

mhGAP Intervention Guide

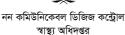
for mental, neurological and substance use disorders in non-specialized health settings

Bangladesh Version 2021





জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট শের-ই-বাংলা নগর, ঢাকা।







Mental Health Gap Action Programme



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শের-ই-বাংলা নগর, ঢাকা

জাতীয় মানসিক স্বাস্থা



নন কমিউনিকেবল ডিজিজ কন্ট্রোল স্বাস্থ্য অধিদপ্তর





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Preface

Mental, neurological and substance use (MNS) disorders are highly prevalent globally. These disorders interfere, in substantial ways, with the ability of a person to perform his/her role in families and in society at large. Recognizing the imperative to provide services for people with MNS disorders and their carers, and to bridge the existing gap between available resources and the large need for these services, the WHO Department of Mental Health and Substance Abuse launched the Mental Health Gap Action Programme (mhGAP) in 2008. In 2010, the mhGAP Intervention Guide (mhGAP-IG) for MNS disorders for nonspecialized health settings was developed to assist in implementation of mhGAP. A simple technical tool based on the mhGAP guidelines, mhGAP-IG presents integrated management of priority MNS conditions using protocols for clinical decision-making. In 2016, mhGAP-IG Version 2.0 was published reflecting the updates of mhGAP guidelines and extensive feedback from the field to enhance the guide in its clarity and usability.

There is wide variability in local circumstances among countries, both in regard to the organization of their health systems and the availability of resources to deliver the recommended interventions. Furthermore, differences also exist in the composition and training of health care personnel, loosely referred to as "non-specialists." For example, in some countries these may be highly skilled doctors with postgraduate

training in family medicine or general practice while in some others, especially in low resource settings, such providers may be community health workers with minimal training. For these reasons, it is recommended that a process of contextualization of the generic version of the mhGAP-IG be implemented in each country setting in order to produce a fully adapted version that meets with the needs of the health system in which it is to be used.

According to the recommendation, we are pleased to present the contextualization of mhGAP-IG Version 2.0 in respect to the context of Bangladesh. A series of consultative workshops were convened to conduct the contextualization. Participants included psychiatrists, neurologists, psychologists, social workers, and general practitioners. Representatives from Noncommunicable Disease Control Programme, Directorate General of Health Services of Bangladesh were also included. The process received technical support from the World Health Organization.

We hope that this contextualized Bangladesh version of the guide will be a key technical tool to deliver care for people with MNS disorders in the country and lead us closer to achieving the goal of Universal Health Coverage.

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INTRODUCTION

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INTRODUCTION

According to the National Mental Health Survey, Bangladesh 2018-19, conducted by National Institute of Mental Health, Bangladesh with the technical guidance of the World Health Organization (WHO), 16.8% of adults and 14% of children (aged between 7 to 17 years) in Bangladesh are suffering from psychiatric disorders. But among the sufferers, 92.3% of adults and 94.5% of children do not access mental health services. There is less than 1 psychiatrist for every 700,000 people. It is clear that relying solely on specialists to provide services for people affected by mental, neurological and substance use (MNS) disorders would prevent millions of people from accessing the services they need.

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

The target user group of mhGAP-IG is non-specialized healthcare providers working at first- and second-level health-care facilities. These providers include primary care doctors, nurses and other members of the health-care workforce. Although mhGAP-IG 2.0 is to be implemented primarily by non-specialists, mental health care specialists may also find it useful in their work.

The mhGAP-IG Bangladesh version 2019 begins with "Essential Care and Practice", a set of good clinical practices and general guidelines for interactions of health care providers with people seeking mental health care. All users of the mhGAP-IG should familiarize themselves with these principles and should follow them as far as possible.

The mhGAP-IG includes a "Master Chart", which provides information on common presentations of the priority conditions and Emergency Presentations of Priority

MNS Conditions. This guides the clinician to the relevant modules. The most serious conditions should be managed first.

The modules, organized by individual priority conditions, are a tool for clinical decision-making and management. Each module is in a different colour to allow easy differentiation.

Each of the modules consists of three sections: Assessment, Management, Follow-up.

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

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

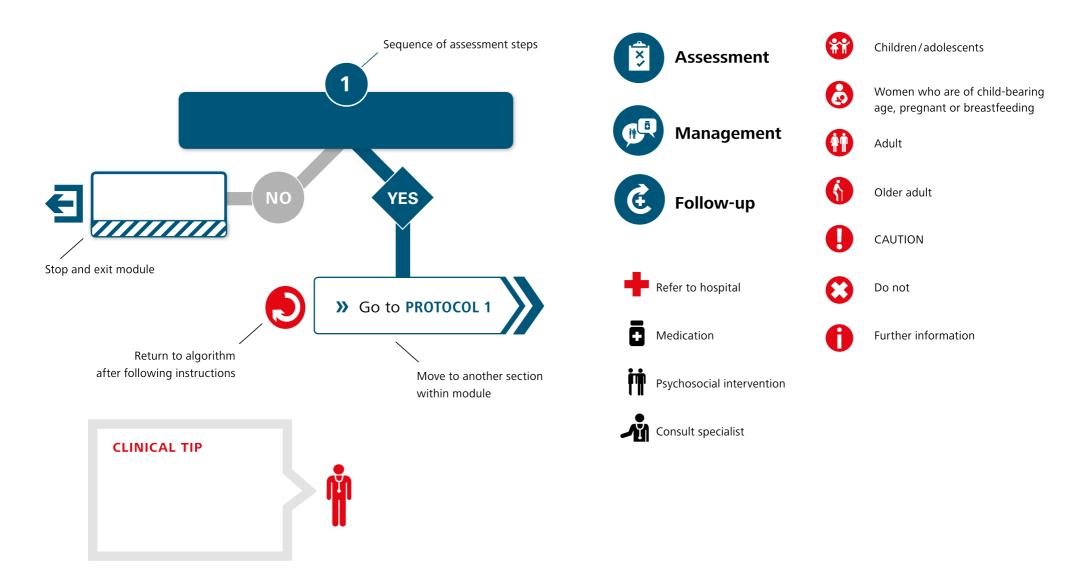
The Follow-up section provides detailed information on how to continue the clinical relationship and detailed instructions for follow-up management.

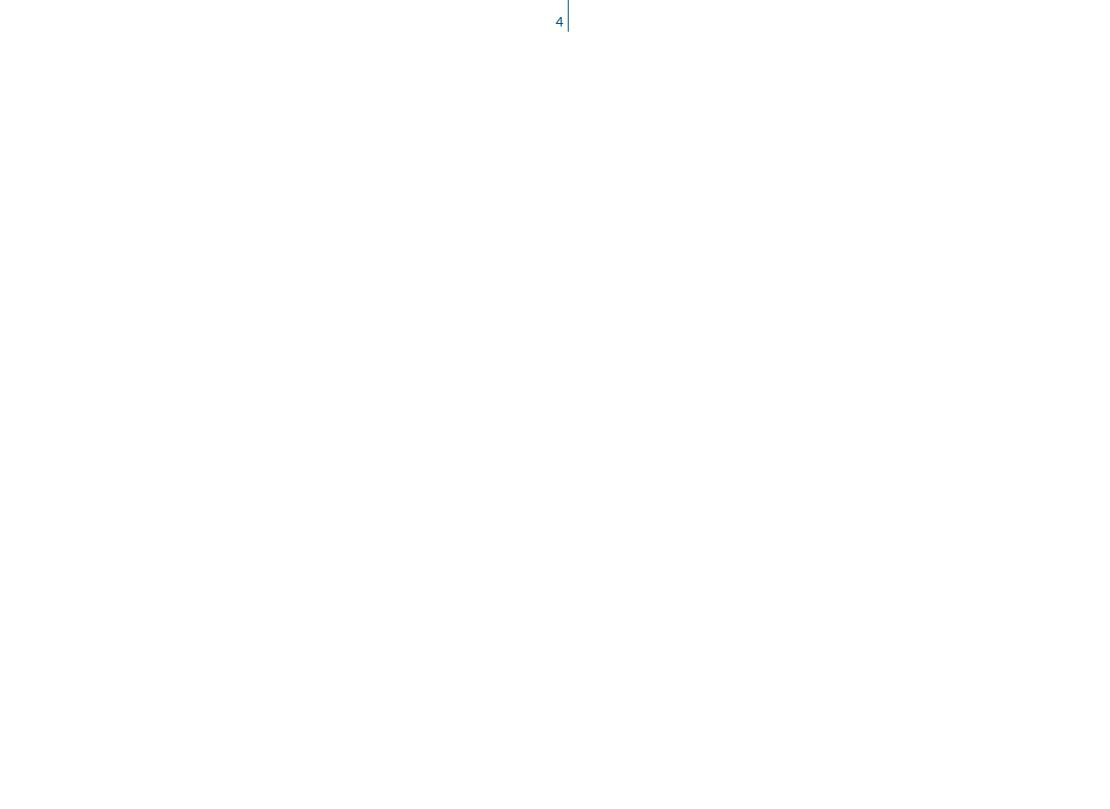
The mhGAP-IG uses a series of symbols to highlight certain aspects within the modules. A list of the symbols and their explanation is given on the following page. Throughout the modules, important points are also highlighted as key clinical tips.

After the modules, four appendices are included covering the referral system in Bangladesh, mental health fact sheet, side-effects and contraindication of medications and additional reading.

At the end of the guide, a glossary of terms used in mhGAP-IG is provided.

Visual Elements & Symbols





ESSENTIAL CARE & PRACTICE

This module outlines the principles of essential care for people with MNS conditions seeking health care and their carers. The first section of this module covers the general principles of clinical care and the second section covers essentials of mental health clinical practice.

A. GENERAL PRINCIPLES

- Principles of communication
- Promote respect and dignity
- B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE
 - Assessment and management of physical health
 - Assessment of MNS conditions
 - Management of MNS conditions

A.GENERAL PRINCIPLES

I. Principles of communication

Consultations in health facilities need to be brief, flexible and focused on the most urgent issues. Good communication skills will help health-care providers achieve these goals and will help deliver effective care to adults, adolescents and children with MNS conditions. Consider the following communication skills and tips:

1. Create an environment that facilitates open communication

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

2. Involve the person with the MNS condition as much as possible

- Even if the person's functioning is impaired, always try to involve them in the discussion.
- >> Do not ignore them by talking only with their carers.
- Always try to explain to the person what you are doing (e.g. during physical examination) and what you are going to do.

3. Start by listening

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

4. Use good verbal communication skills

- » Use simple language. Be clear and concise.
- » Use open-ended questions, summarizing and clarifying statements.
- >> Summarize and repeat key points.
- » Allow the person to ask questions about the information provided.
- 5. Be friendly, respectful and nonjudgemental at all times
- 6. Respond with sensitivity when people disclose difficult experiences (e.g. sexual assault, violence or self-harm)
- 7. Be aware of local cultural factors, gender sensitivity, religious factors

II) Promote respect and dignity

Persons with MNS conditions are often more vulnerable to human rights violations. Therefore, it is essential that in the health care settings, health care providers promote the rights of people with MNS conditions in line with international human rights standards, including the UN Convention on the Rights of Persons with Disabilities (CRPD).

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

DOs

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

DON'Ts

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

B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE

I) Assessment and management of physical health

Persons with MNS conditions are at higher risk of premature mortality from preventable disease and therefore must always receive a physical health assessment as part of a comprehensive evaluation.

Assessment

Take a detailed history and ask about risk factors.

(Physical inactivity, unhealthy diet, tobacco (smoking and smokeless), betel, Yaba, Cannabis and/or other substance use, risky behaviour and chronic disease)

- >> Perform a physical examination.
- Consider a differential diagnosis

Rule out physical conditions and underlying causes of psychiatric presentations by history, physical examination and basic laboratory tests as needed and available.

Management

- » Treat existing physical comorbidities concurrently. Refer to specialist, if needed.
- Provide education on modifiable risk factors to prevent disease and encourage a healthy lifestyle.

II) Assessment of MNS conditions

During assessment of MNS conditions, explore the presenting complaints, then obtain a history including past MNS issues, general health problems, family MNS history, and psychosocial history. Observe the person (Mental Status Exam), establish a differential diagnosis, and identify the MNS condition. As part of the assessment, conduct a physical examination and obtain basic laboratory tests as needed. The assessment is conducted with informed consent of the person.

History taking \rightarrow Physical examination \rightarrow Mental Status Examination (MSE) \rightarrow Differential diagnosis \rightarrow Basic laboratory tests \rightarrow Identify the condition.

History taking

×

1 Presenting complaint

- » Main symptom or reason that the person is seeking care.
- » Ask when, why, and how it started.

(Gather as much information as possible about the person's symptoms and their situation)

2 Past history

- Ask about similar problems in the past, any psychiatric hospitalizations or medications prescribed for MNS conditions, and any past suicide attempts.
- Explore tobacco, and other substance (ganja, yaba, phensidyl, heroin, alcohol etc.) use

3 General health history

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

4 Family history of MNS conditions

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

5 Psychosocial history

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

For children and adolescents, ask about whether they have a carer, and the nature and quality of the relationship between them. (Could be made explicit as children might have the carer accompanying them and might need to be asked in privacy).

ESSENTIAL CARE & PRACTICE

In case of time-constraints, you can also use Golden Questions to detect mental illness in general health care settings (Where there is no psychiatrist: A mental health care manual by Prof. Vikram Patel, 2003)

Golden questions to detect mental illness in general health care settings

- 1. Do you have any problems sleeping at night?
- 2. Have you been feeling as if you have lost interest in your usual activities?
- 3. Have you been feeling sad or unhappy recently?
- 4. Have you been feeling scared or frightened of anything?
- 5. Have you been worried about taking any substance recently?
- 6. How much money and time have you been spending on any substance recently?

If any of the answers are 'yes', ask more detailed questions to confirm the diagnosis.

- Screening interpersonal questions:
 - 1. Economic problems
 - 2. Problems at home

Physical examination

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

Mental Status Examination (MSE)

The mental state is concerned with the symptoms and signs at the time of interviewing the patient. The following format may be used for this examination.

Appearance and behavior: This includes dressing, hygiene, facial expression, motor activities like agitation or retardation, abnormality in motor movement, posture or gait, social behavior and it oddity, patient's ability to establish eye contact, cooperation etc.

Speech: It includes the characteristics of the speech of a person. The speech may be slowed, rapid or pressured, little or much in quantity, fluent or halted, coherent or incoherent etc.

Mood and affect: This includes symptoms and signs involving the regulation and expression of emotion or feeling states. This may be described as sad, depressed, flat, labile, elated, irritable, inappropriate etc.

Content of thought: This includes symptoms and signs involving subject matter of the patient's thoughts. Here the interviewer will look for any false belief, undue suspiciousness (delusion), suicidal ideation etc. in patient's thought.

Perceptual disturbances: This refers to the disturbances in sensory perceptions or experiences occurring in the absence of the appropriate (external) stimulus. This can be described as hallucinations (e.g. auditory (hearing of voices or sounds) or visual (seeing of things or persons) hallucinations). The person may or may not have insight into the unreal nature of the perception.

Cognition: Here the interviewer assesses the patient's level of consciousness, orientation to time, place and person, attention and concentration, memory (including immediate, short-term and long-term memory), judgment, reasoning, decision making capacity, comprehension and the integration of these functions.

Insight: It is evaluated by the patient's understanding of his/her problem.

Differential diagnosis

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

Basic laboratory tests

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

Once a MNS disorder is suspected, always assess for self-harm /suicide (See module - Self-harm/suicide)

III) Management of MNS conditions

Once the assessment is conducted, manage the MNS disorder.



Treatment planning

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

2 Psychosocial interventions III

a) Psychoeducation

Provide information about the condition to the person, including:

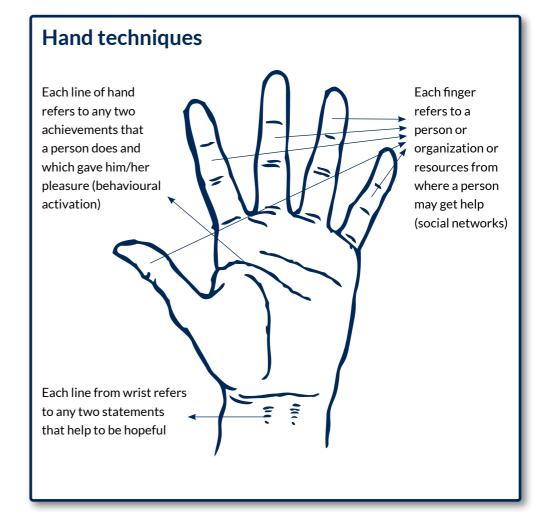
- >> What the condition is and its expected course and outcome.
- » Available treatments for the condition and their expected benefits.
- » Duration of treatment.
- Importance of adhering to treatment, including what the person can do (e.g. taking medication or practicing relevant psychological interventions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

b) Reduce stress and strengthen social supports

Identify and discuss relevant psychosocial issues that place stress on the person and/or impact their life including, but not limited to, family and relationship problems, employment/occupation/livelihood issues, housing, finances, access to basic security and services, stigma, discrimination, etc. Assess and manage any situation of maltreatment, abuse (e.g. domestic violence, eve teasing, bullying) and neglect (e.g. of children or the elderly). Discuss with the person possible referrals to a trusted protection agency or informal protection network, if available. Contact legal and community resources, as appropriate.

- Identify supportive family members and involve them as much as possible and as appropriate
- » Strengthen social supports and try to reactivate the person's social networks.
- Identify prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychosocial support (e.g. family gatherings, visiting neighbours, community activities, religious activities, etc.).

The following exercise is helpful in this regard -



c) Promote functioning in daily activities

- Provide the person support to continue regular social, educational and occupational activities as much as possible.
- Facilitate inclusion in economic activities e.g. handicraft making, catering, cultivation, dairy farming, small scale manufacturing, fishing, shop-keeping, garment related works, sewing, block-boutique-printing, etc.

d) Psychological treatment

Psychological treatments are interventions that typically require substantial dedicated time and tend to be provided by specialists trained in providing them. In Bangladesh, available psychological treatments in specialized settings include Supportive psychotherapy, Cognitive behaviour therapy, Interpersonal therapy, Group therapy, Family therapy etc.

3 Pharmacological interventions

- >> Use pharmacological interventions when available and when indicated.
- In selecting the appropriate essential medication, consider the side effect profile of the medication (short and long term), efficacy of past treatment, or drug-drug interactions.
- Exercise caution when providing medication to special groups such as older people, those with chronic disease, women who are pregnant or breastfeeding, and children/adolescents. Consult a specialist as needed.
- » Avoid prescribing to appease the patient unless justified.

4 Referral to specialist/hospital

Refer to a specialist/hospital, if needed, in case of, for example, non-response to treatment, serious side effects with pharmacological interventions, comorbid physical and/or psychiatric conditions, risk of self-harm/ suicide. (See Appendix I)

5 Follow-up 🤃

After every visit, schedule a follow-up appointment and encourage attendance. Schedule the appointment at a mutually convenient time.

- >> Ideally provide continuity by seeing the same person again.
- Schedule initial follow-up visits more frequently until the symptoms begin to respond to treatment.
- >> Once symptoms start improving, schedule less frequent but regular appointments.
- >> At each follow-up meeting, assess for:
 - Response to treatment, medication side-effects, and adherence to medications and psychosocial interventions.
 - General health status
 - Self-care (e.g. diet, hygiene, clothing, exercise) and functioning in the person's own environment.
 - Psychosocial issues and/or change in living conditions that can affect management.

During the entire follow-up period:

- Acknowledge all progress towards the treatment goals and reinforce adherence.
- Maintain regular contact with the person (and their carer, when appropriate). If available, assign a community worker or another trusted person in the community to support the person (such as a family member).
- Explain that the person can return to the clinic at any time in between follow-up visits if needed (e.g. for side-effects of medications, etc.).
- Have a plan of action for when the person does not show up for appointments.
- Use family and community resources to contact people who have not returned for regular follow-up.
- Consult a specialist if the person does not improve or worsens.
- Document key aspects of interactions with the person and the family in the case notes.

6 Involving carers

- When appropriate, and with the consent of the person concerned, involve the carer or family member in the person's care and keep them informed about the person's health status, including issues related to assessment, treatment, follow-up, and any potential side-effects.
- >> Encourage involvement in self-help and family support groups, where available.

7 Links with other sectors

To ensure comprehensive care and based on the initial assessment, link the person to employment, education, social services (including housing) and other relevant sectors. Ministry of Social Welfare (MoSW) of Bangladesh has autism resource centres and disability support centres. It also has government children homes, baby home, day care, government shelter homes, safe homes etc. There is a social welfare department under MoSW in every government hospital in Bangladesh including mental health facilities. Ministry of Women and Child Welfare (MoWCA) has the National Trauma Counseling Center in Dhaka to provide mental health support to women and children who experience violence. There are government juvenile correction centres in Gazipur. There are also many non-government organizations working on these issues in collaboration with government hospitals.

B Special populations

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8 CHILDREN / ADOLESCENTS

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

\delta WOMEN WHO ARE PREGNANT OR BREAST-FEEDING

- » Liaise with maternal health specialist to organize care.
- » Consider consultation with mental health specialist if available.
- » Exercise caution with pharmacological interventions check toxicity to fetus and passage into breast milk.

OLDER ADULTS

- » Address psychosocial stressors that are particularly relevant to the person, respecting their need for autonomy.
- » Identify and treat concurrent physical health problems
- » Use lower doses of medications.
- » Anticipate increased risk of drug interactions.

MASTER CHART

Overview of Priority MNS Conditions

1. These common presentations indicate the need for assessment.	
2. If people present with features of more than one condition, then all relevant conditions need to be assessed.	
3. All conditions apply to all ages, unless otherwise specified.	
» Multiple persistent physical symptoms (e.g. burning sensation in whole body, chronic pain etc.) with no clear cause	
» Low energy, fatigue, sleep problems	DEPRESSION
» Persistent sadness or depressed mood, anxiety	DEFRESSION
» Loss of interest or pleasure in activities that are normally pleasurable	
» Agitated, aggressive behavior, decreased or increased activity	
» Fixed false beliefs not shared by others in the person's culture	
» Hearing voices or seeing things that are not there	PSYCHOSES
» Marked behavioural changes; neglecting usual responsibilities related to work, school, domestic or social activities	
» Lack of realization that one is having mental health problems	
» Increased talkativeness or rapid speech	
» Increased activity, feeling of increased energy	BIPOLAR
» Unrealistically inflated self-esteem	DISORDER
» Elevated mood	(MANIC EPISODE)
» Impulsive or reckless behaviours such as excessive spending, making important decisions without planning	
» Convulsive movement or fits/seizures	
During the convulsion: loss of consciousness or impaired consciousness, stiffness, rigidity, tongue bite, injury, incontinence of un faeces	rine or EPILEPSY
» After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on o side of the body	one

Child/adolescent being seen for physical complaints or a general health assessment who has:	
» Problem with development, emotions or behaviour (e.g. inattention, over-activity, or repeated defiant, disobedient and aggressive behaviour)	CHILD AND
» Risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases (e.g. HIV/AIDS or history of difficult birth)	ADOLESCENT
Carer with concerns about the child/adolescent's:	MENTAL AND
 » Difficulty keeping up with peers or carrying out daily activities considered normal for age » Debusing (a phone string person of the provide string to a provi	BEHAVIOURAL
» Behaviour (e.g. too active, aggressive, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school)	DISORDERS
Teacher with concerns about a child/adolescent	
» e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work	
» Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place and person)	
» Behavioural problems	
» Mood-related features or loss of emotional control (easily upset, irritable or tearful, apathy (appearing uninterested))	DEMENTIA
» Difficulties in carrying out usual work, domestic or social activities	
Appearing affected by cannabis (distinctive smell, sudden shift in mood from tense to relaxed, red eyes, poor muscle coordination, delayed reaction times, increased appetite, abrupt symptoms of anxiety, panic, and/or hallucination)	
Appearing affected by amphetamine (excited, euphoric, hyperactivity, rapid speech, racing thoughts, disordered thinking, paranoia, aggressive, violent behaviour, dilated pupils, increased blood pressure and heart rate)	DISORDERS
» Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance)	DUE TO
» Emergency presentation due to substance withdrawal, overdose, or intoxication.	SUBSTANCE
» Persons with disorders due to substance use may not report any problems with substance use. Look for:	USE
 Recurrent requests for psychoactive medications including analgesics 	
– Injuries	
 Infections associated with intravenous drug use (HIV/AIDS, Hepatitis C) 	
» Current thoughts, plan or act of self-harm/suicide, or history thereof	
» Extreme hopelessness and despair	SELF-HARM/ SUICIDE
» Any of the other priority conditions, chronic pain, or extreme emotional distress	JUICIDE

OVERVIEW

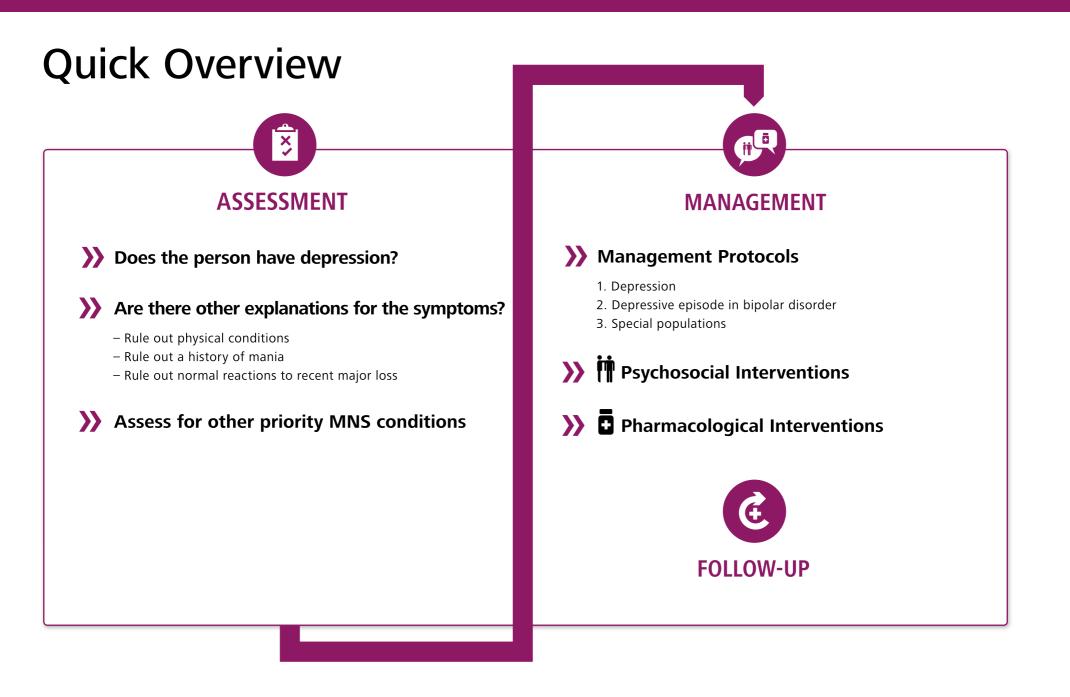
EMERGENCY PRESENTATIONS OF PRIORITY MNS CONDITIONS

EMERGENCY PRESENTATION	CONDITION TO CONSIDER	GO TO MODULE ON
» Act of self-harm with signs of poisoning or intoxication, bleeding from self-inflicted wound, loss of consciousness and/or extreme lethargy	MEDICALLY SERIOUS ACT OF SELF-HARM	SELF-HARM/ SUICIDE
>> Current thoughts, plan, or act of self-harm or suicide, or history of thoughts, plan, or act of self-harm or suicide in a person who is now extremely agitated, violent, distressed or lacks communication	IMMINENT RISK OF SELF-HARM/SUICIDE	SELF-HARM/ SUICIDE
» Acute convulsion with loss of consciousness or impaired consciousness	EPILEPSY STATUS EPILEPTICUS	EPILEPSY
» Continuous convulsions	ALCOHOL OR OTHER SEDATIVE WITHDRAWAL	DISORDERS DUE TO SUBSTANCE USE
» Agitated and/or aggressive behaviour		DEMENTIA
		PSYCHOSES
		DISORDERS DUE TO
		SUBSTANCE USE
» Unresponsive or minimally responsive, slow respiratory rate, pinpoint pupils	SEDATIVE OVERDOSE OR INTOXICATION	DISORDERS DUE TO
		SUBSTANCE USE
Dilated pupils, excited, racing thoughts, disordered thinking, strange behaviour, recent use of cocaine or other stimulants, increased pulse and blood pressure, aggressive, erratic or violent behavior	ACUTE STIMULANT INTOXICATION OR	DISORDERS DUE TO
	OVERDOSE	SUBSTANCE USE
» Smell of alcohol on the breath, slurred speech, uninhibited behaviour; disturbance in	ACUTE ALCOHOL INTOXICATION	DISORDERS DUE TO
the level of consciousness, cognition, perception, affect or behaviour		SUBSTANCE USE
» Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation,	ALCOHOL WITHDRAWAL ALCOHOL	
headache, nausea, anxiety; seizure and confusion in severe case	WITHDRAWAL DELIRIUM	DISORDERS DUE TO SUBSTANCE USE
		JUDJIANCE UJE

DEPRESSION

People with depression experience a range of symptoms including persistent depressed mood (feeling of sadness) or loss of interest and pleasure for at least 2 weeks. People with depression have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas. Many people with depression also suffer from anxiety symptoms and medically unexplained somatic symptoms.

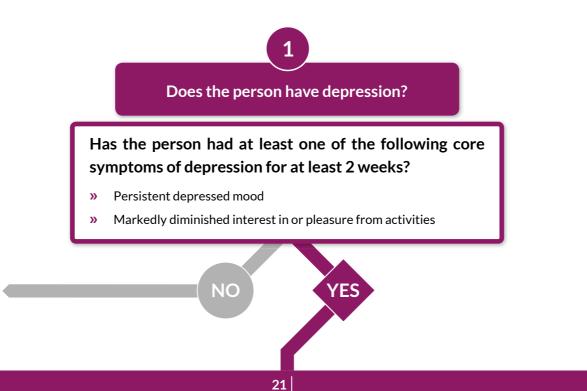
To express depression, Bangla-speaking people may say – 'mon kharap', 'valo lage na', 'mone kosto' etc.



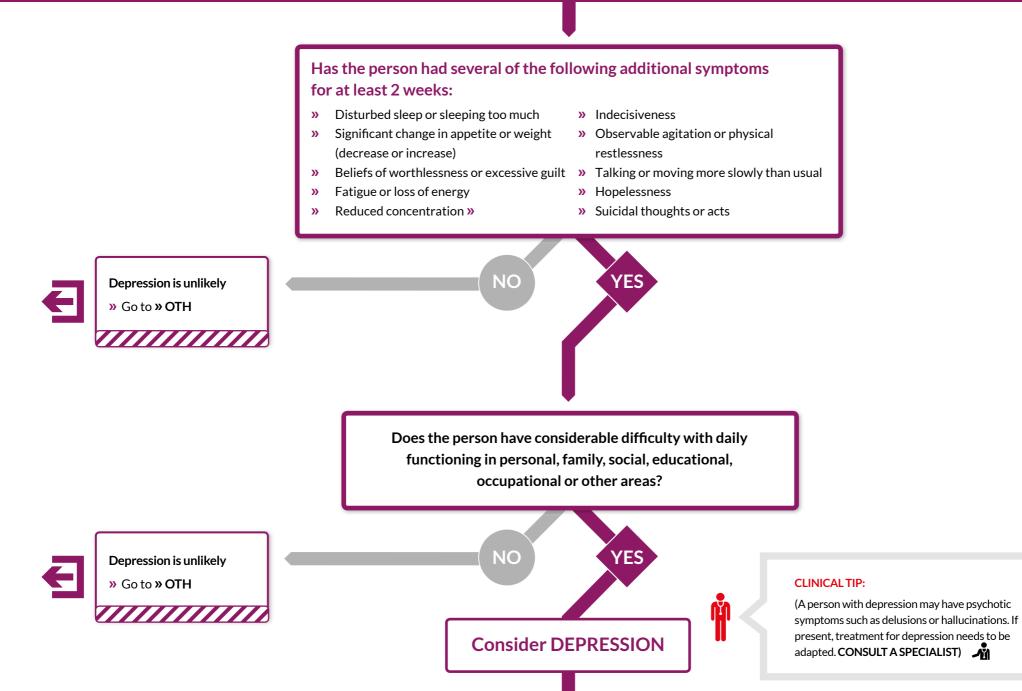


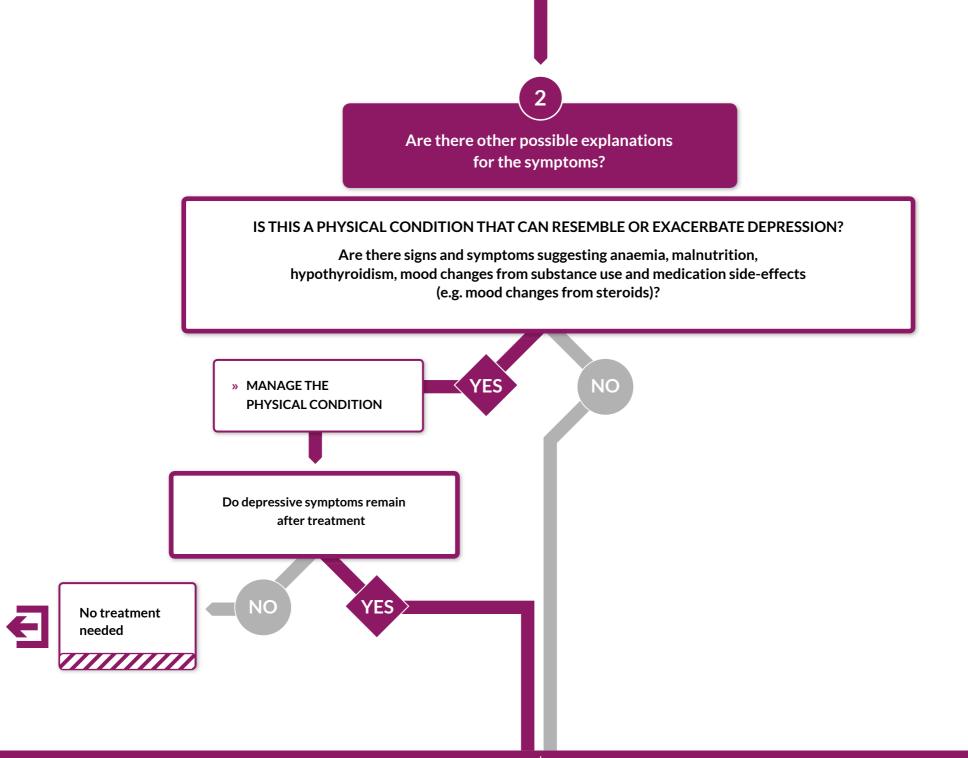
COMMON PRESENTATIONS

- » Multiple persistent physical symptoms (e.g. burning sensation in whole body, chronic pain etc.) with no clear cause
- » Low energy, fatigue, sleep problems
- » Persistent sadness or depressed mood, anxiety
- » Loss of interest or pleasure in activities that are normally pleasurable







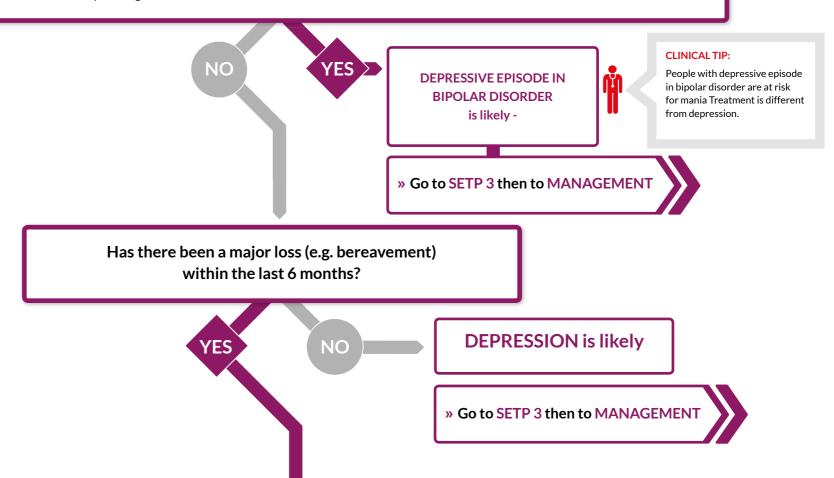


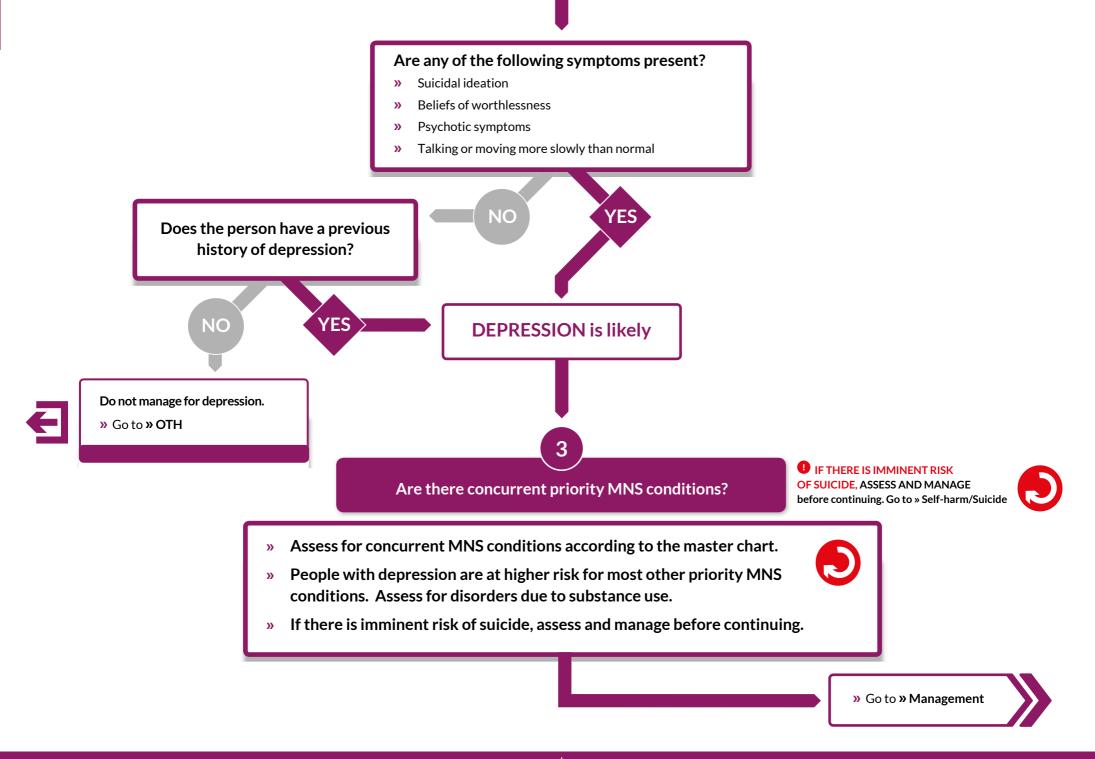
IS THERE A HISTORY OF MANIA?

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

- » Elevation of mood and/or irritability
- » Decreased need for sleep
- Increased activity, feeling of increased energy, increased talkativeness or rapid speech
- Impulsive or reckless behaviours such as excessive spending, making important decisions without planning and sexual indiscretion

- Loss of normal social inhibitions resulting in inappropriate behaviours
- » Being easily distracted
- » Unrealistically inflated self-esteem





MANAGEMENT

DOs

- » Provide psychoeducation.
- » Reduce stress and strengthen social supports.
- Promote functioning in daily activities and community life.
- >>> Consider antidepressants, when needed.
- >> Consider referral to specialist, when needed.
- Offer regular follow-up.

DON'Ts

- DONOT manage the symptoms with ineffective treatments, e.g. vitamin injections.
- In case of Depression in Bipolar disorder, never prescribe antidepressants alone without a mood stabilizer.

PSYCHOSOCIAL INTERVENTIONS

- a) Psychoeducation: key messages to the person and the carers
 - » Depression is a very common condition that can happen to anybody.
 - » The occurrence of depression does not mean that the person is weak or lazy or not religious enough.
 - » People with depression cannot easily control their symptoms by sheer willpower.
 - » People with depression tend to have unrealistically negative opinions about themselves, their life and their future. These views are likely to improve once the depression improves.
 - » Thoughts of self-harm or suicide are common. If they notice these thoughts, they should not act on them, but should tell a trusted person and come back for help immediately.

b) Other measures:

- » Reduction of stressors.
- » Reactivation of the person's previous social network.
- » To start again (or continue) activities that were previously pleasurable.
- » To maintain regular sleeping and waking times.
- » To be as physically active as possible.
- » To eat regularly despite changes in appetite.
- » To spend time with trusted friends and family.
- » To participate in community and other social activities as much as possible.
- c) Brief psychological treatments: If available, consider referral for one of the following brief psychological treatments: (See Appendix I)
 - » Interpersonal therapy (IPT)
 - » Cognitive behavioural therapy (CBT)
 - » Problem-solving counselling

Antidepressants

PHARMACOLOGICAL INTERVENTION

- » For moderate to severe depression start Fluoxetine (an SSRI selective serotonin reuptake inhibitor) as first choice; if sedation required – choose Amitriptyline (a TCA- tricyclic antidepressant).
- » Discuss with the person and decide together whether to prescribe antidepressants. Explain that:
 - Antidepressants are not addictive.
 - It is very important to take the medication every day as prescribed.
 - Some side effects may be experienced within the first few days but they usually resolve.
 - It usually takes several weeks before improvements in mood, interest or energy is noticed.
 - Antidepressant medications usually need to be continued for at least 9-12 months after the resolution of symptoms.
 - Medications should never be stopped just because the person experiences some improvement.

Medication	Dosing
Amitriptyline (TCA)	 Start 25 mg at bedtime. Increase by 25-50 mg per week to 100-150 mg daily. Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses. Elderly/Medically III: Start 25 mg at bedtime to 50-75 mg daily. Children/ Adolescents: Do not use
Fluoxetine (SSRI)	Start 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg. Elderly/medically ill: preferred choice. Start 10 mg daily, then increase to 20 mg. It children/ Adolescents: Do not use

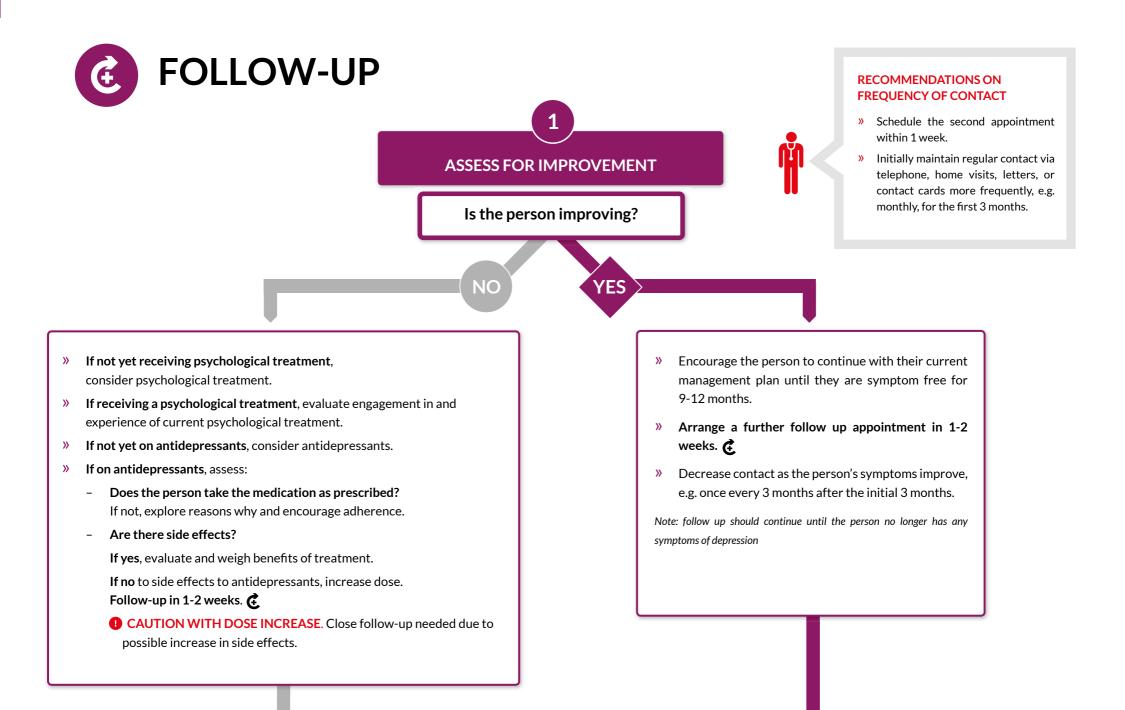
(See Appendix II for side-effects and contraindication of the drugs)

Antidepressants in special populations

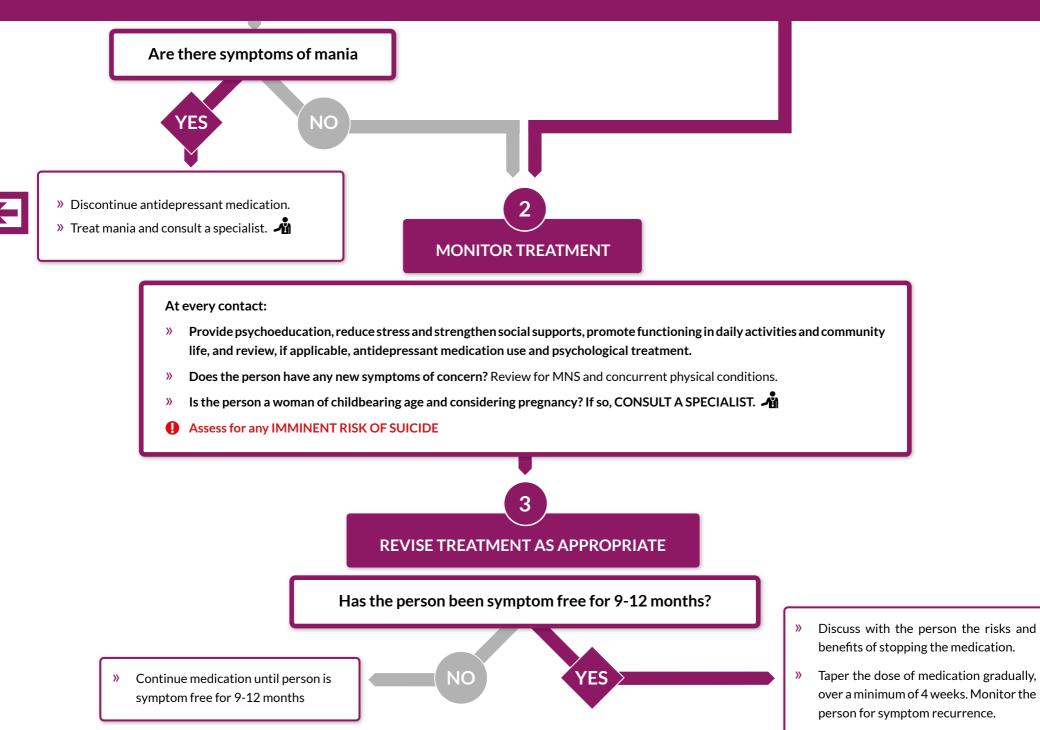
	Adolescents 12 years of age or older	If symptoms persist or worsen despite psychosocial interventions, Refer to specialist for pharmacological treatment.	
8	Women who are pregnant or breastfeeding	 CONSULT A SPECIALIST, if available Avoid antidepressants, if possible, especially during the first trimester. If no response to psychological treatment, consider using with caution the lowest effective dose of antidepressants If breastfeeding, avoid long acting antidepressant medication such as fluoxetine. 	
6	Older adults	Avoid amitriptyline if possible.	
0	Adults with thoughts or plans of suicide	SSRIs are the first choice. Overdose of TCAs such as amitriptyline may be fatal and therefore should be avoided in this group.	
0	People with cardiovascular disease	Do not prescribe amitriptyline.	

MANAGEMENT OF DEPRESSION IN BIPOLAR DISORDER

- » Consult a specialist.
- » If a specialist is not immediately available, follow treatment for depression. However, never prescribe antidepressants alone without a mood stabilizer such as lithium, carbamazepine or valproate because antidepressants can lead to mania in people with bipolar disorder. NEVER PRESCRIBE VALPROATE TO WOMEN OR GIRLS
- » If symptoms of mania develop, tell the person and the carers to stop the antidepressant immediately and return for help.



DEPRESSION

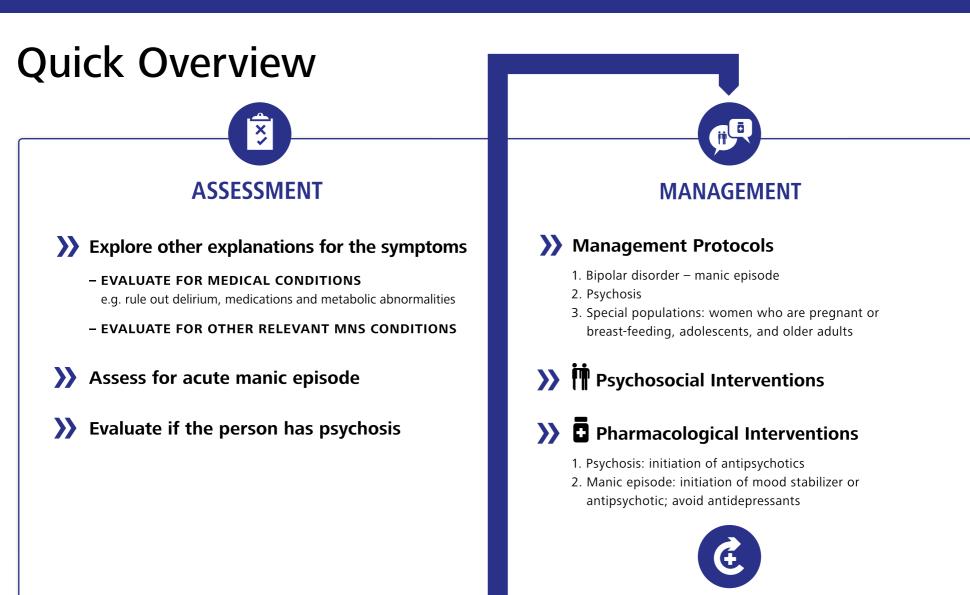


PSYCHOSES

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

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

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



FOLLOW-UP



COMMON PRESENTATIONS

	Psychosis	Bipolar disorder (Manic episode)	
»	Agitated, aggressive or violent behaviour, decreased or increased activity.	»	Increased talkativeness or rapid speech
»	Fixed false beliefs not shared by others in the person's culture.	»	Increased activity, feeling of increased energy
»	Hearing voices or seeing things that are not there.	»	Unrealistically inflated self-esteem
»	Marked behavioural changes, neglecting usual responsibilities related to work,	»	Elevated mood
	school, domestic or social activities, neglect of self-hygiene.	»	Impulsive or reckless behaviours such as excessive spending, making important
»	Lack of realization that one is having mental health problems.		decisions without planning

1

Are there any other explanations for the symptoms?

» Evaluate for medical conditions

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

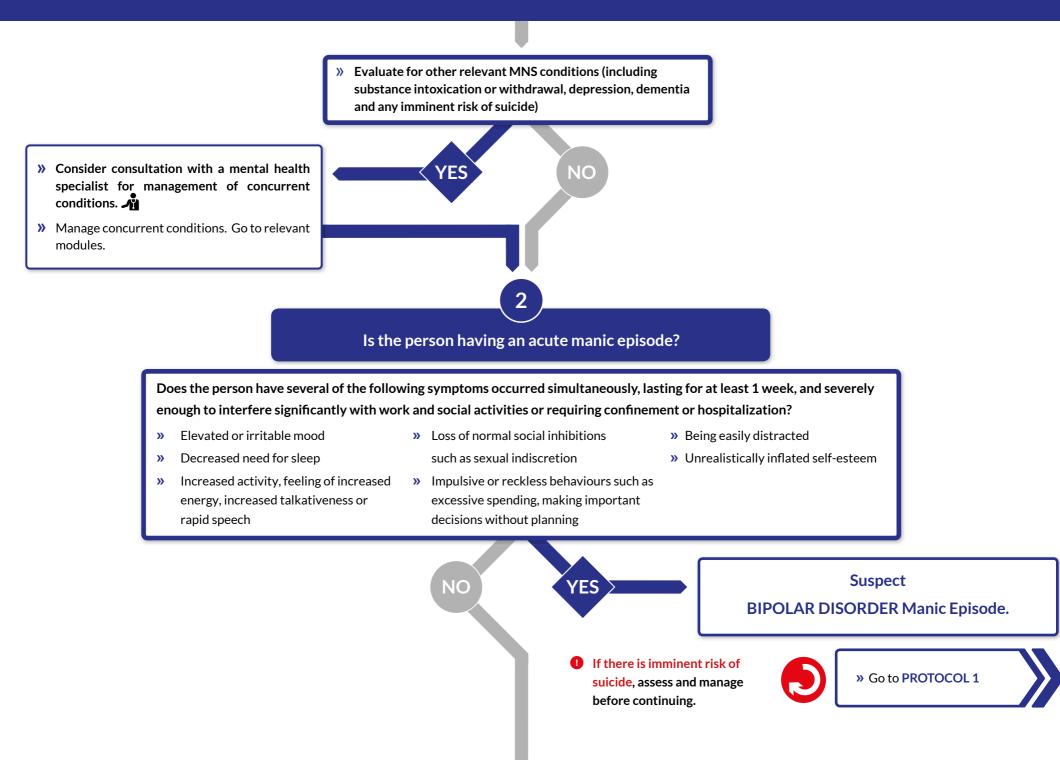
NO

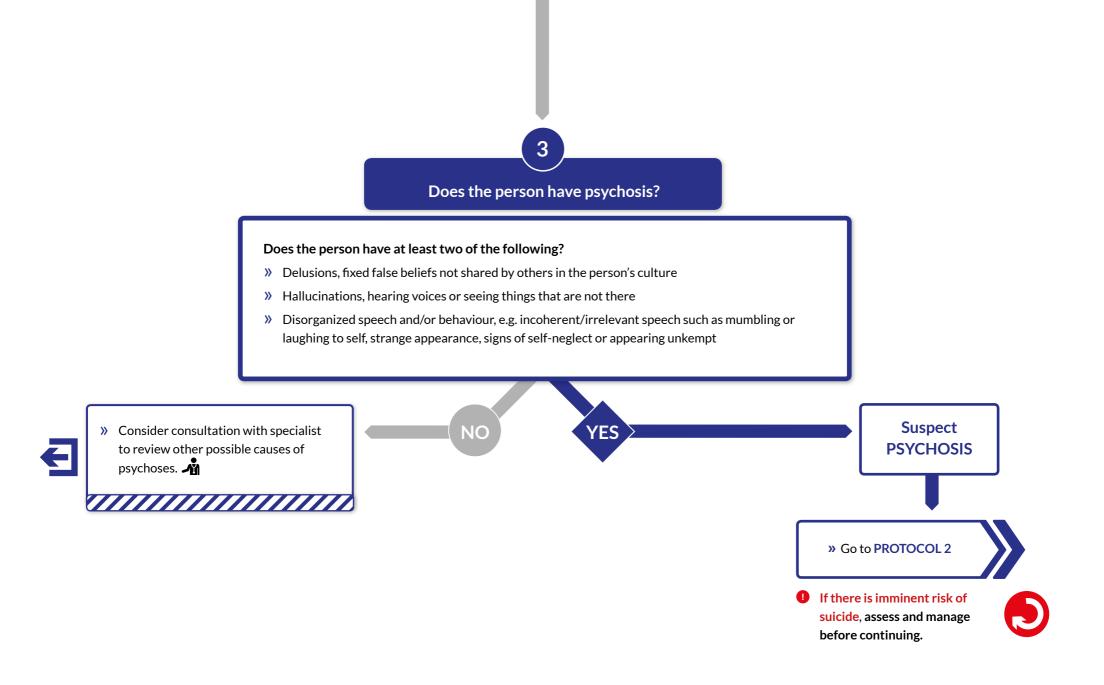
» Assess and manage the acute physical condition, and refer to emergency services/ specialist as needed.

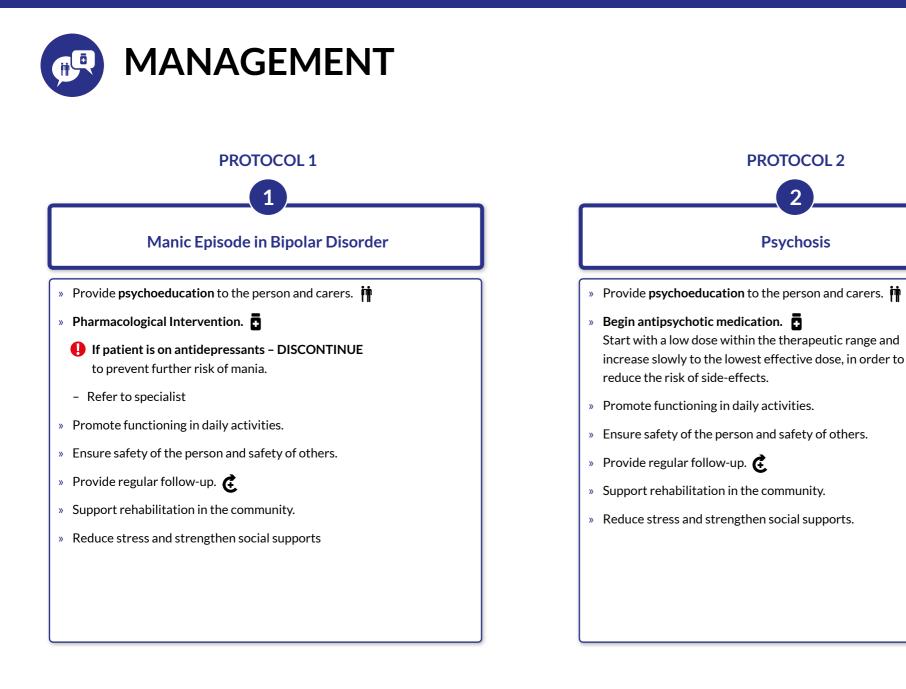
If symptoms persist after management of the acute cause, go to **STEP 2**

PSYCHOSES

YES







PSYCHOSOCIAL INTERVENTION

1. Psychoeducation

Key messages for the person and their carers

- » The symptoms are due to a health condition.
- >> Psychosis and bipolar disorders can be treated, and the person can recover.
- The person or their family is not to be blamed or accused of being the cause of the symptoms.
- » It is not spiritual problem.
- The person needs to take the prescribed medications and return for follow-up regularly. Follow-up early if serious side-effects of medication are noticed.
- Return and/or worsening of symptoms are common and it is important to recognize these early and visit to the health facility as soon as possible. Early symptoms may include sleep disturbances, excessive euphoria, talkativeness etc.
- > A regular schedule should be planned that avoids sleep deprivation and stress for both the person and the carers.
- Cannabis, methamphetamine, alcohol or other nonprescription drugs should be avoided, as they can worsen the symptoms.
- > A healthy lifestyle should be maintained, e.g. a balanced diet, physical activity, regular sleep, good personal hygiene, and no stressors. Stress can worsen symptoms.
- The person should not be told that his or her beliefs are false or not real
- Carers should try to be neutral and supportive, even when the person shows unusual behaviour.

- Expressing constant or severe criticism or hostility towards the person with psychosis should be avoided.
- The person should have freedom of movement while also ensuring that their basic security and that of others is met.
- » Ensure no breaking of human rights.
- In general, it is better for the person to live with family or community members in a supportive environment outside of the hospital setting. Longterm hospitalization should be avoided.

2. Other measures

- » Reactivation of the person's previous social network
- » Promote functioning in daily living activities
- Continue regular social, educational and occupational activities as much as possible. It is best for the person to have a job or to be otherwise meaningfully occupied.
- Facilitate inclusion in economic activities, including culturally appropriate supported employment.

PHARMACOLOGICAL INTERVENTION

Psychosis

- > Antipsychotics should routinely be offered to a person with psychosis.
- » Start antipsychotic medication immediately.
- » Prescribe one antipsychotic at a time.
- Start at lowest dose and titrate up slowly to reduce risk of side effects.
- » Try the medication at a typically effective dose for at

least 4-6 weeks before considering it ineffective.

- Continue to monitor at that dose as frequently as possible and as required for the first 4-6 weeks of therapy. If there is no improvement, see Follow-up. .
- Monitor weight, blood pressure, fasting sugar, cholesterol and ECG for persons on antipsychotics if possible.

CAUTION:

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

Manic episode in Bipolar disorder:

- If patient is on antidepressants: DISCONTINUE ANTIDEPRESSANTS to prevent further risk of mania.
- Refer to specialist
- For behavioural disturbances or agitation consider adding short-term (2-4 weeks maximum) benzodiazepine (diazepam / clonazepam)

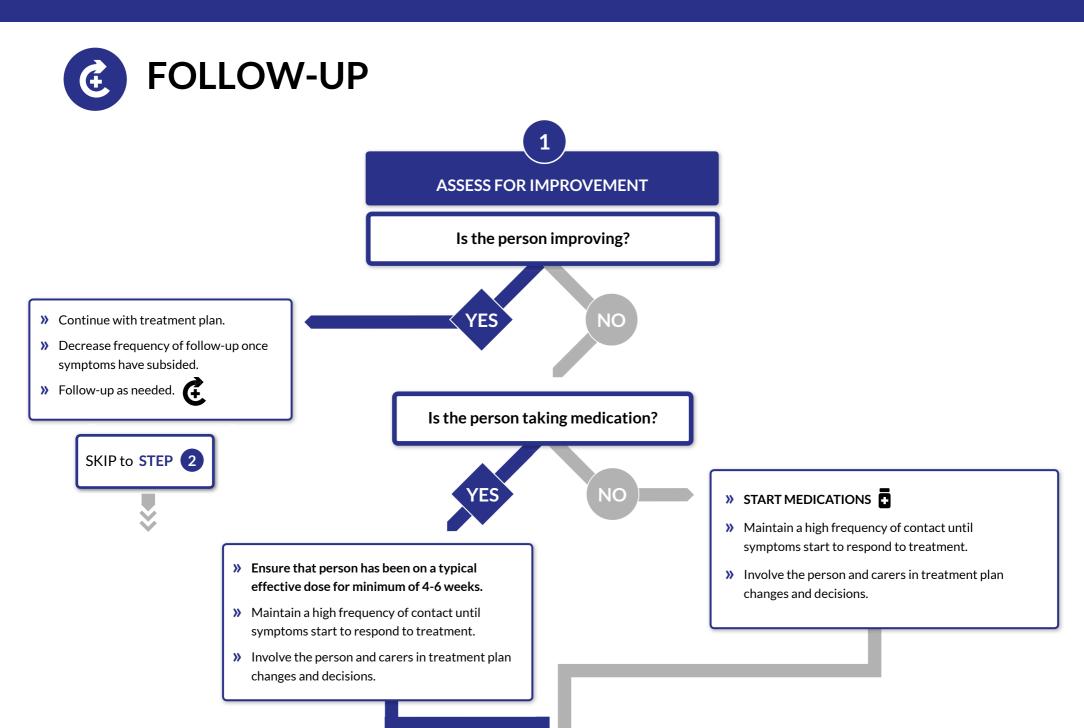
Medications used in psychoses

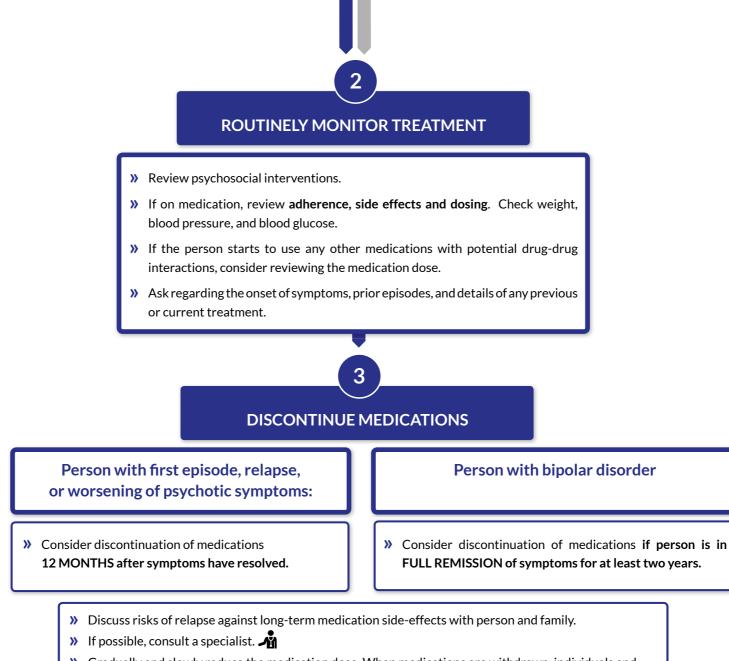
Medication	Dosing
Antipsychotic	
	Start 2.5-5 mg daily. Increase as needed (maximum 20 mg daily).
Haloperidol	Route: oral (p.o.) or intramuscular (i.m.).
Disposidone	Start 1 mg daily. Increase to 2-6 mg daily (maximum 10 mg).
Risperidone	Route: p.o.
Chlorenomine	Start 25-50 mg daily. Increase to 75-300 mg daily (up to 1000 mg may be necessary for severe cases).
Chlorpromazine	Route: p.o
Anticholinergic	
Table and the state of	Start 1 mg daily. Increase to 4-12 mg per day in 3-4 divided doses (maximum 20 mg daily).
Trihexyphenidyl	Route: p.o
Procyclidine	Start 2.5 mg daily. Increase to 5-10 mg per day in 2-3 divided doses (maximum 15 mg daily).
Procyclialite	Route: p.o
Mood stabilizer	
(Should be started by a	a specialist and only if clinical and laboratory monitoring are available.)
	Start 300 mg daily. Increase gradually every 7 days until target blood level reached (maximum 600-1200 mg daily). Monitor every 2-3 months.
Lithium	Route: p.o
	Target blood levels: 0.6-1.0 mEq/liter
	Start 500 mg daily.
Sodium valproate	Increase slowly to 1000-2000 mg daily (maximum 60 mg/kg/day).
	Route: p.o

(See Appendix II for side-effects and contraindication of the drugs)

Special populations

 Liaise with maternal health specialists to organize care. Consider consultation with mental health specialist if available. Explain the risk of adverse consequences for the mother and her baby, including obstetric complications and psychotic relapses, particularly if medication stopped. Consider pharmacological intervention when appropriate and available. 			
TO PRESCRIBE >> Low dose oral haloperidol (with caution and in consultation with a specialist, if available.)	NOT TO PRESCRIBE >> Depot antipsychotics >> Anticholinergics (except in cases of acute, short-term use.) >> Mood-stabilizers (valproate, lithium and carbamazepine)		
	 Consider consultation with mental health specialist if available. Explain the risk of adverse consequences for the mother and her baby, in medication stopped. Consider pharmacological intervention when appropriate and available TO PRESCRIBE Low dose oral haloperidol (with caution and in consultation with a specialist, if available.) Consider consultation with mental health specialist. Use lower doses of medication. 		





- Scradually and slowly reduce the medication dose. When medications are withdrawn, individuals and family members need to be educated to detect early symptoms of relapse. Close clinical monitoring is recommended.
- » In case of several episodes of psychoses, refer to a specialist for the decision to discontinue medication.

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

Clinical situation	Action
The person is not tolerating antipsychotic medication, i.e. the person has extrapyramidal symptoms (EPS) or other serious side effects	 » Reduce the dose of antipsychotic medication. » If side-effects persist, consider switching to another antipsychotic medication. » Consider adding anticholinergic medication for short-term use to treat EPS if these strategies fail or if symptoms are severe.
Adherence to treatment is unsatisfactory	 » Discuss reasons for non-adherence with the person and carers. » Provide information regarding importance of medication. » Consider depot/long-acting injectable antipsychotic medication as an option after discussing possible side effects of oral versus depot preparations.
Treatment response is inadequate (i.e. symptoms persist or worsen) despite adherence to medication	 >> Verify that the person is receiving an effective dose of medication. If the dose is low, increase gradually to lowest effective dose to reduce the risk of side effects. Enquire about substance use and take measures to reduce this. >> Enquire about recent stressful event that may have led to worsening of clinical condition and take measures to reduce stress. Review symptoms to rule out physical and/or other priority MNS conditions. >> If the person does not respond to adequate dose and duration of more than one antipsychotic medication, using one medicine at a time, then antipsychotic combination treatment may be considered; preferably under the supervision of a specialist, with close clinical monitoring.

Management of Persons with Agitated and/or Aggressive Behaviour

ASSESSMENT 💈

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

COMMUNICATION

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

SEDATION AND USE OF MEDICATION

- » Sedate as appropriate to prevent injury.
- » Use diazpeam 5-10 mg p.o per day (up to 20 mg per day)
- » For agitation due to psychosis or mania, consider use of haloperidol 2.5 mg p.o./i.m. hourly up to 4 doses (maximum 10 mg).

CAUTION:

- » High doses of haloperidol can cause dystonic reactions. Use trihexyphenidyl/ procyclidine to treat acute reactions.
- » Never use i.v. diazepam in a primary care setting without adequate resuscitation facility

In cases of extreme violence

- » Seek help from police or staff
- » Use haloperidol 5 mg i.m., repeat in 15-30 mins if needed (maximum 15 mg)
- » Consult a specialist.
- Special populations (adolescents, older adults, woman who are pregnant or breastfeeding)
- » Consult a specialist for treatment. 🐴

PSYCHOSES

EPILEPSY

Epilepsy is a chronic noncommunicable disorder of the brain, characterized by recurrent unprovoked seizures. Epilepsy is one of the most common neurological disorders and with proper treatment, can be well controlled in the majority of people. Epilepsy has many causes. It may be genetic. Epilepsy may occur in people who have a past history of birth trauma, brain injury (including head trauma and strokes), or brain infections. In some people, no cause may be identified. There are different types of epilepsy. This module focuses on convulsive type. Acute presentation of seizures/convulsions warrants emergency treatment & management



ASSESSMENT

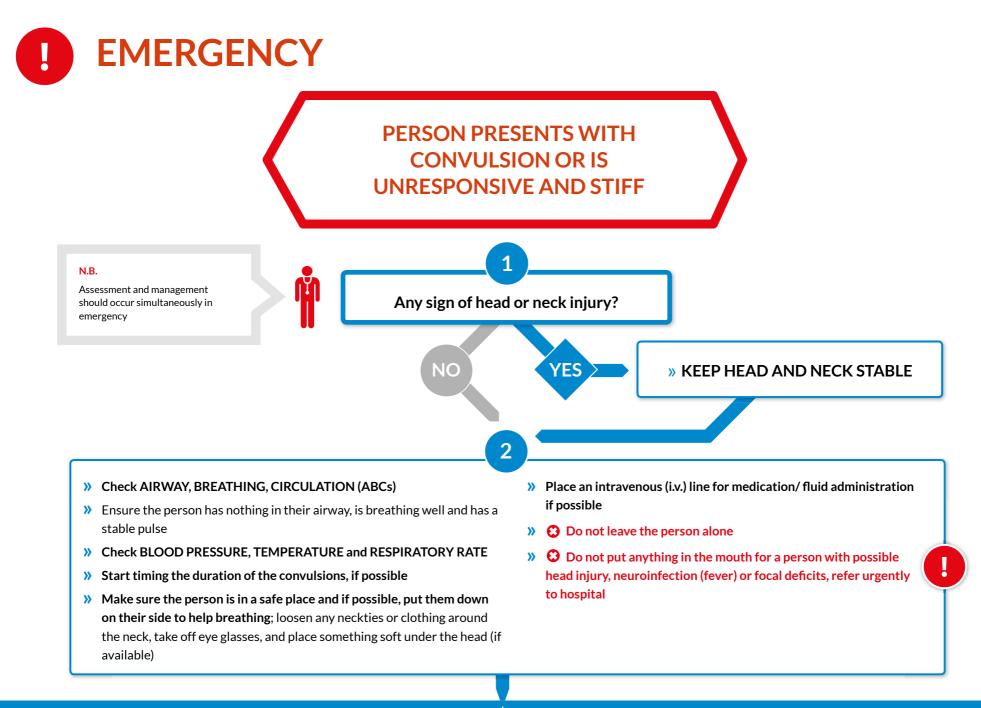
- EMERGENCY: Assessment & management of acute convulsions
- >> Assess if person has convulsive seizures
- Assess for an acute cause(e.g. neuroinfection, trauma, etc.)
- >> Assess if the person has epilepsy and for any underlying causes (by history or examination)
- >> Assess for concurrent priority MNS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

MANAGEMENT

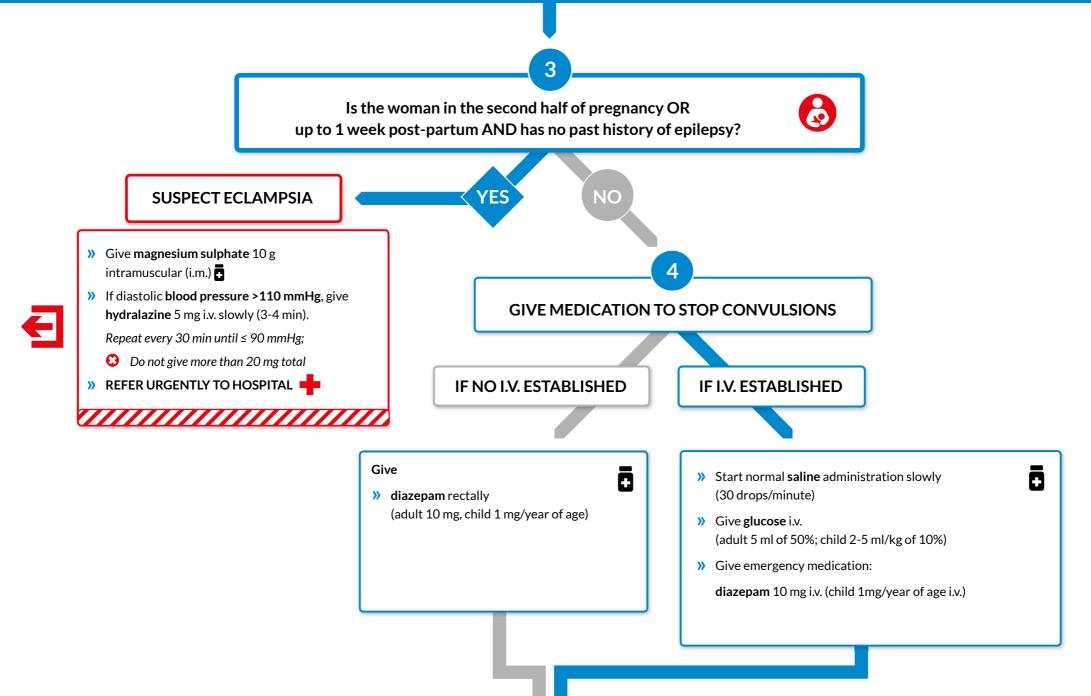
>>> Management Protocol and Special Populations

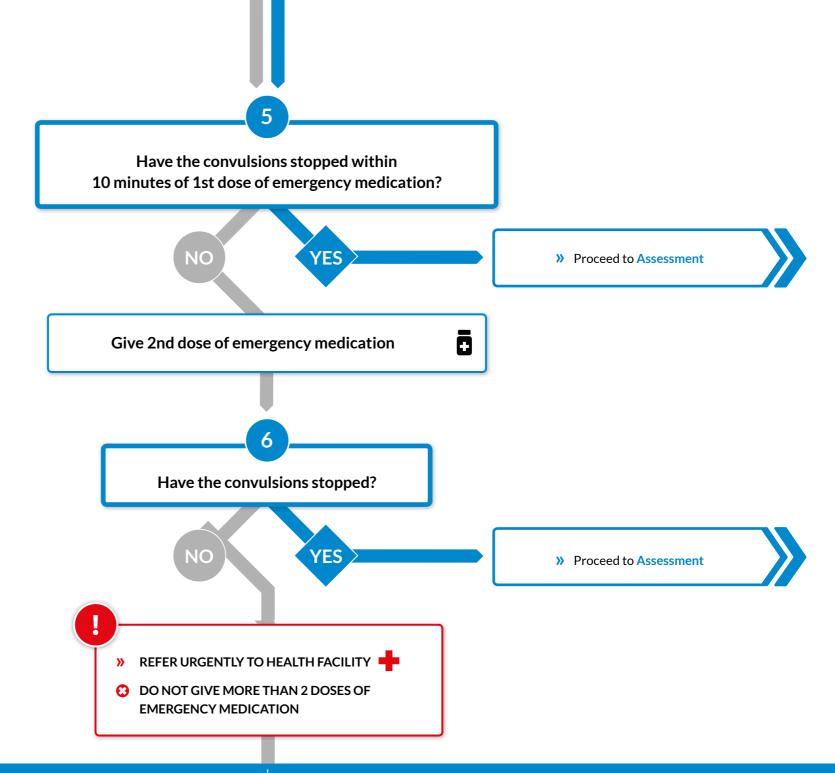
- 1. Epilepsy
- 2. Special Populations (women of childbearing age, children/adolescents, and people living with HIV)
- >> Pharmacological Interventions



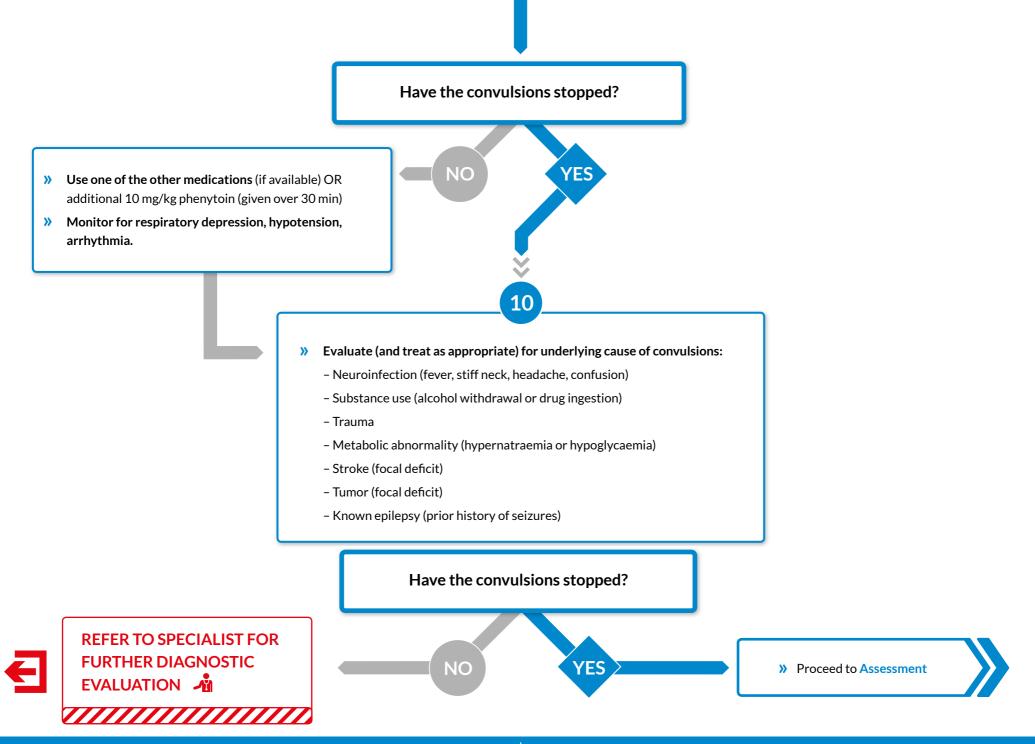


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IS THE PERSON IN STATUS EPILEPTICUS? Convulsions continue after 2 doses of emergency medication, OR » No recovery in between convulsions » SKIP to STEP 10 YES NO (e.g. convulsions stopped after second dose of emergency medication on arrival to health STATUS EPILEPTICUS IS LIKELY facility) Management should occur in health facility 8 Continue to check AIRWAY, BREATHING, and CIRCULATION (ABCs) **>>** Give oxygen » Monitor need for intubation/ventilation continuously **>>** GIVE ONE OF THE FOLLOWING MEDICATIONS INTRAVENOUSLY >> VALPROIC ACID: PHENYOTIN: » 20 mg/kg i.v. once up to maximum dose of 1 g, over 30 min 15-20 mg/kg i.v. up to max dose of 1 g, over 60 min - use second i.v. line (DIFFERENT FROM DIAZEPAM) >> PHENOBARBITAL: 15-20 mg/kg i.v.* up to maximum dose of 1 g, over 100 mg/min. (PHENYTOIN CAUSES SIGNIFICANT DAMAGE IF EXTRAVASATES, MUST HAVE GOOD I.V. LINE!) (*If no i.v. access, can use i.m. phenobarbital (same dose as i.v.))



EPILEPSY

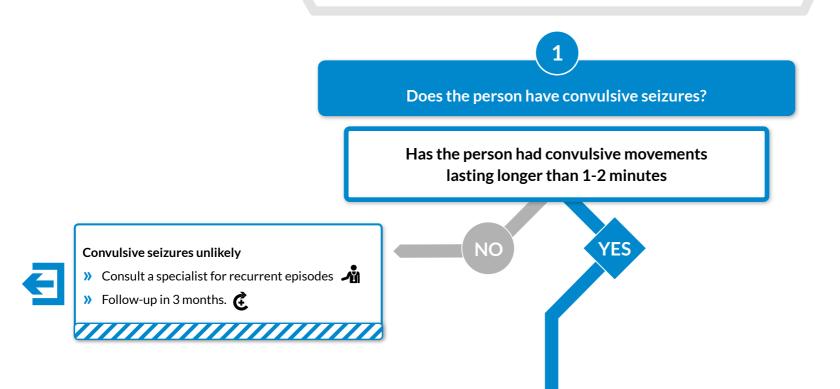
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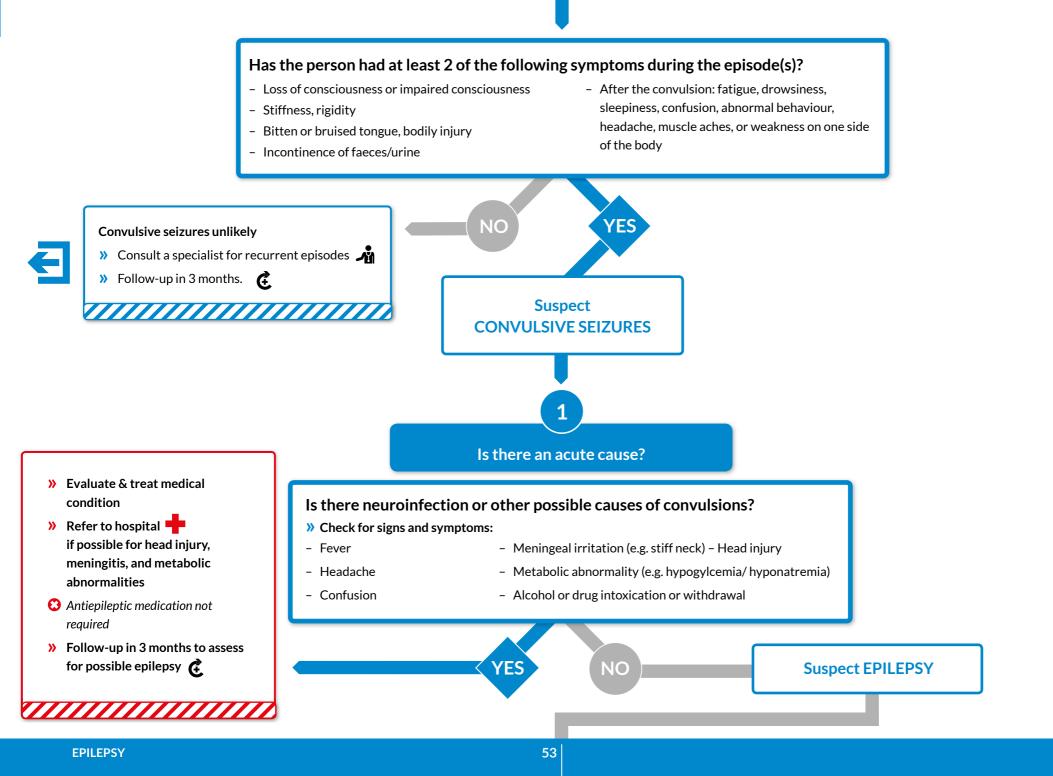
COMMON PRESENTATIONS

» Convulsive movement or fits/seizures

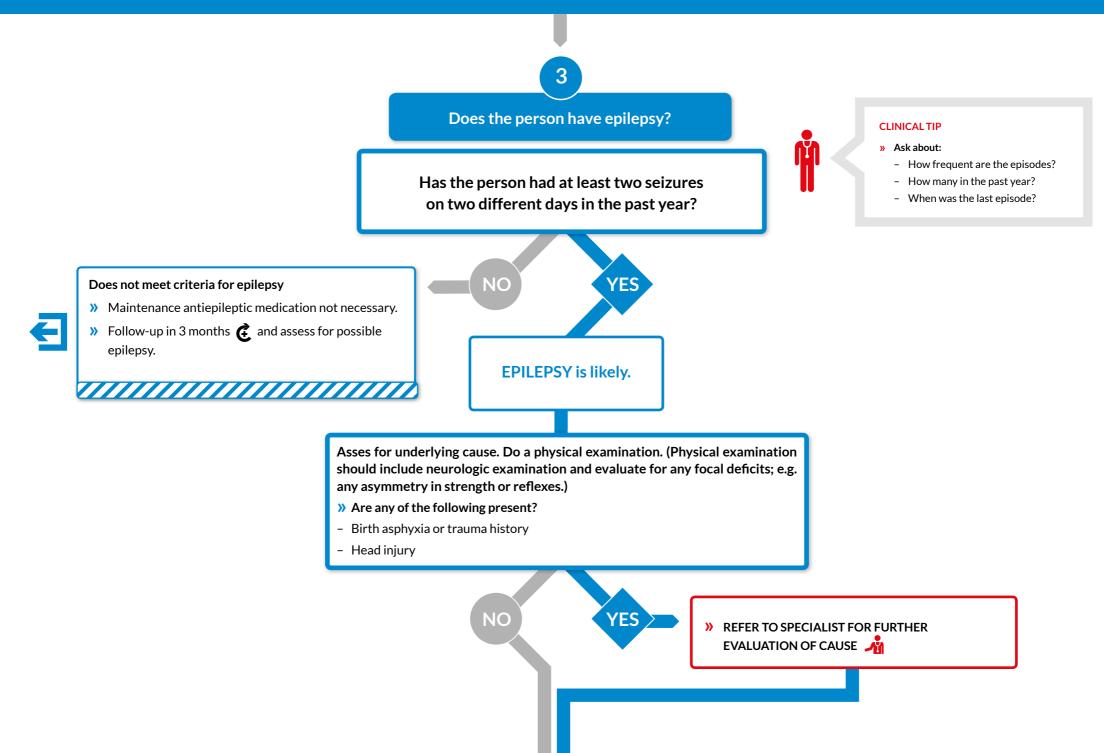
During the convulsion:

- Loss of or impaired consciousness
- Stiffness/rigidity
- Tongue bite, injury, incontinence of urine or faeces
- After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches





EPILEPSY





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



• Please note persons with EPILEPSY are at higher risk for depression, disorders due to substance use. Children and adolescents may have associated mental and behavioural disorders.

» Go to MANAGEMENT

If there is imminent risk of suicide, assess and manage before continuing to management of epilepsy



CLINICAL TIP

- Syncopal (fainting) spells often are associated with flushing, sweating, pallor, and occasionally a feeling of vision darkening prior to an episode. Mild shaking may occur at the end.
- Pseudoseizures are typically associated with a stress trigger. Episodes are often prolonged and can involve nonrhythmic jerking of the body, eyes may be closed, and pelvic thrusting is often seen. There is typically a rapid return to baseline after the episode. Pseudoseizures are common in Bangladesh.
- Syncope and pseudoseizures should be considered during initial evaluation and in cases of treatment failure.

Difference between Seizure and Pseudoseizure

Criteria	Seizure	Pseudoseizure
Consciousness	Patient may be unconscious	Conscious, though may not be able to talk
Pathology	Organic pathology	Psychological conflict
Place	Can occur anywhere	Usually in presence of others
Sleep	May also occur in sleep	Never in sleep
Aura	May be present	Usually absent
Pattern & duration	Similar pattern & duration in every attack	Variable pattern & duration of attack in same patient
Associated features	Tongue-bite, frothing, incontinence, cyanosis usually present during attack	Usually absent
Post-ictal features	Post-ictal headache, confusion, amnesia- usually present	Usually absent
EEG features	Spike and waveforms & Postictal slowing may be present	Usually absent



PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

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

- b. Provide information on: How carers can manage convulsion at home
 - If a seizure starts while the person is standing or sitting, help to prevent a fall injury by gently assisting them to sit or lie on the ground.
 - Make sure that the person is breathing properly. Loosen the clothes around the neck.
 - » Place the person in the recovery position
- A) Kneel on the floor on one side of the person. Place the arm closest to you at a right angle to their body with the person's hand upwards towards the head.
- B) Place the other hand under the side of the person's head, so that the back of the hand is touching the cheek.
- C) Bend the knee furthest from you to a right angle. Roll the person carefully onto his or her side by pulling on the bent knee.
- D) The person's top arm should be supporting the head and the bottom arm will stop the person from rolling too far. Open the person's airway by gently tilting his or her head back and lifting the chin, and check that nothing is blocking the airway.

This maneuver moves the tongue out of the airway and helps the person breathe better and prevents choking from secretions and vomit.

Do not try to restrain or hold the person to the floor.

- Do not put anything in the person's mouth.
- » Move any hard or sharp objects away from the person to prevent injury.
- Stay with the person until the seizure stops and the person regains consciousness.
- c. Provide information on: When to get medical help ()

When a person with epilepsy -

- » appears to have trouble breathing during a convulsion
- has a convulsion lasting longer than 5 minutes outside of a health facility
- » is not waking up after a convulsion

2. Promote functioning in daily activities and community life

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

In addition, inform carers and people with epilepsy that:

- People with epilepsy can lead normal lives, marry and have children, work in most jobs.
- Parents should not remove children with epilepsy from school

EPILEPSY

- » People with epilepsy should avoid -
 - alcohol and recreational substances
 - sleeping too little
 - going to places with flashing lights
 - cooking on open fires
 - swimming alone
 - jobs with high risk of injury to self or others e.g. working with heavy machinery

PHARMACOLOGICAL INTERVENTIONS

- » Choose a medication that will be consistently available.
- » Start with only one antiepileptic medication at lowest starting dose.
- » Increase dose slowly until convulsions are controlled.
- Consider monitoring blood count, blood chemistry and liver function tests, if available.

Antiepileptic medication

© CAUTION!

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

Medication	Dosing		
	Adults	Children	
Carbamazepine	Start 100-200 mg daily in 2-3 divided doses. Increase by 200 mg each week (max 1400mg daily).	Start 5 mg/kg daily in 2-3 divided doses. Increase by 5 mg/kg daily each week (max 40mg/kg daily OR 1400mg daily).	
Phenobarbital	Start 60 mg daily in 1-2 divided doses.	Start 2-3 mg/kg daily in 2 divided doses.	
	Increase weekly by 2.5-5 mg (maximum 180 mg daily).	Increase weekly by 1-2 mg/kg daily depending on tolerance (maximum 6mg daily).	
Phenytoin Start 150-200 mg daily in two divided doses.		Start 3-4 mg/kg daily in 2 divided doses.	
	Increase by 50 mg daily every 3-4 weeks (max 400 mg daily).	Increase by 5 mg/kg daily every 3-4 weeks maximum 300 mg per day).	
Sodium valproate	Start 400 mg daily in 2 divided doses.	Start 15-20 mg/kg daily in 2-3 divided doses.	
	Increase by 500 mg daily each week (maximum 3000 mg daily).	Increase each week by 15 mg/kg daily (maximum 15-40 mg/kg daily).	

(See Appendix II for side-effects and contraindication of the drugs)

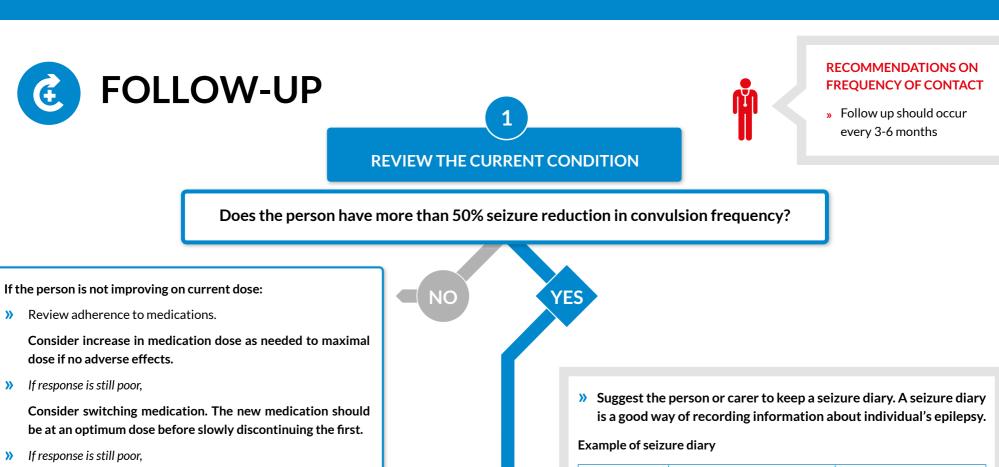
Special populations

Note that interventions are different for EPILEPSY in these populations

Women of childbearing agePregnant women	Concern: Risk of antiepileptic medication to fetus/child	 Advise folate (5 mg/day) to prevent neural tube defects, in all women of childbearing age. AVOID VALPROATE. Avoid phenytoin and sodium valproate. Avoid polytherapy. Multiple medications in combination increase the risk of teratogenic effects during pregnancy. If medications are stopped, they should always be tapered. Advise delivery in hospital. At delivery, give 1 mg vitamin K i.m. to the newborn to prevent haemorrhagic disease.
Breastfeeding women		Carbamazepine is preferred to other medication. Avoid phenytoin and sodium valproate.
😵 Child / adolescent	Concern: Effect of antiepileptic medication on development and/or behavior	 For those with a developmental disorder, manage the condition. For children with behavioural disorder, avoid phenobarbital if possible. Manage the condition.
Solder adults		Use lower doses.
Person living with HIV	Concern: Drug interactions between antiepileptic medications and antiretrovirals	Valproate is preferred due to fewer drug-drug interactions. Avoid phenytoin and carbamazepine when possible.

>>

>>



- Review diagnosis.
- REFER TO SPECIALIST.
- >> Follow-up more frequently. G.

CLINICAL TIP

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

When the seizure occurred		Description of seizure (including body parts affected and duration of seizure)	Medications that were taken	
Date	Time		Yesterday	Today
		·		,

60



At every contact:

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

3

CONSIDER MEDICATION DISCONTINUATION WHEN APPROPRIATE

Has the person been convulsion free for several years?

YES

IF THERE ARE NO PROBLEMS WITH MEDICATIONS

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

- Discuss risk of seizure occurrence with person/carer (if epilepsy is due to head injury, stroke or neuroinfection, there is a higher risk of seizure recurrence off medication), and risks and benefits of discontinuing medications.
- If in agreement, gradually take the person off medication by reducing the doses over 2 months and monitoring closely for seizure recurrence.

EPILEPSY

CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS

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

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

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

EMOTIONAL DISORDERS Emotional disorders are characterized by increased levels of anxiety, depression, fear, and somatic symptoms.

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

Quick Overview

ASSESSMENT

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

MANAGEMENT

>> Management Protocols

- 1. Developmental Delay/Disorder
- 2. Problems with Behaviour
- 3. Attention Deficit Hyperactivity Disorder (ADHD)
- 4. Conduct Disorder

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- 5. Problems with Emotions
- 6. Emotional disorders and Moderate to Severe Depression in Adolescents





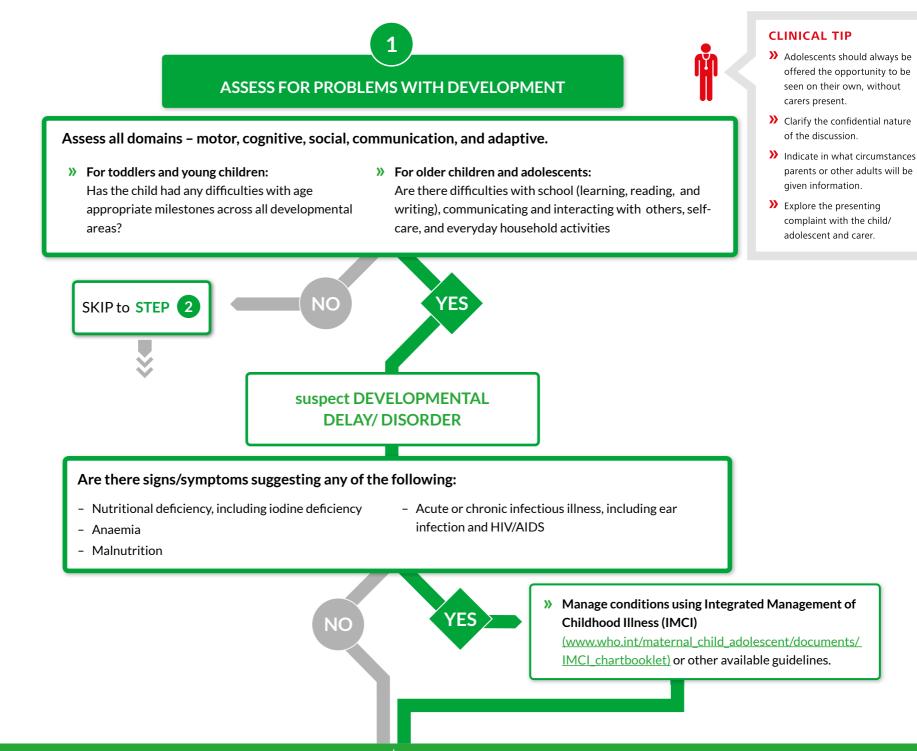
Age group	Developmental disorders	Behavioral disorders	Emotional disorders	
Infants and young children (age <5)	Poor feeding, failure to thrive, poor motor tone, delay in meeting expected developmental milestones for appropriate age (e.g. smiling, sitting, interacting with others, sharing attention, walking, talking and toilet training		 Excessive crying, clinging to a carer, freezing (holding the body very still and being silent) and, or tantrums Extreme shyness or changes in functioning (e.g. new wetting or soiling behaviour or thumb sucking) 	
		Ages 4-18 – Excess over-activity: excessive running around,	 Diminished initiation of play and social interaction Sleep and eating difficulties 	
Middle childhood (age 6-12)	 Delay in reading and writing Delay in self-care such as dressing, bathing, brushing teeth 	extreme difficulties remaining seated, excessive talking or moving restlessly - Excessive inattention, absent-mindedness, repeatedly stopping tasks before completion and	 Recurrent, unexplained physical symptoms (e.g. stomach ache, headache, nausea) Reluctance or refusal to go to school Extreme shyness or changes in functioning 	
Adolescents (age 13-18)	 Poor school performance Difficulty understanding instructions Difficulty in social interaction and adjusting to changes 	 switching to other activities Excessive impulsivity: frequently doing things without forethought Repeated and continued behaviour that disturbs others (e.g. unusually frequent and severe tantrums, cruel behaviour, persistent and severe disobedience, stealing) Sudden changes in behaviour or peer relations, including withdrawal and anger 	 Irritable, easily annoyed, frustrated or depressed mood, extreme or rapid and unexpected changes in mood, emotional outbursts, excessive distress difficulty concentrating, poor school performance often wanting to be alone or stay home 	
All ages	 Difficulty carrying out daily activities considered normal for the person's age; difficulty understanding instructions; difficulty in social interactions and adjusting to changes; difficulties or oddities in communication; restrictive/repetitive patterns of behaviours, interests and activities 		 Excessive fear, anxiety or avoidance of specific situations or objects Changes in sleeping and eating habits Diminished interest or participation in activities Oppositional or attention-seeking behavior 	

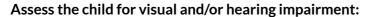
COMMON PRESENTATIONS OF CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS BY AGE GROUP

COMMON PRESENTATIONS

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







For vision assessment, see if the child fails to:

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

For hearing assessment, see if the child fails to:

YES

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

NO

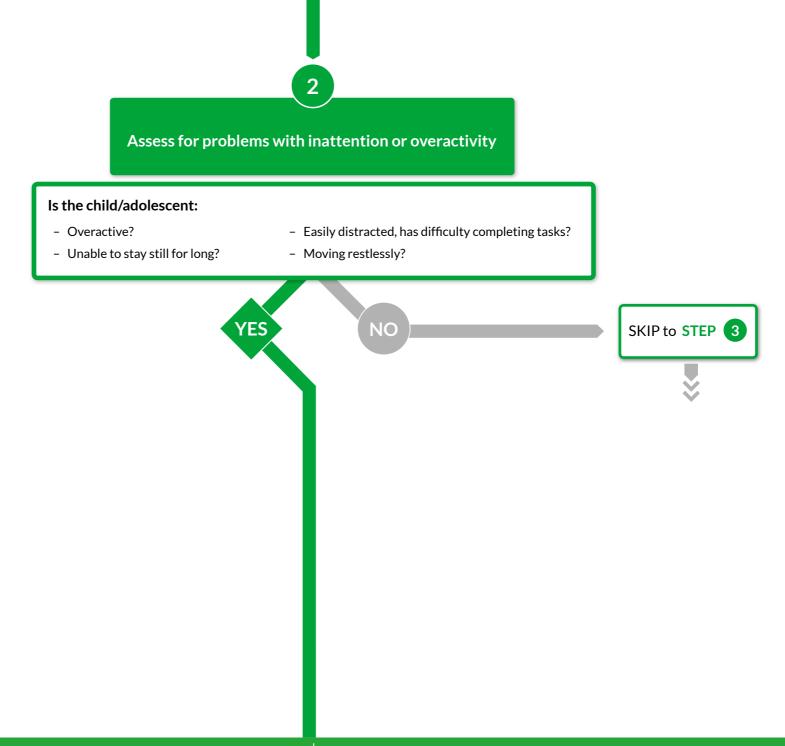
» CONSULT WITH SPECIALIST FOR EVALUATION

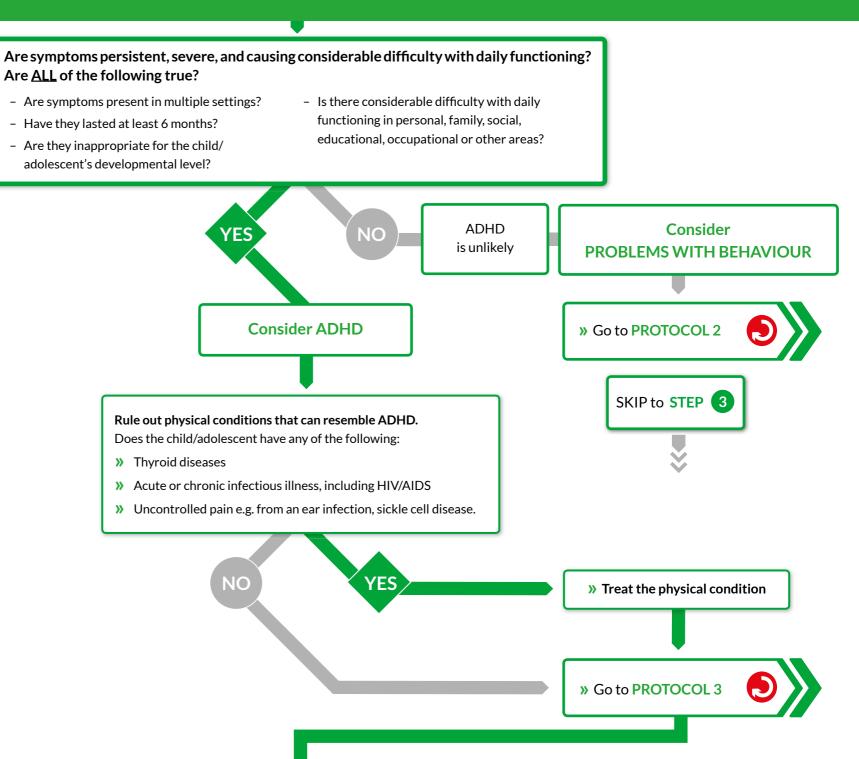
» Go to PROTOCOL 1

Consider Autism spectrum disorder if the child/ adolescent has many of the following symptoms:

- » Fails to respond to his or her name or appears not to hear at times
- Resists cuddling and holding, and seems to prefer playing alone, retreating into his or her own world
- » Has poor eye contact and lacks facial expression
- Doesn't speak or has delayed speech, or loses previous ability to say words or sentences
- » Can't start a conversation or keep one going
- Speaks with an abnormal tone or rhythm and may use a singsong voice or robotlike speech
- » Repeats words or phrases verbatim, but doesn't understand how to use them
- » Doesn't appear to understand simple questions or directions
- » Doesn't express emotions or feelings and appears unaware of others' feelings
- Doesn't point at or bring objects to share interest
- Inappropriately approaches a social interaction by being passive, aggressive or disruptive

- Has difficulty recognizing nonverbal cues, such as interpreting other people's facial expressions, body postures or tone of voice
- >> Performs repetitive movements, such as rocking, spinning or hand flapping
- » Performs activities that could cause self-harm, such as biting or head-banging
- » Develops specific routines or rituals and becomes disturbed at the slightest change
- » Has problems with coordination or has odd movement patterns, such as clumsiness or walking on toes, and has odd, stiff or exaggerated body language
- Is fascinated by details of an object, such as the spinning wheels of a toy car, but doesn't understand the overall purpose or function of the object
- Is unusually sensitive to light, sound or touch, yet may be indifferent to pain or temperature
- » Doesn't engage in imitative or make-believe play
- >> Fixates on an object or activity with abnormal intensity or focus
- >> Has specific food preferences, such as eating only a few foods, or refusing foods with a certain texture





ASSESS FOR CONDUCT DISORDER

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Does the child/adolescent show repeated aggressive, disobedient, or defiant behaviour, for example:

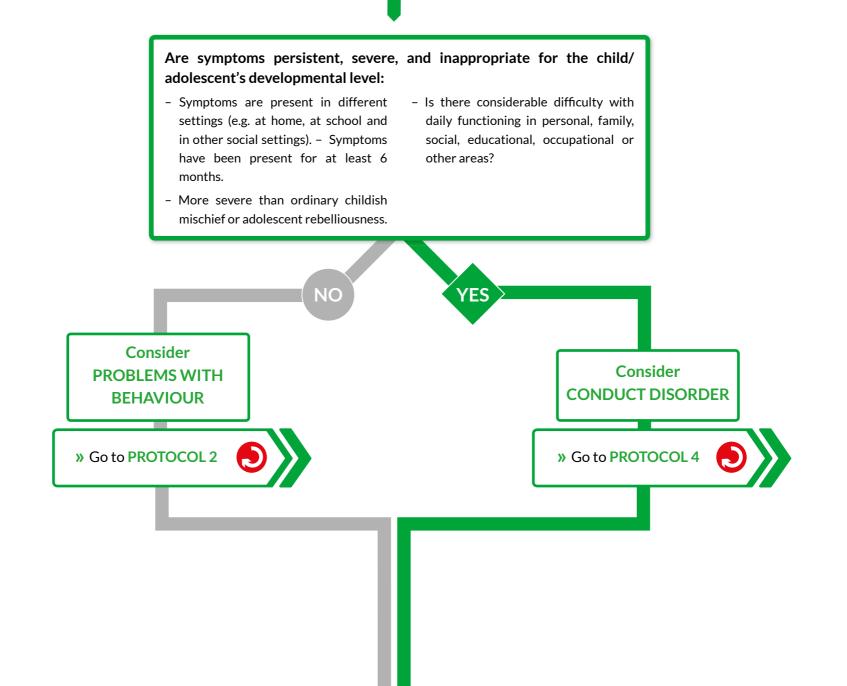
- Arguing with adults
- Defying or refusing to comply with their requests or rules
- Extreme irritability/anger
- Frequent and severe temper tantrums
- Difficulty getting along with others

- Provocative behaviour
- Excessive levels of fighting or bullying
- Cruelty to animals or people
- Severe destructiveness to property, fire-setting
- Stealing, repeated lying, truancy from school, running away from home

SKIP to STEP 4	CONDUCT DISORDER is unlikely	NO	YES	Ň	

CLINICAL TIP: AGE-APPROPRIATE DISRUPTIVE OR CHALLENGING BEHAVIOUR IN CHILDREN/ADOLESCENTS

Toddlers and young children (age 18 months – 5 years)	51, 5, 55		
, , , , , , , , , ,	- Brief tantrums (emotional outbursts with crying, screaming, hitting, etc.), usually lasting less than 5 minutes and not longer than 25 minutes, typically occur less than 3 times per week. Developmentally typical tantrums should not result in self-injury or frequent physical aggression toward others, and the child can typically calm themselves down afterward.		
Middle Childhood (age 6-12)	 Avoidance of or delay in following instructions, complaining or arguing with adults or other children, occasionally losing their temper. 		
Adolescents (age 13-18)	 Testing rules and limits, saying that rules and limits are unfair or unnecessary, occasionally being rude, dismissive, argumentative or defiant with adults. 		



ASSESS FOR EMOTIONAL DISORDERS

4

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

Ask if the child/adolescent:

- Is often feeling irritable, easily annoyed, down or sad?
- Has lost interest in or enjoyment of activities?
- Has many worries or often seems worried?
- Has many fears or is easily scared?

- Often complains of headaches, stomach-aches or sickness?
- Is often unhappy, down-hearted or tearful?

YES

- Avoids or strongly dislikes certain situations (e.g. separation from carers, meeting new people, or closed spaces)?



CLINICAL TIP: AGE-APPROPRIATE FEARS AND ANXIETIES IN CHILDREN AND ADOLESCENTS

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

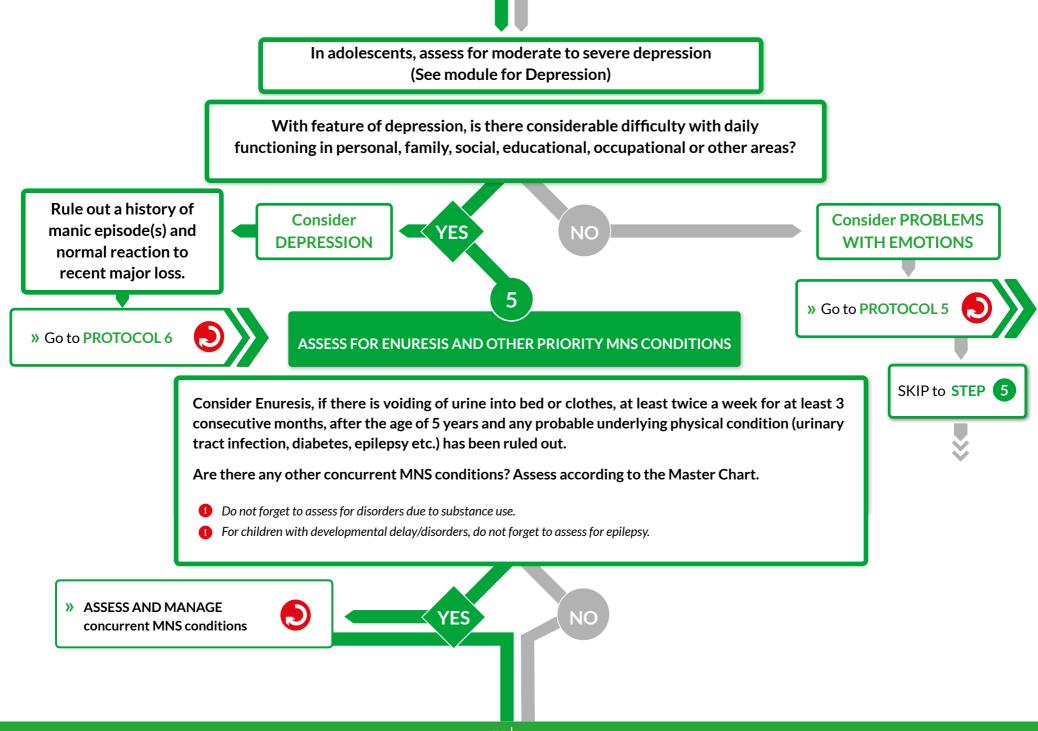
Is there considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas? **PROBLEMS WITH** YES NO » Go to PROTOCOL 5 Consider **EMOTIONAL DISORDER** SKIP to STEP 5

Consider

EMOTIONS

Rule out physical conditions that can resemble or exacerbate emotional disorders. Are there any signs/symptoms suggesting:

- Thyroid diseases - Medication side-effects (e.g. - Anaemia - Infectious illness, including HIV/ - Obesity from corticosteroids or inhaled AIDS - Malnutrition asthma medications) – Asthma » Go to PROTOCOL 6 » Manage the physical condition. YES NO



CLINICAL TIP

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

ASSESS THE HOME ENVIRONMENT

NO

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

Assess for:

Clinical features or any element in the clinical history that suggest maltreatment or exposure to violence.

YES

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

Refer to child protection services if necessary

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

CLINICAL TIP:

WARNING FEATURES OF CHILD MALTREATMENT

CLINICAL FEATURES

- » Physical abuse:
 - Injuries (e.g. bruises, burns, strangulation marks or marks from a belt, whip, switch or other object)
 - Any serious or unusual injury without an explanation or with an unsuitable explanation
- » Sexual abuse:
 - Genital or anal injuries or symptoms that are medically unexplained
 - Sexually transmitted infections or pregnancy
 - Sexualised behaviours (e.g. indication of ageinappropriate sexual knowledge)

» Neglect:

- Being excessively dirty, unsuitable clothing
- Signs of malnutrition, very poor dental health
- » Emotional abuse and all other forms of maltreatment: Any sudden or significant change in the behaviour or emotional state of the child/adolescent that is not better explained by another cause, such as:
 - Unusual fearfulness or severe distress (e.g. inconsolable crying)
 - Self-harm or social withdrawal
 - Aggression or running away from home
 - Indiscriminate affection seeking from adults
 - Development of new soiling and wetting behaviours, thumb sucking

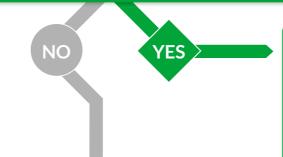
ASPECTS OF CARER INTERACTION WITH THE CHILD/ ADOLESCENT

- » Persistently unresponsive behaviour, especially toward an infant (e.g. not offering comfort or care when the child/ adolescent is scared, hurt or sick)
- » Hostile or rejecting behaviour
- » Using inappropriate threats (e.g. to abandon the child/ adolescent) or harsh methods of discipline

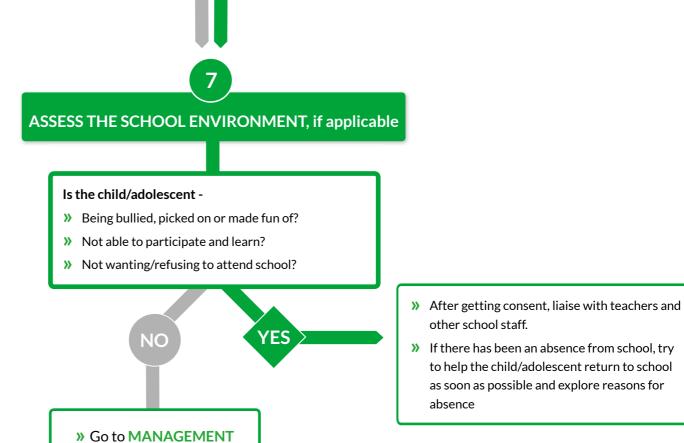
Is the child getting adequate opportunities for play and social interaction/ communication at home?

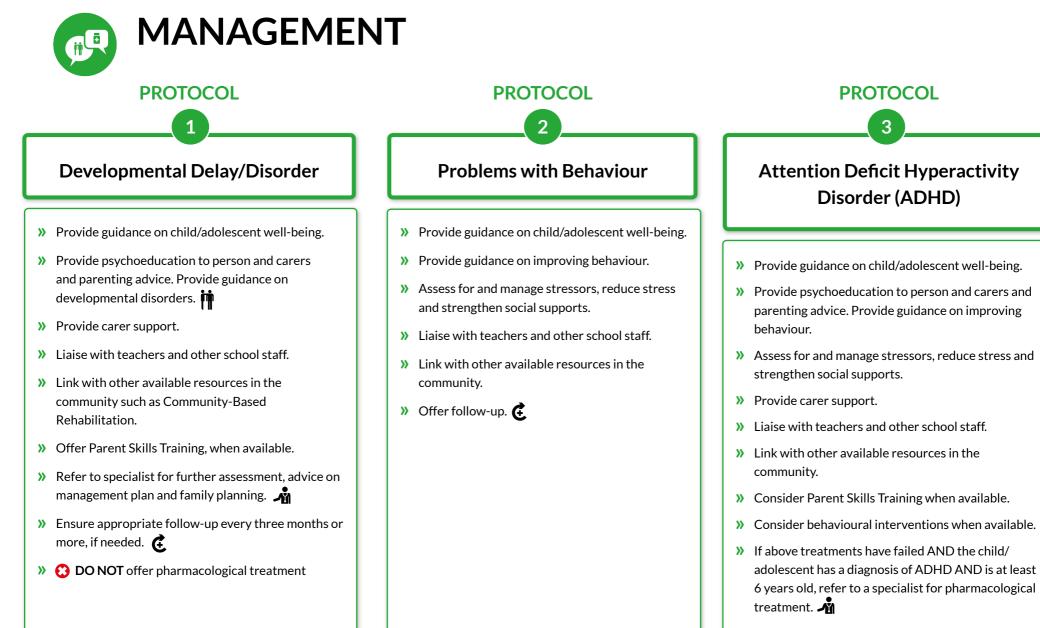
Consider asking:

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



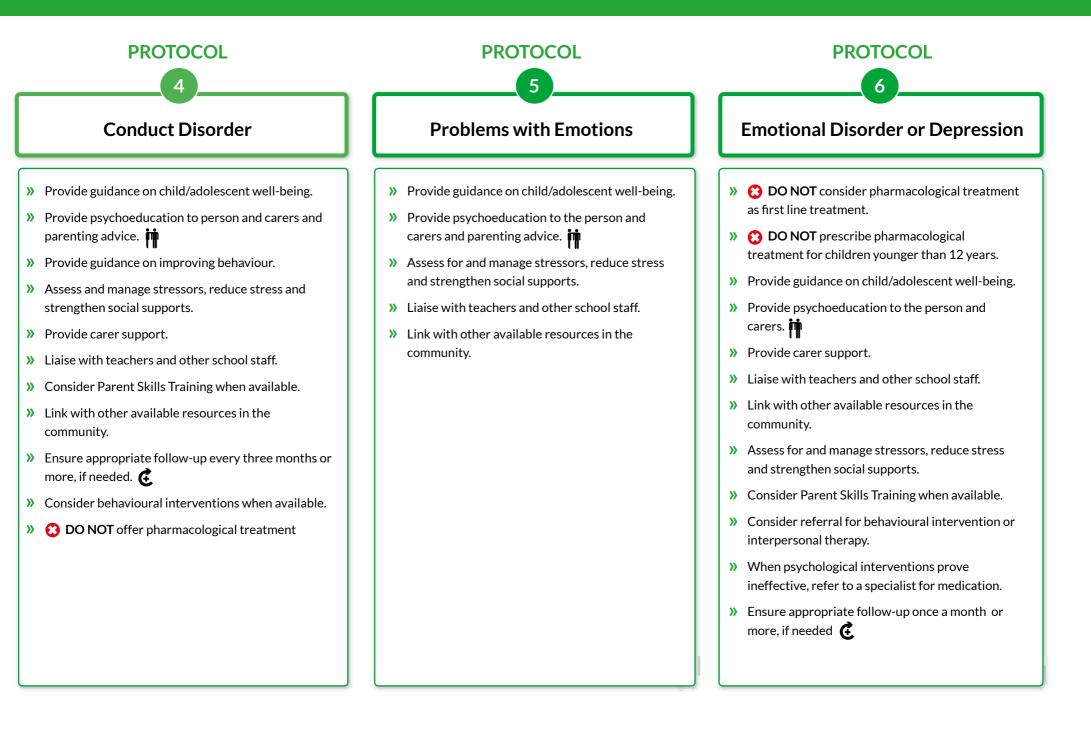
- Provide advice on age-appropriate stimulation and parenting. Refer to Care for Child Development (http://www.who.int/maternal_child_adolescent/ documents/care_child_development/en/)
- » Consider need for additional support for the child including referral to child protection services where available.





» Ensure appropriate follow-up every three months or more, if needed.

CHILD & ADOLESCENT MENTAL & BEHAVIOURAL DISORDERS



PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

Key messages to carers

- Parenting a child/adolescent with an emotional, behavioural or developmental delay or disorder can be rewarding but also very challenging.
- » Parents should show their child that they love their children.
- Persons with mental disorders should not be blamed for having the disorder. Carers should be to be kind and supportive and show love and affection.
- Have realistic expectations and contact other carers of children/ adolescents with similar conditions for mutual support.
- » Children learn best during activities that are fun and positive.
- Emotional disorders are common and can happen to anybody. The occurrence of emotional disorders does not mean that the person is weak or lazy.
- Emotional disorders can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the emotional disorders improve.

2. Guidance to promote child / adolescent well-being and functioning

ENCOURAGE THE CARER TO:

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

- ENCOURAGE AND HELP THE CHILD / ADOLESCENT TO:
- Set enough sleep (Promote regular bed routines and remove TV or other electronic devices with screens from the sleeping area/bedroom.)
- Eat regularly (All children/adolescents need three meals (breakfast, mid-day, and evening) and some snacks each day.)
- Be physically active (If they are able, children and adolescents aged 5-17 should do 60 minutes or more of physical activity each day through daily activities, play, or sports.)
- » Participate in school, community, and other social activities as much as possible.
- » Spend time with trusted friends and family.
- » Avoid the use of drugs, alcohol, and nicotine.

3. Guidance for improving behaviour

Encourage the carer to:

- » Give loving attention, including playing with the child every day.
- » Be consistent about what the child/adolescent is allowed and not allowed to do.
- » Give clear, simple, and short instructions on what the child should and should not do.
- >> Give the child/adolescent simple daily household tasks to do that match their ability level and praise them immediately after they do the task.
- Praise or reward the child/adolescent when his/her behaviour is good and give no reward when behaviour is problematic.
- » Find ways to avoid severe confrontations or foreseeable difficult situations.
- Respond only to the most important problem behaviours and make punishment mild (e.g. withholding rewards and fun activities) and infrequent compared to the amount of praise.

- » Avoid using criticism, yelling.
- > Avoid threats or physical punishment, and abuse. Physical punishment can harm the child-carer relationship; it does not work as well as other methods and can make behaviour problems worse.
- Encourage age-appropriate play (e.g. sports, drawing or other hobbies) for adolescents and offer age-appropriate support in practical ways (e.g. with homework or other life skills).
- » For punishment -use time out or withdrawal of privileges. Do not hit/beat the child.

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

For developmental delay/disorder

ENCOURAGE THE CARER TO:

- » Learn what the child's strengths and weaknesses are and how they learn best, what is stressful to the child and what makes him/her happy, and what causes problem behaviours and what prevents them.
- » Learn how the child communicates and responds (using words, gestures, non-verbal expression, and behaviours).
- » Help the child develop by engaging with her/him in everyday activities and play.
- Involve them in everyday life, starting with simple tasks, one at a time. Break complex activities down into simple steps so that the child can learn and be rewarded one step at a time.
- » Make predictable daily routines by scheduling regular times for eating, playing, learning, and sleeping.
- > Keep their environment stimulating: avoid leaving the child alone for hours without someone to talk to and limit time spent watching TV and playing electronic games.
- » Keep them in the school setting for as long as possible, attending mainstream schools even if only part-time.

- >> Use balanced discipline. When the child/adolescent does something good, offer a reward. Distract the child/adolescent from things they should not do.
- » Avoid threats or physical punishments when the behaviour is problematic.

For emotional problems/disorders including depression in adolescents

- Address any stressful situation in the family environment such as parental discord or a parent's mental disorder. With the help of teachers explore possible adverse circumstances in the school environment.
- » Provide opportunities for quality time with the carer and the family.
- Encourage and help the child/adolescent to continue (or restart) pleasurable and social activities.
- Encourage the child/adolescent to practice regular physical activity, gradually increasing the duration of sessions.
- Consider training the child/adolescent and carer in breathing exercises, progressive muscle relaxation and other cultural equivalents.
- » Make predictable routines in the morning and at bedtime.
- Promote regular sleep habits. Schedule the day with regular times for eating, playing, learning, and sleeping.
- >> For excessive and unrealistic fears:

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

4. Carer support

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

5. Liaise with teachers and other school staff

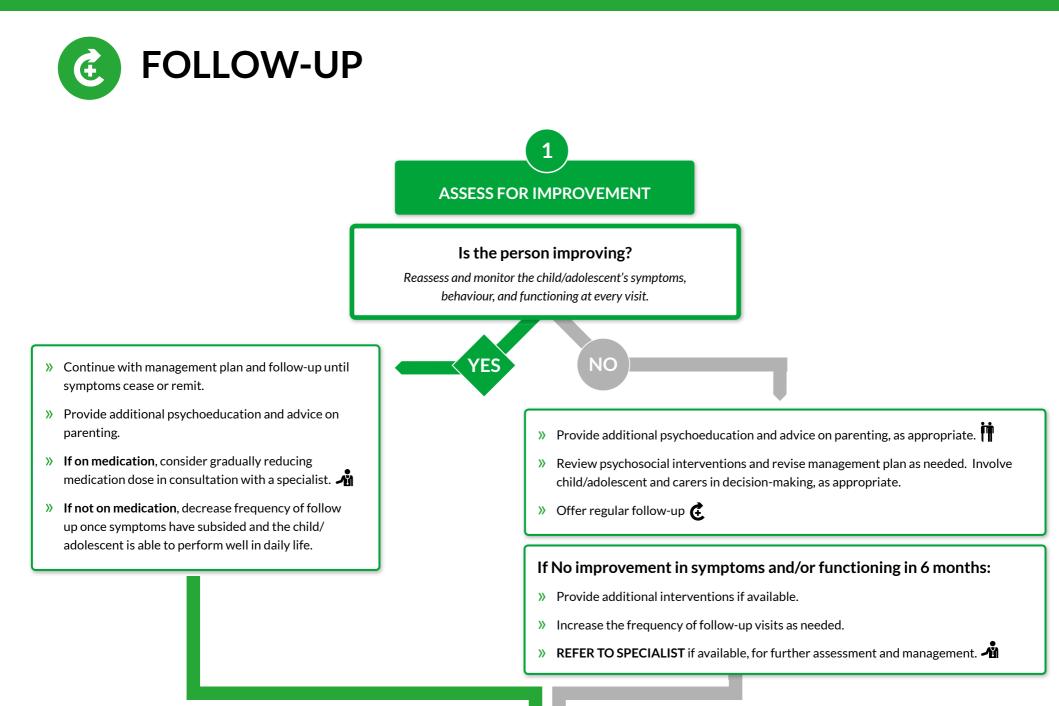
- After getting consent from the child/adolescent and carer, contact the child/ adolescent's teacher and provide advice/ make a plan on how to support the child with learning and participation in school activities.
- » Alternatively pass information to parent to bring to teacher and to bring any information back.
- > Explain that the child/adolescent's mental disorder is affecting their learning/ behaviour/social functioning and that there are things the teacher can do to help.
- >> Ask about any stressful situations that may have an adverse impact on the child's emotional well-being and learning. If the child is being bullied, advise the teacher on appropriate action to stop it.
- » Explore strategies to help engage the child in school activities and facilitate learning, inclusion, and participation.

Simple tips for school

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

Management of Enuresis/ Bed-wetting:

- » Restriction of fluid before bedtime.
- » Lifting the child during the night.
- Increasing the child's bladder capacity by teaching him to 'hold on' for as long as possible when he first feels the desire to urinate.
- » Use of star-charts: to reward success.
- » Medication: Imipramine (if the age is at least 6 years) 12.5-25 mg at night.



MONITOR PHARMACOLOGICAL TREATMENT AS APPLICABLE

Additional monitoring if the adolescent has been prescribed fluoxetine

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

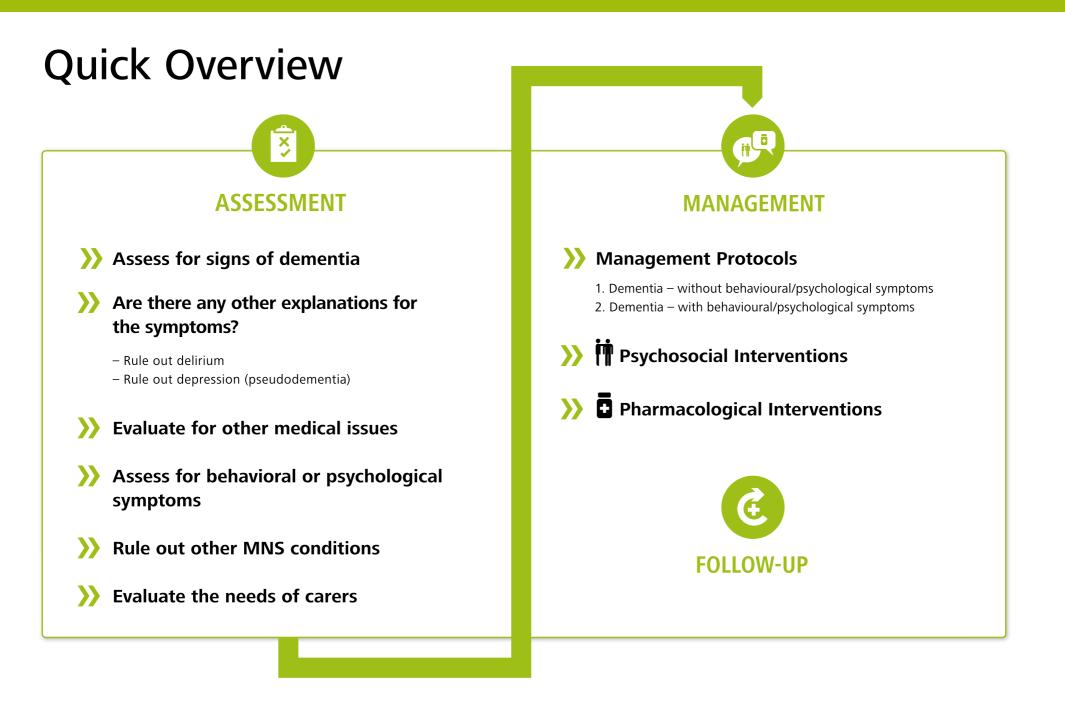
Conduct routine assessments

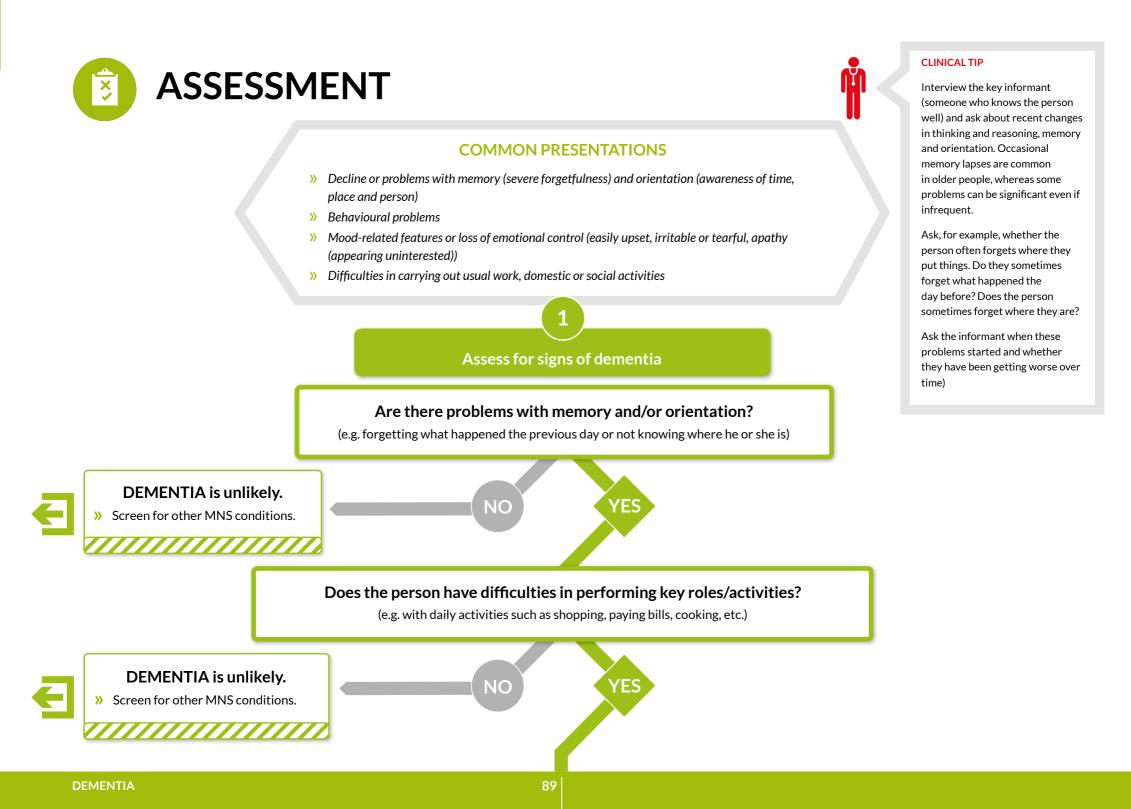
At every visit:

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

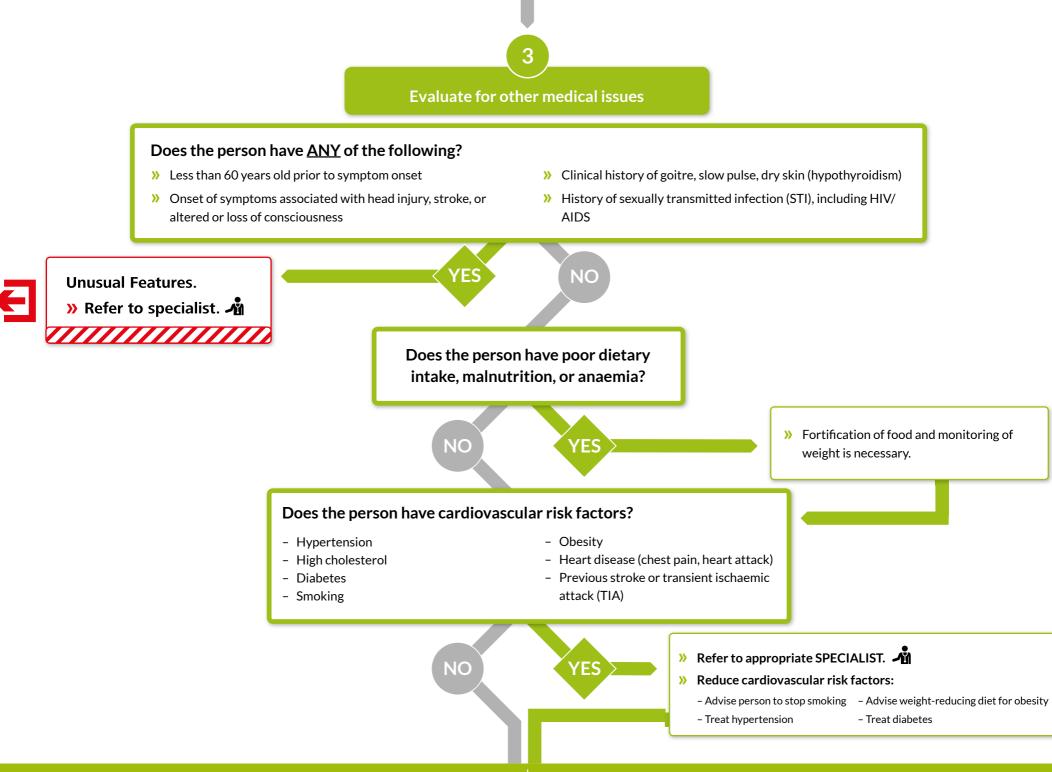
DEMENTIA

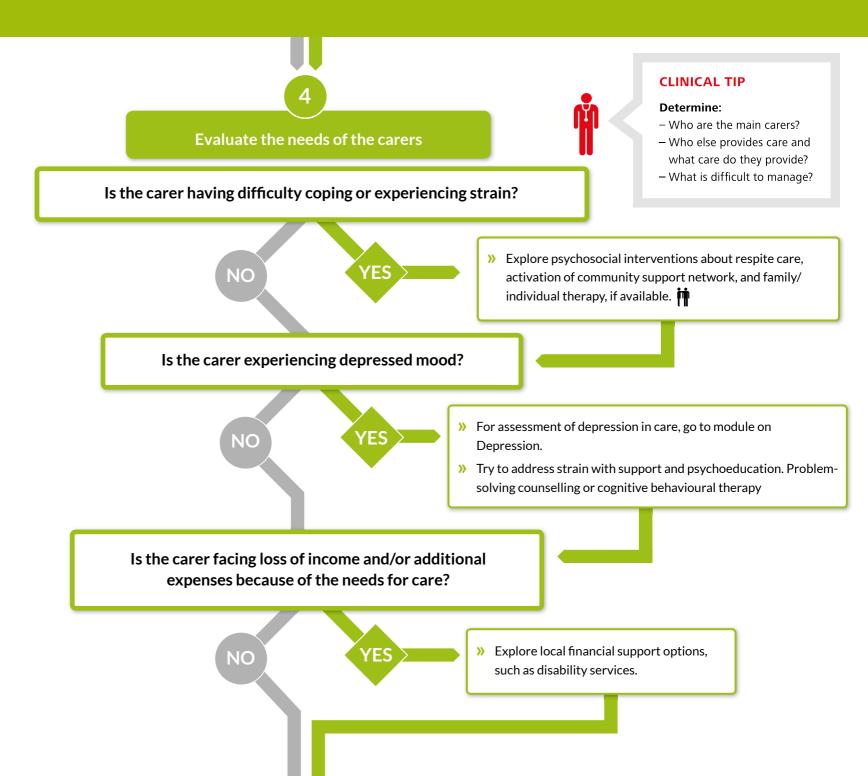
Dementia is a chronic and progressive syndrome due to changes in the brain. Dementia is not part of normal ageing. It is more common in older people. The conditions that cause dementia produce changes in a person's mental ability, personality, and behaviour. Alzheimer's disease is the most common cause; however, dementia can be caused by a variety of diseases and injuries to the brain. With early recognition and supportive treatment, the lives of people with dementia and their caregivers can be significantly improved, and the physical health, cognition, activity, and wellbeing of the person with dementia can be optimized.



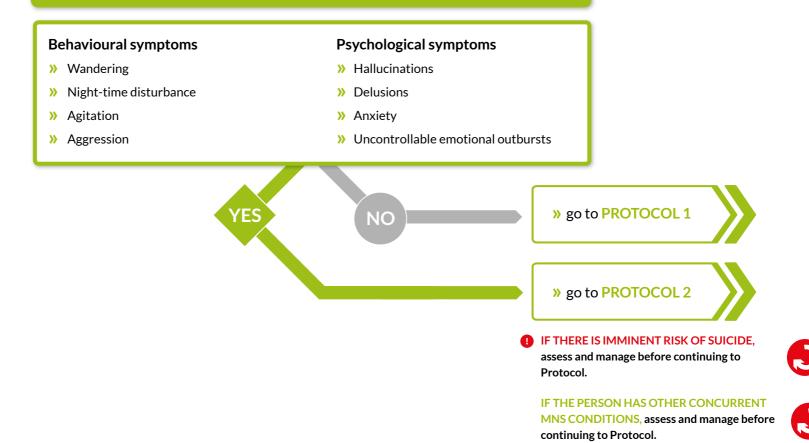


Are there any other explanations for the symptoms? **CLINICAL TIP** >>> Delirium: transient fluctuating Have the symptoms been present and slowly mental state characterized by disturbed attention that develops progressing for at least 6 months? over a short period of time and tends to fluctuate during the course of a day. It may result from acute organic causes such as » Ask for <u>ANY</u> of the following: infections, medication, metabolic NO - Abrupt onset abnormalities, substance - Short duration (days to weeks) intoxication. or substance withdrawal. - Disturbance at night and associated with impairment of consciousness - Disorientation of time and place NO Does the person have moderate YES to severe DEPRESSION? Suspect DELIRIUM YES NO » Manage depression. » Once treated for depression, review criteria » Evaluate for possible medical causes (toxic/metabolic/infectious) for dementia. - Obtain urinalysis to evaluate for infection - Review medications, particularly those with significant anticholinergic **Suspect** side effects (such as antidepressants, many antihistamines, DEMENTIA and antipsychotics) - Evaluate for pain - Evaluate nutritional status, consider vitamin deficiency or electrolyte abnormality





Does the person have <u>ANY</u> of the following BEHAVIOURAL or PSYCHOLOGICAL symptoms of dementia?





DEMENTIA – <u>with</u> behavioural and/or psychological symptoms

PROTOCOL

2

Follow Protocol 1+

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» Manage behavioral and psychological symptoms

If there is imminent risk to the person or carer:

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

PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

Key Messages:

- » Dementia is an illness of the brain and tends to get worse over time.
- > Although there is no cure, there is much that can be done to help and support the person and the family.
- Many specific concerns and behaviors can be managed as they arise. A lot can be done to make the person more comfortable and to make providing support less stressful for the carer.

2. Non-pharmacological management of behavioral and psychological symptoms

- Identify and treat underlying physical health problems that may affect behaviour. Look for pain, infections, etc. on physical exam. Refer to specialist if needed.
- Identify events (e.g. shopping at busy market) or factors (e.g. going out alone) that may precede, trigger, or enhance problem behaviours. Modify these triggers if possible.
- Consider environmental adaptations such as appropriate seating, safe wandering areas, signs (e.g. 'no exit' sign on the street door or signpost to toilet).
- >> Suggest an activity the person enjoys (e.g. going for a walk, listening to music, engaging in conversation), especially when feeling agitated.

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

- >> Give advice to maintain independent toileting skills, including prompting and regulation of fluid intake.
- » Keep the environment at home safe to reduce the risk of falling and injury.
- Recommend making adaptations in the person's home. It can be helpful to add hand-rails or ramps. Signs for key locations (e.g. toilet, bathroom, bedroom) can help ensure that the person does not get lost or lose orientation while home.

- » Recommend physical activity and exercise to maintain mobility and reduce risk of falls.
- » Advise recreational activities (tailored to stage and severity of dementia).
- Manage sensory deficits (such as low vision or poor hearing) with appropriate devices (e.g. magnifying glass, hearing aids).

4. Interventions to improve cognitive functioning

Encourage carers to -

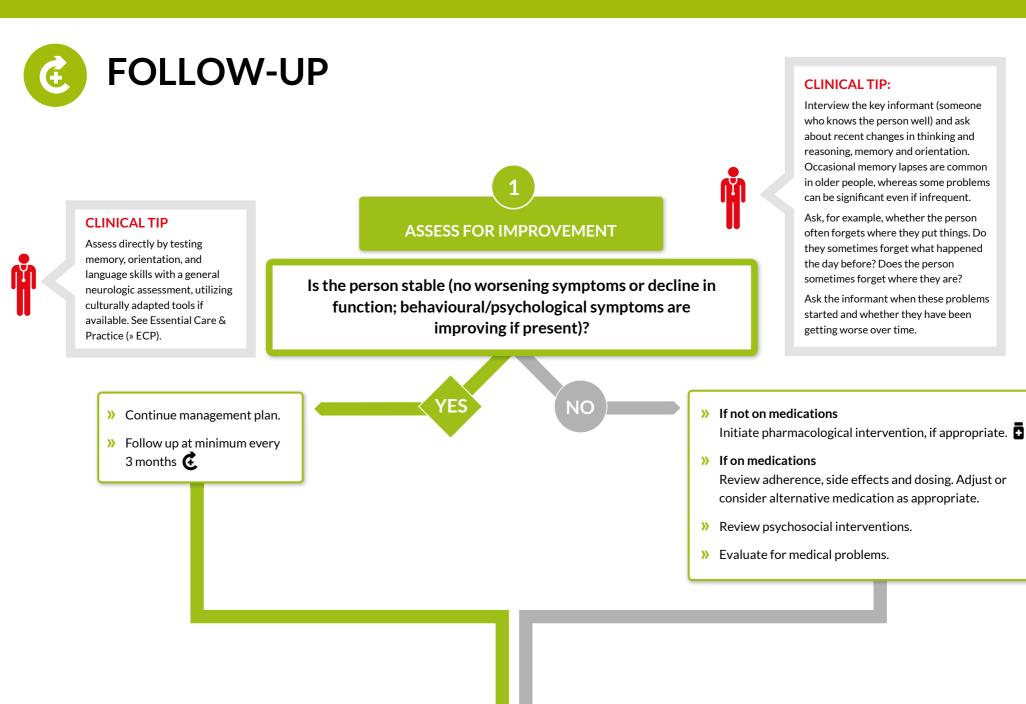
- Provide regular orientation information (e.g. day, date, time, names of people) so that the person can remain oriented.
- >> Use materials such as newspapers, radio, or TV programmes, family albums and household items to promote communication, to orient them to current events, to stimulate memories,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

5. Carer support

- Acknowledge that it can be extremely frustrating and stressful to take care of people with dementia. Carers need to be encouraged to respect the dignity of the person with dementia and avoid hostility towards, or neglect of, the person.
- » caring for their loved one.

PHARMACOLOGICAL INTERVENTIONS

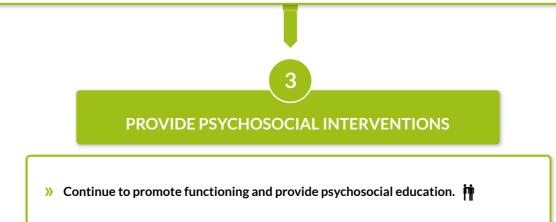
- If there is imminent risk to person or carers, consider antipsychotic medication (risperidone/haloperidol) with the principle of "Start low, go slow" (titrate) and review the need regularly (at least monthly). Avoid i.v. haloperidol and diazepam.
- » To consider cholinesterase inhibitors for Alzheimer's Disease, refer to specialist.



CONDUCT ROUTINE ASSESSMENTS

At each visit, routinely assess and address the following:

- >> Medication side-effects If on antipsychotics, check for extrapyramidal symptoms. Stop or reduce dose if present
- » Medical and MNS co-morbidities
- Ability to participate in activities of daily living and any needs of care
- Safety risks and offer appropriate behaviour modification if disease has progressed (e.g. limit driving, cooking, etc.)
- » New behavioural or psychological symptoms
- >> Symptoms of depression or imminent risk of self-harm/suicide.
- » Needs of the carers.



DEMENTIA

DISORDERS DUE TO SUBSTANCE USE

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

Tobacco is the most commonly used substance in Bangladesh. Other common substances of abuse include cannabis (ganja), methamphetamines (yaba), and opioids (heroin, phensidyl). Most commonly abused prescription drug includes sedatives (benzodiapzepines). Alcohol (mod) is socially acceptable in some ethnic groups, and not in anothers.



EMERGENCY ASSESSMENT: Is intoxication or withdrawal suspected?

- Does the person appear sedated?
- Does the person appear overstimulated, anxious, or agitated?
- Does the person appear confused?

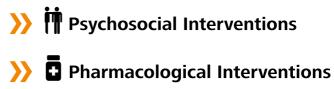
> Does the person use psychoactive substances?

- Is there harmful use?
- >> Does the person have substance dependence?

MANAGEMENT

>> Management Protocols

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





COMMON PRESENTATIONS

- > Appearing affected by cannabis (distinctive smell, sudden shift in mood from tense to relaxed, red eyes, poor muscle coordination, delayed reaction times, increased appetite, abrupt symptoms of anxiety, panic, and/or hallucination)
- > Appearing affected by methamphetamine (excited, euphoric, hyperactivity, rapid speech, racing thoughts, disordered thinking, paranoia, aggressive, violent behaviour, dilated pupils, increased blood pressure and heart rate)
- » Appearing affected by alcohol (e.g. smell of alcohol, slurred speech, sedated, erratic behaviour)
- >> Deterioration of social functioning (i.e. difficulties at work or home, unkempt appearance)
- >> Emergency presentation due to substance withdrawal, overdose, or intoxication.

Acute intoxication

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

Overdose

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

Withdrawal

The experience of a set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance; it has been consumed in high enough doses and for a long enough duration for the person to be physically or mentally dependent on it.

Harmful use

A pattern of psychoactive substance use that damages health, either physical (e.g. liver disease) or mental (e.g. depressive disorder) and often associated with social consequences, e.g. family or work problems.

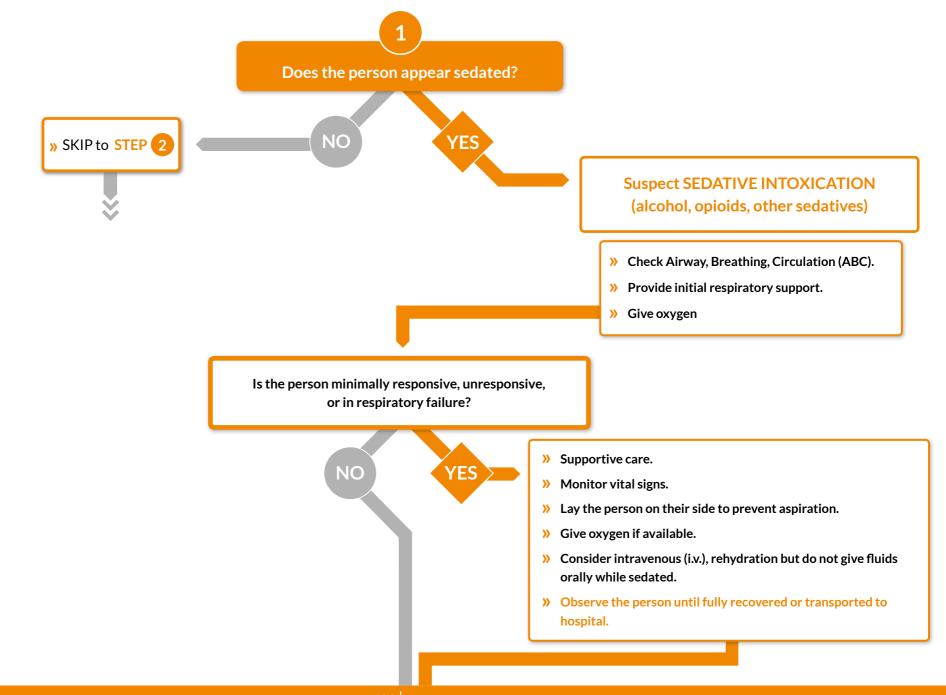
Dependence

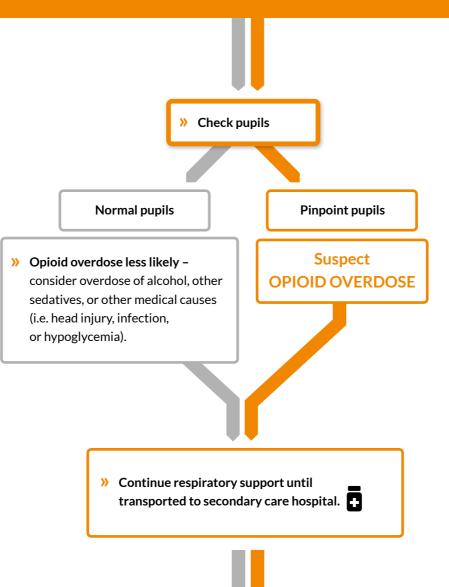
A cluster of physiological, behavioural, and cognitive phenomena in which the use of a psychoactive substance takes on a much higher priority for a given individual than other behaviours that once had greater value. It is characterized by a strong craving to use the substance and a loss of control over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

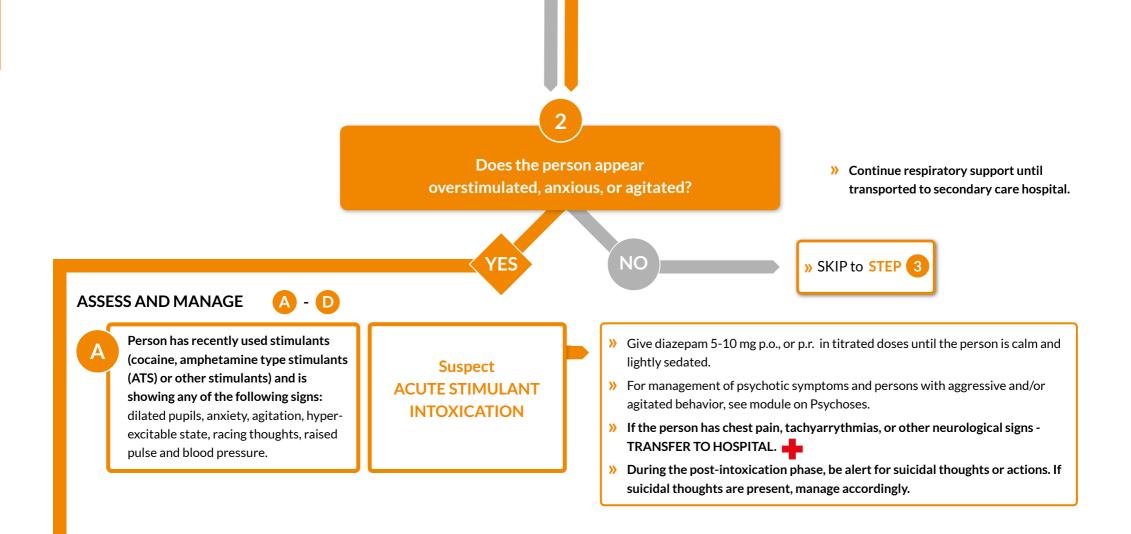
EMERGENCY PRESENTATIONS OF DISORDERS DUE TO SUBSTANCE USE

Alcohol intoxication
Opioid overdose
Stimulant intoxication
Alcohol /other sedative withdrawal
Delirium associated with
substance use









DISORDERS DUE TO SUBSTANCE USE

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

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Suspect ACUTE OPIOID WITHDRAWAL

» Consider an alpha adrenergic agonist, i.e. clonidine

» Refer to specialist

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

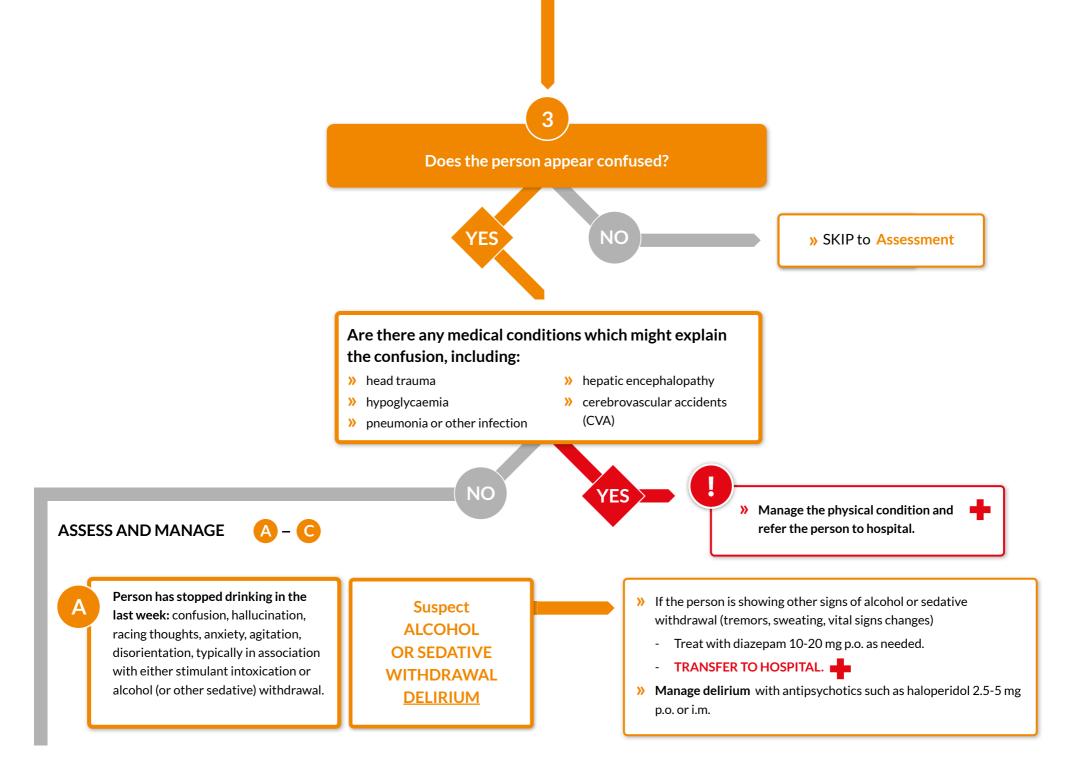
MANAGE WITHDRAWAL

- » Give diazepam 10-20 mg orally (p.o.) and transfer to hospital or detoxification facility.
- » For alcohol withdrawal only: Give thiamine 100 mg daily for five days.

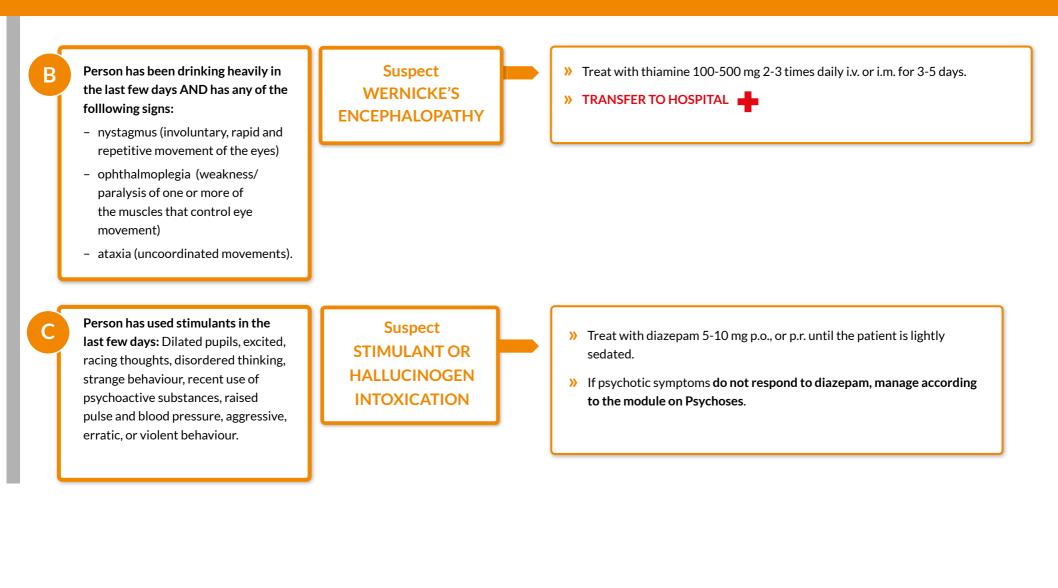
TRANSFER IMMEDIATELY TO A HOSPITAL if the following are present:

- Other serious medical problems, e.g. hepatic encephalopathy, gastrointestinal bleeding, or head injury.
- » Seizures: give diazepam 10-20 mg p.o. or rectum (p.r.) first.
- >> Delirium: give diazepam 10-20 mg p.o. or p.r. first.

Rule out other medical causes and priority MNS conditions



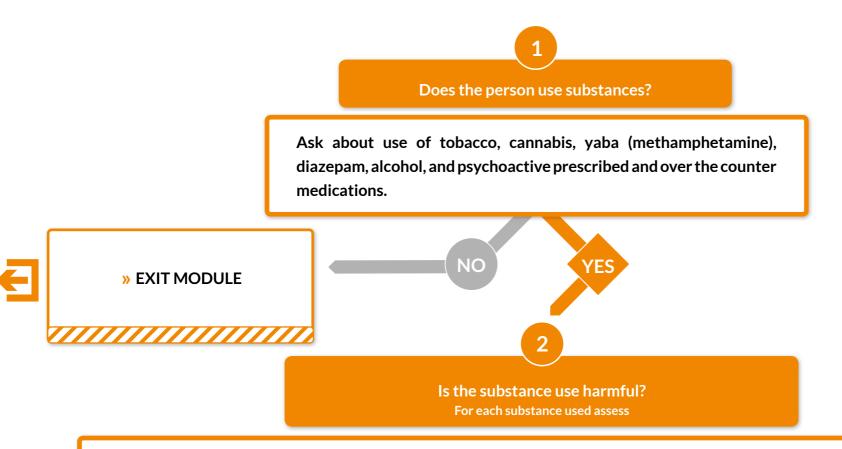
DISORDERS DUE TO SUBSTANCE USE





Psychoactive substances: acute behavioural effects, effects of prolonged use and withdrawal features

	Acute behavioural effects	Effects of prolonged use	Withdrawal features
CANNABIS (Ganja, Marijuana, Pot, Vang, Chorosh)	Normal pupils, red conjunctiva, delayed responsiveness, euphoria, relaxation	Increased risk of anxiety, paranoia and psychosis, lack of motivation, difficulty in concentration, increased risk of vasospasm leading to myocardial infarction and stroke	Depressed or labile mood, anxiety, irritability, sleep disturbance (there may not be any clearly observable features)
AMPHETAMINE, METHAMPHETAMINE (Yaba, Meth, Ice, Baba)	Dilated pupils, increased blood pressure and heart rate, excited, euphoric, hyperactivity, rapid speech, racing thoughts, disordered thinking, paranoia, aggressive, erratic, violent	Hypertension, increased risk of cerebrovascular accidents (CVAs), arrhythmias, heart disease, anxiety, depression	Fatigue, increased appetite, depressed, irritable mood
BENZODIAZEPINE (Sleeping pill)	Slurred speech, disinhibited behavior, unsteady gait	Memory impairment, increased risk of falls in the elderly, risk of fatal sedative overdose	Anxiety, insomnia, tremors, shaking, nausea/ vomiting, increased heart rate and blood pressur seizures, agitation, confusion, hallucinations
OPIOID (Heroin, Phensidyl, Morphin, Omorphon, Dayil)	Pinpoint pupils, drowsiness and falling asleep, decreased awareness, slow speech	Constipation, hypogonadism, adaptations in reward, learning and stress responses	Dilated pupils, anxiety, nausea/vomiting/diarrhea abdominal cramps, muscle aches and pains, headaches, runny eyes and nose, yawning, hair standing up on arms, increased heart rate and blood pressure
TOBACCO (Cigarette, Biri, Tamak, Gul)	Arousal, increased attention, concentration and memory; decreased anxiety and appetite; stimulant-like effects	Lung disease (in tobacco smokers), cardiovascular disease, risk of cancers and other health effects	Irritability, hostility, anxiety, dysphoria, depresse mood, increased heart rate, increased appetite
ALCOHOL (Mod, tari)	Smell of alcohol on breath, slurred speech, disinhibited behavior, agitation, vomiting, unsteady gait	Loss of brain volume, reduction in cognitive capacity, impaired judgement, loss of balance, liver fibrosis, gastritis, anaemia, increased risk of some cancers and a range of other medical problems	Tremors, shaking, nausea/vomiting, increased heart rate and blood pressure, seizures, agitation confusion, hallucinations



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

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

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

- Sexual activity while intoxicated that was risky or later regretted

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- Legal or financial problems
- Inability to care for children responsibly
- Violence towards others

NO

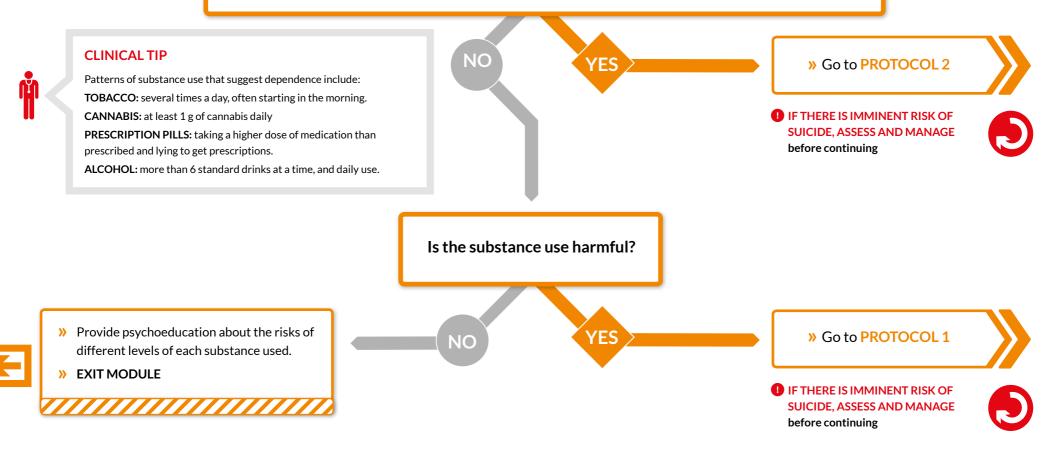
- Poor performance in education, employment roles
- Poor performance in expected social roles (e.g. parenting)

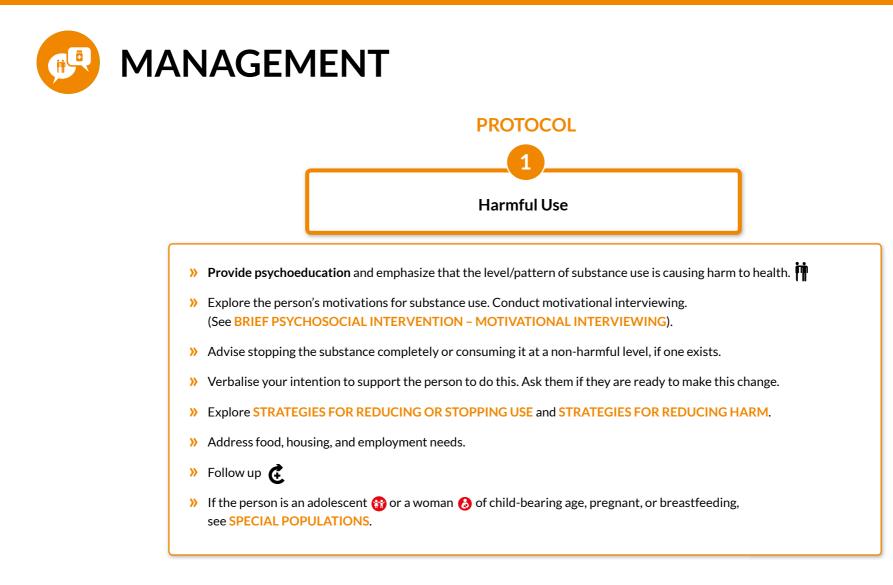
Remember answers for use later during assessment.

3 Is DEPENDENCE likely?

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

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





PROTOCOL

2

Dependence

Opioids	- Maintenance treatment is generally more effective than detoxification.		
	- Assess the severity of dependence and, if appropriate, refer the person for Opioid agonist maintenance treatment, also known as opioid substitution therapy (OST), after detoxification.		
	- In the remainder of cases arrange planned detoxification, if necessary.		
	- An alpha adrenergic agonist, i.e. clonidine may be used during detoxification.		
Benzodiazepines	- Consider gradually reducing the dose of benzodiazepine or a more rapid reduction in an inpatient setting.		
Alcohol	- Advise consumption of thiamine at a dose of 100 mg/day p.o.		
	- Refer to specialist for pharmacologic intervention for detoxification		
Other substances	- Advise stopping the substance completely.		
Including methamphetamine (yaba), Cannabis	- Explore strategies for reducing or stopping use and strategies for reducing harm		
	- Consider referral to peer help groups, if available.		
	- Address food, housing, and employment needs.		
	- Assess and treat any physical or mental health co-morbidity, ideally after 2-3 weeks of abstinence, as some problems will resolve with abstinence.		
	- Provide psychoeducation.		
	- Provide a brief intervention using motivational interviewing to encourage the person to engage in treatment of their substance dependence.		
	- Refer for longer-term psychosocial treatment for persons with ongoing problems related to their substance use, if they do not respond to the initial brief interventions.		
	- Evidence-based psychological therapies for disorders due to substance use include structured individual and group programmes that are run over 6-12 weeks or more.		

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

- Maintain hydration.

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

PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

- Disorders due to substance use can often be effectively treated in primary care, and people can and do get better.
- It is possible to stop or reduce hazardous or harmful use of alcohol and other substances
- > A person is more likely to succeed in reducing or stopping substance use if the decision is their own.

2. Motivational Interviewing (Brief Intervention)

Brief interventions using motivational interviewing is an approach to discussing substance use in a non-judgmental way. Key elements of this process are identifying the positives the person perceives from the drug and then the negatives are explored in a neutral way. Then the person is asked to reflect on the balance of positives and negatives.

It encourages a person to reflect on their own substance use choices. It can be used as part of a very brief encounter for addressing risks or harmful substance use. Throughout the discussion it is important to include all parts of the process: expressing empathy and building an atmosphere of trust, while also pointing out contradictions in their narrative, and challenging false beliefs. Avoid arguing with the person. They should feel that the practitioner is there to support them and not to criticize them. If the person is unable to commit to ending their harmful pattern of substance use at this time, discuss why this is the case, rather than forcing the person to say what they think is expected.

3. Steps to reducing or stopping the use of all substances

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

4. Mutual help groups

Mutual help groups such as Alcoholics Anonymous (AA), or, Narcotics Anonymous (NA), if available locally, can be helpful referrals for persons with disorders due to substance use. They provide information, structured activities, and peer support in a non-judgmental environment.

5. Strategies for preventing harm from drug use

- Encourages the person to engage in less risky behaviour. (e.g. not to drive if intoxicated)
- » If the person injects drugs:
 - Inform the person about the risks of intravenous drug use, which include: being at higher risk of infections such as HIV/AIDS, Hepatitis B and C, skin infections that can cause septicaemia, endocarditis, spinal abscesses, meningitis, and even death.
 - Emphasize the importance of using sterile needles and syringes each time they inject and to never share injecting equipment with others.
 - Encourage and offer, at minimum, annual testing for blood-borne viral illnesses, including HIV/AIDS and Hepatitis B and C.
 - Encourage Hepatitis B vaccination
 - Ensure condom availability
 - Ensure availability of treatment for people with HIV/AIDS and hepatitis

6. Supporting family and carers

- Discuss the impact of disorders due to substance use on other family members, including children, with the person's family and/or carers.
- » Provide information and education about disorders due to substance use.
- Inform them about and help them access support groups for families and carers (if available) and other social resources.

Special Populations



How to Assess the Adolescent:

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

Psychoeducation for the Adolescent

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

WOMAN WHO ARE OF CHILDBEARING AGE, PREGNANT OR BREASTFEEDING

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

PHARMACOLOGICAL INTERVENTIONS

Medications used in the management of disorders due to substance

Medication	Dosage	
Diazepam	Alcohol withdrawal or stimulant intoxication: 10-20 mg every 2 hours (up to 10 mg four times a day in an outpatient setting) until features are no longer observable or the person is lightly sedated	
Clonidine	Opioid withdrawal: Starting dose: 0.1 mg 2-3 times daily. Maximum dose: 1 mg daily.	
Thiamine (Vitamin B1)	Alcohol withdrawal: 100 mg p.o. daily for 5 days to prevent Wernicke's encephalopathy. 100-500 mg i.v. or i.m. 2-3 times daily for 3-5 days to treat Wernicke's encephalopathy.(IN HOSPITAL)	

(See Appendix II for side-effects and contraindication of the drugs)

FOLLOW-UP



At every visit:

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

Recommendations on frequency of contact

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

ONGOING SUBSTANCE USE

» Develop strategies to reduce harm

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

RECENT CESSATION OF USE OR SHIFT TO NON-HARMFUL USE

- » Consider urine testing to confirm abstinence, if available.
- » Give positive feedback to encourage the maintenance of abstinence/non-harmful use
- >> Treat other medical problems
- Consider relapse prevention medications for alcohol and opioid dependence
- Consider referral for psychosocial therapies to prevent relapse and mutual help groups

SIGNS OF CHRONIC SUBSTANCE USE

- » Difficulty caring for self, poor dentition, parasitic skin infections such as lice or scabies, and malnutrition.
- Signs of injection: look for injection sites on arms or legs, with both new and old marks visible. Ask the person where they inject and inspect the sites to make sure there are no signs of local infection.
- Common health complications of injecting drug use: people who inject drugs have a higher risk of contracting infections such as HIV/AIDS, Hepatitis B and C, and tuberculosis. They are also at high risk for skin infections at their injection sites. In some cases, this can spread through the blood and cause septicaemia, endocarditis, spinal abscesses, meningitis, or even death.

INVESTIGATIONS TO CONSIDER:

- >> Urine drug screen: for emergency cases, a urine drug screen should be conducted whenever intoxication, withdrawal, or overdose is suspected, especially in cases when the person is unable to convey what they have ingested.
- » If the person has been injecting drugs, offer serological testing for blood-borne viruses, HIV/AIDS and Hepatitis B and C, etc.
- If the person has had unprotected sex, offer testing for sexually transmitted infections, including HIV, syphilis, chlamydia, gonorrhoea, and human papilloma virus (HPV).
- >> Obtain a tuberculosis test, sputum sample, and a chest x-ray if tuberculosis is suspected. Look for signs and symptoms such as chronic productive cough, fevers, chills, and weight loss.

SELF-HARM/SUICIDE

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

Quick Overview



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

MANAGEMENT

>> Management Protocols

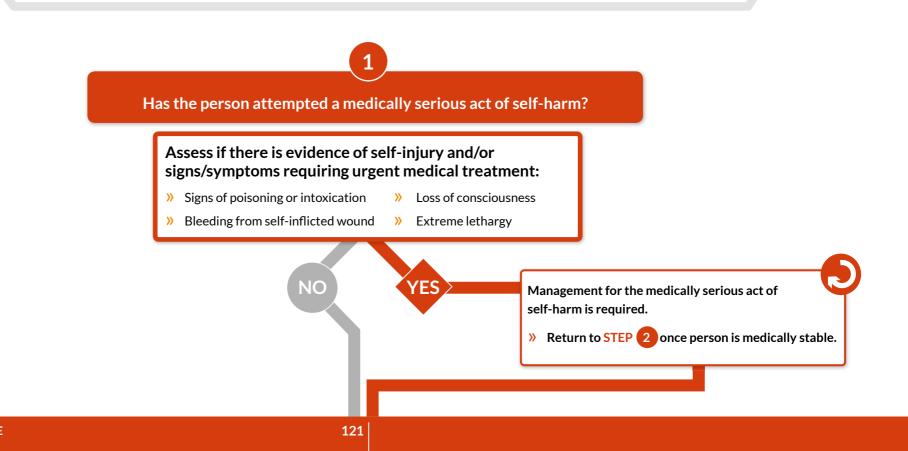
- 1. Medically serious act of self-harm
- 2. Imminent risk of self-harm/suicide
- 3. Risk of self-harm/suicide
- >> General Management and Psychosocial Interventions





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

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

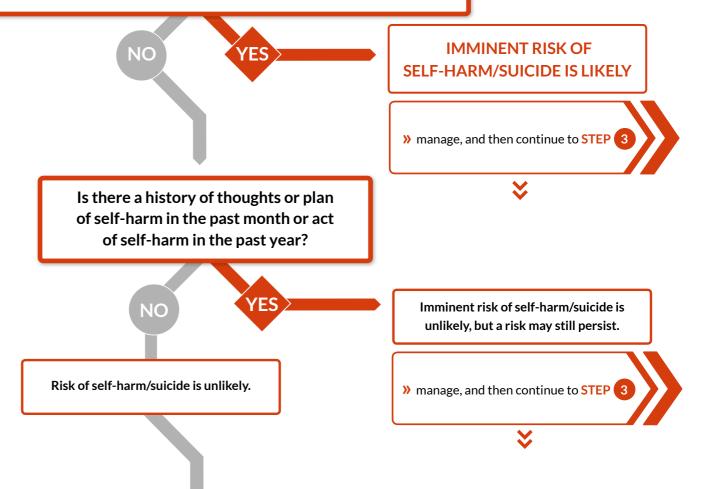


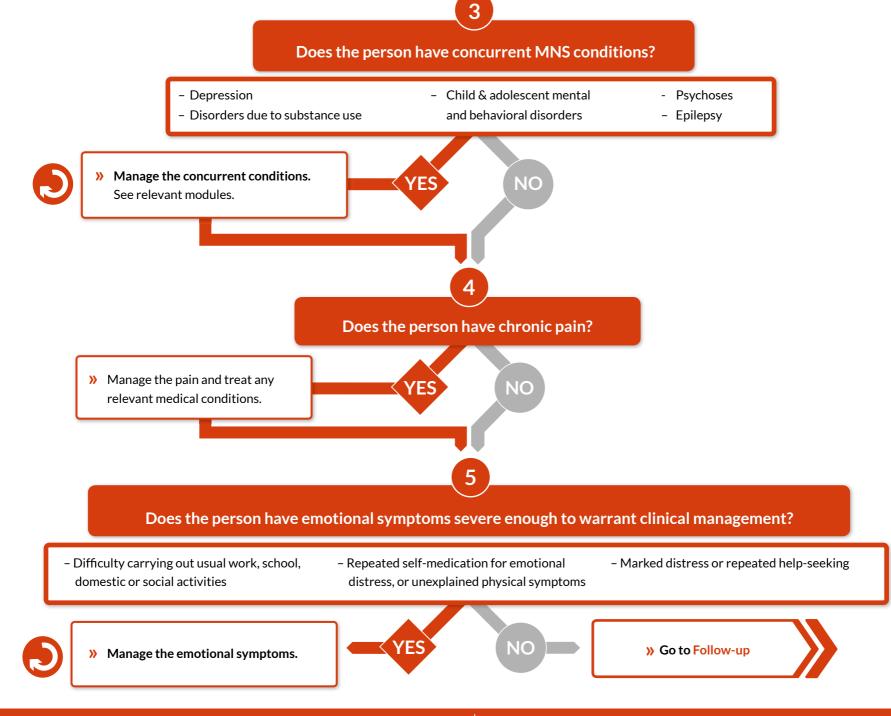
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Is there an imminent risk of self-harm/suicide?

Ask the person and carers if there are <u>ANY</u> of the following:

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





How to talk about suicide or self-harm

- 1. Create a safe and private atmosphere for the person to share thoughts.
 - » Do not judge the person for being suicidal.
 - » Offer to talk with the person alone or with other people of their choice.

2. Use a series of questions where any answer naturally leads to another question. For example:

[Start with the present] How do you feel?

[Acknowledge the person's feelings] You look sad/ upset. I want to ask you a few questions about it.

- » How do you see your future? What are your hopes for the future?
- » Some people with similar problems have told me that they felt life was not worth living.
- » Do you go to sleep wishing that you might not wake up in the morning?
- >> Do you think about hurting yourself?
- >> Have you made any plans to end your life?
- » If so, how are you planning to do it?
- » Do you have the means to end your life?
- >> Have you considered when to do it?
- >> Have you ever attempted suicide?

3. If the person has expressed suicidal ideas:

- » Maintain a calm and supportive attitude
- >> Do not make false promises.



Medically serious act of self-harm

- Place the person in a secure and supportive environment at a health facility.
- » 🕄 Do not leave the person alone.
- » Medically treat injury or poisoning.
- If hospitalization is needed, continue to monitor the person closely to prevent suicide.
- » Care for the person with self-harm.

Risk of self-harm/ suicide

- >>> Remove means of self-harm/suicide.
- > Create a secure and supportive environment; if possible, offer a separate, quiet room while waiting for treatment.
- » 😢 Do not leave the person alone.
- Supervise and assign a named staff or family member to ensure person's safety at all times.
- » Attend to mental state and emotional distress.

For both conditions

- » Offer and activate psychosocial support.
- >> Offer carers support.
- Provide psychoeducation to the person and their carers.
- » Treat the co-occurring MNS condition, if any
- » Consult a mental health specialist, if available. 🐴
- » Maintain regular contact and follow-up.

Management of pesticide intoxication

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

Care for the person with self-harm

- >> Treat people who have self-harmed with the same care, respect and privacy given to other people, and be sensitive to the emotional distress associated with selfharm.
- >> Remove access to means of self-harm.
- >> Ensure continuity of care.
- >> Hospitalization in non-psychiatric services of a general hospital is not recommended for the prevention of self-harm. However, if admission to a general (non-psychiatric) hospital is necessary for the management of the medical consequences of self-harm, monitor the person closely to prevent further selfharm in the hospital.
- » If prescribing medication -
 - Use medicines that are the least hazardous, in case of intentional overdose.
 - Give prescriptions as short courses (e.g. one week at a time).

PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

Key messages to the person and the carers

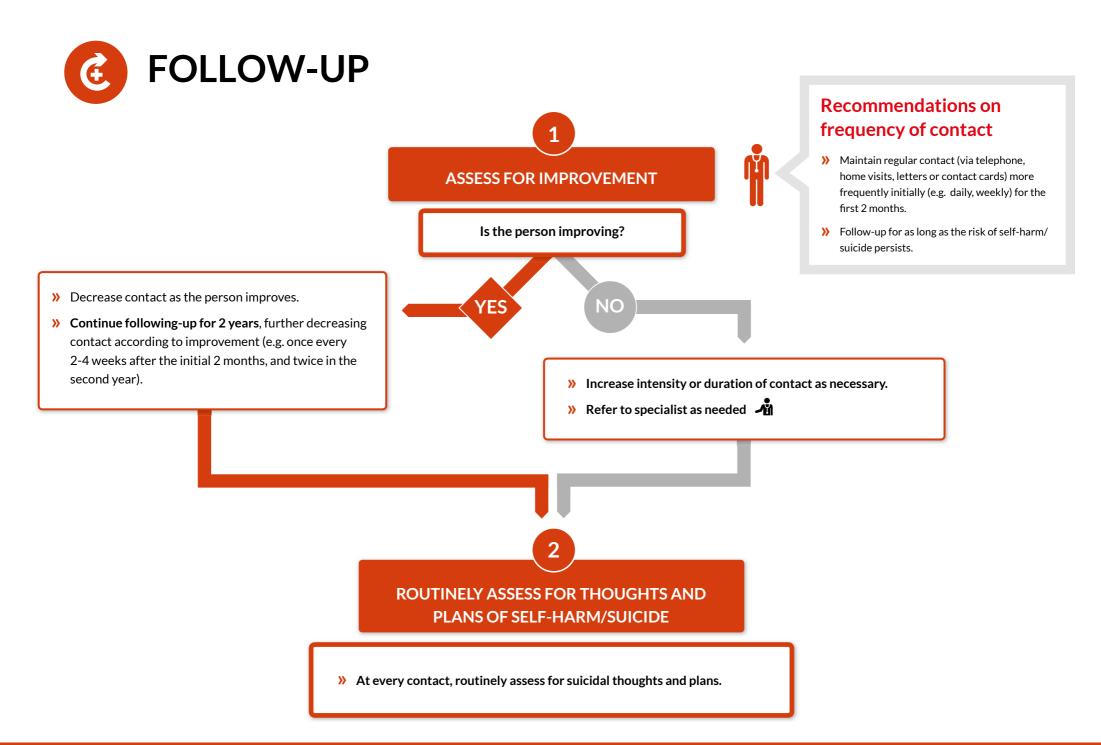
- If one has thoughts of self-harm/suicide, seek help immediately from a trusted family member, friend or health care provider.
- » It is okay to talk about suicide. Talking about suicide does not provoke the act of suicide.
- >> Suicides are preventable.
- Having an episode of self-harm/suicide is an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

2. Offer and activate psychosocial support

- >> Explore reasons and ways to stay alive.
- » Focus on the person's strengths by encouraging them to talk of how earlier problems have been resolved.
- » 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.
- >> Optimize social support from available community resources. These may include informal resources also, such as relatives, friends, acquaintances, colleagues and religious leaders.

3. Carers support

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



OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

This module aims to provide basic guidance on management of a range of mental health complaints not covered elsewhere in this guide. Some of these complaints may be similar to depression, but upon closer examination are distinct from the conditions covered in this guide. Other mental health complaints are considered significant when they impair daily functioning or when the person seeks help for them. Other mental health complaints can be due to stress.

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

Quick Overview



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- **>>** Rule out physical causes that would fully explain the presenting symptoms
- **Rule out depression or other MNS conditions**
- >> Assess if the person is seeking help to relieve symptoms or has considerable difficulty with daily functioning
- >> Assess if the person has been exposed to extreme stressors

>> Assess if there is imminent risk of self-harm/suicide

- >> Management Protocols
 - 1. Other significant mental health complaints

MANAGEMENT

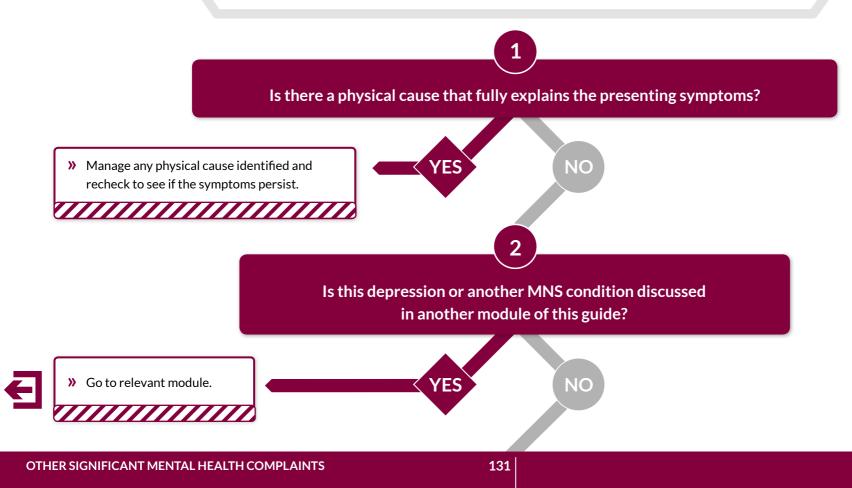
2. Other significant mental health complaints in people exposed to extreme stressors





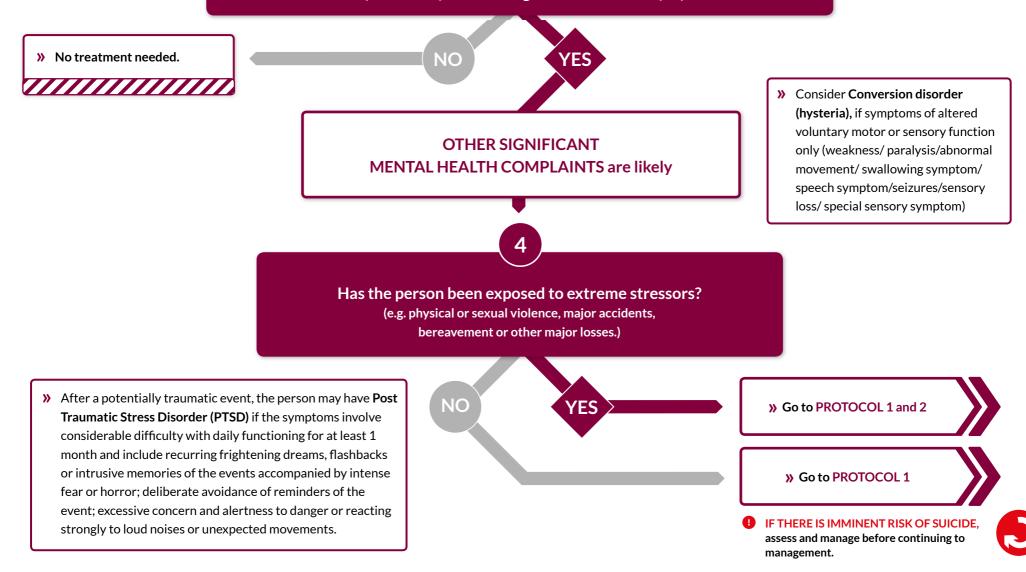
COMMON PRESENTATIONS

- » Feeling extremely tired, depressed, irritated, anxious or stressed.
- > Medically unexplained somatic complaints (i.e. somatic symptoms that do not have a known physical cause that fully explains the symptom). The symptoms may include chronic pain including chest pain, back pain, neck pain, headache, hotness of head, heaviness in head, vertigo, fatigue, inability to move limbs, abnormal movement, swallowing difficulty, convulsion-like attack, fit, faint, loss of hearing, inability to speak, loss of semen causing weakness and other physical problems (Dhat syndrome).





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





PROTOCOL

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

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

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

PROTOCOL



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

- In all cases, whether or not the person presents with emotional, physical or behavioural problems after exposure to an extreme stressor, provide support as described in PROTOCOL 1. Listen carefully.
- » 🖸 DO NOT pressure the person to talk about the event.
- » Address the person's social needs.
 - Ask the person about his/her needs and concerns.
 - **Help** the person to address basic needs, access services and connect with family and other social supports.
 - Protect the person from (further) harm, if needed.
 - **Encourage** the person to return to previous, normal activities, e.g. at school or work, at home, and socially, if it is feasible and culturally appropriate.
- » In case of any major loss explain that:
 - It is normal to grieve for any major loss. One can grieve for a person, a place, or property or the loss of one's own health and wellbeing. Grief has both mental and physical effects.

- People grieve in different ways. Some people show strong emotions while others do not. Crying does not mean one is weak. People who do not cry may feel the emotional pain just as deeply but have other ways of expressing it.
- In most cases, grief will diminish over time. One may think that the sadness, yearning or pain one feels will never go away, but in most cases, these feelings lessen over time.
- In case of the loss of a loved one, discuss and support culturally appropriate adjustment and/or mourning processes.
 - Ask if appropriate mourning ceremonies/rituals have happened or been planned. If this is not the case, discuss the obstacles and how to address them.
- » If prolonged grief disorder is suspected, consult a specialist for further assessment and management.
 - The person may have prolonged grief disorder if the symptoms involve considerable difficulty with daily functioning for at least 6 months and include severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain.

- In the case of reactions to recent exposure to a potentially traumatic event, explain that:
 - People often have reactions after such events. The reactions may be highly variable from person to person and change over time.
 - They can include somatic symptoms such as palpitations, aches and pains, gastric upset, and headaches and emotional and behavioural symptoms that include sleep disturbance, sadness, anxiety, irritation and aggression.
 - Such feelings can be exacerbated or can reappear when reminders of the stressful event or new stressors occur.
 - In most cases the symptoms are likely to diminish over time, particularly if the person gets rest, social support, and engages in stress reduction.
- If post-traumatic stress disorder (PTSD) is suspected, consult a specialist for further assessment and management.
- In case of sleep problems as a symptom of acute stress, offer the following additional management:
 - Explain that people commonly develop sleep problems (insomnia) after experiencing extreme stress.

- Explore and address any environmental causes of insomnia (e.g. noise).
- Explore and address any physical cause of insomnia (e.g. physical pain).
- Advise on sleep hygiene.
- Exceptionally, in extremely severe cases where psychologically oriented interventions (e.g. relaxation techniques) are not feasible or not effective, and insomnia causes considerable difficulty with daily functioning, shortterm (3–7 days) treatment with benzodiazepines may be considered.

Note:

- For adults, prescribe 2.5–5 mg of diazepam at bedtime.
- Do not prescribe benzodiazepines to children or adolescents and in women who are pregnant or breastfeeding.
- Monitor for side-effects frequently when using this medication in older people.
- This is a temporary solution for an extremely severe sleep problem.
- Benzodiazepines should not be used for insomnia caused by bereavement in adults or children.
- Benzodiazepines should not be used for any other symptoms of acute stress or PTSD.

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

SLEEP HYGIENE

DOs

- » Maintain regular hours of bedtime and arising
- If you are hungry, have a light snack before bedtime
- » Maintain a regular exercise schedule
- Give yourself approximately an hour to wind down before going to bed
- If you are preoccupied or worried about something at bedtime, write it down and deal with it in the morning
- » Keep the bedroom cool
- >> Keep the bedroom dark
- >> Keep the bedroom quiet

DON'Ts

- >> Take naps
- >> Exercise right before going to bed
- >> Watch television in bed when you cannot sleep
- >> Eat a heavy meal before bedtime
- >> Drink coffee in the afternoon and evening
- >> If you cannot sleep, smoke a cigarette
- >> Use alcohol to help in going to sleep
- >> Read in bed when you cannot sleep
- Eat in bed
- >>> Exercise in bed
- >> Talk on the phone in bed

RELAXATION TRAINING INSTRUCTIONS

Explain what you will be doing.

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

» Slowly start relaxation exercises and demonstrate breathing.

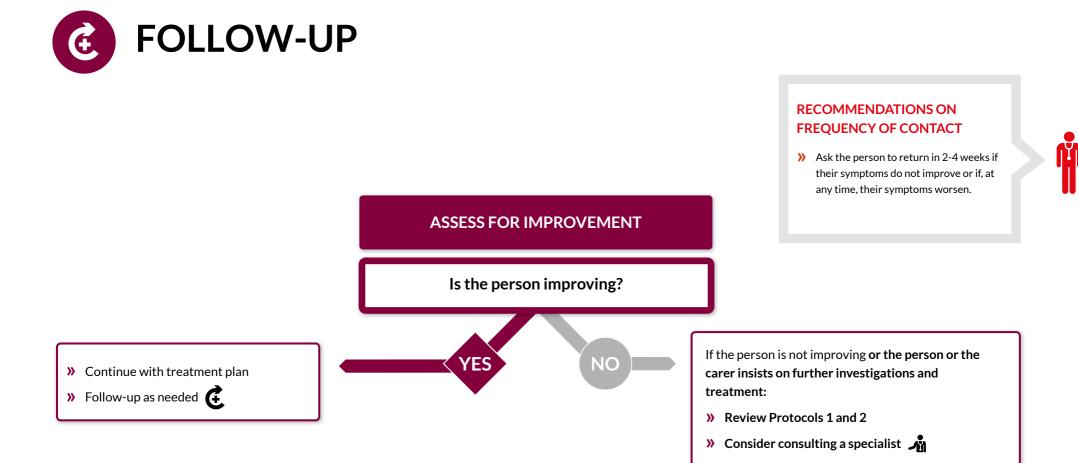
"Gently shake and loosen your arms and legs. Let them go floppy and loose. Roll your shoulders back and gently move your head from side to side. Now place one hand on your belly and the other hand on your upper chest. I want you to imagine you have a balloon in your stomach and when you breathe in you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

>> Focus on breathing techniques.

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

>> Encourage self-practice.

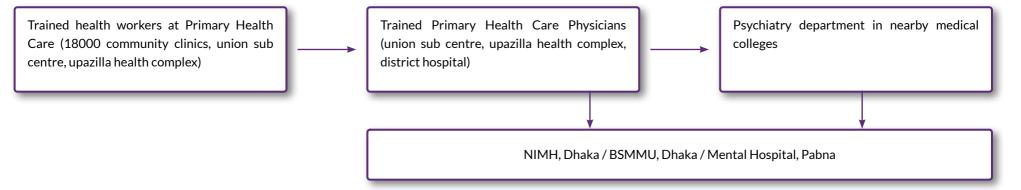
"Try on your own for one minute. This is something you can practice on your own."







Referral systems in mental health in government health facilities



Specialized psychiatric services in government facilities

Institution	Services available for patients
National Institute of Mental Health (NIMH), Agargaon, Dhaka	Out-patient, In-patient, Emergency, Psychotherapy/ Counseling
Mental Hospital, Pabna	Out-patient, In-patient, Emergency, Psychotherapy/ Counseling
Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University (BSMMU), Shahbag, Dhaka	Out-patient, In-patient, Psychotherapy/ Counseling
Department of Psychiatry, All Government Medical College Hospitals	Out-patients mainly, In-patient services and Psychotherapy/ Counseling are available in some facilities
Department of Psychiatry, All Combined Military Hospitals (CMH)	Out-patient, In-patient, Psychotherapy/ Counseling
Central drug addiction Treatment Centre (CTC), Tejgaon, Dhaka	For Substance use disorders - Out-patient, In-patient, Psychotherapy/ Counseling
Department of Clinical Psychology, Dhaka University	Psychotherapy/ Counseling for out-patients
Department of Counseling and Educational Psychology, Dhaka University	Psychotherapy/ Counseling for out-patients



Side-effects and contraindications of drugs

	Drug	Common Side-effects	Serious Side-effects	Cautions/ Contraindications			
Anti- depressants	Amitriptyline Imipramine (TCA) Fluoxetine (SSRI)	Sedation, orthostatic hypotension (risk of fall), blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction. Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in	ECG changes (e.g. QTc prolongation), cardiac arrhythmia, increased risk of seizure. Overdose: seizures, cardiac arrhythmias, hypotension, coma, or death. Bleeding abnormalities in those who use aspirin or other non-steroidal anti-	Should be avoided in persons with cardiac disease, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma. Caution in persons with history of seizure.			
Anti- psychotics	Haloperidol	appetite, and sexual dysfunction. Sedation, dizziness, blurred vision, dry mouth, urinary retention, constipation.	inflammatory drugs, low sodium levels. Orthostatic hypotension, extrapyramidal side effects (EPS), ECG changes (prolonged QT interval), weight gain, galactorrhea, amenorrhea, Neuroleptic malignant syndrome (NMS).	Caution in patients with: kidney disease, liver disease, cardiac disease, long QT syndrome or taking QT-prolonging medications.			
	Chlorpromazine	Sedation, dizziness, blurred vision, dry mouth, urinary retention, constipation, tachycardia.	Orthostatic hypotension, syncope, EPS, photosensitivity, weight gain, galactorrhea, amenorrhea, sexual dysfunction, priapism, NMS, agranulocytosis, jaundice.	Contraindication: impaired consciousness, bone marrow depression, Pheochromocytoma Caution in patients with: respiratory disease, kidney disease, liver disease, glaucoma, urinary retention, cardiac disease, long QT syndrome or taking QT- prolonging medications.			
	Risperidone	Sedation, dizziness, tachycardia.	Orthostatic hypotension, metabolic effects (elevated lipids, insulin resistance, weight gain), EPS, elevated prolactin, sexual dysfunction, NMS.	Caution in patients with: cardiac disease.			

D	rug	Common Side-effects	Serious Side-effects	Cautions/ Contraindications			
Anti- Cholinergic	Trihexyphenidyl Procyclidine	Sedation, confusion and memory disturbance (especially in older adults), tachycardia, dry mouth, urinary retention and constipation.	Angle-closure glaucoma, myasthenia gravis and gastrointestinal obstruction.	Caution in patients with: cardiac, liver, or kidney disease.			
Mood stabilizers	Lithium	Sedation, cognitive problems, tremor, Impaired coordination, hypotension, Ieukocytosis, polyuria, polydipsia, nausea, diarrhea, weight gain, hair loss, rash.	Diabetes insipidus, hypothyroidism, ECG changes (arrhythmia, sick sinus syndrome, T-wave changes). Toxicity: seizures, delirium, coma, and death.	Contraindicated in patients with: severe cardiac or kidney disease. Dehydration can increase lithium levels.			
Anti- epileptics	Sodium valproate (used as mood stabilizer also)	Sedation, headache, tremor, ataxia, nausea, vomiting, diarrhea, weight gain, transient hair loss.	Impaired hepatic function, thrombocytopenia, leucopenia, drowsiness/ confusion, liver failure, Hemorrhagic pancreatitis.	Caution in patients with: underlying or suspected hepatic disease.			
	Carbamazepine (used as mood stabilizer also)	Sedation, confusion, dizziness, ataxia, double vision, nausea, diarrhea, benign leucopenia.	Hepatotoxicity, cardiac conduction delay, low sodium levels, severe rash.	Contraindicated in patients with: history of blood disorders, Kidney, liver, or cardiac disease.			
	Phenobarbital	Sedation, hyperactivity in children, ataxia, Nystagmus, sexual dysfunction, depression.	Liver failure (hypersensitivity reaction), decreased bone mineral density.	Contraindicated in patients with acute intermittent porphyria. Lower doses for patients with kidney or liver disease			
	Phenytoin	Sedation, confusion, dizziness, tremor, motor twitching, ataxia, double vision, nystagmus, slurred speech, nausea, vomiting, constipation.	Hematologic abnormalities, hepatitis, Polyneuropathy, gum hypertrophy, acne, lymphadenopathy	Lower doses for patients with kidney or liver disease.			
Benzodiazepines	Diazepam Clonazepam	Sedation. Prolonged use can lead to dependence.	Respiratory depression	Do not use in people who are sedated. Beware of combining with other sedatives. Patients should not drive.			
Alpha receptor agonist	Clonidine	Sedation, light-headedness, dizziness, headache, nausea/ vomiting, dry mouth, constipation, sexual dysfunction, depression, agitation, low blood pressure, tachycardia, sinus bradycardia, and AV block.		Use caution in cardiac, cerebrovascular, liver and kidney diseases. Avoid in women who are pregnant or breastfeeding			





National Mental Health Survey Bangladesh 2018–2019 Provisional Fact Sheet

Preamble

Mental disorders exert detrimental effects on individuals, families, communities and health services. Disease burden due to mental disorders is very high. A nationwide survey in 2003–2005 revealed prevalence of adult 16.1%1 mental disorders in adult population in Bangladesh.

The 2019 nationwide survey was launched to explore mental health situation through,

- » Estimation of prevalence;
- » Identify stigma, attitude current treatment gap and health seeking behaviour; and
- » Socio-demographic and psychosocial correlates of psychiatric disorders.

Methods

- » Multi-centric (8 divisions), representative (64 districts), stratified (male and female, urban and rural), random cluster sampling (randomly selected clusters);
- The reporting domains were five age groups for adults (18–99 years) and two age groups for children (7–17 years) by residence (urban/ rural) and sex (man/ woman or boy/ girl) strata at national level;
- The estimated sample size for adults was 8,928. Finally, 7,270 completed the individual interview and were included in final analysis. he overall individual response rate is 99.3%;
- Eligible children were sought in the households approached for adults. 2,270 children were approached and fnally,2,246 completed the individual interview and were included in final analysis. The individual response rate is 98.9%. It is

noteworthy that 2000 children were necessary for four reporting domains.

- >> 496 primary sampling units were selected randomly – from 2,93,533 primary sampling units/ enumeration areas2. Eighteen households were selected by systematic random sampling technique from each primary sampling units;
- » Data collection was performed in April–June 2019;
- Data were collected using tablet computers and transferred to the server electronically on a daily basis.



Figure 1: Map of Bangladesh showing the data collection areas (PSUs)

The National Mental Health Survey

Bangladesh 2018–2019 was conducted by National Institute of Mental Health, Dhaka with financial assistance from Non-Communicable Disease Control, Director General of Health Service and technical support of the World Health Organization.

¹ Firoz AHM, Karim ME, Alam MF, Rahman AHM et al. Prevalence, medical care, awareness and attitudes towards mental illness in Bangladesh. Bangladesh Journal of Psychiatry. 2006; 20 (1): 9-36.

² Bangladesh Bureau of Statistics. Housing and Population Census 2011. Available from: http://www. bbs.gov.bd/site/page/47856ad0-7e1c-4aab-bd78-892733bc06eb/Population-and-Housing-Census (accessed on 26 August 2019).

Key results

Table 1: Distribution of adult respondents by age and sex

A == =====	Number (n=7.270)	Man (n=3,465)	Woman (n=3,805)					
Age group	Number (n=7,270)	percent (95% confidence interval)*						
18-29	1667	33.4 (30.5-36.2)	38.8 (36.0-41.6)					
30-39	2110	22.3 (20.5–24.2)	22.7 (20.9-24.5)					
40-49	1564	18.1 (16.4–19.7)	16.5 (15.0-17.9)					
50-59	966	12.8 (11.3-14.2)	10.9 (9.4–12.4)					
60+	963	13.5 (11.9–15.1)	11.2 (9.5–12.9)					

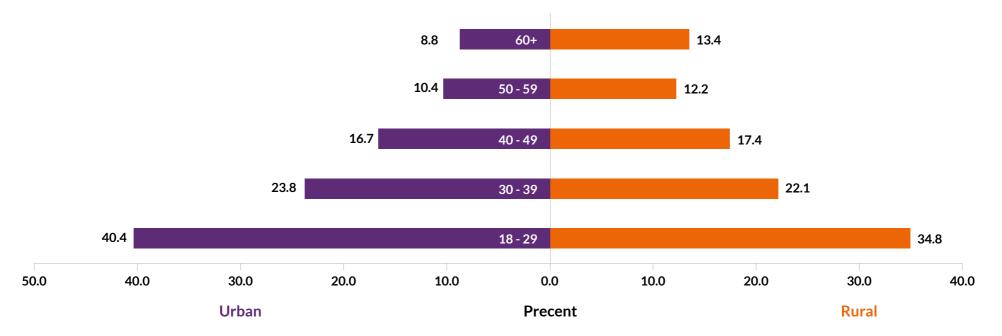
Table 2: Distrib	ution of child respo	ndents by age, s	ex and residence
	Number $(n-2,244)$	percent (95% con	fidence interval*)
Age group	Number (n=2,246) —	Boy (n=1,095)	Girl (n=1,151)

	c gi oup	Number (11-2,240)	Boy (n=1,095)	Girl (n=1,151)
7	7-12	1237	55.4 (51.0-59.8)	56.7 (52.9-60.5)
1	3-17	1009	44.6 (40.2-49.0)	43.3 (39.5-47.1)
			Urban (n=1,035)	Rural (n=1,211)
7	7-12	1237	54.2 (49.8-58.7)	56.1 (52.4-59.9)
1	3-17	1009	45.8 (41.3-50.2)	43.9 (40.1-47.6)

* all percentages denote weighted values

* all percentages denote weighted values

Figure 2: Distribution of adult respondents (percent) by age groups (years) and residence



Variable	Overall (n=7,270)	Man (n=3,465)	Woman (n=3,805)	Urban (n=3,521)	Rural (n=3,749)					
Variable	Percent (95% confidence interval)*, unless stated otherwise									
Age, years										
Mean	38.3 (37.6-38.9)	39.5 (38.6-40.4)	37.1 (36.3-38.0)	36.2 (35.3-37.1)	38.9 (38.2-39.7)					
Education, years										
Mean	6.0 (5.8–6.3)	6.6 (6.3-6.9)	5.8 (4.2)	7.7 (7.3-8.0)	5.5 (5.2–5.7)					
Nuclear family	69.6 (67.4-72.0)	72.8 (69.7–75.8)	66.9 (63.8-70.0)	73.0 (69.4–76.6)	68.6 (65.9-71.4)					
Married	89.1 (87.5-90.6)	89.0 (86.7-91.2)	89.1 (87.2-91.1)	86.1 (83.0-89.1)	90.0 (88.3-91.8)					
Occupation										
Household work	47.5 (44.6-50.5)	0.52 (0.2–0.8)	88.3 (87.0-89.7)	44.9 (43.8-46.0)	48.0 (46.9-49.1)					
Business (small)	9.6 (8.3–10.9)	19.7 (18.1–21.2)	0.6 (0.3-0.8)	11.5 (10.3–12.8)	7.9 (6.9–8.8)					
Farming (own land)	8.4 (7.0-9.8)	18.4 (16.2-20.6)	-	3.1 (2.3-4.0)	14.1 (12.6–15.7)					
Daily labourer	6.1 (5.2-7.0)	12.3 (10.9–13.7)	0.9 (0.5-1.3)	5.6 (4.7-6.6)	7.0 (6.0-8.1)					
Private service	5.2 (4.2-6.1)	8.3 (7.1-9.4)	1.7 (1.2–2.1)	7.5 (6.4–8.6)	2.3 (1.6-2.9)					
Screened positive (self-reporting questionnaire)	21.5 (19.9–23.0)	20.9 (18.8-23.1)	21.9 (19.7-24.1)	24.6 (22.1–27.1)	20.4 (18.6-22.3)					

Table 4. Gross diagnosis of mental disorders (DSM 5^*) in adult

		Men		Women	Urban			Rural		All
	%	95% CI†	%	95% CI†	%	95% CI†	%	95% CI†	%	95% CI†
Anxiety disorders	4.0	3.2 - 4.9	5.4	4.4 - 6.4	4.3	3.4 - 5.3	4.9	4.1 - 5.7	4.7	4.1 - 5.4
Depressive disorders	5.4	4.3 - 6.5	7.9	6.7 - 9.2	7.3	5.7 - 9.0	6.5	5.5 - 7.6	6.7	5.8 - 7.6
Disruptive, impulse control and conduct disorders	0.2	-	0.0	-	0.0		0.1		0.1	-
Major mental disorders (schizophrenia spectrum disorder)	0.9	0.4 - 1.5	1.1	0.6 - 1.6	1.2	0.6 - 1.9	0.9	0.5 - 1.3	1.0	0.7 - 1.4
Major mental disorders (bipolar and related disorder)	0.7	-	0.3	-	0.2	-	0.6	-	0.5	0.2 - 0.8
Neurocognitive disorders	0.3	-	0.5	-	0.6	-	0.3	-	0.4	-
Neurodevelopmental disorders	0.3	-	0.3	-	0.5	-	0.3	-	0.3	-
Obsessive compulsive and related disorder	0.5	-	0.9	0.5 - 1.3	0.8	0.4 - 1.3	0.7	0.3 - 1.0	0.7	0.4 - 1.0
Personality disorders	0.1	-	0.1	-	-	-	0.1	-	0.1	-
Sexual dysfunctions	0.6	-	0.0	-	-	-	0.2	-	0.3	-
Sleep wake disorders	1.0	0.5 - 1.4	1.1	0.5 - 1.6	0.9	0.4 - 1.3	1.1	0.6 - 1.5	1.0	0.7 - 1.4
Somatic symptoms and related disorders	0.9	0.5 - 1.2	3.7	2.8 - 4.5	1.5	1.0 - 2.1	2.6	2.0 - 3.2	2.3	1.8 - 2.8
Substance related and addictive disorder	0.9	0.3 - 1.5	0.1	-	0.7	-	0.4	-	0.5	-
Any Mental Disorder	15.7	14.0 - 17.4	21.5	19.8 - 23.2	18.9	16.9 - 20.9	18.7	17.1 - 20.2	18.7	17.4 -20.0
No mental health disorder	84.30	82.6 - 86.0	78.5	76.8 - 80.2	81.1	79.1 - 83.1	81.3	79.8 - 82.9	81.3	80.0 - 82.6

* American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 2013

† Confidence interval

- Unweighted numbers are <25



Figure 3: Point of treatment in last episode of illness among adults* who had history of mental health disorder (n=91)

Table 5: Gross diagnosis of mental disorders (DSM 5) in children

		evelopmental sorders	Anxie	ty Disorders	control	ive, impulse and conduct sorders	-	ressive orders	-	o-wake orders	dis (Schize	r mental order ophrenia n disorder)	compu	essive Isive and disorders	disorde and l	r mental rs (Bipolar Related orders)
	%	95% CI†	%	95% CI†	%	95% CI†	%	95% Cl†	%	95% Cl†	%	95% CI†	%	95% CI†	%	95% CI†
Boy	6.4	4.4 - 8.4	4	2.5 - 5.6	2.3	1.2 - 3.4	0.2	-	0.5	-	0.2	-	0.1	-	-	-
Girl	3.9	2.5 - 5.4	5.3	3.5 - 7.2	1.1	-	0.5	-	0.2	-	0.3	-	-	-	0.1	-
Urban	4.5	2.7 - 6.3	4.0	2.1 - 5.8	1.9	-	0.3	-	0.5	-	0.3	-	0.02	-	-	-
Rural	5.3	3.7 - 6.9	4.9	3.4 - 6.4	1.6	-	0.4	-	0.3	-	0.2	-	0.1	-	0.1	-
All	5.1	3.8 - 6.4	4.7	3.5 - 6.0	1.7	1.0 - 2.4	0.4	-	0.4	-	0.2	-	0.1	-	0.1	-

* American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 2013

† Confidence interval

- Unweighted numbers are <25



Additional Reading

- 1. mhGAP 2.0: https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/
- 2. mhGAP HIG: https://www.who.int/mental_health/publications/mhgap_hig/en/
- 3. mhGAP operations manual: https://www.who.int/mental_health/mhgap/operations_manual/en/
- 4. **Problem Management Plus** (For the use of behavioural activation, relaxation training, problem solving treatment and strengthening social supports): http://www.who.int/mental_health/emergencies/ problem_management_plus/en/
- 5. Bangladesh National Formulary: http://www.dgda.gov.bd/index.php/publications/51-bangladesh-national-formulary-bdnf-2015
- 6. UN Convention on the Rights of Persons with Disabilities (CRPD): https://www.un.org/development/desa/disabilities/convention-on-the-rights-ofpersons-with-disabilities.html
- 7. Group Interpersonal Therapy (IPT) for Depression: http://www.who.int/mental_health/mhgap/interpersonal_therapy/en
- 8. **Thinking Healthy** (For Cognitive-behavioural therapy for perinatal depression): http://www.who.int/mental_health/ maternal-child/ thinking_healthy/en
- Integrated Management of Childhood Illness (IMCI): www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet
- 10. Care for Child Development:
 - http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/
- 11. Clinical Management of Acute Pesticide Intoxication: http://www.who.int/mental_health/publications/9789241596732/en
- 12. Where there is no psychiatrist: A mental health care manual by Vikram Patel, 2003

APPENDIX

GLOSSARY

TERM	DEFINITION	TERM	DEFINITION			
Activities of daily living (ADLs)	A concept of functioning – activities of daily living are basic activities that are necessary for independent living, including eating, bathing and toileting. This concept has several assessment tools to determine an individual's ability to perform the activity with or without assistance.	Cognitive behavioural therapy with a trauma focus (CBT-T)	Psychological treatment based on the idea that people who were exposed to a traumatic event have unhelpful thoughts and beliefs related to that event and its consequences. These thoughts and beliefs result in unhelpful avoidance of the reminders of the event and a sense of current threat. The			
Agitation	Marked restlessness and excessive motor activity, accompanied by anxiety.		treatment usually includes exposure to those reminders and challenging unhelpful trauma-related thoughts or beliefs.			
Akathisia	A subjective sense of restlessness, often accompanied by observed excessive movements (e.g. fidgety movements of the legs, rocking from foot to foot, pacing, inability to sit or stand still).	Community-based rehabilitation (CBR)	Set of interventions delivered through a multi-sectoral strategy in community settings, using available community resources and institutions. It aims to achieve rehabilitation by enhancing the quality of life for people with disabilities			
Akinesia	The absence or lack of voluntary movement. A state of difficulty in initiating movements or changing from one		and their families, meeting basic needs and ensuring inclusion and participation.			
	motor pattern to another that is associated with Parkinson's disease.	Delirium	Transient fluctuating mental state characterized by disturbed attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment) that develops over a short period o time and tends to fluctuate during the course of a day. It is accompanied by (other) disturbances of perception, memory			
Altered mental status	A changed level of awareness or mental state that falls short of unconsciousness which is often induced by substance intake or other mental or neurological conditions. Examples include confusion and disorientation.					
Alzheimer's disease	A primary degenerative cerebral disease of unknown etiology in the majority of cases with characteristic neuropathological and neurochemical features. The disorder is usually insidious in onset and develops slowly but steadily over a period of		thinking, emotions or psychomotor functions. It may result from acute organic causes such as infections, medication, metabolic abnormalities, substance intoxication or substance withdrawal.			
	several years.	Delusion	Fixed belief that is contrary to available evidence. It cannot			
Bereavement	A process of loss, grief and recovery, usually associated with death.		be changed by rational argument and is not accepted by other members of the person's culture or subculture (i.e., it is not an aspect of religious faith).			
Cognitive behavioural therapy (CBT)	avioural components (aimed at thinking differently, for example		The process by which an individual is withdrawn from the effects of a psychoactive substance. Also referring to a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimized.			

TERM	DEFINITION
Disability	Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range, considered to be normal for a human being. The term disability reflects the consequences of impairment in terms of functional performance and activity by the individual.
Disinhibited behavior/ disinhibition	Lack of restraint manifested in disregard for social conventions, impulsivity and poor risk assessment. It can affect motor, emotional, cognitive and perceptual aspects of a person's functioning.
Disorganized behavior	Behaviour including posture, gait, and other activity that is unpredictable or not goal-directed (e.g., shouting at strangers on the street).
Drug-drug interaction	Situation where two drugs taken by the same person interact with each other, altering the effect of either or both drugs. Interactions can include lessening the effect of a drug, enhancing or speeding up an effect, or having a toxic effect.
Dystonia	Sustained muscle contraction or involuntary movements that can lead to fixed abnormal posture.
Eclampsia	Any condition affecting pregnant women, characterized by seizure or convulsions newly arising in pregnancy. The condition is often associated with pregnancy-induced hypertension, convulsions, seizure, anxiety, epigastric pain severe headache, blurred vision, proteinuria, and oedema that may occur during pregnancy, labour, or the puerperium.
Elevated mood	A positive mood state typically characterized by increased energy and self-esteem which may be out of proportion to the individual's life circumstances.
Extrapyramidal side-effects /	Abnormalities in muscle movement, mostly caused by antipsychotic medication. These include muscle tremors,

TERM	DEFINITION
Family therapy	Counselling that entails multiple (usually more than six) planned sessions over a period of months. It should be delivered to individual families or groups of families, and should include the person living with mental illness, if feasible. It has supportive and educational or treatment functions. It often includes negotiated problem-solving or crisis management work.
Hallucination	False perception of reality: seeing, hearing, feeling, smelling or tasting things that are not real.
Informed consent	The process by which the health care provider discloses appropriate information to a person who can then make a voluntary choice to accept or refuse treatment. informed consent includes a discussion of the following elements: the nature of the decision/procedure; reasonable alternatives to the proposed intervention; the relevant risks, benefits, and uncertainties related to each alternative; assessment of the person's understanding, and the acceptance of the intervention by the person.
Interpersonal	Psychological treatment that focuses on the link between
therapy (IPT)	depressive symptoms and interpersonal problems, especially those involving grief, disputes, life changes and social isolation. It is also known as Interpersonal Psychotherapy.
Irritability/ Irritable mood	A mood state characterized by being easily annoyed and provoked to anger, out of proportion to the circumstances.
Neuroleptic malignant syndrome (NMS)	A rare but life-threatening condition caused by antipsychotic medications, which is characterised by fever, delirium, muscular rigidity and high blood pressure.
Occupational therapy	Therapy designed to help individuals improve their independence in daily living activities through rehabilitation, exercises and the use of assistive devices. In addition, such therapy provides activities to promote growth, self-fulfilment and self-esteem.

TERM	DEFINITION
Oppositional behaviour	Markedly defiant, disobedient, provocative or spiteful behaviour that may be manifest in prevailing, persistent angry or irritable mood, often accompanied by severe temper outbursts or in headstrong, argumentative and defiant behaviour.
Parent Skills Training	A family of treatment programs that aims to change parenting behaviours and strengthen confidence in adoption of effective parenting strategies. It involves teaching parents emotional communication and positive parent-child interaction skills, and positive reinforcement methods to improve children/ adolescent's behaviour and functioning.
Pseudodementia	A disorder resembling dementia but not due to organic brain disease and potentially reversible by treatment; can manifest as symptoms of depression in some older adults.
Psychoeducation	The process of teaching people with MNS disorders and their carers/ family members about the nature of the illness, including its likely causes, progression, consequences, prognosis, treatment and alternatives.
Psychological first aid (PFA)	Provision of supportive care to people in distress who have recently been exposed to a crisis event. The care involves assessing immediate needs and concerns; ensuring that immediate basic physical needs are met; providing or mobilizing social support; and protecting from further harm.
Racing thoughts	Rapid thought pattern with tangential movement from one idea to the next often associated with mania or other mental illnesses.
Relapse	A return to drinking or other drug use after a period, of abstinence, often accompanied by reinstatement of dependence symptoms. The term is also used to indicate return of symptoms of MNS disorder after a period of recovery.
Rigidity	Resistance to the passive movement of a limb that persists throughout its range. It is a symptom of parkinsonism.

TERM	DEFINITION
Self-harm	Intentional self-inflicted poisoning or injury to oneself, which may or may not have a fatal intent or outcome.
Slurred speech	Speech with indistinctive pronunciation.
Social network	A construct of analytical sociology referring to the characteristics of the social linkages among people as a means of understanding their behaviour, rather than focusing on the attributes of individuals.
Social withdrawal	Inability of a person to engage in age appropriate activities or interactions with his or her peers or family members.
Status epilepticus	Defined as 5 min or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery (returning to baseline) between seizures; it can be convulsive or non-convulsive.
Stigma	A distinguishing mark establishing a demarcation between the stigmatized person and others attributing negative characteristics to this person. The stigma attached to mental illness often leads to social exclusion and discrimination and creates an additional burden for the affected individual.
Suicidal thoughts/ ideation	Thoughts, ideas, or ruminations about the possibility of ending one's life, ranging from thinking that one would be better off dead to formulation of elaborate plans.
Tardive dyskinesia	This is dystonia characterized by twisting and sustained muscle spasms that affect regions of the head, neck, and occasionally, the back. It may not improve after stopping the antipsychotic medicine.
Temper tantrum	An emotional outburst from a child or those in emotional distress.
Tremor	Trembling or shaking movements, usually of the fingers, that is an involuntary oscillation of a body part.
Wandering	People living with dementia feel the urge to walk about and in some cases leave their homes. They can often experience problems with orientation, which may cause them to become lost.



জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট শের-ই-বাংলা নগর, ঢাকা।



নন কমিউনিকেবল ডিজিজ কন্ট্রোল স্বাস্থ্য অধিদগুর

