mhGAP Intervention Guide

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

Version 2.0

World Health Organization

Mental Health Gap Action Programme

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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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mhGAP-IG 2.0 » Acknowledgements

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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/mhgap/evidence/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 back-ground 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, supervi-sion 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**

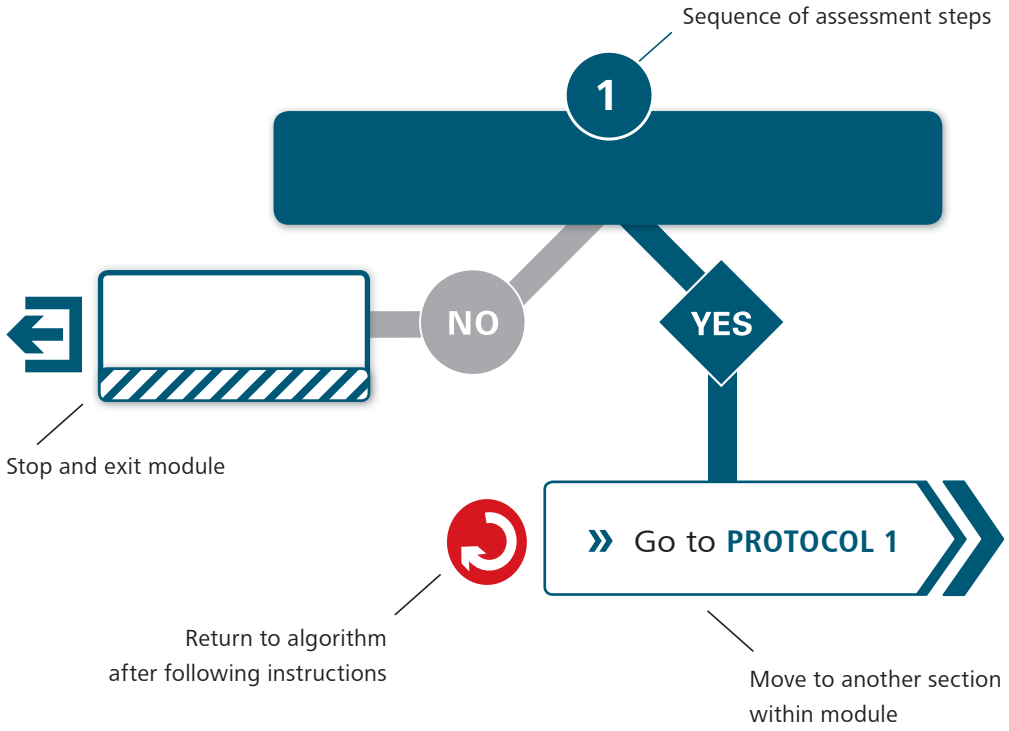
The Assessment section is presented in a framework of flowcharts with multiple clinical assessment points. Each module starts with common presentations of the suspected condition, from which there are a series of clinical assess-ment questions one should move down answering yes or no, which directs the 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



Assessment

Management

Follow-up

Refer to hospital

Medication

Psychosocial intervention

Consult specialist

Children / adolescents

Women who are of child-bearing age, pregnant or breastfeeding

Adult

Older adult

CAUTION

Do not

Further information

CLINICAL TIP

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.

Example of Intervention	Recommended for
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

World Health Organization

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
- 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)

- 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

DISORDERS DUE TO SUBSTANCE USE (SUB)

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

- 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
- 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)

SELF-HARM/SUICIDE (SUI)

- 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

EMERGENCY Presentations of Priority MNS Conditions

EMERGENCY PRESENTATION	CONDITION TO CONSIDER	GO TO
» Act of self-harm with signs of poisoning or intoxication, bleeding from self-inflicted wound, loss of consciousness and/or extreme lethargy	MEDICALLY SERIOUS ACT OF SELF-HARM	SUI
» 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	IMMINENT RISK OF SELF-HARM/SUICIDE	
» Acute convulsion with loss of consciousness or impaired consciousness	EPILEPSY	EPI, SUB
» Continuous convulsions	STATUS EPILEPTICUS	
	ALCOHOL OR OTHER SEDATIVE WITHDRAWAL	
» Agitated and/or aggressive behaviour		DEM, PSY, SUB
» Smell of alcohol on the breath, slurred speech, uninhibited behaviour; disturbance in the level of consciousness, cognition, perception, affect or behaviour	ACUTE ALCOHOL INTOXICATION	SUB
» Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea, anxiety; seizure and confusion in severe cases	ALCOHOL WITHDRAWAL ALCOHOL WITHDRAWAL DELIRIUM	
» Unresponsive or minimally responsive, slow respiratory rate, pinpoint pupils	SEDATIVE OVERDOSE OR INTOXICATION	
» 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	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**

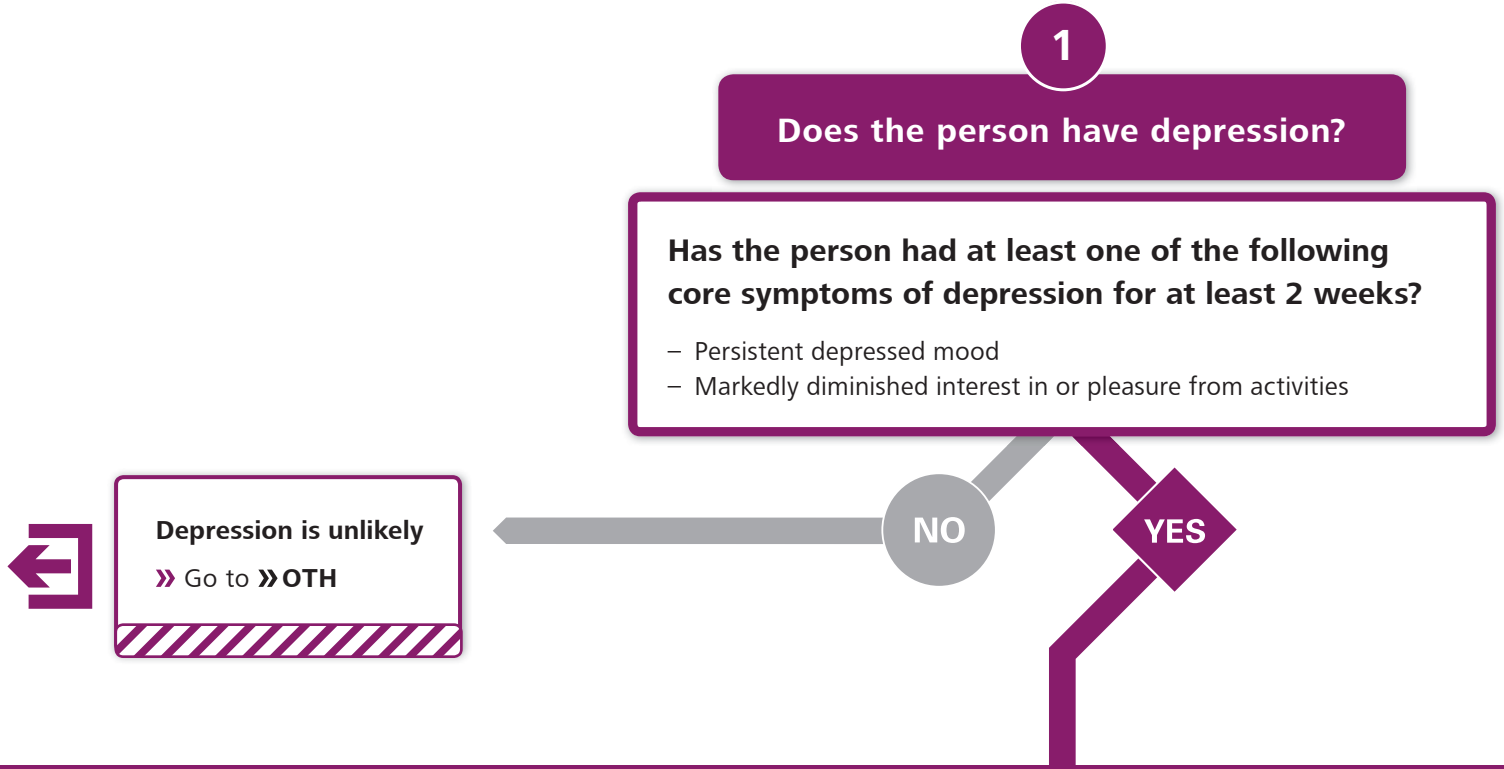
» **Pharmacological Interventions**

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*



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

Depression is unlikely

» Go to **»OTH**

YES

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

NO

Depression is unlikely

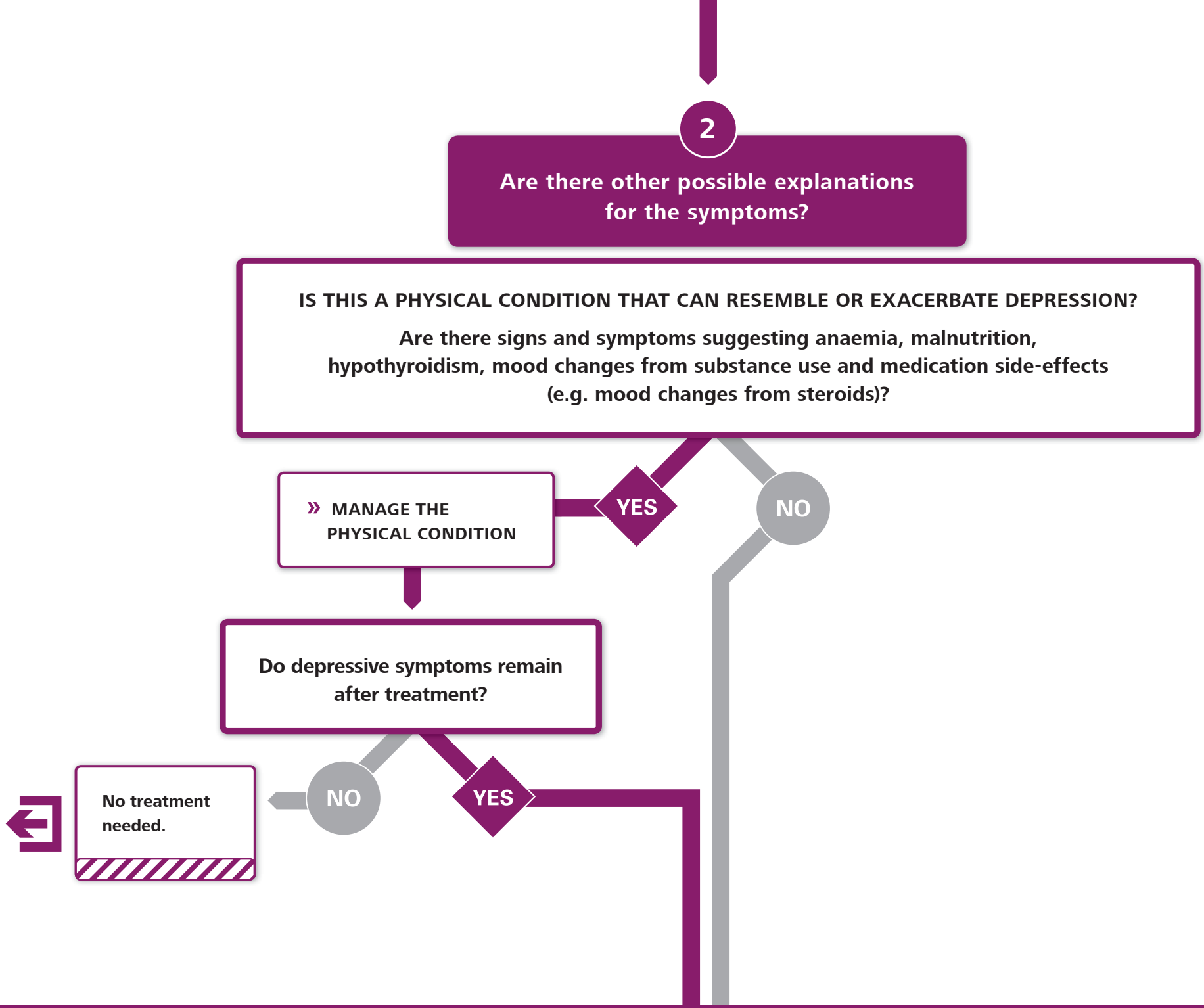
» Go to **»OTH**

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)?
YES
NO
» MANAGE THE PHYSICAL CONDITION
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

NO

YES

Does the person have a previous history of depression?

NO

YES

DEPRESSION is likely

Do not manage for depression.

» Go to **»OTH**

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 anti-depressants 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 anti-depressants if possible, especially during the first trimester.

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

DEP 3 » Follow-up

1

ASSESS FOR IMPROVEMENT

Is the person improving?

NO

- **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.

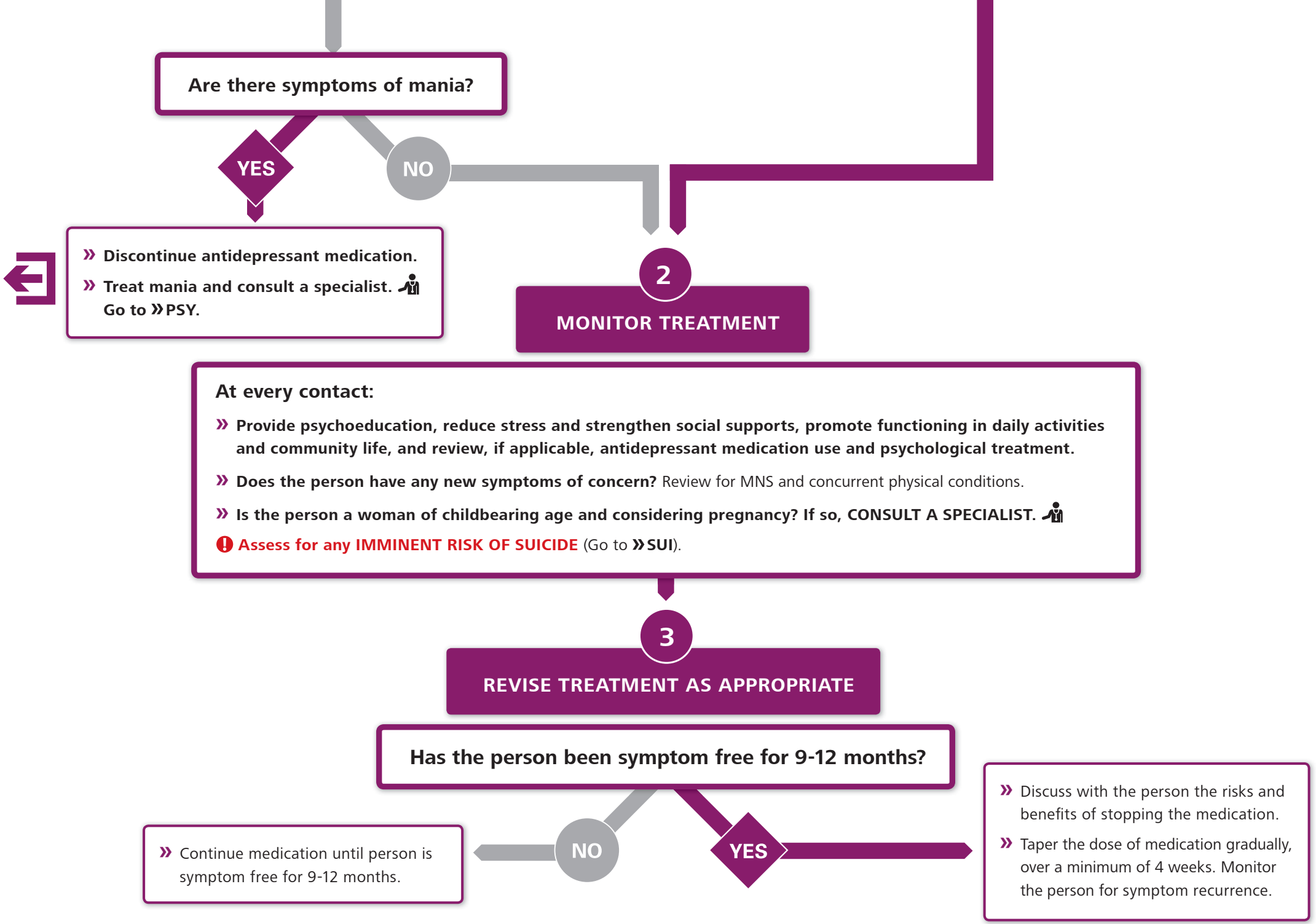
YES

- 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.

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.


Are there symptoms of mania?
YES
NO
» Discontinue antidepressant medication.
» Treat mania and consult a specialist. Go to »PSY.
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.

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?

YES

» **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**

NO

» **EVALUATE FOR DEMENTIA, DEPRESSION, DRUG/ ALCOHOL INTOXICATION OR WITHDRAWAL.**

YES

» **Consider consultation with a mental health specialist for management of concurrent conditions.**

» Manage concurrent conditions. Go to relevant modules.

NO

MANAGEMENT OF ACUTE AGITATION AND/OR AGRESSION

If the person presents with either acute agitation and/or acute agression

» Go to "Management of persons with agitated and/or aggressive behaviour" (**Table 5**) in this module before continuing.

2

Is the person having an acute manic episode?

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 confinement or hospitalization:

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

NO

YES

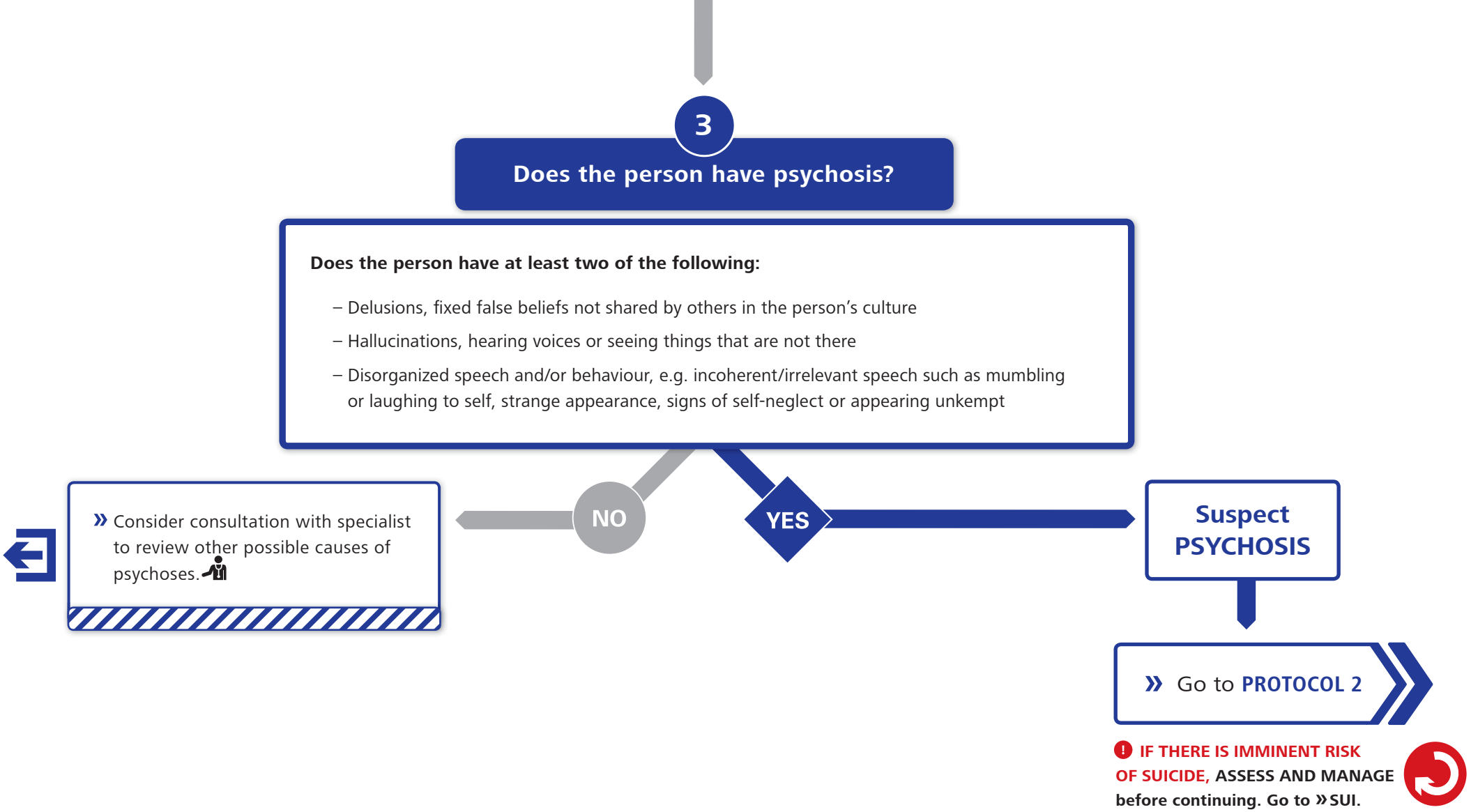
Suspect BIPOLAR DISORDER Manic Episode

CLINICAL TIP Persons with bipolar disorder can experience manic episodes only or a combination of manic and depressive episodes in their lifetime.

» To learn how to assess and manage depressive episode of bipolar disorder, go to **» DEP.**

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

» Go to **PROTOCOL 1**


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
» Consider consultation with specialist to review other possible causes of psychoses.
YES
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** 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, chloropromazine 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:** – 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:** – 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. *6 months on medication is needed to determine full effectiveness of maintenance treatment.*	**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	» 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	» 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	» 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

1

ASSESS FOR IMPROVEMENT

Is the person improving?

YES

- » Continue with treatment plan.
- » Decrease frequency of follow-up once symptoms have subsided.
- » Follow-up as needed.

SKIP to **STEP 2**

NO

Is the person taking medication?

YES

- » **Ensure that person has been on a typical effective dose for minimum of 4-6 weeks.**
- » Maintain a high frequency of contact until symptoms start to respond to treatment.
- » Involve the person and carers in treatment plan changes and decisions.

NO

- » **START ANTIPSYCHOTIC MEDICATIONS** (Go to **Table 1**).
- » Maintain a high frequency of contact until symptoms start to respond to treatment.
- » Involve the person and carers in treatment plan changes and decisions.

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

1 ASSESS FOR IMPROVEMENT

Is the person improving?

YES

- » Follow-up as needed until symptoms have subsided.
- » Continue maintenance medications for at least 2 years.

SKIP to **STEP 2**

NO

Is the person taking medication?

YES

- » Check dosing and side effects. Go to **Table 1 or Table 3**.
- » Ensure that person has been on a typical effective dose of medication for a **minimum of four to six weeks**.
- » If on typical effective dose of medications for four to six weeks with no improvement, consider switching medication. See **Table 3**.
- » If response is still poor, consult a specialist.

NO

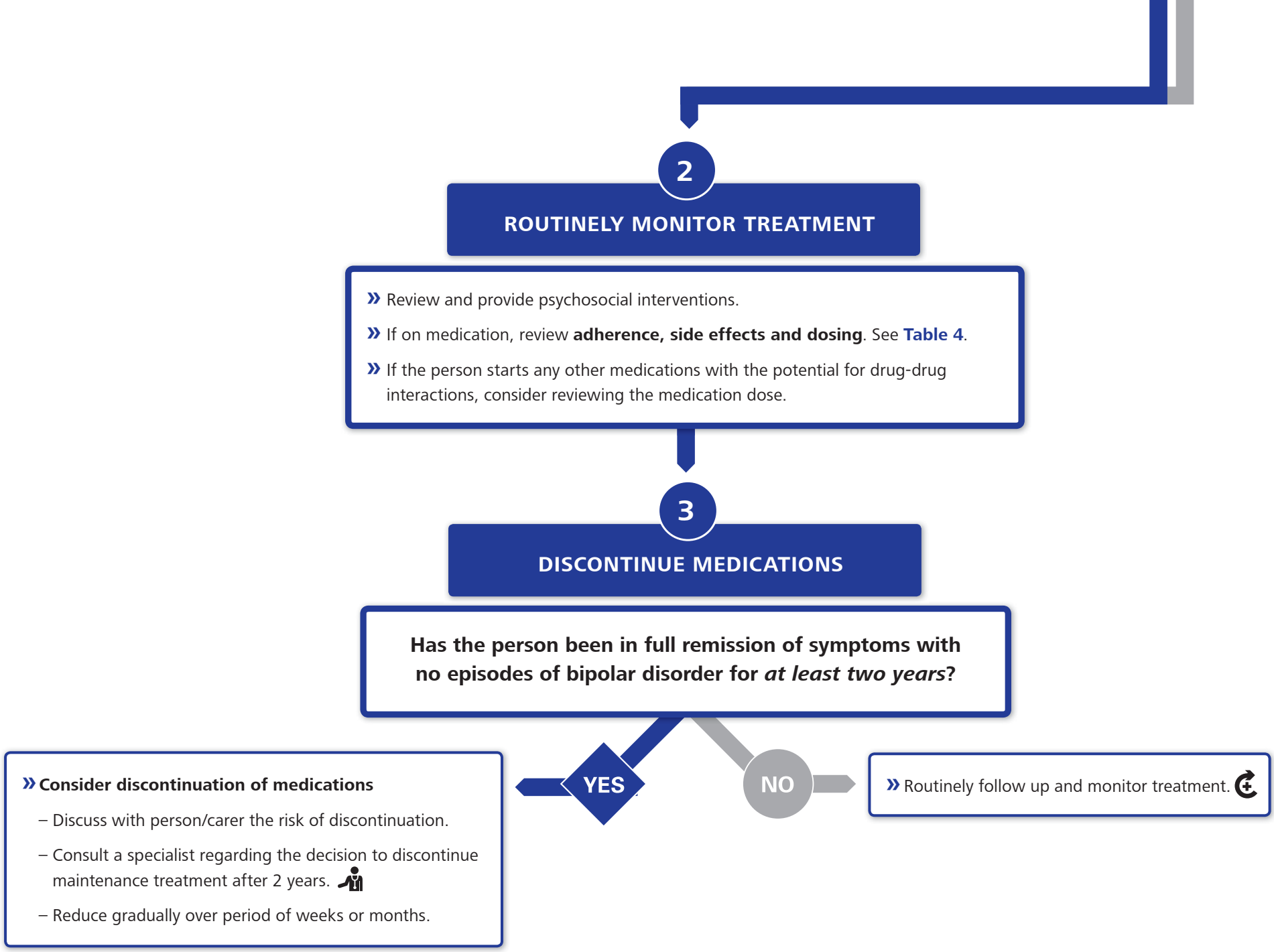
- » **If appropriate, initiate medication.**
- » Review psychosocial interventions.
- » Evaluate for medical problems.

CLINICAL TIP

If switching to another medication, begin that medication first and treat with both medications for 2 weeks before tapering off the first medication.

RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » For acute mania: Initial follow-up should be as frequent as possible, even daily, until acute symptoms respond to treatment. Once symptoms respond, monthly to quarterly follow-up is recommended.
- » For persons not currently in manic or depressed states, follow-up at least every three months. Consider more frequent follow up when needed. Monitor closely for relapse.


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*?
YES
NO
» **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.
» 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

» **KEEP HEAD AND NECK STABLE**

2

- » **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**

3 ! SPECIAL POPULATION: Pregnancy/Post-partum

Is the woman in the second half of pregnancy OR up to 1 week post partum AND has no past history of epilepsy?

YES

SUSPECT ECLAMPSIA

- » Give **magnesium sulphate** 10 g intramuscular (i.m.)
- » If diastolic **blood pressure >110 mmHg**, give **hydralazine** 5 mg i.v. slowly (3-4 min). *Repeat every 30 min until ≤ 90 mmHg;* *Do not give more than 20 mg total*
- » **REFER URGENTLY TO HOSPITAL**

NO

4

» GIVE MEDICATION TO STOP CONVULSIONS

IF NO I.V. ESTABLISHED

Give:

- » **diazepam** rectally (adult 10 mg, child 1 mg/year of age)

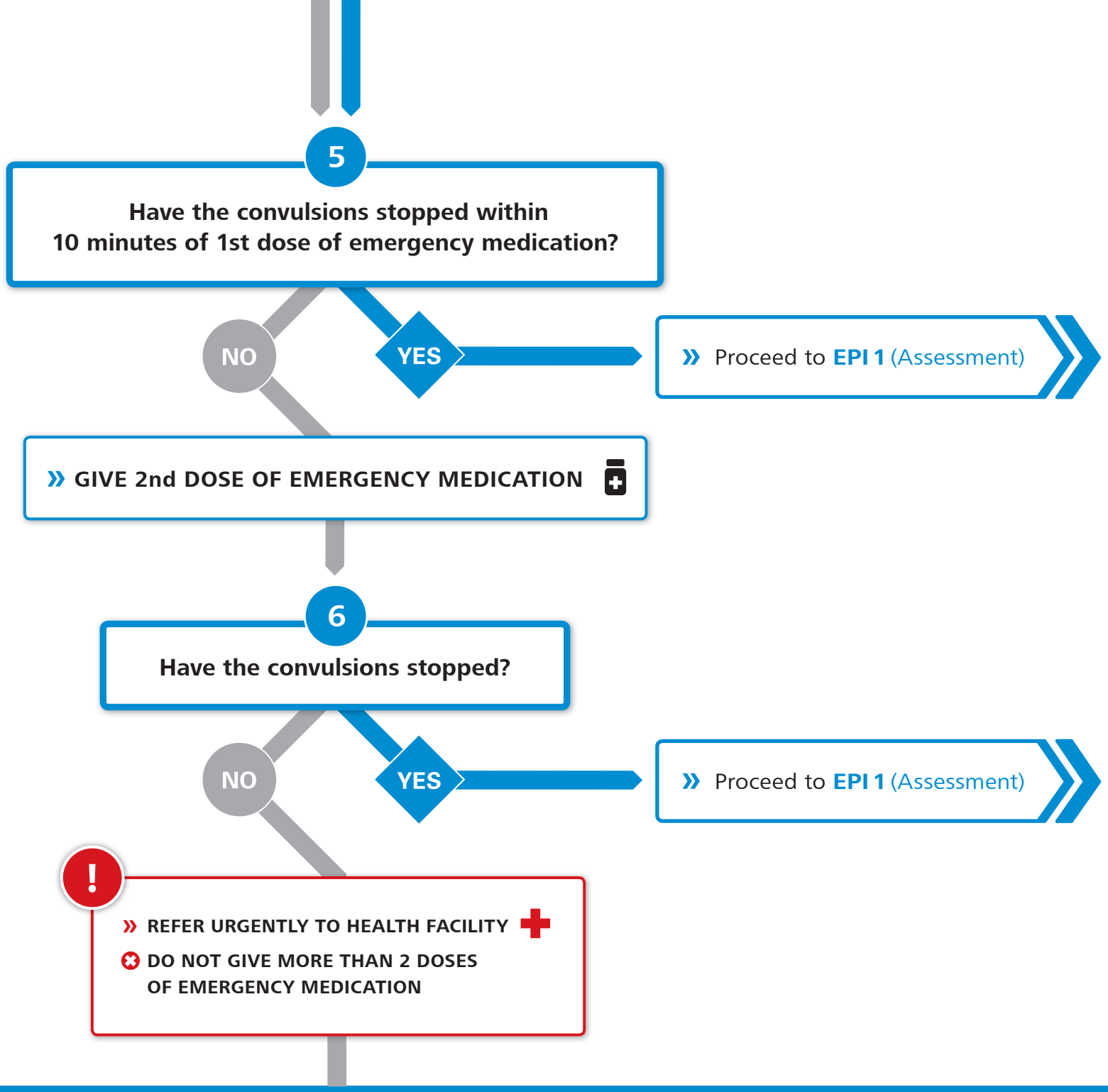
OR

- » **midazolam** buccally/intranasally (5-10 mg adult, child 0.2 mg/kg)

IF I.V. ESTABLISHED

- » Start normal **saline** administration slowly (30 drops/minute)
- » Give **glucose** i.v. (adult 5 ml of 50%; child 2-5 ml/kg of 10%)
- » Give emergency medication:
  - **diazepam** 10 mg i.v. (child 1mg/year of age i.v.)

  OR
  - **lorazepam** 4 mg i.v (child 0.1 mg/kg i.v.)


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

NO

SKIP to STEP 10

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

YES

! STATUS EPILEPTICUS IS LIKELY

Management should occur in health facility

8

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

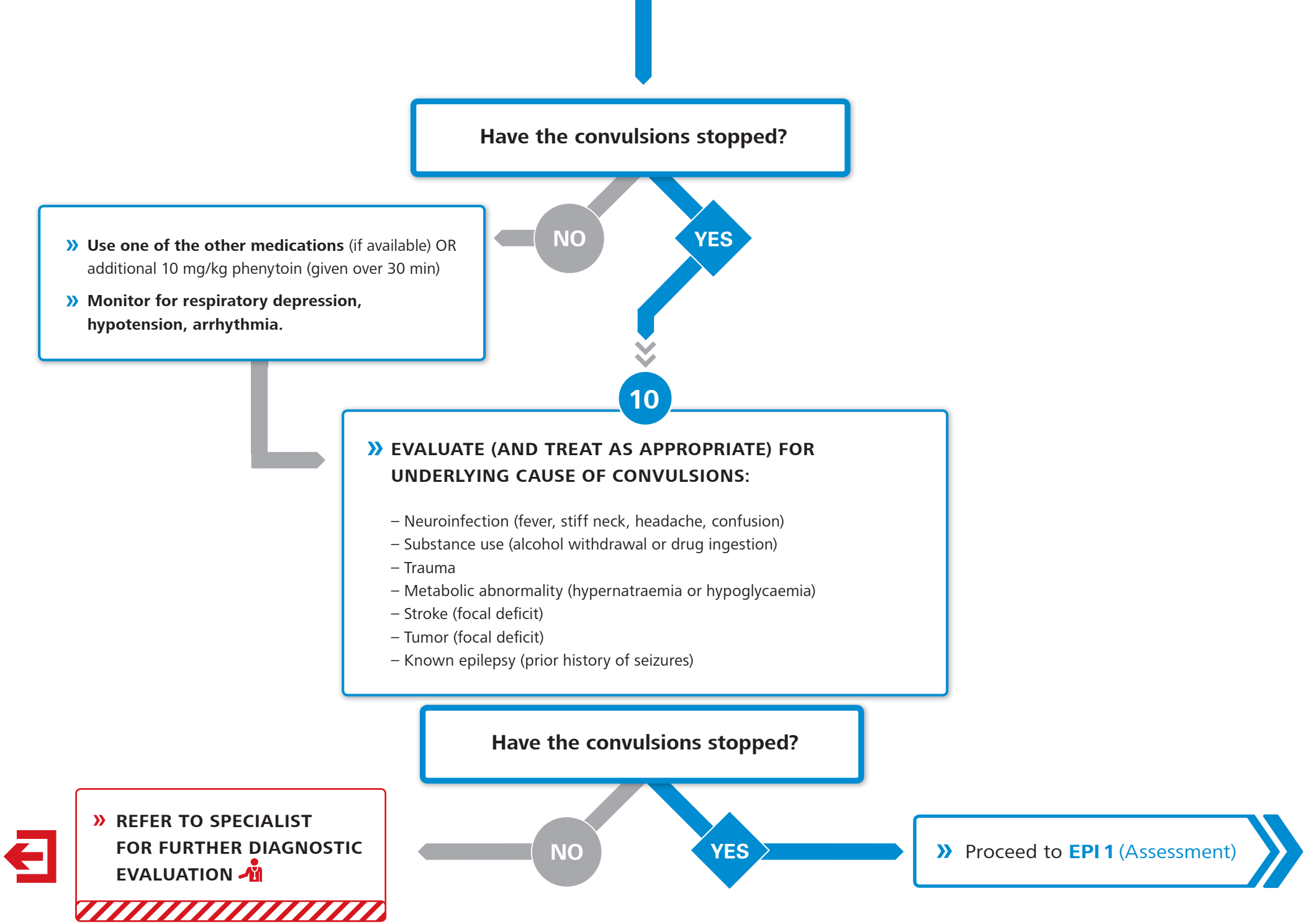
9

GIVE ONE OF THE FOLLOWING MEDICATIONS INTRAVENEOUSLY

- » **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.)

- » **PHENYOTIN:**
  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!*


Have the convulsions stopped?
NO
YES
» Use one of the other medications (if available) OR additional 10 mg/kg phenytoin (given over 30 min)
» Monitor for respiratory depression, hypotension, arrhythmia.
10
» EVALUATE (AND TREAT AS APPROPRIATE) FOR UNDERLYING CAUSE OF CONVULSIONS:
– Neuroinfection (fever, stiff neck, headache, confusion)
– Substance use (alcohol withdrawal or drug ingestion)
– Trauma
– Metabolic abnormality (hypernatraemia or hypoglycaemia)
– Stroke (focal deficit)
– Tumor (focal deficit)
– Known epilepsy (prior history of seizures)
Have the convulsions stopped?
NO
YES
» REFER TO SPECIALIST FOR FURTHER DIAGNOSTIC EVALUATION
» Proceed to EPI 1 (Assessment)

EPI 1 » Assessment

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

Convulsive seizures unlikely

» Consult a specialist for recurrent episodes

» Follow-up in 3 months

YES

CLINICAL TIP

Syncope 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.**

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

NO

Convulsive seizures unlikely

» Consult a specialist for recurrent episodes

» Follow-up in 3 months

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

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

SIMPLE FEBRILE SEIZURE

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

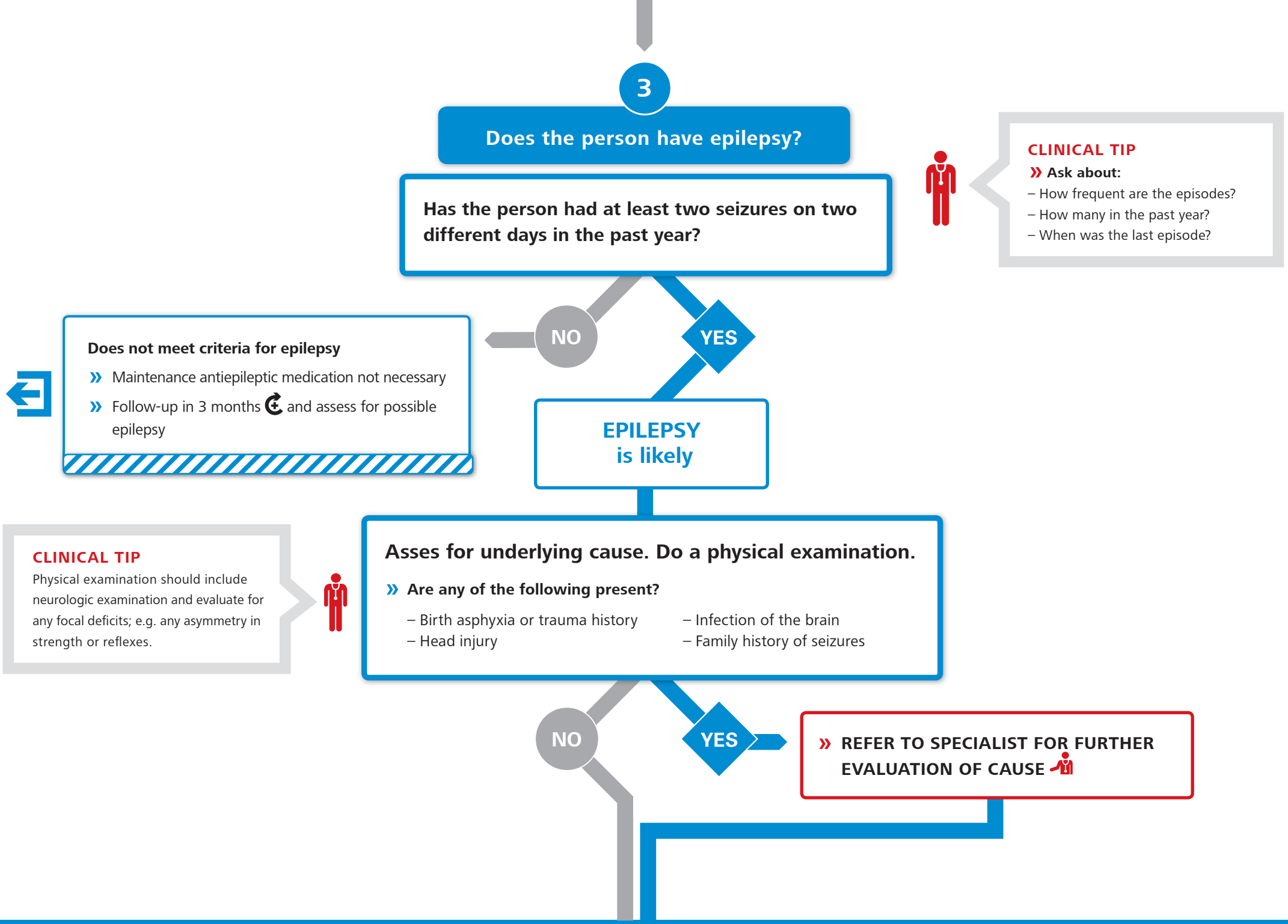
YES

COMPLEX FEBRILE SEIZURE

- » **REFER TO HOSPITAL FOR ADMISSION**

- » **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


3
Does the person have epilepsy?
Has the person had at least two seizures on two different days in the past year?
CLINICAL TIP
» Ask about:
– How frequent are the episodes?
– How many in the past year?
– When was the last episode?
NO
YES
Does not meet criteria for epilepsy
» Maintenance antiepileptic medication not necessary
» Follow-up in 3 months and assess for possible epilepsy
EPILEPSY is likely
CLINICAL TIP
Physical examination should include neurologic examination and evaluate for any focal deficits; e.g. any asymmetry in strength or reflexes.
Asses for underlying cause. Do a physical examination.
» Are any of the following present?
– Birth asphyxia or trauma history
– Head injury
– Infection of the brain
– Family history of seizures
NO
YES
» REFER TO SPECIALIST FOR FURTHER EVALUATION OF CAUSE

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 ADOLSCENTS 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

- » 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.

CHILD / ADOLESCENT

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

- » 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.**

PERSON LIVING WITH HIV

Concern: Drug interactions between antiepileptic medications and antiretrovirals

- » 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 antiepilepileptics. 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	**Adults:** Start 100-200 mg daily in 2-3 divided doses. Increase by 200 mg each week (max 1400mg daily). **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). **Women who are pregnant or breastfeeding:** Use with caution.	**Common:** Sedation, confusion, dizziness, ataxia, double vision, nausea, diarrhea, benign leukopenia. **Serious:** Hepatotoxicity, cardiac conduction delay, low sodium levels.	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	**Adults:** **Start** 60 mg daily in 1-2 divided doses. Increase weekly by 2.5-5 mg (maximum 180 mg daily). **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).	**Common:** Sedation, hyperactivity in children, ataxia, nystagmus, sexual dysfunction, depression. **Serious:** Liver failure (hypersensitivity reaction), decreased bone mineral density.	Contraindicated in patients with acute intermittent porphyria. Lower doses for patients with kidney or liver disease.
PHENYTOIN	**Adults:** **Start** 150-200 mg daily in two divided doses. Increase by 50 mg daily every 3-4 weeks (max 400 mg daily). **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). **Women who are pregnant or breastfeeding:** Avoid **Older adults:** Use lower doses	**Common:** Sedation, confusion, dizziness, tremor, motor twitching, ataxia, double vision, nystagmus, slurred speech, nausea, vomiting, constipation. **Serious:** Hematologic abnormalities, hepatitis, polyneuropathy, gum hypertrophy, acne, lymphadeno-pathy, increase in suicidal ideation.	Lower doses for patients with kidney or liver disease.
SODIUM VALPROATE	**Adults:** **Start** 400 mg daily in 2 divided doses. Increase by 500 mg daily each week (maximum 3000 mg daily). **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). **Women who are pregnant:** Avoid **Older adults:** Use lower doses	**Common:** Sedation, headache, tremor, ataxia, nausea, vomiting, diarrhea, weight gain, transient hair loss. **Serious:** Impaired hepatic function, thrombocytopenia, leukopenia, drowsiness/confusion (valproate-induced hyperammonemic encephalopathy, a sign of toxicity), liver failure, hemorrhagic pancreatitis.	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

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

NO

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.

YES

RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » Follow up should occur every 3-6 months

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

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.

YES

- **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)	– Poor feeding, failure to thrive, poor motor tone, delay in meeting expected developmental milestones for appropriate age (eg. smiling, sitting, interacting with others, sharing attention, walking, talking and toilet training		– 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
Middle Childhood (age 6-12)	– Delay in reading and writing – Delay in self-care such as dressing, bathing, brushing teeth	**Ages 4-18** – 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	– 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)
Adolescents (age 13-18)	– Poor school performance – Difficulty understanding instructions – Difficulty in social interaction and adjusting to changes		– 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)
All Ages	– 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		– 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 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*

1 ASSESS FOR DEVELOPMENTAL DISORDERS

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?

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.

NO → SKIP to STEP 2

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

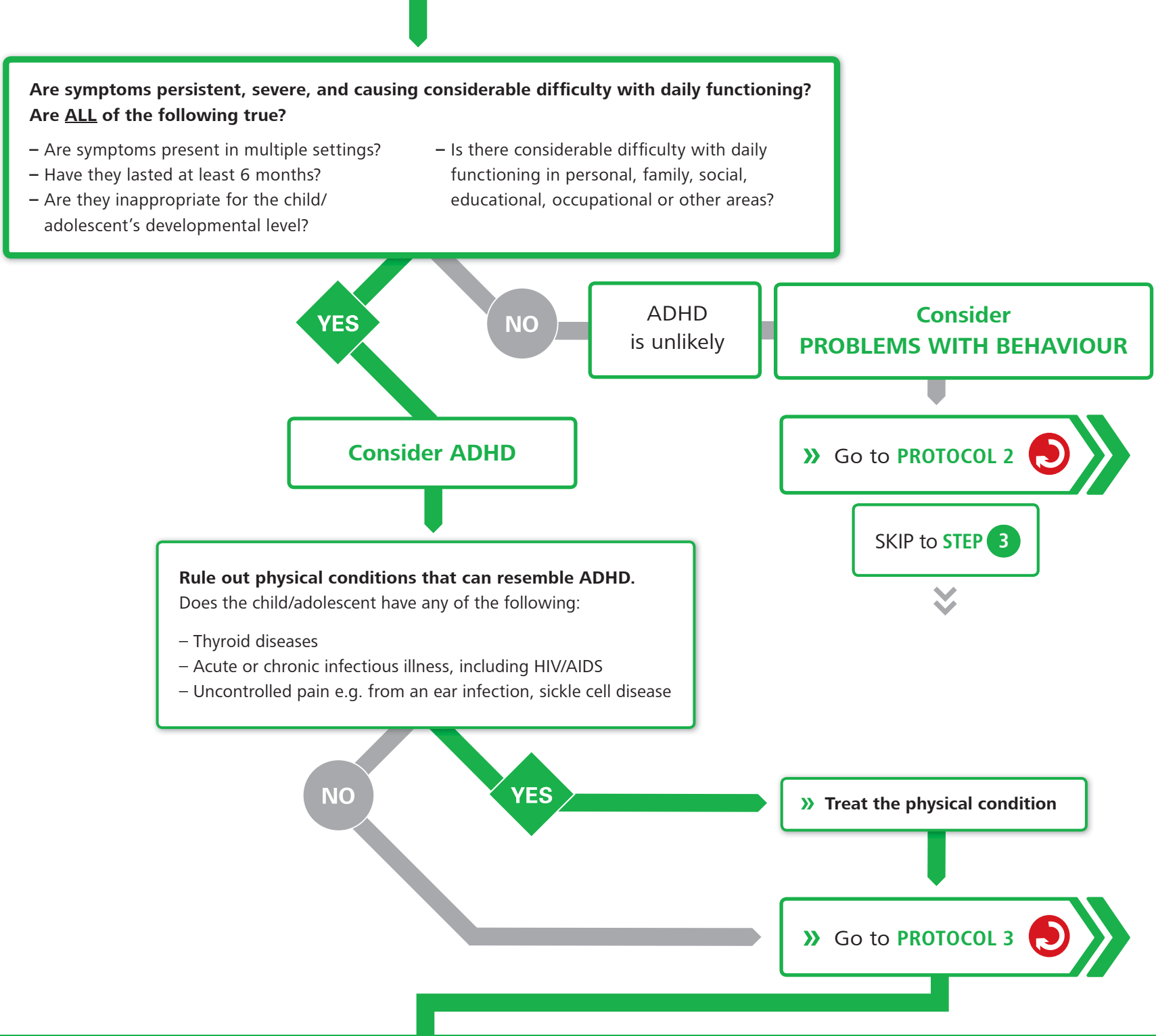
Is the child/adolescent:

– 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
» Go to PROTOCOL 2
SKIP to STEP 3
Consider ADHD
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

NO

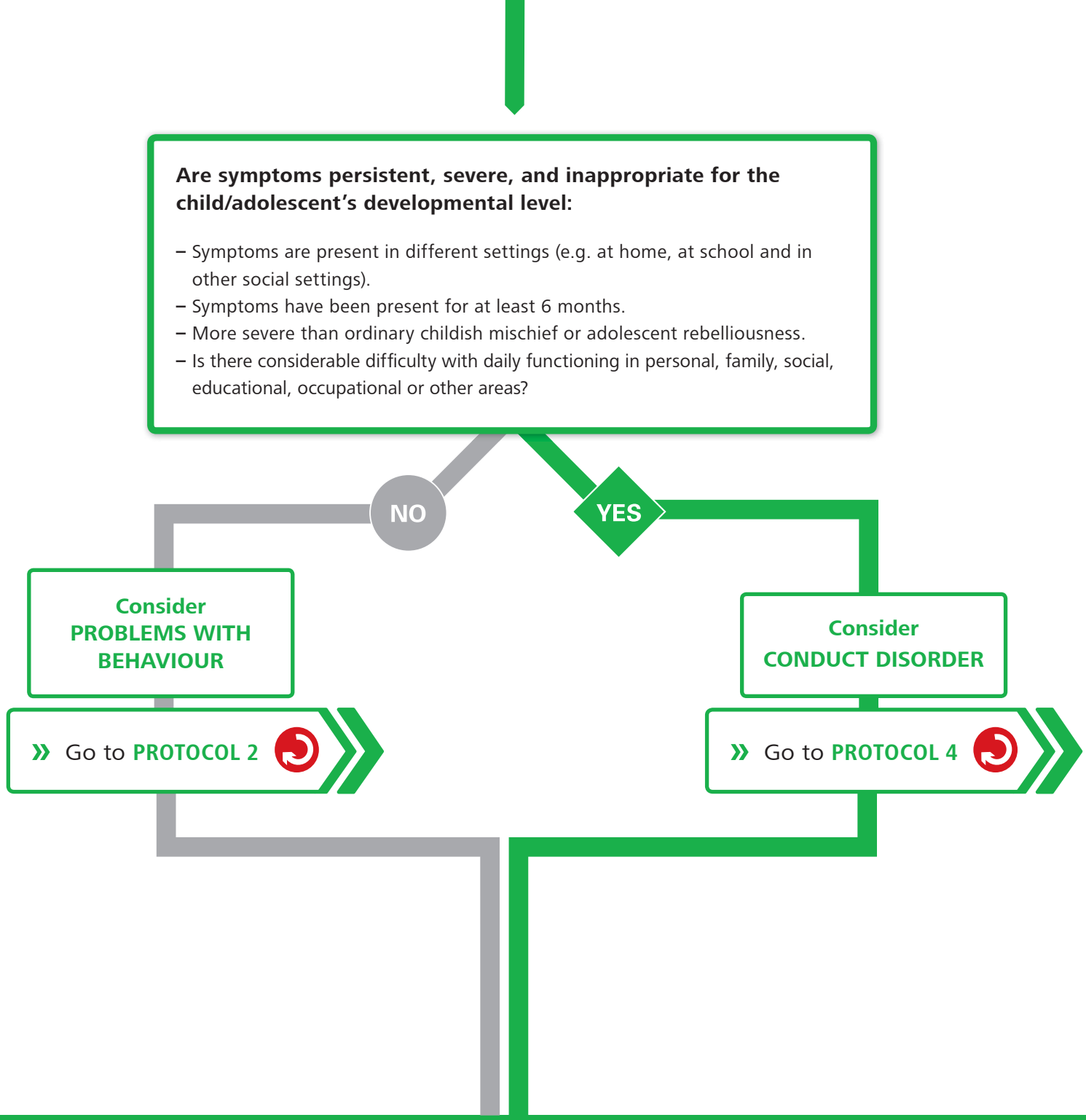
SKIP to STEP 4

CONDUCT DISORDER is unlikely

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.


Are symptoms persistent, severe, and inappropriate for the child/adolescent's developmental level:
– Symptoms are present in different settings (e.g. at home, at school and in other social settings).
– Symptoms have been present for at least 6 months.
– More severe than ordinary childish mischief or adolescent rebelliousness.
– Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?
NO
YES
Consider PROBLEMS WITH BEHAVIOUR
» Go to PROTOCOL 2
Consider CONDUCT DISORDER
» Go to PROTOCOL 4

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)?

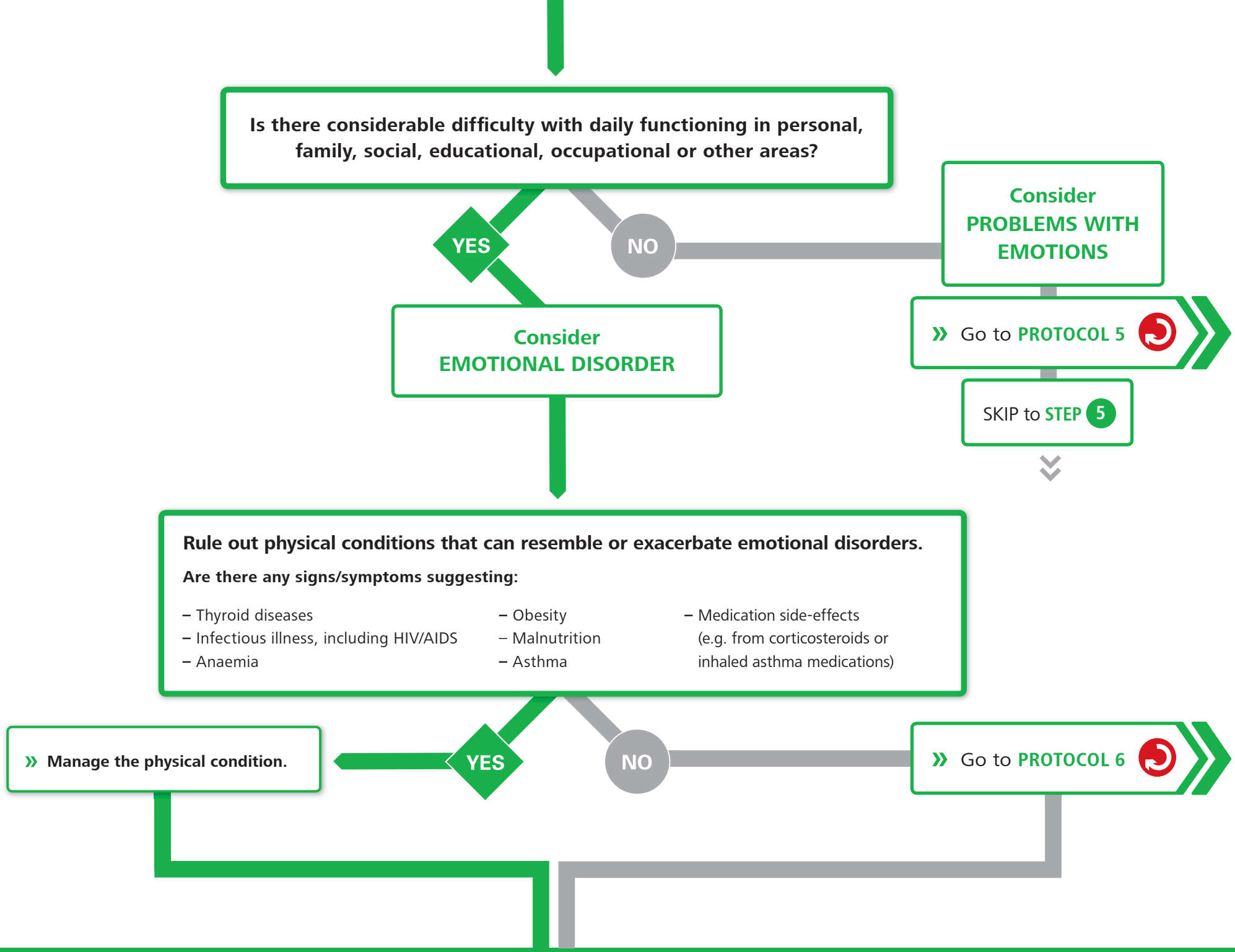
NO

SKIP to STEP 5

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.**

YES

» **ASSESS AND MANAGE concurrent MNS conditions**

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

- 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

NO

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.

YES

» **Assess and manage for carer MNS conditions.**

» **Go to Management 2.6** (Carer support)

NO

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?

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.

NO

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.

Is the child/adolescent:

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

CLINICAL TIP

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

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

» 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.

2.1 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.

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. witholding 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 skillls).

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.

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.
- 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.
- 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

» 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.

NO

» 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.

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 improvemen 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).

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.

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

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*

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**).

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

DEMENTIA is unlikely.
» Screen for other MNS conditions.

YES

Does the person have difficulties in performing key roles/activities?
(e.g. with daily activities such as shopping, paying bills, cooking, etc.)

NO

DEMENTIA is unlikely.
» Screen for other MNS conditions.

YES

2

Are there any other explanations for the symptoms?

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.

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

CLINICAL TIP

Cognitive impairment may be the result of depression – "Pseudodementia"

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

NO

YES

YES

NO

» **Manage depression. Go to » DEP.**

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

Suspect DELIRIUM

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

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

Suspect DEMENTIA

3 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

YES

Unusual Features.

- **Refer to specialist.**

NO

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

YES

- Fortification of food and monitoring of weight is necessary.

NO

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)

YES

- **Refer to appropriate SPECIALIST.**
- **Reduce cardiovascular risk factors:**
  - Advise person to stop smoking
  - Advise weight-reducing diet for obesity
  - Treat hypertension
  - Treat diabetes

NO

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.**

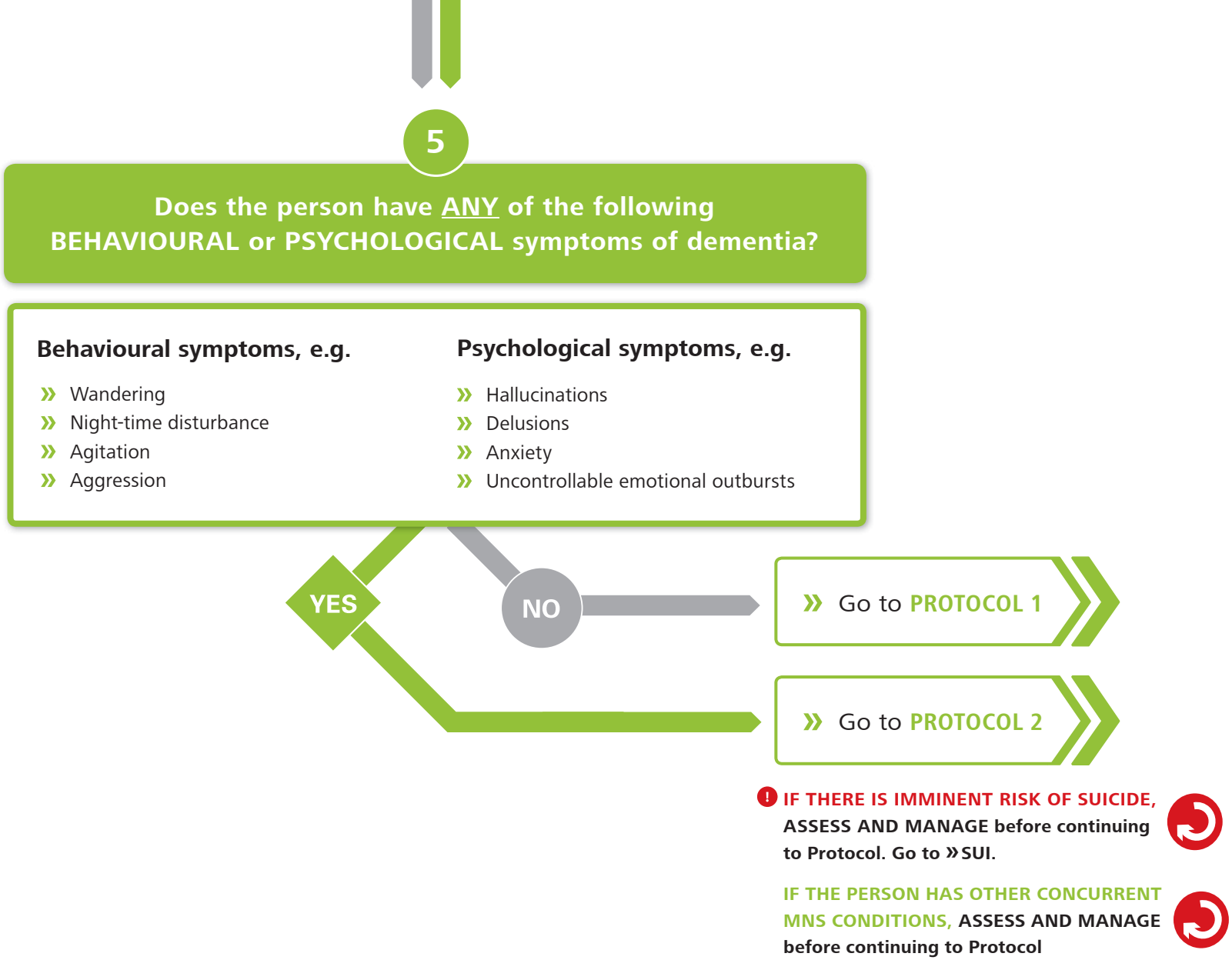
» Try to address strain with support and psychoeducation. Problem-solving counselling or cognitive behavioural therapy.

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 speacialist** 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 Alzhemer'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.

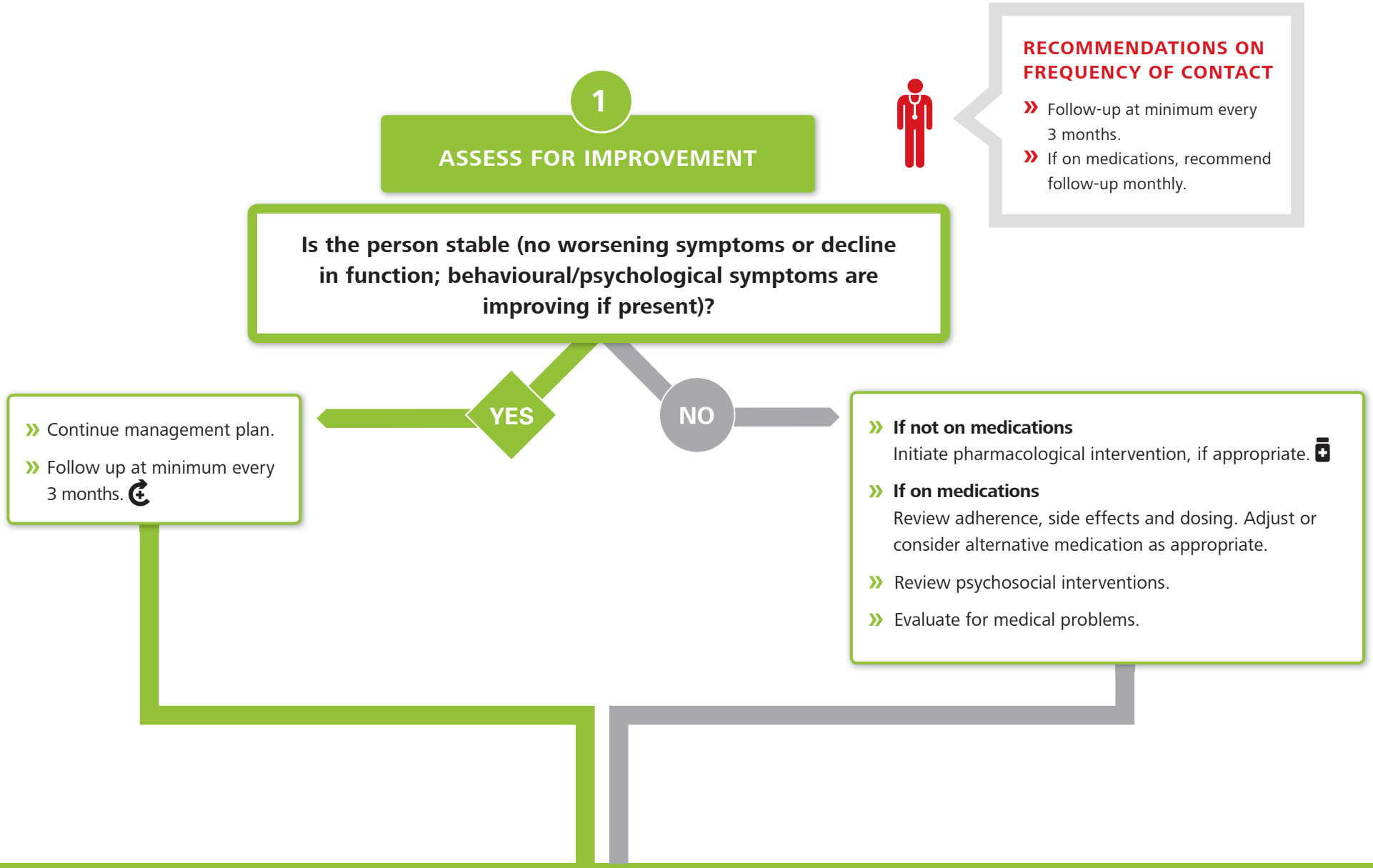
» Follow the principles of:

– "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**

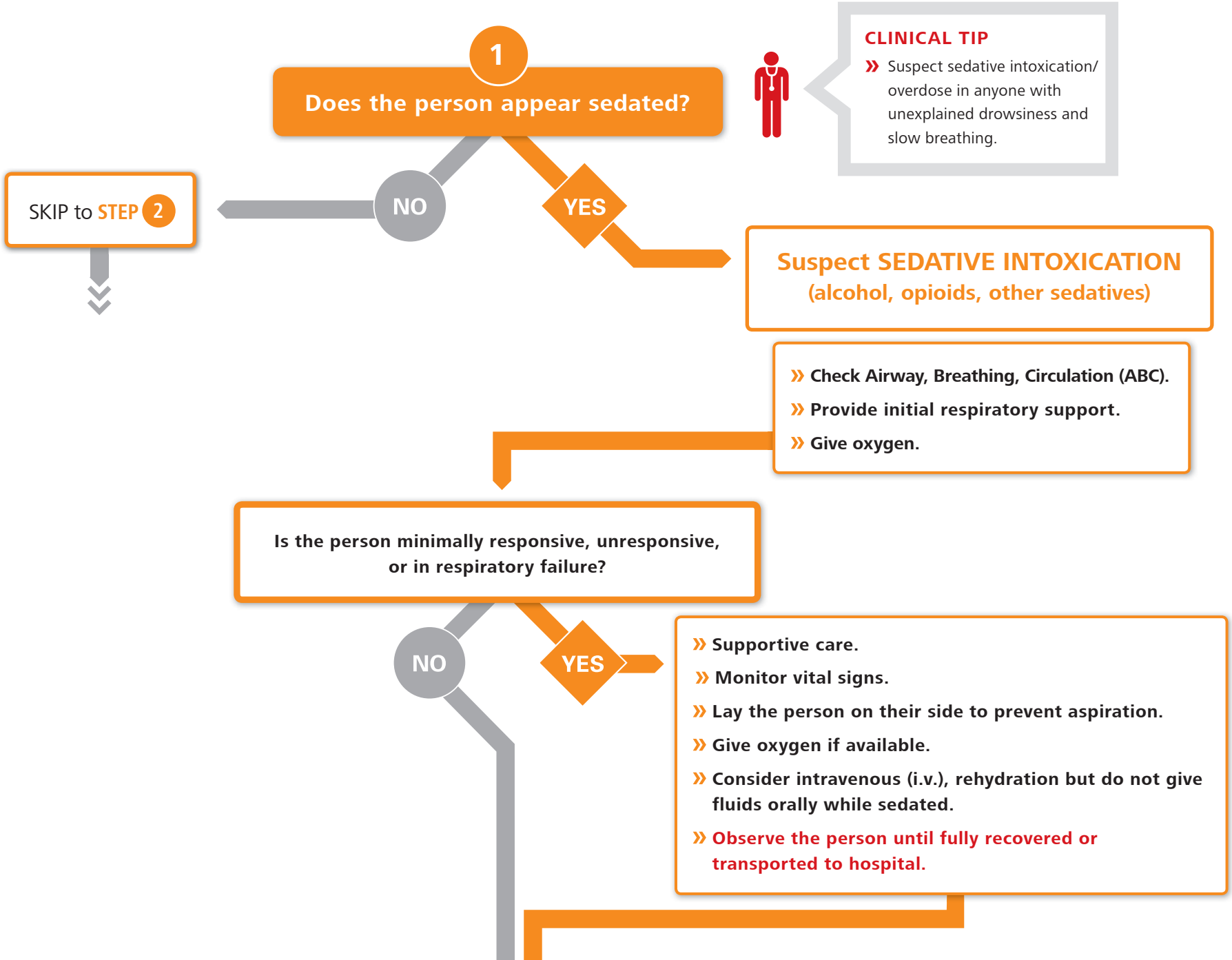
FOLLOW-UP

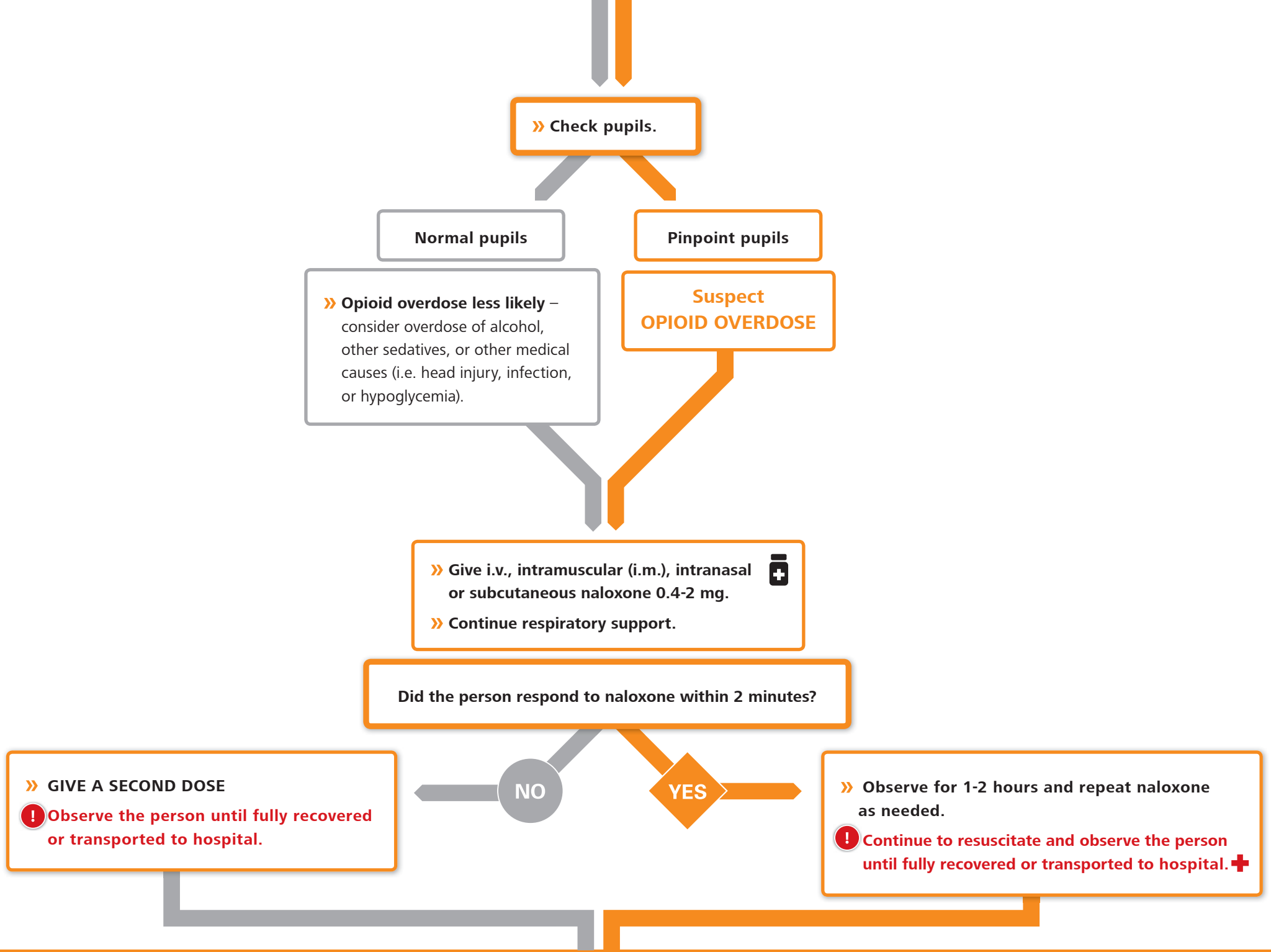
SUB » EMERGENCY

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*


1
Does the person appear sedated?
NO
YES
SKIP to STEP 2
CLINICAL TIP
» Suspect sedative intoxication/ overdose in anyone with unexplained drowsiness and slow breathing.
Suspect SEDATIVE INTOXICATION
(alcohol, opioids, other sedatives)
» Check Airway, Breathing, Circulation (ABC).
» Provide initial respiratory support.
» Give oxygen.
Is the person minimally responsive, unresponsive, or in respiratory failure?
NO
YES
» Supportive care.
» Monitor vital signs.
» Lay the person on their side to prevent aspiration.
» Give oxygen if available.
» Consider intravenous (i.v.), rehydration but do not give fluids orally while sedated.
» Observe the person until fully recovered or transported to hospital.


» Check pupils.
Normal pupils
Pinpoint pupils
» Opioid overdose less likely – consider overdose of alcohol, other sedatives, or other medical causes (i.e. head injury, infection, or hypoglycemia).
Suspect OPIOID OVERDOSE
» Give i.v., intramuscular (i.m.), intranasal or subcutaneous naloxone 0.4-2 mg.
» Continue respiratory support.
Did the person respond to naloxone within 2 minutes?
NO
YES
» GIVE A SECOND DOSE
Observe the person until fully recovered or transported to hospital.
» Observe for 1-2 hours and repeat naloxone as needed.
Continue to resuscitate and observe the person until fully recovered or transported to hospital.

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, tachyarrythmias, 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 folllowing 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 ***Can be life-threatening***	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 ***Can be life-threatening***	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	Irritibility, hostility, anxiety, dysphoria, depresed 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 ***Watch out for suicidal thoughts***	Hypertension, increased risk of cerebrovascular accidents (CVAs), arrythmias, heart disease, anxiety, depression
Khat	Alertness, euphoria, and mild excitation	Lethargy, depressed mode, irritability	Khat users often spend a significant portion of the day chewing khat; consti-pation, 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, incoord-ination, visual disturbances, anxiolysis, sedation	Increased susceptibility to seizures	Decreased cognitive function and dementia, peripheral neuropathy, other neurological sequelae, increased risk of arrythmias 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?

NO

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

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.

YES → » Proceed to **PROTOCOL 2**

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

NO

Is the substance use harmful?
See answer in step 2, above.

YES → » Proceed to **PROTOCOL 1**

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

NO

» 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 canbe 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.	– 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. **CONTRAINDICATED** 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. **CONTRAINDICATED** 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

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

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.

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.

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

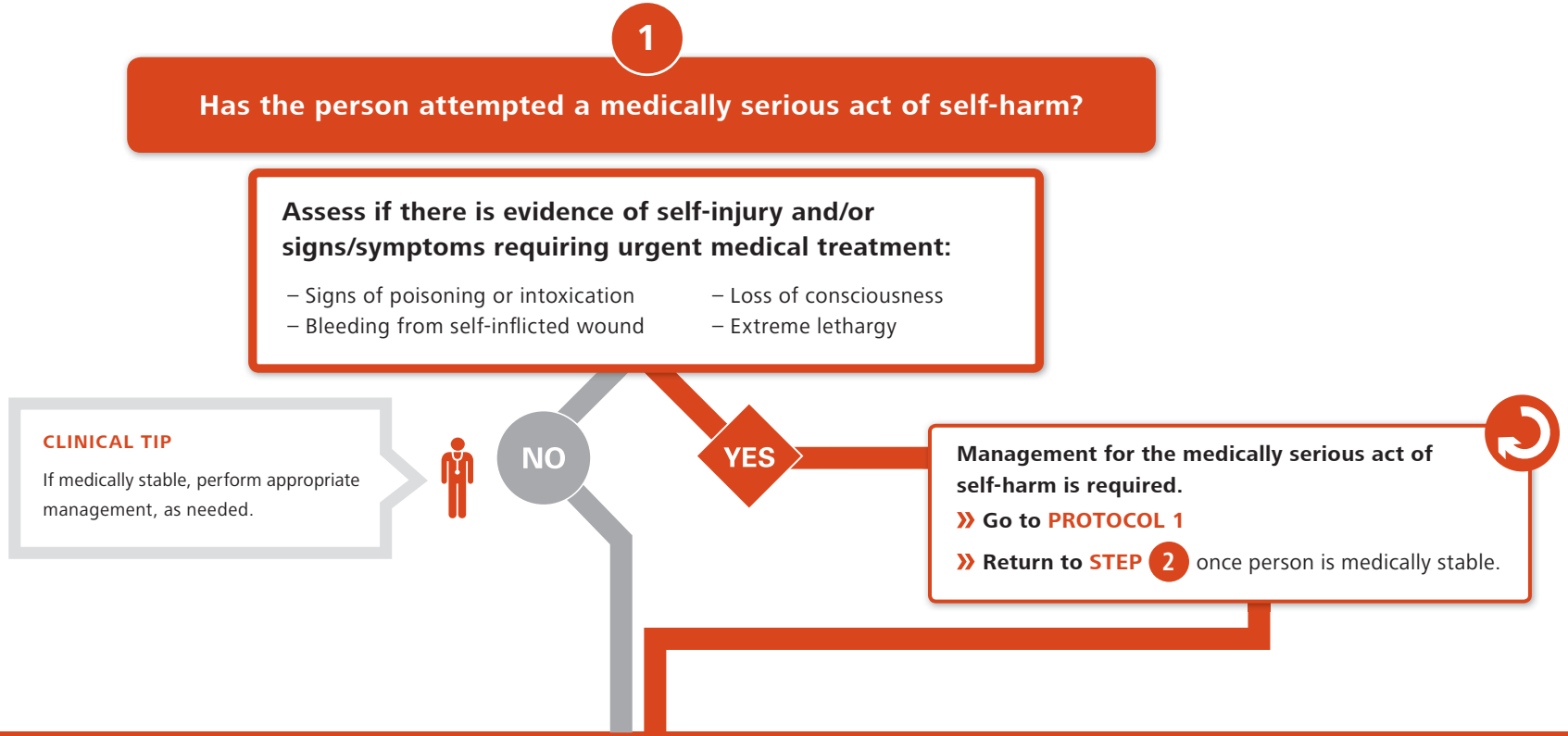
- **Management Protocols**
  1. Medically serious act of self-harm
  2. Imminent risk of self-harm/suicide
  3. Risk of self-harm/suicide
- **General Management and Psychosocial Interventions**

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*



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

YES → **IMMINENT RISK OF SELF-HARM/SUICIDE is likely**

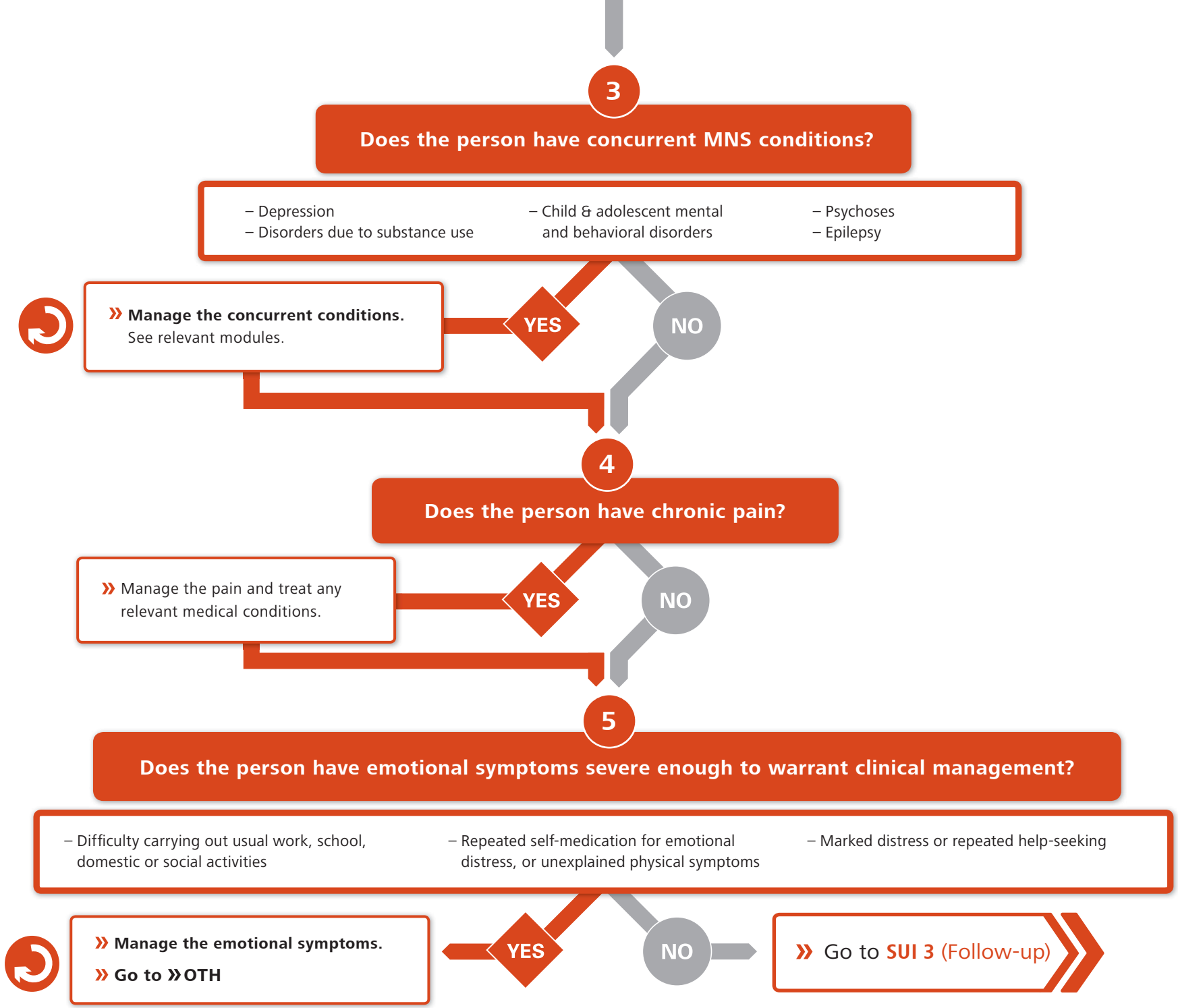
» Go to **PROTOCOL 2**, manage, and then continue to **STEP 3**

NO → **Is there a history of thoughts or plan of self-harm in the past month or act of self-harm in the past year?**

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

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

NO → **Risk of self-harm/suicide is unlikely.**


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

1

ASSESS FOR IMPROVEMENT

Is the person improving?

YES

- » 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).

NO

- » **Increase intensity or duration of contact as necessary.**
- » **Refer to specialist as needed.**

RECOMMENDATIONS ON FREQUENCY OF CONTACT

- » MAINTAIN REGULAR CONTACT (via telephone, home visits, letters or contact cards) more frequently initially (e.g. daily, weekly) for the first 2 months.
- » Follow-up for as long as the risk of self-harm/suicide persists.

2

ROUTINELY ASSESS FOR THOUGHTS AND PLANS OF SELF-HARM/SUICIDE

- » **At every contact, routinely assess for suicidal thoughts and plans. Is the risk of self-harm/suicide imminent? See SUI 1** (Assessment).

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

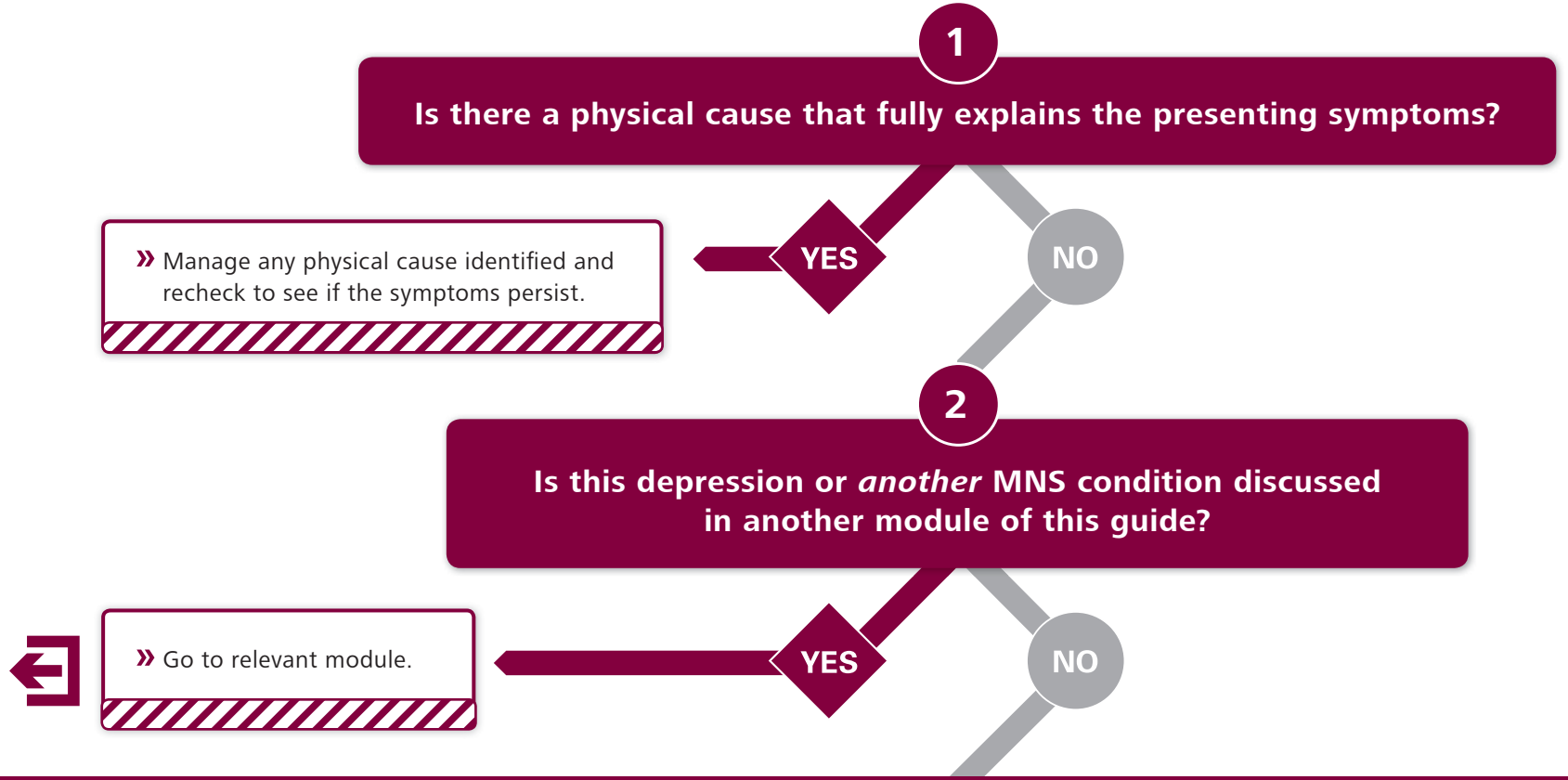
- **Management Protocols**
  1. Other significant mental health complaints
  2. Other significant mental health complaints in people exposed to extreme stressors

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

» **No treatment needed.**

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 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

RECOMMENDATIONS ON FREQUENCY OF CONTACT

» Ask the person to return in 2-4 weeks if their symptoms do not improve or if, at any time, their symptoms worsen.

ASSESS FOR IMPROVEMENT

Is the person improving?

YES

» Contine with treatment plan

» Follow-up as needed

NO

If the person is not improving **or the person or the carer insists on further investigations and treatment:**

» **Review Protocols 1 and 2**

» **Consider consulting a specialist.**

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.

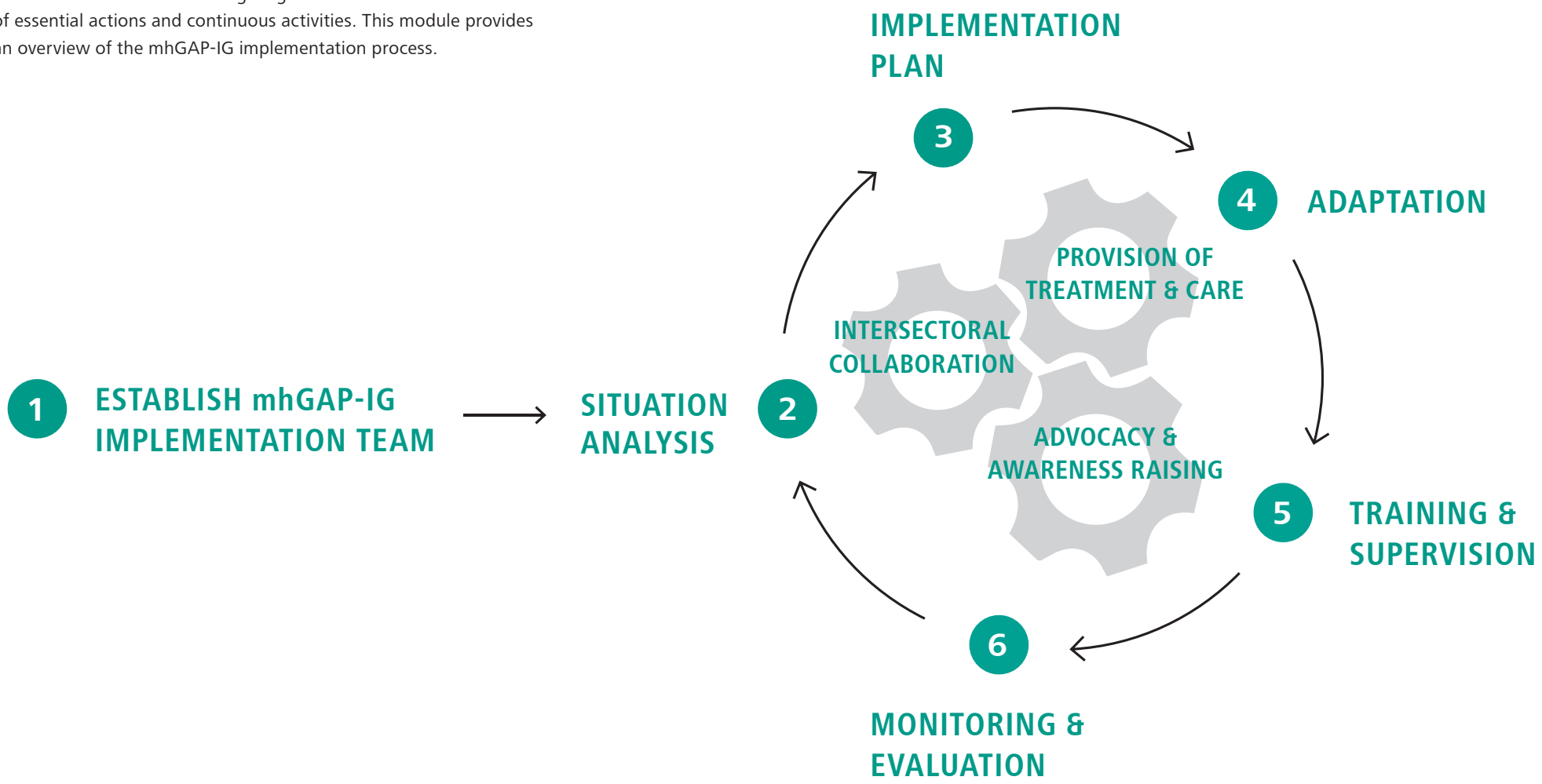
» **Encourage self-practice.**

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

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 responsbile 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 super-vision. 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 & supervison:

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 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 programmmes. 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
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.
Agitation	Marked restlessness and excessive motor activity, accompanied by anxiety.
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.
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).
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.
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**.
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.
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.
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.

TERM	DEFINITION
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.
Autism spectrum disorders	An umbrella term that covers conditions such as autism, childhood disintegration disorder and Asperger's syndrome.
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.
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.
Bereavement	A process of loss, grief and recovery, usually associated with death.
Cerebrovascular accident	A sudden disturbance of cerebral function attributable to vascular disease, principally thrombosis, haemorrhage, or embolism. See **stroke**.
Cognitive	Mental processes associated with thinking. These include reasoning, remembering, judgement, problem-solving and planning.
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).
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
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.
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.
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.
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).
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.
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.
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.
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.

TERM	DEFINITION
Disorganized behaviour	Behaviour including posture, gait, and other activity that is unpredictable or not goal-directed (e.g., shouting at strangers on the street).
Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli.
Dystonia	Sustained muscle contraction or involuntary movements that can lead to fixed abnormal postures. See **tardive dyskinesia**.
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.
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.
Extrapyramidal side-effects / symptoms (EPS)	Abnormalities in muscle movement, mostly caused by antipsychotic medication. These include muscle tremors, stiffness, spasms and/or akathisia.
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.
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
Hallucination	False perception of reality: seeing, hearing, feeling, smelling or tasting things that are not real.
Hepatic encephalopathy	Abnormal mental state including drowsiness, confusion or coma caused by liver dysfunction.
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.
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.
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.
Idiosyncratic reaction	Individual, unpredictable, and non-dose-dependent response to any substance: drowsiness or euphoria, flushing, carpopedal spasms, apnoea, etc.
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.
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.

TERM	DEFINITION
Irritability, irritable mood	A mood state characterized by being easily annoyed and provoked to anger, out of proportion to the circumstances.
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).
Meningeal irritation	Irritation of the layers of tissue that cover the brain and spinal cord, usually caused by an infection.
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.
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.
Motor twitching	See **convulsion**.
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.
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
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.
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.
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.
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.
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.
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.
Polytherapy	Provision of more than one medicine at the same time for the same condition.
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.
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.
Problem-solving counselling	Psychological treatment that involves the systematic use of problem identification and problem-solving techniques over a number of sessions.

TERM	DEFINITION
Pruritus	Itching; an intense sensation that produces the urge to rub or scratch the skin to obtain relief.
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.
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.
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.
Racing thoughts	Rapid thought pattern with tangential movement from one idea to the next often associated with mania or other mental illnesses.
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.
Relaxation training	Involves training in techniques such as breathing exercises to elicit the relaxation response.
Respiratory depression	Inadequate slow breathing rate, resulting in insufficient oxygen. Common causes include brain injury and intoxication (e.g. due to benzodiazepines).
Respite care	Provision of temporary health-care facilities to a person normally cared for at home.
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
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).
Slurred speech	Speech with indistinctive pronunciation.
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.
Social withdrawal	Inability of a person to engage in age appropriate activities or interactions with his or her peers or family members.
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).
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.
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.
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.
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.
Stroke	See **cerebrovascular accident (CVA)**.

TERM	DEFINITION
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.
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.
Temper tantrum	An emotional outburst from a child or those in emotional distress.
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.
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.
Traditional Healing	A system of treatment modalities based on indigenous knowledge of different cultures pertaining to healing.
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.
Tremor	Trembling or shaking movements, usually of the fingers, that is an involuntary oscillation of a body part.
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 antiepiletic medicines is one of its causes.
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.

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**

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