Managing Common Mental Disorders

Training Manual for Primary Care Physicians

(Based on WHO mhGAP guidelines)

International Medical Corps

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About this training manual

This training manual is prepared as part of the MHPSS (Mental health & Psychosocial) response in Bannu for the IDPs from North Waziristan. The curriculum is designed for 6 priority disorders including Stress related disorders, Depression, Psychosis, Children & Adolescents Disorders (with particular emphasis on Learning Disability), Epilepsy & Drug dependence. These disorders were identified as the most commonly presenting disorders to the specialist mental health camps held every month in Bannu to strengthen the existing mental health services.

The contents are based on mhGAP training package prepared by the World Health Organization (http://www.who.int/mental_health/mhgap/en/). The objectives of this training are to enable primary care physicians (and other staff), to recognize and manage common mental disorders in the community and refer cases to specialist services when needed. It is suitable for training primary care physicians in humanitarian crisis or otherwise, anywhere in the country.

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Acknowledgments

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Module 1: Stress related disorders

1.1 Objectives

At the end of the session, doctors should be able to:

1. Recognize the impact of stress on mental health and physical health.
2. Identify different stress related disorders.
3. Manage stress related disorders.
4. Refer appropriately.

1.2 Introduction

Stress is common in daily life. It is commonly recognized as frustration, pressure, change or a conflict. Frustration of not being promoted at work can be stressful. Financial pressure can be stressful. Sometimes, a change e.g., moving house can cause stress. Even happy changes like childbirth can also be stressful. A *conflict* is when one has to make a choice between two options, either of which is difficult. It is, therefore, stressful to face such a situation or to make a decision. Different individuals react to stress in different ways. People who are forcefully displaced from their homes face many challenges, which can lead to immense stress. Vulnerable groups like women, children, older people and those who are disabled are particularly prone to stress in these situations.

Not everyone facing such a stress needs professional help. Many continue to deal with it based on their resilience and existing support. But some can become unwell and need medical attention.

1.3 Common symptoms of stress

Table 1: Common symptoms of stress		
Physical	**Cognitive**	**Behavioural**
▪ Sleep disturbance ▪ Clenched jaw ▪ Digestive upsets ▪ Sense of lump in throat ▪ Difficulty swallowing ▪ Restlessness ▪ Increased heart rate ▪ Muscle tension ▪ Noncardiac chest pain ▪ Dizziness, lightheadedness ▪ Hyperventilation ▪ Sweaty palms ▪ Nervousness	▪ Mental slowness ▪ Confusion ▪ Negative thoughts ▪ Constant worry ▪ Difficulty concentrating ▪ Forgetfulness ▪ Indecisiveness ▪ Feeling overworked ▪ Sense of helplessness	▪ Decreased contact with family and friends ▪ Poor work relations ▪ Sense of loneliness ▪ Avoiding others ▪ Irritability ▪ Failing to set aside times for relaxation through activities such as hobbies, music, art or reading

Table 2: Effects of stress on different systems of the body		
	System/organ	**Common effects on health**
1	Hair	Excessive hair loss Baldness
2	Mouth	Ulcers Dryness
3	Brain	Insomnia Headache Anxiety Depression
4	Heart	Cardiovascular diseases Hypertension
5	Muscles	Pain in neck, shoulders, lower back Muscular twitches
6	Lungs	Precipitation and aggravation of asthma
7	Digestive tract	Gastritis Gastric or duodenal ulcers Ulcerative colitis Irritable bowel syndrome
8	Reproductive organs	In women (Recurrent vaginal infections, menstrual irregularities) In men (Premature ejaculation, Impotence)
9	Skin	Eczema Psoriasis

1.4 Stress related disorders

After exposure to stress, majority of people will experience some degree of distress but will not develop a disorder that requires treatment. Some will develop symptoms that might impair their functioning. These are referred to as stress related disorders. These include Adjustment disorder, Post-traumatic stress disorder (PTSD) or prolonged grief disorder. Their characteristic features are:

1. There is a direct causal link between the stressful event/situation and onset of symptoms.

2. There is pre-occupation with worrying thoughts related to the stressor and sometimes, avoidance of activity or discussions related to the stress.

3. There may be a wide range of emotional symptoms e.g., feeling anxious, tearful, frightened, angry or guilty.

4. There may be multiple somatic symptoms with no clear physical cause e.g., hyperventilation; palpitations; constant muscular tensions e.g., headaches, chest pains; or problems with digestion (symptoms of irritable bowel syndrome are also common).

5. Sometimes, especially in young women, severe stress can lead to Dissociation or Conversion states (previously known as 'Hysteria') where the awareness may be partially or completely lost. The person might experience 'fits' (non-epileptic) or loss of sensations/perceptions (e.g., inability to walk or to see).

6. There is impairment of functioning e.g., difficulty sleeping (may also experience nightmares or continually replaying the event in one's mind), and difficulty concentrating at work, problems coping with housework or responsibilities at work etc.

7. Children might also present with a whole range of symptoms including behavioural disturbance or bed-wetting.

1.5 General management

1.5.1 Establish communication and build trust

- Be genuinely interested and compassionate.
- Build rapport and engage the patient effectively.
- Listening attentively. Allow people to communicate problems in their own words without interruption.
- Discuss the experience at the pace with which the person is comfortable.
- Ensure confidentiality.
- Be confident that you can help with counselling.
- Always offer a follow-up, if the symptoms persist or worsen.

1.5.2 Psychological First Aid (PFA)

This is a humane, supportive, common sense response (usually as part of a humanitarian crisis) to a person who is suffering and who may need support. All health workers including doctors should be able to provide psychological first aid. This includes:

- Listen to the person without pressuring them to talk.
- Provide practical care and support without asking intrusive questions.
- Assess needs and concerns.
- Help the person to address immediate, basic physical needs (e.g. Shelter for the night).
- Help connect to services, family, social supports and accurate information.
- As far as possible, protect people from further harm.

1.5.3 Strengthening positive coping & social supports

- Encourage seeking support of trusted family members, friends or people in the community.
- Build on people's strengths and abilities. Ask what is going well? What coping methods worked in the past? Who can help or support?
- Encourage social activities and normal routines if possible especially for children to attend school attendance, family gatherings, sports etc.
- Identify maladaptive behaviours, for example excessive smoking or use of drugs and alcohol. Explain that these do not help recovery and can lead to new problems.

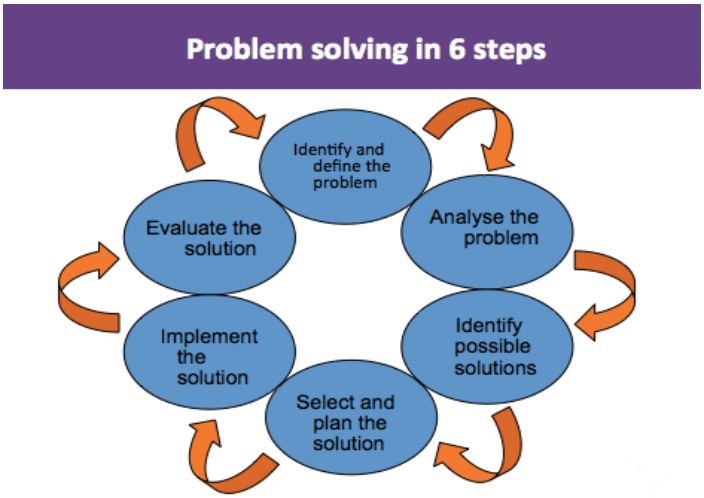
1.5.4 Address psychosocial stressors

- See the person alone and ask about current psychosocial stressors.
- Use problem-solving techniques (see Figure 2) to help the person reduce major psychosocial stressors or relationship difficulties.
- Involve community services and resources (with the person's consent).
- Assess and manage any situation of abuse (e.g. domestic violence) and neglect (e.g. of children or older people).
- As appropriate, identify supportive family members and involve them as much as possible.

In children and adolescents:

- Try to see the child or adolescent alone for part of the interview.
- Explore maltreatment, exclusion or bullying
- As far as possible, work with family and school to ensure the child's safety.
- Assess and manage mental health problems (particularly depression) and psychosocial stressors in parents/family.

Figure 1: Problem solving in 6 steps



1.5.5 Breathing exercises

- Explain that anxiety is associated with rapid, shallow chest breathing
- Practice slow, regular, abdominal breathing as it reduces anxiety
- Train the technique to deep breathe (using diaphragm) without distractions
- Inhale slowly and deeply through the nose, hold to a count of ten and exhale slowly through the mouth.

1.5.6 Progressive muscle relaxation

- Explain that anxiety is associated with tense muscles and that systematically relaxing one's muscles reduces anxiety.
- The technique involves training the person to systematically tense and relax key muscle groups, usually working up from the feet to the top of the body.

1.6 Specific management

1.6.1 Treating Insomnia

- Apply general management strategies discussed above in section 1.4.
- Rule out external causes of disturbing sleep (e.g. noise).
- Rule out and manage possible physical causes (e.g. physical pain), even if the insomnia appears to be related to a stressful event.
- Advise about sleep hygiene (including advice about avoiding tea, coffee, nicotine and alcohol).
- Explain that problems with sleep are common after experiencing extreme stressors.
- Discuss role of Benzodiazepines (See Table 3)
- If the problem persists after one month, re-assess for any concurrent mental disorder.

- If there is no concurrent mental disorder or if there is no response to treatment, refer to a specialist.

Table 3: Role of Benzodiazepines (sleeping tablets)

1. Commonly used Benzodiazepines are: Alprazolam, Bromazepam, Clonazepam etc.
2. Benzodiazepines are drugs of addiction. These can quickly lead to dependence (usually within 4-6 weeks).
3. Doctors often overprescribe benzodiazepines, which is commonly followed by self-medication by patients.
4. Benzodiazepines should only be prescribed for severe insomnia for a very short time only.
5. DO NOT prescribe benzodiazepines for insomnia in children and adolescents.

1.6.2 Treating Bedwetting in children

- Apply general management strategies discussed above in section 1.4.
- Obtain a history of bedwetting to confirm link between the onset of symptom and a stressful event.
- Rule out possible physical causes (e.g. urinary tract infection)
- Assess mental disorders and psychosocial stressors in the family.
- Educate the parents (see Table 4)
- If the problem persists after one month, re-assess for any concurrent mental disorder.
- If there is no concurrent mental disorder or if there is no response to treatment, refer to a specialist.

Table 4: Bed-wetting - working with parents

1. Bedwetting is a common reaction in children who experience stress
2. Parents should not punish or tell the child off for bedwetting as that may add to the child's stress.
3. Parents/ family must remain calm and emotionally supportive
4. Avoid excessive focus/discussion on the symptom in the family and give positive attention to the child at other times
5. Use simple behavioural interventions (e.g. rewarding, avoidance of excessive fluid intake before sleep, rewarding toileting before sleep)

1.6.3 Treating Hyperventilation

- Apply general management strategies discussed above in section 1.4.
- Rule out and manage possible physical causes, even if the hyperventilation started immediately after a stressful event.
- Explain that people sometimes develop this problem after experiencing extreme stressors.

- Maintain a calm approach, where possible remove the sources of anxiety and encourage normal breathing (not deeper and quicker than usual).
- Note that re-breathing into a paper bag is a widely used technique but has not been well researched.
- There are risks if this technique is used with people who have heart disease or asthma.
- DO NOT encourage children to re-breathe into a paper bag
- If the problem persists after one month, re-assess for any concurrent mental disorder.
- If there is no concurrent mental disorder or if there is no response to treatment, refer to a specialist.

1.6.4 Treating Dissociation

- Take a detailed history. In case of a 'fit', differentiate from an epileptic seizure (see Table 5)
- Acknowledge that the symptoms are real, although the cause might not be a neurological one.
- Explain that people sometimes develop this problem after experiencing extreme stress.
- Examine the patient in private (but in the presence of a chaperone, if indicated).
- Make the patient feel understood and reassure about complete recovery.
- Identify and discourage the reinforcement of the symptom (usually in the form of attention by the family).
- Identify underlying conflict, if possible.
- Assess for underlying depression
- If there is no concurrent mental disorder or if there is no response to treatment, refer to a specialist.

Important DO NOTs:

- Do not blame or make fun of the patient
- Do not administer Ammonia or any other coercive method

Table 5: Differences between an Epileptic and Dissociative fit			
	Check	**Epileptic seizure**	**Dissociative 'fit'**
1	Consciousness	Impaired	Not impaired
2	Awareness of surrounding	Lost	Altered or lost
3	Pattern	Regular	Irregular
4	Occurrence	Any time, even during sleep	Usually in the company of people
5	Duration	Few seconds or few minutes	Longer, many minutes to hours
6	Tongue bite	Present	Absent
7	Urinary incontinence	Present	Absent
8	Movements of the body	Consistent with tonic clonic fit	Not consistent with tonic clonic fit
9	Injury	May injure him/herself	Injury rare

1.6.5 Grief counseling

- Be available to listen if the person wishes to discuss loss.
- Discuss and encourage culturally appropriate mourning/adjustment.
- Provide or mobilize social support, where possible.
- For children who have lost parents or other family members, address the need for protection and psychosocial support.
- DO NOT prescribe benzodiazepines to manage symptoms of grief.
- If there is no improvement after 2 months or if there is functional impairment, consider an anti-depressant.
- If there is no response to treatment, refer to a specialist.

Key points

- ✓ Stress affects our physical and mental health
- ✓ Stress related disorders are common and cause impairment of function
- ✓ Counseling is the mainstay of treatment

Module 2: Depression

2.1 Objectives

At the end of the session, doctors should be able to:

1. Diagnose depression.
2. Manage depression.
3. Refer appropriately.

2.2 Introduction

There are changes in mood in different situations as part of our everyday life. Depression is considered when mood changes are more than normal (sometimes even without a reason) and persist for most of the time for a period of more than two weeks. As discussed in module 1, people exposed to adversity may experience symptoms similar to depression but the severity is lesser, there is a direct causative link and there is spontaneous recovery as the stressor resolves.

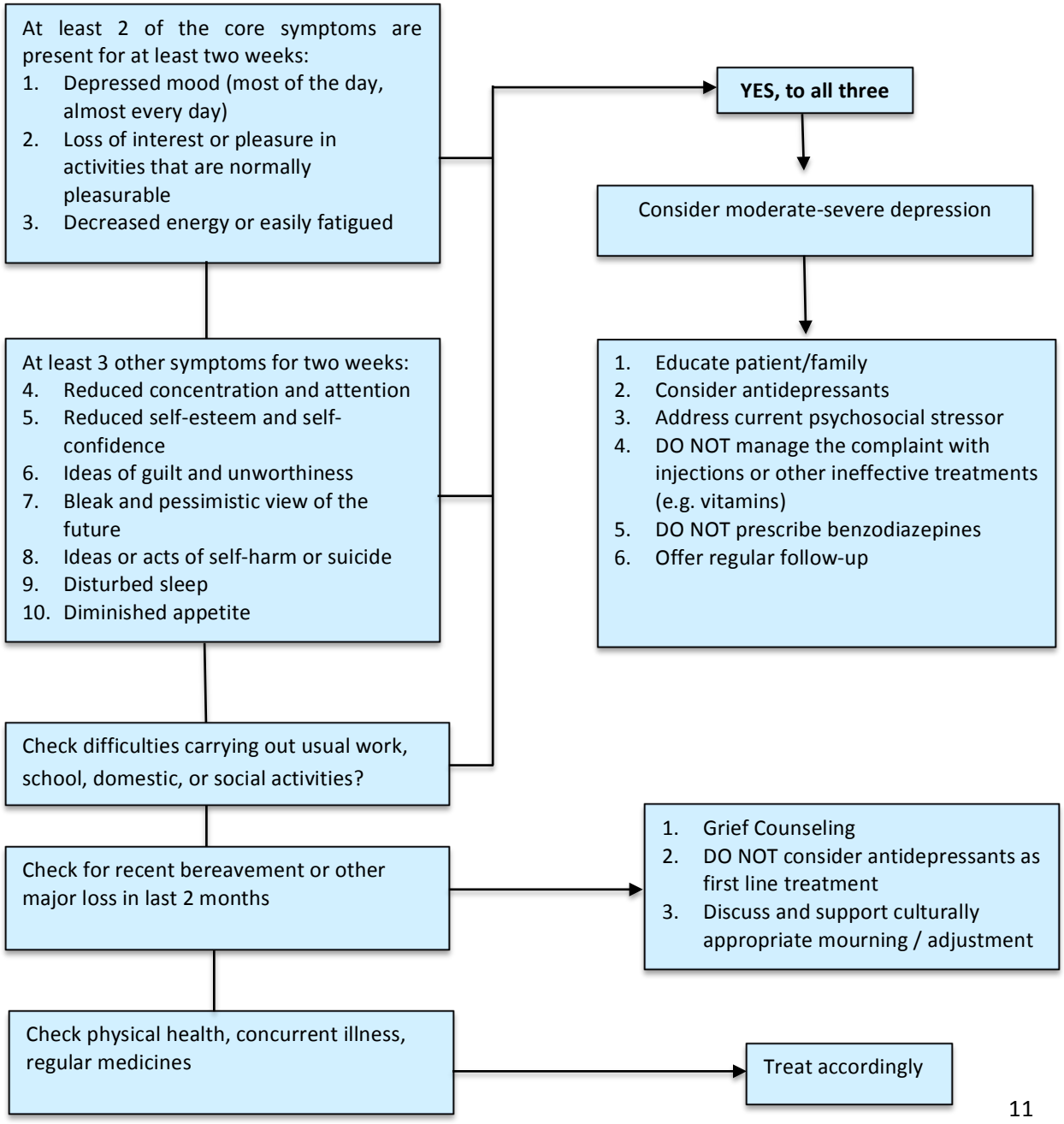
Depression is a common illness. The prevalence is 5% but can go up to 10% in women of childbearing age. Despite the fact that depression is easily treatable, more than half of the cases are not detected or treated. It causes huge burden in terms of domestic, social and occupational functioning. Untreated depression is also the main cause of suicide.

2.3 Assessment

1. Check for symptoms of depression (Table 1), duration and impairment in functioning.
2. Assess risk of self-harm/ suicide.
3. Past history of episodes of:
   a. Depression.
   b. Mania (symptoms include elevated mood, increased activity, over talkativeness & reduced sleep).
4. Family history of depression.
5. Physical health especially hypothyroidism, anemia, hypertension, diabetes, medication use, that can cause or exacerbate depression (such as steroids).
6. Recent bereavement of any major loss in the last two months.
7. Psychotic features (delusions, hallucinations) (see section 3.3).

Table 1: Common symptoms of depression	
1	Depressed mood (most of the day, almost every day)
2	Loss of interest or pleasure in activities that are normally pleasurable
3	Reduced energy / easily fatigued
4	Reduced concentration and attention
5	Reduced self-esteem and self-confidence
6	Ideas of guilt and unworthiness
7	Bleak and pessimistic view of the future
8	Ideas or acts of self-harm / suicide
9	Disturbed sleep, usually reduced but sometimes increased
10	Disturbed appetite, usually reduced but sometimes increased

Flow chart to assess for depression:



2.4 Management

2.4.1 Counselling

1. Educate

   - Depression is a very common illness that can happen to anybody.
   - Patients tend to have unrealistic negative opinions about themselves, their life and their future.
   - Effective treatment is available.
   - It tends to take at least a few weeks before treatment starts to reduce symptoms.
   - Adherence to treatment is important.

2. General advice

   - To continue, as far as possible, activities that used to be interesting or give pleasure.
   - To maintain a regular sleep cycle (i.e., going to be bed at the same time every night, trying to sleep the same amount as before, avoiding sleeping too much).
   - Encourage regular physical activity.
   - Encourage regular social activity, as far as possible.

3. Addressing stressors

   - Offer the person an opportunity to talk, preferably in a private space.
   - Explore patient's understanding of the causes of his or her symptoms.
   - Explore current psychosocial stressors and address social issues or relationship difficulties.
   - Assess any situation of maltreatment, abuse (e.g. domestic violence) and neglect (e.g. of children or older people).
   - Identify supportive family members and involve them.

4. In children and adolescents

   - Assess and manage mental illness (particularly depression, substance use problems) in parents.
   - Assess parents' psychosocial stressors and manage them.
   - Assess and manage maltreatment, exclusion or bullying (ask child or adolescent directly about it).
   - If there are school performance problems, discuss with teacher on how to support the student.

2.4.2 Prescribing an antidepressant

To select an antidepressant (see Table 2), consider the symptom pattern (sedating or non-sedating), the side-effect profile of the medication, and the efficacy of previous antidepressant treatments, presence of co morbid physical illness etc. Always discuss:

- Antidepressants are not addictive.
- There is a delay in onset of action.
- There are potential side effects of medication, which are usually self-limiting.
- The possibility of discontinuation/ withdrawal symptoms on missing doses, and that these symptoms are usually mild and self-limiting.
- The duration of the treatment, noting that antidepressants are effective both for treating depression and for preventing its recurrence.

Table 2: Common Antidepressants

Class	Drug/strength of tab (Trade name)	Dose	Common side effects
Tricyclic Antidepressants (mostly sedating)	Clomipramine 25mg Imipramine 25 mg Dothiepin Hydrochloride 25,75mg	75-150 mg/d (can be used as a single dose at night or divided) 75-150 mg/d (can be used as a single dose at night or divided) 75- 150 mg/d (can be used as a single dose at night or divided)	Dry mouth Constipation Difficulty urinating Dizziness Blurred vision Sedation Orthostatic hypotension
Selective Serotonin Reuptake Inhibitors (SSRIs) (mostly non-sedating)	Fluoxetine 20mg Escitalopram 10mg	20 mg/d (Single dose in the morning) 10 mg (Single dose in the morning)	Restlessness Nervousness Insomnia Anorexia Gastrointestinal disturbances Headache Sexual dysfunction

Do not prescribe an antidepressant in case:

- Depression is mild.
- There is a recent history of bereavement or major loss.
- Depression is due to a physical cause.
- Of a child, a pregnant lady or one who is breastfeeding.

Table 3: Precautions for antidepressant medication in special groups		
1	People at risk of self-harm or suicide	▪ SSRIs are first choice. ▪ Monitor frequently (e.g. once a week). ▪ To avoid overdoses in risk of self-harm/ suicide, ensure a limited supply of antidepressants (e.g. dispense for one week at a time)
2	Adolescents (12-18 years old)	▪ When psychosocial interventions prove ineffective, consider Fluoxetine (but not other SSRIs or TCAs). ▪ Monitor adolescents on fluoxetine frequently (ideally once a week) for suicidal ideas during the first month of treatment
3	Older people	▪ TCAs should be avoided, if possible. SSRIs are first choice. ▪ Monitor side effects carefully. ▪ Consider increased risk of drug interactions, and give greater time for response (a minimum of 6 – 12 weeks before considering that medication is ineffective, and 12 weeks if there is a partial response within this period).
4	People with cardiovascular disease	▪ SSRIs are first choice. ▪ DO NOT prescribe TCAs to people at risk of serious cardiac arrhythmias or with recent myocardial infarction

2.4.3 Monitoring antidepressant treatment

- Identify and try to address reasons for poor adherence (e.g. side-effects, costs, person's beliefs about the disorder and treatment).
- If symptoms do not improve after 4 – 6 weeks, review diagnosis, check compliance and consider increasing the dose.
- If symptoms of mania emerge during treatment, immediately stop antidepressants and assess for and manage mania.
- If symptoms persist after 6 weeks at maximum dose, then consider switching to another treatment or, refer the patient to a specialist.

2.4.4 Terminating antidepressant treatment

- Consider stopping antidepressant medication when:
  a. No or minimal depressive symptoms for 9 – 12 months
  b. Been able to carry out routine activities for that time period

- For TCAs and most SSRIs
  a. Reduce doses gradually over at least a 4-week period.
  b. Remind the person about the possibility of discontinuation/withdrawal symptoms on stopping or reducing the dose, and that these symptoms are usually mild and self-limiting.
  c. Advise about early symptoms of relapse (e.g. alteration in sleep or appetite for more than 3 days) and when to come for routine follow-up.

d. Monitor and reassure for mild withdrawal symptoms (common: dizziness, tingling, anxiety, irritability, fatigue, headache, nausea, sleep problems).

2.4.5 When to refer?

- Risk of suicide or has attempted suicide recently.
- Severe depression.
- History of acute or chronic physical illness or recent head injury.
- History of drug abuse.
- Past history of epilepsy or psychosis.
- Gross memory impairment and disorientation.
- No improvement after 6 weeks of treatment.
- Pregnancy or breastfeeding.

Key points

- ✓ Depression is a common and treatable illness
- ✓ It causes immense distress and disability
- ✓ Treatment includes counseling and antidepressants

Module 3: Psychosis

3.1 Objectives

At the end of the session, doctors should be able to:

1. Diagnose psychosis.
2. Initiate treatment.
3. Refer appropriately.
4. Monitor & follow up.

3.2 Introduction

What is Psychosis?

A syndrome involving the loss of contact with reality, hearing voices or seeing things that are not there, or false beliefs / suspicions. The person may not be aware of his condition/illness.

Common psychotic disorders are:

1. Schizophrenia

- Combination of delusions, hallucinations, thought disorder, disorganized behaviour and negative symptoms.
- The above present for a month or less if successfully treated.
- No mood symptoms or the mood symptoms are brief in relation to the total illness.
- Social, occupational or functional decline.
- The illness cannot be explained by a medical condition or substance induced.

2. Affective Psychosis (Mania or Psychotic depression)

- A clear history of mood symptoms (mania or depression) preceding the psychotic symptoms and persisting beyond the psychotic symptoms.
- The psychotic symptoms are mood congruent i.e. grandiose if elated or nihilistic if depressed.

- Symptoms of manic episode include elevated or irritable mood; excessive energy, activity and talking; reckless behavior; disinhibition etc. These symptoms must last for at least one week.

3. Other psychotic episodes (e.g., Cannabis induced psychosis)

These psychotic disorders have a close temporal relationship with substance use: hallucinations (may be visual) and less negative symptoms. The psychosis must arise during intoxication or withdrawal states in drug induced psychosis.

Course of psychosis

Acute psychosis is when the symptoms started or there is a worsening of symptoms within last 3 months. It can be a first episode or a relapse. The patient may recover completely or partially from an acute episode. Chronic psychosis may last for years with either a relapsing/remitting course or a continuous downhill course.

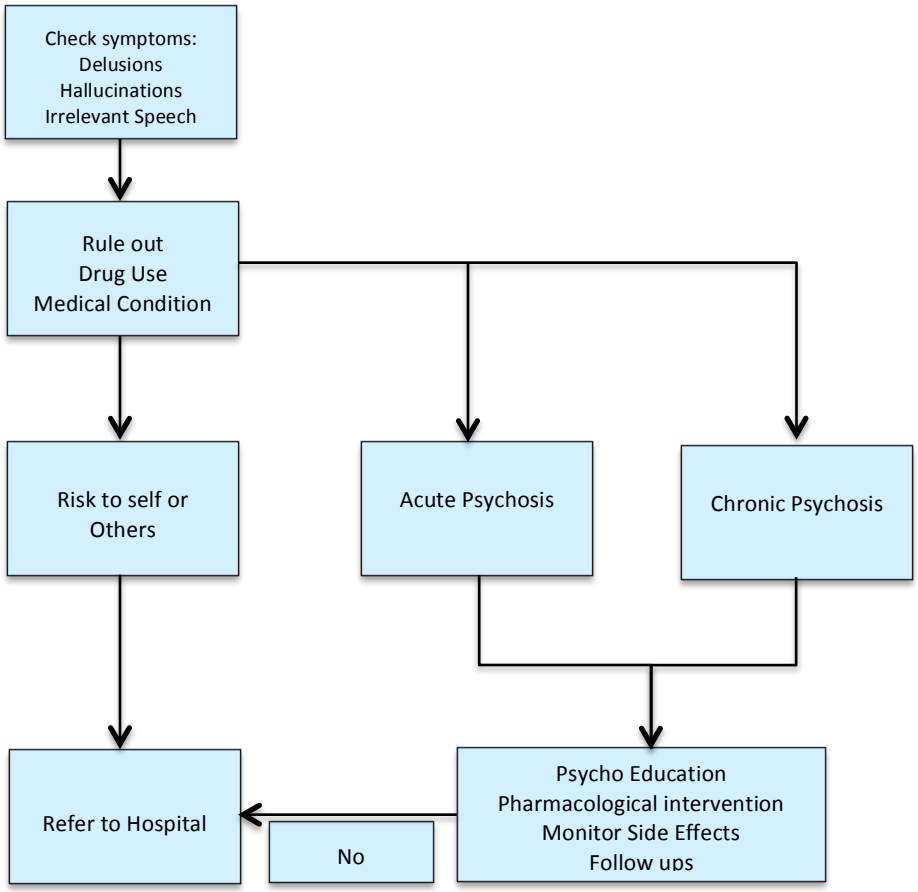
3.3 Assessment

1. Identify symptoms of psychosis (Table 1).
2. Ask about previous episodes and treatment.
3. Rule out psychotic symptoms caused by substance use e.g., cannabis or alcohol.
4. Rule out psychotic symptoms caused by delirium due to acute medical conditions e.g., cerebral malaria, systemic infection, sepsis, head injury etc.

Table 1: Common symptoms of psychosis

	Domain	Symptoms
1	Changes in speech	May be incoherent or disorganized (words or sentences might not be linked) or irrelevant.
2	Abnormal beliefs (Delusions)	An abnormal or false belief that the person believes to be true e.g., a paranoid believe that some people are conspiring to kill the patient.
3	Abnormal perceptions (Hallucinations)	▪ An experience of clearly hearing voices or seeing things when there is no real stimulus. ▪ The patient might be noticed to mumble or talk to himself.
4	Changes in emotions	▪ An inability to experience normal emotions like sadness or pleasure. The patient might appear indifferent or inappropriate in his emotional reactions.
5	Changes in social behaviour	▪ Social withdrawal and decreased interaction with friends and

		family ▪ Self neglect and passivity ▪ Loss of interest and motivation ▪ Lack of responsibility in daily activities
6	Changes in behavior	▪ Might be inappropriate or disorganized. ▪ Often unaware that they are unwell and ~~are~~ often brought to the doctor by their family. ▪ They believe that what they are worrying about is actually happening (lack of insight) e.g., if a patient is paranoid, he might refuse to get out of the house or a patient may behave aggressively even without a provocation.



3.4 Management

1. Every person's experience is different and unique to them. Attaching a specific name or label to a psychotic illness initially is not always helpful.
2. Share assessment with family and explain psychosis.
3. Explain treatment options weighing risks and benefits.
4. Encourage psychosocial support for person and family.
5. Ensure compliance and follow up.

3.4.1 Guidelines for drug treatment

1. The choice of anti-psychotic medication should be a joint decision between the doctor and patient.
2. Prescribe one antipsychotic medication at a time.
3. Consider intramuscular treatment only if oral treatment is not feasible. Do not prescribe long-term injections (depot) for control of acute psychotic symptoms.
4. "Start low, go slow": Start with a low dose within the therapeutic range (see the antipsychotic medication table for details) and increase slowly to the lowest effective dose, in order to reduce the risk of side effects.
5. Try the medication at an optimum dose for at least 4 – 6 weeks before considering it ineffective.
6. Continuous' rather than 'intermittent' dosing should be used to avoid relapse and deterioration of mental state.

Table 2: Common anti-psychotic drugs & side effects

Class	Drug	Dose	Route	Common side effects
Older Antipsychotic	Haloperidol Tab/Inj	2mg – 15mg	Oral I/M	Extrapyramidal side effects Tremors Muscular rigidity Tardive dyskinesia Akathasia Acute dystonia Sedation Urinary hesitancy
Non sedating newer antipsychotic	Risperidone Tab/Drops	1mg – 4mg Starting dose	Oral	Sedation Weight gain Elevation of blood sugar
Depot anti-psychotic injection	Injection Fluphenazine Decanoate	12.5 – 100 mg every 2 – 5 weeks	Deep I/M injection in gluteal region	(See Haloperidol)

3.4.2 Extra pyramidal symptoms

These are characterized by muscle rigidity, tremor and slowness of movements. There might be fixed facial expressions and slurred speech. These occur more commonly with the use of the older antipsychotics such as Haloperidol. Symptoms appear within days of starting medication but usually improve within 3 months of treatment.

a. Dystonia

Dystonia is the sustained contraction of a group of muscles most commonly involving the tongue, jaw, neck and trunk. Spasms are sometimes painful and can be frightening.

b. Tardive dyskinesia

This usually occurs following prolonged use (over years) of antipsychotic medication and presents with abnormal facial movements such as smacking lips, chewing, sucking, twisting the tongue, side to side movements of the jaw or jerky, often purposeless limb movements.

c. Akathisia

It is severe motor restlessness, resulting in an inability to remain in one place for long.

Management of extrapyramidal side effects

- Reduce the dose of antipsychotic medication. Consider changing to a newer anti-psychotic drug.
- If dose reduction is ineffective, consider an anti-cholinergic to counteract side effects (Tab Procyclidine 5mg – 10mg). Anticholinergics are for short-term use if extrapyramidal side effects are acute, severe or disabling.
- Acute dystonia usually occurs within 1 or 2 days of beginning treatment and is usually transient. This usually responds effectively to Inj. Procyclidine 5mg I/M.

3.4.3 Educate patient & family

1. Psychosis is a serious but manageable condition, regular treatment & follow up is very important.
2. Regular social, educational and occupational activities should be continued, as far as possible.
3. The patient has a right to be (and should be) involved in treatment decision, when possible.
4. Staying healthy is very important (e.g. healthy diet, physical activity, personal hygiene).
5. Family should be helped to recognize symptoms, if these relapse.
6. Family members should avoid expressing constant criticism or hostility towards the patient.
7. A person with psychosis may have difficulties functioning in high-stress environments.
8. It is best for the person to have a job or to be otherwise meaningfully occupied.

3.4.4 Follow up

Patients on anti-psychotic medication must be regularly followed up. At each follow up visit, assess and monitor:

- Symptoms
- Side-effects of medications
- Adherence to medication and follow up
- Check weight, pulse and blood pressure
- Check baseline investigations including fasting blood glucose.
- Assess and manage concurrent medical conditions
- Assess the need for educating & supporting the patient & the family

3.4.5 When to refer?

- If the response to treatment is inadequate
- If you suspect alcohol/drug intoxication or withdrawal
- If you suspect an underlying physical illness as a cause of psychosis
- If there is associated risk of harm to self or others

Key points

- ✓ Psychotic disorders are treatable
- ✓ Early identification and treatment is very important
- ✓ Psychosis can be managed in primary health care

Module 4: Child and Adolescents Mental Health (CAMH) & Learning Disability

4.1 Objectives

At the end of the session, doctors are able to:

1. Assess normal development & identify common childhood disorders.
2. Diagnose learning disability.
3. Guide parents for further management.
4. Refer appropriately.

4.2 Introduction

1. Mental health problems are common in children and adolescents.
2. 10 - 20% of children and adolescents have significant psychosocial distress or mental health problems.
3. Half of all lifetime cases of mental disorders start by age 14; 70% by age 24.
4. Suicide is the third leading cause of death among adolescents.
5. They might have difficulties with development, emotions, behavior, education or social activities.
6. They might be exposed to abuse or neglect.
7. The families often face stress and financial pressures.

4.3 Child development

Child development is the process of growing and acquiring new skills (i.e. walking and grasping objects, communicating, playing, interacting with others). It is not just about growing and learning motor (movement) skills. It is a complex process, determined by the biological brain development, influenced in part by the quality of interactions with others (i.e. family).

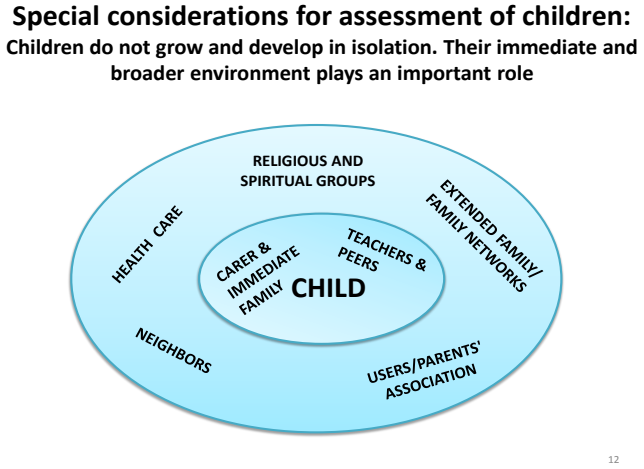
Table 1: Different domains of child development		
	Domain	**Example**
1	Motor (movement) skills	Sitting up, walking, skipping Picking up objects, using a spoon, drawing
2	Communication & speech	Babbling (e.g. say 'bababa'), pointing, using words
3	Social interaction	Smiling, waving goodbye, taking turns with others
4	Learning (cognitive)	Problem solving, exploring the environment, doing math

Clinical examination should include:

1. Assess milestones of development (see Table 2).
2. For older children, check school performance or everyday household activities.
3. Look for visual or hearing impairment.
4. Check any nutritional deficiencies (i.e. iodine deficiency) or chronic medical conditions.
5. Assess factors in the environment, which might be affecting the child (Figure 1).

Table 2: Milestones of development	
Age	**Child's capability**
6 months	Sit with support Reach for objects
1 year	Crawl on hands and knees Stand up with support Try to imitate words and sounds Pick things up with thumb and one finger
2 years	Walk, climb and run Point to objects when they are named (e.g., nose, eyes) Scribble if given a pencil or crayon Make sentences of two or three words
3 years	Walk, run, climb, kick and jump easily Say own name and age Feed without help Toilet trained
5 years	Speak in sentences and use many different words Play with other children Dress without help Count up to 10

Figure 1: Factor to be considered in assessing a child



4.4 Common presentations in children

- **Learning disability (Intellectual disability / mental retardation)**

  It is suspected when there is a substantial delay in learning skills in more than one domain. The onset is in the childhood and often persists into adulthood. Children can learn new skills, but they develop much more slowly than other children.

- **Autism**

  The features are impaired social behaviour, communication and language and a narrow range of interests and activities that are repetitive. It starts in infancy and early childhood. Usually there is some degree of intellectual disability.

- **Attention deficit hyperactivity disorder (ADHD)**

  The main features are impaired attention and over activity that affects child's functioning in daily life and learning. The child does not focus on the task, leaves it unfinished and switches to the next one. This usually starts before the age of six. Persists in all situations and is excessive for his age.

- **Conduct disorder**

  It is characterized by a repeated and persistent pattern of dissocial, aggressive and defiant conduct. Some examples of such behaviours are excessive level of fighting or

bullying, cruelty to animals or other people, severe destructiveness to property, fire setting, stealing, lying, running away from home etc.

- **Separation anxiety disorder**

  An emotional disorder, where the main focus of anxiety is fear of separation from attachment figure (usually mother). Such anxiety arises in early years of the child. It is excessive and leads to significant problems in social functioning.

- **Mood disorder**

  Children with mood disorders may present with mood changes, irritability, disturbed behaviour or disturbed biological functions. Performance at school may be affected. Change in psychosocial environment of the child should be taken in account.

4.5 Assessment of learning disability

Intellectual disability is characterized by impairment of skills across multiple developmental areas (cognitive, language, motor and social) during the developmental period.

1. Assess the core signs
    a. Delay in developmental milestones
    b. School performance and daily functioning
    c. Oddities in communication and restricted/repetitive behaviours
2. Assess the risk factors for delay
    a. Visual and hearing impairment
    b. Nutritional deficiencies and chronic medical conditions
    c. Maternal depression and poorly-stimulating environment

3. Assess for co-occurring depression, epilepsy, and behavioral problems

Table 3: Common causes of learning disability

Prenatal period	Malnutrition Maternal infection
Natal period	Prolonged labour Peripartum haemorrhage Birth asphaxia
Post natal period	Malnutrition (iron, iodine deficiency) Infections Jaundice Non-stimulating environment

4.6 Management of learning disability

4.6.1 Working with parents

Explain:

- The nature of problem and that the child can learn new skills but slowly. Help identify both, child's strengths and weaknesses.
- Need to train the child in self-care and hygiene tasks (e.g. toilet training, dressing).
- Need to stimulate the child and involve him in everyday family life.
- Need to establish routines (e.g. having regular times for eating, playing, homework, and sleeping).
- Need to recognize stressful situations for the child, identify the causes of problem behaviours and strategies to prevent them.

Provide support to the family. Parents need to be empowered and not blamed. Help the family accept the child, avoid stigma and feelings of guilt.

4.6.2 Working with teachers/school

- Encourage attendance in mainstream schools whenever possible. Emphasize the need to work closely with teachers to help the child learn.
- Ask to have the child to be seated at the front of the class.
- Give the child extra time to understand assignments.
- Break long assignments into smaller pieces.
- Protect the child against bullying.

4.6.3 Behavioural management

- Make a list of problem behaviours and select one at a time to manage.
- Make clear rules and everyone must follow these at all times.
- Desired behaviour should be encouraged, by rewarding it immediately (Positive reinforcement). The reward could be praising the child, giving a hug, clapping or even a sweet.
- Punishment or scolding the child should be avoided.
- All efforts to modify behavior must be consistent.
- Adults should demonstrate the behaviour they want to see.

4.6.4 Referral to specialist

- All children with developmental delay should be seen for further assessment, at least once, by a specialist (pediatrician, mental health specialist, neurologist).
- If there is no improvement or further deterioration in development or behavior.
- If you suspect danger to the child or others.
- If physical health is affected (such as nutrition problems).
- Limit financial burden on families seeking multiple opinions and further investigation.

Key Points

- ✓ Children need a holistic assessment including their development & environment
- ✓ Many causes of learning disability are preventable
- ✓ Medication should not be prescribed for disturbances of behaviour

Module 5: Epilepsy

5.1 Objectives

At the end of session, doctors should be able to:

1. Diagnose epilepsy.
2. Manage epilepsy.
3. Refer appropriately.

5.2 Introduction

Seizure: Seizures are episodes of brain malfunction due to abnormal electrical discharges

Epilepsy: An illness involving recurrent, unprovoked seizures.

- 80% of people suffering from epilepsy live in the developing world.
- 50% patients develop epilepsy before the age of 18 years. It is more commonly seen in patients with mental retardation.
- Treatment gap for epilepsy is huge (56% to 80%).

Types of epilepsy:

- Convulsive type
- Non-convulsive type

5.3 Assessment

- Epilepsy is diagnosed clinically.
- A careful history and an eyewitness account are essential.
- Baseline investigations may be needed to rule out physical cause of epilepsy. EEG, CT scan might not be conclusive.

Table1: Causes of epilepsy	
Age group	**Possible causes**
New born	Birth trauma Congenital malformations Jaundice Metabolic disorder Infections
Childhood	Genetic
Adults	Cerebrovascular diseases Tumours Head injury Drug withdrawl
Note: In ¾ of the cases no cause can be found	

5.4 Management

1. After two episodes of unprovoked seizures, treatment should be started. The aim of treatment is to:

   - Start treatment with only one antiepileptic drug.
   - Initiate treatment with the lowest dose and build up slowly until complete seizure control is obtained

2. Educate patient and family about:

   - The delay in onset of effect and the time course of treatment
   - Potential side effects of treatment & risks
   - Risk of abrupt discontinuation or missing doses
   - Keep a seizure diary
   - Need for regular follow-up

3. Children with epilepsy must be assessed for developmental and behavioural disorders. If there is a developmental and behavioural disorder:

   - Refer to a specialist
   - Avoid phenobarbital and phenytoin

4. For women of childbearing age:

   - Always give Folate 5 mg/day to prevent birth defects
     Avoid Sodium Valproate, as it can cause birth defects
   - If pregnant:

Refer to a specialist
Avoid using more than one antiepileptic drug
Advise hospital delivery and more frequent antenatal visits
At delivery, give 1mg vitamin K I/M to the newborn

- For breast feeding

  The anti-epileptic medicines presented in this module are safe for breastfeeding
  But some other anti-epileptic medications may NOT be safe.
  Always consult a specialist

5. How to withdraw treatment?

   - Consider when there is no seizures for at least 2 years
   - Consult with specialist, if available.
   - Discuss decision with patient/family & risk of the seizures starting again.
   - Long-term antiepileptic drug therapy might be required, e.g. in cases of epilepsy secondary to head trauma or neuro-infections, or if the seizures were difficult to control.
   - Reduce treatment gradually over 2 months.

6. When to refer?

   - Seizures are not controlled despite good compliance.
   - Patient is not responding to a single drug.
   - Co-morbidity is present.
   - Before stopping anticonvulsants, where specialist is available.

Table 2: Common drugs for treating epilepsy (Anticonvulsants / Anti-epileptics)

Drug		Children		Adolescents	
		Starting dose	Maintenance dose	Starting dose	Maintenance dose
1	Carbamezapine	5 mg/kg/day	10–30 mg/kg/day	100–200 mg/day	400–1400 mg/day
2	Valproate	15–20 mg/kg/day	15–30 mg/kg/day	500 mg/day	500–2000 mg/day
3	Phenytoin	3–4 mg/kg/day	3–8 mg/kg/day (max 300 mg/day)	150–200 mg/day	200–400 mg/day
4	Phenobarbitone	2–3 mg/kg/day	2–6 mg/kg/day	60 mg/day	60–180 mg/day

Table 3: Common side effects of Anti-convulsant drugs		
	Drug	**Common side effects**
1	Carbamezapine	Ataxia Diplopia Blurring of vision Bone marrow suppression Steven Johnson syndrome
2	Valproate	Sedation Tremors Transient hair loss Hepatotoxic
3	Phenytoin	Drowsiness Double vision Ataxia Long-term: Gum hyperplasia Coarse face (children) Hirsutism
4	Phenobarbitone	Drowsiness Behavioral disturbance

5.5 Emergency management

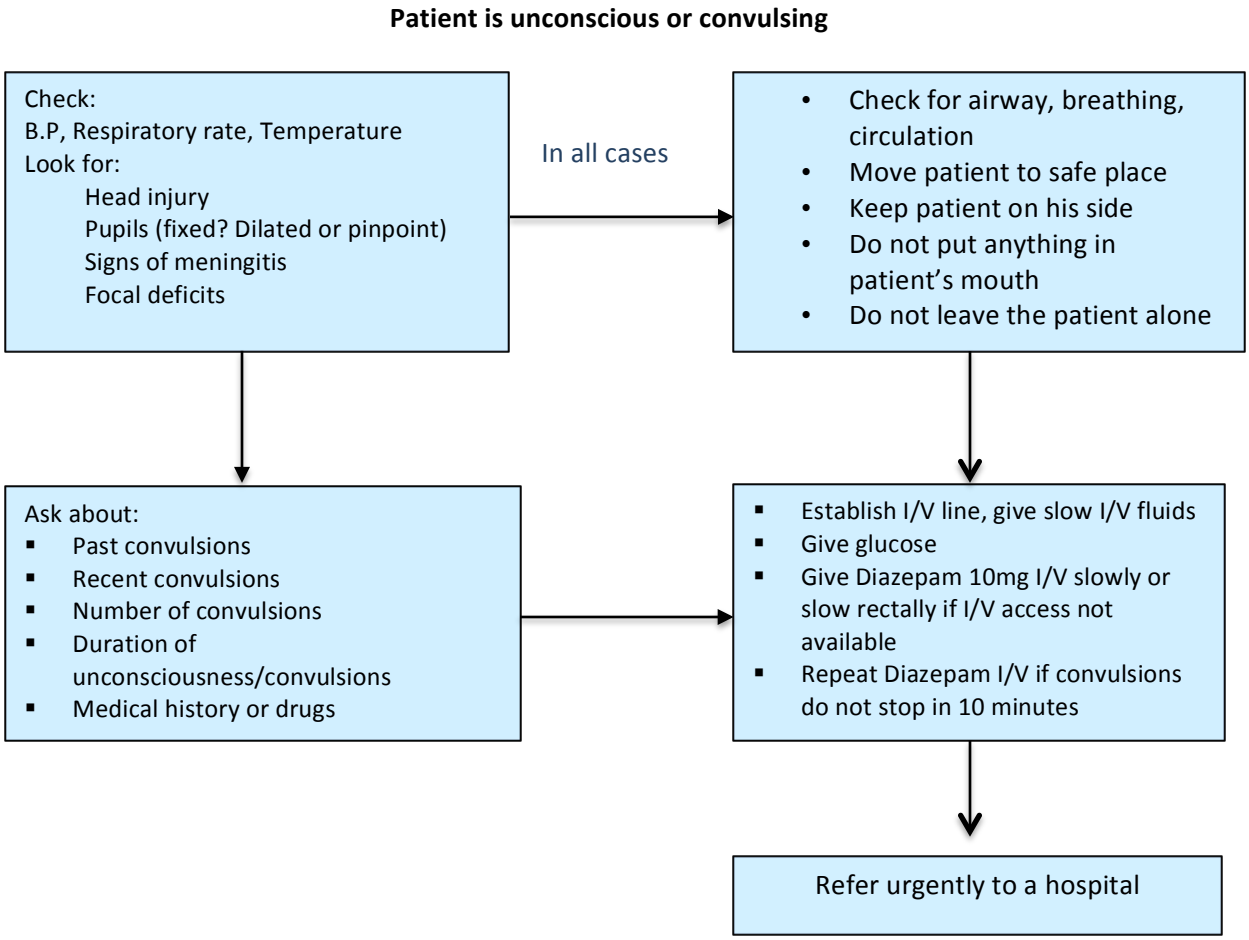


Table 4: First aid for epilepsy

1. Lay the person down, on their side, with their head turned to the side to help with the breathing and prevent aspirating secretions and vomit.
2. Make sure that the person is breathing properly.
3. Do not try to restrain or put anything in the person's mouth.
4. Remove any potentially dangerous objects, near the person.
5. Stay with the person until the seizure stops and they wake up.
6. Sometimes people with epilepsy know or feel that the seizures are coming. In that case they should lie down somewhere safe to protect themselves from falling.

Key Points

People with epilepsy can lead normal lives:

- ✓ They can marry and have children
- ✓ Children with epilepsy should not be removed from school
- ✓ They can work in most jobs but should avoid certain jobs (e.g., working with heavy machinery, open fires, heights or open water sources)

Remember that epilepsy is not contagious, so no one will catch seizures by helping.

Module 6: Drug Dependence

6.1 Objective

At the end of the session, doctors should be able to:
1. Diagnose drug dependence and withdrawal.
2. Assess motivation to change.
3. Minimize harm & manage.
4. Refer appropriately.

6.2 Introduction

Common drugs of abuse are Benzodiazepines, Cannabis, and Opioids.

Drug dependence is pattern of symptoms including:

1. Evidence of *tolerance
2. A physiological withdrawal state
3. Strong desire or sense of compulsion to take drugs
4. Difficulties in controlling drug use
5. Progressive neglect of responsibilities or interests
6. Drug use persisting despite harmful consequences

*Tolerance is a state in which a person no longer responds to a drug as they did before, and a higher dose is required to achieve the same effect.

Drug withdrawal

Withdrawal is a term used to refer to either individual symptoms or overall state which may result when the person ceases the repeated use of a psychoactive drug.
A withdrawal syndrome that can develop after stopping the use of a drug will vary according to the type of drug the person was using. General features include:

1. Craving for substance
2. Anxiety
3. Restlessness
4. Insomnia
5. Impaired attention
6. Irritability

6.3 Assessment

6.3.1 Taking a history

- Ask about illicit drug use in a non-judgmental way.
- Check details of consumption and any behaviors associated with drug use that may risk health/ harm others (e.g. drug smoking, drug injection, activities when intoxicated, financial implications, capacity to care for children, violence toward others).
- Explore development of drug use in relation to other life events.
- Check dependence by asking about developing tolerance and experiencing withdrawal symptoms.

Table 1: Clinical presentations of drug dependence

Drug	State	Symptoms/signs
Benzodiazepine	Intoxication	Sedation, slowed and slurred speech, depressed respiration
	Chronic use	Impaired cognition and memory
	Withdrawal	Usually lasts one- two weeks: anxiety, agitation, muscle cramps, abdominal cramps, raised pulse and blood pressure, insomnia, and (when severe) seizures and delirium
Cannabis	Intoxication	Red conjunctivae, delayed responsiveness, normal pupil size
	Chronic use	Self-neglect, poor hygiene, anxiety, and sometimes psychosis
	Withdrawal	Usually lasts about one - two weeks: mood swings, anxiety and muscle cramps
Opioid	Intoxication	Drowsiness, slow speech small pupils, slow pulse, depressed respiration
	Chronic use	Self-neglect, constipation, lack of sex drive, signs of injection, complication of unsafe injection (hepatitis,HIV/AIDS)
	Withdrawal	Usually lasts 3-6 days: Anxiety, restlessness, dilated pupils, muscle aches, nausea, vomiting, diarrhea, abdominal cramps, headache, raised pulse &blood pressure, yawning, runny nose, piloerection (goosebumps)

6.3.2 Physical examination

Look for signs of drug use:

- Signs of injection
- Pupils (relevant to most drugs)
- Stigmata of liver disease (relevant to injecting drug use)
- Cachexia (relevant to self-neglect)
- Weight loss
- Look for common health complications of injecting drug use
- Evidence of HIV, Hepatitis B or C and TB infection

6.3.3 Assess motivation

- Assess the impact of drug use on different aspects of patient's life.
- Find out if the patient is willing to stop or change his pattern of drug use or to make changes in his life?
- Help the patient understand the need to address their drug use problems and to strengthen their motivation for change.

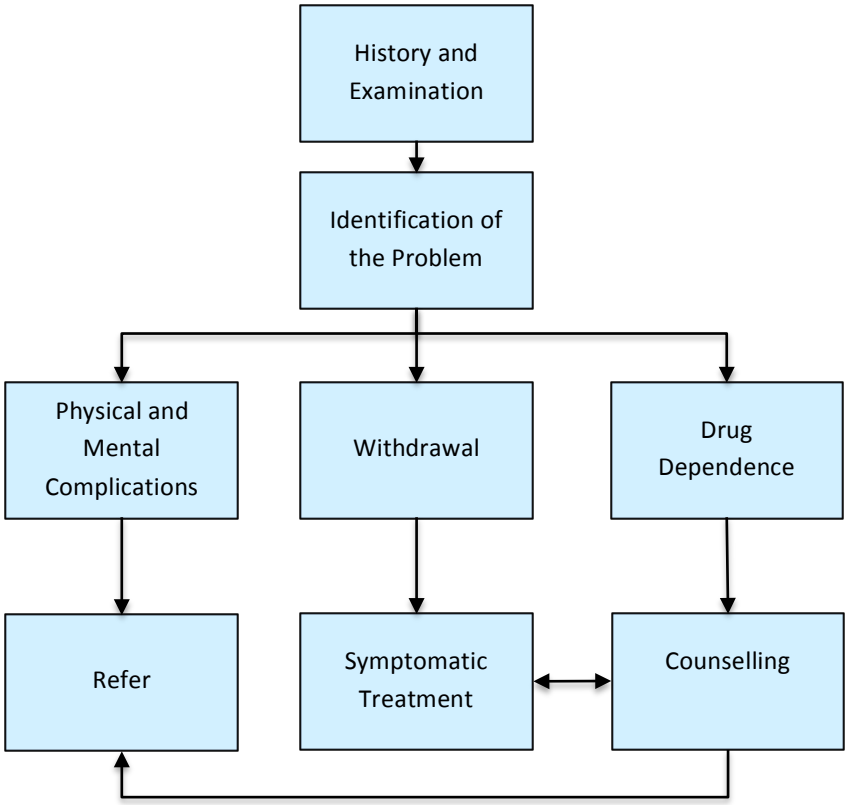
6.3.4 Basic investigations

- Haematological investigations
  - Haemoglobin, ESR, blood counts
  - Renal function tests
  - Liver function tests
  - Hepatitis B
  - Hepatitis C
  - Tests for HIV antibody
- Chest X Ray
- ECG
- Urine test for 'Drug screen'

6.3.5 Complications of drug use

- General: Anemia, poor nutrition, dental caries.
- Drug related: Side effects (e.g. constipation, hallucinations), overdose, and withdrawal.
- Route related: Smoking (asthma, respiratory infections), injection (cellulitis, abscess).
- Sharing needles: Hepatitis B and C, HIV and other blood borne diseases.

6.4 Management



6.4.1 Brief intervention

1. Engage the patient to discuss positive and negative effects of their drug use.
2. Avoid confrontation, arguments or blame.
3. Encourage the patient to make decisions to change their pattern of drug use.
4. If the patient is not ready to stop or reduce use, even then ask him the to see you again, perhaps with a family member or friend.

6.4.2 Harm-reduction

1. If the patient is injecting, discuss risks, less risky techniques and using sterile equipment.
2. Advise tests for blood-borne viral illnesses, when needed.
3. Treat complications of drug use and other medical and psychiatric problems.
4. Provide psychosocial support, even if the person does not wish to cease using drugs at this time.
5. Develop a relationship to continue with efforts to encourage treatment.

6.4.3 Symptomatic treatment for withdrawal

1. Provide support and information.
2. Encourage oral fluids; an intravenous infusion should be used only in dehydrated states where the patient is unable to drink.
3. Ensure fluid and electrolyte balance.
4. Monitor vital signs regularly.
5. Treat any infection immediately.
6. Treat symptoms, as required (see Table 2).

Table 2: Treatment of withdrawal symptoms

Symptom	Drug	Dose
Agitation	Haloperidol (Serenace)	Up to 15 mg/d
Diarrhoea	Loperamide hydrochloride (Imodium)	Up to 6 - 8 mg/d
Nausea, vomiting	Metoclopramide hydrochloride (Maxolon)	As required, up to three times/d
Stomach cramps	Hyoscine butylbromide (Buscopan)	As required, up to three times/d
Muscular pains	Non steroidal anti inflammatory drugs	As required

6.4.4 Withdrawal from Benzodiazepines

1. Reduce dose gradually.
2. If withdrawal symptoms occur consider maintaining the patient on the same dose and adopt a slower pace of reduction.
3. Reduce the dose further in smaller fortnightly steps, preferably to reduce more slowly than too quickly.
4. Stop completely: this may vary from 4 weeks to a year or more, after initiating the reduction, again depending on individuals.
5. Always assess for underlying mental illness, if untreated.

6.4.5 When to refer?

1. Mental illness is suspected but could not be diagnosed.
2. In case of severe mental illness.
3. In case of severe withdrawal where detoxification is preferred under specialist supervision.
4. In case of severe physical complications (e.g., aspiration pneumonia, respiratory depression)
5. When there is risk of harm to self or others.
6. In case opinions are needed for the purposes of assisting the court.

Key points

- ✓ Advise detoxification only if the patient is motivated
- ✓ Harm reduction is an important part of treatment
- ✓ Refer for further treatment if there is no improvement