provide information on less risky injection techniques. Emphasize the importance of using sterile needles and syringes each time they inject and to never share injecting equipment with others.
- » Provide information on how to access needle and syringe exchange programs where they exist or other sources of sterile injection equipment.
- » Encourage and offer, at minimum, annual testing for blood-borne viral illnesses, including HIV/AIDS and Hepatitis B and C.
 - Encourage Hepatitis B vaccination
 - Ensure condom availability
 - Ensure availability of treatment for people with HIV/AIDS and hepatitis

Treatment of co-morbidities:

- » Have a low threshold for screening for TB in people who have disorders due to substance use.
- » Consider investigations for and treatment of sexually transmitted diseases.

2.4 Carer Support

Supporting family and carers:

- » Discuss the impact of disorders due to substance use on other family members, including children, with the person's family and/or carers.

- » Provide information and education about disorders due to substance use.

- » Offer an assessment of their personal, social, and mental health needs. Offer treatment for any priority mental health disorders.
- » Inform them about and help them access support groups for families and carers (if available) and other social resources.

CLINICAL TIP:

HIV/TB/HEPATITIS and SUBSTANCE USE

- » People who inject drugs are at increased risk of HIV/AIDS and hepatitis, particularly if they do not use sterile injection equipment or have unsafe sex in exchange for drugs; once infected, they also have a worse prognosis. HIV/AIDS also increases the risk of TB infection, and active TB is a main cause of death in people living with HIV/AIDS. People who use alcohol and drugs heavily are also at increased risk for TB. Therefore, a common presentation is of a person who has a combination of drug use, particularly i.v. heroin use, and infection with TB, HIV/AIDS, and hepatitis at the same time.
- » Services that treat people who use drugs and alcohol should regularly test all people who inject drugs for HIV/AIDS and hepatitis, and should have a high level of suspicion for TB in any person with a cough, fever, night sweats, or weight loss.
- » Treatment of HIV/AIDS and TB requires taking daily medications, where every single day is important. Directly observing the treatment can improve treatment adherence. If the person is also opioid dependent, providing daily observed methadone or buprenorphine treatment at the same place and time will further facilitate treatment adherence.
- » Hepatitis treatments occur daily or weekly. Patients with Hepatitis B or C should be advised to avoid alcohol completely.



Special populations

ADOLESCENTS

How to Assess the Adolescent:

- » Clarify the confidential nature of the health care discussion, including in what circumstances the adolescent's parents or carers will be given any information.
- » Ask what else is going on in the adolescent's life? Identify the most important underlying issues for the adolescent. Keep in mind that adolescents may not be able to fully articulate what is bothering them.
- » Open-ended questions may be helpful in eliciting information in the following areas: Home, Education & Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Safety, and Suicide/Depression. Allow sufficient time for discussion. Also assess for other priority mental health conditions. If any priority conditions are identified, see » CMH.

Psychoeducation for the Adolescent:

- » Provide the adolescent and their parents with information on the effects of alcohol and other substances on individual health and social functioning.
- » Encourage a change in the adolescent's environment and activities, rather than focusing on the adolescent's behaviour as being a "problem." Encourage participation in school or work and activities that occupy the adolescent's time. Encourage participation in group activities that are safe and facilitate the adolescent's building of skills and contribution to their communities. It is important that adolescents take part in activities which interest them.
- » Encourage parents and/or carers to know where the adolescent is, who they are with, what they are doing, when they will be home, and to expect the adolescent to be accountable for their activities.

WOMEN WHO ARE OF CHILD-BEARING AGE, PREGNANT, OR BREASTFEEDING

Alcohol Use

- » Advise women who are **pregnant** or considering becoming pregnant to **avoid alcohol completely**.
- » Inform women that consuming even small amounts of alcohol early in pregnancy can harm the developing fetus, and that larger amounts of alcohol can result in a syndrome of severe developmental problems (Fetal Alcohol Syndrome).
- » Advise women who are **breastfeeding** to **avoid alcohol completely**.
- » Given the benefits of exclusive breastfeeding (particularly in the first 6 months), if mothers continue to drink alcohol they should be advised to limit their alcohol consumption, and to minimise the alcohol content of their breast milk, such as by breastfeeding before drinking alcohol and not again until after blood levels fall to zero (allowing approximately 2 hours for each drink consumed, i.e. 4 hours if two drinks are consumed), or by using expressed breast milk.

CAUTION

All mothers with harmful substance use and young children should be offered any social support services that are available, including additional postnatal visits, parenting training, and child care during medical visits.

Drug Use

- » Inquire about the woman's menstrual cycle and inform her that substance use can interfere with the menstrual cycle, sometimes creating the false impression that pregnancy is not possible.
- » Discuss the harmful effects of illicit drugs on fetal development and ensure that the woman has access to effective contraception.
- » Advise and support women who are **pregnant** to **stop using all illicit drugs**. Pregnant opioid dependent women should generally be advised to take an opioid agonist such as methadone.
- » Screen babies of mothers with drug use disorders for withdrawal symptoms (also known as Neonatal Abstinence Syndrome). Neonatal Abstinence Syndrome due to maternal opioid use should be treated with low doses of opioids (such as morphine) or barbiturates. For more details please refer to Guidelines for the identification and management of substance use and substance use disorders in pregnancy Available on http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf.
- » Advise and support **breastfeeding mothers not to use any illicit drugs**.
- » Advise and support mothers with disorders due to substance use to breastfeed exclusively for at least the first 6 months, unless there is specialist advice not to breastfeed.

PHARMACOLOGICAL INTERVENTIONS

TABLE 1: Medication Chart

CLASS/INDICATION	MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS/CAUTIONS
BENZODIAZEPINES To treat alcohol withdrawal, stimulant intoxication, and psychosis	Diazepam	10-20 mg for observable features of alcohol withdrawal or stimulant intoxication every 2 hours until features of alcohol withdrawal/stimulant intoxication are no longer observable or the person is lightly sedated. Lower doses (up to 10 mg four times a day) for alcohol withdrawal in an outpatient setting.	Sedation and respiratory depression which can be life threatening. Prolonged use can lead to dependence.	 Do not use in people who are sedated. Beware of combining with other sedatives. Patients should not drive. Duration of effect may be prolonged in persons with severe liver disease. Supervise dosing to minimise the risk of: diversion (i.e. selling the medication to somebody else).
OPIOID ANTAGONISTS To treat opioid overdose	Naloxone	0.4-2 mg i.v., i.m., subcutaneous or intranasal. Repeat doses as needed.	Discomfort or withdrawal symptoms may result.	
VITAMINS To prevent or treat Wernicke's encephalopathy	Thiamine (Vitamin B1)	100 mg p.o. daily for 5 days to prevent Wernicke's encephalopathy. 100 mg – 500 mg i.v. or i.m. two to three times daily for 3-5 days to treat Wernicke's encephalopathy.		
OPIOID AGONISTS To treat opioid withdrawal and dependence	Methadone	Opioid withdrawal: Methadone initial dose 20 mg, with a supplemental dose of 5-10 mg 4 hours later if necessary. Opioid maintenance: initial dose 10-20 mg with supplementary dose of 10 mg if needed, increasing the daily dose by 5-10 mg every few days if needed until the person is no longer experiencing opioid withdrawal and not using illicit opioids. Maintain until ready to cease opioid agonist treatment.	Sedation, confusion, nausea, vomiting, constipation, possible hormonal changes, decreased sex drive, ECG changes such as prolonged QT interval or bradycardia, hypotension, respiratory depression.	Use with caution in patients with cardiac or respiratory disease.
	Buprenorphine	Initial dose of 4-8 mg, increasing by 4-8 mg each day as needed until the person is no longer experiencing opioid withdrawal and not using illicit opioids. Maintain until ready to cease opioid agonist treatment.	Sedation, dizziness, ataxia, nausea, vomiting, constipation, respiratory depression.	<ul style="list-style-type: none"> – Use with caution in congestive heart failure, respiratory disease, or liver disease. – Potential for abuse. – Abrupt cessation can cause withdrawal symptoms.
	Morphine sulphate	10-20 mg as an initial dose with 10 mg extra dose if needed.	Sedation and respiratory depression which can be life threatening. Prolonged use can lead to dependence.	 Do not use in people who are sedated. Beware of combining with other sedatives. The person should not drive. Supervise dosing to minimise the risk of diversion. Give longer acting opioids, such as methadone or buprenorphine, once per day to outpatients, when available.

CLASS/INDICATION	MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS/CAUTIONS
ALPHA ADRENERGIC AGONISTS To treat opioid withdrawal	Clonidine	Start 0.1 mg 2-3 times daily. Increase as tolerated in divided doses to manage withdrawal symptoms, to a maximum of 1 mg daily.	Sedation, light-headedness, dizziness, headache, nausea/vomiting, dry mouth, constipation, sexual dysfunction, depression, agitation, low blood pressure, tachycardia, sinus bradycardia, and AV block.	Use caution in cardiac, cerebrovascular, and liver disease. Use lower doses in kidney disease. Be aware of the potential for abuse. Monitor vital signs closely. ✖ DO NOT stop abruptly, as withdrawal can cause rebound hypertension. Avoid in women who are pregnant or breastfeeding. 
	Lofexidine	Start 0.4 - 0.6 mg twice daily. Increase as needed by 0.4-0.8 mg daily. Maximum single dose: 0.8 mg. Maximum daily dose: 2.4 mg (in 2-4 divided doses).	Sedation, light-headedness, low blood pressure, ECG changes such as prolonged QT interval and sinus bradycardia.	Use caution in cardiac, cerebrovascular, and renal disease. Avoid in patients with prolonged QT syndrome, metabolic disarray, or if they are taking any other QT-prolonging medications. Monitor vital signs closely. ✖ DO NOT stop medication abruptly, as withdrawal may cause rebound hypertension.
MEDICATIONS TO PREVENT RELAPSE IN ALCOHOL DEPENDENCE To suppress the urge to drink	Acamprosate	Start 2 tablets of 333 mg p.o. each 3 times per day for 12 months. If the person weighs less than 60 kg, give 2 tablets 2 times per day p.o. for 12 months.	Diarrhoea, flatulence, nausea/vomiting, abdominal pain, depression, anxiety, suicidality, itching. Occasionally, a maculopapular rash can occur, and rarely, bullous skin reactions.	In moderate kidney disease, give a lower dose, 333 mg p.o. 3 times per day. ✖ CONTRAINDED in severe kidney disease and liver disease.
	Naltrexone	Start 50 mg daily for 6-12 months. In opioid dependence, ensure that there has been no opioid use in the last 7 days (for example by administration of dose of naloxone).	Sedation, dizziness, nausea/vomiting, abdominal pain, insomnia, anxiety, reduced energy, joint and muscle pain. Monitor liver function due to risk of liver toxicity.	Risk of FATAL OVERDOSE in patients who use opioids more than 24 hours after their last dose of naltrexone, due to the rapid loss of antagonistic effect. ✖ DO NOT use in patients with liver failure or acute hepatitis.
	Disulfiram	Start 200-400 mg daily.	Drowsiness, dizziness, headache, flushing, sweating, dry mouth, nausea/vomiting, tremor, foul body odour, sexual dysfunction. Rarely, psychotic reactions, allergic dermatitis, peripheral neuritis , or hepatic cell damage can occur. Severe reactions can lead to confusion, cardiovascular collapse, and death.	Tricyclic antidepressants (TCAs), monamine oxidase inhibitors (MAOIs), antipsychotics, vasodilators, and alpha or beta adrenergic antagonists make the disulfiram-alcohol reaction more serious. Sensitisation to alcohol continues 6-14 days after taking disulfiram, even if in small amounts. ✖ DO NOT use with alcohol, as reactions can be life-threatening or fatal. ✖ DO NOT use in women who are pregnant or breastfeeding.  ✖ CONTRAINDED in people with hypertension, heart, liver, or kidney disease, a history of cerebro-vascular accidents, psychosis, impulsivity, or if at risk of suicide.



SUB 3 » Follow-up

1

ASSESS FOR IMPROVEMENT



RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » **Harmful use:** Follow-up in one month. Follow-up as needed thereafter.
- » **Dependence:** Follow-up several times per week in the first two weeks, then weekly in the first month. Once improving, decrease frequency to monthly and as needed thereafter.

At every visit, assess:

- » Quantity and frequency of substance use, mental health, physical health, risk and protective factors (e.g. relationships, accommodation, employment, etc.)
- » Ask about factors that lead to substance use and consequences of substance use

ONGOING SUBSTANCE USE

- » Develop strategies to reduce harm
- » Treat health problems
- » Develop strategies to reduce use
- » Arrange detoxification or maintenance treatment if client agrees
- » Conduct frequent review and outreach

RECENT CESSATION OF USE OR SHIFT TO NON-HARMFUL USE

- » Consider urine testing to confirm abstinence
- » Give positive feedback to encourage the maintenance of abstinence/non-harmful use
- » Treat other medical problems
- » Consider relapse prevention medications for alcohol and opioid dependence
- » Consider psychosocial therapies to prevent relapse and mutual help groups
- » Support factors which reduce the risk of relapse such as housing and employment

LONG TERM CESSATION OR NON-HARMFUL USE

- » Consider occasional urine testing to confirm non-use
- » Positive feedback
- » Support factors which reduce the risk of relapse (such as housing and employment)
- » Treat other medical problems
- » Encourage participation in mutual help groups
- » Less frequent review

BOX 2. SIGNS OF CHRONIC SUBSTANCE USE & INVESTIGATIONS TO CONSIDER

SIGNS OF CHRONIC, HEAVY ALCOHOL CONSUMPTION:

- » **Liver disease:** look for jaundiced (yellow) skin and eyes, palpable and tender liver edge (in early liver disease), ascites (distended abdomen filled with fluid), spider naevi (spider-like blood vessels visible on the surface of the skin), and altered mental status (hepatic encephalopathy).
- » **Cerebellar damage:** Look for problems with balance, walking, coordinating movements, and nystagmus.
- » **Investigations to consider:**
 - Liver enzymes: elevated liver enzymes and elevated ammonia indicate liver disease.
 - Complete blood count: look for macrocytic anaemia and low platelets.

SIGNS OF CHRONIC DRUG USE:

- » Difficulty caring for self, poor dentition, parasitic skin infections such as lice or scabies, and malnutrition.
- » Signs of injection: look for injection sites on arms or legs, with both new and old marks visible. Ask the person where they inject and inspect the sites to make sure there are no signs of local infection.
- » Common health complications of injecting drug use: people who inject drugs have a higher risk of contracting infections such as HIV/AIDS, Hepatitis B and C, and tuberculosis. They are also at high risk for skin infections at their injection sites. In some cases, this can spread through the blood and cause septicaemia, endocarditis, spinal abscesses, meningitis, or even death.
- » Investigations to consider:
 - Urine drug screen: for emergency cases, a urine drug screen should be conducted whenever intoxication, withdrawal, or overdose is suspected, especially in cases when the person is unable to convey what they have ingested.
 - If the person has been injecting drugs, offer serological testing for blood-borne viruses, HIV/AIDS and Hepatitis B and C, etc.
 - If the person has had unprotected sex, offer testing for sexually transmitted infections, including HIV, syphilis, chlamydia, gonorrhoea, and human papilloma virus (HPV).
 - Obtain a tuberculosis test, sputum sample, and a chest x-ray if tuberculosis is suspected. Look for signs and symptoms such as chronic productive cough, fevers, chills, and weight loss.

DISORDERS DUE TO SUBSTANCE USE

SELF-HARM / SUICIDE

Suicide is the act of deliberately killing oneself. Self-harm is a broader term referring to intentional self-inflicted poisoning or injury, which may or may not have a fatal intent or outcome.

Any person over 10 years of age experiencing any of the following conditions should be asked about thoughts or plans of self-harm in the last month, and about acts of self-harm in the last year:

- » Any of the priority MNS conditions. See Master Chart (»MC)
- » Chronic pain
- » Acute emotional distress



Evaluate for thoughts, plans and acts of self-harm during the initial assessment and periodically thereafter, as required. Attend to the person's mental state and emotional distress.

CLINICAL TIP:

Asking about self-harm does NOT provoke acts of self-harm. It often reduces anxiety associated with thoughts or acts of self-harm and helps the person feel understood. However, try to establish a relationship with the person before asking questions about self-harm. Ask the person to explain their reasons for harming themselves.

SUI » Quick Overview



ASSESSMENT

- » Assess if the person has attempted a medically serious act of self-harm
- » Assess for imminent risk of self-harm/suicide
- » Assess for any of the priority MNS conditions
- » Assess for chronic pain
- » Assess for severity of emotional symptoms



MANAGEMENT

- » Management Protocols
 1. Medically serious act of self-harm
 2. Imminent risk of self-harm/suicide
 3. Risk of self-harm/suicide
- » General Management and Psychosocial Interventions



FOLLOW-UP



SUI 1 » Assessment

ASSESS FOR SELF-HARM/SUICIDE IF THE PERSON PRESENTS WITH EITHER:

- Extreme hopelessness and despair, current thoughts/plan/act of self-harm suicide or history thereof, act of self-harm with signs of poisoning/intoxication, bleeding from self-inflicted wound, loss of consciousness and/or extreme lethargy, OR
- Any of the priority MNS conditions, chronic pain or extreme emotional distress

1

Has the person attempted a medically serious act of self-harm?

Assess if there is evidence of self-injury and/or signs/symptoms requiring urgent medical treatment:

- Signs of poisoning or intoxication
- Bleeding from self-inflicted wound
- Loss of consciousness
- Extreme lethargy

CLINICAL TIP

If medically stable, perform appropriate management, as needed.

NO

YES

Management for the medically serious act of self-harm is required.

» Go to PROTOCOL 1

» Return to STEP 2 once person is medically stable.

2

Is there an imminent risk of self-harm/suicide?

Ask the person and carers if there are ANY of the following:

- **Current** thoughts or plan of self-harm/suicide
- History of thoughts or plan of self-harm in the past month or act of self-harm in the past year
in a person who is now extremely agitated, violent, distressed or lacks communication

NO

YES

IMMINENT RISK OF SELF-HARM/SUICIDE is likely

» Go to **PROTOCOL 2**, manage, and then continue to **STEP 3**

Is there a history of thoughts or plan of self-harm in the past month or act of self-harm in the past year?

NO

YES

Imminent risk of self-harm/suicide is unlikely, but a risk may still persist.

Risk of self-harm/suicide is unlikely.

» Go to **PROTOCOL 3**, manage, and then continue to **STEP 3**

3

Does the person have concurrent MNS conditions?

– Depression

– Disorders due to substance use

– Child & adolescent mental
and behavioral disorders– Psychoses
– Epilepsy

» Manage the concurrent conditions.

See relevant modules.

YES

NO

4

Does the person have chronic pain?

» Manage the pain and treat any
relevant medical conditions.

YES

NO

5

Does the person have emotional symptoms severe enough to warrant clinical management?

– Difficulty carrying out usual work, school,
domestic or social activities– Repeated self-medication for emotional
distress, or unexplained physical symptoms

– Marked distress or repeated help-seeking

» Manage the emotional symptoms.
» Go to »OTH

YES

NO

» Go to SUI 3 (Follow-up)



SUI 2 » Management

PROTOCOL

1

Medically Serious Act of Self-Harm

- » **For all cases:** Place the person in a secure and supportive environment at a health facility.
- » **✖ DO NOT leave the person alone.**
- » Medically treat injury or poisoning. If there is acute pesticide intoxication, follow "Management of pesticide intoxication". (2.1)
- » If hospitalization is needed, continue to monitor the person closely to prevent suicide.
- » Care for the person with self-harm. (2.2)
- » Offer and activate psychosocial support. (2.3)
- » Offer carers support. (2.4)
- » Consult a mental health specialist, if available.
- » Maintain regular contact and **Follow-Up.**

PROTOCOL

2

Imminent Risk of Self-Harm/Suicide

- » Remove means of self-harm/suicide.
- » Create a secure and supportive environment; if possible, offer a separate, quiet room while waiting for treatment.
- » **✖ DO NOT leave the person alone.**
- » Supervise and assign a named staff or family member to ensure person's safety at all times.
- » Attend to mental state and emotional distress.
- » Provide psychoeducation to the person and their carers. (2.5)
- » Offer and activate psychosocial support. (2.3)
- » Offer carers support. (2.4)
- » Consult a mental health specialist, if available.
- » Maintain regular contact and **Follow-Up.**

PROTOCOL

3

Risk of Self-Harm/Suicide

- » Offer and activate psychosocial support. (2.3)
- » Consult a mental health specialist, if available.
- » Maintain regular contact and **Follow-Up.**

2.1 Management of pesticide intoxication

- » If the health care facility has a minimum set of skills and resources, then treat using the WHO document, "Clinical Management of Acute Pesticide Intoxication" (http://www.who.int/mental_health/publications/9789241596732/en).

Otherwise, transfer the person immediately to a health facility that has the following resources:

- Skills and knowledge on how to resuscitate individuals and assess for clinical features of pesticide poisoning;
- Skills and knowledge to manage the airway; in particular, to intubate and support breathing until a ventilator can be attached;
- Atropine and means for its intravenous (i.v.) administration if signs of cholinergic poisoning develop;
- Diazepam and means for its i.v. administration if the person develops seizures.
- » Consider administering activated charcoal if the person is conscious, gives informed consent, and presents for care within one hour of the poisoning.
- » Forced vomiting is not recommended.
- »  Oral fluids should not be given.

2.2 Care for the person with self-harm

- » Place the person in a secure and supportive environment at a health facility ( do not leave them alone). If the person must wait for treatment, offer an environment that minimizes distress; if possible, in a separate, quiet room with constant supervision and contact with a designated staff or family member to ensure safety at all times.
 - » Remove access to means of self-harm.
 - » Consult a mental health specialist, if available. 
 - » Mobilize family, friends and other concerned individuals or available community resources to monitor and support the person during the imminent risk period (see "Offer and activate psychosocial support". [\(2.3\)](#))
 - » Treat people who have self-harmed with the same care, respect and privacy given to other people, and be sensitive to the emotional distress associated with self-harm.
 - » Include the carers if the person wants their support during assessment and treatment; if possible, the psychosocial assessment should include a one-to-one interview between the person and the health worker, to explore private issues.
 - » Provide emotional support to carers/family members if they need it. [\(2.4\)](#)
 - » Ensure continuity of care.
- » Hospitalization in non-psychiatric services of a general hospital is not recommended for the prevention of self-harm. However, if admission to a general (non-psychiatric) hospital is necessary for the management of the medical consequences of self-harm, monitor the person closely to prevent further self-harm in the hospital.
 - » **If prescribing medication:**
 - See relevant mhGAP-IG modules for pharmacological interventions in the management of concurrent conditions.
 - Use medicines that are the least hazardous, in case of intentional overdose.
 - Give prescriptions as short courses (e.g. one week at a time).

PSYCHOSOCIAL INTERVENTIONS

2.3 Offer and activate psychosocial support

» Offer support to the person

- Explore reasons and ways to stay alive.
- Focus on the person's strengths by encouraging them to talk of how earlier problems have been resolved.
- Consider problem-solving therapy to help people with acts of self-harm within the last year, if sufficient human resources are available. Go to **Essential care and practice » ECP**

» Activate psychosocial support

- Mobilize family, friends, concerned individuals and other available resources to ensure close monitoring of the person as long as the risk of self-harm/suicide persists.
- Advise the person and carers to restrict access to means of self-harm/suicide (e.g. pesticides/toxic substances, prescription medications, firearms, etc.) when the person has thoughts or plans of self-harm/suicide.
- Optimize social support from available community resources. These include informal resources, such as relatives, friends, acquaintances, colleagues and religious leaders or formal community resources, if available, such as crisis centres, and local mental health centres.

2.4 Carers support

- » Inform carers and family members that asking about suicide will often help the person feel relieved, less anxious, and better understood.
- » Carers and family members of people at risk of self-harm often experience severe stress. Provide emotional support to them if they need it.
- » Inform carers that even though they may feel frustrated with the person, they should avoid hostility and severe criticism towards the vulnerable person at risk of self-harm/suicide.

2.5 Psychoeducation

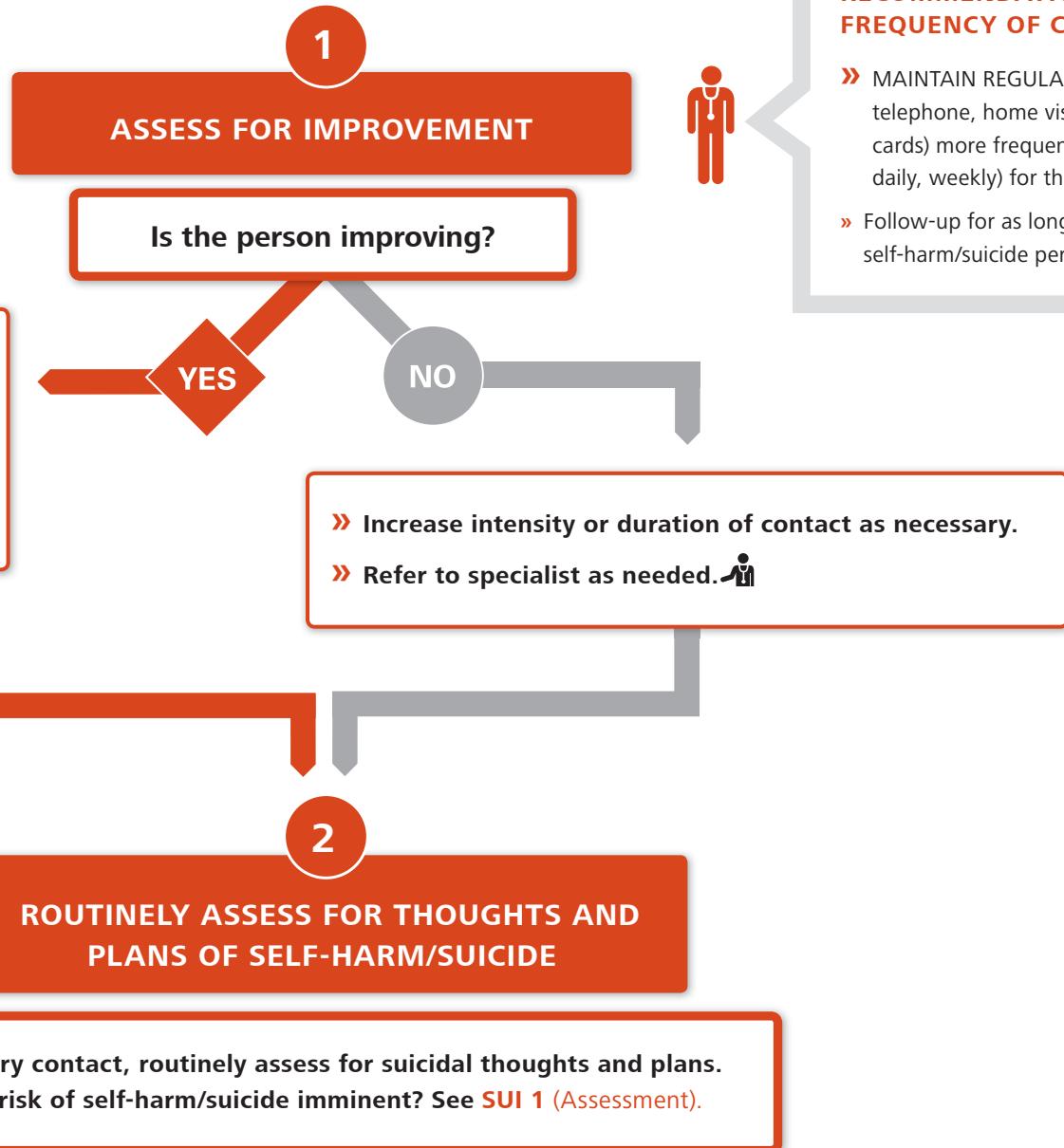
» Key messages to the person and the carers

- If one has thoughts of self-harm/suicide, seek help immediately from a trusted family member, friend or health care provider.
- It is okay to talk about suicide. Talking about suicide does not provoke the act of suicide.
- Suicides are preventable.
- Having an episode of self-harm/suicide is an indicator of severe emotional distress. The person does not see an alternative or a solution. Therefore, it is important to get the person immediate support for emotional problems and stressors.
- Means of self-harm (e.g. pesticides, firearms, medications) should be removed from the home.
- The social network, including the family and relevant others, is important for provision of social support.



SUI 3 » Follow-up

» Decrease contact as the person improves.
» **Continue following-up for 2 years**, further decreasing contact according to improvement (e.g. once every 2-4 weeks after the initial 2 months, and twice in the second year).



SELF HARM / SUICIDE

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

This module aims to provide basic guidance on management of a range of mental health complaints not covered elsewhere in this guide. Some of these complaints may be similar to depression, but upon closer examination are distinct from the conditions covered in this guide.

Other mental health complaints are considered significant when they impair daily functioning or when the person seeks help for them. Other mental health complaints can be due to stress.

- » This module should not be considered for people who meet the criteria for any of the mhGAP priority conditions (except self-harm).
- » This module should only be used after explicitly ruling out depression.
- » This module should be used when helping adults. In case the person is a child or adolescent, go to » CMH.

OTH » Quick Overview



ASSESSMENT

- » Rule out physical causes that would fully explain the presenting symptoms
- » Rule out depression or other MNS conditions
- » Assess if the person is seeking help to relieve symptoms or has considerable difficulty with daily functioning
- » Assess if the person has been exposed to extreme stressors
- » Assess if there is imminent risk of self-harm/suicide



MANAGEMENT

» Management Protocols

1. Other significant mental health complaints
2. Other significant mental health complaints in people exposed to extreme stressors



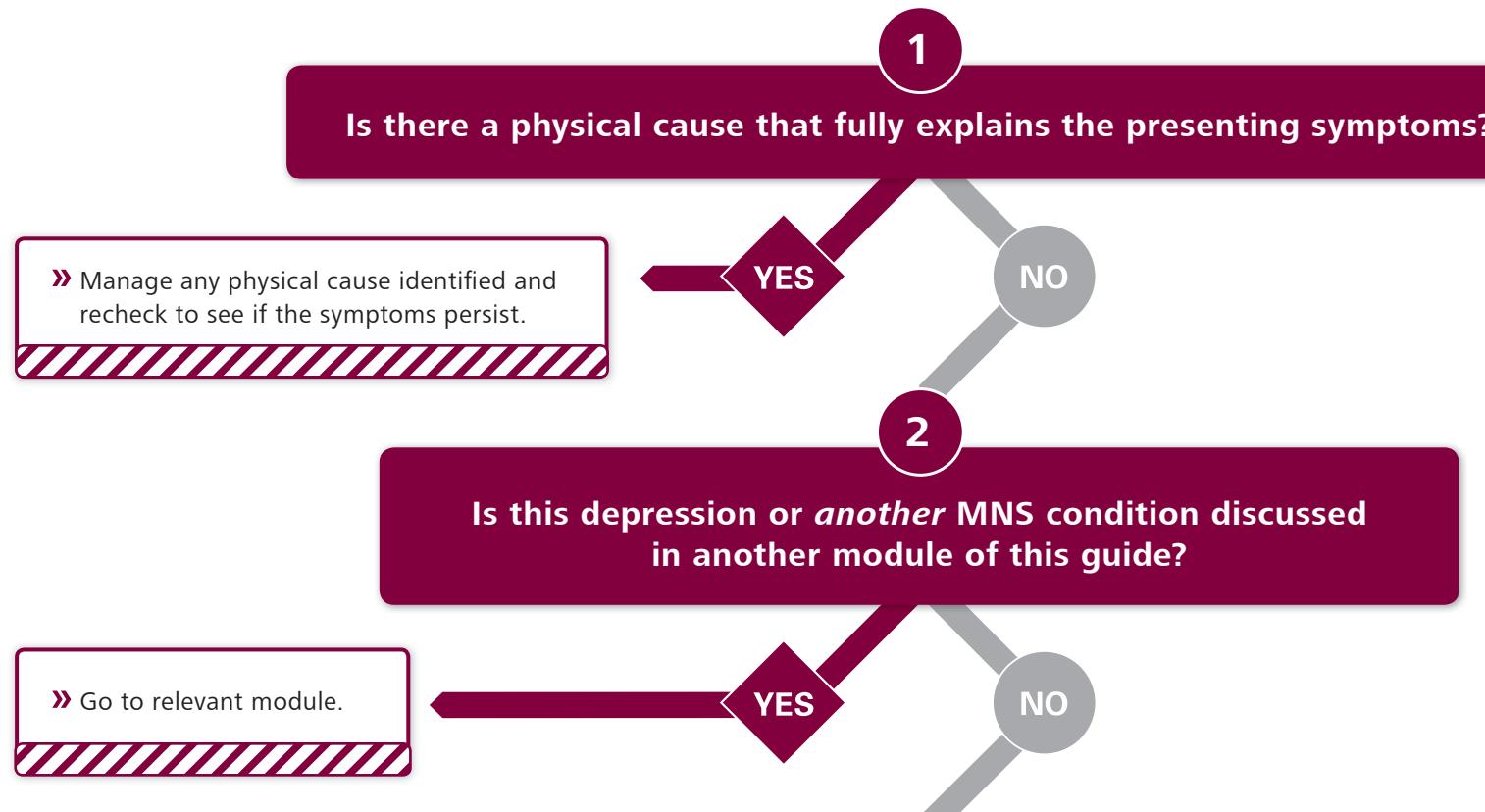
FOLLOW-UP



OTH 1 » Assessment

COMMON PRESENTATIONS OF OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

- Feeling extremely tired, depressed, irritated, anxious or stressed.
- Medically unexplained somatic complaints (i.e. somatic symptoms that do not have a known physical cause that fully explains the symptom).



3

Is the person seeking help to relieve symptoms or having considerable difficulty with daily functioning because of their symptoms?

» No treatment needed.

NO

YES

**OTHER SIGNIFICANT
MENTAL HEALTH COMPLAINTS** are likely

4

Has the person been exposed to extreme stressors?
(e.g. physical or sexual violence, major accidents, bereavement or other major losses)

NO

YES

» Go to **PROTOCOL 1 and 2**

» Go to **PROTOCOL 1**

! IF THERE IS IMMINENT RISK OF SUICIDE,
ASSESS AND MANAGE before continuing
to Protocol 1 and 2 (Go to »SUI).





OTH 2 » Management

PROTOCOL

1

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

- » ✗ **DO NOT prescribe anti-anxiety or antidepressant medicines** (unless advised by a specialist).
- » ✗ **DO NOT give vitamin injections or other ineffective treatments.**
- » **In all cases, reduce stress and strengthen social supports as described in Essential care and practice (ECP).**
 - Address current psychosocial stressors.
 - Strengthen supports.
 - Teach stress management such as relaxation techniques (see **Box 1** at end of module).
- » **When no physical condition is identified that fully explains a presenting somatic symptom, acknowledge the reality of the symptoms and provide possible explanations.**
 - Avoid ordering more laboratory or other investigations unless there is a clear medical indication, e.g. abnormal vital signs.
 - In case a further investigation is ordered anyway, reduce unrealistic expectations by telling the person that the expected result is likely to be normal.

- Inform the person that no serious disease has been identified. Communicate the normal clinical and test findings.
- If the person insists on further investigations, consider saying that performing unnecessary investigations can be harmful because they can cause unnecessary worry and side-effects.
- Acknowledge that the symptoms are not imaginary and that it is still important to address symptoms that cause significant distress.
- Ask the person for their **own explanation** of the cause of their symptoms, and ask about their concerns. This may give clues about the source of distress, help build a trusting relationship with the person and increase the person's adherence to treatment.
- Explain that emotional suffering/stress often involves the experience of bodily sensations, such as stomach aches, muscle tension, etc. Ask for and discuss potential links between the person's emotions/stress and symptoms.
- Encourage continuation of (or gradual return to) daily activities.
- Remember to apply the practice of reducing stress and strengthening social support. Go to »**ECP**.

PROTOCOL

2

**OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS
IN PEOPLE EXPOSED TO EXTREME STRESSORS**

(e.g. physical or sexual violence, major accidents, bereavement or other major loss)

» In all cases, whether or not the person presents with emotional, physical or behavioural problems after exposure to an extreme stressor, provide support as described in PROTOCOL 1. Listen carefully.

» ~~DO NOT~~ DO NOT pressure the person to talk about the event.

» Address the person's social needs.

- Ask the person about his/her needs and concerns.

- Help the person to address basic needs, access services and connect with family and other social supports.

- Protect the person from (further) harm, if needed.

- Encourage the person to return to previous, normal activities, e.g. at school or work, at home, and socially, if it is feasible and culturally appropriate.

» In case of any major loss explain that:

- It is normal to grieve for any major loss. One can grieve for a person, a place, or property or the loss of one's own health and wellbeing. Grief has both mental and physical effects.

- People grieve in different ways. Some people show strong emotions while others do not. Crying does not mean one is weak. People who do not cry may feel the emotional pain just as deeply but have other ways of expressing it.

- In most cases, grief will diminish over time. One may think that the sadness, yearning or pain one feels will never go away, but in most cases, these feelings lessen over time. Sometimes a person may feel fine for a while, then something reminds them of the loss and they may feel as bad as they did at first. There is no right or wrong way to feel grief. Sometimes one might feel very sad, other times numb, and at other times one might be able to enjoy oneself. These experiences usually become less intense and less frequent over time.

» In case of the loss of a loved one, discuss and support culturally appropriate adjustment and/or mourning processes.

- Ask if appropriate mourning ceremonies/rituals have happened or been planned. If this is not the case, discuss the obstacles and how to address them.

» If prolonged grief disorder is suspected, consult a specialist for further assessment and management. 

- The person may have prolonged grief disorder if the symptoms involve considerable difficulty with daily functioning **for at least 6 months** and include severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain.

» In the case of reactions to recent exposure to a potentially traumatic event, explain that:

- People often have reactions after such events. The reactions may be highly variable from person to person and change over time.
- They can include somatic symptoms such as palpitations, aches and pains, gastric upset, and headaches and emotional and behavioural symptoms that include sleep disturbance, sadness, anxiety, irritation and aggression.
- Such feelings can be exacerbated or can reappear when reminders of the stressful event or new stressors occur.
- In most cases the symptoms are likely to diminish over time, particularly if the person gets rest, social support, and engages in stress reduction. Go to »ECP.

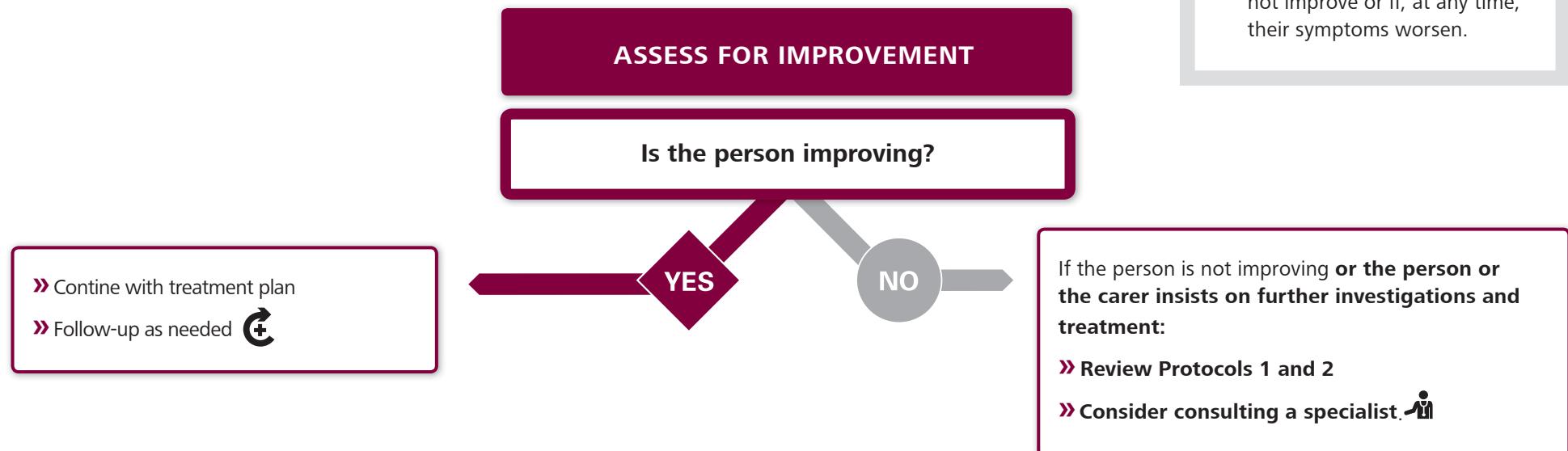
Go to **Box 1**.

» If post-traumatic stress disorder (PTSD) is suspected, consult a specialist for further assessment and management. 

- After a potentially traumatic event, the person may have PTSD if the symptoms involve considerable difficulty with daily functioning **for at least 1 month** and include recurring frightening dreams, flashbacks or intrusive memories of the events accompanied by intense fear or horror; deliberate avoidance of reminders of the event; excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements.



OTH 3 » Follow-up



BOX 1: RELAXATION TRAINING INSTRUCTIONS

» Explain what you will be doing.

"I am going to teach you how to breathe in a way that will help relax your body and your mind. It will take some practice before you feel the full benefits of this breathing technique. The reason this strategy focuses on breathing is because when we feel stressed our breathing becomes fast and shallow, making us feel more tense. To begin to relax, you need to start by changing your breathing. Before we start, we will relax the body."

» Slowly start relaxation exercises and demonstrate breathing.

"Gently shake and loosen your arms and legs. Let them go floppy and loose. Roll your shoulders back and gently move your head from side to side. Now place one hand on your belly and the other hand on your upper chest. I want you to imagine you have a balloon in your stomach and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach." Demonstrate breathing from the stomach – try to exaggerate the pushing out, and pulling in, of your stomach.

» Focus on breathing techniques.

"Try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out; then breathe in. If you can, breathe in through your nose and out through your mouth. The second step is to slow the rate of your breathing down. Take three seconds to breathe in, two seconds to hold your breath, and three seconds to breathe out. I will count with you. You may close your eyes or keep them open. Slowly breathe in, 1, 2, 3. Hold, 1, 2. Now breathe out, 1, 2, 3." Repeat this breathing exercise for approximately one minute, rest for one minute then repeat the cycle two more times.

» Encourage self-practice.

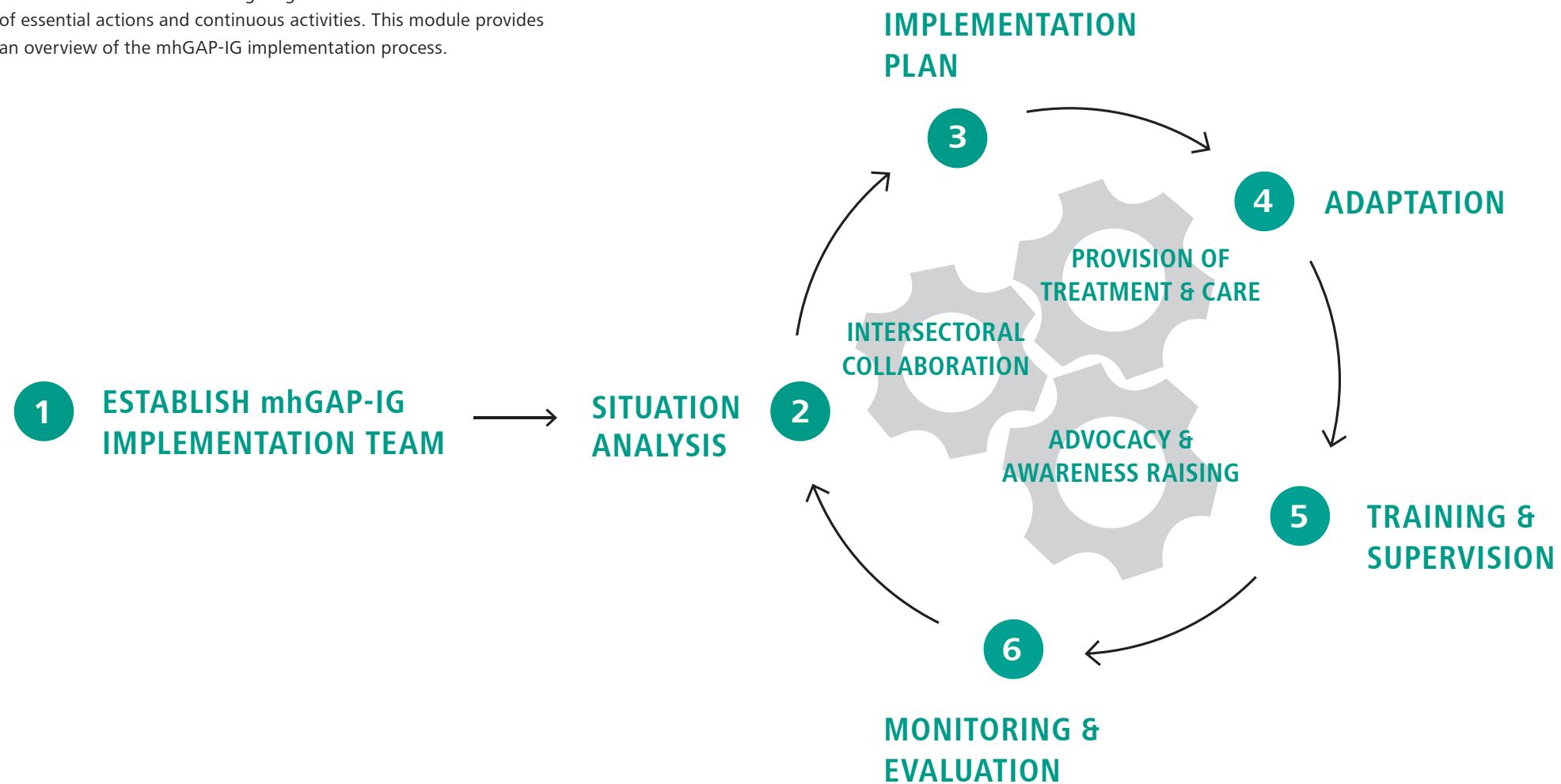
"Try on your own for one minute. This is something you can practice on your own."

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

IMPLEMENTATION OF mhGAP-IG

mhGAP-IG implementation process

A number of actions are recommended to programme planners to implement this guide in non-specialized health care settings. This can be summarized in the following diagram which includes a number of essential actions and continuous activities. This module provides an overview of the mhGAP-IG implementation process.



1 Establish mhGAP-IG implementation team

- » It may be necessary to have one or more teams depending upon the geographical area/regions to be covered.
- » Clearly delineate the purpose and terms of reference of the implementation teams and develop a work plan for each of the team/s members. One of the key functions of this team is to oversee the implementation process.
- » Build upon any existing body or group rather than establishing a new one, for example, a health committee or community advisory group. Sometimes there is more than one group. Merging groups or establishing a new group with the participation of members from all of them could be a solution.
- » Members of the implementation team should include at least one member of each of the following categories: civil society and service users, policy makers, actual and potential financial supporters or donors, programme managers, service providers and communication officers.
- » Form smaller action groups or task forces to focus on specific activities, e.g. an action group to implement training activities and another to implement advocacy & awareness raising activities. Always clearly identify the functions of a task force and the role of each of its member.

2 Situation analysis

The main objective of the situation analysis is to inform the planning, adaptation and implementation process regarding resources and needs for MNS conditions. This process involves desk reviews, e.g. checking WHO Mental Health Atlas Country Profile, the WHO Assessment Instrument for Mental Health Systems (AIMS) report or already existing assessments, and interviews and group discussions with multiple stakeholders to answer the following questions:

- » What kind of needs and resource assessments must be done first? What is already known?
- » What are the national policies pertaining to mental health, the staff capacities in the country/region and organizations providing mental health services?
- » What are the belief systems and care seeking behaviours around mental health in the country/region?
- » What potential barriers exist in relation to implementation of mhGAP-IG exist, for example, stigma and discrimination towards people with MNS conditions, national health priorities that supersede MNS conditions, etc.

3 mhGAP-IG implementation plan

Based on the situation analysis, develop a plan for mhGAP-IG implementation to answer the following questions:

WHERE

- » Where will mhGAP-IG be implemented, (e.g. facilities, districts, cities)?

WHEN

- » When will each of the mhGAP-IG activities be implemented, (e.g. timeline for adaptation, training of trainers, training activities, supervision and advocacy activities)?

WHAT

- » What are the resources needed and available for mhGAP-IG implementation, including financial and human resources and infrastructure, (e.g. facilities, medication supply)?

WHO

- » Who will be trained and what knowledge and skills do they already have, (e.g. the skills and knowledge that PHC nurses and physicians already have), and who will be responsible for each activity, (e.g. who will train and supervise)?

HOW

- » How can you improve communication and referral pathways across different levels of the system, while also introducing the new service?
- » How can you collect data on mhGAP-IG implementation activities and integrate it into health information system indicators?

4 Adaptation

mhGAP-IG adaptation is the process of deciding on and producing the changes needed in the mhGAP-IG, its training materials, monitoring & evaluation (M&E) tools and other tools to fit a particular country or district context.

Purpose of mhGAP-IG adaptation:

To make it feasible to implement the guide including its assessment and management components through the local health system.

- » To ensure that the guide is acceptable in the local socio-cultural context.
- » To use local terms to improve communication with users and carers.
- » To clarify referral pathways.
- » To make materials consistent with relevant national treatment guidelines and policies, as appropriate.
- » To provide a basis for the development of appropriate training programmes and tools.
- » To ensure M&E indicators are in line with national health information systems.

Method of mhGAP-IG adaptation:

- » Organize a workshop with a group of different stakeholders to contextualize and adapt the mhGAP-IG, its training materials and M&E and other tools.
- » Include experts representing relevant disciplines, (e.g. psychiatry, addiction, neurology, paediatrics, social work and psychology), people representing different levels of general health care, (e.g. public health practitioners, primary health care providers, family medicine specialists, nurses, pharmacists, health information system practitioners), service users and policy makers.
- » Use the situation analyses conducted for the regions in which mhGAP-IG will be implemented.
- » Ensure that the adaptation process is in line with national documents, (e.g. the national health policy, legislation and plan, clinical protocols and guidelines used in general/primary health care and the national medicine list).

5 mhGAP-IG training & supervision

An important aspect of mhGAP-IG implementation is the training of healthcare providers working in non-specialist settings to deliver interventions as front line personnel, along with mechanisms to ensure their continued support and supervision. Although the intervention guide is to be implemented primarily by non-specialists, it requires coordinated effort by specialists and public health experts to ensure its optimum delivery.

The objective of mhGAP-IG training is to teach non-specialist healthcare providers the skills and knowledge needed to assess and manage people with priority MNS conditions. The duration of training depends on the local adaptations made, as well as on the knowledge and skills that non-specialist healthcare providers already have. Usually this training process takes several full days and can be conducted face-to-face or via e-learning, depending on feasibility.

The training structure can follow a cascade plan with two levels: a master facilitator trains ‘trainers’ who then train the non-specialist front-line healthcare providers.

mhGAP-IG train the trainers:

The objective is to ensure that trainers are skilled and confident in their ability to train non-specialist healthcare providers and act as informed resources for these providers.

mhGAP-IG trainers/supervisors should have the following characteristics:

- » Be specialists in MNS health care (psychiatrist, psychiatric nurse, neurologist, etc.), physicians or nurses trained and experienced in managing MNS conditions using mhGAP-IG, and/or existing supervisors for the general health system.
- » Have clinical skills and experience in mental health and/or management of MNS conditions.
- » Have skills and experience with administrative aspects of managing MNS conditions, including record keeping, follow-up and referral.
- » Be good facilitators and problem-solvers.
- » Available for support and supervision, including regular supervisory visits.

The training agenda:

The trainers are expected to conduct future mhGAP-IG training courses and provide support and supervision to health care providers. Apart from training in the assessment and management of people with MNS conditions, as described in the mhGAP-IG, they will learn about methods of training, planning of curricula, methods of supervision and quality assurance.

mhGAP-IG support & supervisor:

Participants in the mhGAP-IG training course (mhGAP-IG trainees) are usually non-specialized health care staff working in primary or secondary health care clinics/hospitals. They require ongoing help to transfer what they have learned in training to their clinical practices. Supervision is seen as part of the continuum of education required to create competent mhGAP health care providers. Support and supervision not only aims to assist mhGAP-IG trainees to deliver improved mental health care (clinical supervision) but also provides support in the work environment related to mhGAP-IG implementation (administrative and program supervision).

Specific goals of support & supervision:

- » Assist in the transfer of skills and knowledge from the mhGAP-IG training into clinical practice.
- » Ensure adequate delivery of mental health interventions that are in line with mhGAP-IG and address areas for further skills development.
- » Identify and assist with problems faced by mhGAP-IG trainees in managing complicated clinical situations.
- » Help motivate non-specialized health care workers to provide good quality care for people with MNS conditions.
- » Ensure necessary records and administrative procedures for MNS conditions, such as referrals and follow-up, are established and/or integrated into existing systems at the local health care facilities.

» Ensure that the supply of medicine, medical equipment and other support systems for mhGAP-IG implementation are operational.

» Demonstrate and encourage respectful, non-judgmental attitudes and ethical treatment that promotes and protects the human rights of individuals with MNS conditions.

» Provide support to healthcare providers experiencing stress.

6 Monitoring & Evaluation

Monitoring and Evaluation (M&E) can provide information about whether a programme is making a difference and for whom; it can identify programme areas that are on target or aspects of a programme that need to be adjusted. Information gained from M&E can demonstrate to programme implementers and funders that their investments are paying off. M&E provides vital information for learning from past experiences, improving service delivery, planning, resource allocation and demonstrating results as part of accountability to key stakeholders. The phrase, “what gets measured gets done,” summarises the importance of monitoring & evaluation in programme planning and implementation.

M&E involves planning, coordinating, collecting, analysing and using data from national, district and local levels, including health facilities and mhGAP-IG facilitators, trainees and supervisors; therefore, it will be helpful if the mhGAP-IG implementation team appoints a M&E coordinator or sub-committee to plan and carry this out.

Some examples of indicators that can be used to monitor mhGAP-IG implementation are: facility-level indicators, e.g. number of non-specialist health care providers trained on mhGAP-IG, number of support and supervisory visits to each health facility implementing mhGAP-IG; and system-level indicators, e.g. number of health facilities using mhGAP-IG to assess and manage persons with MNS conditions, number of health facilities with an uninterrupted supply of essential medicines for MNS conditions.

Ensure that the indicators are part of the national health information system. Collecting data using indicators will assist in monitoring mhGAP-IG. They will also assist in reporting on national mental health every two years to the WHO Mental Health Atlas, to monitor progress on implementation of the Mental Health Action Plan 2013-2020.

Evaluate the mhGAP-IG implementation process, identify successes as well as needs for improvement and update the situation analysis.

In addition to the six actions described above, there are three continuous activities that form an essential part of mhGAP-IG implementation. These are described in the sections below.

A. PROVISION OF TREATMENT AND CARE:

The mhGAP-IG recommends a number of pharmacological and psychological interventions be provided by non-specialised health care providers. It recommends, for example, problem solving therapy (PST) and Interpersonal Therapy (IPT) for adult depression. WHO has developed psychological interventions in simplified form. These are scalable interventions and their delivery requires a less intense level of specialist human resource use. It means that the intervention has been modified to use fewer resources compared with conventional psychological interventions and that people with and without previous training in mental health care can effectively deliver low-intensity versions of PST and IPT as long as they are trained and supervised. Examples of WHO scalable psychological interventions manuals which are part of the mhGAP package include: the WHO Problem Management Therapy PM+ manual, the WHO Interpersonal Therapy manual (IPT), the WHO Thinking Healthy manual for maternal depression, and the WHO Parental Skills training manual.

Essential medicines can be used to treat symptoms of MNS conditions, to shorten the course of many disorders, reduce disability and prevent relapse. Essential medicines are part of the WHO Model Lists of Essential Medicines. Access to essential medicines is a component of “the right to [the highest attainable standard of] health.”

There are four main groups of medications that target priority MNS conditions mentioned in this guide:

- » antipsychotics for psychotic disorders;
- » drugs used in mood disorders (depressive or bipolar);
- » anticonvulsants/antiepileptics;
- » medications used for management of substance withdrawal, intoxication or dependence .

The experiences of many countries demonstrate that improvements in the supply and use of medicines are possible. Access of populations to essential medicines are determined by: (i) a rational selection of medicines; (ii) making prices affordable; (iii) ensuring sustainable financing; and (iv) availability of reliable health and supply systems.

B. ADVOCACY AND AWARENESS RAISING:

Mental health advocacy uses information in deliberate and strategic ways to influence others to create change. It involves the promotion of the needs and rights of people with mental disorders, as well as that of the general population. Advocacy is different from education. Education informs and helps create understanding of an issue. Advocacy, on the other hand, aims to persuade. This is done through requests and calls for specific actions. One basic principle is that advocacy is only effective when the target audience is asked to do something. Mobilizing people means asking them to become part of the solution.

Examples of advocacy actions

Advocacy actions within the general population:

- » Include and mobilize people with MNS conditions and their carers in the advocacy actions. Ensure that the community has direct and positive social contact with people with MNS conditions.
- » Use the media to increase awareness of mental health issues, e.g. through public announcements, magazine features and announcement at health centers, while at same time emphasizing the need for responsible reporting, particularly regarding suicide.
- » Provide education about mental health issues in public places (e.g. schools, health care centers).
- » Hold public events and lectures around mental health themes.

Advocacy actions with health and mental health workers:

- » Promote an understanding of the importance of community care, community participation and human rights of people affected with MNS conditions.
- » Provide adequate training and support to mental health and general health workers.

C. NETWORKING AND INTERSECTORAL COLLABORATION:

mhGAP-IG implementation requires collaboration amongst various sectors and stakeholders, such as:

- » **Specialist and non-specialist health services and care-providers:** e.g. psychologists, community health workers, social workers, inpatient or outpatient service providers, outreach care workers.
- » **Service users:** e.g. groups or individuals living with the same condition, family members with the same condition or caring for someone with the same condition (after seeking consent from all those involved).
- » **Family and friends:** Identify the person's prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychological and social support (e.g. family gatherings, outings with friends, visiting neighbors, social activities at work sites, sports, community activities) and encourage the person to resume these activities.
- » **Informal community supports:** e.g. spiritual groups, saving groups, recreational groups, women groups, youth support groups, cultural groups, self-help groups, helplines.
- » **Education and employment:** e.g. schools, education, income generating or vocational training programmes. Specifically, suicide prevention programmes in school settings that include mental health awareness training and skills training to reduce suicide attempts and suicide deaths among adolescent students.
- » **Non-governmental organizations:** e.g. legal aid, child protection services, gender based violence programmes or psychosocial support programmes.
- » **Government services and benefits:** e.g. public justice systems, child welfare, pension, disability, transportation discounts.

To facilitate efficient collaboration between these groups, it is important to:

- » Ensure that members of the mhGAP-IG implementation team have **clear roles and functions**.
- » **Prepare a list of resources and benefits** to help non-specialized health care staff make meaningful links for those with mhGAP priority conditions, their carers and other family members by **gathering information from the situational analysis and regularly updating the list based on new information**.

GLOSSARY

TERM	DEFINITION	TERM	DEFINITION
Activities of daily living (ADLs)	A concept of functioning – activities of daily living are basic activities that are necessary for independent living, including eating, bathing and toileting. This concept has several assessment tools to determine an individual's ability to perform the activity with or without assistance.	Ataxia	Failure of muscular coordination. People with ataxia have problems with coordination because parts of the nervous system that control movement and balance are affected. Ataxia may affect the fingers, hands, arms, legs, body, speech, and eye movements.
Agitation	Marked restlessness and excessive motor activity, accompanied by anxiety.	Autism spectrum disorders	An umbrella term that covers conditions such as autism, childhood disintegration disorder and Asperger's syndrome.
Agranulocytosis	A blood disorder in which there is an absence of granulocytes (a type of white blood cell). It is an acute condition involving a severe and dangerous leukopenia, also known as drug-induced secondary agranulocytosis.	Autonomy	The perceived ability to control, cope with and make personal decisions about how one lives on a daily basis, according to one's own rules and preferences.
Akathisia	A subjective sense of restlessness, often accompanied by observed excessive movements (e.g. fidgety movements of the legs, rocking from foot to foot, pacing, inability to sit or stand still).	Behavioural activation	Psychological treatment that focuses on improving mood by engaging again in activities that are task-oriented and used to be enjoyable, in spite of current low mood. It may be used as a stand-alone treatment, and it is also a component of cognitive behavioural therapy.
Akinesia	The absence or lack of voluntary movement. A state of difficulty in initiating movements or changing from one motor pattern to another that is associated with Parkinson's disease.	Bereavement	A process of loss, grief and recovery, usually associated with death.
Altered mental status	A changed level of awareness or mental state that falls short of unconsciousness which is often induced by substance intake or other mental or neurological conditions. Examples include confusion and disorientation. See delirium and confusional state .	Cerebrovascular accident	A sudden disturbance of cerebral function attributable to vascular disease, principally thrombosis, haemorrhage, or embolism. See stroke .
Alzheimer's disease	A primary degenerative cerebral disease of unknown etiology in the majority of cases with characteristic neuropathological and neurochemical features. The disorder is usually insidious in onset and develops slowly but steadily over a period of several years.	Cognitive	Mental processes associated with thinking. These include reasoning, remembering, judgement, problem-solving and planning.
Anticholinergic side-effects	Anticholinergic medicines block the effects of acetylcholine at muscarinic receptors. Anticholinergic effects include dryness of the mouth, urinary frequency or retention, palpitations and sinus tachycardia.	Cognitive behavioural therapy (CBT)	Psychological treatment that combines cognitive components (aimed at thinking differently, for example through identifying and challenging unrealistic negative thoughts) and behavioural components (aimed at doing things differently, for example by helping the person to do more rewarding activities).
Aplastic anaemia	A disease characterized by the inability of blood stem cells to generate new mature cells. This disease is also characterised by low levels of red blood cells, white blood cells, and platelets. This disease may present with pallor, fatigue, dizziness, increased risk of infection or increased bruising or bleeding.	Comorbid, comorbidity	Describing diseases or disorders that exist simultaneously.
		Confidentiality	Privacy in the context of privileged communication (such as patient doctor consultations) and medical records is safeguarded.
		Confusion, confusional state	A state of impaired consciousness associated with acute or chronic cerebral organic disease. Clinically it is characterized by disorientation, slowness of mental processes with scanty association of ideas, apathy, lack of initiative, fatigue, and poor attention. In mild confusional states, rational responses and behaviour may be provoked by examination but more severe degrees of the disorder render the individual unable to retain contact with the environment.

TERM	DEFINITION	TERM	DEFINITION
Contingency management therapy	A structured method of rewarding certain desired behaviours, such as attending treatment and avoiding harmful substance use. Rewards for desired behaviours are reduced over time as the natural rewards become established.	Disorganized behaviour	Behaviour including posture, gait, and other activity that is unpredictable or not goal-directed (e.g., shouting at strangers on the street).
Convulsion, convulsive movement	Clinical or subclinical disturbances of cortical function due to a sudden, abnormal, excessive, and disorganized discharge of brain cells (see seizure). Clinical manifestations include abnormal motor, sensory and psychic phenomena.	Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli.
Delirium	Transient fluctuating mental state characterized by disturbed attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day. It is accompanied by (other) disturbances of perception, memory, thinking, emotions or psychomotor functions. It may result from acute organic causes such as infections, medication, metabolic abnormalities, substance intoxication or substance withdrawal.	Dystonia	Sustained muscle contraction or involuntary movements that can lead to fixed abnormal postures. See tardive dyskinesia .
Delusion	Fixed belief that is contrary to available evidence. It cannot be changed by rational argument and is not accepted by other members of the person's culture or subculture (i.e., it is not an aspect of religious faith).	Eclampsia	Any condition affecting pregnant women, characterized by seizure or convulsions newly arising in pregnancy. The condition is often associated with pregnancy-induced hypertension, convulsions, seizure, anxiety, epigastric pain, severe headache, blurred vision, proteinuria, and oedema that may occur during pregnancy, labour, or the puerperium.
Detoxification	The process by which an individual is withdrawn from the effects of a psychoactive substance. Also referring to a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimized.	Elevated mood	A positive mood state typically characterized by increased energy and self-esteem which may be out of proportion to the individual's life circumstances.
Disability	Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range, considered to be normal for a human being. The term disability reflects the consequences of impairment in terms of functional performance and activity by the individual.	Extrapyramidal side-effects / symptoms (EPS)	Abnormalities in muscle movement, mostly caused by antipsychotic medication. These include muscle tremors, stiffness, spasms and/or akathisia.
Disinhibited behaviour, disinhibition	Lack of restraint manifested in disregard for social conventions, impulsivity and poor risk assessment. It can affect motor, emotional, cognitive and perceptual aspects of a person's functioning.	Family therapy	Counselling that entails multiple (usually more than six) planned sessions over a period of months. It should be delivered to individual families or groups of families, and should include the person living with mental illness, if feasible. It has supportive and educational or treatment functions. It often includes negotiated problem-solving or crisis management work.
Disorganized / disordered thinking	A disturbance in the associative thought process typically manifested in speech in which the person shifts suddenly from one topic to another that is unrelated or minimally related to the first. The individual gives no indication of being aware of the disconnectedness or illogicality of his or her thinking.	Fetal alcohol syndrome	Fetal alcohol syndrome is a malformation syndrome caused by maternal consumption of alcohol during pregnancy. It is characterized by prenatal and/or postnatal growth deficiency and a unique cluster of minor facial anomalies that presents across all ethnic groups, is identifiable at birth, and does not diminish with age. Affected children present severe central nervous system abnormalities including: microcephaly, cognitive and behavioural impairment (intellectual disability, deficit in general cognition, learning and language, executive function, visual-spatial processing, memory, and attention).
		Fits	Colloquial term for convulsions. See convulsion .
		Focal deficits	Neurological signs that are observable bodily phenomena or responses suggestive of the localization of a relatively circumscribed lesion of the nervous system.

TERM	DEFINITION	TERM	DEFINITION
Hallucination	False perception of reality: seeing, hearing, feeling, smelling or tasting things that are not real.	Irritability, irritable mood	A mood state characterized by being easily annoyed and provoked to anger, out of proportion to the circumstances.
Hepatic encephalopathy	Abnormal mental state including drowsiness, confusion or coma caused by liver dysfunction.	Maculopapular rash	A rash that consists of both macules (flat (impalpable), circumscribed areas of skin or areas of altered skin colour (e.g. freckles)) and papules (small raised spots on the skin, often dome-shaped and less than 5 mm in diameter).
Herbal products	A range of folk medicines, many of them empirically discovered hundreds of years ago to be effective, derived from or consisting of portions of plants. In many cultures, knowledge about the efficacy of herbal remedies is carefully preserved and handed on by oral tradition from one generation to the next.	Meningeal irritation	Irritation of the layers of tissue that cover the brain and spinal cord, usually caused by an infection.
Hyperarousal	Intense and prolonged autonomic discharge accompanied by a state of frozen watchfulness and alertness to environmental stimuli. Such responses are seen most frequently in post-traumatic stress disorders and often associated with substance use or withdrawal.	Meningitis	A disease of the meninges (the membranes covering the brain and spinal cord) usually caused by an infection with a bacterial, viral, fungal, or parasitic source.
Hypersensitivity reaction	Hypersensitivity reactions are the adverse effects of pharmaceutical formulations (including active drugs and excipients) that clinically resemble allergy. It belongs to type B adverse drug reactions, which are defined by the WHO as the dose-independent, unpredictable, noxious, and unintended response to a medicine taken at a dose normally used in humans. It covers many different clinical phenotypes with variable onset and severity.	Motivational enhancement therapy	A structured therapy (lasting 4 or less sessions) to help people with substance use disorders. It involves an approach to motivate change by using motivational interviewing techniques i.e. engaging the person in a discussion about their substance use including perceived benefits and harms in relation to the persons own values, avoiding arguing with the person if there is resistance, encouraging the person to decide for themselves what their goal may be.
Idiosyncratic reaction	Individual, unpredictable, and non-dose-dependent response to any substance: drowsiness or euphoria, flushing, carpopedal spasms, apnoea, etc.	Motor twitching	See convulsion .
Informed consent	The process by which the health care provider discloses appropriate information to a person who can then make a voluntary choice to accept or refuse treatment. informed consent includes a discussion of the following elements: the nature of the decision/procedure; reasonable alternatives to the proposed intervention; the relevant risks, benefits, and uncertainties related to each alternative; assessment of the person's understanding, and the acceptance of the intervention by the person.	Myasthenia gravis	A disorder of neuromuscular transmission characterized by fatigable weakness of cranial and skeletal muscles. Clinical manifestations may include fluctuating diplopia and ptosis, and fatigable weakness of facial, bulbar, respiratory, and proximal limb muscles.
Interpersonal therapy (IPT)	Psychological treatment that focuses on the link between depressive symptoms and interpersonal problems, especially those involving grief, disputes, life changes and social isolation. It is also known as Interpersonal Psychotherapy.	Neonatal abstinence syndrome	Intrauterine exposure to addictive drugs can lead to neonatal withdrawal symptoms. Withdrawal symptoms are usually neurological, preventing normal autonomic function. The clinical presentation of drug withdrawal is variable and dependent on several factors, such as, the type and dose of drug used, and rate of metabolism and excretion of the mother and infant.
		Neuroinfection	Infection involving the brain and/or spinal cord.
		Neuroleptic malignant syndrome (NMS)	A rare but life-threatening condition caused by antipsychotic medications, which is characterised by fever, delirium, muscular rigidity and high blood pressure.

TERM	DEFINITION	TERM	DEFINITION
Occupational therapy	Therapy designed to help individuals improve their independence in daily living activities through rehabilitation, exercises and the use of assistive devices. In addition, such therapy provides activities to promote growth, self-fulfilment and self-esteem.	Pruritus	Itching; an intense sensation that produces the urge to rub or scratch the skin to obtain relief.
Oppositional behaviour	Markedly defiant, disobedient, provocative or spiteful behaviour that may be manifest in prevailing, persistent angry or irritable mood, often accompanied by severe temper outbursts or in headstrong, argumentative and defiant behaviour.	Pseudodementia	A disorder resembling dementia but not due to organic brain disease and potentially reversible by treatment; can manifest as symptoms of depression in some older adults.
Orthostatic hypotension	Sudden drop of blood pressure that can occur when one changes position from lying to sitting or standing up, usually leading to feelings of light-headedness or dizziness. It is not life-threatening.	Psychoeducation	The process of teaching people with MNS disorders and their carers/family members about the nature of the illness, including its likely causes, progression, consequences, prognosis, treatment and alternatives.
Parent Skills Training	A family of treatment programs that aims to change parenting behaviours and strengthen confidence in adoption of effective parenting strategies. It involves teaching parents emotional communication and positive parent-child interaction skills, and positive reinforcement methods to improve children/adolescent's behaviour and functioning.	QT prolongation	A potential medication induced side-effect of ventricular myocardial repolarization characterized by a prolonged QT interval on the electrocardiogram (ECG) that can lead to symptomatic ventricular arrhythmias and an increased risk of sudden cardiac death.
Phaeochromocytoma	A neuroendocrine tumour of the medulla of the adrenal glands causing symptoms (mainly headaches, palpitations and excess sweating) and signs (mainly hypertension, weight loss and diabetes) reflecting the effects of epinephrine and norepinephrine on alpha- and beta-adrenergic receptors.	Racing thoughts	Rapid thought pattern with tangential movement from one idea to the next often associated with mania or other mental illnesses.
Polyneuropathy	Disorder and functional disturbance of the peripheral nerves. This may be manifest as numbness of the extremities, paraesthesia ("pins and needles" sensations), weakness of the limbs, or wasting of the muscles and loss of deep tendon reflexes.	Relapse	A return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. The term is also used to indicate return of symptoms of MNS disorder after a period of recovery.
Polytherapy	Provision of more than one medicine at the same time for the same condition.	Relaxation training	Involves training in techniques such as breathing exercises to elicit the relaxation response.
Porphyria	Porphyrias constitute a group of diseases characterized by intermittent neuro-visceral manifestations, cutaneous lesions or by the combination of both. Clinical signs of the disease usually appear in adulthood, but some porphyrias affect children. Direct or indirect neurotoxicity may cause neurological manifestations.	Respiratory depression	Inadequate slow breathing rate, resulting in insufficient oxygen. Common causes include brain injury and intoxication (e.g. due to benzodiazepines).
Privacy	The state of being free from unsanctioned intrusion. For example, personal privacy in daily living activities (e.g. for clients in residential facilities) or confidential health records.	Respite care	Provision of temporary health-care facilities to a person normally cared for at home.
Problem-solving counselling	Psychological treatment that involves the systematic use of problem identification and problem-solving techniques over a number of sessions.	Rigidity	Resistance to the passive movement of a limb that persists throughout its range. It is a symptom of parkinsonism.
		Saving group	A saving activity in which the poor can accumulate a large amount of money quickly by pooling their savings in a common fund which can then be used by the group or a member of the group for productive investment.
		Seizure	Episode of brain malfunction due to disturbances of cortical function resulting in sudden, abnormal, excessive, and disorganized discharge of brain cells. Clinical manifestations include abnormal motor, sensory and psychic phenomena.
		Self-harm	Intentional self-inflicted poisoning or injury to oneself, which may or may not have a fatal intent or outcome.

TERM	DEFINITION	TERM	DEFINITION
Serotonin syndrome	Characterised by an excess of serotonin in the central nervous system, associated with the use of various agents, including selective serotonin reuptake inhibitors (SSRIs). Serotonin syndrome may result in muscle rigidity, myoclonus, agitation, confusion, hyperthermia, hyperreflexia as well as dysautonomic symptoms, with a risk of shock with low peripheral vascular resistance, seizures, coma, rhabdomyolysis and/or disseminated intravascular coagulation (DIC).	Suicidal thoughts / ideation	Thoughts, ideas, or ruminations about the possibility of ending one's life, ranging from thinking that one would be better off dead to formulation of elaborate plans.
Slurred speech	Speech with indistinctive pronunciation.	Tardive dyskinesia	This is dystonia characterized by twisting and sustained muscle spasms that affect regions of the head, neck, and occasionally, the back. It may not improve after stopping the antipsychotic medicine.
Social network	A construct of analytical sociology referring to the characteristics of the social linkages among people as a means of understanding their behaviour, rather than focusing on the attributes of individuals.	Temper tantrum	An emotional outburst from a child or those in emotional distress.
Social withdrawal	Inability of a person to engage in age appropriate activities or interactions with his or her peers or family members.	Thrombocytopenia	Abnormally low number of platelets in the blood. This disease may present with increased bruising or haemorrhaging. Confirmation is by identification of decreased platelet count in a blood sample.
Spider naevus	A cluster of minute red blood vessels visible under the skin, occurring typically during pregnancy or as a symptom of certain diseases (e.g. cirrhosis or acne rosacea).	Toxic epidermal necrolysis	Life-threatening skin peeling that is usually caused by a reaction to a medicine or infection. It is similar to but more severe than Stevens-Johnson syndrome.
Spinal abscess	A condition of the spinal cord, caused by an infection with a bacterial, viral, or fungal source. This condition is characterized by a focal accumulation of purulent material within the spinal cord. This condition may present with fever, back pain and neurological deficits. Transmission is through haematogenous spread of the infectious agent.	Traditional Healing	A system of treatment modalities based on indigenous knowledge of different cultures pertaining to healing.
Status epilepticus	Defined as 5 min or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery (returning to baseline) between seizures; it can be convulsive or non-convulsive.	Transient ischaemic attack (TIA)	A transient episode of acute focal neurological dysfunction caused by focal ischemia of the brain or retina, without demonstrated acute infarction in the clinically relevant area of the brain. Symptoms should resolve completely within 24 hours.
Stevens-Johnson syndrome	Life-threatening skin condition characterized by painful skin peeling, ulcers, blisters and crusting of mucocutaneous tissues such as mouth, lips, throat, tongue, eyes and genitals, sometimes associated with fever. It is most often caused by severe reaction to medications, especially antiepileptic medicines.	Tremor	Trembling or shaking movements, usually of the fingers, that is an involuntary oscillation of a body part.
Stigma	A distinguishing mark establishing a demarcation between the stigmatized person and others attributing negative characteristics to this person. The stigma attached to mental illness often leads to social exclusion and discrimination and creates an additional burden for the affected individual.	Vitamin K deficiency disease of the newborn	Lack of vitamin K can cause severe bleeding in newborn babies usually immediately after birth but sometimes up to 6 months of age. Bleeding may be cutaneous, gastro-intestinal, intracranial or mucosal. Maternal intake of antiepileptic medicines is one of its causes.
Stroke	See cerebrovascular accident (CVA) .	Wandering	People living with dementia feel the urge to walk about and in some cases leave their homes. They can often experience problems with orientation, which may cause them to become lost.

**For more information,
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Mental, neurological and substance use (MNS) disorders are highly prevalent, accounting for a substantial burden of disease and disability globally. In order to bridge the gap between available resources and the significant need for services, the World Health Organization launched the Mental Health Gap Action Programme (mhGAP).

The objective of mhGAP is to scale-up care and services using evidence-based interventions for prevention and management of priority MNS conditions. The mhGAP Intervention Guide version 1.0 for MNS disorders for non-specialist health settings was developed in 2010 as a simple technical tool to allow for integrated management of priority MNS conditions using protocols for clinical decision-making.

With uptake in over 90 countries, mhGAP-IG 1.0 version has had widespread success. It is our pleasure to present mhGAP version 2.0, with updates incorporating new evidence-based guidance, enhanced usability, and new sections to expand its use by both health care providers as well as programme managers.

It is our hope that this guide will continue to provide the road-map to deliver care and services for people with MNS disorders around the world and lead us closer to achieving the goal of universal health coverage.

The mhGAP-IG version 2.0 includes the following sections:

- » **Essential Care & Practice**
- » **Master Chart**
- » **Depression**
- » **Psychoses**
- » **Epilepsy**
- » **Child & Adolescent Mental & Behavioural Disorders**
- » **Dementia**
- » **Disorders due to Substance Use**
- » **Self-harm/Suicide**
- » **Other Significant Mental Health Complaints**
- » **Implementation of mhGAP-IG**



World Health Organization

MENTAL HEALTH CARE

*in Settings Where Mental Health
Resources Are Limited*

An Easy-Reference **GUIDEBOOK**

*for Healthcare Providers
in Developed and Developing Countries*

PAMELA SMITH, MD



MENTAL HEALTH CARE

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Pamela Smith, MD

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The field guide is not a substitute for comprehensive psychiatry, psychology, or other related mental health texts but is meant to be a concise, quick reference guide providing an outline of core concepts and basic interventions in mental health care. Efforts have been made to confirm the accuracy of the information presented and to describe generally accepted practices. Application of this information in a particular situation remains the responsibility of the practitioner or health care provider.

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Preface & Acknowledgements

In communities where little or no mental health care exists, people with mental conditions are at risk for increased illness, stigma, and abuse. Their fundamental right to mental health & happiness can be compromised. Providing mental health care training to health care workers and raising awareness among individuals within resource-limited communities serves as a significant means not only to improving access to care to individuals but also to preserving human rights. This field guide aims to be a contribution to the broader effort to improve the health, dignity, and quality of life for individuals in resource -limited settings worldwide with mental conditions.

Pamela Smith, MD, completed specialty training in psychiatry at New York – Presbyterian University Hospital of Columbia & Cornell and later served on the faculty of the UCLA Medical School as an assistant clinical professor in psychiatry. She has worked in international humanitarian aid providing mental health support to people living with HIV/AIDS in Uganda, to survivors of the tsunami in Indonesia and Sri Lanka, to survivors of the earthquake in Haiti, and to refugees of the conflict in Darfur, Sudan. Dr. Smith has participated in coordinating projects with organizations and agencies including the AIDS Healthcare Foundation (AHF), International Medical Corps (IMC), World Health Organization (WHO), UNICEF, and United Nations High Commission for Refugees (UNHCR). In addition, she has served on the peer review panel of the United Nations/Inter-Agency Standing Committee Mental Health Task Force developing international guidelines for mental health interventions during emergency disaster relief. Dr. Smith has also provided clinical services (general adult outpatient psychiatry, telepsychiatry) to varied resource-limited communities in urban and rural areas of the United States and has worked for the U.S. Indian Health Services (IHS) supporting the mental health of Native Americans.

A special thanks to Aleksandra Bajic, PharmD for assistance with the medication guide and much gratitude is extended to Whitney A. Relf, PhD, MA (Disabilities Consultant) and Blaire Relf (research assistant) for contributions to the sections on intellectual disability, autism spectrum disorder, ADHD, and Tourette's disorder.

Medical Abbreviations List

bid –twice daily	po- by mouth
BP –blood pressure	prn -as needed
cap -capsule	q –every
CBC –complete blood (cell) count	qhs– every bedtime
CNS– central nervous system	qid– 4 times daily
DSM -Diagnostic Statistical Manual	SNRI– selective norepinephrine
dx –diagnosis	reuptake inhibitor
EKG– electrocardiogram	SR - slow release
EPS-extrapyramidal symptoms	SSRI-selective serotonin reuptake
ESR-erythrocyte sedimentation rate	inhibitor
HR– heart rate	sx-symptoms
ICD– International Classification of Diseases	TD– tardive dyskinesia
IM-intramuscular	tid –three times daily
IV– intravenous	WHO– World Health Organization
MAOI-monoamine oxidase inhibitor	XL– extended length
Meq/L– milliequivalent/liter	XR– extended release
mg– milligram	
ml– milliliter	
MSE– mental status examination	
ng– nanogram	
NMS– neuroleptic malignant syndrome	

Introduction

PURPOSE OF THE GUIDE

The guidebook is intended to be a tool for community or hospital-based healthcare providers working in settings where access to mental health resources has been limited or non-existent (e.g. in remotely located, economically impoverished, or nature/human-related disaster-affected communities in developed or developing countries). It is a condensed, easy-reference handbook providing an outline of core concepts and basic interventions in mental health care. The guide is not a substitute for comprehensive psychiatric, psycho-social, or other related mental health texts or training and it is imperative that practitioners or health care workers are responsible in the interpretation and application of information. In addition, differences in cultural beliefs and practices will influence the manner and extent to which the guide is used by individuals in varied regions.

Presented in this guidebook is an allopathic (western) approach to identifying and managing various mental health conditions. The allopathic medical system represents only one method for dealing with mental health issues and other systems of care may have a different relevance or applicability in varied parts of the world.

Introduction

USING THE GUIDE

How Healthcare Providers Of Varied Disciplines Can Use Different Aspects Of The Guide

Health providers of varied disciplines will find information in the field guide relevant to their practice. In addition, educators can use different aspects of the manual as a source of material for different types and levels of training activity.

All chapters will provide readers with a basic understanding of key topics in the field of mental health. Descriptions of conditions and important issues within the mental health field are written using terminology that can be appreciated by both the professional and the lay person.

The “Medication Guide” section may be especially useful to allopathic physicians and other clinicians such as physician assistants, nurse practitioners, and medical officers (who have the authority to prescribe medication under the supervision of a physician in some countries). In areas using allopathic methods, where nurses, midwives, and social workers are called upon to provide support for people with psychological distress, the counseling interventions, contained in chapters discussing specific mental health conditions, may be particularly useful.

The mental health information contained in this guide useful to varied health care providers (including laypeople, families, and individuals with psychological conditions) is outlined on the following page.

Introduction

MENTAL HEALTH INFORMATION FOUND IN THE GUIDE THAT MAY BE USEFUL TO HEALTHCARE PROVIDERS OF VARIED DISCIPLINES

Healthcare Provider	General Information & Allopathic Interventions
Health policy-makers & other health administrators; Program Directors	Demographics on mental health care in varied regions of the world Integration & collaboration among different health systems Mental health duties for primary care providers & mental health service organization and design
Mental Health Trainers; Educators	Mental health training curricula for primary care providers of varied disciplines
Physicians; Medical Officers; Physician Assistants, Nurse Practitioners;	Signs and treatment of major mental health conditions; maternal & child mental health How to prescribe psychotropic medication and manage side effects Counseling techniques
Pharmacists	Medication therapy for mental health conditions
Nurses; Midwives	Signs and treatment of major mental health conditions Maternal & child mental health How to administer psychotropic medication & recognize side effects Counseling techniques for individuals and groups
Social Workers	Signs of major mental health conditions Counseling techniques for individuals and groups; How to provide community education & help communities organize psychosocial activities
Community Mental Health Workers/ Aides	Basic signs of mental distress; support for individuals & groups; How to provide community education & help communities organize psychosocial activities

I: Mental Health Worldwide

PART I: MENTAL HEALTH WORLDWIDE

The World Health Organization (WHO) has defined mental health as a “state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

Global mental health refers to the international perspective on varied aspects of mental health and has been defined as “the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide” (Koplan et al, 2009). Neuropsychiatric disorders contribute to approximately 13% of the global burden of disease and create (to varying degrees among countries) burden in every country in the world.

Assessments of mental health resources worldwide are done with the aim of shedding light on the most recent global view of resources available to prevent neuropsychiatric disorders, provide intervention, and protect human rights. WHO reports of mental health worldwide have examined resources with regard to geographic region and economic status. Categorizing countries into regions is one way to organize the huge volume of information about mental health structures and services throughout the world. In addition, looking at regions may be useful from an economic perspective. It has been established that many nations have no or very limited mental health programming and need to utilize the support of other countries to develop a system of care. Being in a region where a high percentage of neighboring countries have resources can be useful for a country in the same area that has limitations. In addition, using the resources of a nation nearby may be less expensive and a faster process than relying on resources from a far distance.

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An examination from the economic perspective allows the identification of specific types of mental health issues prevalent in countries with different income levels. This information can potentially guide the planning of mental health policies, legislation, programs and services. The information may also be useful to funding agencies providing financial support to countries that want to develop resources.

Limitations of Global Studies & Reports

Trying to understand the status of mental health care in countries throughout the world has been a challenging process. Existing reports and studies have taken the best measures possible to be scientific and accurate in collecting, analyzing, and placing in perspective results of data. Nevertheless, these studies are not without their limitations.

With regard to a discussion of mental health care by global region, data may be limited by the way regions have been categorized. In a report on global mental health (WHO, 2005) “regions” are not necessarily divided precisely or purely by global or physical location (i.e. a “region” may include countries that are not physically located on the same continent). In some cases, the “regional” similarity appears to be related to historical, cultural, or economic factors that may link and make a group of countries comparable for analysis.

Other limitations include an inability to obtain information from all countries on all variables, variations in how different countries define mental health concepts, and variations from country to country in sources of information.

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Information presented in this section comes from reports and studies that have inherent limitations, therefore specific conclusions and summary statements will have limitations as well. Data from the WHO is particularly highlighted. One reviewing this information should continue to follow subsequent studies, reports, and related literature from varied sources to gain a full and accurate perspective of global mental health care.

Recent Data

Results of a recent assessment of 184 of 196 World Health Organization (WHO) member states (representing 95% of WHO member states and 98% of the world's population) have indicated that there is a growing burden of neuropsychiatric disease and that mental health resources remain insufficient (WHO 2011). The burden of disease is much greater in low income countries compared to high income countries. However, the number of beds in mental hospitals is reduced in the majority of countries which may be an indication of a shift from institutional care to community-based care.

In the WHO 2011 report, geographic regions were classified as Africa (AFR), the Americas (AMR), Eastern Mediterranean (EMR), Europe (EUR), South/South-East Asia (SEAR), and the Western Pacific (WPR) and income levels were described in terms of high (gross national per capita income of US\$ 12,276 or more), upper-middle (US\$ 12,275 – \$3,976), lower-middle (US\$ 3975 - \$1006), and low (US\$ 1005 or less). A summary of key findings is provided in the next section.

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Indicators of Global Mental Health (WHO, 2011)

- 1) Governance
- 2) Financing
- 3) Mental health care delivery of services
- 4) Human resources
- 5) Medicines for mental & behavioral disorders
- 6) Information systems.

1) Governance

Mental Health Policy

Data indicates that in about 60% of countries, a dedicated or officially approved mental health policy exists, covering approximately 72% of the world's population. Dedicated mental health policies are more present in EMR, EUR, and SEAR compared to AFR, AMR, and WPR. Data from the World Bank income group also indicates that mental health policies tend to exist in high income countries (77.1%) compared to low income countries (48.7%). Regions with the highest percentage of countries that have recently adopted or updated mental health policies include WPR (87%), EMR (85%), and EUR (84%) while regions with the lowest percentage of countries adopting or revising policies are AFR (56%) and SEAR (57%). The AMR tallied 67% of its countries adopting or updating policies.

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Mental Health Plan

In 72% of the WHO member countries providing data (accounting for 95% of the world's population), a mental health plan (or scheme realizing the objectives of mental health policy) has been outlined. Regions with the greatest percentage of countries with plans include EMR (74%), SEAR (80%) and EUR (81%). Fewer plans were in place in WPR (62%), AMR (66%), and AFR (67%). Regarding income group, wealthier countries had a tendency to have plans compared to countries with low income.

Mental Health Legislation

Worldwide, 59% of people live in a country where dedicated or officially approved mental health legislation exists with legislation present least in AFR (44.4%) and SEAR (40%) and most in AMR (56.3%), EMR (57.9%), EUR (80.8%), and WPR (53.8%). Higher (i.e. high and upper-middle) income countries tended to have legislation present compared to lower (i.e. lower-middle and low) income countries.

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2) Financing

The global median mental health expenditures per capita are \$1.63 USD. There is a significant difference in median mental health expenditures per capita among income groups, ranging from \$0.20 USD in low income countries to \$44.84 USD in high income countries. The median percentage of health budget allocated to mental health is highest in the EUR (5.0%), 3.75% in EMR, 1.95% in WPR, 1.53% in AMR, 0.62% in AFR, and 0.44% in SEAR. Regarding income group, the median percentage of health budget allocated to mental health is highest for high income countries (5.1%), 2.38% for upper-middle income countries, 1.90% for lower-middle countries, and lowest or 0.53% for low income countries. Sixty-seven percent (67%) of financial resources worldwide are directed toward mental hospitals /institutions as opposed to community-based facilities (note: only 74 of 184 countries provided responses/data).

3) Mental Care Delivery of Services

The delivery of mental health services has been assessed with regard to a) services provided by primary health care (PHC) clinicians; b) mental health facilities (outpatient, day treatment, general hospital psychiatric ward, community residential, and mental hospital facilities); and c) Aspects of service (length of mental hospital stay, follow up care, psychosocial interventions, and distribution of beds across facilities).

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a) PHC mental health care delivery

A majority of countries allow PHC physicians to prescribe (or continue prescribing) medicines for mental and behavioral disorders either without restrictions (56%) or with some legal restrictions (40%). Restrictions include allowing prescriptions only in emergency settings or in certain categories of medicines. The percentage of respondent countries not allowing any form of prescription by PHC physicians is 3%. Regarding nurses, 71% of countries do not allow them to prescribe (or continue to prescribe), 26% of countries allow prescribing with restrictions, and 3% allow prescribing without restrictions.

b) Mental health facilities

Regarding the number of facilities worldwide, outpatient facilities out number day treatment facilities, mental hospitals, community residential facilities, and psychiatric beds in general hospitals. Outpatient facilities are defined as facilities that focus on the management of mental disorders and related clinical problems on an outpatient basis. A day treatment facility refers to a facility providing care to individuals during the day. A mental hospital is defined as a specialized hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. A community residential facility is a non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. The global median number of outpatient facilities is 0.61 (per 100,000 population), 0.05 day treatment facilities, 0.04 mental hospitals, and 0.01 community residential facilities. The global median number of psychiatric beds in general hospitals is 1.4 per 100,000 population.

c) Aspects of mental health service

High income countries tend to have more facilities and higher admission & utilization rates. A majority of people admitted to mental hospitals stay less than one year, however 23 % of those admitted still remain longer than a year.

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Regarding follow-up care (i.e. home visits to check medications, to monitor signs of relapse, and to assist with rehabilitation), only 32% of countries have a majority of facilities that provide follow-up. Regarding income level 45% of high income countries provide follow-up care at a majority of facilities while 39% of upper-middle income, 29% of lower-middle income, and 7% of low income countries provide follow-up at a majority of facilities.

Regarding psychosocial interventions, only 44% of countries have a majority of countries providing these services. Upper-middle income and high income countries provide more psychosocial care at a majority of facilities(61% and 59% respectively) compared to lower-middle (34%) and low income countries (14%).

The global median rate for all beds in community residential facilities, mental hospitals, and psychiatric wards within general hospitals is 3.2 beds per 100,000 population. Across WHO regions, there is great disparity. That is, the rates in the AFR (0.60), EMR (0.62) and SEAR (0.23) are significantly lower than the global mean, while the rate in EUR countries (7.09) is more than double the world median.

4) Human resources

Worldwide, nurses represent the most common health professional graduate working in the mental health sector (5.15 per 100,000 population). Globally, the next most common health professional graduate working in the mental health sector is the medical doctor (3.38 per 100,000 population). Regarding psychiatrists, the median rate ranges from 0.05 per 100,000 population in AFR to 8.59 per 100,000 population in EUR. Regarding other health personnel working in the mental health sector, the median rate of other medical doctors ranges from 0.06 (AFR) to 1.14 (EUR) per 100,000 and for nurses ranges from 0.61 (AFR) to 21.93 (EUR) per 100,000. The median rate of psychologists ranges from 0 (WPR) to 2.58 (EUR) per 100,000; social workers from 0 (WPR) to 1.12 (EUR) per 100,000; occupational therapists from 0 (SEAR and WPR) to 0.57 (EUR) per 100,000; and other health workers from

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0.04 (SEAR) to 17.21 (EUR) per 100,000.

With regard to income group, there is significant disparity in the number of doctors, nurses, and psychologists working in the mental health sector. For psychologists, the median rate of these clinicians working in the mental health sector is over 180 times greater in high income compared to low income countries. In high income countries, the median rate of psychiatrists is 8.59 compared to 0.05 in low income countries.

Worldwide, 2.8% of training for doctors is focused on psychiatry and mental health related topics. Variability across regions exists ranging from 2.2% in AMR to 4.0% in SEAR. For nurses, 3.3% of training is focused on psychiatry and mental health-related topics with moderate variability among regions ranging from 2.0% in SEAR and 4.0% in AFR

5) Medicines for mental & behavioral disorders

Worldwide, the median expenditure per person per year on medicines for mental and behavioral disorders has been estimated to be about \$7 (\$6.81) USD. However, the actual expenditure is likely to be lower, as fewer than 30% of countries involved in the recent WHO survey reported data, with those responding being disproportionately from high income countries.

6) Information systems

According to the WHO 2011 report, mental health data is collected for individuals receiving treatment from mental hospitals, general medical hospitals, day treatment and outpatient facilities. Less data tends to be collected from primary care and community residential facilities.

II. Mental Health Capacity Building

PART II. MENTAL HEALTH CAPACITY BUILDING:

Increasing Access to Care Through Integration & Collaboration

INTEGRATING MENTAL HEALTH CARE INTO EXISTING HEALTH FACILITIES

Integrating mental health care into existing community facilities can be an effective and efficient way to deliver mental health services to a large number of people living in areas with limited resources.

The integration process involves **training** existing primary health-care practitioners based in the community and has been utilized in western (allopathic) health systems. General practitioners and healthcare workers are trained to make basic mental health assessments, to provide basic therapeutic interventions, and to refer to more specialized interventions (if available) individuals who have more serious psychiatric symptoms.

The integration process may also involve working with government agencies and other institutions to develop mental health policies, to promote deinstitutionalization and provision of community-based acute and continuing care (for those with the most serious and disabling conditions), and to incorporate mental health training programs into medical, nursing, and graduate schools.

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Telepsychiatry

Telepsychiatry refers to the use of communications and information technologies for training and, in some cases, directly delivering mental health care. It has been especially beneficial for populations living in isolated communities and remote regions.

Through video-conferencing (one form of technology) general practitioners in areas with limited or no access to mental health services can gain access to a mental health specialist located in a different region for ongoing consultations and supervision. In addition, mental health training programs that utilize telepsychiatry have the potential to reduce costs while maintaining an efficient and effective means for providing technical advice and information.

RECOMMENDATIONS FOR MENTAL HEALTH TRAINING CURRICULA & DUTIES FOR VARIED HEALTHCARE PERSONNEL

Suggested curricula and duties for varied primary care providers are outlined in the tables on the following pages. In addition, guidelines on how to teach primary healthcare staff to provide mental health care are offered in the pages to follow.

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Physicians, Medical Officers, Physician Assistants, Nurse Practitioners

Suggested Mental Health Curriculum	Suggested Duties
<p>A. The Psychiatric History & Mental Status Exam</p> <p>B. Symptoms, Diagnosis & Treatment of:</p> <ol style="list-style-type: none"> 1. Schizophrenia & Other Psychotic Conditions 2. Mood Disorders 3. Anxiety Disorders 4. Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions 5. Delirium (Neuro-cognitive disorders) 6. Dementia (Neuro-cognitive disorders) 7. Alcohol & Drug Use Disorders 8. Epilepsy/Seizures Disorders 9. Maternal Mental Health; Neuro-developmental Disorders and Common Psychiatric & Behavioral Conditions in Children & Adolescents 10. Loss & Bereavement 11. Psychiatric Emergencies (suicide/ agitation) <p>C. Other Issues:</p> <ol style="list-style-type: none"> 1. Institutionalization 2. Mental Health Care in Disaster Relief 3. Stigma and discrimination & legal and ethical issues in the mental health setting 	<p>a) Perform psychiatric history and mental status examination; formulate diagnoses and treatment plans</p> <p>b) Prescribe psychotropic medication and manage side effects</p> <p>c) Provide counseling directly or provide referral to staff implementing counseling</p>

II. Mental Health Capacity Building

Nurses & Midwives

Suggested Mental Health Curriculum	Suggested Duties
<p>A. The Psychiatric History & Mental Status Exam</p> <p>B. Symptoms, Diagnosis & Treatment of:</p> <ul style="list-style-type: none"> 1. Schizophrenia & Other Psychotic Conditions 2. Mood Disorders 3. Anxiety Disorders 4. Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions 5. Delirium (Neuro-cognitive disorders) 6. Dementia (Neuro-cognitive disorders) 7. Alcohol & Drug Use Disorders 8. Epilepsy/Seizure Disorders 9. Maternal Mental Health; Neuro-developmental Disorders and Common Psychiatric & Behavioral Conditions in Children & Adolescents 10. Loss & Bereavement 11. Psychiatric Emergencies (suicide/ agitation) <p>C. Other issues:</p> <ul style="list-style-type: none"> 1. Community Mental Health Nursing 2. Institutionalization 3. Mental Health Care in Disaster Relief 4. Stigma and discrimination & legal and ethical issues in the mental health setting 5. Mental health promotion, psycho-education, and advocacy 	<p>a) Perform mental health evaluations; child development assessments (in some countries midwives may be focused on this activity); refer to physician for medications if indicated</p> <p>b) Administer medications prescribed by physicians (<i>*nurses & midwives in some countries also prescribe under physician supervision</i>)</p> <p>c) Recognize medication side effects and refer to the physician for treatment</p> <p>d) Implement counseling techniques directly or refer to staff who implement counseling</p>

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Social Workers

Suggested Mental Health Curriculum	Suggested Duties
<p>A. The Psychiatric History & Mental Status Exam</p> <p>B. Symptoms, Diagnosis & Treatment of:</p> <ul style="list-style-type: none"> 1. Schizophrenia & Other Psychotic Conditions 2. Mood Disorders 3. Anxiety Disorders 4. Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions 5. Delirium (Neuro-cognitive disorders) 6. Dementia (Neuro-cognitive disorders) 7. Alcohol & Drug Use Disorders 8. Epilepsy/Seizure Disorders 9. Maternal Mental Health; Neuro-developmental Disorders and Common Psychiatric & Behavioral Conditions in Children & Adolescents 10. Loss & Bereavement 11. Psychiatric Emergencies (suicide/ agitation) <p>C. Other issues:</p> <ul style="list-style-type: none"> 1. Institutionalization 2. Mental Health Care in Disaster Relief 3. Stigma and discrimination & legal and ethical issues in the mental health setting 4. Mental health promotion, education, and advocacy 	<p>a) Provide guidance regarding basic needs (food, shelter, safety, education, access to healthcare, etc...)</p> <p>b) Refer individuals in need to mental health evaluation (in some countries social workers perform evaluations)</p> <p>c) Implement counseling (in some countries social workers implement individual, family, & group counseling)</p> <p>d) Implement community education (focused on stigma; maintaining mental wellness; and recognition of signs of psychological distress)</p> <p>e) Assist communities in organizing psychosocial activities</p>

II. Mental Health Capacity Building

Community Mental Health Workers/Aides

Suggested Mental Health Curriculum	Suggested Duties
<p>A. Basic Signs & Symptoms of:</p> <ul style="list-style-type: none"> 1. Schizophrenia & Other Psychotic Conditions 2. Mood Disorders 3. Anxiety Disorders 4. Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions 5. Delirium (Neuro-cognitive disorders) 6. Dementia (Neuro-cognitive disorders) 7. Alcohol & Drug Use Disorders 8. Epilepsy/Seizure disorders 9. Maternal Mental Health; Neuro-developmenal Disorders and Common Psychiatric & Behavioral Conditions in Children & Adolescents 10. Loss & Bereavement 11. Psychiatric Emergencies (suicide; agitation) <p>B. Basic Types of Support Available in the Community</p> <p>C. How to Refer Individuals in the Community to Evaluation and Support</p> <p>D. Basic Information on:</p> <ul style="list-style-type: none"> 1. Mental Health Care in Disaster Relief 2. Institutionalization 3. Stigma and discrimination & legal and ethical issues in the mental health setting 4. Mental health promotion, psycho-education, and advocacy 	<p>a) Identify and refer individuals in need to mental health evaluations</p> <p>b) Provide individual, family, & group psychological support</p> <p>c) Implement community education (focused on stigma; maintaining mental wellness; and recognition of signs of psychological distress)</p> <p>d) Assist communities in organizing psychosocial activities</p>

II. Mental Health Capacity Building

GUIDELINES FOR TEACHING PRIMARY HEALTHCARE STAFF TO PROVIDE MENTAL HEALTH CARE

One approach to training primary healthcare staff to provide mental health care involves a) establishing learning goals and objectives that are relevant and applicable to the existing practices of the primary care staff; b) developing theoretical mental health presentations and practical on-the-job supervision sessions that are effective and convenient; and c) utilizing comprehensive evaluations to monitor and further enhance learning. It is important that those teaching have the appropriate level of education or experience in their areas of instruction and that trainees have a basic level of understanding that will allow them to comprehend the instruction.

A) Establishing Learning Goals & Objectives – What is the information trainees are expected to learn?

Objectives may be defined as the learning needed to reach a particular goal. Trainers must decide on the desired goal of their training sessions and then develop clear objectives that will lead to the goal.

Goals and objectives need to be relevant or directly applicable to the real situations staff face in their primary care settings.

Example: A goal of a mental health training course for a group of primary care doctors may be that they learn to provide an effective treatment for an individual with a particular mental health condition. Objectives toward this goal may include their a) learning to take a psychiatric history; b) learning the varied signs and symptoms of varied mental health conditions; and c) learning the varied types of therapies to manage conditions. A number of objectives may be involved in achieving an overall goal.

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B) Theoretical Presentations & On-the Job Supervision

Lecture presentations

Theoretical information may be presented in many forms. A lecture format that is interactive (i.e. involves audience participation) and offers a clear outline can be effective. However, lengthy or numerous lectures should be minimized for primary care staff who may be overwhelmed already with several tasks and responsibilities. Staff participating in training sessions will absorb more information if it is presented in a manner that is concise and relates directly to their existing work activities.

It can be helpful to consider the Who, What/Why, Where, and How when outlining a lecture:

- 1) Who are you presenting to?
 - a) Understand who your audience is; know their level of education, experience or understanding in general;
 - b) Always treat the audience respectfully and allow questions; provide clear explanations;
 - c) Take time to put an audience and yourself at ease by having some informal interaction before getting into the core presentation (e.g. use opening joke, story or “ice-breaker” activity).

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2) What information or skills do you need them to understand and Why is this information important for them to know?

- a) Start with a welcome and introduction (and informal interaction);
- b) Reiterate why it is important that they have attended;
- c) Provide an outline of the session that states topics to be discussed and a general time frame for the discussion;
- d) Make clear what they can expect from the session (desired outcome and objectives) and why it is important for them to attain this information;
- e) Start with a broad outline of the information and then get more specific;
- f) Conclude with a summary of the key points of the discussion.

3) Where will you be presenting the information?

- a)Take time to prepare your space so that it is conducive to effective learning (Is there enough space for all participants to see and hear you? Are there electrical outlets in the room? Is there an adequate setting for breaks?; Are toilets nearby? etc...).

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- 4) Specifically How will I present the information (what types of materials or aids will be useful in presenting the information)?
- a) What aids are available and feasible to use (chalkboard or whiteboard? projectors?; flip charts?; microphones? Is there electricity or a generator to power electronic aides? Etc...);
 - b) Are take-home materials used (books, handouts, brochures, etc...).

On-the-job supervision

Theoretical information must be practically applied to real situations faced by the primary care staff. Having a knowledgeable supervisor teach and monitor as a trainee works directly with patients will reinforce that trainee's learning and understanding of the theoretical concepts. Clients should be made aware of the role of the supervisor prior to sessions and should be reassured that information will not be used inappropriately.

C) Evaluation Of Teaching

Evaluations of the trainees and trainers (and training programs) are indicators of whether or not teaching has been effective and learning has been achieved. Evaluations are also useful in monitoring progress and providing feedback and guidance on how to enhance the instruction and learning process. Outlined in the box on the following page are elements that may be included in evaluations.

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Elements of Training Evaluations

The following information can be useful in monitoring and determining the effectiveness of trainings:

1) Trainee evaluation

Trainee name (use ID numbers for confidentiality)

Trainee level of education/experience in MH care

Dates of participation and completion of coursework

list of all sessions/courses completed

list of courses repeated

theoretical & practical examination scores

theoretical & practical re-examination scores

2) Trainer & program/course/session evaluation

trainee survey evaluating quality of teaching, coursework, and examinations (was trainer an effective speaker/communicator; were topics clear; were teaching aids adequate; did exam questions reflect material presented, etc...)

3) Program/course/session evaluation

total trainee enrollment

number of trainees with successful completion of the program

trainee attrition (number of drop-outs before completion of the program)

number of trainees requiring repetition of coursework/re-examination

progress/clinical outcome (condition of patients treated by trainees at the start of treatment compared to their condition at the end of treatment)

patient/community survey evaluating services provided by trainees

II. Mental Health Capacity Building

HOW TO DEVELOP COLLABORATIONS

Cultures and societies throughout the world and throughout time have found ways to describe and manage human emotions and behavior. Some societies have created organized systems of mental health care while others have adopted different approaches. Collaboration implies a coexistence among systems and approaches with each contributing its own unique methods for managing the health of individuals. The advantage of a health care system that utilizes collaboration is that varied options for care become available, increasing the potential for effective outcomes.

Ways that practitioners from different health systems develop collaborations

- a) Invitations to consultations;
- b) Cross-referral - For example, some problems may potentially be better treated by one form of medicine compared to another (e.g. stress, anxiety, bereavement, conversion reactions, and existential distress may be managed with significant effect by non-allopathic practitioners, while allopathic practitioners may be have more effective treatments for severe mental disorders and epilepsy);
- c) Joint assessments;
- d) Joint training sessions;
- e) Joint clinics;
- f) Shared care (e.g. non-allopathic practitioners may be prepared to learn how to monitor psychotic patients on long-term allopathic medication and to provide places for patients to stay while receiving allopathic treatments).

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Advantages of collaboration

- a) Increased understanding of the way emotional distress and psychiatric illness is expressed and addressed and a more comprehensive picture of the type and level of distress in the affected population;
- b) Improved referral systems;
- c) Continuing relationship with healers of varied types to whom many people turn for help;
- d) Increased understanding of community members' spiritual, psychological and social worlds;
- e) Greater acceptance of new services by community members;
- f) Identifying opportunities for potential collaborative efforts in healing and thus increasing the number of potentially effective treatments available to the population;
- g) Establishing services that may be more culturally appropriate;
- h) The potential opportunity to monitor and address any human rights abuses occurring within different systems of care.

Activities Prior to Collaboration

Before pursuing collaboration in an unfamiliar setting, the health-care provider should first develop (as best as possible) an understanding of the national policies and attitudes regarding various types of practitioners. For example, some governments discourage or ban health care providers from collaborating with traditional healers. Other governments encourage collaboration and have special departments engaged in the formal training of healers, as well as in research and evaluation of traditional medicine.

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Organizing Collaborations

To facilitate collaboration, the healthcare provider should make an assessment of the other systems of care present in the community. This may be difficult for providers who are outsiders to the community. Being respectful and establishing trust with members of the community is very important. Outlined below are suggestions on how to obtain information about other systems.

- a) Contact local community members who are a diverse sample of the community if possible (i.e. speak to women, men, elderly/adolescent individuals, members of different ethnicities, etc...). Ask them where they seek help for mental health difficulties and whom they use for emotional support.
- b) Ask primary health care providers and midwives what systems exist, including pharmacies.
- c) Ask the people encountered in the health facilities how they perceive their problems, and who else they see or have seen previously for assistance.
- d) Contact local religious leaders and ask whether they provide supportive or healing services and who else in the community does so.
- e) Use the help of community representatives or providers to organize a meeting with the local practitioners.
- f) Remember that more than one system of care may exist, and that practitioners in one system may not acknowledge or discuss others.
- g) Be aware that within a community, local practitioners may compete over patients or be in conflict over the appropriate approach.

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It is important next to establish a rapport and ongoing dialogue with the practitioners. Encouraging and actively organizing forums for information-sharing and cross-training is important. A variety of practitioners should play a role in the trainings and discussions about practical administrative issues, such as creating a cross-referral process should be included on agendas. After a series of effective trainings has occurred, consider organizing specific collaborative services where needed (if possible).

A Caution Regarding Some Healing Practices

It should be noted that some healing practices may be harmful, since they include beatings, prolonged fasting, cutting, prolonged physical restraint or expulsion of ‘witches’ from the community. The challenge in such cases is to find constructive ways of addressing harmful practices, as far as is realistic. Before supporting or collaborating with any healing practice, it is essential to determine what those practices include and whether they are potentially beneficial, neutral, or harmful. Sometimes maintaining a respectful distance is the best option, rather than seeking collaboration.

III. Conditions & Issues: Overview

PART III. MENTAL HEALTH CONDITIONS & ISSUES: Identification and Interventions

OVERVIEW

The allopathic (western) medical system represents one approach to dealing with mental health issues and managing mental health conditions. Allopathic mental health care may be described as a system of care in which staff has been trained in medical science, behavioral science, formal psychotherapy and provides services in inpatient hospitals, outpatient clinics, and other community facilities. This system of care is one form of support that is used today, commonly in high-income societies. Non-allopathic types of care may include traditional, indigenous, complementary, alternative, informal, and local medicine and in some countries are utilized as a primary or complementary means of care. These systems may involve the use of animal or mineral based medicines, religious or spiritual interventions, and manual techniques, either singularly or in combination.

Presented in this part of the guidebook is an allopathic approach to managing various mental health conditions. Basic theoretical concepts, counseling interventions, and medication therapies are described.

III. Conditions & Issues: How to Identify Symptoms

HOW TO IDENTIFY PSYCHOLOGICAL SYMPTOMS

Descriptions of mental health and illness

Someone with a “healthy mind” has clear thoughts, the ability to solve the problems of daily life, enjoys good relationships with friends, family, and work colleagues, is spiritually at ease, and can bring happiness to others (V.Patel 2002).

Mental illness can be defined as any illness experienced by a person which affects their emotions, thoughts or behavior, is out of keeping with their cultural beliefs and personality, and produces a negative effect on their lives or the lives of their families. Symptoms of illness can appear in the form of persistent changes in mood, perception of reality, or capacity to organize or maintain thoughts. Such changes will interfere with the person’s usual beliefs, personality or social function.

The psychiatric history & mental status examination (MSE) are tools used to identify psychological distress and symptoms of illness. Information and observations obtained can be used to guide the healthcare provider’s impressions and therapeutic interventions.

III. Conditions & Issues: How to Identify Symptoms

The Psychiatric History

Psychological distress and mental illness may be influenced by past and present experiences and circumstances. A psychiatric history is a description of the habits, activities, relationships, and physical conditions that have shaped the way one feels, thinks, and behaves. The psychiatric history is obtained by interviewing the individual or asking a series of questions associated with their psychological function. Outlined below are the standard elements of the psychiatric history.

Elements of the Psychiatric History

- 1) Identifying data – name, age, race, sex.
- 2) Chief complaint – a concise statement of the patient's psychiatric problem in his or her own words.
- 3) History of present illness – current circumstances in which current psychiatric symptoms have occurred.
- 4) Previous psychiatric history – any prior psychiatric symptoms, treatment (therapy or medication); prior psychiatric hospitalizations.
- 5) Medical history – history of significant medical conditions, treatments/surgeries; current medications; history of allergies to medications or other agents; history of head injuries; seizures; loss of consciousness or other neurological disorders.

III. Conditions & Issues: How to Identify Symptoms

- 6) Family psychiatric history – any blood relatives with history of psychiatric symptoms, treatment, or psychiatric hospitalizations.
- 7) History of alcohol or drug abuse or dependence – length or period of abuse/dependence; date and amount of last use; history of drug treatment or rehabilitation programs.
- 8) Social history – place of birth; description of family members; marital status; education obtained; occupations past and present.

The Mental Status Examination

The purpose of the MSE is to assess the individual's current emotional state and capacity for mental function. The mental status examination is an organized systematic framework for noting observations that are made while interviewing individuals. In general, it involves categorizing observations in terms of behavior and appearance; thought, feelings, judgment, insight, and other functions such as memory and concentration.

III. Conditions & Issues: How to Identify Symptoms

Elements of the Mental Status Examination (MSE)

- 1) General Appearance – e.g. gait; grooming; posture.
- 2) Motoric behavior (i.e. physical movements)–e.g. physical agitation or retardation; tremors; anxiety.
- 3) Speech – e.g. slow; rapid; loud; soft/inaudible; stuttering; slurring; paucity; over-inclusive.
- 4) Attitude –e.g. cooperative; irritable; angry; aggressive; defensive; guarded; apathetic.
- 5) Mood – e.g. sad; happy; irritable; angry; elevated or expansive.
- 6) Affect or facial expression – e.g. congruent or incongruent with mood; flat; blunted; fluctuating.
- 7) Thought content – e.g. delusions (persistent belief that is inconsistent with reality), paranoia; suicidal or homicidal thoughts.
- 8) Thought processing – e.g. logical/illogical; repetitive; disjointed; tendency to go on tangent; concrete. Decelerated; slowed; rapid succession of ideas.
- 9) Perception – e.g. auditory, visual, tactile, or olfactory hallucinations.
- 10) Judgment – e.g. ability to understand relationships between facts and to draw appropriate conclusions.
- 11) Insight – e.g. is the patient able or willing to understand his or her condition?

III. Conditions & Issues: How to Identify Symptoms

12) Cognition

- a) level of consciousness – e.g. alert; cloudy; confused.
- b) orientation - i.e. to self, place, date, time.
- c) memory – i.e. long-term (events of the past such as place of birth; date of marriage or graduations); recent (events of yesterday or last week); short-term (test recall of 3 items after a period of 5 minutes).
- d) concentration or attention (serial 7 test – start at 100 and count backwards by 7).
- e) executive function or ability to reason – test using abstraction tasks (e.g. ask how are an apple and banana similar? Ask individual to interpret a proverb appropriate to culture); test naming or word finding skill (e.g. can the individual name different parts of a watch/time-piece).
- f) visual-motor coordination, in basic terms, may be defined as the brain's ability to coordinate information perceived by a sensory organ (the eyes) with complex motor functions (such as writing). Visual-motor coordination is tested by asking the individual to draw an object or figure visualized. For example, draw a circle that is connected to a rectangle and ask the individual to copy the figure. An inability to copy the figure accurately may be an indication of conditions such as brain damage due to medical disease or drug abuse (e.g. Alzheimer's disease; alcohol dementia;), schizophrenia, or mental retardation.

III: Conditions & Issues: Psychotic Conditions

PSYCHOTIC CONDITIONS:

Schizophrenia & Other Psychotic Conditions

The term “psychosis” has been used to describe individuals who misinterpret reality or experience and express distortions (out of the realm of reality) in perception, thought, and feeling. Distortions may lead to disruption in function with family, friends at school, or at work. Some psychotic conditions may run in families and their specific causes are not fully understood while other psychotic conditions are due to medical conditions or substances affecting the mental state.

Schizophrenia

Schizophrenia is a chronic disorder that may be characterized by a decline in motivation, socialization and function, diminished emotional expression, disorganized or abnormal motor behavior (i.e. physical movement) and distorted sense of reality (with disturbances in perception and/or the expression of thought). Worldwide prevalence estimates have ranged between 0.5% and 1%. Theories regarding the cause have been proposed and have included a genetic, biological, psychosocial, and infectious basis for the disease. Schizophrenia has been described in many cultures.

III: Conditions & Issues: Psychotic Conditions

Signs/Characteristics of Schizophrenia

- * Decline in level of function and ability to socialize (this can be expressed as withdrawal, detachment or isolation from others; this may also be expressed as aggression).
- * Thoughts are expressed in an impaired or illogical manner (i.e. incoherence; one may appear to have long pauses, a “blank” or a lapse in thought; one may easily or repeatedly lose the point in conversation; thoughts are disjointed with the association between thoughts being lost).
- * Delusional thought (thoughts that are inconsistent with reality and persistently maintained).
- * Impaired perception (hallucinations – auditory hallucinations or hearing people or things that are not physically present are the most common in schizophrenia; visual hallucinations or hallucinations of taste, touch, and smell may occur but are less common).
- * Diminished or incongruent emotional expressions (appearing expressionless; crying easily over things that are not typically sad); abnormal physical movement (catatonia).
- * Altered motivation (ambivalence about doing activities or complete loss of motivation for activities).
- * Symptoms persist (for at least 6 months) and are not due to a medical condition or substance abuse.

III: Conditions & Issues: Psychotic Conditions

Other Psychotic Conditions (DSM V/ US classification system)

Aside from schizophrenia, psychosis may occur due to other conditions including delusional disorder (delusion is the prominent symptom); schizopreniform (schizophrenia-like symptoms for < 6 months); schizo-affective disorder (both mood and psychotic symptoms are prominent); brief psychosis (psychotic symptoms<1 month); post partum psychosis (psychotic symptoms after giving birth); and psychosis secondary to psychoactive substances or medical conditions.

Counseling Interventions For Schizophrenia & Other Psychotic Conditions

1. Outline a weekly schedule with the individual. A structured routine helps one to know what to do and expect - this can reduce the stress and anxiety that can precipitate symptoms. Clearly list the core activities of daily living (showering, shaving, dressing, supply shopping, food preparation, cleaning) so that basic self-care skills are maintained. Include chores so that a sense of responsibility is maintained. Include pleasure activities. Be sure there is a good balance between indoor and outdoor activities. Also be sure to incorporate activities that involve social interaction.
2. Reward constructive actions. Determine the items or situations that the patient values and reward him/her with them when appropriate behavior is displayed (e.g. offer a valued reward for having completed all chores and activities of daily living adequately).

III: Conditions & Issues: Psychotic Conditions

3. Help the individual identify situations that cause stress or anxiety as these can be triggers for a relapse of illness. Help the individual limit involvement in these situations. If the situation is unavoidable, help the individual think in advance about what may occur and how he/she will respond.
4. Emphasize medication compliance. Discuss with the doctor medication options and regimens that will make taking pills easy.
5. Ask the health provider to explain the kind of side effects that might be expected and what to do about them.
6. Emphasize keeping track of appointments. Missed appointments and doses of medicine can put the patient at risk for a return of illness.
7. Educate family or caretakers. Educate that agitation or odd behavior are symptoms of schizophrenia and are not intentional. Relapse is possible and should be anticipated. Review the signs and symptoms of schizophrenia.

Medication Therapy

See the “Medication Guide” section of the manual for details on medication therapy.

III: Conditions & Issues: Mood-Related Conditions

MOOD -RELATED CONDITIONS:

Major Depression & Bipolar Disorder

Major Depression

Depression has been generally described as a decline in mood that persists for an extended period, represents a decrease from a previous level of function, and causes some impairment in function. Depression contributes significantly to the global burden of disease affecting an estimated 350 million people worldwide. According to the World Mental Health Survey (conducted in 17 countries) approximately 1 in 20 people on average reported an episode of depression in the previous year. In many cultures depression is expressed commonly as somatic or physical complaints (e.g. fatigue, generalized pain, digestive problems, headache). Psychotic symptoms may also occur. Other signs and characteristics of depression are outlined below.

Signs & Characteristics

- Persistent depressed mood and loss of pleasure in activities that normally give pleasure;
- weight loss or gain;
- insomnia (i.e. too little sleep) or hypersomnia (i.e. too much sleep);
- psychomotor agitation (i.e. agitated movement) or retardation (i.e. slowed movement); energy loss;
- feelings of worthlessness or guilt;
- poor concentration or memory; indecisiveness;
- hopelessness or suicidal thoughts with the intention to act or with specific plans made;

III: Conditions & Issues: Mood-Related Conditions

- symptoms are not due to a medical condition or substance capable of influencing the central nervous system.

Studies have indicated that biological, genetic, and psychosocial factors play a role in depression. Biological factors include disturbances in neurotransmitters (molecules mediating communication between brain cells), abnormal immune system function, and abnormal regulation of hormones. Genetic causes have been implicated through studies of patterns of illness in families (e.g. first degree relatives, twins) and studies of genetic material. Psychosocial factors (life events and environmental stressors) have been suggested as an influence as well. Depression may be diagnosed through psychiatric history, mental status examination and eliminating other causes with laboratory or other diagnostic tests. Depression is treated with counseling interventions and, in severe cases, medication.

Counseling Interventions for Depression

If symptoms are persistent and severe, refer to a crisis center/doctor/hospital for further evaluation, diagnosis, & treatment.

Offer support: emphasize that there is no shame in feeling depressed; help the individual identify others who can serve as a support (family, friends); help him/her identify & focus on personal strengths and the positives in a challenging situation; help him/her identify & focus on what they can control; ask about hopeless and suicidal feelings and the intent to act on these feelings.

Medication Therapy

See the “Medication Guide” section of the manual for details on medication therapy.

III: Conditions & Issues: Mood-Related Conditions

Bipolar Disorder

Bipolar disorder is a type of mood disorder characterized by distinct phases of sustained depression and/or distinct periods of a mood which is persistent and abnormally elevated, expansive , or irritable. Psychosis may be present also in either phase. According to research analyzing World Health Organization (WHO) mental health survey data, the prevalence rates for bipolar spectrum disorder (BPS) worldwide vary, but illness severity and patterns of co-morbidity are similar.

The table below outlines important features of the most severe form of bipolar disorder, bipolar type I disorder.

Signs & Characteristics

DISORDER	ETIOLOGY (cause)	SYMPTOMS	DIAGNOSIS
Bipolar I	- Evidence for Genetics as a factor - Biological factors - Environmental factors	<p><i>Manic Phase:</i> Elevated/ irritable mood; excessive energy or agitation; elevated esteem or grandiosity; rapid thoughts; decreased need for sleep; excessive or pressured speech; distractibility; impulsive, potentially harmful behavior</p> <p><i>Depressive Phase:</i> depressive symptoms satisfy criteria for a full major depressive episode (SEE DEPRESSION SECTION OF THIS CHAPTER FOR SPECIFIC SYMPTOMS)</p>	Symptoms are identified through mental status examination (MSE); Rule out substance and medical causes via diagnostic tests if available (i.e. toxicology screens, thyroid function tests, chemistries, CBC, brain imaging)

III: Conditions & Issues: Mood-Related Conditions

Other Types of Bipolar Disorders

- 1) Bipolar II – presence of at least one major depressive episode and one hypomanic (i.e. less severely manic) episode. No manic episode has occurred. The criteria for a hypomanic episode is the same as for a manic episode except that in a hypomanic episode the symptoms do not cause significant impairment in social or occupational function. Psychosis may occur with this condition.
- 2) Substance/Medication induced Bipolar Disorder - persistent and prominent elevated, expansive, or irritable mood (with or without depressive symptoms) that occurs in the context of using a substance or medication which can cause bipolar symptoms. The disturbance causes significant distress or impaired function. The disturbance does not occur during a period of delirium.

III: Conditions & Issues: Mood-Related Conditions

Counseling interventions for Mania/Bipolar Disorder

1. Educate the family/caretakers. Educate the family and patient that agitation, mood fluctuation, and impulsivity are common symptoms of bipolar disorder and are not intentional. Relapse is possible and should be anticipated. Review with them the signs and symptoms of bipolar disorder. Emphasize the importance of medication compliance.
2. Emphasize medication compliance. Discuss with the doctor medication options and regimens that will make taking pills easy (e.g. use of pill organizer boxes; explore whether once a day dosing is appropriate and possible).
3. Reward constructive actions. Determine the items or situations that the patient values and reward him/her with them when appropriate behavior is displayed (e.g. offer a valued reward for having contained impulsive behaviors).
4. Encourage a routine schedule. Outline a weekly schedule with the individual. A structured routine helps one to know what to do and expect and helps to reduce the stress and anxiety that can precipitate symptoms.
5. Help the individual identify situations that cause stress or anxiety as these can be triggers for a relapse of illness. Help the individual limit involvement in these situations. If a stressful situation is unavoidable, help the patient think in advance about what may occur and how he/she will respond. Breathing and relaxation exercises can reduce anxiety felt in these situations (see chapter on “Anxiety Conditions” for breathing and relaxation exercises).
6. Emphasize keeping track of appointments. Missed appointments can lead to the individual’s running out of medication. Missing doses of medicine can put the individual at risk for a return of symptoms and a relapse of illness.

III: Conditions & Issues: Mood-Related Conditions

Medication Therapy

See “Medication Guide” section of manual.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

ANXIETY-RELATED CONDITIONS, OBSESSIVE-COMPULSIVE DISORDER (OCD) & POST-TRAUMATIC STRESS DISORDER (PTSD)

Anxiety may be defined as a state of neurological arousal characterized by both physical and psychological signs. Anxiety may be a normal reaction that acts as a signal to the body that aspects of its systems are under stress. Prevalence estimates of anxiety disorders are generally higher in developed countries than in developing countries according to global mental health survey data. The specific neuro-biological mechanisms underlying anxiety are complex and may involve genetic, biological, and psychological factors. Common signs of anxiety are outlined in the table below:

Physical signs	Psychological signs
Headache	Feeling of dread
Muscle tension	Poor concentration
Back pain	Impaired sleep
Abdominal pain	Impaired sexual desire
Tremulousness or “shakiness”	
Fatigue	
Numbness	
Shortness of breath	
Palpitations	
Sweating	
Hyper-vigilant reflexes (easily startled; “jumpy”)	

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

Anxiety “disorders” are considered when the signals triggered by the body produce prolonged physical or psychological discomfort or a pattern and degree of distress that disrupts normal function. An anxiety disorder is considered if no underlying medical illness, substance intoxication (or withdrawal), medication toxicity, or toxicity of other agents can be identified as the cause. Types of anxiety disorders, obsessive-compulsive disorder or OCD, and post-traumatic stress disorder or PTSD (described in western literature/DSM-V) are outlined below.

1. Anxiety-Related Disorders (Anxiety Disorders)

A) Generalized Anxiety Disorder (GAD)

GAD is defined as chronic, constant anxiety that persists throughout the day consistently for at least 1 month.

B) Panic Disorder

Panic disorder involves a sudden, spontaneous onset of overwhelming anxiety symptoms.

C) Agoraphobia

Agoraphobia involves experiencing anxiety and fear in the context of feeling unable to escape in situations such as being in open or enclosed spaces, of being alone outside the home, or of being in a crowd, or using public transportation.

D) Phobia

An irrational fear of a particular object or situation causing anxiety symptoms.

E) Social Phobia/Social Anxiety Disorder

Specific irrational fear/discomfort in social or public situations.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

2. Obsessive-Compulsive Disorder (OCD)

The presence of obsessions (i.e. constant intrusive thoughts or urges causing anxiety symptoms) and/or compulsions (i.e. unusual and excessive behaviors or mental acts one is compelled to perform repetitively in order to reduce anxiety to a dreaded situation or event).

3. Post-traumatic Stress Disorder (PTSD) & Acute Stress Disorder

Anxiety occurs in the context of an overwhelming major life stressor. The stressful event is continuously re-experienced (during dreams or wakefulness) causing hyper-arousal and a tendency toward avoidance. If symptoms persist for greater than 1 month PTSD is indicated; if symptoms persist for less than 1 month, acute stress disorder is diagnosed.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

Counseling Interventions: Exercises for Anxiety-Related Conditions, Obsessive-Compulsive Disorder (OCD), & Post-Traumatic Stress Disorder (PTSD)

A) Breathing Exercise

(May be especially useful for panic; agoraphobia; generalized anxiety; phobias; social phobia/anxiety; post-traumatic & acute stress).

Shortness of breath is a common feeling that many people get when anxious. When one feels out of breath the natural tendency is to breathe in more or faster. This can lead to hyperventilation which can make anxiety worse.

An effective way to manage abnormal breathing when anxious is to do the following:

- Breathe in slowly to the count of three.
- Breathe using your abdomen instead of the chest.
- When you get to three, slowly breathe out to the count of three seconds.
- Pause for three seconds then breath in again for 3 seconds.
- Continue this exercise for five minutes.
- Practice twice a day.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

B) Muscle relaxation exercise

(May be especially useful for panic; agoraphobia; generalized anxiety; social anxiety; post-traumatic & acute stress).

For each of the muscle groups in your body, tense the muscles for 5–10 seconds, then relax for 10 seconds. Only tense your muscles moderately (not to the point of inducing pain). Don't force the release of the muscle tension - simply let go of the tension in your muscles and allow them to become relaxed. Relax your muscles in the following order:

Hands — clench one fist tightly, then relax. Do the same with the other hand.

Lower arms — bend your hand down at the wrist, as though you were trying to touch the underside of your arm, then relax.

Upper arms — bend your elbows and tense your arms. Feel the tension in your upper arm, then relax.

Shoulders — lift your shoulders up as if trying to touch your ears with them, then relax.

Neck — stretch your neck gently to the left, then forward, then to the right, then to the back in a slow rolling motion, then relax.

Forehead and scalp — raise your eyebrows, then relax.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

Eyes — look about, rotating your eyes, then relax.

Jaw — clench your teeth (just to tighten the muscles), then relax.

Tongue — press your tongue against the roof of your mouth, then relax.

Chest — breathe in deeply to inflate your lungs, then breath out and relax.

Stomach — suck your tummy in to tighten the muscle, then relax.

Upper back — pull your shoulders forward with your arms at your side, then relax.

Lower back — while sitting, lean your head and upper back forward, rolling your back into a smooth arc thus tensing the lower back, then relax.

Buttocks — tighten your buttocks, then relax.

Thighs — while sitting, push your feet firmly into the floor, then relax.

Calves — lift your toes off the ground towards your shins, then relax.

Feet — gently curl your toes down so that they are pressing into the floor, then relax.

Enjoy the feeling of relaxation: Take some slow breaths while you sit still for a few minutes, enjoying the feeling of relaxation.

Practice once or twice a day. During the day, try relaxing specific muscles whenever you notice that they are tense.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

C) Problem-solving exercise

(May be especially useful for generalized anxiety & social anxiety).

Choose one or two problems that are particularly bothersome and make a decision to try to resolve them as best as possible.

1. On a sheet of paper, list the specific problems.
2. List five or six possible solutions to the problem. Write down any ideas that occur to you, not merely the ‘good’ ideas.
3. Evaluate the positive and negative points of each idea.
4. Choose the solution that best fits your needs.
5. Plan exactly the steps you will take to put the solution into action.
6. Review your efforts after attempting to carry out the plan. Praise all efforts. If unsuccessful, start again.

D) Managing negative, distorted thinking

(May be especially useful for generalized anxiety; social anxiety; & obsessive-compulsive disorder).

Significant anxiety can influence thoughts and emotions and progress to negative, pessimistic feelings and even irrational, distorted thoughts.

Management of negative distorted thoughts involves:

- Identifying the negative, distorted thoughts
- Substituting these thoughts with more realistic ideas (create a list of alternative thoughts that are realistic, positive and counter each negative thought listed). This is an important skill that can help reduce anxiety symptoms.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

E) Graded exposure (Gradual exposure to feared objects or situations). *The relevance of the examples listed will vary among different cultures and societies.*

This may be particularly useful for phobias. It incorporates the breathing and relaxation exercises as well. The key strategy for overcoming fears of this kind involves creating a plan or hierarchy of steps. The individual is gradually exposed to the fearful object or situation, in small steps, so that eventually less anxiety is experienced when the object or situation is present. For example, a woman refuses to go on a public bus fearing that it will have an accident. However, she must use a bus to get to work and run important errands such as going to the market.

First – teach the breathing and relaxation exercises to the individual since these techniques will be important in reducing the anxiety felt during moments when an aspect of the frightening object or situation is present.

Second – clearly outline with the individual the steps of the exposure process:

- Start with a picture of the frightening object (bus).
- Look at pictures of a bus or take a trip to a bus stop without actually getting on the bus.
- Take a very brief bus ride (1 or 2 stops).
- Increase the amount of time on the bus.

III: Conditions & Issues: Anxiety-Related Conditions, OCD, & PTSD

During each step, the individual should be expressing his/her feelings, using breathing and relaxation to control anxiety occurring in the moment.

In separate sessions, use the exercise in “Managing Negative, Distorted Thinking” to correct thought distortions, misconceptions or fears about the object or situation.

Medication Therapy for Anxiety-Related Conditions, OCD, & PTSD

See “Medication Guide” section of the manual.

III: Conditions & Issues: Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Somatic Symptom Disorder

Signs/characteristics

Given the connection between the mind (brain) and body, it is possible for individuals to express emotional distress as physical (somatic) symptoms. A somatic symptom disorder should be considered if one is excessively and persistently preoccupied with physical symptoms such that daily life and function are adversely affected.

Individuals with somatic symptom disorder may present with excessive thoughts, feelings, and behaviors associated with somatic symptoms. Constant anxiety about symptoms or health in general may be present, the seriousness of symptoms may be exaggerated and persistently emphasized, and excessive time and energy are spent focused on the symptoms. One somatic symptom (particularly pain) or more may be experienced and symptoms may or may not be associated with another medical condition. In severe cases, individuals may repeatedly visit health services, have a tendency to request only symptom relief, and have little ability to accept that no physical illness is present when diagnostic testing is unremarkable.

US studies have indicated that the prevalence of somatic symptom disorder is 5%-7% in the general adult population and females tend to report more somatic symptoms than do males. In addition, somatic symptom disorder is related to high rates of co-morbid conditions including anxiety, depression, and medical disorders.

III: Conditions & Issues: Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Counseling Interventions For Somatic Symptom Disorder

General considerations:

- Acknowledge that the individual's complaints are real but avoid recommending unnecessary or new medications for each new symptom if examinations and diagnostic tests are unremarkable.
- Ask the individual's opinion about potential causes of symptoms.
- Support the concept of wellness rather than a focus on symptoms and illness.
- Discuss emotional stress that may have accompanied symptoms originally. Explain that stress may be related to the physical symptoms experienced. A brief respite may be helpful for individuals complaining in relation to recent stress. If indicated, offer relaxation methods that can decrease tension.
- For individuals with chronic complaints schedule regular, time-limited appointments with the same clinician if possible.

III: Conditions & Issues: Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Exercise

For individuals who have some insight about the connection between their emotions and physical complaints the following technique may be useful.

1. Have the individual list his/her physical complaints, severity of the complaints, activities involved in as physical problems are experienced, and the emotions that are occurring as the physical problems are experienced:

<i>Physical problem</i>	<i>Severity of problem (scale of 1-10; 10=very severe)</i>	<i>Activities</i>	<i>Emotions</i>
1. headache	8	Going to the market	irritable
2.			
3.			

2. Explore with the individual, the possible connection between the physical complaint and emotions experienced.
3. Discuss possible ways to adjust the activities so that emotional distress is reduced (i.e. changing the day or time of day to a time when there are no other chores to do; reducing the amount done at one time in order to have more free time; using the help of others; incorporating a pleasurable activity into a trip to the market; praising and rewarding oneself for the efforts).

III: Conditions & Issues: Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Medication Therapy For Somatic Symptom Disorder

Medication Therapy for Somatic Symptom Disorder

1. Treatment of underlying/co-existing medical conditions is important.
2. Antidepressant and/or anti-anxiety medications for underlying/co-existing depression and/or anxiety is recommended.

See the “Medication Guide “ section of the manual for medication therapy for depression and anxiety conditions.

III: Conditions & Issues: Somatic Symptom Disorder & Psychological Factors Affecting Other Medical Conditions

Psychological Factors Affecting Other Medical Conditions

Signs/Characteristics

Psychological factors affecting other medical conditions involve the presence of one or more psychological or behavioral factors that negatively affect a medical condition by precipitating, exacerbating or increasing the severity and/or extent of illness (e.g. increased asthma symptoms after experiencing stress). Psychological/behavioral factors may include depression, anxiety, stressful life events, and maladaptive personality traits, coping style, and relationship style.

Counseling Interventions & Medication Therapy

Treatment involves stabilization of any medical symptoms present, use of anti-anxiety and antidepressant medication for co-existing anxiety disorders or depression, counseling, and psychotherapy.

Counseling interventions

See the previous section (Somatic Symptom Disorder) for a useful exercise.

Medication therapy

See the “Medication Guide “ section of the manual for medication therapy for depression and anxiety conditions.

III: Conditions & Issues: Substance Use Disorders

SUBSTANCE USE DISORDERS

Signs/Characteristics

A) Definitions regarding psychoactive substances (i.e. substances that activate the brain and cause effects on thoughts, emotions, and behaviors).

1. Intoxication – maladaptive behavior associated with recent drug ingestion.
2. Withdrawal – adverse physical & psychological symptoms that occur following cessation of the drug.
3. Tolerance – the need for more substance to attain the same level of effect.
4. Abuse or Misuse – a maladaptive pattern of use leading to repetitive problems and negative consequences (i.e. use in dangerous situations such as driving; use leading to legal, social and occupational problems).

III: Conditions & Issues: Substance Use Disorders

5. Dependence (addiction) — continued desire for and use of a psychoactive substance to satisfy pleasurable urges and/or to alleviate the effects of withdrawal. Dependence may be psychological or physical in nature.

Psychological dependence:

- Persistent substance use, despite evidence of its harmful consequences.
- Difficulties in controlling the use of the substance.
- Neglect of interests and an increased amount of time taken to obtain the substance or recover from its effects.
- Evidence of tolerance such that higher doses are required to achieve the same effect.
- Compulsion or craving: a strong desire to take the substance.
- Anxiety or mood disturbance occurs if drug is not taken.

Physical dependence:

- Physical symptoms occur if drug is not taken (e.g. headache; gastrointestinal distress; changes in blood pressure, heart rate; sweating; tremors; muscular pain).

III: Conditions & Issues: Substance Use Disorders

B) Effects of Selected Psychoactive Substances

Alcohol

Worldwide, alcohol consumption and problems related to alcohol vary widely, but , in most countries, the burden of disease and death remains significant. Alcohol consumption is the world's third largest risk factor for disease and disability behind high blood pressure (first) and smoking (second). In middle-income countries, it is the greatest risk. The world's highest alcohol consumption levels are found in developed countries.

Intoxication Symptoms: Slurred speech; unstable walking; mood change; aggression; anxiety; psychosis; sleep disturbance; and delirium.

Withdrawal Symptoms (occurring several hours to a few days after cessation of use that has been heavy and prolonged): Nausea; headache; nystagmus (rapid horizontal movement of eyeballs); unstable blood pressure or heart rate; psychosis; anxiety; mood disturbance; sleep disturbance; delirium; and seizure.

III: Conditions & Issues: Substance Use Disorders

Cannabis

Worldwide, cannabis (with a global annual prevalence ranging from 2.6 to 5.0 per cent) remains the most widely used illicit drug according to the United Nations Office on Drugs and Crime (UNODC) 2012 report.

Intoxication Symptoms: Elevated or depressed mood; anxiety; inappropriate laughing; paranoia; hallucinations; red eyes; increased appetite; dry mouth; increased heart rate.

Studies have indicated an association between high doses of cannabis and delirium, panic, ongoing psychosis may occur. In addition, Long-term use has been linked to anxiety, depression, and loss of motivation.

Withdrawal Symptoms (occurring 1 week after cessation of prolonged, heavy use, i.e. a few months of daily or near daily use): Depressed or irritable mood; anxiety; restlessness; sleep disturbance; poor appetite; and weight loss.

III: Conditions & Issues: Substance Use Disorders

C) Interventions for Substance Use Disorders

- Refer to medical evaluation, diagnosis, & medical stabilization as indicated.
- Assess for underlying psychiatric conditions (e.g. depression, anxiety).
- Refer to drug counseling program if available or psychological services for treatment.

Additional Counseling Interventions For Substance Use Disorders

1. Anxiety and depression may underlie substance abuse. Also, some individuals with bipolar disorder or a psychotic disorder may use alcohol or drugs to self-medicate or deal with symptoms. It is therefore important to evaluate for these psychiatric conditions and provide or refer to the appropriate treatments. For some individuals, drug and alcohol use is decreased if underlying anxiety, mood disturbance, or other distress is relieved.
2. Teach breathing and relaxation techniques as a means for controlling anxiety (see chapter on “Anxiety Disorders” for technique instructions).
3. Encourage individuals to identify people who can be contacted for support when cravings or distress occurs. Another who is also recovering from addiction and is sober can be a good ally.

III: Conditions & Issues: Delirium & Dementia

NEUROCOGNITIVE DISORDERS: DELIRIUM & DEMENTIA

The term “neurocognitive disorder” refers to a significant decline from a previous level of function in one or more of cognitive realms including awareness (orientation, consciousness), complex attention (sustained, selective, and divided attentions); executive function (planning, decision making, mental flexibility); learning and memory; language; perceptual-motor (visual perception and construction, integration of visual perception with movement); and social cognition (recognition of emotions, ability to consider other’s mental state). Types of neurocognitive disorders include: 1) delirium and 2) major & mild neurocognitive disorders (dementia).

1) Delirium

Delirium is a disturbance particularly in the ability to focus, sustain, or shift attention. Other characteristics of delirium may include additional deficits in cognition (e.g. memory, perception), rapid onset, a fluctuating course, reversibility, agitation, irritability, and psychosis (i.e. distortion of reality). Causes of delirium may include brain disease, systemic disease (e.g. heart disease), drugs, medications, and other toxins.

Neuropsychiatric symptoms of delirium may be identified through a thorough mental status examination. The underlying cause of disease may be identified, if resources are available, through a complete battery of laboratory and diagnostic tests [e.g. blood chemistries, complete blood count, chest x-ray, urinalysis & toxicology, electrocardiogram (EKG), computerized tomography (CT) scan, or magnetic resonance imaging of the brain].

III: Conditions & Issues: Delirium & Dementia

2) Major/Mild Neurocognitive Disorder (Dementia)

Major neurocognitive disorder (dementia) may be difficult at times to differentiate from delirium, as there are a number of shared characteristics, particularly cognitive deficits (e.g. memory deficit). In general, a pervasive cognitive and intellectual decline with a lack of impaired awareness or consciousness is what distinguishes dementia from delirium. Other characteristics of the disorder may include slow onset; an ongoing, continuous course; irreversibility; agitation; irritability; depression; psychosis; and a gradual, permanent decline in function.

“Mild” neurocognitive disorder differs from the major disorder in the degree of disturbance present. Cognitive deficits are modest and do not interfere to a level where independent function is significantly impaired.

Conditions causing neurocognitive disorder include Alzheimer’s disease, frontotemporal lobar degeneration, Lewy body disease, vascular disease, brain trauma, brain tumors, infections (e.g. HIV), alcoholism, drug abuse, medications, other toxins, and poor oxygen supply.

A thorough mental status exam with particular attention to the evaluation of cognitive function will elucidate symptoms of major and mild neurocognitive disorder. Laboratory and diagnostic tests can identify underlying causes of disease.

III: Conditions & Issues: Delirium & Dementia

INTERVENTIONS

Patients identified as having symptoms of delirium or dementia should be referred to the hospital for further evaluation, diagnosis, and treatment.

A) Delirium

- Adjust sensory stimulation as indicated (i.e. decrease stimulation if the person is agitated; increase if the person is sensory deprived).
- Place the person in an area that is safe and secure (no dangerous objects or hazards nearby) and where he/she can be observed easily.

B) Major/Mild Neurocognitive Disorders (Dementia)

- Arrange the environment so that there are clear cues for orientation to date, time, place.
- Incorporate proper nutrition, exercise, & mentally stimulating activity.
- Provide support for the family (e.g. education, group therapy).

Aids to enhance function:

Memory aids: Calendars; organizers; outline routines for daily activities; checklists; pill boxes; and timers.

Physical aids: Canes; wrist weights

Physical and mental stimulatory aids: Exercise such as walking, stretching, ball throwing; identify/encourage previous hobbies; card/board games; puzzles; encourage storytelling, singing; Encourage time with others who will stimulate (talkative friends).

III: Conditions & Issues: Delirium & Dementia

Medications

Benzodiazepines and antipsychotics are used with caution to treat severe agitation associated with delirium.

Antidepressants may be indicated for depressive symptoms associated with dementia. Elderly individuals with dementia-related psychosis treated with atypical antipsychotic medications are at an increased risk of death (due to infectious or cardiovascular conditions). HIV dementia may be treated and potentially reversed with antiretroviral therapy.

III: Conditions & Issues: Epilepsy

EPILEPSY

Epilepsy is a chronic disorder of the brain affecting approximately 50 million people in the world, with nearly 80% of the people with epilepsy found in developing countries. The condition is characterized by recurrent seizures (i.e. brief episodes of involuntary shaking) which may involve a part of the body (partial) or the entire body (generalized). Seizures are due to excessive electrical discharges within a network of brain cells and may be accompanied by loss of consciousness and control of bowel or bladder function.

Signs/characteristics of Epilepsy

The cause of epilepsy in 70% of cases is unknown. Other causes may include infection, brain injury, drugs/alcohol, vascular disease, or a nutrient imbalance. These conditions may cause “seizures” or destabilization and abnormal stimulation of nervous system cells. Seizures may be characterized as either partial (localized) or generalized (global):

- 1) Partial (focal) seizure – originates in a localized area and remains localized.
 - a) simple - consciousness is not affected (e.g. motor).
 - b) complex - some localized or specific areas of the brain may have more complex associations and function than other areas. Seizure activity within these circuits may result in “complex-localized” seizures.

III: Conditions & Issues: Epilepsy

Complex-localized seizures may be characterized by an “aura” or a set of abnormal sensory signals such as light flashes, smells and noises that precede the onset of a seizure. Consciousness may also be impaired with this type of seizure.

- c) secondarily generalized – seizure spreads locally to generally.

2) Generalized seizure– originates centrally and continues generally (i.e. globally).

- a) absence/petit mal (typical symptoms may include staring; stop mid-sentence then continue). May be typical or atypical in presentation.
- b) tonic-clonic/grand mal (aura; all 4 limbs involved; unconscious; incontinence; post-ictal confusion, headache, or excessive sleep).
- c) other generalized seizures include myoclonic (involuntary twitching of a muscle or group of muscles); clonic (involuntary rhythmic jerking); and atonic (“drop attack” or lapse of muscle tone).

Psychiatric Manifestations

Change in personality is common while psychosis and violence have been found to occur less frequently than previously perceived. Temporal lobe epilepsy has been associated with instability in mood.

III: Conditions & Issues: Epilepsy

Counseling Interventions For Epilepsy

1. Educate the family/caretakers. Review with them the signs and symptoms of epilepsy. Provide guidance on what to do if one has a seizure. Emphasize the importance of medication compliance. Explain to parents that epilepsy has been associated with behavioral change and conduct disturbance in children and provide them with guidance on how to set limits and reinforce constructive behaviors.
2. Help the individual identify situations that cause stress or anxiety as these can be triggers for a relapse of illness. Help the individual limit involvement in these situations or (if situation is unavoidable) help the individual think in advance about what will occur and how he/she will respond. Breathing and relaxation exercises can be incorporated to help reduce anxiety felt in these situations (see chapter on Anxiety-Related Conditions for breathing and relaxation exercises).
3. Emphasize keeping track of appointments. Missed appointments can lead to the individual's running out of medication. Missing doses of medicine can put him/her at risk for a return of symptoms and a relapse of illness.
4. Medication Compliance. The individual should discuss with the doctor medication options and regimens that will make taking pills easy (use pill organizer boxes; is once a day dosing possible?).

Medication Therapy

See “Medication Guide” section of the guide.

III: Conditions & Issues: Sleep Disturbance

SLEEP DISTURBANCE

Signs/characteristics

A disturbance in sleep can occur as a part of or separately from a psychiatric condition. Studies from western cultures have indicated that insomnia (decreased ability to sleep) is common and can have many causes (e.g. as a primary condition or due to a secondary cause such as medical illness, psychiatric conditions, medications, or drugs and alcohol). Sleep disturbance is one of the commonest responses to stress.

Counseling Interventions For Sleep Disturbance

Sleep hygiene (measures to create a regular sleep pattern)

- 1) Set a regular bedtime and make efforts to adhere to it even if not tired.
- 2) Make efforts to arise at the same time each morning.
- 3) Avoid napping during the day.
- 4) Exercise during the day. Practice relaxation exercises in the evening (e.g. meditation, yoga).
- 5) Ensure a comfortable sleep space.
- 6) Limit activating substances (e.g. caffeine, alcohol, nicotine); none in the second half of the day is recommended.
- 7) Address any underlying medical or psychiatric disturbance.

III: Conditions & Issues: Sleep Disturbance

Medication Therapy

See “Medication Guide” section of manual.

III: Conditions & Issues: Loss & Bereavement

LOSS & BEREAVEMENT

Signs/Characteristics

Grief is the name for the feelings accompanying the loss of any loved person, place, or object. This can include one's home, one's health (e.g. being diagnosed with a long term illness or having a limb amputation) and one's country or culture (e.g. being a refugee).

Loss and the process of grieving (bereavement) is complex and will vary from one individual to the next. Emotional responses to loss, death and dying have been described by Kubler-Ross and include:

- a) Denial – There is an inability to accept that the loss has occurred. This may be accompanied by a feeling of shock, surprise and numbness. One cannot believe that such a thing could happen to him/her.
- b) Anger – anger and hostility may be experienced. Blaming others or oneself for not preventing the loss is a common theme.
- c) Bargaining – belief that if one acts or thinks differently the loss can be retrieved (or in the case of dying, the loss can be avoided). One may feel severe guilt (“Maybe this would not have happened if I had been more attentive...”).
- d) Depression or emotional breakdown – the reality of the loss sets in. There can be feelings of unbearable loneliness, sadness, loss of motivation and interest; the person may withdraw from contact with others. Anxiety, panic, and thought disorganization can occur. Emotional distress may also be expressed as agitation, fatigue, impaired sleep, and impaired appetite.

III: Conditions & Issues: Loss & Bereavement

- e) Acceptance – one is able ultimately to place the loss in perspective and move on to new activities and relationships.

Initially, it was believed that these reactions occurred in a linear, stage-like fashion, however, responses do not have to follow an established order. The feeling may occur in rapid succession or in combination (e.g. depression and anger). In addition, caregivers to dying individuals may also experience these reactions.

A variety of factors may influence a person's ability to manage loss. These factors may include:

1. Age/emotional maturity.
2. Personality traits - capacity for resiliency, independence, disappointment, patience.
3. Belief systems - What does this loss represent? How does one view death – as a part of the life cycle or as a horrible event to be avoided? One may believe that the spirit of a deceased loved one can live on through the memories maintained by his/her survivors.
4. Psychological defense mechanisms - e.g. sublimating or neutralizing loss through humor or humanitarian actions.
5. Personal expectations.
6. Support system - family, friends, healthcare workers.

III: Conditions & Issues: Loss & Bereavement

Counseling Interventions

Individuals will vary in the way and degree to which they grieve. People with prolonged distress or distress affecting their function should be evaluated for major depression and other psychological conditions.

The following general points may be useful in helping people through the grieving process:

1. Ensure that normal culturally appropriate mourning processes have been able to take place.
2. Provide reassurance that the grieving process is normal despite the painful feelings it causes. Do not force talking. People choose their own times and situations to share feelings – but make it clear that you can listen if they wish to share their painful experiences and feelings.
3. Encourage finding simple ways to enjoy positive memories of the past (e.g. through photographs and stories).
4. Provide reassurance that unbearable, painful feelings can decrease over time.
5. Recommend adequate rest and exercise.
6. Help the individual understand that it is not unusual for people to experience dreams, nightmares, visions or desire to talk to the dead.

III: Conditions & Issues: Loss & Bereavement

7. Recommend avoiding making large, complex decisions.
8. Help the individual be aware that there may be events or circumstances when painful feelings about the loss are triggered (e.g. birthdays, anniversaries, other deaths, etc...). Being prepared for this will diminish the impact.
9. Help one understand that loss involves change and that new activities or relationships may be a part of the change.

III: Conditions & Issues: Loss & Bereavement

Loss & Bereavement in Children

A) General

Children at different stages of development have different reactions to loss. Some individuals may develop an understanding sooner or later than their peers, however, in general, children begin to develop an understanding of the finality of death around the age of five. Studies (western) indicate that children who suffer an early bereavement have a higher incidence of psychiatric disorders in later childhood. In addition, adults who are bereaved of a parent in childhood are more vulnerable to psychiatric disorders than the general population. When additional losses are experienced, they may be more prone to depression and anxiety than the general population.

B) Children Under Age 5

Under five, children do not understand the irreversibility of death. Children under five generally demonstrate unrealistic or “magical” thinking that results in misconceptions about causes and effects. They also have an egocentric or self-centered view of the world leading to a feeling of responsibility for a death (e.g. “Mommy won’t come back because I was naughty...”). Reactions are similar to those following any separation where the longer the absence, the greater the distress. A child may appear detached as though he or she does not care.

III: Conditions & Issues: Loss & Bereavement

C) Children Age 5 – 10years

After the age of five, children can understand that death is irreversible, however, they still may not regard it as something that can affect them. They may continue to have some magical, concrete, and egocentric thinking. Children at this age have a concept of good and bad, become curious about cause and effect, and are able to articulate concern for others. Children may express the desire to stay connected to the dead parent.

III: Conditions & Issues: Loss & Bereavement

D) Age 10 - Adolescence

During this stage, children begin to develop an understanding of abstract concepts regarding death (e.g. death is universal and inevitable and can affect them personally). They also become aware of inconsistencies and can experience the conflict between concepts such as justice versus injustice and the desire for independence versus the need for closeness. Death can feel confusing and conflictual - individuals at this age may express feelings of indifference, detachment, identification, or nostalgia. Additional common immediate reactions to death for children in this age range are listed in the box below.

Common Immediate Reactions to Death/Loss (children age 10-adolescence)

Shock & disbelief	Guilt, self-reproach and shame
Dismay and protest	Physical complaints
Apathy and feeling stunned	School problems
Continuation of usual activities	Regressive behavior
Anxiety	Social isolation
Vivid memories	Fantasies
Sleep problems	Personality changes
Sadness and longing	Pessimism about the future
Anger and acting out behavior	Rapid maturing

III: Conditions & Issues: Loss & Bereavement

E) Guidelines for Managing Loss & Bereavement in Children

When a child has experienced a loss, it is best not to hide the truth. Children need clear, honest, consistent explanations appropriate to their level of development. They need to accept the reality of the loss not to be protected from it. Magical thinking should be explored and corrected. What is imagined may be worse than reality and children may be blaming themselves for events beyond their control. Encourage a supportive environment where open communication is possible, difficult questions are answered, and distressing feelings are tolerated. Allow children to express grief in a manner they find appropriate, to express to the people they most trust and feel comfortable, and to express at a time of their choosing.

If a child has lost a parent or significant caretakers, the child will need to be provided consistent, enduring, appropriate care. The more continuity with the child's previous life, the better. Children may wish to avoid traumatic reminders, especially in the beginning, but complete removal from a familiar environment may cause more pain and problems in the long term. They should be reunited with caring extended family if available.

III: Conditions & Issues: Loss & Bereavement

Loss & Bereavement in Disasters/Catastrophic Emergencies

A disaster or catastrophic emergency may be defined as a significant nature-related (e.g. earthquakes, tsunami, hurricanes, floods, etc) or human-related event (e.g. armed conflict) that directly threatens life or compromises the basic needs required to sustain life (i.e. food, shelter, water & sanitation, security, disease control, or access to health care). Losses and grief under these circumstances can be devastating and overwhelming. There may be formal supportive efforts provided by various humanitarian organizations or less formal support by individuals and other neighboring communities.

For organizations lending aid, the Inter-agency Standing Committee (IASC) Task Force on Mental Health and Psychosocial Support has developed guidelines for primary (acute phase) and secondary/comprehensive (reconsolidation phase) social and psychological interventions that may be useful in helping individuals and communities recover constructively (see the chapter, “An Approach to Care: Crisis Situations—Disaster/ Emergency Settings”).

III: Conditions & Issues: Maternal Mental Health

MATERNAL MENTAL HEALTH

Maternal mental health disorders are a public health challenge posing a significant personal, social, and economic burden on women, their babies, their families, and society. Studies indicate that depression and anxiety are about two times as prevalent worldwide in women than in men and tend to occur at their highest rates during childbearing years (i.e. puberty to menopause). The incidence of depression and anxiety is highest in the year following delivery compared to during pregnancy or at a time of no pregnancy. In developed countries, suicide is one of the most common causes of maternal death during the year after delivery. While psychosis post-partum is uncommon, in developing countries, rates may be higher (due to infection as a contributing factor).

Risk Factors for Developing Mental Health Disorders (during pregnancy and in the first year following delivery)

1. poverty
2. extreme stress
3. exposure to domestic, gender-based, or sexual violence
4. limited social support network
5. natural disasters or emergency & conflict situations migration

III: Conditions & Issues: Maternal Mental Health

Pregnancy & Mental Health

While the majority of women cope well with the changes associated with pregnancy and motherhood, some experience distress that can potentially affect the health of both mother and child. Major depression and some anxiety disorders are common in the general population and may also be seen in pregnant women.

Other issues that may occur as a result of maternal mental disorders during pregnancy include poor sleep, poor eating and inadequate weight gain, increase in stress hormone potentially (causing high blood pressure, pre-eclampsia, & early/ complicated delivery for the mother and impaired growth for the developing baby), poor motivation to seek prenatal, perinatal, and postnatal care, and alcohol and other substance abuse (e.g. cigarettes, illicit drug).

Although conditions such as depression and anxiety may be treated with medication, drugs are used with significant caution during pregnancy. There have been studies with some antidepressant agents that indicate efficacy but these studies are very limited and still advise caution due to the potential risk to the fetus.

Helping the mother make lifestyle adjustments and utilize the support of family, friends, and educational resources is highly emphasized. Prevention is important - a healthcare provider who is able to identify depressive or anxiety symptoms early and provide support can reduce a mother's potential for developing a depressive or anxiety disorder.

III: Conditions & Issues: Maternal Mental Health

Post - Partum Conditions

The mother may experience distress following the delivery of the child. Conditions after birth may include post-partum sadness (also known as post-partum “blues”), post-partum depression, or post-partum psychosis. Specific symptoms and management of these conditions are outlined in the table on the following page.

Maternal mental disorders may have a significant effect not only on the mother but also on the infant and other family members. For example, depression and anxiety in the mother may lead to poor mother-infant attachment, affecting the child’s social, emotional, and cognitive development. In addition, marital problems including disruption of marriage and abuse by the partner may occur as a result of mental illness in a mother after child-birth.

III: Conditions & Issues: Maternal Mental Health

Post Partum Conditions

<i>Condition</i>	<i>Symptoms</i>	<i>Management</i>
<i>Post-partum Sadness or "Blues"</i>	Common; Mildly depressed mood, irritability, anxiety, insomnia, tearfulness (often 1-10 days after delivery)	Symptoms remit spontaneously but educate mother and family that this occurrence is common; however, symptoms persisting beyond 2 weeks should be evaluated (for the possibility of a depressive disorder).
<i>Post-partum Depression</i>	Sadness; anger; insomnia; fatigue; impaired sleep; impaired appetite; decreased sexual interest; crying spells without obvious cause; worthlessness; hopelessness; poor memory and concentration.	Creating a supportive environment for the mother; encouraging self-care. Counseling and education about symptoms; monitor for suicidal thoughts; antidepressant medication if symptoms are severe and persistent (take caution with mothers who are breast-feeding). See section on "Mood Disorders - Depression" for treatment.
<i>Post-partum Psychosis</i>	Uncommon; disorganized thought; delusions that the child may be defective or dying, or that he or she is not her real child. She may also have ideas of killing her child to protect him against illogical threats.	Education about symptoms; monitor for homicidal thoughts; anti-psychotic medication only for severe, persistent psychotic symptoms (take caution with mothers who are breast-feeding). See section on "Psychotic Disorders" for treatment.

III: Conditions & Issues: Mental Health Issues in Children

MENTAL HEALTH ISSUES IN CHILDREN

1. Neurodevelopmental Disorders

The neurodevelopmental disorders are conditions that tend to occur early in the developmental period and may include impairments in intelligence, executive function, learning, and social skills. Personal, social, academic, and occupational functioning may be limited with some disorders manifesting with deficits and delays in reaching normal developmental milestones. Symptoms often occur prior to a child's entering grade school and often occur co-morbidly with other neurodevelopmental disorders.

The Diagnostic & Statistical Manual of Mental Disorders-Fifth Edition (DSM-V) classifies neurodevelopmental disorders into categories including intellectual disabilities, communication disorders, autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), specific learning disorder, motor disorders, and other neurodevelopmental disorders. In this chapter, specific conditions that are emphasized include intellectual developmental disorder, autism spectrum disorder, ADHD, and Tourette's disorder (motor disorder).

A) Intellectual Disability (intellectual developmental disorder)

Intellectual disability, or intellectual developmental disorder, is a condition of disabled mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. An individual's adaptive functioning in daily life may be impaired such that he or she is unable to become an independent and responsible member of society.

III: Conditions & Issues: Mental Health Issues in Children

The global prevalence of intellectual disability is about two out of every hundred persons. Prenatal causes of intellectual disability include genetic syndromes, inborn errors of metabolism, brain malformations, maternal disease, and environmental influences. Perinatal and postnatal causes have included complications during labor and delivery, oxygen deprivation, traumatic brain injury, infections, demyelinating disorders, seizure disorders, severe and chronic social deprivation, and toxic metabolic syndromes and intoxications. A diagnosis of intellectual disability requires that an individual has impaired intellectual and adaptive functioning relative to the individual's age, gender, and socio-culturally matched peers. The onset of these deficits is during the developmental period before adulthood. Treatments for intellectual disability include early behavioral intervention, special education, specialized services, adaptive skill training, and transition planning.

B) Autism Spectrum Disorder

Autism spectrum disorder is a condition of impaired social communication and social interaction and the presence of restricted, repetitive patterns of behavior, interests or activities. Across US and non-US countries, the prevalence of autism spectrum disorder is approximately 1% of the population. Many factors may place a child at risk for autism spectrum disorder, such as advanced parental age, low birth weight, premature birth, or fetal exposure to valproic acid. Twin concordance studies have indicated heritability estimates ranging from 37% to 90%. Various genetic mutations have also been suggested as a contributing factor in some cases. A diagnosis of autism spectrum disorder is considered with the occurrence of continual deficits in reciprocal social communication and interaction and patterns of behavior, interests, or activities that are significantly restricted or repetitive. Symptoms begin during early childhood and hinder daily functioning. Effective treatments for autism spectrum disorder are early intervention services including applied behavioral analysis.

III: Conditions & Issues: Mental Health Issues in Children

Dealing with intellectual disability and autism spectrum disorder: general points

Intellectual disability and autism spectrum disorder are chronic conditions. It is possible to help both the child and family make adaptations in their environment and interactions that will facilitate stable functioning. It is important to make a thorough evaluation of the child's psychiatric history (especially the developmental history) and perform a mental status examination. Be sure to ask about relatives who have had a similar condition.

Educate the family about the fact that the child has both limitations and potential. If available, seek evaluation by a specialist who can provide additional input on the specific diagnosis, degree of limitations, and the appropriate interventions. The important tasks will be accepting what the child cannot do and encouraging the development of skills the child possesses and can further develop.

Because comorbidity may occur with other neurodevelopmental, mental, and medical conditions (e.g. intellectual disability can be associated with conditions such as hyperactivity, depression, and epilepsy) inquire about these problems and provide or refer them to the appropriate treatment.

The family should provide structure by organizing a routine schedule for the child to follow that is appropriate to the child's level of function. This routine will help the child know what to expect and what to do – this can minimize anxiety and distress. The schedule should include a list of core activities of daily living that are appropriate to level of function so that basic self-care skills are fostered and maintained (e.g. washing; dressing; keeping the room tidy; food preparation, going to the market).

III: Conditions & Issues: Mental Health Issues in Children

Include chores appropriate to the level of function so that a sense of responsibility is maintained. Whenever possible, have the child be actively involved in deciding work and pleasure activities. Be sure there is a good balance between indoor and outdoor activities. Also be sure to incorporate activities that involve social interaction.

Fostering “protective” factors can prevent the deterioration of a child’s condition and help children to achieve their goals. Important protective factors include good physical health, healthy parent-child attachment, and a cohesive family unit within a supportive social network.

III: Conditions & Issues: Mental Health Issues in Children

C) Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD may be defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that causes significant impairment in social or academic (occupational for adults) function (or marked distress) and is more frequent and severe than is typically observed in individuals at a comparable level of development.

ADHD occurs in approximately 5% of children and 2.5% of adults in most cultures, according to population surveys. Sources have indicated that low birth weight, premature delivery, smoking and alcohol use during pregnancy, exposure to environment toxicants, and brain injury are factors that have been variably correlated with ADHD, but are not known to be causal. ADHD heritability rates are rather high and specific genes have been correlated with the disorder.

Signs/Characteristics

Symptoms may exist as inattention singly or as hyperactivity/impulsivity, or a combination of inattention + hyperactivity/impulsivity. Symptoms of ADHD usually become apparent in primary school or other environments that are structured settings demanding task completion. In the school setting, teachers' observations are important. Teachers are in a position to compare patterns of compliance, on-task behavior, capacity for fundamental learning tasks (e.g. reading, spelling, arithmetic) and disruptiveness with other children pursuing similar tasks. A diagnosis of ADHD requires a continuous pattern of inattention and/or hyperactivity-impulsivity that negatively affects an individual's functioning or development.

III: Conditions & Issues: Mental Health Issues in Children

Specific symptoms related to inattention may include:

- Poor attention to detail in work, school, and activities.
- Not attentive when spoken to.
- Easily distracted by external stimuli.
- Forgetfulness.
- Inconsistent follow through or execution of tasks and activities.
- Tendency to lose items associated with tasks or activities to be completed.
- Problem organizing activities or tasks.
- Tendency to dislike activities that require the capacity to be attentive.
- Impaired school performance and fundamental learning skills (e.g. reading, spelling, arithmetic) as a result of poor attention capacity

III: Conditions & Issues: Mental Health Issues in Children

Specific symptoms related to hyperactivity and impulsivity include:

- Inability to sit quietly or be at rest when appropriate to do so.
- Excessive physical activity (e.g. climbing, running, jumping) when not appropriate.
- Speaking excessively.
- Tendency to interrupt or intrude on others' activities.
- Tendency to speak or act out of turn .

Reminder:

Not every child with problems at school or increased energy or activity level is considered to have ADHD. It is considered a problem ONLY if there is continuing interruption in school achievement or appropriate social interaction.

III: Conditions & Issues: Mental Health Issues in Children

Management of ADHD

Avoid physical punishment as it aggravates the problem - rewarding the child for good behavior is more effective. Never give the child two tasks at the same time (i.e. give him or her one play activity or one toy at a time).

Educate the family that the child has a problem, needs help, and that patience is necessary. However, help the family also understand that they should not shy away from setting limits and should not be manipulated by the child. Teach the family interventions such as how to structure the child's day and organize his or her activities. Stimulant medications (e.g. methylphenidate) should be considered only if the problem persists and interferes with function and the child has shown no response to behavioral interventions.

III: Conditions & Issues: Mental Health Issues in Children

Management – Structuring the Child’s Day

Children with ADHD may need help in organizing, therefore:

- Schedule. Have the same routine every day, from wake-up time to bedtime. The schedule should include homework time and playtime (including outdoor recreation and indoor activities). If a schedule change must be made, make it as far in advance as possible.
- Organize needed everyday items. Have a place for everything and keep everything in its place. This includes clothing, backpacks, and school supplies.
- Use homework and notebook organizers. Stress the importance of writing down assignments and bringing home needed books.
- Children with ADHD need consistent rules. Set consistent rules that they can understand and follow. If rules are followed, give a token of praise. Children with ADHD often receive, and expect criticism. Look for good behavior and praise it.

III: Conditions & Issues: Mental Health Issues in Children

D) Tourette's Disorder

Tourette's disorder is a condition of multiple motor and vocal tics that occur for at least 1 year in variable frequencies. Tics are sudden, rapid, recurrent, nonrhythmic motor movements or vocalizations. The global prevalence of Tourette's disorder ranges from 1 to 30 per 1,000 persons according to studies. Research suggests Tourette's disorder is an inherited disorder, for which specific genes have been identified. Risk factors may include birth complications, older paternal age, lower birth weight, and maternal smoking or alcohol consumption during pregnancy.

A diagnosis of Tourette's disorder requires the presence of multiple motor tics and one or more vocal tics that occur for at least 1 year, and begin before age 18 years. Also, the tics cannot be due to substance use or another medical condition. Medication and behavioral therapy help to treat tics that cause physical injury or pain, or that interfere with daily functioning. However, some individuals have tics that do not interfere with their daily functioning and do not need treatment.

III: Conditions & Issues: Mental Health Issues in Children

2. Emotional and Behavioral Problems

A) Depression and anxiety

Depression and some anxiety disorders are common in the adult population but occur with notable frequency in children as well. Depression and anxiety may coexist and, as with other conditions, may be expressed differently from one individual to the next. These conditions may be expressed in behavior or other nonverbal expressions, since children are at an early stage in their emotional maturity. A depressed child may appear sad, angry or agitated and may isolate from others. Children with anxiety, depression or a combination of both may also experience sleep problems or exhibit poor performance in school.

Management of depression or anxiety in children involves providing support for the child and education for the family. Antidepressant medications are not recommended for children (some medicines have been shown to increase distress and ideas of suicide) and many short-term anti-anxiety medicines have potential for addiction. Help the child and family identify the actions that may represent the distress and help them to identify the circumstances in which these actions occur. Even though a child's emotions are developing he or she can still be taught basic ways to verbalize distress. Using simple culturally appropriate picture charts showing different emotions and situations with which the child can identify, can be a way to begin discussions about feelings. Encourage the verbalization of distress. Verbalization can improve another's (family, schoolmates, teachers) ability to understand the child's problem and provide a more effective response. Help the child recognize and understand that negative feelings such as anger and disappointment are natural human emotions and that there are constructive ways to manage these emotions (i.e. help the child to identify and anticipate difficult situations and teach the child a variety of healthy responses to the situations).

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It is equally important to help caretakers with distress obtain support, as children's emotions can often reflect the emotional climate within their environment. For example, a depressed parent may not have the energy or motivation to attend to the child's basic emotional needs. This can turn into psychological distress and emotional problems for the child.

B) Elimination Disorders

Enuresis (bed-wetting)

Enuresis may be defined as the inability of the child to control his bladder (after 5 years of age). The condition is not related to a secondary cause (such as a medical problem or ingestion of diuretic agents) but is psychological in nature. Enuresis may occur during sleep or while awake. Enuresis causes a lot of stress and shame for the child and can lead to more serious problem if not treated early. A thorough psychiatric history, mental status examination with emphasis on the developmental history, medical history, and social environment is important.

Management of Enuresis

A medical evaluation should be done to eliminate underlying medical causes for the problem. Be sure to assess for environmental conditions (e.g. if the wetting occurs during school time, is it due to dirty toilets, or unavailable toilets at school?). Also assess for other underlying psychological distress (e.g. the child who wets the bed may experience nightmares or night terrors and may be too afraid to go to the toilet).

III: Conditions & Issues: Mental Health Issues in Children

Helpful Techniques

- Avoid bedtime fluid intake.
- The child should avoid an excess of foods or drinks that can stimulate urination (diuretics).
- The child should be taught to empty the bladder before going to sleep. Exercises to strengthen the bladder musculature may be used as well (e.g. start urination for 2-3 seconds, then stop the urination and hold for 5 seconds. Then resume and complete urination. Practicing this action each time the child must urinate can help to strengthen the muscles that control urine outflow).
- If the child is old enough, involve him/her in washing the bed sheets or clothes to decrease guilt and increase a sense of control and worth (sometimes the child has guilt believing that he/she causes inconvenience or distress for others).
- Another intervention that encourages self-esteem, self-control and self-worth is a calendar or chart that indicates progress in the child's decreased bed-wetting behavior. Instructions for creating the chart are outlined on the next page.

III: Conditions & Issues: Mental Health Issues in Children

Monitoring Bed-wetting – the progress chart/calendar

- Make an attractive chart for the child that includes the days of the week (or use a calendar).
- Make the design simple since it is the child who will be actively filling in the chart.
- Have the child mark √ for the dry days and X for wet days (try to use the expressions “wet and dry” to minimize the stigma of the problem).
- To make it more fun, you can also have the child color the dry days with green and the wet days with red (or draw a sun for dry and clouds for wet etc...).
- At the end of each week ask the child to count dry and wet days and give him a reward for each improvement (e.g. if he had 5 wet days on the first week and 4 on second then offer a token of praise. If he maintains this improvement for 2 weeks continue to reward him; with additional improvement offer additional rewards).
- If after one month you are not getting benefits, reconsider underlying causes and another medical work-up.

III: Conditions & Issues: Mental Health Issues in Children

Progress Chart for Monitoring Bedwetting

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

III: Conditions & Issues: Mental Health Issues in Children

C) Conduct Disorder

Conduct disorder may be defined as a persistent or repetitive pattern of behavior that involves aggression toward people or animals, destruction of property, deceitfulness or theft, and serious violations of well-established rules or social norms. Conduct disorder in children has been associated with infant temperament, lower-than-average intelligence, and instability in the family. In addition, violent behaviors have been correlated with physical or sexual abuse and alcoholism or drug use within the family.

An assessment not only of the child but also of the family and other environmental influences will elucidate information that will guide treatment. Education on how to identify and express emotions may be useful to the child and families. Alcohol and drug treatment should be recommended to those in need. Threats to a child's safety should be reported to the appropriate authorities.

III: Conditions & Issues: Adolescent Psychosocial Issues

ADOLESCENT PSYCHOSOCIAL ISSUES

Neuropsychiatric disorders are a leading cause of health-related burden for youth, accounting for 15–30% of the disability-adjusted life-years (DALYs) lost during the first three decades of life. With regard to the global perspective (particularly regarding low and middle-income countries), important psychosocial issues in adolescents have included substance abuse, violent behavior, and unsafe sexual behavior.

Substance Abuse

Risk factors associated with adolescent substance abuse include:

- Male gender
- Youth
- Genetics
- Mental health
- Poor personal/social skills
- Family dysfunction
- Dysfunctional peer group
- Limited educational or occupational opportunities

Peer pressure, excitement/enjoyment, self image, risk taking/rebellion, curiosity, and experimentation are reasons cited by youth to use substances.

III: Conditions & Issues: Adolescent Psychosocial Issues

Factors that may be protective include a supportive family, individual motivation, high self esteem, and low motivation for impulsivity. In addition, having educational or occupational opportunities and an interest and capacity for socialization may reduce the risk for engaging in substance abuse.

Intervention:

- Evaluate mental and medical status
- Stabilize acute psychiatric and medical conditions
- Assess for underlying chronic psychiatric conditions; assess current social situation
- Provide information – regarding effects of drug
- Provide support – offer encouragement and referral to supportive services

Violence & Adolescents

From a global perspective, studies have indicated that violent death is not uncommon among adolescents and young adults. Among youth 10-29 years of age worldwide, each year approximately 250 000 homicides occur, constituting 41% of the annual total number of homicides globally. Social, political, and economic upheaval may be strong predictors of youth conflict (as opposed to poverty alone). In addition, adolescent girls (age 12-17) may be at particular risk for being sexually violated.

III: Conditions & Issues: Adolescent Psychosocial Issues

Risk Factors for Violence:

1) Individual Factors

- Gender
- Age
- Gang membership
- Psychiatric factors
- History of victimization
- Social dysfunction
- Drug use

2) Interpersonal Factors

- Exposure to violence

3) Community Factors

- Neighborhood deprivation

4) Societal Factors

- Culture of violence
- Social & economic inequality

III: Conditions & Issues: Adolescent Psychosocial Issues

Managing Adolescent Violence

Dealing with youth violence involves continued research that will help guide effective interventions. Development and government agencies will need to play a role in establishing policies which serve to change cultural and social norms that support violence. Raising awareness of the health consequences of youth violence and the importance of prevention is an important focus. Youth violence prevention policies and programs should be created. Specific preventive measures may include developing life skills in children and adolescents, decreasing the availability and harmful use of alcohol, and decreasing access to lethal means (e.g. guns, knives, pesticides).

Victims/Survivors of Violence

Youth are especially vulnerable regarding violence given their level of dependence, limited capacity to protect themselves, and limited power and participation in decision-making processes. Health care providers, relief workers and protection officers should devote special attention to their psychosocial needs.

Interventions for victims/survivors of violence:

- Protection
- Medical support as indicated
- Psychosocial support
- Monitoring by health facilities
- Education (i.e. individuals, families, communities)

III: Conditions & Issues: Adolescent Psychosocial Issues

Unsafe Sexual Behavior

Studies suggest evidence of high risk behavior among youth (e.g. being sexually active at a young age and irregular use of condoms). Factors that promote or perpetrate unsafe sexual behavior have included: personal factors; proximal environment; distal or broader social context; and interaction among factors.

1) Personal factors:

- Knowledge & beliefs
- Perception of low personal risk
- Self expectations
- Perceived costs & benefits
- Intentions
- Self-esteem

III: Conditions & Issues: Adolescent Psychosocial Issues

2) Proximal Environment:

Interpersonal Factors	Immediate Living Environment
<ul style="list-style-type: none">• Negotiating condom use• Coercive, male-dominated sexual relationships• Peer pressure• Interactions with adult	<ul style="list-style-type: none">• Lack of access to condoms• Low access to media• Lack of recreational facilities• Living on the street• Being in prison

3) Broader Social Context

- a) Culture
- b) Societal structure

* urban vs rural conditions

* poverty

4) Interaction among factors

III: Conditions & Issues: Adolescent Psychosocial Issues

Interventions:

- Psychosocial/psychiatric & medical assessments
- Provide factual information regarding safe sex practices
- Referral to supportive services

III: Conditions & Issues: Crisis Situations

CRISIS SITUATIONS

1) AGITATION & AGGRESSIVE BEHAVIOR

Potential Causes

- Uncontrolled psychiatric condition such as mania, bipolar disorder, or psychosis.
- Untreated medical condition affecting the brain as an infection, tumor, or metabolic disease.
- Medication toxicity caused by an excessive amount or variety of medicines ingested.
- Alcohol or drug intoxication and withdrawal.

Intervention for Agitation/Aggression

- Alert and elicit the help of other healthcare staff or authorities.
- Take distance and help others remain a safe distance from the agitated person.
- Safety – if possible, try to remove from the environment items that are potentially hazardous to safety. Remain calm and confident.
- Listen, pay attention, do not argue.
- If possible (without subjecting yourself to harm) try to talk down or deescalate the individual by using a soft speech tone, expressing support and reassurance, and minimizing physical gestures.

III: Conditions & Issues: Crisis Situations

2) SUICIDE

Risk Factors (western studies)

- Age (15-24yrs; elderly)
- Male gender
- Intense, prolonged suicidal thinking
- Past suicidal behavior

General questions to ask about suicide:

Do you feel very sad?

Do you feel that no one cares about you?

Do you feel you cannot go on?

Do you feel that life is not worth living?

Do you sometimes wish you were dead?

Have you thought of ending your life?

Are you having such thoughts now?

How often?

Have you actually made any plan?

III: Conditions & Issues: Crisis Situations

Intervention for High risk Suicide (The person has a definite plan & the means to do it immediately).

- Stay with the person. Never leave the person alone.
- Gently talk to the person and remove the pills, knife, gun, insecticide, etc. (distance the means of suicide).
- Contact a mental health professional immediately, if available; Contact the local emergency services (or police) if mental health professionals are not available; Arrange for an ambulance and hospitalization.
- Contact the family or others significant to the individual and enlist their support.
- If a professional is not available for ongoing support, arrange future meetings at regular intervals and maintain ongoing contact.

III: Conditions & Issues: Crisis Situations

3) DISASTER/EMERGENCY SETTINGS

A. General

Disasters or emergencies may be defined from different perspectives and have been characterized based on their potential for causing:

- Overwhelming physical environmental damage.
- Significant human morbidity or mortality.
- Impaired psychosocial function of individuals and communities.
- Impaired economic capacity of individuals or communities.
- Mobilization of revenue by organizations or government agencies to provide relief.

A disaster/emergency may be defined as a significant nature-related (e.g. earthquakes, tsunami, hurricanes, floods, etc) or human-related event (e.g. armed conflict) that directly threatens life or compromises the basic needs required to sustain life (i.e. food, shelter, water & sanitation, security, disease control, or access to health care).

Disaster/emergency relief is defined in this text as the relief or assistance provided by various organizations or agencies in response to a nature-related or human-related emergency.

III: Conditions & Issues: Crisis Situations

B. Phases of disaster/emergency relief & mental health interventions

A disaster or emergency relief effort may be described in terms of phases that include an acute **emergency phase** and **post-emergency or reconsolidation phase**. An affected population may experience varied degrees or fluctuate between phases depending on regional circumstances. The acute emergency phase has been defined as the period where crude mortality rate is increased due to circumstances or an environment in which basic needs (i.e. food, shelter, security, water/sanitation, disease control, and access to health care) are diminished.

During the emergency phase the focus is primarily on social interventions such as restoration of basic needs (i.e. food, shelter, security, water/sanitation, disease control, and access to health care). Psychological and psychiatric interventions during this phase are aimed at acute situations: the relief of acute distress through psychological first aid (see the next page); evaluation and treatment of severe conditions including suicidal intentions, psychosis, mania, severe depression, and epilepsy; and ensuring the availability of psychotropic medications for patients with pre-existing psychiatric conditions.

III: Conditions & Issues: Crisis Situations

Elements of Psychological First Aid (Sources: IASC Task Force on Mental Health & Psychosocial Support, 2007)

Elements Of Psychological First Aid

- Allowing survivors to discuss the events if they desire, without pressure; respect one's wish not to talk.
- Listening.
- Conveying compassion.
- Assessing and addressing basic needs (i.e. shelter, food, protection, health care, etc...).
- Discuss ways to manage or cope with stress (discourage destructive actions such as alcohol or substance abuse; encourage culturally appropriate constructive normal daily activities).
- Encouraging but not forcing company from significant others.
- If available, refer to local support mechanisms/mental health clinicians particularly if distress has been severe and sustained.
- Minimize the use of anti-anxiety medicines such as benzodiazepines which can be addictive (e.g. diazepam or alprazolam). If anxiety is severe and sustained (such that ability to function or manage self care is impaired) short-term use of an anti-anxiety medicine on an as needed basis can be used (i.e. start by giving a three day supply and instruct the individual to only use medicine in moments of overwhelming distress). Refer individuals with severe or sustained distress for further psychiatric evaluation and treatment if resources are available. Do not institute therapies or medications that require long-term or ongoing monitoring if no mechanism for monitoring (i.e. facilities or mental health staff trained to follow up) is established and available.

III: Conditions & Issues: Crisis Situations

The post-emergency or reconsolidation phase has been defined as the period when basic needs have been restored to pre-emergency levels or to a standard within the population that represents a stable health condition. Emergency phase social, psychological, and psychiatric interventions are continued as needed during this phase. Post-emergency social interventions are focused on outreach and education while psychological and psychiatric evaluation and treatment services are further integrated into the existing primary health care structure.

III: Conditions & Issues: Gender-Based Violence

GENDER-BASED VIOLENCE IN INSECURE SETTINGS

Overview

In this discussion, an insecure setting is comparable to an emergency/ disaster relief (or humanitarian emergency) setting which may include communities uprooted or displaced by war, communities affected by natural disasters, or communities that have lost their integrity or structure due to other destabilizing circumstances. Gender-based violence (GBV) has been associated with insecure settings. Because of the serious nature and impact of GBV, the subject is addressed exclusively in this chapter.

The data on the prevalence and incidence of GBV in insecure settings have limitations due to under-reporting of incidents. Under-reporting occurs for many reasons including fear of retaliation and re-victimization, stigma, self blame, and mistrust of authorities. Data available on GBV have indicated, a female victim and male perpetrator are involved most frequently. While men and boys may also be vulnerable to sexual violence (particularly in situations of torture and detention) the majority of survivors/victims of sexual violence have been females.

Because there is a tendency for under-reporting, it is important that healthcare staff working in unstable environments have an awareness and willingness to take constructive action when violence is suspected. This chapter provides an outline of information on the nature, causes, effects, and active interventions associated with gender-based violence in insecure settings.

III: Conditions & Issues: Gender-Based Violence

Definitions & Causes of Gender-Based Violence (GBV)

Gender-based violence (GBV) has been defined broadly as any harmful act that is imposed against an individual's will, and that is based on socially ascribed (gender) differences between males and females. Specific types of GBV may vary across countries, regions, and cultures and may include: a) domestic violence; b) forced/early marriage; c) harmful traditional practices (e.g. female genital mutilation, honor killings, widow inheritance); d) trafficking; and e) sexual violence.

Regarding sexual violence, it may be described as an unwanted, destructive sexual advance that is executed (e.g. as a sexual action) or implied (e.g. as sexual verbal expression). Studies have indicated that power and control underlie the perpetration as opposed to an amorous attraction or desire. Forms of sexual violence seen in insecure settings have included: rape (most often cited); attempted assaults; verbal sexual threats and humiliating comments; molestation or repeated unwanted advances; domestic violence toward a spouse; and incest toward a family relative.

Reports have indicated that groups associated with GBV perpetration in insecure settings may include fellow refugees; other clan members; religious or ethnic groups; military personnel; relief workers; and family members. Regarding sexual violence, the survivor often knows the perpetrator.

III: Conditions & Issues: Gender-Based Violence

Potential factors contributing to gender-based violence (GBV) in insecure settings

- A) Displacement and the loss of community structures (due to social and armed conflict; natural disaster; or poverty and limited social and economic resources). Women and children may become separated from family and community supports, rendering them vulnerable to exploitation and abuse.
- B) In conflict situations, women and children may be targeted particularly and GBV may be used as a tool for interrogation. Power and domination are employed with an intent to intimidate, humiliate, and control or hurt others. Abduction and sexual slavery occur in this setting.
- C) Local populations may perceive refugees who receive special aid as privileged and therefore attack.
- D) Male disrespect toward women leading to inequality in providing women food, shelter, security, and other necessities.
- E) As a means for survival, women may be in the vulnerable position of bartering sex for food, shelter, and other necessities putting them at risk for abuse and violence.

III: Conditions & Issues: Gender-Based Violence

Effects of GBV

The effects of GBV may manifest as medical, psychological, social, and economic problems:

- A) Medical:* sexually transmitted disease (e.g. syphilis, HIV); damage to the reproductive tract and susceptibility to chronic infections leading to pelvic inflammatory disease; unwanted pregnancy; unsafe abortion; and death from injuries.
- B) Psychological:* depression; terror; guilt; shame; loss of self-esteem; and suicide.
- C) Social:* rejection by a spouse, family, and community; loss of relationship with children.
- D) Economic:* loss of home, property, and security provided by family.

III: Conditions & Issues: Gender-Based Violence

Active Interventions for GBV Incidents

In an insecure setting, efforts should be made, if possible, to identify and help coordinate local resources for protection, medical care, and psychosocial care.

1) Protection:

- A) Maintain confidentiality.
- B) Give individuals privacy, do not force them to express more than they desire, and reassure that they are in a safe setting while with you.
- C) Allow the individual to have family or friends be present if desired; if the incident has been recent, be aware that a medical evaluation may be required.
- D) Contact the police if the individual is amenable.

2) Medical Care – refer and provide an escort to medical care as indicated.

In cases of sexual assault/rape it is important to be aware of local and national laws (where they exist) and the procedures to collect forensic evidence as indicated. Procedures often indicate that the survivor should not wash, urinate, defecate, or change clothes before the medical exam in order to preserve important evidence.

III: Conditions & Issues: Gender-Based Violence

A complete history of the incident and a physical examination should be conducted. As indicated, the history should include the nature of sexual contact, menstrual history, and mental state. The physical exam should note the condition of clothing, presence of foreign materials, evidence of physical trauma, and, as indicated, involve the collection of materials such as hair particles, fingernail scrapings, sperm, saliva, and blood samples.

Tests and treatments as indicated (e.g. tests for pregnancy, HIV, and syphilis; appropriate treatments for medical issues) should be provided. In addition, comprehensive counseling and follow-up medical care should be offered.

3) Psychosocial care

Reactions to GBV

Common reactions to GBV include fear, guilt, shame and anger. Survivors may adopt strong defense mechanisms that include forgetting, denial and deep repression of the events. Reactions vary from minor depression, grief, anxiety, phobia, and somatic problems to serious and chronic mental conditions. Extreme reactions to sexual violence may result in suicide or, in the case of pregnancy, physical abandonment or elimination of the child.

III: Conditions & Issues: Gender-Based Violence

Supportive Counseling

Objectives of supportive counseling include helping survivors to understand what they have experienced, to express and place in perspective negative emotions, and to access support networks and services. Specific counseling points may include:

- Asking questions in a non-judgmental, non-intrusive, relevant manner; also, be aware that details and the sequence of information may change as the emotional state changes.
- If self-blame emerges, reassure the survivor that the perpetrator is to blame.
- Assess needs or concerns for safety and help the survivor develop a realistic safety plan.
- Always provide accurate information about services and facilities.
- Empower the survivor; always allow individuals to make their own choices and decisions.
- Encourage re-engagement in a daily routine and in activities with family and supports within the community.
- Discourage comfort in alcohol or other substance abuse.

III: Conditions & Issues: Gender-Based Violence

Community-Level Support

Community-based activities have been shown to be effective in helping to decrease trauma for GBV survivors. Supportive interventions on the community level include: a) identifying and training traditional, community-based support workers; b) developing women's support groups or support groups specifically designed for survivors of sexual violence and their families; and c) creating special drop-in centers for survivors where they can receive confidential and compassionate attention.

Children & Adolescents

Children and youth are especially vulnerable to GBV given their level of dependence, limited capacity to protect themselves, and limited power and participation in decision-making processes. Health personnel assisting children should have the appropriate level of training and skills. Age appropriate language and creative communication methods should be used (e.g. drawing, games, story-telling). Never coerce or restrain abused children and include trusted family members in the treatment process. Children should not be removed from family care for treatment unless there is abuse or neglect and protection is required.

Regarding adolescents, females may be specifically targeted for sexual violence in situations of armed conflict and severe economic hardship. Health care providers, relief workers and protection officers should devote special attention to their psychosocial needs.

III: Conditions & Issues: Gender-Based Violence

Other Issues

GBV & Domestic Violence

Be cautious in situations where violence has occurred by a spouse or other family member (domestic violence). The survivor and/ or other relatives may be susceptible to further danger and retaliation, especially if the abuser is aware that the incident has been reported. Assess each case on an individual basis, utilizing the support of other colleagues in deciding an appropriate response. Health care providers may choose to refer the matter to a disciplinary committee, inform the authorities, or provide discreet advice to the survivor about the potential options.

Children of Rape

Children born as a result of rape are susceptible to stigma, abuse and even abandonment. Therefore, these children must be monitored closely. Families and mothers particularly should be offered education and support. Foster placement and, later, adoption should be considered if the child is rejected, neglected or abused in other ways.

III: Conditions & Issues: HIV/AIDS & Mental Health

HIV/AIDS & MENTAL HEALTH

HIV/AIDS Global Summary

Worldwide, an estimated 34 million people were living with HIV at the end of 2010. In 2010, there were 2.7 million new HIV infections. Most newly infected people live in Sub-Saharan Africa and the annual number of newly infected individuals continues to decline. In 2010, an estimated 1.9 million people became infected representing a 16% decrease from the estimated 2.2 million newly infected in 2001. However in regions including the Middle east and North Africa, the annual number of people newly infected with HIV has increased to 59,000 in 2010 compared to 43,000 in 2001. In addition, since 2008, the incidence of HIV infection has grown in Eastern Europe and Central Asia.

Globally, the annual number of people dying from AIDS-related causes continues to decline with an estimated 1.8 million in 2010 compared to 2.2 million in 2005. The number of people dying annually from AIDS-related causes began to decline in 2005 and continues to decrease in sub-Saharan Africa, the Caribbean, and South and Southeast Asia. Unfortunately, AIDS-related deaths have increased dramatically in Central Asia, East Asia, Eastern Europe, the Middle East, and North Africa

The availability of antiretroviral therapy in low- and middle-income countries worldwide (particularly countries in Sub-Saharan Africa) has been responsible for preventing 2.5 million deaths since 1995. Since 1995, more than 350,000 children (86% from Sub-Saharan Africa), have been spared from contracting HIV due to antiretroviral prophylaxis being available to pregnant women living with the virus.

III: Conditions & Issues: HIV/AIDS & Mental Health

New evidence-based studies have indicated also that people living with the HIV are less likely to transmit the virus and that individuals who are HIV-negative and have taken antiretroviral pre-exposure prophylaxis orally as a tablet or vaginally in gel form have reduced their risk of contracting the virus.

HIV/AIDS & Mental Health –General Overview

HIV disease has the capacity to affect the physical, psychological, and social well-being of individuals. A number of the medical diseases associated with HIV manifest as neurological or neuropsychiatric illnesses (e.g. neuropathy, central nervous system infections and tumors). People infected by the virus may be burdened also by emotions such as fear, anger, and guilt, which, if not placed in perspective, may contribute to more severe psychiatric conditions. In addition, social consequences of HIV disease have included stigma, loss of household income and financial stability, and the destruction of family and community structures.

Mental health support in general (e.g. psychoeducation; supportive group, family, and individual counseling; and, in the case of severe illness, medication therapy) may play a role in influencing the overall health of individuals whose lives have been affected by the epidemic. Special forms of counseling, such as HIV information/prevention counseling and adherence counseling, are associated with mental health and are important to decreasing the spread of infection and the proliferation of disease.

III: Conditions & Issues: HIV/AIDS & Mental Health

Medical Aspects of HIV/AIDS

HIV (Human Immunodeficiency Virus) is a type of virus (specifically a retrovirus) that can invade and destroy cells of the immune system. HIV can cause AIDS (or Acquired Immunodeficiency Syndrome) which is a collection of symptoms or medical conditions that indicate immune dysfunction.

HIV can enter the body through blood, semen, vaginal fluid, and breast milk. HIV is most often transmitted through sexual contact or the transfer of contaminated blood (through blood transfusions or intravenous drug abuse). Infants can be infected in the uterus or through breast-feeding when their mothers are infected with HIV.

Data from several countries indicates that the acquisition and transmission of HIV is reduced with abstinence from sexual activity, condom use, decreased sharing of contaminated drug paraphernalia, screened blood products used for transfusions, and the use of antiretroviral medication . Education and HIV testing are the means by which individuals can understand and take action to prevent or manage disease.

III: Conditions & Issues: HIV/AIDS & Mental Health

Measures of Immunity & HIV Infection: CD4+ Immune Cells & Viral Load

CD4+ T lymphocytes (CD4+ T cells) are cells of the immune system that play a role in protecting the body from certain infections. HIV targets CD4+ T cells, disables their normal function, and facilitates a genetic process that leads to proliferation of the virus. CD4+ T cells can be measured through analysis of a blood sample. The US National Institute of Allergy and Infectious Diseases (NIAID) has cited a normal CD4+ T cell count as 800-1200mm³ (other sources have cited a normal range = 500-1500mm³). A low CD4+ T cell count is an indication of impairment of an aspect of the immune system and raises suspicion for HIV disease. Experts have indicated that counts of less than 500mm³ usually mean damage to the immune system, counts less than 200mm³ mean severe damage, and counts less than 50mm³ mean damage of even greater severity. When antiretroviral medications are used CD4+ T cell counts improve.

The viral “load” is a measure of the amount of viral particles in a given blood sample and may be an indication of one’s response to treatment and prognosis. The viral load found in blood has been found to accurately reflect the total burden of HIV in the body.

III: Conditions & Issues: HIV/AIDS & Mental Health

Phases of HIV Infection

HIV should be viewed as a spectrum of disorders ranging from acute (primary) infection with or without an acute retroviral syndrome, to the asymptomatic state, to advanced disease.

A) Acute Primary Infection

Once HIV enters the body, the virus infects a large number of CD4+ T cells and rapidly multiplies, significantly increasing the viral load. Studies have indicated that following primary infection, as many as 50-70% of infected individuals may develop an acute “flu-like” syndrome, also known as acute retroviral syndrome (ARS). This has been estimated to occur 3-6 weeks after infection and may last from 1-4 weeks. Symptoms of ARS may include fever, sweats, fatigue, joint pain, headache, sore throat and enlarged lymph nodes or glands. Some individuals may also experience a skin rash and neuropsychiatric symptoms such as confusion, mood changes, and personality changes. As the immune system mounts a response, the viral load declines and the CD4+ T cell count rises and reconstitutes. As the immune response progresses, symptoms of ARS decrease. Most individuals will then enter a period of clinical latency where the virus is less active.

B) Clinical Latency

During this phase, the virus is still present in the body, but is less active. Many individuals do not have any symptoms of HIV infection. The duration of this period can vary greatly among individuals, but the median has been estimated to be 10 years.

III: Conditions & Issues: HIV/AIDS & Mental Health

C) Advanced Disease - Progression to AIDS

While symptoms of HIV disease may develop during any phase of infection, the extent of illness is generally increased as the CD4+ T cell count declines. More severe complications of infection have been associated with CD4+ T cell counts $< 200\text{mm}^3$. AIDS is diagnosed when an HIV-infected individual has one or more opportunistic infections (discussed in the following sections) and has a CD4+ T cell count $< 200\text{mm}^3$ (or CD4 percentage $< 14\%$ according to the US Center for Disease Control classification).

The World Health Organization (WHO) has developed a clinical staging system (outlined below) for resource-constrained settings where extensive laboratory testing may not be readily available. In this system, AIDS is diagnosed based on the clinical symptoms observed upon examination.

WHO HIV/AIDS Clinical Staging System (for Adults & Adolescents)

A. Primary HIV Infection: asymptomatic; Acute retroviral syndrome (ARS).

B. Clinical Stage 1: asymptomatic, persistent generalized lymphadenopathy (in at least two sites, not including inguinal, for longer than 6 months); this stage may last for several years.

III: Conditions & Issues: HIV/AIDS & Mental Health

C. Clinical Stage 2 (mild symptomatic stage): moderate weight loss (< 10% of total body weight); recurrent respiratory infections (e.g. bronchitis, otitis media, and pharyngitis, sinusitis); skin conditions (e.g. angular cheilitis, fungal nail infections, herpes zoster, papular pruritic eruptions, recurrent oral ulcerations, and seborrheic dermatitis).

D. Clinical Stage 3 (moderate symptomatic stage): severe weight loss (>10% of total body weight); unexplained diarrhea > 1 month; pulmonary tuberculosis; severe bacterial infections including pneumonia, pyelonephritis, empyema, pyomyositis, meningitis, bone and joint infections, and bacteraemia; other conditions including recurrent oral candidiasis, oral hairy leukoplakia, and acute necrotizing ulcerative stomatitis, gingivitis, or periodontitis.

E. Clinical Stage 4 (severe symptomatic stage): HIV wasting syndrome, HIV encephalopathy, and varied conditions associated with opportunistic infections and tumors related to HIV/AIDS (see next section).

Opportunistic Infections (OIs)

The term opportunistic indicates an infection that takes the “opportunity” to flourish when there is compromised function of the immune system. OIs include Toxoplasma encephalitis, cryptococcus, cytomegalovirus, Pneumocystis carinii pneumonia (PCP), Mycobacterium avium complex (MAC), Mycobacterium tuberculosis, herpes simplex, and cryptosporidiosis. The causes, locations, symptoms and treatments for some of these conditions are outlined in the table on the next page.

III: Conditions & Issues: HIV/AIDS & Mental Health

Opportunistic Infections (OIs) Associated with HIV/AIDS

Name of Opportunistic Infection (OI)	Agent causing Infection	Site of Infection	Symptoms (Sx)	Treatment
Candida albicans	fungus	Mouth/throat, esophagus; vagina	<u>Mouth</u> : white patches on gums, tongue or lining of the mouth; pain; difficulty swallowing; loss of appetite. <u>Vagina</u> : itching, burning, thick, white discharge	Anti-fungal medication
Cryptococcus neoformans	fungus	brain (meninges)	headache, fever	Antifungal medication
Cryptosporidium	parasite	gastrointestinal tract	significant diarrhea	no direct treatment for the parasite; ARV
Cytomegalovirus (CMV)	virus (herpes family)	eyes, nervous system, intestines	Inflammation of the retina, nerves, brain issue, esophagus and bowels	Anti-viral medication
Herpes Simplex (HSV)	virus (alpha herpes sub-family)	mouth, genitals	cold sores/fever blisters; genital sores/lesions	Antiviral medication; there is no cure for HSV though use of antiretrovirals (ARV) may reduce frequency and severity of attacks
Mycobacterium avium complex (MAC) & Mycobacterium tuberculosis (TB)	bacterium	MAC: lungs, lymph glands, liver spleen, blood, bone marrow, intestines, and other organs. TB: lungs, brain, kidneys, or spine.	<u>MAC</u> : constitutional sx; will depend on organs involved (diarrhea, sx of hepatitis, pneumonia; lymphadenopathy; impaired blood count). <u>Latent TB</u> : no symptoms; active <u>TB</u> : cough, night sweats, fever, weight loss, chills, and fatigue.	MAC: antimycobacterial medication course; special precautions to prevent spread of infection. TB: long-term antimycobacterial medication course (beware of liver damage); special precautions to prevent spread of infection.
Pneumocystis Jirovecii (Carinii)	parasite	lungs	dry cough, shortness of breath, fever	Antiparasitic medication
Toxoplasma gondii	parasite	brain	Inflamed brain tissue causing headache, fever, weakness in an arm or leg; seizure may also occur	Anti-parasitic medication

III: Conditions & Issues: HIV/AIDS & Mental Health

Tumors associated with HIV/AIDS

Tumors associated with HIV/AIDS include Kaposi's Sarcoma and Primary Central Nervous System (CNS) Lymphoma. The causes, locations, symptoms and treatments for these conditions are outlined in the table below.

Tumors associated with HIV/AIDS

Tumor Name	Cause	Site of Tumor	Symptoms (Sx)	Treatment
Kaposi's Sarcoma	tumor of the blood vessels	skin most commonly; also lungs, brain, liver, mouth	<u>Skin:</u> painless, purple/black lesions; <u>Lungs:</u> shortness of breath, productive cough/sputum; <u>Brain:</u> seizures; liver dysfunction	depending on area affected cosmetic treatment; chemotherapy or radiation therapy for more extensive disease
Primary Central Nervous System (CNS) Lymphoma	tumor of lymph cells	brain	focal neurological signs depending on location of lesions	radiation and chemotherapy

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Medication Therapy For HIV

Significant advances in antiretroviral therapy have been made since the advent of the first US government-approved medication in 1987, zidovudine (AZT). With the development of highly active antiretroviral therapy (HAART), HIV-1 infection has become a chronic, manageable disease for individuals with stable suppression of the virus and access to treatment.

HAART is the combination of several antiretroviral medicines used to slow the rate at which HIV multiplies in the body. A combination of three or more antiretroviral medicines (often referred to as a “cocktail”) is more effective than using just one medicine (monotherapy) to treat the virus. The current recommendation for starting HAART in the United States is to begin therapy when the CD4+ T cell count falls to 500cells/ml or below. There are sources that have also indicated that, in mid- and low income countries, initiation of therapy is recommended for a CD4+ T cell count of 350cells/ml or below.

Anti-retroviral medications generally target or interfere with steps in the reproductive cycle of the virus. There are 6 classes of anti-retroviral medications currently available:

- 1) Nucleoside Reverse Transcriptase Inhibitors (NRTIs)
- 2) Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)
- 3) Protease Inhibitors (PIs)
- 4) Integrase Inhibitors (IIs)
- 5) Fusion Inhibitors (FIs)
- 6) Chemokine Receptor Antagonists (CRAs).

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The use of these medications depends on a variety of factors including simplicity or complexity of use, efficacy determined by clinical evidence, side-effect profile, practice guidelines, and clinician preference. Particular concerns that play a role in which medications are initiated or used for maintenance therapy include adverse effects, co-infection with hepatitis B virus or hepatitis C virus, pregnancy, and resistance. Outlined below and on subsequent pages are lists of antiretroviral medications currently in use.

Nucleoside Reverse Transcriptase Inhibitors (NRTI)

Abacavir (Ziagen)

Didanosine (Videx)

Emtricitabine (Emtriva)

Lamivudine (Epivir)

Stavudine (Zerit)

Tenofovir (Viread)

Zidovudine (Retrovir)

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Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)

Delavirdine (Rescriptor)

Efavirenz (Sustiva)

Nevirapine (Viramune, Viramune XR)

Rilpivirine (Edurant)

Protease Inhibitors (PI)

Atazanavir (Reyataz)

Darunavir (Prezista)

Fosamprenavir (Lexiva)

Indinavir (Crixivan)

Lopinavir/Ritonavir (Kaletra)

Nelfinavir (Viracept)

Ritonavir (Norvir)

Saquinavir (Invirase)

Tipranavir (Aptivus)

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Integrase Inhibitor (II)

Raltegravir (Isentress)

Chemokine Receptor Antagonist (CRA)

Maraviroc (Selzentry)

Fusion Inhibitor (FI)

Enfuvirtide (Fuzeon)

Combination Formulations

Atripla - Tenofovir + emtricitabine + efavirenz

Combivir - Zidovudine + lamivudine

Complera – Tenofovir + emtricitabine + rilpivirine

Epzicom - Abacavir + lamivudine

Stribild – elvitegravir + cobicistat + emtricitabine + tenofovir

Trizivir - Abacavir + lamivudine + zidovudine

Truvada - Tenofovir + emtricitabine

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While antiretroviral therapy can help control proliferation of the virus and allow the body to recover its ability to fight infections, it is not a cure. If antiretroviral therapy is discontinued, the virus will recur. Other reasons for treatment failure may include drugs or herbal preparations that interfere and reduce the level of antiretroviral medication in the system; a patient's being too ill (i.e. overwhelmed by not only HIV infection but also other infections or illnesses); an individual's inability to tolerate the medicine (e.g. due to significant side effects); resistance; or poor adherence to the prescribed medications.

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Resistance

HIV makes every effort to survive in the body. If there is anti-retroviral medication in the system but not at a level to effectively disable the virus, the virus can potentially mutate or change to a form that can resist the effects of the medication. This capacity to change and resist medication effects is termed **resistance**. Resistance is an important reason why HIV drugs stop working. Missed doses of medication or continuing on a drug regimen that is not effective can encourage resistance. Interactions with other medicines that reduce HIV medication in the system or a poor ability to absorb HIV medication into the bloodstream can also contribute to resistance.

Adherence

The risk of resistance may be reduced by maintaining adherence to the anti-retroviral medicines prescribed. Adherence, in simple terms, means the ability to take medications as prescribed. Specifically, adherence involves a) taking the appropriate anti-retroviral drugs; b) taking the drugs on the appropriate schedule; and c) taking the drugs in the correct manner (e.g. with or without food). One hundred percent adherence is required for treatment to be effective. With precise adherence, antiretroviral therapy will be successful. With poor adherence continued viral replication and increased viral load may occur, the CD4+ T cell count may decrease (increasing the risk for opportunistic infections), and the potential for resistance may emerge. It can be challenging for individuals to maintain 100% adherence. Adherence counselling provides those with difficulty support and techniques to improve and maintain adherence. Specific techniques are outlined in a subsequent section of this chapter.

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HIV & Sexually Transmitted Diseases (STDs)

Sexually transmitted diseases (STDs) are infections that are passed from one individual to another through sexual contact. The infections may be caused by varied pathogens such as viruses (e.g. HIV, hepatitis) or bacteria (e.g. syphilis, gonorrhea). STDs may increase a person's risk for becoming infected with HIV by causing conditions that allow easier passage of the virus into the body (e.g. passage through open sores, ulcers, and irritations). The inflammatory process (resulting from damage by certain STDs to the skin surface) increases the presence and concentration of immune cells to the area that can serve as targets for HIV (e.g. CD4+ cells). In addition, those infected with HIV, who contract subsequent STDs, are at increased risk of transmitting the virus to sexual partners. Studies indicate that those infected with HIV and also have other STDs can shed the virus in their genital secretions. The higher the concentration of HIV in genital fluids, the more likely the virus may be spread to a partner.

Contracting an STD may have serious implications for one who is HIV-positive. Some STDs are curable or eradicated with antibiotic treatment (e.g. gonorrhea, syphilis). However, others may not be eradicated fully and may be associated with potentially fatal diseases such as cancer (HPV, Hep C) and liver failure (Hep B, Hep C). The table on the next page outlines a number of STDs that have been associated with HIV.

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Sexually Transmitted Diseases (STDs) Associated With HIV

Bacterial

Syphilis

Gonorrhea

Chlamydia

Trichomoniasis

Viral

Hepatitis A (Hep A)

Hepatitis B (Hep B)

Hepatitis C (Hep C)

Herpes Simplex Virus (HSV)

Human Papilloma Virus (HPV)

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Psychiatric Conditions & Psychosocial Issues Associated with HIV/AIDS

1. Psychiatric Conditions

HIV-related medical conditions causing psychiatric symptoms

a) HIV-related dementia

Dementia is defined generally as a mental disorder causing impaired intellectual functioning (e.g. ability to reason), impaired memory and orientation, distractibility, changes in mood and personality, and impaired judgment. Dementia may be caused by varied conditions such as degenerative brain diseases (e.g. Alzheimer's Disease), vascular (blood vessel) disease, or chronic alcohol or drug abuse. The onset of dementia is typically insidious or slow lasting months to years. Dementias that involve ongoing degeneration or destruction of brain tissue are usually irreversible.

HIV may directly damage brain tissue leading to a dementia-like syndrome. Over the years, several names have been attached to more severe and milder aspects of HIV-related dementia and have included AIDS dementia complex (ADC), HIV associated dementia (HAD), HIV-encephalopathy, subacute encephalitis, HIV cognitive/motor complex (HIV CMC), minor cognitive-motor disorder, and HIV associated neurocognitive disease (HAND).

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The dementia associated with HIV can develop over weeks or chronically over years. Symptoms may be similar to those associated with other types of dementia and include decreased short-term memory, decreased attention and concentration, disturbance in word finding, decelerated thought processing, psychomotor retardation (i.e. slowed movement), impaired reasoning and intellect, and, in advanced disease, impaired visual-spatial function (i.e. aspect of brain function that analyzes and understands space in two and three dimensions). Personality changes and mood disturbances such as depression may occur. Less commonly, manic symptoms (agitation, irritability, impulsivity, and excessive talkativeness) and psychosis (hallucinations, delusions, irrational suspiciousness, or paranoia) may be present. Motor deficits (i.e. impaired movement) are also a part of the HIV-related dementia syndrome and may include muscle weakness, increased or decreased muscle tone, spasticity movements, muscle rigidity or “cogwheeling,” and over or under-reactive reflexes.

A complete medical and psychiatric evaluation are important in evaluating an individual with HIV who presents with neurocognitive symptoms. Where available, laboratory tests (e.g. complete blood count, CD4 count, HIV viral load, chemistry screen, urinalysis, blood/urine cultures, ECG, chest x-ray, and, when applicable, drug toxicology screen, thyroid function tests, and B6 & B12 vitamin levels) and neuroimaging (e.g. magnetic resonance imaging or MRI) are used in the evaluation of HIV-related dementia.

HIV-related dementia has been treatable. That is, symptoms may be reduced with anti-retroviral therapy. Specific psychiatric symptoms of the dementia syndrome may be addressed with particular treatments as well. For example, if agitation has developed and is severe, low dose antipsychotic may be used (e.g. olanzapine or seroquel if available or chlorpromazine). Low dose antipsychotics may be used if hallucinations are present as well. Avoiding antipsychotics causing extrapyramidal symptoms (EPS) is generally recommended.

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Use of antipsychotics in elderly individuals for psychosis related to other (non HIV-related) dementias has not been recommended due to increased risk of death. Caution is also taken with elderly people with HIV-related dementia. Antidepressants are helpful in treating associated depression. Benzodiazepines that are metabolized by the body in a relatively short period (i.e. those with short half-lives such as lorazepam) may be useful for anxiety and insomnia. However, it is important to be aware that benzodiazepines have also been associated with uninhibited behavior (i.e. disinhibition) and cognitive impairment. They should be used short-term and in the lowest effective doses.

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b) CNS infections and tumors

Individuals with significant HIV disease may be prone to central nervous system (CNS) infections and tumors that can present with a combination of neurological and psychiatric symptoms. These conditions are outlined in detail below and include neurosyphilis, cryptococcal meningitis, toxoplasmosis, cytomegalovirus (CMV) encephalitis, aseptic meningitis, progressive multifocal leukoencephalopathy (PML), and CNS lymphoma.

Neurosyphilis

Syphilis is an infection caused by the spirochete, *Treponema pallidum*, and has several stages of disease. The primary stage is characterized by enlarged lymph nodes in the groin region and a painless “chancre” or sore that may be located on the genitals. This may disappear without treatment but secondary syphilis characterized by fever, swollen lymph nodes, rash, and genital lesions may appear after approximately 2 years. During this stage a syphilitic meningitis with headache, nausea, stiff neck, and occasional cranial nerve deficits, may occur. However, more commonly, there are no neurological symptoms but diagnostic tests analyzing spinal fluid may be abnormal. The latent or next phase is also characterized by abnormal diagnostic blood tests and minimal clinical symptoms.

The last stage or tertiary phase is when neurosyphilis (syphilis affecting brain tissue) occurs. During this phase other organs including the heart and eyes may be affected as well. Neurosyphilis may present with or without symptoms , however diagnostic tests (of spinal fluid) remain abnormal. Syphilis in this stage may cause meningitis or a stroke. There may also be syphilitic dementia associated with seizures, mania, agitation, and grandiose delusional thoughts. Tabes dorsalis (ataxia/loss of balance, lower extremity paresthesia and paresis, hyporeflexia, incontinence, and

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sharp pains) may occur. “Gummas” or degenerated brain tissue surrounded by thick, fiber-like tissue may, on rare occasion, lead to a space-occupying brain mass.

Syphilis may be suspected or detected through tests including VDRL (Venereal Disease Research Laboratory), RPR (rapid plasma reagent), MH-ATP (microhemiagglutination – assay for treponema pallidum), and FTA (fluorescent treponemal antibody). In some instances lumbar puncture may be indicated. Treatment with antibiotics is effective.

Cryptococcal Meningitis

Cryptococcus neoformans is a fungus that commonly causes meningitis (swelling of the protective outer-sheath of the brain) in AIDS patients. Symptoms may occur within days or weeks. Early symptoms may be fever, lethargy, persistent, progressive headache; seizure and delirium may occur. Stiff neck typically associated with other types of meningitis is not necessarily present. Some individuals may develop focal neurological symptoms including paralysis of cranial nerves causing blindness and deafness, partial muscle weakness, and over-active reflexes.

Treated or untreated, the disease may progress to produce complications including seizure, stroke, swelling of the brain, and coma. Permanent nerve damage and dementia may be long-lasting complications. Cryptococcus is detected usually by analyzing blood and spinal fluid for presence of the fungus. Antifungal antibiotics are used as treatment.

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Toxoplasmosis

Toxoplasmosis is an infection caused by the parasite, *Toxoplasma gondii*. It is characterized by multiple abscesses that cause swelling of brain tissue or encephalitis.

Initial symptoms may include enlarged lymph nodes in the neck and flu-like symptoms such as headache, fever, malaise. Localized neurological signs may be present and include partial muscle weakness, partial loss of sensation, partial loss of sight, inability to comprehend or communicate speech, memory loss, and seizure. Delirium may develop with disease progression. Nausea, vomiting, and lethargy may be an indication of increased pressure within the skull as the brain tissue continually inflames.

If available, a computerized tomography (CT) or magnetic resonance imaging (MRI) scan may reveal the presence of the disease (ring-enhancing lesions). Anti-parasitic medication has been an effective treatment.

Cytomegalovirus (CMV) Encephalitis

CMV belongs to the family of Herpes viruses and in addition to neurological disease is associated with disease of the eyes, lungs, esophagus, intestines, and adrenal gland. Neuropsychiatric manifestations of CMV include primarily encephalitis (global swelling or inflammation of brain tissue). Symptoms associated with encephalitis include fever, headache, lethargy, delirium, dementia, seizure, and coma. Occasionally facial and ocular cranial nerve impairments, and weakness of the lower limbs occurs. A definitive diagnosis is made through brain biopsy (analysis of a sample of brain tissue). The recommended treatment is antiviral medication.

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Aseptic Meningitis

A form of meningitis may occur where no pathogen or germ is evident on diagnostic analysis (i.e. no bacteria evident in spinal fluid). This has been referred to as aseptic meningitis. Symptoms may emerge within days to weeks and include headache with or without stiff neck or fever, lethargy and delirium. Rarely impairment of the cranial nerve that controls movements of the facial muscles occurs.

If available, a CT or MRI will indicate inflammation of the tissues that make up a protective sheath enveloping the brain (meninges) and analysis of the spinal fluid will be abnormal.

There is no specific treatment – however the condition may resolve on its own. Supportive measures (e.g. IV fluid), antiretroviral therapy, pain medication, and steroids are used empirically.

Progressive Multifocal Leukoencephalopathy (PML)

PML is caused by a virus (John Cunningham or JC virus) that infects and destroys oligodendrocytes (i.e. CNS cells that produce a protective cover that aids the transmission of nervous impulses from one nerve cell to another) and other supportive cells (astrocytes). Neurological and psychiatric symptoms have included impaired cognition (e.g. memory and concentration), weakness and sensory loss, impaired vision, slurred speech, loss of muscle coordination, dizziness, seizures, inability to understand or communicate speech, inability to read, and inability to recognize faces.

If available, an MRI is preferred to CT as lesions in white matter of the brain will be more evident. The prognosis for PML is poor although some antiretroviral medications have been associated with prolonged life.

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Primary CNS Lymphoma

Central nervous system (CNS) lymphoma associated with AIDS occurs most commonly when there is severe immunodeficiency. Symptoms include headache, seizure, lethargy, and delirium. Focal or localized neurological signs are not uncommon and may include impaired capacity to understand or communicate speech, muscle weakness, and cranial nerve deficits. If available, a CT or MRI scan may reveal one or more homogenous, mass lesions. Treatment involves radiation, steroids, and/or chemotherapy.

c) Other Medical Conditions & Medications

Other medical conditions seen in HIV-infected individuals causing psychiatric symptoms have included kidney disease (HIV-associated nephropathy and end-stage renal disease), liver disease (hepatitis C, cirrhosis), and endocrine disorders (hypothyroidism, diabetes mellitus, hypotestosteronism, and adrenal insufficiency). Antiretroviral therapy (ART) can be toxic and cause neurobehavioral disturbances. In particular, efavirenz has been associated with cognitive changes, headache, dizziness, insomnia, nightmares, and even suicidal thought. Symptoms appear to be related to blood levels and tend to decrease gradually over time, however. HIV-infected individuals who are taking interferon for treatment of coinfection with the hepatitis C virus (HCV) may be at risk for depression. Antidepressant medication is indicated if depressive symptoms are persistent and debilitating.

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Psychiatric Illnesses Associated with HIV/AIDS

According to western studies (United States), psychiatric illnesses occurring commonly in individuals with HIV or AIDS include depression, anxiety disorders, adjustment disorder, and substance abuse. With certain conditions, mania and psychosis have also been observed.

Studies from the United States have indicated that depression and suicidal thoughts and attempts may be increased in people infected with HIV. Risk factors for suicide have included a recently positive HIV test, having lost close friends to AIDS, poor social and financial support, continuous relapses of medical illnesses associated with HIV, and the presence of dementia or delirium.

According to American studies, anxiety disorders that occur with frequency in individuals with HIV have included generalized anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder. An adjustment disorder, according to the DSM V, is characterized by emotional or behavioral distress occurring in response to an identifiable stressor within 3 months of the stressor. Adjustment disorder with anxiety or depressive features has been associated with HIV and AIDS.

Substance abuse may play a role in putting individuals at risk for contracting HIV or may occur as a means of self-medicating distress after infection has been realized. Intravenous drug abuse or sharing contaminated drug paraphernalia remains a significant mode of HIV transmission throughout the world. People who abuse substances are at risk for engaging in unsafe sexual practices which contributes to the spread of the disease. People with HIV who do not have access to mental health services may abuse substances in order to cope with stress, further complicating or perpetuating HIV disease and emotional distress.

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Studies have indicated that mania has been associated with opportunistic infections (e.g. cryptococcal meningitis) and medications (e.g. efavirnez). In addition, it has occurred as an aspect of HIV-associated dementia. For those with a pre-existing bipolar disorder, an exacerbation of symptoms tends to occur most commonly, but not exclusively, in the context of HIV-associated dementia. Psychotic symptoms (e.g. hallucinations) have been observed as an aspect of HIV-associated dementia .

The specific symptoms and treatments for depression, anxiety disorders, adjustment disorder, substance abuse, and mania are outlined in previous chapters. Regarding psychiatric medication therapy, drugs that are less likely to interfere with or potentiate the side effects of anti-retroviral medicines are recommended.

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2. Psychological Issues

Common Emotions

Fear, uncertainty, anger, and guilt are emotions often experienced by individuals infected by HIV.

Individuals may be fearful and uncertain about the effect the virus will have on their bodies and their lives in general. They may fear subsequent medical tests, losing the capacity to function at full strength, and losing the support of friends and family. Providing them education and information can reduce fear and uncertainty. For example, directly teaching or referring individuals to healthcare providers who can educate them about test procedures, medications, and recognizing symptoms of illness early can help them feel in greater control of their circumstances. In addition helping them identify reliable supports (family, friends, clergy, therapist, etc...) can allay fears of abandonment.

Anger is common and may be rooted in a sense of unfairness. That is, an individual may feel that he or she has been unduly afflicted. Anger may also stem from a fear of losing control of one's life or a fear of social stigma, rejection, or abandonment. It will be important to help the patient understand that having anger is alright and a natural human response. The issue is how the anger is managed. Helping the individual identify and utilize constructive, productive ways to discharge anger is imperative.

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Guilt is another emotion that is often experienced by individuals infected with HIV. A person with HIV may feel that he or she has brought the virus onto him or herself and should be blamed and punished. Some experience guilt about introducing HIV into the lives of others. They may feel that they have created burden and distress for spouses, partners, parents, children, or friends. Individuals burdened with overwhelming guilt, should be counseled on how to detach negativity and punishment from the virus. Help them understand that, in reality, the virus has nothing to do with punishment. Anyone, “good” or “bad,” has the potential to become infected. In addition, reinforce patients’ self esteem and sense of worth. Having the patients remind themselves of who they are outside of having HIV can bolster self confidence and esteem. Having them recall what people who love them (i.e. family, partners, friends) like about them can reinforce self esteem.

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Loss of control

With the advent of Highly Active Antiretroviral Therapy (HAART), people with HIV are living longer and may be less severely debilitated by disease. HAART may contribute to one's maintaining a sense of independence and control over his or her life. Emphasizing one's capacity to function and providing reassurance and reinforcement of function can help individuals living with HIV preserve self-esteem and self-worth.

Caregivers should allow patients to take the lead in expressing what feels like too much or too little help. Those caring for individuals with HIV disease may find it useful to listen without necessarily providing advice to resolve a problem. Attending to non-verbal clues and keeping an open channel of communication can be useful.

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Newly Diagnosed Individuals

Reactions will vary among people newly diagnosed with HIV. It will be important to help the individual identify support that suits his or her individual needs (e.g. some utilize family, friends, mental health professionals, literature about HIV disease, or spiritual resources). In addition, providing factual, practical information will help dispel fear and uncertainty. Assessing the patient's level of comfort with disclosing his or her HIV status and the need to make previous partners aware is important.

Death & Dying

Despite the advances in treatment, in some areas of the world, HIV/AIDS still remains a serious disease from which individuals may die.

Emotional responses to death and dying, including denial, anger, bargaining, depression, and acceptance, have been described by Kubler-Ross and are outlined in detail in the chapter on "Loss & Bereavement." These emotions are not necessarily experienced by patients in a particular sequence and caregivers may also experience these reactions. Helping both patients and caregivers accept the limitations on what they can do or control within the situation is important. Helping individuals identify and focus on the positives and reframe negative thoughts can be useful. Patients and caregivers should be encouraged to identify and actively incorporate into their lives those things that give them pleasure.

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3. Social Issues

Women & HIV/AIDS

HIV and AIDS in women can significantly impact households and societies. In many developing countries, women are the primary caregivers of the family. When the mother becomes ill, young daughters are often pulled from school, forfeiting an education to help in the home. In some cultures, if a woman loses her husband she may be at risk of losing land or property. Faced with such a challenge, some women have been driven to prostitution in exchange for food or other goods.

Social stigma

Social stigma is common in many societies and can interfere with family and community support for individuals contracting disease. Individuals with HIV or AIDS have the burden of being rejected by family and friends and may even be accused of “contaminating” or tainting a family’s name.

Poverty

In countries that are already poverty stricken, the AIDS epidemic may cause households an even greater decline into complete destitution. Households that are already impoverished may have difficulty overcoming additional adversity. AIDS may cause the loss of productive household members resulting in loss of income.

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Decreased income means less ability to feed, cloth, or educate family members. In some instances families separate and children may be forced to start working early to support the family.

High Medical Costs

The high medical costs associated with HIV and AIDS treatment can potentially devastate families and individuals in both developed and developing countries. For example, in the United States, people with HIV/AIDS without insurance or other financial resources may be unable to access adequate care. There are limitations on support for the indigent. Even for those who have some form of health insurance, the high cost of medical services and medications are not always adequately covered. Despite increases in funding for HIV/AIDS in recent years, many developing countries continue to have limited access to services and medications.

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Specialized Counseling Associated With HIV/AIDS

HIV voluntary counseling & testing (VCT)

a. HIV counseling

The aim of HIV counseling is to decrease the acquisition and transmission of HIV through providing effective *information* and *prevention counseling*.

Information

It is suggested that all who are recommended or request HIV testing receive information that includes the risk factors for transmission; how to prevent transmission; benefits of getting tested; the consequences of not testing if one is at risk; importance of and explicit instructions on how to obtain test results; the meaning or interpretation of results; how and where to obtain additional information about HIV; and how and where to obtain additional services if indicated (e.g. medical, psychological, social services).

Information should always be provided in a manner that is appropriate to culture, language, age, and developmental level. While face-to-face, client-counselor sessions are recommended for prevention counseling, pamphlets or videos are appropriate (and an efficient means) for providing information about HIV.

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Prevention counseling

There have been a number of proficient models for HIV prevention counseling. The client-centered HIV prevention counseling approach has been shown to be both efficient and effective. Client-centered counseling focuses on the client's own unique situation and involves helping the client outline and achieve an explicit behavior change goal to decrease the chance of acquiring or transmitting HIV. For individuals taking the standard HIV test, the client-centered approach involves two brief, in-person or face-to-face sessions with a health provider or counselor. In the first session, an assessment of the client's personal HIV risk is made; a risk behavior (if any) and action to change that behavior is identified and discussed; the HIV test is performed; and the client is asked to return in 2 weeks for results.

In the second session, progress made in changing the previously identified risk behavior is discussed, additional behavior change actions are outlined as needed, HIV test results are provided and discussed, and referral to additional services is offered as indicated.

With rapid testing, there may be either one or two sessions depending on test results. Individuals with preliminary positive rapid HIV test results will have another session when they return for their confirmatory results. Clients at risk for HIV but with negative rapid HIV test results receive one session of counseling that includes a risk-reduction plan. While not obligated to return, they should be offered the opportunity to come back for a follow-up session to discuss their efforts to implement the plan.

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Client-centered HIV Prevention Counseling – Session #1

1st SESSION

1. Assess the client's personal risk for HIV. *What in particular puts this individual at risk for HIV?* Ask in a non-judgmental way and use active, attentive listening to determine whether the client engages in risk behaviors such as unprotected sex with others who may be at risk for HIV; abuse of intravenous drugs or other mind-altering substances that could alter judgment or has had blood transfusions or exposure to contaminated blood products. Risk also involves one's maintaining misconceptions such as the belief that he or she could never be afflicted or that their culture or society could never understand or accept using precautions against HIV. It is important to help the client identify and understand these "risks" as well. Discuss in a sensitive manner the circumstances that put them at risk. Remember that this is not the time to discuss the meaning of test results (this is covered at another point in the counseling process). Also, the counselor should not engage in discussions of additional problems unrelated to the client's specific HIV risk factors (discussing other illnesses, social problems, etc...). There will be another time in the counseling process to address these issues as well.
2. Explore attempts already made to reduce risk behaviors. If the client already engaged in risk-reducing behavior, acknowledge his or her success. Also, encourage discussion of the challenges that made decreasing risk behavior difficult and discuss how these challenges were managed.
3. If there is an identifiable risk factor (e.g. unprotected sex) and action has not been taken already to decrease the risky behavior, discuss a *specific, concrete action* that can help reduce the risk (e.g. provide information on the proper use of and how to obtain condoms and ask the client to use them between now and the time he returns for the HIV test results).
4. Describe, discuss, and answer questions regarding the HIV testing process.

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Client-centered HIV Prevention Counseling – Session #2

2nd SESSION

1. Discuss the progress made in changing the previously identified risk behavior.
2. Identify additional risk behaviors and outline concrete actions to change the behaviors (as indicated).
3. Provide and discuss the meaning of the HIV test results (see the section on the next page on “HIV Testing”).

Offer referral to additional services, as indicated (i.e. medical, psychological, social).

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b. HIV testing

The HIV test is designed to detect antibodies to the virus. A confirmed positive test result indicates that antibodies are present and that HIV infection has occurred. Test kits used currently have the capacity to screen varied body fluids including blood products (whole blood, serum, and plasma), oral fluid, and urine (see the table on the next page). Factors influencing the type of test kit used by a health facility may include the ease of sample collection, cost, accuracy or sensitivity of the test, client preferences and acceptability, and the likelihood of clients returning for results.

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HIV Tests and Their Properties

Test Type	Type of Body Fluid Collected	Availability of Preliminary Test Results (time frame)	Comments
Standard HIV Test Enzyme Immuno-Assay (EIA) Test	Blood (serum, plasma) via phlebotomy	2 weeks; results obtained in person	High accuracy or sensitivity; easy to process a large number of tests in a short time frame; client must return for test result increasing the potential for no return
Oral Fluid Test (EIA)	Fluid from surface of tissues within the mouth	2 weeks; results obtained in person	Noninvasive sample collection decreasing potential for spread of infection
Urine Test (EIA)	Urine via urine cup	2 weeks; results obtained in person	Noninvasive sample collection decreasing potential for spread of infection
Home Sample Collection Test	Dried blood drop via finger stick and sample is sent to a lab for analysis	3 – 7 days; results obtained by telephone	Convenient; greater privacy and anonymity; less invasive sample collection
Rapid Test	Blood (serum, plasma) via phlebotomy or less invasive finger stick	10 – 20 minutes; results obtained in person	Convenient; less invasive sample collection; client is already present for result (chance for no return for results is diminished)
Ora-Quick (oral in-home HIV test)	Fluid from surface of tissues within the mouth	20-40 minutes	Available over-the-counter
Polymerase Chain Reaction (PCR) Test	Blood	3-7 days	Used to test blood supplies or babies born to HIV positive mothers; expensive

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Positive HIV Test Results

If an initial HIV test result is positive, additional confirmatory tests are done to verify the result (i.e. Western Blot Test with results available in 2 weeks). An HIV test is considered positive only after both the initial and confirmatory tests are positive. A confirmed positive test is an indication that HIV infection has occurred.

Negative HIV Test Results

A negative HIV test result strongly indicates the absence of HIV infection and does not warrant repeating unless there has been new exposure to an infected partner (or partner of unknown HIV status) or exposure to other risk factors (e.g. contaminated drug paraphernalia; working with potentially contaminated blood products or body fluids). An HIV test may be falsely negative if the test was performed prior to seroconversion (i.e. before an individual exposed to virus has developed detectable antibodies to the virus). After exposure to the virus, it may take 4 – 12 weeks before the body develops HIV antibodies that will be detectable by testing. In this situation, individuals should be instructed to repeat the test in 3 months. If the result is negative yet concern still remains (e.g. if one is sure that he or she has had sexual contact with an infected person or contact with contaminated body fluids) another test may be performed 6 months after the exposure.

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Adherence Counseling

The ability to take medications as prescribed is termed adherence. One hundred percent adherence is required for antiretroviral medication therapy to be effective. With poor adherence continued viral replication may occur and the CD4+ T cell count may continue to decrease, increasing the risk for opportunistic infections and advanced disease. In addition, non-adherence can lead to resistance (where the HIV changes in character or “mutates” and becomes resistant to a medication’s previous effect) resulting in treatment failure. Managing adherence to antiretroviral medication therapy can be a significant challenge for people with HIV disease. Outlined below are a few direct and indirect measures utilized to monitor medication adherence.

Measures of Medication Adherence

- Viral load testing
- Pill counts MEMS (medication event monitoring system) bottle cap
- Self report tools
- One-on-one direct interview by counselor
- Reports from caregivers
- Pharmacy tracking of medication pickup/delivery
- Clinic visits

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Adherence counseling involves identifying and addressing *patient, provider, and medication regimen* factors that may contribute to one's difficulty in taking antiretroviral medication as prescribed.

Patient factors contributing to non-adherence

- a) Patient commitment and readiness for treatment.
- b) Social demographics – stability of living situation and work schedule are important factors.
- c) Psychological factors – depression; psychoactive drug abuse may interfere with adherence to antiretroviral medication.
- d) Individual cultural/religious beliefs – beliefs around the need or use of medication may influence adherence.
- e) Physical factors - presence of other medical illnesses.

Management of patient factors :

- a) Evaluate and develop patient's knowledge and understanding of the need for antiretroviral therapy.
- b) Evaluate patient's motivation and commitment to antiretroviral therapy. Peer interventions (interactions with and education from others who are managing HIV disease) have been shown to be effective.
- c) Assess and address mental health issues and behavioral/coping skills with appropriate referrals to support.

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Provider factors contributing to non-adherence

- a) General support and support when a change in medication therapy is warranted.
- b) Patient education.
- c) Medication reminders.
- d) Use of multidisciplinary team when possible so that care and support can be comprehensive.
- e) Ongoing support – studies indicate that adherence diminishes over time when interaction or support from providers is diminished.
- f) Access to obstetric and pediatric care as indicated.

Management of provider factors:

- a) Providers must offer: education about HIV disease; the need for antiretroviral therapy; the relationship between adherence, resistance, and treatment failure; and significant effects and side effects of medication.
- b) Adherence interventions should be offered at the beginning, at points of change, and throughout an established course of therapy.
- c) Medication pill boxes, MEMS (medication event monitoring system) bottle caps, alarms, calendars, diaries, phone reminders, and incentive items (gifts) should be utilized as indicated to help patients keep track of their medicines.

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- d) A multidisciplinary team approach should be utilized to foster a well-rounded view and management of the patient.

Medication regimen factors contributing to non-adherence

- a) individual history and lifestyle which will vary and influence choices of therapy;
- b) dosing frequency;
- c) drug class pill burden; drug interactions and side effects.

Management of medication regimen factors:

- a) Evaluation of lifestyle such as eating, sleeping, and work patterns.
- b) Evaluating a patient's preferences regarding pill size and number of pills to be taken.
- c) Potential for drug interactions and side effects should be carefully assessed.

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HIV/AIDS & Disaster/Emergency Settings

Emergency situations such as armed conflicts (war) or natural disasters have the potential to create conditions that make people vulnerable to disease. Challenges within the emergency setting associated with the spread of HIV have included increased economic hardship; disabled health, social and educational services; disabled monitoring and maintenance of blood supply; increased drug abuse; and violent sexual crimes.

Increased Economic Hardship

Economic hardship can increase vulnerability to HIV. In armed conflict situations widows and children left behind may become vulnerable and with little protection. They may become targets of sexual abuse. In addition, women who are left with no means to support themselves, following the loss of family or possessions, may resort to prostitution for survival, potentially increasing the risk of infection.

Disabled Health, Social, & Educational Services

During emergencies people may not be able to receive adequate healthcare because facilities are poorly supplied, have been destroyed, or have closed down. Healthcare personnel may have been lost or internally displaced. Similarly, institutions and personnel used to educate people about HIV/AIDS may be affected.

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Disabled Monitoring & Maintenance of Blood Supply

During emergencies, health services may no longer have the capacity to screen blood products adequately and sometimes are forced to recycle existing supplies such as gloves and needles. Although efforts are made to maintain good hygiene and sanitation, the risk for contamination may be increased.

Increased Drug Abuse

In the emergency setting people may become homeless and forced onto the streets where there is greater exposure and access to illicit drugs. Law enforcement services may be disabled making it easier for illegal drugs to be trafficked and sold to greater numbers of people.

Violent Sexual Crimes

Law enforcement agencies may function less efficiently and effectively during emergencies compromising the safety of individuals within communities. In armed conflict situations, women may be at increased risk for being sexually assaulted. Increases in violent crimes such as rape may be seen.

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COUNSELING GUIDE

GUIDELINES FOR COUNSELING, COMMUNITY EDUCATION, & COMMUNITY PSYCHOSOCIAL DEVELOPMENT

Counseling—General

Mental health counseling is an important intervention for helping people maintain mental wellness. Counseling is focused on educating, guiding, and referring people in the community to psychological support services as opposed to psychotherapy where professional therapists administer established formal techniques.

Specifically, counseling involves empathetic listening, understanding the basic signs of psychological distress, and problem solving skills including basic advice on how to cope with distress, and obtain a more detailed evaluation and treatment if necessary. Counselors also provide individuals, families, and the community with information about mental wellness and raise the public's awareness of stigma and other key mental health issues through community education activities.

Individual Counseling

Counseling for individuals may aim to improve knowledge or to provide an outlet for expressing feelings associated with mental conditions. Basic counseling interventions for individuals are outlined in sections of the manual that discuss specific mental conditions.

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Group Counseling

There are many different types of therapeutic groups. People can come together on a variety of shared concerns, issues, and conditions. Some groups require a different approach from other groups (e.g. a group focused on medical issues and their consequences ask for a different approach than a group focused on psychological issues or traumatic experiences). In some groups the group leaders will find some participants who are eager to share their experiences and some who are hesitant to speak. The intellectual and emotional levels of the groups may vary and therefore impact the methods used and program planning. Some groups may be led by professional psychotherapists while others, such as self help groups, are initiated by facilitators with basic group support skills.

Self-help groups

A self-help group is a group of people with similar experiences who meet on a regular basis to help each other to deal with issues related to a health condition or specific experience. People with similar experiences can help each other in the healing process. In self-help groups people can find support, attention, and other participants who can be examples of how to deal with problems. These groups are usually flexible and without a set number of sessions. Participants may attend when they want and facilitation or leadership of the group is less structured. Self help groups may be useful as a single supportive intervention or in combination with other interventions such as individual counseling.

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The purpose of self help groups is to provide a means for:

- 1) Sharing information and knowledge about a problem;
- 2) meeting others who can empathize because of having a similar experience;
- 3) support and empowerment;
- 4) recognition and acknowledgement;
- 5) self expression and making contact;
- 6) regaining self confidence;
- 7) learning alternative constructive coping methods.

Advantages and ways that self-help groups may differ from professional psychotherapy groups include:

- 1) Leaders and participants have had similar experiences and both openly share their experiences. There is less potential for power differences between facilitator and group members.
- 2) Self-help groups may be less expensive (and therefore more accessible) as professional therapists may charge significant fees for their services.

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Possible disadvantages of self help groups include:

- 1) Potential periods where emotional turbulence and conflict between group members is less controlled since there is less structure and professional guidance;
- 2) No guarantee of continuity since regular attendance is not a set rule and group leadership can change frequently;
- 3) Screening participants is limited, so there may be difficulty in managing the needs of individuals who have emotional or intellectual capacities that vary significantly from other group members;
- 4) In acutely stressful situations such as situations of massive loss, people may find that sharing experiences with others amplifies their distress rather than reduces it.

How to lead a self help group

Usually groups are led by two co-leaders who have had experiences similar to other group members and who have been participants in a self help group in the past. The advantage of having two leaders is that they can be a support for one another when difficult issues emerge, the group can continue uninterrupted if one leader must miss a session, and logistical organizational tasks may be shared.

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It is important for group leaders to have some basic knowledge of psychological conditions so that additional supportive resources may be offered to individuals who appear to have additional needs. During group sessions it is common for individuals to express strong emotions (e.g. anger) and it is also common for overall themes or attitudes to emerge from the group as a whole (e.g. “scape-goating” - the group appears to “gang up on” or blame a particular member for a conflict or distress that has emerged within the group).

Other common problems that arise in groups include one individual dominating the discussion, individuals selectively withdrawing or refusing to speak, or individuals being excluded from the discussion. It is important that leaders have an awareness and basic knowledge of problematic emotions and themes – sometimes these emotions and themes can be so strong that the group becomes distracted and led astray from the constructive purpose of their gathering. Group leaders can play a role in helping the group recognize, acknowledge, and keep in perspective the strong emotions and themes.

The group leaders must be in a place in their lives where they have come to terms with or placed in perspective the thoughts and feelings they have had related to their own distressing experience or life event. Being in the group setting with others in distress can potentially trigger difficult emotions. The group leaders need to be able to recognize and manage these situations without adding emotional burden to vulnerable group members. The goal for the self-help leaders is to initiate the group or start them on a path to expressing and operating independently or without facilitation.

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Managing self-help sessions

Sessions may be started by having participants share their name (usually first name only for the sake of privacy) and their reason for coming to the group. Group “rules” should be mentioned so that members have an idea about what is expected from them and from others. It should be emphasized that the purpose of outlining rules is not to be controlling, but to create an environment where respect and expectations are equal for all. Again, self-help groups are flexible – people may attend when they want and as many sessions as they want. Self-help groups are usually open to all with a similar experience and ongoing. It should be clear what time the group starts and ends, how often the group meets, and where the group is to be held regularly (i.e. the usual location). Asking group members to respect one another’s privacy is important (i.e. do not share members information with people not involved in the group). Also, the leaders should emphasize that violence of any kind (e.g. physical assault or verbal attack) is not acceptable and grounds for dismissal from the group.

The participants should be encouraged to share the actual experiences that have caused distress, how these experiences have impacted their lives and function, and the emotions they have felt as a result. The point of the group is to have members realize that they are not alone and that it is human and natural to experience emotions that can feel negative or painful. The group discussions should also help people develop an awareness of their own strengths and serve as an environment where they are constantly reminded of their strengths. In addition, hearing about ways that others have coped can help individuals increase and enhance their own methods of coping.

When individuals express strong emotions, such as anger, allow them to express openly. Their feelings should be acknowledged.

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Others who can relate to the individual's emotions should share these feelings. In addition, people should be allowed to express their feelings about seeing another express anger. Allowing group members to talk about how they have managed this emotion is important. The methods mentioned by the group that have led to a sense of hope and peace should be emphasized. If there is excessive aggression or potential for abuse – remind the entire group members of the ground rules about violence and aggression.

After a number of sessions (the actual number will vary from group to group) members should have developed an idea about the purpose, structure, and operation of the group. The goal for co-leaders is to transfer this understanding, withdraw ultimately as facilitators, and allow the group to run independently.

Family Support

Family members are often the caretakers of individuals with mental conditions. They may provide the emotional and physical support and may also manage the economic expenses related to mental health treatments and care. Being exposed to distress, family members are vulnerable to becoming distressed. In addition, they may become victims of stigma by association - they may be rejected by others in the community who do not understand mental conditions, leading to a feeling of isolation and limited social activity.

Providing families with specific information and practical methods of support is important. Teaching family members about signs and

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symptoms of a condition, treatments, and what to expect (or not expect) from treatments is necessary. Providing advice on how to structure time and their living environments to reduce stress is helpful. Family members may find it useful to meet with a group of others who share the same situation as a means for emotional support.

Questions Families Commonly Ask:

1. Will he/she recover?
2. Can he/she work?
3. Can he/she live at home?
4. Will he/she have to take medications for life?
5. Can he/she have children?
6. (In conflict and disaster situations) Will this experience (loss, disaster, stressful event) make him/her mentally ill?

The answers to these questions may come from varied clinicians. It is important that the healthcare provider (whether it is a nurse, doctor, or mental health aide) do his or her best to address the questions directly or refer the family to the appropriate resources and providers who can address the questions.

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Community Education

Community education & the stigma of mental illness

People who are different from the norm within a society may experience stigma by others who feel uneasy, embarrassed, or too threatened to talk about behavior they perceive as different. Feelings of shame, disgrace, or rejection can occur in those who are stigmatized.

The stigma surrounding mental illness is strong, has placed a wall of silence around the issue, and can be attributed to misbelief about mental conditions, misconceptions about psychiatric medications, and poor tolerance of the community of people with mental illness. Stigma towards people with a mental illness can have a detrimental effect on their ability to obtain services, their recovery, the type of treatment and support they receive, and their acceptance in the community.

Reducing stigma means empowering those with mental conditions and changing the attitudes of uninformed people in the community. It is important to highlight the individual's positive aspects and his or her capacity to make contributions to the family and society. Encourage the person to take part in the community.

A counselor can be a good model for the community by treating those suffering from mental conditions with empathy, humanity, dignity, and respect and relating to the person, not the illness. Modeling or demonstrating positive communication skills towards the individual when other people are present is a way to teach others how to interact appropriately and respectfully.

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Liaising and building up trusting relationships with the families of those affected, fosters understanding and decreases frustration. Lastly, organizing activities or talks within the community to raise awareness about mental health, illness, and stigma can improve knowledge and tolerance.

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Community Psychosocial Development Through Psychosocial Activities

Communities impacted by significant social stressors (e.g. chronic poverty, social/political conflict, armed conflict, natural disaster) can benefit from interventions aimed to stabilize, maintain, or develop the community's social structure and function. A community's social state is influenced by the psychological and social well-being of its members. Community psychosocial development involves helping communities organize activities, events, and projects (that members engage in as a group) to foster social or relational well-being between individuals and psychological well-being within individuals. Psychosocial activities, events, and projects may serve as the modes or venues to bring members together to understand the facts, identify relevant issues, and devise effective solutions related to significant social stressors. Good psychosocial development of the community depends on the active participation of community members in identifying their priorities and deciding on solutions.

Purpose of psychosocial activities, events, & projects

For communities impacted by significant social stressors, psychosocial activities, events, and projects may play a role in:

- 1) Reestablishing a sense of normalcy;
- 2) Rebuilding social ties between individuals and reestablishing functioning social networks;
- 3) Helping community members gain knowledge and place in perspective the facts associated with the significant social stressors;

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- 4) Helping community members identify the relevant, priority problems and issues related to the social stressor;
- 5) Helping the community develop effective, culture-appropriate interventions to manage the problems and issues;
- 6) Helping members identify and institute culture-appropriate means for generally empowering or increasing the capacity to affect their circumstances, enrich their individual lives, and enrich the structure and function of their communities.

Helping communities organize psychosocial activities, events, & projects

The process of organizing psychosocial activities, events, and projects should stem from the community and will vary from one cultural group to another. Outlined below are a few suggestions on how to facilitate the organizational process:

1. Meet with community members or representatives to assess the interest and desire for psychosocial activities, events, or projects.
2. Provide information on the purpose and potential benefits of organizing psychosocial activities, events, and projects.
3. Identify and collaborate with existing groups, organizations, or individuals who have been playing a role already in addressing the social stressors and organizing supportive activities.
4. Support and respect community members' participation in identifying their priorities and determining solutions considered effective.

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Examples of psychosocial activities, events, & projects fostering community psychosocial development

A variety of modes or venues may be used to foster support and psychosocial development in communities affected by significant social stressors. Modes or venues have included recreational, cultural, educational, and work-related activities (events and projects) that are didactic and creative in nature. Listed below are a few examples:

1. Recreational activities (e.g. sports, games, hobbies).
2. Cultural events (e.g. musical concerts and other artistic performances; art exhibits).
3. Educational projects (e.g. lectures; mobile libraries; academic school quizzes/competitions).
4. Work-related projects (e.g. job training seminars; development of business organizations and networks).

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MEDICATION GUIDE

The guide is intended for use by authorized prescribers only. Medications included in this section are mainly from lists of essential psychotropic medicines recommended by the World Health Organization (WHO) for use in settings where mental health care is limited or nonexistent.

General prescribing principles

1. Prior to prescribing medication be clear about the psychiatric diagnosis and target symptoms.
2. Be aware of underlying medical conditions, alcohol & drug abuse, or drug-drug interactions that may be a factor in the presenting psychiatric symptoms.
3. Be clear about expected side effects, potential drug interactions and potential for dependence.
4. Ask patients about other medications they are taking including self prescribed or herbal remedies and caution them against combining medications or consulting other practitioners without informing the prescriber.
5. Pursue full medication trials with adequate doses and duration of treatment.
6. Monitor side effects.
7. Make efforts to simplify medication regimens to encourage compliance.
8. Avoid poly-pharmacy (multiple or redundant medications).
9. Adjust doses appropriately for special populations such as the elderly and children.
10. Keep records of patient response & side effects throughout the treatment course.

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Psychotropic Medications Included on WHO Model List of Essential Medicines (2011)

Medication for Psychotic Conditions

1. Chlorpromazine (hydrochloride) (*100mg tab; 25mg/5ml syrup; 25mg/ml injection in 2ml ampoule*)
2. Fluphenazine (decanoate or enantate) (*25mg in 2ml ampoule injection*)
3. Haloperidol (*2mg tab, 5mg tab; 5mg in 1ml ampoule injection*)

Medication for Depression

1. Amitriptyline (hydrochloride) (*25mg tab*)
2. Fluoxetine (20mg tabs)

Medication for Bipolar Disorder

1. Carbamazepine (*100mg scored tab; 200mg scored tab*)
2. Lithium carbonate (*300mg tab or capsule*)
3. Valproic acid (*200mg, 500mg [sodium salt] enteric coated tabs*)

Medication for Generalized Anxiety and Insomnia

1. Diazepam (*2mg, 5mg scored tab*)

Medication for Obsessive Compulsive Disorder

1. Clomipramine (*10mg, 25mg capsules*)

Medications Used in Established Substance Dependence Programs

1. Methadone (*5mg/ml, 10mg/5ml oral solutions; 5mg/ml, 10mg/ml oral solutions [hydrochloride]*)

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Medication Therapy for Schizophrenia/Psychotic Conditions

DRUG NAME	DOSING	SIDE EFFECTS	COMMENT
Chlorpromazine	<p>Oral: 10mg tid -qid or 25mg bid-tid. After 1-2 days may increase by 20-50mg twice weekly. Usual dose is 200-600mg daily in divided doses. Maximum dose is 800mg daily in divided doses.</p> <p>IM (for acute agitated psychosis): 25mg & may repeat 25mg-50mg in 1-4 hours if needed. May then gradually increase by 25-50mg q 4-6 hours. Maximum: 400-500mg / day</p>	<p>Sedation; constipation; urinary retention; orthostasis; arrhythmia; may make a seizure more possible in patients with an existing seizure disorder; tardive dyskinesia with long-term use</p>	<p>Low potential for EPS; may also be used in low dose for agitation not responsive to anti-anxiety medications</p>

*Drugs in the shaded boxes are included on the WHO (World Health Organization) Model List of Essential Medicines (2011).

**Atypical antipsychotic—this class is associated with the metabolic syndrome and increased mortality in elderly patients with dementia-related psychosis.

Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions.

Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects.

For an explanation of the abbreviations included in the tables, see the “Medical Abbreviations List” in the front of the manual.

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(Medication therapy for schizophrenia/psychotic conditions continued...)

DRUG NAME	DOSING	SIDE EFFECTS	COMMENT
Fluphenazine (oral)	Starting dose: 2.5mg-10mg/day in divided doses at 6—8 hour intervals. May increase to a maximum 40mg/day in divided doses if necessary. Maintenance dose: 1-5mg/day.	Sedation; EPS; Tardive dyskinesia with long-term use	High potential for EPS. Not indicated for use in children.
Fluphenazine Decanoate (25mg/ml IM long-acting injection)	Initial: 12.5-25mg q 2-4 weeks. Dose may be titrated as high as 50mg IM q 2 - 4 weeks. NOTE: 12.5mg of decanoate q 2-4 weeks=10mg / day of oral	Sedation; EPS; Tardive dyskinesia with long-term use	High potential for EPS; consider use in patients with chronic psychosis who are noncompliant with oral medications. Not indicated for use in children.
Haloperidol (oral tablets & IM 5mg/ml short-acting injection as lactate)	Oral: 0.5-5mg 2-3 times/day. Maximum: 30mg/day. IM injection (lactate) for immediate tranquilization of severe agitation: 5mg q 30-60 minutes to a maximum 10-20mg.	Sedation; EPS; Tardive dyskinesia with long-term use	High potential for EPS; may also be used in low dose for <u>severe agitation</u> not responsive to anti-anxiety medications
Haloperidol Decanoate (50mg/ml long-acting injection)	Initial: 10-20 times daily oral dose q 4 weeks. Maintenance dose is 10-15 times initial oral dose. NOTE: 100mg of decanoate q 4 weeks=10mg/day of oral.	Sedation; EPS; Tardive dyskinesia with long-term use	High potential for EPS; consider use in patients with chronic psychosis who are non-compliant with oral medication. Not indicated for use in children.

*Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011). Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual.

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(Medication therapy for schizophrenia/psychotic conditions continued...)

DRUG NAME	DOSING	SIDE EFFECTS	COMMENT
Perphenazine	Less severe symptoms: 4-8mg, 3 times/day (Maximum: 24 mg/day) Severe symptoms: 8-16mg 2-4 times/day (maximum: 64mg/day).	Sedation; dry mouth; tachycardia; hypotension; moderate EPS; seizure	Moderate potential for EPS
**Risperidone (oral)	Initial: 2mg/day in 1-2 divided doses; may be increased by 1-2mg/ day up to a maximum 6mg/day in divided doses.	Sedation; EPS; Tardive dyskinesia with long-term use	Less potential for EPS than haloperidol but EPS risk increased at doses > 4mg daily

*Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

**Atypical antipsychotic—this class is associated with the metabolic syndrome and increased mortality in elderly patients with dementia-related psychosis.

Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions.

Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects.

For an explanation of the abbreviations included in the tables, see the “Medical Abbreviations List” in the front of the manual.

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While medications from the WHO Model List of Essential Medicines (in addition to a few drugs with different properties) have been presented previously, several other antipsychotic medications have been developed and utilized for the treatment of psychotic conditions (e.g. schizophrenia). These medications are listed in the table below.

Other Antipsychotic Medications

Medication Class	Typical (low potency)	Typical (high potency)	Atypical
Drug Name	Prochlorperazine Trifluoperazine	Droperidol Loxapine Pimozide Thiothixene	Aripiprazole Asenapine Clozapine Iloperidone Lurasidone Olanzapine Paliperidone Quetiapine Ziprasidone

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Special notes regarding antipsychotic medications

- 1) Remission of chronic, severe psychotic symptoms may require at least 4-6 weeks of antipsychotic medication therapy.
- 2) EPS = extra-pyramidal symptoms (tremor; akathisia or a subjective sense of physical restlessness; muscular stiffness or "cogwheel" rigidity; shuffling walking pattern; stooped posture; drooling or uncontrolled seepage of saliva from the mouth). Observation (e.g. viewing for tremors, drooling, stooped posture, and a shuffling walking pattern) and physical examination (e.g. flexing the elbow joints and feeling the arm muscles for tightness or rigidity) are ways to detect symptoms. Studies (western research) indicate that EPS is more common with high potency typical antipsychotics (e.g. haloperidol and fluphenazine) than with low potency antipsychotics (e.g. phenothiazines such as chlorpromazine). High doses of antipsychotic medication are associated with an increased risk for EPS. Western studies (United States) have found that symptoms are more common in men under the age of 35 who have muscular body types. EPS typically occur within the first 4 weeks of antipsychotic use and are reversible with discontinuation of the drug. Symptoms may disappear within days to months after antipsychotic medication has been stopped. If a patient needs to remain on medication to control severe psychotic symptoms, EPS may be reduced with anticholinergic medicines such as trihexyphenidyl or diphenhydramine and, for akathisia specifically, propanolol and benzodiazepines (i.e. diazepam, lorazepam, and clonazepam).

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- 3) Tardive dyskinesia = involuntary, jerking or twisting motion of muscles (usually head, limbs, or trunk); Tardive dyskinesia is irreversible and antipsychotic medication should be immediately discontinued if symptoms occur.
- 4) Neuroleptic malignant syndrome (NMS) = can occur due to antipsychotic medication especially in those with underlying medical illness. Symptoms include muscle rigidity; inability to move; mutism; unstable blood pressure or heart rate; extremely high temperature; sweating & agitation. This condition is life-threatening therefore medication must be discontinued immediately and emergent medical assistance must be sought.
- 5) Metabolic Syndrome = abnormalities in glucose metabolism, lipid metabolism, body weight/fat distribution, and blood pressure generally associated with schizophrenia and atypical antipsychotic medications. Patients treated with atypical antipsychotics should be monitored for these conditions.

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Drugs to treat extra-pyramidal symptoms caused by antipsychotic medications

DRUG NAME	DOSING	SIDE EFFECTS & CONTRAINdications
Amantadine	100mg po twice daily; may increase to a maximum 300mg daily in divided doses if necessary.	Nausea; headache; orthostasis; insomnia; ataxia; anxiety; depression; hallucinations; delirium
Benztropine	1-2mg po bid – tid depending on severity of EPS. When EPS remits discontinue.	Dry mouth; constipation; blurred vision; urinary retention; hyperthermia; euphoria; delirium
Biperiden	2mg po daily—2mg po tid	Blurred vision; bradycardia; constipation; disorientation; drowsiness; dry mouth; euphoria; hypotension; orthostatic hypotension; sleep disturbance; urinary retention
Diphenhydramine	25-100mg po daily; may be increased by 25-50mg daily to 100mg/day	Sedation; dry mouth
Trihexyphenidyl	1mg po daily; safe to increase dose to up to 5-15mg/day in 3-4 divided doses.	Dry mouth; constipation; blurred vision; urinary retention; hyperthermia; euphoria; delirium

Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual. Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

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Medication Therapy For Depression

Antidepressant medications

Varied classes of antidepressant medication have been shown to be effective for symptoms of depression. Each class acts differently on neuro-chemical receptors (e.g. serotonin, norepinephrine, dopamine) in the brain to yield effects. The classes of antidepressant medications commonly used include:

Alpha-2 antagonists (atypical)

Dopamine reuptake inhibitors (atypical)

MAOI (monoamine oxidase inhibitors)

SNRI (selective norepinephrine reuptake inhibitors)

SSRI (selective serotonin reuptake inhibitor)

Tetracyclics (act on varied receptors)

Tricyclics (act on varied receptors)

SSRI, SNRI, and atypicals are newer than tetracyclic and tricyclic antidepressants and are associated with fewer side effects and less lethality if taken in overdose.

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NOTES FOR ALL ANTIDEPRESSANT MEDICATIONS LISTED IN THIS SECTION:

1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) Studies in the United States have indicated that antidepressants may increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults age 18-24 with major depressive disorder. A number of agents are not approved in the United States for use in the pediatric population. 4) For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual. Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

Antidepressant Medication	DOSING	SIDE EFFECTS	COMMENT
AMITRIPTYLINE (tricyclic) *blood level monitoring is required	50—150mg/day either as a single dose or in divided doses. May be gradually increased up to 300mg/day (divided doses). Check blood level every 1-4 weeks; <i>If blood test is not available, monitor for symptoms of toxicity and adjust accordingly.</i> Requires therapeutic blood level monitoring. Therapeutic blood level should be between 100-250ng/ml)	Sedation; arrhythmia; constipation; urinary retention; may make a seizure more possible in patients with an existing seizure disorder	*If blood test is not available, monitor for symptoms of toxicity (flu; fever; muscle/joint aches; nausea or vomiting; abnormal HR; delirium)

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(Antidepressant medications continued...)

Antidepressant	DOSING	EFFECTIVE - MAXIMUM DOSE RANGE	SIDE EFFECTS	COMMENT
BUPROPION (dopamine-reuptake inhibitor)	Immediate Release (IR): 100mg bid; after 4 days can increase to 100mg tid. Sustained Release (SR): 150mg qam for 4 days then 150mg q am & q afternoon. Extended Release (XL)=150 mg/day for 4 days then increase to 300mg/day.	IR= 300-450mg (divided doses) SR =300 - 400mg/day (divided doses) XL = 300 - 450 mg /day	seizure risk is increased with history of bulimia	<i>May be especially useful for depression that includes poor energy as a symptom due to its activating potential</i>
FLUOXETINE (SSRI)	20mg every morning (due to stimulating effect); Lower doses of 5-10mg/day have been used as a starting dose. May increase after several weeks (by 20mg/day increments). Doses>20mg/day may be given in bid doses (i.e. morning & afternoon) or as a single morning dose.	20-80mg Daily	Insomnia or agitation due to stimulating effect	<i>May be especially useful for depression that includes poor energy as a symptom due to its activating potential</i>
SERTRALINE (SSRI)	25-50mg daily; safe to increase dose by 25-50mg every 7 days to 100mg.	50-200mg daily	Gastrointestinal distress; delayed ejaculation	

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While medications from the WHO Model List of Essential Medicines (in addition to a few drugs with different properties) have been presented previously, there are several other antidepressant medications that have been developed and utilized for the treatment of major depression. These medications are listed in the table below.

Other Antidepressant Medications

Medication Class	Drug Name
Alpha-2 Antagonist	Mirtazapine
Monoamine oxidase Inhibitor (MAOI)	Phenelzine selegiline Tranlcypromine
Selective Serotonin Reuptake Inhibitor (SSRI)	Citalopram Escitalopram Fluvoxamine Paroxetine Vilazodone (5HT1A partial agonist)
Serotonin/Norepinephrine Reuptake Inhibitor (SNRI)	Desvenlafaxine Duloxetine Venlafaxine
Tetracyclic	Maprotiline
Tricyclic	Amoxapine Clomipramine Desipramine Doxepin Imipramine Nortriptyline Protriptyline

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Medication Therapy for Mania/Bipolar Disorder

Lithium, anticonvulsants (e.g. carbamezapine, lamotrigine, oxcarbazepine, topiramate, valproate) and atypical antipsychotic medications (e.g. aripiprazole, olanzapine, risperidone, ziprasidone) have been used to manage manic symptoms. A combination of an antidepressant (to stabilize depressive symptoms) and an anti-manic medication (to stabilize manic symptoms) may be used concomitantly for treatment of bipolar disorder. An anti-psychotic medication may be added if psychotic symptoms are present.

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Medications for bipolar disorder

DRUG NAME	DOSING	SIDE EFFECTS	INDICATION & COMMENTS
Carbamazepine (blood level monitoring is required)	Tablets/capsules: 400mg/day in divided doses (e.g. 200mg tabs bid). Oral suspension: 400mg/day in 4 divided doses (e.g. 100mg qid). May adjust by 200mg/day increments. Maximum dose = 1600mg/day. Monitor blood levels (therapeutic range = 4-12mcg/mL).	Dizziness; stomach upset; ataxia; Rarely causes liver disease or skin rash; rarely depression of red and white blood cells causing anemia/agranulocytosis/susceptibility to infections	Stabilizes manic phase of bipolar I & mixed bipolar disorder; Normally white blood cell levels are monitored but if no test available, monitor for symptoms of toxicity (flu; fever; weakness; muscle/joint aches; nausea or vomiting; abnormal HR; delirium)

DRUG NAME	DOSING	SIDE EFFECTS	INDICATION & COMMENTS
Lithium Carbonate (blood level monitoring is required)	For acute mania: 600mg tid to achieve effective levels of 1-1.5mEq/L; monitor levels twice weekly until stabilized. Maintenance: 300mg tid -qid to maintain serum levels of 0.6-1.2 mEq/L. Then monitor levels every 1-3 months.	Thirst; increased urination; tremor; weight gain	Stabilizes manic episodes and is maintenance treatment of bipolar disorder; If serum test is not available monitor for evidence of toxicity (ataxia; dysarthria irritability; vomiting; confusion/delirium; stupor; seizure)

Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011). Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual.

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(Medications for bipolar disorder continued)

DRUG NAME	DOSING	SIDE EFFECTS	INDICATION/ COMMENTS
**Risperidone (oral)	Initial: 2-3mg daily; may increase dose by 1mg /day to a maximum of 6mg daily.	Sedation; EPS; Tardive dyskinesia with long-term use	Stabilizes acute manic phases or mixed episodes of bipolar disorder ; Less potential for EPS than haloperidol but EPS risk increased at doses > 4mg/day
Valproic Acid (blood level monitoring is required)	750mg/day in divided doses; increase dose rapidly to desired clinical effect. Maximum dose: 60mg/kg/day. Blood level should be monitored (therapeutic level= 50-125mcg/mL).	Gastro-intestinal distress; sedation; tremor; ataxia; hepatic toxicity	Stabilizes manic phases of bipolar disorder

Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011). Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual.

***Atypical antipsychotic—this class is associated with the metabolic syndrome and increased mortality in elderly patients with dementia-related psychosis.*

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While medications from the WHO Model List of Essential Medicines (in addition to a few drugs with different properties) have been presented previously, other anti-manic and mood-stabilizing medications have been developed and utilized for the treatment of mania and bipolar disorder. These medications are listed below.

Other Anti-manic Medications

Medication Class	Anti-manic/ Atypical Antipsy- chotic	Anti-manic/ Anticonvulsant
Drug Name	Asenapine Olanzapine	Divalproex

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Medication Therapy for Anxiety-Related Conditions, Post-Traumatic Stress Disorder (PTSD), & Obsessive-Compulsive Disorder (OCD)

General

- a) The benzodiazepine class of medication is commonly used for anxiety but caution should be used in prescribing since tolerance, dependence, and serious withdrawal may occur. Use of the benzodiazepines in short-term is usually recommended.
- b) For chronic anxiety conditions (e.g. panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress, social anxiety disorder) other agents such as SSRIs (selective serotonin reuptake inhibitors – e.g. fluoxetine, paroxetine, sertraline, citalopram, escitalopram), SNRIs (selective norepinephrine reuptake inhibitors – e.g. duloxetine, venlafaxine), buspirone, and tricyclics (clomipramine) have been effective.

NOTES FOR MEDICATIONS IN THIS SECTION:

1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) Studies in the United States have indicated that antidepressants may increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults age 18-24 with major depressive disorder (DSM IV criteria). A number of agents are not approved in the United States for use in the pediatric population. 4) For an explanation of the abbreviations included in the tables, see the "Medical Abbreviations List" in the front of the manual. Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

DRUG NAME	INDICATIONS	DOSING	SIDE EFFECTS	COMMENTS
CLOMIPRAMINE	Obsessive — Compulsive Disorder (OCD)	Initial: 25mg /day; may gradually increase as tolerated over the first 2 weeks to 100mg in divided doses. Maintenance: May further increase to recommended maximum of 250mg/day; may give as a single daily dose once tolerated.	Dry mouth, constipation, nausea,, increased appetite, weight gain, dizziness, nervousness.	No addiction potential; <i>Studies in the United States have indicated that antidepressants may increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults age 18-24 with major depressive disorder.</i>

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(Medication therapy for anxiety-related conditions continued...)

DRUG NAME	INDICATIONS	DOSING	SIDE EFFECTS	COMMENTS
DIAZEPAM	Intermittent anxiety; generalized anxiety disorder (GAD)	Oral tab or IM injection: 2–10mg 2–4 times daily as needed	Sedation; respiratory depression; delirium	Onset in 20–30minutes; Long-acting; Has addiction potential
FLUOXETINE	Obsessive compulsive disorder (OCD); Panic disorder; post-traumatic stress disorder (PTSD); social anxiety disorder	OCD: Initial: 20mg/day; may increase after many weeks to 20–60mg/day (maximum 80mg/day). <u>Panic disorder:</u> Initial 10mg/day; after 1 week increase to 20mg/day; after many weeks, may continue to increase if necessary (to a maximum 60mg/day). <u>PTSD:</u> 20mg/day; if necessary may increase after many weeks to maximum 40mg/day. <u>Social anxiety disorder:</u> 20mg/day; if necessary, may increase after many weeks to a maximum 40mg/day.	Insomnia or agitation due to stimulating effect	No addiction potential; <i>Studies in the United States have indicated that antidepressants may increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults age 18–24 with major depressive disorder.</i>
PAROXETINE	Generalized anxiety disorder (GAD); Obsessive compulsive disorder; panic disorder (OCD); Post traumatic stress disorder (PTSD); Social anxiety disorder	Generalized anxiety disorder: start 20mg qam; may increase weekly by 10mg qam (maximum=50mg qam but >20mg/day may not have additional benefit) <u>OCD:</u> start 20mg qam; may increase weekly by 10mg qam to 40mg qam (maximum=60mg qam). <u>Panic disorder:</u> start 10mg qam; may increase weekly by 10mg qam to 40mg qam (maximum=60mg/day). <u>PTSD:</u> start 20mg qam; may increase weekly by 10mg qam (maximum=50mg qam but >20mg/day may not have additional benefit). <u>Social anxiety disorder:</u> start 20mg qam; may increase weekly by 10mg qam (maximum=60mg qam but >20mg/day may not have additional benefit). For all disorders reduce gradually upon discontinuation.	Agitation if discontinued abruptly; gastrointestinal distress; delayed ejaculation	No addiction potential; <i>Studies in the United States have indicated that antidepressants may increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults age 18–24 with major depressive disorder.</i>

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Medication Therapy for Epilepsy

DRUG NAME	DOSING	SIDE EFFECTS	INDICATION & COMMENTS
Carbamazepine (blood level monitoring is required)	Initial (tablets): 400mg/day in 2 divided doses. Increase by up to 200mg/day in 3-4 divided doses until optimal response and therapeutic levels are achieved. Usual dose = 800-1200mg/day. Maximum dose = 1600mg/day. Therapeutic serum level = 4-12 mcg/mL	dizziness; stomach upset; Rarely causes liver disease or skin rash; rarely depression of red and white blood cells causing anemia or susceptibility to infections; Normally white blood cell levels are monitored but if no test available, monitor for symptoms of toxicity (flu; fever; weakness; muscle/joint aches; nausea or vomiting; abnormal HR; delirium)	Tonic-Clonic; partial (focal)
Clonazepam	Initial daily dose not to exceed 1.5mg given in 3 divided doses; may increase by 0.5-1mg every 3rd day until seizures are controlled or side effects observed. Maintenance: 0.05-0.2mg/kg; do not exceed 20mg/day.	Sedation; ataxia; confusion; respiratory depression	For absence seizure, myoclonic seizures, infantile spasms, & childhood epilepsies. There is addiction potential with this drug.
Diazepam (Rectal gel)	Acute anticonvulsant treatment: 0.2mg/kg; may be repeated in 4-12 hours if needed. Do not use for more than 5 episodes per month or more than 1 episode every 5 days.		Acute anticonvulsant treatment

NOTES: 1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) For an explanation of the abbreviations included in the table, see the "Medical Abbreviations List" in the front of the manual. 4) Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

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(Medication Therapy for Epilepsy continued...)

DRUG NAME	DOSING	SIDE EFFECTS	INDICATION & COMMENTS
Phenobarbitol (blood level monitoring is required)	60-180mg daily. Therapeutic range = 10-40mcg/mL	Sedation; ataxia; confusion; dizziness; depression; skin rash	Tonic-clonic; partial (focal); has addiction potential
Phenytoin (blood level monitoring is required)	Initial: 100mg tid. May increase at 7–10 day intervals. Maximum: 200mg tid. Therapeutic blood level = 10-20mcg/mL	Potential toxicity; Normally blood levels are monitored due to toxicity potential but if no test available, monitor for symptoms of toxicity (flu; fever; weakness; muscle/joint aches; nausea or vomiting; abnormal HR; delirium)	Tonic-clonic; complex partial (focal)
Valproic Acid (blood level monitoring is required)	Absence: 1.5mg/kg/day; increase 5-10mg/kg/day at weekly intervals until therapeutic level reached. Max=60mg/kg/day. Complex partial: 10-15mg/kg/day; increase 5-10mg/kg/day at weekly intervals until therapeutic level reached. Max=60mg/kg/day. Therapeutic blood level = 50-125mcg/mL	Sedation; gastrointestinal distress; tremor; hepatic toxicity	Absence seizures; complex partial (focal); also myoclonic seizure

NOTES: 1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) For an explanation of the abbreviations included in the table, see the "Medical Abbreviations List" in the front of the manual. 4) Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (revised March 2011).

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Medication Therapy For Sleep Disturbance

- 1) Every effort to correct a sleep disturbance utilizing good sleep hygiene should be attempted first prior to prescribing sedative medication. Secondary conditions contributing to the sleep disturbance need to be addressed and stabilized prior to prescribing medication.

- 2) See the table on the following page for specific medications that can be helpful for insomnia. In general, non-habit forming (non-addictive) medications should be tried first and medications should be prescribed in limited quantities on a prn or “as needed” basis.

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Medications for Sleep Disturbance

SLEEP MEDICATION	DOSING	SIDE EFFECTS	COMMENT
DIAZEPAM	2-10mg at bedtime as needed.	Sedation; respiratory depression; delirium	Onset in 20-30minutes; Long-acting; Has addiction potential
DIPHENHYDRAMINE	50mg at bedtime as needed.	Sedation; dry mouth	No addiction potential
LORAZEPAM	1-2mg at bedtime as needed. Maximum = 4mg at bedtime.	Sedation; respiratory depression; delirium	Onset in 20-30 minutes; short-acting; Has addiction potential
TRAZODONE	25-50mg at bedtime. Maximum = 200mg at bedtime.	Sedation; arrhythmia; constipation; urinary retention	No addiction potential

NOTES: 1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) For an explanation of the abbreviations included in the table, see the "Medical Abbreviations List" in the front of the manual. 4) Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

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Medications For Agitation: Benzodiazepines

NOTES:

1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions. 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) For an explanation of the abbreviations included in the table, see the "Medical Abbreviations List" in the front of the manual. 4) Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

DRUG NAME	DOSING	SIDE EFFECTS	COMMENT
DIAZEPAM	Oral: 5-10mg q 30-60 minutes until effective. Maximum=40mg/day. IM (moderate agitation): 2-5mg and may repeat if needed in 3-4 hours. IM (severe): 5-10mg and may repeat if needed in 3-4 hours.	Sedation; respiratory depression; delirium	Onset in 20-30minutes; Long-acting; Has addiction potential
LORAZEPAM	Oral or IM: 1-2mg q 30-60 minutes as needed to achieve calm. Maximum: 4mg/day.	Sedation; respiratory depression; delirium	Onset in 20-30 minutes; short-acting; Has addiction potential

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Medications For Severe Agitation: Low Dose Antipsychotics

NOTES: 1) Only common side effects are noted. Prescribers should check the medication literature for all potential side effects and drug interactions; 2) Children, the elderly, adults with small body composition, and individuals with medical illness or nutritional deficiencies may require smaller initial & maintenance doses for effect and may be more susceptible to side effects. 3) For an explanation of the abbreviations included in the table, see the "Medical Abbreviations List" in the front of the manual. 4) Drugs in the shaded boxes are included on the WHO Model List of Essential Medicines (2011).

DRUG NAME	DOSING	SIDE EFFECTS	COMMENT
Chlorpromazine (oral or IM Injection) <i>FOR SEVERE, ACUTE AGITATION that is <u>not</u> responsive to other anti-anxiety medications</i>	Oral: 25mg tid. IM: 25mg & may repeat 25mg-50mg in 1-4 hours if needed. May then gradually increase by 25-50mg q 4-6 hours. Maximum: 400-500mg /day	Sedation; constipation; urinary retention; orthostasis; arrhythmia; May make a seizure more possible in patients with an existing seizure disorder; Tardive dyskinesia with long-term use	Low potential for EPS
Haloperidol (oral or IM) <i>FOR SEVERE, ACUTE AGITATION that is <u>not responding</u> to other anti-anxiety medications</i>	Oral: 0.5-5mg 2-3 times/day. Maximum: 30mg/day. IM injection (lactate) for immediate tranquilization of severe agitation: 5mg q 30-60 minutes to a maximum 10-20mg.	Sedation; EPS; Tardive dyskinesia with long-term use	High potential for EPS

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In communities where little or no mental health care exists, people with mental conditions are at risk for increased illness, stigma, and abuse. Their fundamental right to mental health and happiness can be compromised. In *Mental Health Care in Settings Where Mental Health Resources Are Limited*, author Pamela Smith MD presents a handbook for community and hospital-based health providers who work in remote or impoverished areas in developed and developing countries.

Designed to be used as a concise, easy-reference source, it provides an outline of core concepts and basic interventions in mental health care. This guide addresses conditions such as depression, bipolar disorder, schizophrenia, anxiety disorders, post-traumatic stress disorder, obsessive-compulsive disorder, substance abuse, dementia, child and adolescent issues, violence, and HIV/AIDS and mental health. Smith also provides insights on the recent state of mental health care worldwide and the means for increasing access to care in resource-limited areas.

Mental Health Care in Settings Where Mental Health Resources Are Limited communicates how providing mental health care training to health workers and raising awareness among other individuals within these challenged communities serves as a significant means not only to improving access to care but also to preserving human rights and dignity.

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