World Health Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean

Implementing the mental health Gap Action Programme intervention guide

A job aid for non-specialist health professionals

mhGAP

Mental Health Gap Action Programme

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean, Mental Health Gap Action Programme

Title: Implementing the mental health Gap Action Programme intervention guide: a job aid for non-specialist health professionals / World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, [2021] | Includes bibliographical references.

Identifier: ISBN 978-92-9022-469-3 (pbk.) | ISBN 978-92-9022-479-2 (online)

Subjects: Mental Disorders - prevention and control | Substance-Related Disorders | Neurodevelopmental Disorders | Psychotic Disorders | Guideline

Classification: NLM WM 140

Contents

Preface

The revised mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0 (known as mhGAP-IG 2.0) has been widely used all over the world since 2016. The mhGAP-IG 2.0 presents integrated management of priority mental, neurological and substance use (MNS) conditions using protocols for clinical decision-making. The priority conditions included are depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide and other significant emotional or medically unexplained complaints.

This operational guide has been developed to help non-specialists to conduct standardized clinical interviews and examinations, and deliver interventions, as outlined in the mhGAP-IG 2.0. The clinical protocols in the mhGAP-IG have been supplemented by evidence-based clinical tools, including key questions and examination techniques where necessary. The mhGAP-IG protocols highlight the areas to be examined, but do not direct users on how to conduct the examination. For example, based on a diagnostic criterion for a disorder, a list of symptoms has been provided in the mhGAP-IG 2.0. However, since non-specialists have no prior training in mental health care, their capacity to elicit these symptoms is limited. Currently, they follow the directions given by trainers, who tend to interpret the facilitator's guide according to their clinical expertise. Therefore, there is a wide variation in how non-specialists apply these protocols after their training.

In most developing countries, the predominant model of health care is biomedical. As a result, pre-service trainings (medical and nursing) do not emphasize skills to interview or build a therapeutic alliance with the patient. To address this gap, some clinical questions have been developed to help health care providers to use the mhGAP-IG modules. For each area of investigation, the operational guide begins by asking an open-ended question, which is followed by a set of closed-ended questions. In addition, simple clinical tests have been included (e.g. cognitive testing) to facilitate more effective examinations for specific MNS conditions. The operational guide also sets a clear direction for the health care provider to benefit from additional information from carers during the assessment. A separate set of questions has been provided for the carers, where pertinent. In addition, a set of clinical cases has been provided (Annex 2) to help health care providers to practise their skills for clinical decision-making.

A further objective of the operational guide is to help health care providers to remain patient-centred and to protect the rights of the patient. Issues such as patient privacy and the need for confidentiality have been emphasized. Clear guidelines have been added for clinical scenarios where the health care provider might need to share vital information with others, and tips are provided on how to do so.

No modifications of the format or content of the clinical protocols in the mhGAP-IG 2.0 have been suggested. All references are provided at the end of the operational guide.

ESSENTIAL CARE & PRACTICE

A. GENERAL PRINCIPLES

I. Use Effective Communication Skills

COMMUNICATION TIP #1

Create an environment that facilitates open communication

The health care provider should create a private and safe environment for conducting an assessment.

Start by explaining:

- That you will be making brief notes during the consultation, so that you do not miss something important.
- That you will refer to your (mhGAP-IG) guide (on your table/phone or a master chart on your wall) to check important points.
- How much time you will spend doing the consultation/ examination.
- That you would like to see the patient alone first (with a chaperone where needed) for an assessment, and will then invite the family member for further discussion.

Then close the door to ensure privacy and reassure the patient that the consultation is confidential.

COMMUNICATION TIP #2

Involve the person

The health care provider should involve the patient in every step of the assessment and management of the condition. They should aim to work together with the patient to establish common treatment goals.

To see a health care provider for emotional/psychological difficulties may be seen as stigmatizing or admitting to a weakness. So, patients may find it difficult to get involved in the intervention as a whole or in parts of it. Some patients may come with expectations that the health care provider will fix their problems. It is important to address the patient's expectations and educate them about the role of the health care provider *(1)*.

Following are some examples of questions that can be used throughout the assessment to actively engage the person, rather than giving a lecture.

- What do you already know about your condition?
- What questions do you have?
- What problems are affecting you the most?
- Would you like to work with me to explore possible solutions for your problems? *(1)*

COMMUNICATION TIP #3

Start by listening

The health care provider should:

- Be focused on the interview/assessment.
- Avoid distractions (e.g. using a phone, doing other things or talking to other people).
- Listen carefully.
- Use non-verbal gestures to indicate that they are listening (e.g. "uh-huh", "OK", "I see" and "hmm").
- Be empathic by conveying that they understand the person's feelings.

Some examples are:

- That sounds like a very challenging experience.
- I understand how painful this has been for you.
- You have experienced many stresses in life.
- You have been through a very difficult time.
- I can see why you are so sad/frightened, etc. *(1)*

COMMUNICATION TIP #4

Be friendly, respectful and non-judgmental at all times
The health care provider should be aware of their own bias towards people with mental health conditions and make active efforts not to judge them for any limitations.

COMMUNICATION TIP #5

Use good verbal communication skills

Open-ended questions
These questions invite patients to start a discussion and let them tell about their experience in their own words. The noticeable aspect of open-ended questions is that they are short and suggest no anticipated reply.
Some examples are:

- How are you feeling?
- How did you travel here?
- What do you like to do?
- Tell me about yourself.
- Can you describe your problems? *(2)*

Closed-ended questions
Once the person had an opportunity to describe their problems, a list of closed-ended questions can help to check a list of symptoms. The closed-ended questions have may have "Yes" or "No" answers, which may not describe fully what the patient wants to say.
Some examples are:

- Are you feeling sad?
- Did you come here by bus?
- Do you enjoy your work?
- Do you sleep well? *(2)*

The skill of taking an accurate history in a given time lies in the balance between "closed" and "open" questions.

COMMUNICATION TIP #6

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

The health care provider needs to be extremely sensitive when asking these questions. The confidentiality of disclosed information is essential. It is very important to remain gentle and respectful during an assessment.

To help a person feel comfortable talking about difficult or embarrassing topics, always acknowledge the difficulty and thank them for being trusting.
For example:

- Thank you for sharing this experience with me.
- I understand how difficult it must be for you.
- This is something that does happen to other people and/or children, and it is not their fault that it happens.
- I will not tell anyone about this without your consent. *(1)*

B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE

Assessment of physical health

It may be that there is a lack of focus on physical health during assessment and treatment, and/or that the symptoms of the MNS condition contribute to the patient neglecting their physical health care (e.g. people with severe depression do not take medications prescribed for their physical health condition). Therefore, when assessing a person with possible MNS conditions, always assess their physical health as well.

- ***Detailed history***

Take a detailed history and ask about risk factors, including physical inactivity, inappropriate diet, tobacco use, harmful alcohol and/or substance use, risky behaviours and chronic disease *(2, 3)*.

- ***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 *(2, 3)*.

- ***Identify comorbidities***

Often, a person may have more than one MNS condition or a physical illness at the same time. It is important to assess and manage comorbidities when they occur.

Conduct MNS assessment

History taking

1. Presenting complaint

Presenting complaints are the main problems that the person is presenting with, and these are the primary reasons for the visit. These are best understood in the person's own words.

Start with open-ended questions, then focus on relevant areas with more specific closed-ended questions as necessary.
Some examples of open-ended questions are:

- Why have you come to see me today?
- When did this start?
- How long has this been happening?
- How did this start?
- What do you think is happening to you? *(4)*

2. Past MNS history

Past MNS history means the past history of these complaints or any hospitalization related to MNS, and any history of alcohol or drug use in the past (the patient may not see that as an MNS history).
For example:

- Has anything like this happened to you in the past?
- Have you ever felt unwell before?
- When you felt this way in the past, did you seek help?
- What treatment did you receive? Were you admitted to a hospital?
- When you felt like this in the past, how did you cope? (Explore alcohol, drugs or tobacco use)
- When you felt like this in the past, did you ever try to harm yourself or kill yourself? *(4)*

3. General health history

Ask the patient about any health problems in the past, their health beliefs and any treatments they received.
For example:

- Have you ever been ill?
- How was that illness treated?
- Do you take any medication?
- Do you have any allergies or reactions to medicines?
- Do you know what the medication is for? (In cases where they are taking some medication) *(4)*.

4. Family history of MNS conditions

- Has any member of your family suffered from a mental disorder?
- If yes, was that member of the family treated? (If yes, check details)
- Is there history of suicide in the family? *(2, 3)*

5. Psychosocial history

- Do you work/study/attend school? (If yes, check details)
- Who is the main earner in the family?
- Do you face any financial pressures? (Check if there are any debts etc.)
- Where do you live? Is it your own house? Who else lives there?
- Are there any stressors in your life?
- Who is your main support? *(2–4)*

Assessment for MNS conditions

1. Physical examination
2. Mental status examination

A mental status examination (adapted for non-specialists) may include the following.

Behaviour and appearance

Signs involving the way a person looks or acts.
For example:

- Level of consciousness (alert, hypervigilant, sedated)
- Dress (casual, appropriate for weather, careless, dishevelled)
- Grooming (style of hair, degree of makeup, shaven/unshaven, clean, unkempt)
- Attitude
- Eye contact
- Cooperative, hostile, evasive, threatening
- Psychomotor agitation or retardation *(2, 3)*.

Speech

Signs involving the way a person speaks.
For example:

- Rate (rapid, slowed, pressured or hard to interrupt)
- Volume (loud, soft, monotone, highly inflected or dramatic)
- Coherent or incoherent
- Disorganized *(2, 3)*.

Mood and affect

Signs involving the regulation and expression of emotions or feeling states.
For example:

- Depressed
- Elated
- Blunted or flat
- Labile *(2, 3)*.

Thought

Signs involving abnormalities of form or content of thoughts. Some examples are given below.

Form

- Flight of ideas
- Loosening of associations (disorganized)
- Thought broadcasting, insertion or withdrawal *(2, 3)*.

Content

Delusions

Delusions are fixed false beliefs not shared by others in the person's culture. For example, delusions of grandeur or paranoid delusions.

- Have you wanted to stay away from other people? If yes, why? *(5)*
- Have you been suspicious of their intentions? Or that they might actually harm you? *(5)*
- Do other people seem to laugh at you? Talk about you? Spy on you? *(5)*
- Do you have the feeling that you are being blamed for something, or even accused? *(5)*
- Do you receive messages in the newspapers, or on TV or radio? *(6)*
- Do you feel those things were arranged so as to have a special meaning for you, or even that harm might come to you? Can you describe that? *(6)*

Suicidal ideation

- How do you see the future currently? *(5)*
- What are your hopes for the future? *(4)*
- Can you see any future? *(5)*
- Do you find yourself helpless to solve your problems in life? *(5)*
- Do you sometimes feel that life might not be worth living? *(5)*
- Do you think there is no hope for you in the future? *(4)*

Obsession and compulsions

- Do you have any ideas that are intrusive or repetitive?
- Are there things you do over and over in a repetitive manner?
- Are there things you must do in a particular order?
- Do you wash your hands often or count things over and over?
- Do you perform specific acts to reduce certain thoughts? *(2)*

Phobias

Phobias are extreme fears that cause people to avoid certain situations.

- Do you have any fears, including fear of animals, needles, heights, snakes, public speaking or crowds? *(2)*

Perceptual disturbance

Signs related to sensory perceptions occurring in the absence of the appropriate (external) stimulus. The person may or may not have insight into the unreal nature of the perception. For example, Illusions and hallucinations (auditory, visual, olfactory, tactile or gustatory).

- Do you ever seem to hear voices when there is no one about?
- Have you ever had visions, or seen things other people couldn't see?
- Is there anything unusual about the way things look or sound, or smell and taste? *(5)*

Cognitive functions

Signs and clinical findings indicative of a disturbance in mental abilities and processes related to orientation, attention, memory, judgment, reasoning, problem-solving, decision-making, comprehension, and the integration of these functions. Some examples are given below.

Consciousness

Levels of consciousness are determined by the interviewer and are rated as:

- Coma, characterized by unresponsiveness.
- Stuporous, characterized by response to pain
- Lethargic, characterized by drowsiness.
- Alert (characterized by full awareness) *(7)*.

Orientation

Orientation is checked by time, place and person.

- What is your full name? (Person)
- Do you know where you are? (Place)
- What is the month, date, year, day of the week, and time? (Time) *(2)*.

Concentration and attention

Ways to test concentration are given below.

- Ask the patient to subtract 7 from 100, then to repeat the task from that response (this is known as the "serial 7" test). If the patient could not subtract 7s, then simplify it and ask to subtract 3s from 20.
- Ask the patient to spell the word "world" forwards and backwards.
- Ask the patient to count backwards from 20 (20, 19, 18, etc.).
- Ask the patient to name the days of the week backwards (Sunday, Saturday, Friday, etc.). *(2, 3)*

Document the patient's reaction times to particular questions, because this may provide valuable information.

Memory

Ways to test memory are given below.

Registration and recall

- Say the names of three unrelated objects (table, book, penny) clearly and slowly.
- After you have said all three, ask him/her to repeat them.
- Ask the patient to remember these three items. *(2, 3)*

Recent (short-term) memory

- What did you eat for dinner last night?
- Can the patient recall the interviewers name?
- Ask the patient to repeat the three items given above (after a few minutes). *(2, 3)*

Remote (long-term) memory

- What was the name of your first-grade teacher? *(2, 3)*

(Verify the information later with an informed family member.)

Insight

- Does the person agree that he/she might be unwell?
- Does the person agree that there is a change in him/her today/recently?
- Does the person agree that he/she could have some sort of mental health problem?
- Does the person agree he/she needs treatment for these problems?
- Does the person accept treatment? *(2, 3)*

3. Differential diagnosis

4. Basic laboratory tests

- Complete blood count
- Blood glucose
- Kidney function tests
- Electrolytes
- Liver function tests
- Thyroid function tests
- Syphilis serology
- Hepatitis C antibody test
- Pregnancy test
- Urine routine examination
- Toxicology screen (urine)
- Electrocardiogram
- Chest radiograph *(2, 3)*.

Manage MNS condition

1. Treatment planning

Each module has its own management needs and interventions for specific MNS conditions. Therefore, this section aims to introduce general guidelines only.

2. Psychosocial interventions

Psychoeducation

The health care provider should start by inquiring:

- What do you think is happening to you?
- Do you know about your condition?
- Do you have any questions? *(8)*

Then follow the relevant guidelines for psychoeducation in specific MNS modules.

Reduce stress and strengthen social supports

The health care provider should start by inquiring:

- What are your sources of stress?
- What can you do about these?
- What comforts you when you are upset?
- Do you talk to anyone about your problems and what you are going through?
- Is there any person who you feel can give you support?
- What changes do you need to make to strengthen your social network?
- Is there anybody you could move closer to you who could offer you more support? *(1)*

Then follow the relevant guidelines for reducing stress and strengthening social support in specific MNS modules.

Promote functioning in daily activities

The health care provider should start by inquiring:

- When you were feeling better, what is one task, at home or at work, that you were doing regularly and that you are no longer doing or do less?
- What is one pleasant or enjoyable activity that you could start doing again, or do more often?
- Are there any activities that give you joy and strength?
- Could you do those activities more often? *(1)*

Then follow the relevant guidelines on promoting functioning in daily activities in specific MNS modules.

3. Pharmacological interventions

The health care provider should start by inquiring:

- How do you feel about taking a medicine that can treat your condition?
- Do you know anything about this medication?
- Do you know about the dose of the medication?
- Do you know about the possible side-effects of medication?
- Do you have any concerns regarding medication?
- Do you know how long would you need to take this medication?
- Do you have any questions? *(2, 3)*

Explain the following to the patient and carers:
The importance of taking the medication as prescribed.
The dose, duration of treatment and potential side-effects of medications.

Then follow the relevant guidelines on pharmacological treatments in specific MNS modules.

Summary

The following summary will help to initiate a clinical assessment and should be considered before each module.

- After greeting the patient and introducing yourself, explain:
  - That you will be making brief notes during the consultation so that you do not miss something important.
  - That you will refer to your (mhGAP-IG) guide (on your table/phone or a master chart on your wall) to check important points.
  - That you would like to see the patient alone first for an assessment (with a chaperone, where needed), and will then invite the carer(s) for further discussion.
  - How much time you will spend on this consultation and examination.
- Then close the door to ensure privacy and reassure the patient that the consultation is confidential.
- Start the interview with an open-ended question inviting the patient to describe the problem or the main reasons for seeking help. It is best not to interrupt (for at least a minute) and carefully note down all complaints.

Some examples are as follows.

- Can you tell me what brings you to see me today? *(5)*
- Have you had any recent health (physical or mental) problems? *(6)*
- Could you describe your symptoms/problems? When did it/these first start? *(6)*
- Please can you share what has been troubling you? *(8)*

- A list of questions has been provided for each area of examination to help the health care provider, but not all questions need to be asked from each patient.
- For planning treatment, all efforts should be made to involve patients in treatment decisions instead of imposing any advice. For psychosocial interventions, patients should also be actively engaged by attentively listening to the person. The health care provider should explore what the patient already knows about their options, how much would they like to know, identify gaps in their knowledge, share relevant facts about treatment and allow them to ask as many questions as needed.
- Assessment of a patient with an MNS condition comprises the following components. Refer to each module for specific guidelines.
  - Interview of the patient.
  - Examination of their mental state.
  - Physical examination.
  - Information from the carer.
  - Laboratory investigations.

DEPRESSION

See the Summary on page 9 which helps to initiate a clinical assessment.

The assessment of a patient suffering from depression requires additional considerations, which are described below.

- Create a safe and private atmosphere for the person to share thoughts. It is important to ask these questions WITHOUT any judgement. These may be difficult questions and will need to be asked sensitively.

- People with severe depression might experience hopelessness, thoughts of self-harm or suicidal ideation. It is important to assess the risk of self-harm or suicide, when needed.

ASSESSMENT

Box 1

Does the person have depression?

Box 1.1

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

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

If the patient describes a) persistent depressed mood, or b) markedly diminished interest in or pleasure from activities in his/her opening account, confirm these symptoms. Otherwise, ask direct questions to check these core symptoms.

The health care provider should be familiar with local terms and expressions to describe a depressed mood (sadness) and use these terms as well.

• *Persistent depressed mood*

The health care provider should note their own observations, as well as ask the following questions.

- How has your mood been? How long have you felt like that? *(5)*
- May I ask some questions regarding feelings of sadness or depression? *(6)*
- Do you keep reasonably cheerful or have you been very depressed or sad recently? *(5)*
- What has your mood been like lately? Or, how would you describe your mood? *(5)*
- Are you crying a lot lately? *(8)*
- Are you often getting angry/upset lately? *(8)*

• *Markedly diminished interest in or pleasure from activities*

- How has your interest in things been? If reduced, how long has that been so? *(5)*
- How is your interest in your work, family, hobbies, personal care, environment etc.? *(5)*
- What are you usually interested in? What do you like doing? *(5)*
- Have you been able to positively enjoy things like taking a walk, or working at your hobbies and your interests? Having a nice meal with friends? *(6)*
- Have you lost your interest in doing these things? *(5)*
- Have you noticed any loss of interest in activities, hobbies or work? *(9)*
- Are you losing interest in most things like work, hobbies and other things you usually enjoy? *(10)*

Box 1.2

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

- ***Disturbed sleep or sleeping too much***

- How has your sleep been? *(5)*
- Have you noticed any changes in your sleep? *(5)*
- Have you had any trouble getting to sleep during the past month? *(5)*
- How long do you lie awake? *(5)*
- Do you wake up early in the morning? *(5)*
- During the last 2 weeks, have you woken up at least 2 hours before you want to every day? *(10)*
- Do you feel particularly bad when you first get up, but feel better later in the day? *(10)*
- Are you sleeping more than usual? *(5)*
- Do you take any sleeping tablets? How often? *(5)*

- ***Significant change in appetite or weight (decrease or increase)***

- What has your appetite been like recently? *(5)*
- Have you noticed any changes in your appetite? *(5)*
- Do you have less appetite than usual almost every day? *(10)*
- Have you lost any weight during the past 3 months? *(5)*
- Do you have a much larger appetite than usual almost every day? *(10)*
- Is there any change in your weight? *(5)*
- Have you gained/lost any weight during the past 3 months? *(5)*

- ***Beliefs of worthlessness or excessive guilt***

- Do you experience any negative thoughts? For example:
- Do you feel like a failure?
- Do you feel disappointed in yourself?
- Do you blame yourself for your problems?
- Do you feel you are worthless? *(5)*

- ***Fatigue or loss of energy***

- How are your energy levels? *(5)*
- Do you get easily tired during the day? Also when you have not done anything especially hard? *(5)*
- Are you talking/moving/working less than is normal for you? *(10)*
- Has anyone else noticed any change in your energy levels? *(10)*

- ***Reduced concentration***

The health care provider should note their observations and ask the following questions:

- What has your concentration been like recently?
- Can you read an article in the paper or watch a TV programme right through?
- Do your thoughts drift so that you don't take things in?
- When you are talking to another person, can you concentrate on what they are saying to you? *(5)*

To test concentration, do the following tests.

- Ask the patient to name the days of the week backwards (Sunday, Saturday, Friday, etc.) *(2, 3, 11)*.
- Ask the patient to count backwards from 20 *(19, 18, 17, etc.) (2, 3, 11)*.

- ***Indecisiveness***

- How is your ability to make decisions? *(5)*
- Are you finding it difficult to make decisions? *(5)*
- Can you decide simple matters easily? *(5)*
- Can you make decisions concerning daily matters? *(5)*
- Are you able to make up your mind about things you ordinarily have no trouble deciding about? *(10)*

- ***Observable agitation or physical restlessness***

The health care provider should note their observations and ask the following questions.

- Do you feel fidgety or restless? *(5)*
- Do you have to keep pacing up and down? *(5)*
- Do you find yourself engaging in hand wringing, nail biting, hair-pulling or biting of lips? *(9)*
- Do you have to be moving all the time, e.g. you can't sit still or can't keep your hands still when sitting? *(10)*
- Does anyone else notice that you move all the time? *(10)*

- ***Talking or moving more slowly than usual***

The health care provider should note their observations and ask the following questions.

- Do you seem to have slowed down in your movements or to have too little energy recently?
- How much has it affected you? *(5)*

- ***Hopelessness***

This may be a difficult question, and needs to be asked sensitively.

- How do you see the future currently?
- Has life seemed quite hopeless?
- Can you see any future?
- Have you given up, or does there still seem some reason for trying? *(5)*

- ***Suicidal thoughts or acts***

This may be a difficult question, and needs to be asked sensitively.

- Have you ever felt that life isn't worth living? *(5)*
- Did you ever feel like ending it all? *(5)*
- What did you think you might do? *(5)*
- Did you actually try? *(5)*
- Did you make a suicide plan? *(10)*
- Did you attempt suicide? *(10)*

If there is risk of self-harm or suicide, inform the patient that you might have to discuss your concerns with his/her family.

If there is risk of self-harm or suicide, refer to the module on self-harm and suicide for further assessment.

Box 1.3

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

This question needs to be adapted depending on the role and responsibilities of the patient.

For example:

- For a person who is employed, check if responsibility towards work is affected.
- For a person who is married, check if responsibility towards their partner is affected.
- For a parent, check if responsibility towards childcare is affected.
- For a student, check if responsibility towards academic study is affected.
- Check if self-care is affected (e.g. rest, exercise, personal care, social activity, prayer, etc.).

Other related questions are:

- Have you missed work or been unable to do housework, go shopping or travel etc. in the last month? *(5)*
- How much interference has there been in your activities because of depression? What sort of a problem is it? *(6)*
- Has there been a decrease in actual time spent doing activities, or a decrease in productivity? *(9)*
- Have you stopped working because of your present illness? *(9)*
- To what extent do the problems affect your work or relationships with other people? *(5)*
- Do you try to avoid the company of other people? *(6)*
- How much difficulty do you have in getting along with people who are close to you? *(12)*
- Have the symptoms affected your functional capacity in some other way? *(5)*
- How much difficulty do you have in taking care of your household responsibilities? *(12)*
- How much difficulty do you have in your day-to-day work/school? *(12)*
- How much difficulty do you have in doing your most important work/school tasks well? *(12)*

Box 2

Are there other possible explanations for the symptoms?

Box 2.1

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)?

The health care provider should note their observations, ask screening questions AND conduct a physical examination.

Ask the following questions, if needed:

- Do you have any medical illnesses? *(8)*
- Are you taking any other medications? (Such as steroids) *(8)*
- Do you frequently feel cold when others do not? *(13)*

Look for signs of a physical illness, for example:

- Pallor
- Weight loss
- Goiter (enlarged thyroid gland)
- Dry, rough skin
- Coarse hair or hair loss
- Eye and face swelling *(13)*.

Box 2.2

Is there a history of mania?

Ask whether the person has ever had an episode where any of the following symptoms were present:

- 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 or making important decisions without planning.
- Unrealistically inflated self-esteem.

For further assessment, refer to the module on psychosis (Box 2).

Box 2.3

Has there been a major loss (e.g. bereavement) within the last 6 months?

- Has there been a major loss within the last 6 months?
- Can you please describe your loss?
- How are you coping with your loss?
- How has this loss affected you? *(14)*

Box 3

Are there concurrent priority MNS conditions?

See Annex 1 for relevant screening questions.

MANAGEMENT

Psychosocial interventions

2.1 Psychoeducation

The health care provider should start by inquiring:

- What do you think is happening to you?
- Do you know about depression?
- Let me tell you about the common symptoms of depression. Do these symptoms describe your condition?
- Do you have any questions? *(8)*

Then follow the guidelines in 2.1 to educate the patient.

2.2 Reduce stress and strengthen social support

The health care provider should start by inquiring:

- What comforts you when you are upset?
- Do you talk to anyone about your problems and what you are going through?
- Is there any person who you feel can give you support? *(1)*

Then follow the guidelines in 2.2 to strengthen social support.

2.3 Promote functioning in daily activities

The health care provider should start by inquiring:

- When you were feeling better, what is one task, at home or at work, that you were doing regularly and that you are no longer doing or do less?
- What is one pleasant or enjoyable activity that you could start doing again or do more often? *(1)*

Then follow the guidelines in 2.3 to promote functioning in daily activities.

MANAGEMENT

Pharmacological interventions

Consider antidepressants

The health care provider should start by inquiring:

- How do you feel about taking a medicine that can treat your condition?
- Do you know anything about antidepressant medications?
- Do you know about the dose of the medication?
- Do you know about the possible side-effects of medication?
- Do you have any concerns regarding medication?
- Do you have any questions? *(2, 3)*

Explain the following to the patient and carers:

- The importance of taking the medication as prescribed.
- The dose, duration of treatment and potential side-effects of medications.

Then follow the guidelines in 2.4 to prescribe medication.

FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the person improving?

- How have you been?
- Have you noticed any improvement?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving?
- Have you been able to do the things you were doing before this illness?
- Are you taking the medication as prescribed?
- Are there any side-effects? *(14)*

See Annex 2 for a set of cases for practicing skills in clinical decision-making.

PSYCHOSIS

See the Summary on page 9 which helps to initiate a clinical assessment.
The assessment of a patient suffering from psychosis requires additional considerations, which are described below.

The assessment for psychosis is challenging, because the patient might not fully understand that they are unwell and therefore might not be willing for consultation/ examination/management.

It is often difficult to follow a strictly structured assessment, but the health care provider should still aim to remain organized and systematic.

For patients without insight, most of the information will be sought from a family member or carer who knows the patient well. Sometimes, the health care provider needs to see the family member without the patient's consent (if the patient is aggressive or unwilling for consultation).

Examining the patient is extremely important, because clinical presentation will help in diagnosis when patients are too unwell to describe their experiences.

Patients suffering from psychosis might not accept treatment. This situation can be challenging, especially in countries where mental health legislation is not implemented. In such cases, the health care provider should discuss the dilemma with the family and ensure that the safety of the patient and others is not compromised.

ASSESSMENT

Box 1

Are there any other explanations for the symptoms?

The health care provider should note their observations, ask screening questions, conduct a physical examination and consider laboratory investigations.

Box 1.1

Evaluate for medical conditions

When a person presents with marked disturbance of behaviour or thoughts (irrelevant behaviour or speech), the health care provider should rule out the possibility of delirium (e.g. due to an acute physical condition) or medication side-effects. This is particularly important if the patient is elderly or if the patient is likely to be physically unwell.

Observe:

- Confusion
- Disoriented in time, place and person
- Talking irrelevantly and incoherently
- Not paying attention to instructions, not engaging
- Agitation and restlessness *(2)*.

Ask the patient (if well enough):

- How have you been?
- What brings you here?
- Do you have any problems/concerns?
- For how long you have been unwell?
- Could you tell me more about it? *(15)*

Examine the patient:

- What time of the day is it? *(16)*
- What is this place where we are sitting? *(16)*
- What is the name of the person who has come along with you? *(16)*
- Ask the patient to name the days of the week backwards (Sunday, Saturday, Friday, etc.). *(11)*
- Ask the patient to count backwards from 20 (19, 18, 17, etc.). *(11)*

Physical examination and investigations:

- Conduct a thorough physical examination (or as much as possible)
- Review laboratory tests (rule out infections, dehydration, metabolic abnormalities)
- Review recent medications (such as anti-malarial medication, steroids). *(2, 3)*

Ask the carers:

- Can you describe the problem?
- How long has the patient been unwell?
- What are the changes in his/her behaviour?
- Has the patient been overly agitated and aggressive, or been quiet and withdrawn?
- Has the patient been forgetful or disoriented (about time, place)?
- Has the patient been suffering from fever, vomiting, diarrhoea, cough, rigidity? *(2, 3)*

Box 1.2

Evaluate for dementia, depression, drug/alcohol intoxication or withdrawal

See Annex 1 for relevant screening questions.

Box 2

Is the person having an acute manic episode?

Box 2.1

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?

Ask the patient:

- ***Elevated or irritable mood***
  - How has your mood been?
  - Are you feeling sad or happy?
  - Have you sometimes felt particularly cheerful and on top of the world, without any reason? *(5)*
- ***Decreased need for sleep***
  - How has your sleep been?
  - Do you need less sleep than usual? *(5)*
- ***Increased activity, feelings of increased energy, increased talkativeness or rapid speech***
  - How have your energy levels been?
  - Do you feel particularly full of energy lately, or full of exciting ideas?
  - Do you find yourself extremely active, but not getting tired?
  - Have you developed any new interests lately?
  - Have you been talking more than usual?
  - Have you been having racing thoughts, like your mind is working fast than usual?
  - Have you ever felt that you have a lot of energy and can do anything? *(5)*
- ***Loss of normal social inhibitions, such as sexual indiscretion***
  - Have you made any inappropriate comments, especially towards strangers?
  - Have you been sexually more active than usual? *(2, 5)*
- ***Impulsive or reckless behaviour, such as excessive spending or making important decisions without planning***
  - Have you been acting differently recently?
  - Have you been shopping excessively?
  - Have you made any unusual decisions recently? *(5)*
- ***Being easily distracted***
  - How has you attention/focus been?
  - Do you get distracted easily? *(5)*
- ***Unrealistically inflated self-esteem***
  - Do you believe that you have special powers and that you are on a special mission on earth?
  - Do you believe that you are better than everyone else and that other people are inferior to you?
  - Do you believe that you are a prophet or a president who has been assigned special duties? *(5)*

Examine the patient:

- Overactive, e.g. not sitting in one place, moving back and forth in chair.
- Overconfident, e.g. shaking hands, moving around as if the place belongs to him/her.
- Disinhibited, e.g. singing songs, overfamiliar behaviour, making inappropriate comments.
- Elated in mood, e.g. joyous, cheerful.
- Having flight of ideas, e.g. moving rapidly from one idea to another.
- Having pressure of speech, e.g. talking excessively, difficult to interrupt.
- Easily distractible, e.g. loses focus due to stimuli in the surroundings. *(17)*

Ask the carers:

In cases where the patient is too unwell to be interviewed, ask the carer(s) about the above symptoms.
Some examples are:

- Has the patient been more active than usual?
- Has the patient been talking more than usual, e.g. is it difficult to interrupt him/her while talking?
- Has the patient been sleeping less than usual?
- Has the patient been expressing grandiose ideas, e.g. about having special powers, claiming to be a prophet or president?
- Has the patient been elated and joyful (without any reason)?
- Has the patient been making sexually inappropriate remarks or indulged in sexually inappropriate acts?
- Has the patient been spending excessive money or making irresponsible decisions? *(5)*

Box 3

Does the person have psychosis?

Box 3.1

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

Ask the patient:

- ***Delusions, fixed false beliefs not shared by others in the person's culture***

  - Have you wanted to stay away from other people? If yes, why? *(5)*
  - Have you been suspicious of their intentions? Or that they might actually harm you? *(6)*
  - Do other people seem to laugh at you? Talk about you? Spy on you? *(5)*
  - Do you have the feeling that you are being blamed for something, or even accused? *(5)*
  - Do you receive messages in the newspapers, or on TV or radio? *(6)*
  - Do you feel those things were arranged so as to have a special meaning for you, or even that harm might come to you? Can you describe that? *(6)*

- ***Hallucinations, hearing voices or seeing things that are not there***

  - What about your imagination, have you noticed anything different?
  - Do you ever get the feeling that something odd is going on, which you can't explain?
  - Do you ever seem to hear voices when there is no one about?
  - Have you ever had visions, or seen things other people couldn't see?
  - Is there anything unusual about the way things look or sound, or smell and taste? *(5)*

Examine the patient:

- ***Appearance***
  - Odd or inappropriate appearance, e.g. wearing odd clothes, ornaments; odd posture/gestures/gait etc.
  - Signs of self-neglect *(6)*.
- ***Behaviour***
  - Aggressive, e.g. agitated, abusive, threatening
  - Violent, e.g. breaking things, hitting others
  - Looks paranoid
  - Constantly fiddling, changing position, standing or sitting down
  - Fearful of surroundings, suspicious of people around *(6)*.
- ***Speech***
  - Incoherent/irrelevant speech: the meaning of speech is obscured by distorted grammar; lack of logical connection between one part of a sentence and another, or between sentences; and sudden irrelevancies
  - Fails to answer, questions have to be repeated, answers restricted to minimum necessary, no extra sentences
  - Self-muttering, self-talking *(6)*.
- ***Mood***
  - Flat in mood, e.g. having no facial expressions
  - Inappropriate mood, e.g. inappropriate smiles *(6)*.
- ***Beliefs***
  - Odd but firm beliefs which are difficult to explain.
  - Paranoid ideas, e.g. that someone is going to harm him/her *(6)*.
- ***Hallucinations***
  - Responding to voices, e.g. through gestures, talking to himself/herself.
  - Might or might not confirm that he/she can hear some voices *(6)*.
- ***Insight***
  - Does not believe or accept that he/she is unwell.
  - Does not accept that their beliefs are not true.
  - Does not recognize that they need any treatment *(6)*.

Ask the carers:

In cases where the patient is too unwell to be interviewed, ask the carer about the above symptoms. Some examples are:

- How has the patient been behaving?
- Have you noted any odd/abnormal behaviour?
- Has there been a change in his/her behaviour that has led to disruption and/or violence?
- Does the patient think that people around them are trying to cause harm or conspiring to kill them?
- Does the patient talk to himself/herself or respond to voices not present in the surroundings?
- Is there any self-neglect?
- Does the patient recognize that he/she is unwell and needs treatment? *(2)*.

MANAGEMENT

Psychosocial interventions

2.1 Psychoeducation

The health care provider should start by inquiring:

- What do the person and the carers already know about psychosis?
- What are the gaps and misconceptions in their knowledge about psychosis?
- What questions do they have about psychosis? *(15)*

Then follow the guidelines in 2.1 psychoeducation to educate the patient and their carers.

2.2 Reduce stress and strengthen social supports

The health care provider should start by inquiring:

- What comforts you when you are upset?
- What are your sources of support?
- Who do you talk to about your problems and what you are going through?
- What activities help you to reduce stress? Have you been doing these? *(1)*

Then follow the guidelines in 2.2 to support the patient and their carers.

2.3 Promote functioning in daily living activities

The health care provider should start by inquiring:

- Are you attending school? If not, can you start doing that?
- Are you attending work? If not, can you start doing that?
- Are you doing household chores? If not, can you start doing them?
- What is one task, at home or at work, that you were doing regularly that you are no longer doing or do less?
- What is one enjoyable activity that you could start doing again or do more often? *(1)*

Then follow the guidelines in 2.3 to promote functioning in daily living.

2.4 General advice for carers

The health care provider should start by inquiring:

- Who are the main carers? Who else provides care? What care do they provide?
- What difficulties do they face? How do they usually cope with stress?
- How has this situation affected them? Is there any support available for the carers?
- What are the options available to support the carers? *(4)*

Then follow the guidelines in 2.4 to advise the carers.

Pharmacological interventions

2.5 Consider anti-psychotic medication

Involve the patient and the carers (as much as possible).
If the patient is too unwell initially, try to involve him/her as soon as their condition improves.

The health care provider should start by inquiring:

- How do you feel about taking a medicine that can treat your condition?
- Do you know anything about anti-psychotic medication?
- Do you know about the dose of the medication?
- Do you know about the possible side-effects of medication?
- Do you have any concerns regarding medication?
- Do you have any questions? *(2, 3)*

Explain the following to the patient and carers:

- The importance of taking the medication as prescribed.
- The dose, duration of treatment and potential side-effects of medications.

Then follow the guidelines in 2.5 to prescribe medication.

FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the person improving?

- How have you been?
- Have you noticed any improvement?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving?
- Have you been able to do the things you were doing before this illness? *(14)*

Box 2

Routinely monitor treatment

- Are you taking the medication as prescribed?
- Are there any side-effects?
- Are you taking any other medication? *(1)*

See Annex 2 for a set of cases for practising skills in clinical decision-making.

EPILEPSY

See the Summary on page 9 which helps to initiate a clinical assessment.

The assessment of a patient suffering from epilepsy requires additional considerations, which are described below.

The assessment of epilepsy is based on a detailed and careful history, both from the patient and from an informant (usually a family member) who has witnessed a seizure. If the informant is not present, an eyewitness account can also be sought over the telephone. In some cases, the family can also help by video recording the seizure.

The section on the management of emergency presentation of epilepsy is self-explanatory. Therefore, no further questions have been added.

ASSESSMENT

Box 1

Does the person have convulsive seizures?

Box 1.1

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

- What was the duration of seizure? How long did the seizure last? *(2)*

Exclude pseudo-seizures (non-epileptic seizures)
These are typically associated with a stress trigger; episodes are often prolonged and can involve non-rhythmic 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.

Ask the patient:

- Have you suffered any stressful situation, emotional trauma or abuse?
- Can you recall what happened during the seizure?
- Were you aware of your surroundings during the seizure?
- Were you able to talk during the seizure?
- How long did the seizure last for?
- During the seizure, did you suffer from a tongue bite or any other injury, or lose bladder control?
- Have you ever suffered from a mental illness in the past?
- Is there a history of psychiatric illness in your family? *(18)*

Ask the carers:

- Is there a history of trauma or abuse in the past?
- Did the patient recall the events during the seizure?
- Was the patient able to talk during the seizure?
- Was the patient aware of their surroundings during the seizure?
- What was the duration of the seizure?
- Was there a tongue bite, any injury or loss of bladder control during the seizure?
- Has the patient had any psychiatric illness in the past?
- Is there a history of psychiatric illness in the patient's family? *(18)*

Box 1.2

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

Ask the carers:

- What happens to the patient during the seizure?

Then check whether the patient had the following symptoms DURING the seizure:

- ***Loss of consciousness or impaired consciousness***

Ask the patient:

- Do you have any recollection of the episode (seizure)? *(19)*

Ask the carers:

- Was the patient able to relate to the environment during the seizure?
- Was the patient able to talk/respond during the seizure? *(19)*

- ***Stiffness, rigidity***

- What was the state of the body during the seizure?
- Did the face, body, arms or legs become stiff?
- Did the eyes, mouth, face, head, arms or legs move abnormally? *(19)*

- ***Bitten or bruised tongue, bodily injury***

- Did the patient sustain any injury during the seizure?
- Did the patient ever bite his/her tongue during the seizure? *(19)*

- ***Incontinence of faeces/urine***

- Did the patient wet or soil himself/herself (pass urine or faeces) during the seizure? *(19)*

Then check whether the patient had the following symptoms AFTER the seizure:

- Fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches or weakness on one side of the body

Ask the patient:

- How did you feel after the seizure?
- Did you have a headache? Muscle aches? Confusion? Weakness? *(19)*

Ask the carers:

- Was the patient confused or tired?
- Could the patient speak normally?

Box 2

Is there an acute cause?

Is there neuroinfection or other possible causes of convulsions?

The health care provider should note down their observations, ask screening questions AND conduct a physical examination.

Following are some examples of possible causes of convulsions.

- ***Fever/infection***
  - Were you ever unwell with fever?
  - Are you HIV positive?
  - Are you on any medication? *(2, 3, 19)*
- ***Meningeal irritation (e.g. stiff neck)***
  - Were you ever unwell with severe stiffness of neck? Vomiting? (2, 3, 19)
- ***Head injury***
  - Have you ever suffered a head injury? Particularly one associated with loss of consciousness, prolonged loss of memory and fracture of the skull? *(2, 3, 19)*
- ***Metabolic abnormality (e.g. hypoglycaemia)***
  - Do you have any physical illness?
  - Do you have diabetes?
  - If yes, was your blood glucose level checked at the time of the seizure? Do you take any medications for diabetes? *(2, 3, 19)*
- ***Alcohol or drug intoxication or withdrawal***
  - Do you use alcohol/drugs?
  - If yes, what substances do you use? How many days per week do you use this substance?
  - When was the last time you used alcohol/drugs? *(5)*

Box 3

Does the person have epilepsy?

Box 3.1

Has the person had at least two seizures on two different days in the past year?

- How frequent are the episodes?
- How many in the past year?
- When was the last episode?

Box 3.2

Assess for underlying cause. Do a physical examination.

The health care provider should note down their observations, ask screening questions AND conduct a physical examination including a neurologic examination.

Check for history of:

- Neck stiffness and vomiting, meningitis
- Cerebral malaria
- Asphyxia or respiratory distress at birth.
- Head injury in the past, particularly associated with loss of consciousness, prolonged loss of memory and fracture of the skull
- Seizures in the family *(19)*.

Following a seizure, examine:

- Size of pupils. Are they dilated/pinpoint/unequal/unreactive?
- Weakness on one side of body or in one limb.
- Abnormal coordination *(20)*. (To check: ask the patient to close their eyes; touch the patient's index finger and ask him/her to use that finger to touch the tip of their nose, then repeat the same with the middle finger.)

Box 4

Are there concurrent MNS conditions?

See page 6 for a summary which helps to initiate an assessment.

MANAGEMENT

Psychosocial interventions

2.1 Psychoeducation

- ***Provide information on nature and treatment of epilepsy***

The health care provider should start by inquiring:
- What do you know about epilepsy?
- What do you think is the cause of epilepsy? (Explore commonly held myths)
- What do you know about the treatment of epilepsy?
- Do you have any questions regarding epilepsy?
- Do you have any concerns regarding medications? *(21)*

Then follow the guidelines in 2.1 to educate the patient.

- ***Provide information on how carers can manage convulsion at home***

The health care provider should start by inquiring:
- How are you managing seizures at home?
- What are your concerns about the safety of the patient?
- Do you restrain the patient during the seizures?
- Do you put anything in the patient's mouth during seizures? *(14)*

Then follow the guidelines in 2.1 to help carers to manage a seizure at home.

- ***Provide information on when to get medical help***
- Do you know when to get medical help? *(14)*

Then follow the guidelines in 2.1 on indications for seeking medical help.

2.2 Promote functioning in daily activities and community life

The health care provider should start by inquiring from the carers:
- What are your concerns about epilepsy that may interfere with daily activities?
- What concerns do you have about their life decisions (e.g. attending school, or marriage and jobs)?
- Are you aware of the necessary precautions to be taken for the safety of a patient with epilepsy (e.g. swimming alone, sleeping too little)? *(1)*

Then follow the guidelines in 2.2 to promote functioning in daily activities.

Pharmacological interventions

2.3 Initiate antiepileptic medications

The health care provider should start by inquiring:

- How do you feel about taking a medicine that can treat your condition?
- Do you know anything about anti-convulsant medication?
- Do you know about the dose of the medication?
- Do you know about the possible side-effects of medication?
- Do you have any concerns regarding medication?
- Do you have any questions? *(2, 3)*

Explain the following to the patient and carers:

- The importance of taking the medication as prescribed.
- The dose, duration of treatment and potential side-effects of medications.

Then follow the guidelines in 2.3 to prescribe medication.

FOLLOW-UP

Box 1

Review the current condition

Box 1.1

Does the patient have more than 50% seizure reduction in convulsive frequency?

- How have you been?
- Have you noticed any improvement?
- Has the frequency of your seizures reduced?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving? *(14)*

Box 2

Monitor treatment

- Are you taking the medication as prescribed? If not, why not?
- Are you experiencing any side-effects?
- Are you taking any other medication?
- Do you have any concerns/questions?

See Annex 2 for a set of cases for practising skills in clinical decision-making.

CHILD AND ADOLESCENT MENTAL AND BEHAVIOURAL DISORDERS

See the Summary on page 9 which helps to initiate a clinical assessment.
The assessment of a child or adolescent suffering from a mental or behavioural disorder requires additional considerations, which are described below.

The assessment of a child/adolescent comprises the following components *(2)*:

- Assessment of the child/adolescent.
- Assessment of parents/family/home environment.
- Assessment of teachers/peers/school environment.

Parents/carers should be asked to attend the assessment interview. It is always helpful to see the family interact.

For younger children, the main informants are usually the parents. For children over the age of 6, the aim should be to see the child alone for a brief period as well (with the permission of the parents). Adolescents should always be offered the opportunity to be seen on their own. Always reassure them about the confidentiality of the information they share. If there are concerns about their safety, relevant information should be shared with their consent *(2)*.

ASSESSMENT

Box 1

Assess for developmental disorders

Box 1.1

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

It is extremely important for the health care provider to be aware of patterns of normal development to be able to recognize any delay/different patterns (see Table 1).

Table 1. Signs for developmental milestones *(4)*

Age	Warning signs to watch for
By the age of **1 month**	Poor suckling at the breast or refusing to suckle Little movement of arms and legs Little or no reaction to loud sounds or bright lights Crying for long periods for no apparent reason Vomiting and diarrhoea, which can lead to dehydration
By the age of **6 months**	Stiffness or difficulty moving limbs Constant moving of the head (this might indicate an ear infection, which could lead to deafness if not treated) Little or no response to sounds, familiar faces or the breast Refusing the breast or other foods
By the age of **12 months**	Does not make sounds in response to others Does not look at objects that move Listlessness and lack of response to the caregiver Lack of appetite or refusal of food
By the age of **2 years**	Lack of response to others Difficulty keeping balance while walking Injuries and unexplained changes in behaviour (especially if the child is cared for by others) Lack of appetite
By the age of **3 years**	Loss of interest in playing Frequent falling Difficulty manipulating small objects Failure to understand simple messages Inability to speak using several words Little or no interest in food
By the age of **5 years**	Fear, anger or violence when playing with other children, which could be signs of emotional problems or abuse
By the age of **8 years**	Difficulties making and keeping friends and participating in group activities Avoiding a task or challenge without trying, or showing signs of helplessness Trouble communicating needs, thoughts and emotions Trouble focusing on tasks and in understanding and completing schoolwork Excessive aggression or shyness with friends and family

A comprehensive evaluation of a child is composed of interviews with the parents, the child and other family members; it is also important to gather information regarding the child's current school functioning.

For young children

Parents are likely to be anxious and may have issues around acceptance of any developmental delays, or have fears that they may be blamed for their child's problems. Time should be taken to put them at ease and explain the purpose of questions. They should be encouraged to talk spontaneously about the problems before focused questions are asked.

Observing young children speak, relate to parents, draw and play with toys may be helpful in assessing their stage of development.

Ask the parents:

- Were there any difficulties with (age appropriate) milestones across all developmental areas? (Sometimes, it helps if the parents are guided to compare the child's development with other children in the family.)
- Is the child behaving like other children of the same age?
- What kinds of things can the child do alone (sitting, walking, eating, dressing or toileting)?
- How does the child communicate with you?
- Does the child smile at you?
- Does the child react to his/her name?
- How does the child talk to you?
- Is the child able to ask for what he/she wants?
- How does the child play?
- Is the child able to play well with other children of the same age? *(4)*

For older children and adolescents

Children may not be able or willing to express their ideas and feelings in words. Observations of their behaviour and interactions during the interview are very important.

It is essential to begin by establishing a friendly atmosphere and winning the child's confidence. Start with a discussion of neutral topics such as pets, favourite games or birthdays, before turning to the presenting problem.

Children are more suggestible than adults and might try to give the answer an adult would want, so it is useful to avoid leading questions.

Ask the parents:

- Does the child go to school and, if so, how they are managing schoolwork (learning, reading and writing)? Everyday household activities?
- How much help does the child need to do daily activities or self-care (e.g. at home, school, work)?
- Does the child face any difficulties communicating and interacting with others? *(4)*

Ask older children/adolescents:

- Are you going to school? If yes, which grade?
- How are you doing in school?
- Are you able to finish your schoolwork?
- Do you have any problems understanding lessons? Doing homework?
- Do you have difficulties in school because you cannot understand or follow instructions? *(4)*

Box 1.2

Are there signs/symptoms suggesting any of the following?

The health care provider should note their observations, ask screening questions AND conduct a physical examination.

If there is delay in developmental milestones, rule out treatable or reversible conditions that can contribute to the developmental delay.

Some of the preventable and treatable causes of developmental delay are: nutritional deficiency including iodine deficiency; anaemia; malnutrition; and acute or chronic infectious illness, including ear infection and HIV/AIDS.

Look for signs of a physical illness, for example:

- Pallor
- Mouth ulcers
- Brittle nails
- Dry skin
- Pitting oedema (after applying pressure on dorsum of foot for a few seconds, a pit remains after the finger is removed)
- Lethargy
- Weight loss, visible severe wasting and absence of fat
- Swelling in the neck
- Hair changes, such as thin hair
- Fever
- Ear discharge
- Painful swelling behind the ear
- Enlarged lymph nodes *(22)*.

Box 1.3

Assess the child for visual and/or hearing impairment

- ***Vision assessment***

Observe if the child can do the following:

- Look at your eyes
- Follow a moving object with the head and eyes
- Grab an object
- Recognize familiar people *(4)*.

If not, inform the parent that the child may have impaired vision and they should consult a specialist.

- ***Hearing assessment***

Observe if the child can do the following:

- Turn their head to see someone behind them when they speak
- Show a reaction to loud noise
- Make a lot of different sounds (tata, dada, baba) *(4)*.

Box 2

Assess for problems with inattention or hyperactivity

It is important to assess the child in at least two different settings.

The health care provider should note their observations and ask the following questions.

2.1 If the child/adolescent is:

- ***Overactive***
  - Does the child/adolescent run about or climb too much when remaining seated is expected? *(23)*
- ***Unable to stay still for long***
  - Does the child/adolescent leave their seat when remaining seated is expected? *(23)*
- ***Easily distracted/has difficulty completing tasks***
  - Is the child/adolescent easily distracted by noises or other stimuli?
  - Is the child/adolescent unable to complete homework?
  - Does the child/adolescent not pay attention to details or make careless mistakes with, for example, homework? *(23)*
- ***Moving restlessly***
  - Does the child/adolescent run about or climb too much when remaining seated is expected? *(23)*

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

- Symptoms are present in multiple settings (home, school, playground).
- Symptoms have lasted at least 6 months.
- Symptoms are inappropriate for the child/adolescent's developmental level.
- There is considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas.

2.3 Rule out physical conditions that can resemble attention deficit hyperactivity disorder (ADHD)

The health care provider should note down their observations, ask screening questions AND conduct a physical examination.

Look for signs of a physical illness, for example:

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

Box 3

Assess for conduct disorder

The assessment relies on information elicited from parents/carers and teachers/school professionals regarding the presence and severity of symptoms in school, home and social settings.

It is important to be aware of age-appropriate disruptive behaviour in childhood and adolescence.

Box 3.1

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***
  - Does the child actively defy or refuse to go along with adults' requests or rules? *(23)*

- ***Extreme irritability/anger, frequent and severe temper tantrums***
  - Does the child frequently lose their temper? *(23)*
  - Does the child show severe tantrums, which result in self injury or physical aggression?

- ***Difficulty getting along with others***

Compared to others of his/her age, how well does your child:

  - Get along with his/her brothers and sisters?
  - Get along with other kids?
  - Behave with his/her parents? *(24)*

- ***Provocative behaviour***
  - Does the child deliberately annoy people? *(23)*

- ***Excessive levels of fighting or bullying***
  - Does the child bully, threaten or intimidate others?
  - Has the child used a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife, gun)? *(23)*

- ***Cruelty to animals or people***
  - Has the child been physically cruel to people?
  - Has the child been physically cruel to animals? *(25)*

- ***Severe destructiveness to property, fire-setting***
  - Has the child deliberately set fires to try and cause serious damage? *(23)*

- ***Stealing, repeated lying, truancy from school, running away from home***
  - Has the child stolen things that have value?
  - Has the child stolen things of value without confronting a victim?
  - Does the child skip school without permission?
  - Does the child stay out at night despite parental rules? *(23)*

Box 3.2

Are symptoms persistent, severe and inappropriate for the child/adolescent's developmental level?

Are ALL of the following true?

- Are symptoms present in multiple settings (home, school, playground)?
- Have the symptoms lasted for at least 6 months?
- Are the symptoms 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?

Box 4

Assess for emotional disorders

(prolonged, disabling distress involving sadness, fearfulness, anxiety or irritability)

The health care provider should note down their observations and ask the following questions.

Box 4.1

Ask if the child/adolescent:

- ***Is often feeling irritable, easily annoyed, downhearted or sad***
  - How has your mood been?
  - May I ask some questions about feelings of sadness or depression? *(6)*
  - Do you keep reasonably cheerful, or have you been very depressed or sad recently? *(5)*
  - Are you often getting angry/upset lately?

- ***Has lost interest in or enjoyment of activities***
  - Are you losing interest in most things, such as work, hobbies and other things you usually enjoy? *(10)*

- ***Has many worries or often seems worried***
  - Do you have many worries about your future?
  - Do you feel worried most of the time during the day? *(5)*

- ***Has many fears or is easily scared***
  - Do you often feel scared?

- ***Often complains of headaches, stomach aches or sickness***
  - Do you often have headaches severe enough to affect your daily functioning?

- ***Is often unhappy, downhearted or tearful***
  - Are you crying a lot lately? *(5)*

- ***Avoids or strongly dislikes certain situations (e.g. separation from carers, meeting new people, or closed spaces)***
  - Do you feel easily scared of social situations, e.g. performing in front of others?
  - Do you feel scared when you are away from your carers?
  - Do you feel scared of closed spaces? *(2)*

Box 4.2

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

- Do you find any difficulty in your day-to-day work/school? *(12)*
- Do you find any difficulty in doing your most important work/school tasks well? *(12)*
- Do the symptoms result in frequent absences from school? *(26)*
- Do the symptoms result in your school grades dropping? *(26)*
- Do you find it difficult to bathe or dress yourself? *(12)*
- How well do you take care of your health? *(27)*
- Do you find it difficult to get involved with sports? *(27)*
- Do you find it difficult to get involved with activities other than sports? *(27)*
- Do you find it difficult to get along with your family, friends or teachers? *(27)*

Box 4.3

Rule out physical conditions that can resemble or exacerbate emotional disorders

The health care provider should note their observations, ask screening questions AND conduct a physical examination.

Look for signs of a physical illness, for example:

- Thyroid diseases
- Infectious illness, including HIV/AIDS
- Anaemia
- Obesity
- Malnutrition
- Asthma
- Medication side-effects (e.g. from corticosteroids or inhaled asthma medications) *(13)*.

Box 4.4

In adolescents, assess for moderate to severe depression

The health care provider should note their observations and ask screening questions.

- ***Does the adolescent have problems with mood (feeling irritable, down or sad) OR have they lost interest in or enjoyment of activities?***
  - Do you keep reasonably cheerful or have you been very depressed or sad recently? (Present State Examination.) *(5)*
  - Are you losing interest in activities such as work, hobbies or other things you usually enjoy? *(10)*

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

- ***Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?***
  - Has there been a decrease in actual time spent in activities or decrease in productivity? *(9)*
  - Have you stopped working because of your present illness? *(9)*
  - Do you find it difficult to bathe or dress yourself? *(12)*
  - Have your problems interfered with your social activities (such as visiting with friends, relatives, etc.)? *(12)*
  - To what extent do the problems affect your work or relationships with other people? *(5)*
  - Do you try to avoid the company of other people? *(6)*
  - How much difficulty do you have in getting along with people who are close to you? *(12)*
  - Have the symptoms affected your functional capacity in some other way? *(5)*
  - How much difficulty do you have in taking care of your household responsibilities? *(12)*
  - How much difficulty do you have in your day-to-day work/school? *(12)*
  - How much difficulty do you have in doing your most important work/school tasks well? *(12)*

Box 5

Assess for other priority MNS conditions

See Annex 1 for relevant screening questions.

Box 6

Assess the home environment

Box 6.1

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

Ask the child/adolescent:

- How are things at home?
- Has anything stressful or difficult been happening recently?
- Has anyone at home or outside the home hurt or upset you in any way?
- What happens when you do something your parents/carers do not like?
- What happens in your home when people get angry? *(2)*

Ask the carers:

- Are there any difficult or painful situations at home that may be affecting your child/adolescent?
- Has anyone at home been hurt or upset by anything recently?
- How do you discipline your child? *(2)*

Assess for maltreatment or exposure to violence

The health care provider should always be alert to the possibility of maltreatment. They should note down their observations, ask screening questions AND conduct a physical examination.

It is helpful to create a safe environment and ensure confidentiality during assessment of possible abuse. The child should be interviewed carefully with sensitivity and empathy.

When abuse is established, it is important to assess whether there are chances of continued risk of abuse. The presence of a single sign does not necessarily prove child abuse is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination.

To help a client feel comfortable talking about difficult or embarrassing topics, always acknowledge the difficulty and thank them for being trusting *(1)*. For example:

- Thank you for sharing this experience with me. I understand how difficult it must be for you.

Ask the child/adolescent:

- ***Physical abuse***
  - Do you feel that you live in a safe place? *(28)*
  - In the past year, have you ever felt threatened in your home? *(28)*
  - Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? *(29)*

- ***Sexual abuse***

The health care provider needs to be extra sensitive in these questions. The confidentiality of disclosed information is essential. It is very important to remain gentle and respectful during assessment.

For example:

- There is something that I would like to discuss, but I don't want to make you uncomfortable or embarrassed at all. I am concerned about your safety and I want to help you. It is entirely your decision whether you want to talk to me about it or not, OK?
- Please don't feel under any pressure to talk about something you feel uncomfortable about. I am concerned that someone might have hurt you or done things to you against your will, and that you might still be at risk of this happening again.
- This is something that does happen to other people and/or children, and it is not their fault that it happens.
- I am definitely not going to judge you if this has happened to you.
- I will not tell anyone about this without your consent. *(1)*

- ***Neglect***

The health care provider should note down their observations, and any signs of neglect.

For example:

- Being excessively dirty, unsuitable clothing.
- 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.

For example:

- 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.

Assess for any recent or ongoing severe stressors (e.g. illness or death of a family member, difficult living and financial circumstances, being bullied or harmed)

- Has there been a major loss within the last 6 months?
- Can you describe your loss?
- Has there been any difficult event/situation happening in the family?
- Can you describe it?

Box 6.2

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

See Annex 1 for relevant screening questions.

Box 6.3

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

- 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?

Box 7

Assess the school environment

The school environment may be assessed by:

- Asking the adolescent directly.
- Asking the parents, in the case of a child.
- Asking the teacher (after seeking permission of the adolescent or parents of a child).

- ***Is the child/adolescent being bullied***

- Is there anything about school that has been worrying/upsetting you?
- Is there anything about school that you haven't told anyone?
- Has anyone teased you or called you names recently? *(30)*
- Have you been threatened physically or actually hurt by another student recently? *(30)*

For a child, modify the above questions to ask parents/teachers.

- ***Is the child/adolescent not able to participate and learn***

- How do you participate in the classroom?
- How do you relate to other children?
- How often do you find it hard to speak with the other kids at school? *(31)*
- Do you find it difficult to participate in academic activities with other children in your classroom at school? *(31)*

For a child, modify the above questions to ask parents/teachers.

- ***Is the child/adolescent not wanting/refusing to attend school***

- Have you been attending school regularly?
- How often do you miss school?
- Is there a reason for you to avoid school?
- Do you frequently refuse to attend school because of anxiety and fear?
- How often do you have bad feelings about going to school because you are afraid of something related to school (for example: tests, school bus, teacher, other children)? *(32)* (School refusal assessment scale.)

For a child, modify the above questions to ask parents/teachers.

Psychosocial interventions

Psychosocial interventions are considered the treatment of choice for children and adolescents, and are always preferred to pharmacological treatments.

Psychoeducation and support to the carers helps all families, irrespective of the nature of the disorders in children and adolescents.

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

The health care provider should start by carefully observing and inquiring:

- How the carers interact with the child/adolescent.
- How much time do they spend in quality interactions with the child/adolescent?
- How carers play and communicate with the child/adolescent.
- How do they address problems in the child/adolescent's behaviour? Punishment?
- How aware they are about the challenges of developmental stage of the child/adolescent.
- What are the daily activities and habits of child/adolescent, e.g. sleeping and waking up time? *(2)*

Identify the strengths in parenting and reinforce their efforts.

Identify the gaps in parenting and follow the guidelines in 2.1 to educate them.

Always check what the carers understand and remember from this discussion, and check if they have further questions before finishing.

2.2 Psychoeducation to person and carers and parenting advice

The health care provider should start by inquiring:

- What do the carers already know about the problem?
- What are the efforts that the carers are making?
- What are the challenges they face?
- What are their expectations?
- Do they know of anyone else facing similar challenges? *(2)*

Then follow the guidelines in 2.2 to educate the carers.

2.3 Guidance for improving behaviour

The health care provider should start by inquiring:

- What are the problems identified in the child/adolescent's behaviour?
- Under what circumstances is the behaviour likely to occur?
- Under what circumstances is the behaviour least likely to occur?
- How do the carers respond after the behaviour? Do they use punishment? *(2)*

Then follow the guidelines in 2.3 for improving behaviour.

2.4 Psychoeducation for developmental delay/disorder

The health care provider should start by inquiring:

- What are the strengths of the child?
- What are the weaknesses of the child?
- How does the child learn best?
- What is stressful for the child?
- What makes the child happy?
- What causes problem behaviours?
- What improves problem behaviours?
- How does the child communicate? *(2)*

Then follow the guidelines in 2.4 to educate the carers about developmental delay.

2.5 Psychoeducation for emotional problems/disorders including depression in adolescents

The health care provider should start by inquiring:

- What do they understand about the cause of emotional problems/disorders?
- What are the stressful situations at home?
- What are the stressful situations at school?
- What do they understand about the possible solutions for the emotional problems/disorders?
- Do they have any questions regarding the emotional problems/disorders? *(2)*

Then follow the guidelines in 2.5 to educate the carers about emotional disorders.

2.6 Carer support

The health care provider should start by inquiring:

- What impact does the child's condition have on the carer?
- How are they coping? Personally? Socially? Emotionally?
- What sources of support do the carers have? *(1, 2)*

Then follow the guidelines in 2.6 to support the carers.

2.7 Liaise with teachers and other school staff

The health care provider should (seek consent from the parents/adolescent to) inquire from the teachers:

- How is the child participating in the school activities?
- How is the condition affecting the child's learning? Behaviour? Social functioning?
- How are the teachers responding?
- Are there any stressful situations that are adversely affecting the child/adolescent?
- What strategies can be helpful in engaging the child in school activities? In facilitating learning and participation? *(2)*

Then follow the guidelines in 2.7 to liaise with teachers and other school staff.

FOLLOW-UP

Box 1

Assess for improvement

On every visit, check:

- Is the child/adolescent improving?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving? *(2)*

Conduct routine assessment (Box 2) and regular monitoring (Box 3).

See Annex 2 for a set of cases for practising skills in clinical decision-making.

DEMENTIA

See the Summary on page 9 which helps to initiate a clinical assessment. The assessment of a patient suffering from dementia requires additional considerations, which are described below.

The assessment of a patient with dementia comprises the following components:

- Interview of the patient.
- Examination of their mental state.
- Physical examination (for people with dementia, a careful physical examination is essential to rule out sensory impairments and co-morbid physical illnesses).
- Information from the carer (for people with dementia, information from a carer who knows the patient well or lives with the patient is important).
- Laboratory investigations.

If it is difficult for people with dementia to visit a health care facility, home visits should be considered.

ASSESSMENT

Box 1

Assess for signs of dementia

Box 1.1

Are there problems with memory and/or orientation?

Ask the patient:

- Have you been having any problems recently?
- Are you having difficulties with your memory? If yes, check duration, progressive, gradual decline etc.
- Do you often forget the names of the people around you?
- Do you often struggle to name the objects around you, such as spoon, remote control, glasses etc.?
- Have you ever lost your way around? *(11)*

Ask the carer (someone who knows the person well):

- Does the person have problems remembering which day it is? *(33)*
- Does the person have problems remembering things, such as names? *(34)*
- Does the patient frequently forget what happened the previous day? *(33)*
- Does the patient have more trouble remembering things that have happened recently? *(33)*
- Does the patient have more trouble recalling conversations a few days later? *(33)*
- Does the person lose his/her way while walking or driving in familiar places? *(33)*
- Does the person have problem remembering the date? *(33)*
- Does the patient have difficulty knowing where he/she is? *(33)*

Examine the patient:

- What time of the day is it? *(16)*
- What is this place where we are sitting? *(16)*
- What is the name of the person who has come along with you? *(16)*
- I am going to give you an address, please repeat it at the end of the test, e.g. 42 West Street. *(11)*
- Do you know the name of the current president/prime minister/monarch? *(11)*

Box 1.2

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

Ask the patient:

- Are you able to manage money and financial affairs (e.g. paying bills, budgeting)? *(33)*
- Are you able to manage your medication independently? *(33)*
- Do you need more assistance with transport (either private or public)? *(33)*
- Do you forget appointments, family occasions etc.? *(35)*
- Do you have difficulties in writing cheques and paying bills? *(35)*
- Do you find it difficult to do shopping independently (e.g. for clothing or groceries)? *(33)*

Ask the carer:

- Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)? *(33)*
- Is the patient less able to manage his/her medication independently? *(33)*
- Does the patient need more assistance with transport (either private or public)? *(33)*
- Does the patient forget appointments, family occasions, holidays? *(35)*
- Does the patient have difficulties in writing cheques and paying bills? *(35)*
- Does the patient find it difficult to do shopping independently (e.g. for clothing or groceries)? *(33)*

Box 2

Are there any other explanations for the symptoms?

Box 2.1

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

Exclude delirium

The health care provider should note their observations, ask screening questions (from carers) and examine the patient for signs of delirium *(36)*.

- How did the problems start?
- Did the problems start abruptly, showing a change from the patient's usual baseline functioning? *(16)*
- Is there evidence of an acute change in mental status from the patient's baseline? *(16)*

Impairment of consciousness and attention

- Is the patient fully alert/conscious?
- Does the patient have difficulty focusing their attention; for example, being easily distractible, or having difficulty keeping track of what was being said?
- Ask the patient to name the days of the week backwards (Sunday, Saturday, Friday, etc,) *(11)*.
- Ask the patient to count backwards from 20 *(19, 18, 17, etc.) (11)*.

Perceptual distortion, illusions and hallucinations

- Does the patient show any evidence of perceptual disturbances; for example, hallucinations such as hearing voices (talking to himself/herself, responding to voices through gestures). *(16)*
- Do you ever seem to hear voices when there is no one about? *(5)*
- Have you ever had visions, or seen things other people couldn't see? *(5)*

Disorientation of time

- What time of the day is it?
- What is this place where we are sitting?
- What is the name of the person who has come with you? *(16)*

Impairment of immediate recall

- Does the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions? *(16)*
- I am going to give you an address, and you are going to repeat it at the end of the test, e.g. 42 West Street. *(11)*
- I am going to name three objects, please repeat them back and then remember them because I will ask you to name them again in a few minutes. These are: apple, table, penny. *(37)*

Psychomotor disturbances

- Does the patient have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time or moving very slowly? *(16)*
- Does the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position? *(16)*

Disturbance of the sleep-wake cycle

- Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night? *(16)*

Physical examination

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

Exclude depression

See Annex 1 for relevant screening questions.

Box 3

Evaluate for other medical issues

The health care provider should note their observations, ask screening questions AND conduct a physical examination.

- Was the patient younger than 60 years when the symptoms started?
- Was the onset of symptoms associated with head injury, stroke, or altered or loss of consciousness?
- Is there clinical history of goitre, slow pulse, dry skin? (Hypothyroidism)
- Is there history of sexually transmitted infection, including HIV/AIDS?
- Does the person have poor dietary intake, malnutrition or anaemia?
- Does the person have cardiovascular risk factors? For example: hypertension, high cholesterol, diabetes, smoking, obesity, heart disease (chest pain, heart attack), previous stroke or transient ischaemic attack. *(2, 3, 13)*

Box 4

Evaluate the needs of the carers

Box 4.1

Is the carer having difficulty coping or experiencing strain?

- Do you feel your health has suffered because of your involvement with your relative?
- Do you feel strained when you are around your relative?
- Do you feel angry when you are around your relative?
- Do you feel stressed, between caring for your relative and trying to meet other responsibilities for your family or work?
- Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?
- Do you feel that you don't have as much privacy as you would like because of your relative?
- Do you feel that your social life has suffered because you are caring for your relative? *(38)*

Box 4.2

Is the carer experiencing depressed mood?

The health care provider should note down their observations and ask the following questions.

- How has your mood been?
- Do you keep reasonably cheerful or have you been very depressed or sad recently? *(5)*
- How has your interest in things been? *(5)*
- If reduced, how long has that been so? (Note if it is more than 2 weeks)
- Are you losing interest in most things, such as work, hobbies and other things you usually enjoy? *(10)*
- Do you easily get tired during the day? Also when you have not done anything especially hard? *(5)*

Box 4.3

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

- Do you feel that you don't have enough money to take care of your relative in addition to the rest of your expenses?
- Do you have any financial support from the family?
- Do you have access to any financial support for your relative's care, e.g. a disability allowance? *(37)*

Box 5

Does the person have any of the following behavioural or psychological symptoms of dementia?

The health care provider should note their observations, ask screening questions AND conduct a physical examination.

- ***Behavioural symptoms, e.g. wandering, night-time disturbance, agitation, aggression***

  - Does the patient wake you during the night, rise too early in the morning, or take excessive naps during the day?
  - Is the patient resistive to help from others at times, or hard to handle? *(39)*

- ***Psychological symptoms, e.g. hallucinations, delusions, anxiety, uncontrollable emotional outbursts***

  - Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?
  - Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?
  - Does the patient seem sad or say that he/she is depressed?
  - Does the patient become upset when separated from you?
  - Does he/she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?
  - Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?
  - Does the patient appear to feel too good or act excessively happy? *(39)*

DEM 2 >> MANAGEMENT > PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

The health care provider should start by inquiring:

- What do you think is happening to you?
- Do you know about dementia?
- Do you have any questions?

Then follow the guidelines in 2.1 to educate the patient.

2.2 Manage behavioural and psychological symptoms

It is helpful to explore the underlying cause presenting with behavioural and psychological symptoms. The management focuses on treatment of the identified underlying cause.

The health care provider should start by inquiring:

- Which situations are likely to trigger behavioural and psychological symptoms?
- Are there any events and situations that happen just before the behavioural and psychological symptoms?
- What are the consequences of the behavioural and psychological symptoms?
- Do the consequences appear to maintain the symptoms?
- What are the options available to modify the triggering and maintaining factors for behavioural and psychological symptoms?
- Are there any possible activities which the patient can enjoy or use for distraction? *(2, 3)*

Then follow the guidelines in 2.2 to manage these symptoms.

2.3 Promote functioning in activities of daily living and community life

The aim is to improve functioning, and promote safety and independence of the patient.

The health care provider should start by inquiring:

- What are the options to promote physical activity for the patient?
- Are there any measures which can be taken to make the environment safer?
- Does the patient have any sensory deficits which can be managed?
- When the patient was feeling better, what is one task, at home or at work, that they were doing regularly and that they are no longer doing or do less?
- What is one pleasant or enjoyable activity that the patient could start doing again or do more often? *(1)*

Then follow the guidelines in 2.3 to promote functioning in activities of daily living.

2.4 Interventions to improve cognitive functioning

The health care provider should start by inquiring:

- Is there an established daily routine for the patient?
- How can the carers follow an established daily routine for the patient's care?
- Is the environment free of any noise and distractions?
- What are the options available to stimulate memories?
- What are the options available for providing orientation in day, date, time and names of persons? *(2, 3)*

Then follow the guidelines in 2.4 to improve cognitive functioning.

2.5 Carer support

The health care provider should start by inquiring:

- Who are the main carers?
- Who else provides care?
- What care do they provide?
- What is difficult to manage?
- What are the options available to provide support for the carers?
- How do the carers usually cope with stress?
- Is there any support available for the carers? *(4)*

Then follow the guidelines in 2.5 to strengthen support for the carers.

For more information, refer to WHO's iSupport: a programme for carers of people with dementia *(40)*, https://www.who.int/mental_health/neurology/dementia/isupport/en/.
For online training of the carers *(41)*: https://www.isupportfordementia.org/en.

DEM 2 >> MANAGEMENT > PHARMACOLOGICAL INTERVENTIONS

2.6 Pharmacological interventions

The health care provider should start by inquiring:

- How do you feel about taking a medicine that can treat your condition?
- Do you know anything about these medicines?
- Do you know about the dose of the medication?
- Do you know about the possible side-effects of the medication?
- Do you have any concerns regarding the medication?
- Do you have any questions? *(2, 3)*

Explain the following to the patient and carers:

- The importance of taking the medication as prescribed.
- The dose, duration of treatment and potential side-effects of medications.

Then follow the guidelines in 2.6 to prescribe medication

FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the patient stable?

No worsening symptoms or decline in function; behavioural/psychological symptoms are improving if present.

Examine the patient:

Check previous findings in Box 1.1 and 1.2.

Ask the carers:

- How has the patient been?
- Have you noticed any improvement (in behavioural/psychological symptoms)?
- What problems (symptoms) are not improving?
- Is there any change in functioning?
- Do you have any concerns/questions? *(14)*

Box 2

Conduct routine assessments

Ask the carers:

- Is the patient tolerating the medication?
- Has the patient been well?
- Is the patient participating in activities of daily living?
- Do you have any concerns about the safety of the patient?
- Are there any new behavioural/psychological symptoms?
- How has the patient been in his/her mood? Have you noticed depression?
- How have you been? How are you coping?
- Do you have any concerns/questions? *(14)*

Box 3

Provide psychosocial interventions

Continue to provide psychosocial interventions (2.1–2.6), as needed.

See Annex 2 for a set of cases for practising skills in clinical decision-making.

DISORDERS DUE TO SUBSTANCE USE

See the Summary on page 9 which helps to initiate a clinical assessment.

The assessment of a patient suffering from disorders due to substance use requires additional considerations, which are described below.

- Conduct the interview with a non-judgmental approach and use an opening statement such as "I am going to ask some routine questions about smoking and substance dependence, is that alright with you?".

- You should be familiar with the commonly used substances in your local context.

- It is important to rule out other MNS conditions in people suffering from disorders due to substance use.

The section on the assessment and management of emergency presentations of disorders due to substance use is self-explanatory. Therefore, no further questions have been added.

ASSESSMENT

Box 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.

- ***Do you smoke cigarettes?***
  - If yes, how long have you been smoking?
  - How did you start smoking?
  - Have you ever tried to stop?
  - If yes, which factors were helpful?
  - Which factors led to a relapse?
  - Is there anyone else in your family or social circle who smokes?

- ***Do you drink alcohol?*** *(4)*
  - If yes, how long have you been drinking and in what form?
  - How did you start drinking?
  - Have you ever tried to stop?
  - If yes, which factors were helpful?
  - Which factors led to a relapse?
  - Is there anyone else in your family or social circle who drinks alcohol?

- ***Do you use illegal drugs?*** *(4)*
  - If yes, what kind of drugs do you use?
  - How do you take them – by mouth, injection, snorting?
  - How long have you been using these drugs and in what form?
  - How did you start using these drugs?
  - Have you ever tried to stop?
  - If yes, which factors were helpful?
  - Which factors led to a relapse?
  - Is there anyone else in your family or social circle who uses these drugs?

- ***Do you use any prescribed medicines that can cause dependence (e.g. sleeping tablets or stimulants)?***
  - If yes, which medicines do you use?
  - How long have you been using these medicines? Why were the drugs prescribed?
  - Have you ever tried to stop?
  - If yes, which factors were helpful?
  - Which factors led to a relapse?
  - Is there anyone else in your family or social circle who uses these medicines?

Box 2

Is the substance use harmful?

- For each substance used, assess:

• Frequency and quantity of use

- How many days per week do you use this substance? *(5)*
- How much do you use per day? *(5)*
- Has there been an increase in your consumption recently?

• Harmful behaviours

- Does your substance use cause you any problems? *(5)*
- What type of problems? *(5)*

Some examples of harmful behaviours are:

• *Injuries and accidents*

- Have you experienced health problems since you started drinking alcohol or using drugs? *(4)*
- Have you ever been injured while you were under the influence of alcohol or drugs? *(4)*

• *Driving while intoxicated*

- Have you ever been found intoxicated while driving?

• *Drug injection, sharing needles, reusing needles*

- Do you ever use injection/needles for substance use?
- If yes, do you reuse needles?
- Have you ever shared needles with other people?

• *Relationship problems as a result of use*

- Has your alcohol or drug use ever caused a problem with your partner? With your family? *(4)*

• *Sexual activity while intoxicated that was risky or later regretted*

- Have you ever engaged in sexual activity (which was either risky or regretted later) when intoxicated?

• *Legal or financial problems*

- Have you ever been in trouble with money because of alcohol or drug use? *(4)*
- Have you ever broken the law because of alcohol or drug use? *(4)*
- Have you engaged in illegal activities in order to obtain drugs? *(42)*

• *Inability to care for children responsibly*

- Have you ever found it hard to take care of your child/ family because of alcohol or drug use? *(4)*

• *Violence towards others*

- Have you ever hurt someone after taking alcohol or drugs? *(4)*

• *Poor performance in education, employment roles*

- Do you miss work because of your substance use? *(5)*
- Do you have memory loss lasting for several hours? *(5)*
- Have you ever lost a job or done badly at work because of your alcohol or drug use? *(4)*

• *Poor performance in expected social roles (e.g. parenting)*

- Do you face problems socially because of your substance use? *(5)*

Box 3

Is dependence likely?

Box 3.1

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

- ***High levels of frequent substance use***
  - How much substance do you consume? (See Clinical tip for amounts/patterns that suggest dependence.)

- ***A strong craving or sense of compulsion to use the substance***
  - What happens if you do not use the substance during the day – how do you feel? *(14)*

- ***Difficulty self-regulating the use of that substance, despite the risks and harmful consequences***
  - Can you control your consumption? *(14)*
  - How difficult do you find it to stop, or go without the substance? *(43)*
  - Do you think your use of (substance) is out of control? *(43)*

Also check for continued use of alcohol or drugs despite advice to stop *(14)*.

- Did you continue the use in pregnancy or breastfeeding? (When applicable)
- Did you continue the use despite problems with your stomach or liver because of drinking or drug use?
- Did you continue the use along with medications that have harmful interactions with alcohol or drugs, such as sedatives, analgesics or tuberculosis medications?

- ***Increasing levels of use tolerance and withdrawal symptoms on cessation***
  - Do you need an increased amount of substance to feel the same effects as before?
  - Do you experience any signs of withdrawal?

In the case of opioids, check for the following *(44)*:

- Pulse rate
- Sweating
- Yawning
- Tremor of outstretched hands
- Restlessness
- Pupil size
- Runny nose or tearing (not accounted for by cold symptoms or allergies)
- Gooseflesh skin (hairs standing up on arms can be felt).

SUB 2 >> MANAGEMENT > PSYCHOSOCIAL INTERVENTIONS

2.1 Psychoeducation

The health care provider should start by inquiring:

- What does the person already know about drug use?
- What are the gaps in knowledge of the person about drug use?
- What questions does the person have about drug use?

Then follow the guidelines in 2.1 to educate the patient.

2.2 Motivational interviewing (brief intervention) *(45)*

The health care provider should place the person at the centre of the discussion. They should not give their own opinion on what needs to be done. The person should be helped to make a choice to manage their problem. Always set a realistic target.

The objectives of a motivational interview are to:

- Assess whether the person sees alcohol or drug use as a problem.
- Assess if the person is ready to do something about it.
- Help the person to understand his/her level of preparedness to change.
- Encourage the person to take a step forward to address their drug use/dependence.

• *Invite them for a discussion, rather than give a lecture*

- Can we talk about your substance use problem?

Then give a summary of your assessment.

• *Explore why the person uses the substance*

- What does the substance do?
- How does it help you?
- What are the perceived benefits of substance use?
- What kind of pleasure do you get when taking alcohol or drugs?

• *Ask the person to think about the consequences of his/her substance use*

- Do you think you may have a problem with alcohol/drugs?
- Do you see any negative aspects of taking alcohol/drugs?
- Do you ever regret using alcohol/drugs?

• *Use the cues to highlight negative aspects of alcohol/drug use further.*

For example:

- How much money do you spend on buying alcohol/drugs? Per week? Per month? Per year?
- What else could you be doing with that money?

• *Explore their willingness to change and past experiences*

- Do you need to change your current drug use?
- Do you want to change this pattern?
- Have you thought about stopping or reducing your alcohol/drug use?
- Have you tried to stop or reduce alcohol/drug use in the past?
- What were the difficulties that you faced?

• *Explore if the person is using alcohol/drugs to try to cope or dismiss problems in life*

- Tell me about the problems that you face in life.
- How does alcohol/drugs help you to deal with these problems?
- Is not thinking about the problem really a good thing? Does that make the problem go away?

• *When the person decides to make the change, then support them and facilitate making the change*

- What do they need to do to make the changes they want?
- What can the health care provider do?
- What steps do they need to take to make that plan a reality?

2.3 Strategies for reducing and stopping use

After the motivational interview, if the person identifies the next step, help them to implement it.
Providing choices reinforces the sense of personal control and responsibility for making a change, and can help to strengthen the client's motivation for change.

The health care provider should start by inquiring:

- When do you feel the greatest urge to use the substance? How can you avoid the cues?
- When you last used the substance, what was happening in your life? Were you having any problems? What can be done about those?
- Do you have easy access to alcohol/drugs? What can be done about that?
- Do you have contact with other people who use alcohol/drugs? What can be done about that?
- Who are the people who could provide support and help for the changes you want to make?

Then follow the guidelines in 2.3 to help to reduce and stop drug use.

For further help, refer the patient to WHO's Self-help strategies for cutting down or stopping substance use: a guide, https://www.who.int/substance_abuse/publications/assist_self_help/en/.

2.4 Mutual help groups

Follow the guidelines in 2.4.

2.5 Strategies for preventing harm from drug use and treating related conditions

If, after motivational interviewing, a person feels that they are not ready to stop or reduce their substance use, then encourage them to look for ways to minimize the risks involved.
For example *(14)*:

- They must not drive when intoxicated.
- They should try to eat food when they use alcohol.
- They could try changing the type of alcohol they drink to something less strong.
- If they are injecting opioids, they should ensure the needles are clean, and they should never share a needle with other people.

Then follow the guidelines in 2.5 to prevent further harm.

2.6 Carer support

The health care provider should start by inquiring:

- Who are the main carers?
- Who else provides care?
- What care do they provide?
- What difficulties do they face?
- How do they usually cope with stress?
- How has this situation affected them?
- Is there any support available for the carers?
- What are the options available to provide support for the carers?

Then follow the guidelines in 2.6 to support the carers.

SUB 3 >> FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the patient improving?

Recommendations on frequency of contact *(14)*:

- Harmful use: follow-up in 1 month and as needed thereafter.
- Dependence: follow-up several times per week in the first 2 weeks, then weekly in the first month. Once improving, decrease frequency to monthly and as needed thereafter.

The health care provider should remain non-judgmental, even if there is a relapse.

At every visit, check:

- Is the person improving?
- What substances is the person still using? And what amount?
- Is the person completely abstinent from substance use?
- What are the factors which are protecting him/her from substance use?
- How has their physical health been?
- Are there any signs of MNS disorders (e.g. depression, psychosis)?

See Annex 2 for a set of cases for practising skills in clinical decision-making.

SELF-HARM/SUICIDE

See the Summary on page 9 which helps to initiate a clinical assessment.

The assessment of a patient suffering from self-harm or a suicide attempt requires additional considerations, which are described below.

This module is designed to assess the risk of:

- Further harm in a person who presents after an act of self-harm.
- Self-harm/suicide in a person who presents with extreme hopelessness and despair.
- Self-harm/suicide in a person who presents with current thoughts/plans of self-harm/suicide.

This is a highly sensitive assessment which needs unhurried and careful examination. The skill to assess risk of self-harm needs to be practiced. The assessment for self-harm or risk of suicide should be done ONLY when a person is medically well or has been medically treated for self-harm/poisoning.

Please note that 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 to feel understood. However, try to establish a relationship with the person before asking questions about self-harm.

Always interview the patient first and then, with his/her permission, invite the family to join in. It is best practice not to see the family alone without the consent of the patient.

Create a safe and private atmosphere for the person to share thoughts. It is important to ask these questions WITHOUT any judgement. These may be difficult questions and will need to be asked sensitively.

SUI >> ASSESSMENT

Box 1

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

Box 1.1

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

- The health care provider should be familiar with the signs of common poisoning in their health care context.
- If the patient has presented with overdose or poisoning, monitor the vital signs (blood pressure, temperature, respiratory rate and heart rate).
- If the patient does not look fully alert, check level of consciousness:
  - Initially observe the patient for spontaneous eye-opening.
  - Try to engage the patient in conversation and assess if they are orientated.

Following are some suggested questions:

- Can you hear me?
- Can you tell me your name?
- Do you know where you are at the moment?
- Do you know what the date is today?
- Can you move your fingers?

- Ask the patient to perform a two-part request (e.g. "Lift your right arm off the bed and make a fist") *(46)*.
- During the examination, look out for the following signs/symptoms, for example, in the case of organophosphate poisoning *(47)*:
  - General physical examination: blurred vision, pupil size, increased lacrimation, increased sweating.
  - Cardiovascular system: bradycardia, hypotension.
  - Respiratory system: difficulty breathing, wheezing, cough, running nose.
  - Gastrointestinal system: increased salivation, nausea and vomiting, abdominal pain, diarrhoea, faecal incontinence.
- In cases of self-cutting:
  - Remain non-judgmental.
  - Calm the person, provide care and let him/her know you mean to help.
  - Assess the severity of the wound: cuts that do not involve fat or muscle tissue (superficial), are not bleeding heavily, are less than half an inch long and do not involve the face, can be managed without stitches *(48)*.
  - Conduct a detailed assessment of the suicide risk in all patients, if they are willing.
  - If not, always offer to make a follow-up appointment to re-assess.
- Do NOT continue the assessment if the patient is not medically stable or fully treated. Explain your concerns to the family and ensure that the patient does not leave the health facility without a complete assessment.

Box 2

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

Box 2.1

Check for current thoughts or plan of self-harm/suicide

Ask the patient:

Following are a series of questions to ask the patient, where an answer should naturally lead to another question. Always start with an open-ended question, for example:

- Can you please tell me what happened (in the case of an act of self-harm or attempted suicide)?
- How do you feel? *(4)*
- (Acknowledge the person's feelings): You look sad/upset.
- Is it alright if I ask you a few questions about that? *(4)*

- Ask about negative thoughts, e.g. hopelessness
- How do you see the future currently? *(5)*
- What are your hopes for the future? *(4)*
- Can you see any future? *(5)*
- Do you find yourself helpless in solving your problems in life?
- Do you sometimes feel that life might not be worth living? *(5)*
- Do you think there is no hope for you in the future? *(4)*
- Have you given up, or does there still seem to be some reason for trying? *(5)*

- Ask about negative thoughts, e.g. whether life is worth living
- What are some of the aspects of your life that make it worth living? *(49)*
- What are some of the aspects of your life that may make you feel or think that your life is not worth living? *(49)*
- Some people in a similar situation have said that life was not worth living. Do you go to sleep wishing that you might not wake up in the morning? *(4)*
- Do you find yourself wishing for life to end?
- Have you ever felt that life isn't worth living? *(5)*

- Ask about negative thoughts, e.g. suicidal thoughts

It is best to pick a clue from what the patient might already have said about hopelessness/suicidal ideas and explore further. If not, then check:

- Have you ever thought of harming yourself or trying to take your own life? Can you describe these thoughts?
- Do you think or feel this way presently?
- How frequently have you had these thoughts and feelings? *(49)*
- Do these thoughts intrude into your thinking and activities? *(49)*

- Ask about suicide attempts/suicidal acts
- Have you thought about acting on these thoughts? *(49)*
- How close do you feel you have come to acting?
- What stopped you from acting on them? *(49)*
- Do you have a plan to harm yourself or take your own life? If so, describe your plan. *(49)*
- Do you have the means to end your life? *(4)* (For example, check if the patient has been saving tablets for an overdose or knows where a gun is kept in the house etc.)
- Have you prepared by writing a note, making a will, practising the plan, or ensuring measures such that you would unlikely be discovered? *(50)*
- Did you actually try? *(50)*
- What did you do? Did you leave a note?
- Did you make a suicide plan? Or did you attempt suicide? *(10)*

Ask the carers:

(If the patient is too unwell to interview, e.g. currently extremely agitated, violent, distressed or lacks communication.)

- In your view, how has the patient been feeling?
- Has he/she had a recent loss or trauma, for example, separation from his/her spouse? *(34)*
- Has the patient ever mentioned any negative thoughts (hopelessness, suicidal ideation)?
- Can you please explain what happened (in cases of an act of self-harm)?
- In your view, was this a dangerous attempt? (For example, if someone tried to hang himself/herself or take poison/pesticides, it would be considered as a fairly serious attempt; on the other hand, if he/she scratched their wrist with a pen, it would be less serious.) *(34)*
- How did you find out about it?
- Is there a history of mental illness in the family?
- Is there a history of suicide/attempted suicide in the family?

Examine the patient:

Note if the patient is:

- Agitated and constantly fiddling, changing posture, restless, standing or sitting down *(6)*
- Depressed
- Withdrawn or is unwilling to communicate *(4)*
- Violent (e.g. using abusive language, hitting others or threatening to kill others) *(6)*.

Box 2.2

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

Ask the patient:

- Have you ever acted on these thoughts in the past? *(49)*
- If you have not acted on them, how close do you feel you came to acting?
- What stopped you from acting on them? *(49)*
- Were there other times during the last year when you tried to harm yourself?
- What exactly happened then?
- Were there events in your life that preceded this, such as a sudden loss or feelings of depression?
- Were other people present when you did this? *(50)*
- How did you get help afterwards? Did you receive treatment after your attempt? *(50)*
- How did you feel after your attempt? Did you feel relief or regret at being alive? *(50)*

Ask the carers:

(If the patient is too unwell to interview, e.g. currently extremely agitated, violent, distressed or lacks communication.)

- In your view, how has the patient been feeling?
- Has he/she had a recent loss or trauma, for example, separation from his/her spouse? *(34)*
- Has the patient ever mentioned any negative thoughts (hopelessness, suicidal ideation)?
- Has the patient ever attempted to harm himself/herself in the past?
- If yes, can you please explain what happened?
- In your view, what led the patient to do so?
- How did you find out about it?

Box 3

Does the person have concurrent MNS conditions?

See Annex 1 for relevant screening questions.

Box 4

Does the person have chronic pain?

Chronic pain is an emotional experience and is defined as pain lasting longer than 6 months *(51)*.

- In your view, what could be the cause of the pain?
- How long have you experienced this pain (in weeks)?
- Where do you feel the pain?
- What does the pain feel like?
- What helps relieve the pain?
- What worsens the pain?
- How is this pain affecting you?
- Have you received any treatment for the pain?

Box 5

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

This question needs to be adapted depending on the role and responsibilities of the patient.

For example:

- For a person who is employed, check if responsibility towards work is affected.
- For a person who is married, check if responsibility towards their partner is affected.
- For a parent, check if responsibility towards childcare is affected.
- For a student, check if responsibility towards academic study is affected.

Check if self-care is affected (e.g. rest, exercise, personal care, social activity, prayer etc.).

- Do you face any difficulty in carrying out your usual work, school, domestic or social activities?
- Has this present condition affected your performance/ work/daily activities/level of functioning?
- Have you been self-medicating for being upset or worried?
- Do you have problems of vague or repeated physical symptoms, for which no cause has been identified?
- Have you been seeking repeated medical consultations recently?

Psychosocial interventions

2.1 Offer support to the person

DO NOT:

- Give a lecture.
- Offer solutions.
- Leave the person alone.

Explore reasons and ways to stay alive.
Always start by acknowledging the severity of distress. This is best done AFTER listening and understanding the patient's experience as well as possible.
For example:

- I understand how difficult this has been for you.

Then gently ask something like:

- Who are the people that care for you the most?
- Who are the people that you care about the most?
- What do you care about the most?
- Is there anything/anyone that gives you a reason for you to live?

A statement to instil hope might help. For example: most people who have also been in a situation where they lost hope, discover that this state changes with time.

Focus on the person's strengths by encouraging them to talk of how earlier problems have been resolved.

- Have you ever found it as difficult, or close to this, in the past? What happened back then?
- What has helped you in the past?
- Who has been your main support in difficult times before?
- What are some of the things that give you comfort, strength and energy? *(4)*

Consider problem-solving therapy to help people with acts of self-harm within the last year, if sufficient human resources are available *(1)*.

- Ask the patient to list all the problems they are currently facing.
- Then discuss which problems, or parts of the problems, might have a solution.
- Highlight the possible solutions where the patient has some control or influence over the problem.
- Check if there is someone else who might be able to provide some help.

2.2 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.

- How is your relationship with your family?
- In what way do your family and friends support you, and in what way do you feel stressed by them?
- Who do you feel most comfortable sharing your problems with?
- When you are not feeling well, who do you turn to for help or advice?
- When was the last time you spoke to them? Do they know about your problems?

Advise the person and carers to restrict access to means of self-harm/suicide (e.g. pesticides/toxic substances, prescription medications, firearms, etc.) if the person has thoughts or plans of self-harm/suicide.

- Check if the patient has any means to harm their life, such as over-the-counter medicines/prescription medicines, knives, firearms etc.? *(4)*

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.

- Would you like some help in contacting your friends/family?
- Would you like me to help you to connect with anyone else/any service?

2.3 Carers support

Inform carers and family members that it is OK to ask about thoughts of suicide and self-harm, and that doing so can often help a person feel relieved, less anxious, less embarrassed and better understood.

Always start by asking questions, and not by providing suggestions/advice. Attentively listening to the carer is the most essential part of providing support.

- Have you spoken to the patient about what happened? (Use carer's name)
- Do you have any concerns about asking the patient about his/her feelings? About how he/she has been feeling? Or about the act of self-harm?

Then gently encourage the carer to discuss the matter further with the patient, suggesting that the communication might help the patient recover.

Carers and family members of people at risk of self-harm and suicide may experience severe stress themselves. Encourage them to seek out emotional supports to be able to process their feelings.

- How are you dealing with the present situation?
- What are your foremost concerns/worries?
- Are you afraid about what the future holds for your relative? *(52)*
- Do you feel embarrassed over your relative's behaviour? *(52)*
- Do you feel that your relative currently affects your relationship with other family members or friends in a negative way? *(52)*
- Do you feel that you do not have enough money to care for your relative, in addition to the rest of your expenses? *(52)*
- Do you feel that because of the time you spend with your relative, you do not have enough time for yourself/other responsibilities? *(52)*
- Do you feel your health has suffered because of your involvement with your relative? *(52)*
- Are you able to carry out other daily activities, such as work or participation in family/community events?
- Do you get enough rest or are you feeling fatigued?
- Are there other people who can help you when you are not able to care for the person (for example, when you are sick or very tired)? *(4)*

If carers seem too distressed or unstable, offer them an independent assessment (for MNS conditions, e.g depression).

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.

2.4 Psychoeducation

The health care provider should start by inquiring:

- What do you think is happening to you? *(14)*
- Do you have any questions? (Try to identify gaps in the patient's knowledge.)

Then follow the guidelines in 2.1 to educate the patient.

SUI 3 >> FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the person improving?

- How have you been?
- Have you noticed any improvement?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving?

Check adherence to medicines, if prescribed:

- Are you taking the medication as prescribed? *(14)*
- Are there any side-effects of the medication? *(14)*

FOLLOW-UP 2 ROUTINELY ASSESS FOR THOUGHTS/ PLANS OF SELF-HARM/SUICIDE

Box 1

Using a cue from an earlier response, gently ask:

- How is the future looking now?
- Do you feel that life is not worth living?
- Have you been thinking about ending your life?
- If yes, have you made any plans?

See Annex 2 for a set of cases for practising skills in clinical decision-making.

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

See the Summary on page 9 which helps to initiate a clinical assessment. The assessment of a patient suffering from other significant mental health complaints requires additional considerations, which are described below.

Assessing people with other significant mental health complaints can be challenging, especially if they are returning frequently with medically unexplained somatic symptoms.

Following are some of the challenges during assessment:

- They may return to seek help multiple times *(14)*.
- They may take a lot of time.
- They may insist on tests and medications.
- The health care provider may become frustrated.

How to communicate with people with other significant mental health complaints *(14)*:

- Try not to judge the person.
- Make the person feel welcome and accepted.
- Listen carefully.
- Do not dismiss the person's concerns.
- Acknowledge that the symptoms are real.
- Be conscious of your own feelings, in case you become frustrated.

OTH 1 >> ASSESSMENT

Box 1

Is there a physical cause that fully explains the presenting symptoms?

- Is there any history of repeated physical investigations in the past?
- What were the results of the physical investigation?

Conduct a general physical examination followed by appropriate medical investigations.

Following are some of the signs to note during examination *(22)*:

- Vital signs (fever, heart rate, respiratory rate and blood pressure)
- Pallor
- Mouth ulcers
- Brittle nails
- Dry skin
- Pitting oedema (after applying pressure on dorsum of foot for a few seconds, a pit remains after the finger is removed)
- Lethargy
- Weight loss, visible severe wasting and absence of fat
- Swelling in the neck
- Hair changes (e.g. thin hair)
- Fever
- Ear discharge
- Painful swelling behind the ear
- Enlarged lymph nodes.

Basic laboratory tests:

- Complete blood count
- Blood glucose
- Kidney function tests
- Electrolytes
- Liver function tests
- Thyroid function tests
- Hepatitis C antibody test
- Pregnancy test
- Urine routine examination
- Toxicology screen (urine)
- Electrocardiogram
- Chest radiograph *(3)*.

Box 2

Is this depression or another MNS condition discussed in another module of this guide?

See Annex 1 for relevant screening questions.

Box 3

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

This question needs to be adapted depending on the role and responsibilities of the patient.

For example:

- For a person who is employed, check if responsibility towards work is affected.
- For a person who is married, check if responsibility towards their partner is affected.
- For a parent, check if responsibility towards childcare is affected.
- For a student, check if responsibility towards academic studies is affected.
- Check if self-care is affected (e.g. rest, exercise, personal care, social activity, prayer etc.),

Other related questions are:

- Have you missed work or been unable to do housework, go shopping or travel etc. in the last month? *(5)*
- How much interference there has been in your activities because of depression? What sort of problem is it? *(6)*
- Has there been a decrease in actual time spent in activities or decrease in productivity? *(9)*
- Have you stopped working because of the present illness? *(9)*
- To what extent do the problems affect your work or relationships with other people? *(5)*
- Do you try to avoid the company of other people? *(6)*
- How much difficulty do you have in getting along with people who are close to you? *(12)*
- Have the symptoms affected your functional capacity in some other way? *(5)*
- How much difficulty do you have in taking care of household responsibilities? *(12)*
- How much difficulty do you have in your day-to-day work/school? *(12)*
- How much difficulty do you have in performing your most important work/school tasks well? *(12)*

Box 4

Has the person been exposed to extreme stressors?

(For example, physical or sexual violence, major accidents, bereavement or other major losses)

To help a client feel comfortable talking about difficult or embarrassing topics, always acknowledge the difficulty and thank them for being trusting.

For example:

Thank you for sharing this experience with me. I understand how difficult it must be for you.

- Have you been exposed to a life-threatening event?
- Has your life been in danger?
- At home or in the community, have you experienced something that was very frightening, horrific or has made you feel very bad?
- Has you experienced any transportation accident?
- Has there been a history of physical violence?
- Has there been a history sexual abuse?
- Have you been exposed to a natural disaster?
- Have you experienced the death of a loved one?
- Have you been exposed to a major loss?

OTH >> MANAGEMENT

Protocol 1 Other significant mental health complaints

- The health care provider should explore the previous treatments and their outcomes.
  - Did the person receive any medications for their symptoms?
  - Did the person receive any anti-anxiety or antidepressant medications, despite no evidence of depression?
  - Did the person receive any vitamin injections, despite no evidence of improvement in symptoms?
  - What was the effect of medications on symptoms?
  - Did the person undergo any physical investigations?
  - What were the results of the physical investigations?

- The health care provider should note:
  - DO NOT prescribe anti-anxiety or antidepressant medicines (unless advised by a specialist).
  - DO NOT give vitamin injections or other ineffective treatments.
  - DO NOT order more laboratory, or other, investigations unless there is a clear medical indication (e.g. abnormal vital signs). Unnecessary clinical investigations may reinforce the person's belief that there is a physical problem.

- When no physical condition is identified that fully explains a presenting somatic symptom, acknowledge the reality of the symptoms and provide possible explanations.

Inform the person that no serious disease has been identified. Communicate the normal clinical and test findings. Explain:
- We did not find any serious physical problem. I do not see a need for any more tests at this point.

If the person insists on further investigations, consider saying:
- Performing unnecessary investigations can be harmful, because they can cause unnecessary worry and side-effects.

- It is important to 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.
  - What does the person understand about their symptoms?
  - In the person's view, what could be the cause of the symptoms?
  - When do they experience the symptoms?

- Explain the link that emotional suffering/stress has with 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.
- What are the triggers for the symptoms?
- What situations precede the symptoms?
- What aggravates these symptoms?
- How does the person find relief from the symptoms?

- In all cases, provide basic psychosocial support.

- Collaborate with the person to explore and identify problems in his/her life.

Steps of problem-solving:
- Identify and define the problem.
- Analyse the problem.
- Identify possible solutions.
- Select and plan the solution.

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

It is essential not to pressure the person to talk about the potentially traumatic event. If they want to talk about it, then you can listen; but DO NOT force them to talk.

- Address the person's social needs

– *Ask*

Ensure that the person's social needs are met; ensure that they have access to food, shelter, safety, clothes, water and all the basics that a person requires to survive.

– *Help*

If the person does not have their basic needs met, then link them with agencies and people that can help them and ensure that those needs are met.

– *Protect*

Make sure that the person is safe. Talk with them about where they feel safe, discuss risk plans, telephone numbers they can call and link them with family members, other organizations, etc. that can help to ensure they are not exposed to more harm.

– *Encourage*

Talk to the person about the importance of trying to engage with their normal activities as a way of making them feel better; keeping to a routine and/or engaging with other people, being distracted by work and school – all of these things are important for the person.

- In the case of any major loss
  - Has there been a major loss within the last 6 months? *(14)*
  - Can you please describe your loss?
  - How are you coping with your loss?
  - How has this loss affected you?
  - What does the person understand regarding the normal process of grief?
  - Do they have any questions regarding grief?
- In the case of the loss of a loved one, discuss and support culturally appropriate adjustment and/or mourning processes
  - Is the grieving person participating in the mourning processes?
  - Are there any barriers to the mourning processes?
  - What could be done to facilitate the mourning processes?
- If prolonged grief disorder is suspected, consult a specialist for further assessment and management
  - What is the duration of the grief process?
  - Has the grief adversely affected daily functioning?
  - Has the grief has adversely affected daily functioning for more than 6 months?
  - Does the person experience intense longing for the deceased?
- In the case of reactions to recent exposure to a potentially traumatic event
  - How have you been affected by the disaster/conflict? Has your life been in danger?
  - Have you experienced something that was very frightening or horrific, or has made you feel very bad?
  - What does the person understand regarding reactions to traumatic events?
  - What are the gaps in the knowledge of the person?
  - Do they have any questions?

OTH >> FOLLOW-UP

Box 1

Assess for improvement

Box 1.1

Is the patient improving?

- How have you been?
- Have you noticed any improvement?
- What problems (symptoms) are resolving/getting better?
- What problems (symptoms) are not improving?
- Have you been able to do the things you were doing before this illness? *(14)*

See Annex 2 for a set of cases for practising skills in clinical decision-making.

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ANNEXES

ANNEX 1

Screening questions to assess for priority MNS conditions

The health care provider should note their observations, ask screening questions AND conduct an examination.

Depression

Ask the patient:

- How has your mood been?
- (If depressed) How long have you felt like this?
- How has your interest in things been?
- How has your sleep been?
- What has your appetite been like recently?
- Do you experience any negative thoughts?
- How are your energy levels?
- What has your concentration been like recently?
- How is your ability to make decisions?
- How do you see the future currently?
- Have you ever felt that life isn't worth living? *(1)*

Examine the patient:

- Looks sad/depressed.
- Avoids eye contact.
- Responding slowly with delayed answers.

For a detailed assessment, refer to the module on depression on page 11.

Psychosis

Ask the patient:

- Are you aware of any strange or worrying experience that other people don't seem to notice?
- Do you ever seem to hear voices when there is no one about?
- Do you agree that you are unwell and might need treatment? *(1, 2)*

Ask the carers:

- Does the person have delusions (fixed false beliefs not shared by others in the person's culture) e.g. has the person been suspicious that people may harm him/her?
- Do you observe the patient standing still for long periods of time, or laughing/crying for no apparent reason?
- Do you notice that the patient doesn't recognize that he/she is unwell and doesn't feel the need to take treatment for their mental health problem?
- Do you notice that the patient makes no sense while talking and there is no relation between the sentences that he/she uses in a conversation?

For a detailed assessment, refer to the module on psychosis on page 23.

Epilepsy

Ask the patient:

- Have you ever had a seizure (fit)? *(3)*

Ask the carers:

- Has the person had convulsive movements (lasting longer than 1–2 minutes)?
- Did the person sustain loss of consciousness or impaired consciousness during seizures?
- Did the person bite his/her tongue during the seizures?
- Did the person lose bladder control during the seizure?
- Did the person experience confusion or fatigue after the seizure? *(3)*

For a detailed assessment, refer to the module on epilepsy on page 35.

Dementia

Ask the patient:

- Have you been having any problems recently?
- Are you having difficulties with your memory? If yes, check duration, and whether it is progressive, gradual decline, etc. *(4)*
- Do you often forget the names of the people around you? *(5)*
- Do you often struggle to name the objects around you, e.g. spoon, remote control, glasses etc.? *(6)*
- Have you ever lost you way around? *(6)*

Ask the carer (someone who knows the person well):

- Have you noticed that the patient has been forgetting things over the past few months? *(7)*
- Has the forgetfulness been getting gradually worse over this period? *(7)*
- Does the person lose his way while out walking or driving in familiar places? *(6)*
- Does the patient frequently forget what happened the previous day? *(8)*
- Does the patient have more trouble recalling conversations a few days later? *(6)*

Examine the patient:

- Note confusion, disorientation.
- I am going to give you an address, please repeat it at the end of the test, e.g. 42 West Street *(4)*.
- Do you know the name of the current president/prime minister/monarch? *(4)*

For a detailed assessment, refer to the module on dementia on page 63.

Disorders due to substance use

Ask the patient:

- Do you use any substance, e.g. cannabis, opioids, alcohol?
- How long have you been consuming this substance and how often do you use it?
- Has there been any recent increase in the amount you use, or change in the pattern of consumption?
- Do you get anxious, irritable or not able to sleep if you don't take the substance?
- Do you experience any other withdrawal symptoms? *(1)*

Examine the patient:

- Aggressive, e.g. agitated, abusive, threatening
- Violent, e.g. breaking things, hitting others
- Looks paranoid
- Slurred speech
- Pinpoint pupils
- Watering eyes, running nose, abdominal cramps, nausea, vomiting *(1, 7, 9)*.

Ask the carer:

- Do you know or suspect that the patient might be using a substance, e.g. cannabis, opioids, alcohol?
- How long has the patient been consuming this substance and how often is the use?
- Has there been any recent increase in the amount they use, or change in the pattern of consumption?
- Have you noticed any withdrawal symptoms if the patient doesn't take the substance? *(7, 9)*

For a detailed assessment, refer to the module on disorders due to substance use on page 75.

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ANNEX 2

Practice cases: assessment and management

Depression

DEP 1 A woman with postnatal depression

A 23-year-old woman had her first baby 2 months ago. For a few days after childbirth, she appeared tearful and mixed up. The midwife reassured her that she was only passing through a brief phase of emotional distress, as experienced by many mothers. She suggested that her husband spends more time supporting her and caring for the baby. Following this, the patient remained stable for some time. However, after a month she began to feel tired and her sleep was disturbed. She started waking up very early in the morning, even though the baby was still sleeping. Her mind was filled with negative thoughts about herself and about her baby, which scared her. Gradually, she started losing interest in her own self-care and household responsibilities.

- How would you assess her?
- What further questions would you ask to confirm depression?
- How would you assess the risk of self-harm/suicide?
- How would you manage her?

DEP 2 A banker who needs help with psychosocial interventions

A 27-year-old banker was engaged, but his fiancée broke off the engagement because she was interested in someone else. He started feeling anxious and irritable. After a few months, he became depressed and started avoiding his friends as he was embarrassed about the break-up. His problems worsened when he could not focus on his work and his boss issued a warning. After that, he could not sleep well and started blaming himself for all these problems. He is not keen on taking any medication.

- How would you help him?

DEP 3 A woman with depression and sleeping tablets

A 58-year-old woman lost her husband last year. She has two sons who left the village for better employment opportunities. She developed disturbed sleep and loss of appetite soon after her husband died. A few months later, she started complaining of headaches, backache and problems with digestion. She saw a doctor who prescribed sleeping pills and vitamins. She felt better immediately, particularly because her sleep improved. However, within 2 weeks her sleep got worse again and she went back to the clinic. She was given more sleeping pills and injections. This went on for months, until she could no longer sleep without the sleeping pills.

- What is your assessment?
- What further questions would you ask to confirm the diagnosis?
- Which other MNS conditions would you rule out?
- How would you manage her?

DEP 4 A student with depression and bereavement

A 19-year-old student lives with her grandparents after the death of her parents. She has been a good student, but now seems to be struggling with her studies. She finds it difficult to concentrate on her work and is preoccupied with constant worries. She often gets angry about minor issues. Her mood remains low most of the time and occasionally she ends up crying. She does not enjoy listening to music or watching movies and has stopped going for walks because of feeling fatigued. She sleeps for 6–7 hours at night but does not feel fresh and is always late for her classes.

- How would you confirm depression?
- How do you rule out grief?
- How would you manage her?

DEP 5 Depression in old age

A 69-year-old man has been brought in by his family after he refused to drink fluids for 24 hours. For the past 3 weeks, the family has noticed that he appeared to have slowed down, was crying often and expressing ideas of hopelessness including suicidal ideation. They are also worried that he has lost weight and seemed perturbed by some "voices". He has had a similar episode in the past, although no episodes of mania have been reported.

- How would you rule out physical conditions that might resemble or exacerbate depression?
- How would you rule out psychosis?
- How would you manage this case?

Psychosis

PSY 1 A withdrawn man with self-neglect

A 20-year-old man has been brought in by his mother. His mother reports that for the past year he has not been the same person as before. He is no longer studying and prefers to stay at home being idle. He does not participate in any activities and remains emotionally indifferent to happenings in the house. You observe that he is wearing summer clothes although it is cold and raining. He looks like he has not washed for weeks. When you talk to him, he avoids eye contact. He looks at the ceiling as if looking at someone and is occasionally seen talking to himself. His mood is neither sad nor happy, rather he is devoid of any emotions. At times, it is difficult to understand the meaning when he talks. He fails to acknowledge that he is unwell or that he requires treatment.

- How would you rule out possible causes?
- How would you proceed to assess him further?

PSY 2 A paranoid man

A 25-year-old man comes to the accident and emergency department. The family reports that he has been socially withdrawn and unusually quiet for the past year. He believes that there are intelligence agencies spying on him and that they want to catch him in relation to a special global operation. He can see digital cameras installed around the house for his constant surveillance by the spies. On mental status examination, you find that he is firmly fixed on the belief that he is being chased around and being watched all the time. He hears voices, which comment on his actions and pass him commands. He does not believe that he has a mental illness and refuses any treatment.

- How would you manage him?

PSY 3 A woman who is restless and overtalkative

A 30-year-old woman has been brought to the outpatient clinic by her family members. For the past week, she has been talking more than usual and her voice has gone hoarse due to excessive talking. She is persistently active for most of the day and fails to get more than 2 hours of sleep during the night. She has been spending recklessly on shopping and has been buying stuff that she does not necessarily need. She claims that she is in charge of the family and others must follow her instructions at all times. On mental status examination, she has pressured speech and racing thoughts. She is overconfident and overfamiliar. She shakes hands with the doctor, which is considered culturally inappropriate. She has overinflated ideas about herself and her wealth. She does not believe that she has any illness and insists on going back home.

- How would you treat her?
- What follow-up care would you offer?

PSY 4 A woman after childbirth

A 35-year-old married woman gave birth to her second son 2 weeks ago. Since childbirth, she has been neglecting self-care and has not been taking care of the baby. She has been saying that she does not feel connected to her son and claims that the baby belongs to someone else. She has been crying excessively and has not been sleeping well. She gets into arguments with her husband and mother-in-law for no good reason and ends up breaking things in the house. Her husband reports that she had a similar episode when their first child was born, 3 years ago.

- What is the possible diagnosis?
- How would you rule out other causes?

PSY 5 A young man who is aggressive

A 20-year-old man has been brought to the outpatient clinic by his father and brothers. He is seen to be agitated and aggressive towards family members, and they have had to physically restrain him to prevent violence. His brother reports that he has been behaving aggressively for the past 2 days, since he went out with his friends and probably smoked cannabis. He has been suspecting everyone in the house of being against him and trying to kill him by poisoning his food. They want the patient to be admitted in the hospital, as they are not able to contain him at home.

- How will you manage this patient?

PSY 6 An elderly woman who is confused

A 65-year-old woman has been brought to the clinic in a confused state. Her son reports that she has been forgetting the time and place for the past 2 days. She gets unduly aggressive and irritable as the evening approaches. She has not been sleeping and has been refusing food. On examination, her pulse is rapid and her temperature is raised. She has been complaining of burning micturition and frequent visits to the toilet for voiding, even before behavioural symptoms appeared.

- How would you investigate this case?
- How would you manage her?

Epilepsy

EPI 1 An old man with seizure and jerky movements

A 70-year-old man presents to the emergency room with a history of a single seizure. His wife described that he was making an odd gurgling noise, with his head deviated to the left and his left arm stiffened. This was followed by generalized jerky movements. There is also evidence of tongue biting. The episode lasted for 2 minutes, where the patient was unresponsive, and it took 10 minutes for the man to fully recover.

- How would you proceed with the assessment?

EPI 2 An adolescent who dropped out of school

A 14-year-old boy had "episodes" where he felt strange and noticed a funny smell, and then blacked out. His parent said that his whole body shook and that he lost control over his bladder during these episodes. Afterwards, he felt confused and sore. It happened at school 2 years ago, and he was told not to come back so as not make the other children sick. He misses school and his parents want to know if he can go back.

- What advice do you have for his parents?

EPI 3 A girl stopped medication

A 17-year-old girl is attending the clinic for a follow-up visit, accompanied by her mother. She was diagnosed with epilepsy by the doctor 3 months ago, after she had two seizures in a month. She was commenced on medication and has been well since then. Her mother is very keen to discontinue the medication.

- How would you proceed?

EPI 4 A woman who has seizures that last for hours

A 27-year-old woman was brought to the hospital by her husband. She was diagnosed with epilepsy 3 months ago and has been on regular medications since then. Her husband is concerned that her condition has worsened, with an increasing frequency of fits over the past week. This happened when he disclosed that he has to leave the city for 2 months to complete an important work contract. The husband described that these episodes last for hours. The patient confirmed that during these episodes, she could hear her husband talking but feels completely paralysed and unable to respond.

- How would you re-assess?

EPI 5 A pregnant woman and epilepsy

A 23-year-old married woman was diagnosed with epilepsy 5 years ago. Since then, she has been taking sodium valproate 1000 mg/d regularly. She has remained well with the medication, without any incidents of seizures during these years. She has come to see you in an emergency after she discovered that she is 6 weeks pregnant.

- How would you proceed with the management?

Children and adolescent mental and behavioural disorders

CMH 1 Delayed development

A woman in a village had a very difficult labour which lasted for 2 days. Finally, the midwife suggested that she should be taken to the hospital, which was 3 hours away. At the hospital, she had a caesarean section and a baby girl was born. The baby did not cry immediately after birth and had to be kept in an incubator for a few days. Both parents took good care of the baby, who seemed to be healthy for the first 6 months. However, they noticed that she took longer to sit up by herself and to walk than their older son. For example, their son started walking when he was a year old, but the baby girl started walking when she was nearly 2 years old. Her speech was also delayed. She could not call her mother when she was 3 years old. It was then that they realized that something was not right and went to see their doctor.

- How should the doctor assess the child?

CMH 2 A boy with drug dependence

The mother of a 15-year-old boy has sought help after she discovered that he had been stealing money from her purse. The doctor finds out that his father works in another country and visits home once a year for 3 weeks. During his stay, he would constantly drink alcohol and fight with his wife. The boy had grown up witnessing horrifying scenes of domestic violence. He started to miss classes when he was 11 years old. When his mother found out, she hit him. She was scared that his father would blame her. Over the years, the boy started spending more time with other boys in the village, smoking cigarettes. About 6 months back, his friends suggested that they smoke some new stuff available in the market. Now he was dependent on the drug and needs it every day.

- How should the doctor help?

CMH 3 An adolescent with emotional problems

A bright 14-year-old student has become noticeably quiet and withdrawn recently. Her academic performance was also declining. The teacher arranged to see the parents to discuss her concerns. The mother attended the meeting alone and had no idea why her daughter was not doing well. The teacher noticed that the mother herself was distracted and looked unhappy, so she asked if there were any problems at home. The mother broke down and explained that her husband left them some months ago and was not supporting them any longer. The teacher referred her to the local psychologist for support.

- How should the psychologist assess the child's condition?

CMH 4 An overactive child

An 8-year-old boy is taken to the health care provider because his teachers have reported that he constantly moves in the classroom and disturbs other children. She has also observed that he cannot focus on class work. His mother describes that he has always been a difficult and overactive child, who could never sit still and play with toys like his sister does.

- How would you assess him further?
- What advice would you give his mother?

CMH 5 A different boy

The mother of a 4-year-old boy is seeking your help, as advised by his teacher. This is their first child and they have no experience of parenting. The teacher says the child sits on his own and bangs toys together. He piles things up on top of each other, in the corner, but does not enter into the role-play that the other children enjoy. His mother describes that he does not make eye contact and does not communicate as other children in the neighbourhood do. He has always preferred to play on his own, even if other children are around. She has noticed that he is fascinated with things that spin such as fans, and sometimes he will pick up pieces of string and twirl them in his fingers, watching intently. When excited, he jumps up and down on his toes or flaps his hands.

- How would you complete the assessment?

Dementia

DEM 1 An aggressive woman

A 75-year-old woman has been becoming forgetful over the past 5 years. The main problem experienced by the family at the moment is that she gets very angry and aggressive. Her aggression generally happens in two contexts: when her daughter encourages her to take a bath; and at night, when she tends to get up from her bed and wander around the house (occasionally she leaves the house as well). When her daughter tries to get her back into bed and/or back into the house, she screams that she has to find her babies and refuses to let her daughter touch her or accompany her back into the house. At times she has become violent, hitting her daughter How would you help her?

DEM 2 A confused woman

An elderly woman was admitted to hospital for 2 weeks for hip replacement surgery. Prior to developing mobility issues, she did her household work, enjoyed watching TV shows and chatting to her friends. She has no psychiatric history. After the surgery, she experienced agitation that worsened at night-time. She has now started to refuse to drink or eat. When the doctor spoke to her, she was confused about her whereabouts and insisted she wanted to go home. She also accused the nurses of stealing her money.

- How would you assess and manage her?

DEM 3 An elderly widower

An 88-year-old man was widowed 6 months ago and now lives with his eldest son, daughter-in-law and three grandchildren. Over the past 6 weeks, he has been seeing and hearing things (including his dead wife). He often talks to her and encourages his grandchildren to speak to her. This is distressing for his son and grandchildren. He also explains that he often feels insects crawling over his skin. He tried to show his family, but they do not see anything. The insects scare him, and he can become quite aggressive.

- How would you assess him?

DEM 4 A man with memory problems and irritability

A 66-year-old bank manager is brought to the health care provider by his family. He took early retirement 18 months ago, after he found it difficult to concentrate at work. Recently, he has become increasingly forgetful. His moods are variable, and he gets irritated easily. He had a similar episode 6 months ago, following which he began losing his way while driving. He lives with his wife, who is very supportive. He has no previous psychiatric history, but has suffered from hypertension for 20 years and from diabetes for 15 years. He has smoked 30 cigarettes a day for 50 years.

- Which factors are important in his assessment?
- How would you manage him?

DEM 5 Home visit for an elderly gentleman

You are visiting a 63-year-old man at home. His wife is distressed because he repeatedly asks her to remove insects from the floor, when she can see nothing there. He has been in bed for 3 days with fever. He frequently gets up and wanders around without knowing where he is going. His wife says on one occasion he burst out laughing for no reason. She describes that he becomes more confused in the evening and at night, and has urinated in the cupboard. He was entirely well a week back and able to help her with household chores and gardening. His wife reports that occasionally he forgets the names of distant relatives but, otherwise, his memory has been fine.

- What are the likely causes?
- How would you investigate further?
- What advice will you give to his wife?

DEM 6 A man with abnormal movements

A 78-year-old man attends the health care provider for an urgent appointment. His daughter is extremely worried because of uncontrollable movements in his eyes, neck and face since the morning. He lives on his own following the death of his wife last year and has been very low since then. His sleep and appetite have been poor, and he has lost about 2 kg in weight over the past year. Two days ago, he went to the general practitioner's surgery complaining of hearing voices and was prescribed haloperidol 0.5 mg twice daily. Last night, he could not keep his balance and even fell down in the bedroom.

- How would you deal with the emergency?
- How would you re-assess his condition?
- How would you treat him further?

Disorders due to substance use

SUB 1 A student on opioids

You have been asked to see a high school student, who is average academically but hardworking and honest. Over the past few months, his mother has noticed a change in his behaviour. He appeared withdrawn, spent a lot of time away from home and was less interested in his schoolwork. Then one day, the school informed his parents that he had not been attending classes regularly and had failed his exams. Around the same time, his mother noticed that some money was missing from her purse. She was worried that he seemed to be hanging around with a new group of friends, whom he did not introduce to his parents. On a second visit, the student disclosed to you in confidence that he had been using heroin for several months, and now he was "hooked". He had tried to stop on many occasions, but each time he felt so sick that he just went back to using the drug. He said he wanted help, but did not want his parents to know.

- How would you proceed?

SUB 2 A middle-aged man who drinks

A 44-year-old man has been attending the health clinic for several months with various physical complaints. His doctor was aware of his drinking but had never assessed him for dependence. His main complaints were that his sleep was disturbed, he often felt sick in the mornings and that he was often missing work. One day, he came to the clinic with a severe burning pain in the stomach area. The doctor noticed that he was sweating profusely, and his hands appeared to be shaking. On a detailed inquiry, the doctor found out that he had been drinking every day and his total consumption had been gradually increasing over the past few months.

- What other questions should the doctor ask to complete his assessment?

SUB 3 A paranoid young man

A 23-year-old man presents to the health care provider in an extremely agitated state because his life is at risk. He is sure that people are watching him when he walks through the town, and that they talk about him and are planning to kill him. He can trust no one, including his friends. He has come to the hospital rather than go to the police because he believes the police are also part of this conspiracy. He feels that these people are jealous of his talents and success, as he has special powers. His mother reports that he was well until a few days ago, when he went to a local festival with his friends. She is also aware that his friends use some drugs.

- What are the possible causes?
- How would you manage him?

SUB 4 A very unwell young man

An 18-year-old young man is brought to the health care provider by his father with complaints of nausea, vomiting, body ache, fever, shivering and poor sleep over the past 2 days. He complains of having the 'flu, but his father is worried that his symptoms may be related to his ongoing drug use. The young man started smoking when he was 14 and has been smoking cannabis and using other drugs for the past 2 years. More recently, his father discovered that he was also injecting drugs.

- What is the possible cause?
- How would you manage the present condition?
- What would be your follow-up plan?

SUB 5 A woman on sleeping tablets

A 34-year-old woman presented to a local doctor complaining of feeling anxious all the time and having disturbed sleep. Her problems started 8 months ago, and she was prescribed sleeping tablets (alprazolam 0.5 mg every night) by a doctor. The medicines helped her initially; she started to sleep better and the anxiety also reduced, but then this improvement stopped. She has tried increasing the prescribed dose, but there is still no relief. She is unable to do her housework and has stopped all social activities.

- How would you assess her?

SUB 6 A man using opioids

A 22-year-old man is brought to the health care provider by his brother, who has been concerned about a gradual deterioration in his mood and behaviour over the past 6 months. The patient was caught stealing money from his brother's wallet the previous week. He admitted that he was using drugs. He was initially smoking heroin "on the foil" regularly, but then started using injections 6 months ago. He denies that heroin use is a problem and feels that his family is overreacting. He thinks he is in control and can easily stop the drug use.

- How would you assess him for dependence?

Self-harm/suicide

SUI 1 A woman who cuts herself

An 18-year-old woman has come to see the health care provider with her father. She has self-inflicted lacerations to her left arm. Her father had discovered her relationship with a much older man and reacted strongly. They had an argument, after which she locked herself in her room and cut herself out of frustration. She has harmed herself before, after her family did not allow her to go on a school trip. Her father claims to care for her very much but is not willing to change his mind about accepting her relationship. However, he is keen to support her in other ways.

- How would you intervene?

SUI 2 A student who took an overdose

A 16-year-old student at a local school has attempted to end his own life by taking an overdose of sleeping pills. His friend took him to hospital for treatment. Apparently, he took the pills after they had an argument. His girlfriend had recently broken off their relationship and he was devastated about it. Unfortunately, other students had started to gossip about his situation. As a result, he stopped talking to his friends at school.

- How would you help him?

SUI 3 A woman who ingested pesticide

A 30-year-old woman was brought urgently to the health centre by her husband after she drank a bottle of pesticide. The health care provider managed to save her life and has now come to see her on the ward as she is stable. She has been unhappy for 2 weeks. Her husband has already told the health care provider that she had her first child less than a month ago.

- How should the health care provider proceed to assess her?

SUI 4 A man who jumped off the roof

As a health care provider, you meet a 30-year-old man who jumped from a roof to kill himself. During assessment, he tells you that he was commanded by voices to jump off the roof. He has been suspicious and fearful that people were plotting against him for the past 9 months. He left his job because he felt people are spying on him. He is a diabetes patient and there is a history of suicide in the family.

- How would you assess him further?
- How would you manage him?

SUI 5 A man who has thoughts of self-harm

A 45-year-old man presents to his general practitioner with feelings of hopelessness, sadness and helplessness. He says that he cries for no reason, and has difficulty sleeping. He noticed that the problems began about 6 weeks ago and he has not been able to pull himself out of it. He has been smoking more than usual and has stopped going to work. When on his own, he admitted that he had thought about driving his car into the local lake.

- How would you assess him?

Other significant mental health complaints

OTH 1 A lonely woman

A 69-year-old woman presents with physical aches and pains all over her body, as well as frequent headaches and low mood. She states that she has been crying a lot recently because of the pains. She says she feels lonely as her family and grandchildren have moved to a different city. She is staying active and spends time with friends. She is able to cook and attend to her daily chores, but she has low motivation for trying anything new. She feels sad and is in pain.

- How would you help her?

OTH 2 A worried man

A 45-year-old man attends a primary health care clinic with stomach ache. He describes the pain as so severe that he has problems catching his breath. He has had to take a lot of time off from work because of his stomach pains. He is the main breadwinner in the family and feels very anxious because his boss is very demanding. The man is worried that his boss might not understand how unwell he is. He is struggling to sleep at night, as he is always thinking about what he has to do.

- How would you assess him further?

OTH 3 A man who is not recovering

A 35-year-old man presents with pain in his body, breathing problems, dizziness and nausea when he bends forward. He says that he has been experiencing these problems for approximately 4 years and has seen countless doctors and specialists. He had to leave his job as a mechanic because he could no longer bend forward. He says the severity of the symptoms has stayed the same over the years, but he has become increasingly frustrated and is tired of living with the symptoms and trying to find out what is wrong with him. He is hoping that you will investigate his case with more advanced examinations.

- How would you manage him?

OTH 4 A bereaved young woman

A 22-year-old woman attends a primary health care clinic complaining of aches and pains all over her body. She explains that she is socially isolated and does not want to see people as they just make her very angry and she finds them unhelpful. She feels sad all the time. After some time, she explains that her father died 4 months ago. She was close to her father. She misses him and is angry, and does not understand how people can carry on as normal.

- How would you help her?

OTH 5 A woman with backache

A 55-year-old woman presents asking for medication for her backache. The results of the physical examination were entirely normal. She has been coming in a lot lately with physical symptoms that do not seem to have a cause, and the health care provider suspects this might be an “other significant mental health complaint”. She is living alone now, as her daughter recently moved out, and she has felt very lonely at times.

- How would you deal with her?

Mental, neurological and substance use 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 mental, neurological and substance use conditions.

This operational guide has been developed to help non-specialists conduct standardized clinical interviews and examinations, and deliver interventions, as outlined in the mhGAP Intervention Guide, version 2 (mhGAP-IG 2.0) for mental, neurological and substance use disorders in non-specialist health settings. The clinical protocols in the mhGAP-IG 2.0 have been supplemented by evidence-based clinical tools, including key questions and examination techniques where necessary. A further objective of this guide is to help health care providers remain patient-centred and protect the rights of the patient, emphasizing issues such as the need for patient privacy and confidentiality, and providing tips for health care providers in clinical scenarios in which vital information may need to be shared with others.

The guide includes the following sections:

- **Essential care and practice**
- **Depression**
- **Psychosis**
- **Epilepsy**
- **Child and adolescent mental and behavioural disorders**
- **Dementia**
- **Disorders due to substance use**
- **Self-harm/suicide**
- **Other significant mental health complaints.**

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