REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL CLINICAL GUIDELINES FOR MANAGEMENT OF COMMON MENTAL DISORDERS

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FOREWORD

Mental health is a critical public health issue globally and in Kenya, and mental disorders have been on the rise affecting millions of individuals across all demographics. It is estimated that one in every ten people in Kenya has a common mental disorder with 25% of outpatients and 40% of inpatients having a mental health condition.

The Government is committed to ensuring that the country attains the highest health standards as per the Constitution of Kenya 2010, the Kenya Mental Health (Amendment) Act 2022 and the Bottom-Up Economic Transformation Agenda (BETA). To achieve this, the Ministry of Health has prioritized mental health as a key policy priority as outlined in the Kenya Mental Health Policy 2015-2030 and Kenya Primary Health Care Strategy 2019-2024.

To improve access to quality mental health services, the Ministry of Health has made significant strides towards integration of mental health in primary care and the capacity development of healthcare workers. In line with this, we have developed the National Clinical Guidelines for Management of Common Mental Disorders to equip healthcare workers with necessary skills and knowledge for the assessment and management of common mental disorders.

The Ministry of Health commits to work closely with relevant stakeholders to fully support the implementation of these guidelines. I therefore call upon all healthcare providers and practitioners to adhere to the set standards and guidelines to deliver quality mental healthcare services in the country.

Dr. Patrick Amoth, EBS

Director General for Health

Ministry of Health

EXECUTIVE SUMMARY

Mental, neurological and substance use disorders are highly prevalent globally and locally, accounting for a significant burden of disease and disability. The most significant impact of mental health lies mainly in the number of years of life lived with the disability following the onset of the mental illness which can be devastating to individuals, families, and communities.

However, mental health care in Kenya is relatively inaccessible, inconsistent, and inadequate with a wide human resource gap. Additionally, stigma and discrimination associated with mental health problems are barriers to the health-seeking behaviour of persons with mental health conditions, further worsening their condition.

The Kenya Mental Health Policy aims at ensuring that Kenyans have access to comprehensive, integrated, and high-quality mental health services at all levels of healthcare through strengthening of mental health systems and capacity development of the healthcare workers.

These guidelines have been developed to provide a remedy to the prevailing situation and aim to bridge the treatment gap by providing mental health literacy to healthcare workers on evidence-based recommendations for the assessment and management of common mental disorders.

These clinical guidelines cover the management of the following common mental disorders:

- Psychotic disorders
- Depression
- Bipolar disorder
- Anxiety disorders
- Post-traumatic stress disorder
- Neurocognitive disorders
- Common mental disorders in Children & Adolescents
- Sleep-wake disorders
- Psychiatric emergencies
- Maternal mental illness

These guidelines also cover special considerations for managing specific populations and Psychosocial interventions used in management of common mental disorders.

These guidelines have been designed to enable its usability by various categories of healthcare workers without specialized psychiatric training. This is evident in the systematic approach undertaken across the document outlining:

i. Modalities for diagnosis that include diagnostic criteria, and procedures for assessment and examination
ii. Recommended management/treatment modalities that include psychosocial and pharmacological interventions
iii. Indications for referral

Furthermore, it offers guidance on clinical decision-making for comprehensive patient care through a multidisciplinary approach.

Adherence to these guidelines by practitioners at different service delivery points will facilitate the smooth delivery of standardized and quality mental health services. They, however, do not substitute for further training and need to be considered jointly with other supporting policy documents and technical guidelines. These guidelines shall be reviewed occasionally to capture new insights into mental healthcare provision.

In conclusion, the implementation of these National Clinical Guidelines for Management of Common Mental Disorders will improve access to quality mental health services across the country.

Dr. Issak Bashir

Ag. Director: Directorate of Family Health

Ministry of Health

ACKNOWLEDGEMENT

The Publication of the 1st National Clinical Guidelines for Management of Common Mental Disorders is a major milestone towards improving access to mental health services in the country. These guidelines were developed through a consultative process with key health stakeholders whose inputs contributed significantly to enriching this document.

Our sincere gratitude to the leadership of the Ministry of Health through the offices of the Cabinet Secretary for Health and Principal Secretary of Medical Services for their overall direction and guidance which enabled the success of the entire process.

We are grateful to the Director General for Health, under whose technical direction steered the process of developing these guidelines, with support from the Directorate of Family Health. We appreciate the multisectoral technical working group for their commitment and expertise in developing a user-friendly and evidence-based document.

We are obliged to all the stakeholders involved in developing these clinical guidelines, including developmental partners, healthcare workers from various counties, professional associations, NGOs, service users, academia, researchers and the private sector.

Lastly, we acknowledge PEPFAR and CDC for their financial support in the development process.

Dr. Mercy Karanja

Ag. Head: Division of Mental Health

Ministry of Health

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ABBREVIATIONS AND ACRONYMS

AA	Alcohol Anonymous
ADHD	Attention Deficit Hyperactivity Disorder
AUD	Alcohol Use Disorder
BAT	Behavioral Activation Therapy
BEST-PICK	Behaviour, Emotions, Speech, Thoughts, Perception, Insight, Cognition and Knowledge.
BS	Blood Slide for malaria
CBT	Cognitive Behavior Therapy
CIT	Crisis Intervention Therapy
CL	Calcium Levels
CMH	Community Mental Health
CRPD	Convention on the Rights of Persons with Disabilities
CT scan	Computerized Tomography
CT	Cognitive Therapy
CVA	Cerebral Vascular Accidents
DKA	Diabetic Ketoacidosis
DT	Delirium Tremens
ECT	Electroconvulsive Therapy
EE.G.,	Electroencephalogram
EMDR	Eye Movement Desensitization and Reprocessing
EPD	Edinburg Perinatal/Postnatal Depression
EPS	Extrapyramidal Side Effects
FBC	Full Blood Count
FFT	Family-Focused Therapy
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IP	Interpersonal Psychotherapy
IT	Interpersonal Therapy
IV	Intravenous
LFT	Liver Functioning Test
MAOIs	Monoamine Oxidase Inhibitors
MCV	Mean Corpuscular Volume
MI	Motivational Interviewing
MNS	Mental Neurological Substance abuse
MRI	Magnetic Resonance Imaging
MSE	Mental Status Assessment
OD	Once a Day
PQH-9	Patient Health Questionnaire version 9
PST	Problem Solving Therapy
PTSD	Post-Traumatic Stress Disorder
RBS	Random Blood Sugar
SSRI	Selective Serotonin Reuptake Inhibitors
SUD	Substance Use Disorder
TCA	To Come Again
TFT	Thyroid Functioning Test
UEC	Urea Electrolytes Creatinine
WHO	World Health Organization
WKS	Wernicke Korsakoff Syndrome

SECTION 1: INTRODUCTION TO THE GUIDELINES

1.1. Background

The World Health Organization defines mental health as a "state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community" (World Health Organization, 2022). On the other hand, mental illnesses or disorders are health conditions characterized by significant changes in emotions, thinking, or behaviour, or a combination of these, often associated with distress and/or problems functioning in social, work, or family activities (World Health Organization, 2022).

Mental illnesses significantly impact individuals' quality of life and, when untreated, contribute to overall socioeconomic burden, loss of productivity, and negative social implications such as homelessness and poverty. They are among the most significant contributors to the global burden of disease and disability (World Health Organization, 2022).

It is estimated that about 25% of outpatients and 40% of inpatients in health facilities in Kenya have a mental condition (Kenya National Commission on Human Rights [KNCHR], 2011), with the most frequent diagnoses being depression, substance abuse, stress-related, and anxiety disorders (Ndetei et al., 2008). Further, the probable prevalence of psychosis in Kenya is at an average of 1% of the population (Kiima & Jenkins, 2012).

However, about 75-85% of people with a mental illness may be misdiagnosed or go untreated when they visit a health facility, as general healthcare workers in Kenya diagnose only 4.1% of mental illnesses (Ndetei et al., 2009).

To reduce this burden, it is critical to build the capacity of available healthcare workers to be able to diagnose and manage common mental disorders in all healthcare settings.

1.2. Aims and Objectives of the Guidelines

The primary goal of these guidelines is to improve the quality of mental health care by providing standardized approach to assessment, diagnosis and treatment of common mental disorders. This will enhance the mental well-being of individuals, reduce the burden of mental illness and promote mental wellness.

The key objectives are:

1. To promote evidence-based practices in the management of mental health conditions by equipping healthcare workers with uniform skills and knowledge for assessment, diagnosis and treatment
2. To improve early detection and ensure appropriate timely interventions to prevent complications
3. To promote the integration of mental health services at primary care level in order to bridge the mental health treatment gap in the country

1.3. Target Audience

These guidelines are intended for a wide range of stakeholders including:

1. Health care providers including general practitioners, mental health professionals and other healthcare workers involved in mental health care.
2. Policy makers and health service managers responsible for planning, financing and overseeing mental health service delivery.
3. Community health workers are involved in facilitating referral and linkage to health care systems, providing health education, and offering basic psychosocial support.

1.4. Scope of the guidelines

This guideline focuses on the management of the following common mental disorders:

- Schizophrenia and other Psychotic disorders
- Depressive disorders
- Bipolar disorders
- Anxiety disorders
- Post Traumatic Stress Disorder (PTSD)
- Neurocognitive disorders (Alzheimer's Dementia)
- Neurodevelopmental disorders (ASD, ADHD)
- Somatic symptom disorders
- Sleep-wake disorders
- Psychiatric emergencies (Acute Psychosis, Delirium, Substance withdrawal and overdose, Self-harm, Suicide, EPSE)
- Maternal mental illness (Postpartum depression and birth-related PTSD)

They apply to various healthcare settings including:

- Primary Health Care
- Secondary and Tertiary facilities
- Community outreach programs

They should be implemented at service delivery points to facilitate convenient interaction with relevant service providers, accompanied by comprehensive algorithms for swift and accessible reference.

1.5. Limitations

These guidelines do not cover all mental health conditions outlined in the DSM-5 and ICD-11 but focus on the most prevalent mental disorders based on trends in Kenyan healthcare services.

1.6. Guiding principles

These guidelines were developed as guided by the following principles:

- **Evidence-based Interventions**: Management of various conditions is informed by evidence and best practices in the world.
- **Policy and legal framework[1]:** The guideline is guided by the available Kenya Health policy, Kenya Mental Health Policy, and Mental Health Act 2022 amongst other Kenya health policies.
- **Quality of care:** These guidelines aim to attain the highest standards of care and improve outcomes in the delivery of mental health care services.
- **Cost-effectiveness:** These guidelines aim to have quality outcomes, employing affordable, acceptable, and accessible mental health diagnostic and management modalities.
- **Integrated care:** The guidelines promote a collaborative, multidisciplinary approach among health care providers with seamless referrals and integrated treatment plans across various healthcare settings.
- **Human Rights and Ethical approach:** The guideline is oriented to a human rights and patient-centered approach by the WHO QualityRights Mental Health initiative. It emphasizes the need to respect patient autonomy and dignity (World Health Organization, 2017).
- **Universal Health Care approach:** The guidelines aim to build the capacity of primary healthcare providers to increase universal access to mental health services across the country

1.7. Guideline Development Process

The guidelines were developed through a comprehensive stakeholder engagement process, led by the Ministry of Health through the Division of Mental Health, ensuring the inclusion of diverse perspectives and expertise. This collaborative approach involved a series of workshops for content development and validation, where healthcare professionals, industry experts, and policymakers actively participated. This facilitated in-depth discussions, allowing for the integration of the latest evidence-based best practices and real-world needs and experiences of all relevant parties. The collaborative efforts ensured that the guidelines were not only scientifically robust but also practical and applicable in various healthcare settings.

1.8. Structure of the document

The guideline is organized as follows:

Section 1: Introduction: An overview of mental health and background information on the document
Section 2: Approaches To Management of Common Mental Disorders: General guidelines for assessing, diagnosing and treating mental disorders.
Section 3: Management of Specific Common mental disorders: Step -by-step guide in the management of the listed common mental disorders.
Section 4: Psychosocial Interventions for mental health.
Section 5: Annexes, References & List of Contributors.

SECTION 2: APPROACHES TO MANAGEMENT OF MENTAL HEALTH DISORDERS

2.1. Key Component of the Management Approach

The approach to the management of mental health conditions involves varied and comprehensive strategies tailored to each individual's needs. They involve the integration of medical, psychological, and social interventions delivered in a continuum of care by a multi-disciplinary team of healthcare providers.

Table 1: Key components of the management approach

Component	Description	Goal
Comprehensive Assessment	Evaluation of an individual's physical, psychological, emotional, and social well-being. This involves taking detailed medical and psychiatric history, conducting physical and mental status examinations, and utilizing standardized assessment tools.	To identify symptoms, diagnose conditions, and formulate a treatment plan. To understand the individuals' overall mental health, including any potential co-occurring disorders, risk and protective factors, social circumstances and needs.
Treatment Planning	Development of treatment plans that address individual's specific needs including their mental health condition, co-occurring physical illnesses, social needs and treatment preferences. These plans often combine pharmacotherapy, psychotherapy and social interventions (biopsychosocial approach). Treatment plans should be personalized and flexible, adapting to the individual's evolving needs and responses to treatment.	To set clear, achievable goals for treatment to guide progress and evaluate effectiveness.
Pharmacotherapy and medication management	Use of medications that may include antidepressants, antipsychotics, mood stabilizers, and anxiolytics,	To alleviate symptoms, improve functioning, and

Component	Description	Goal
	prescribed based on the diagnosis and individual response. Regular follow-ups are necessary to monitor efficacy, manage side effects and make necessary adjustments to ensure optimal results	enhance the quality of life for individuals
Psychotherapy	Engagement in various forms of talk therapy, therapy, such as cognitive-behavioral therapy (CBT), interpersonal therapy, dialectical behavior therapy (DBT), and other evidence-based therapies tailored to address specific mental health conditions and individual needs. Psychotherapy can be used alone or in conjunction with medication.	To help individuals understand and manage their thoughts, emotions, and behaviours. It provides a supportive environment where patients can explore their feelings, identify underlying issues, develop coping strategies, and work through challenges.
Psychoeducation	Educating individuals and their families and/or their caregivers about their condition, treatment options, and coping strategies.	To help patients and caregivers understand the diagnosis, recognize symptoms, adhere to treatment plans, and make informed decisions about their care. It helps reduce stigma, enhance self-management skills, and foster a collaborative approach between patients, their families, and healthcare providers.
Social support and rehabilitation	Providing practical assistance to individuals to manage their conditions, and regain or improve	To promote long-term recovery, prevent relapse, foster a sense of purpose

Component	Description	Goal
	functional abilities and quality of life, through community reintegration, vocational training, social skills development, and life skills training. This is achieved by working with network of family, friends, support groups, and professionals.	and belonging, and improve overall quality of life.
Long-Term Maintenance	Regular follow-up appointments to monitor progress, adjust treatment plans as necessary, and provide ongoing	To provide long-term support, prevent relapse and maintain mental well-being
Referral and linkage	Directing and facilitating access to appropriate services and resources tailored to patients' specific needs including specialized treatment and support services	To provide comprehensive, timely, and coordinated care, enhancing the effectiveness of treatment plans and improving patient outcomes.

Table 2: Key Principles in Supporting Individuals with Mental Illness

Principles of helping someone manage mental illness
1. Collaborate with the Patient: Develop a treatment plan together, assess their readiness for treatment, and encourage symptom monitoring and help-seeking behaviour. 2. Educate the Patient: Provide information on the treatment duration, potential medication side effects, alternative options, importance of adherence, and likely prognosis. 3. Involve Family and Community: Engage the patient's family in their care and connect them to community support resources. 4. Ensure Effective Follow-Up: Provide consistent and appropriate follow-up care. 5. Facilitate Specialist Referrals: When necessary, refer the patient to specialists. 6. Promote Holistic Treatment: Address both mental and physical health needs. 7. Take Extra Care with Specific Demographics: Pay special attention to children, the elderly, and women of childbearing age.

2.2. Comprehensive mental health assessment

A comprehensive mental health assessment typically consists of several key components to thoroughly evaluate the patient's psychological, emotional, and social well-being as follows:

Table 3: Key components of comprehensive mental health consultation

PARAMETER	DETAILS
Presenting complaint	• This should be from either the patient and/or the next of kin (or person accompanying the patient) • Ask open-ended questions • Include all present signs and symptoms

History of Presenting Complaints	• Ask probing questions
	• Explore each the presenting complaint in more detail as follows:
	  ○ Nature
	  ○ Onset
	  ○ Triggers
	  ○ Exacerbating/relieving factors
	  ○ Progression
	  ○ Associated symptoms or disability

Medical history	• Significant medical illnesses both current and past • Infectious diseases history/chronic diseases • Hospitalizations • Accidents/injuries • Systemic review • Surgical history • Current and past medications • Current health care providers • Allergies
Psychiatric history	• Symptoms/mental illnesses • Suicide attempts or thoughts • Type of treatment(s) • Medication treatment • Hospitalizations
Family history	• Family tree • Family environment, relationships and support • Family medical and psychiatric history including suicidal behavior • Substance use in the family
Premorbid personality	• "How would your family or friends describe you when you were well?" • Reactions and attitudes to various things in life • Level of socialization (introvert or extrovert)

PARAMETER	DETAILS
Personal & social history	• Birth and early development • Education • Employment and occupations • Marital status and children • Living situation • Criminal history and legal issues • Social responsibilities • Housing status and safety concerns • Employment • Social support systems • Religious affiliations and beliefs
Drug use history	• Types substances (licit and illicit), ever used and current use • Age of onset/duration of use • Effects of substance use on physical, psychological, and emotional/social functioning • Changes in patterns of substance abuse, withdrawal signs and symptoms, tolerance • Modes/route of substance abuse • Current level of use • Addiction treatment history and outcomes
Psychosexual History	• For females: menarche, Last Normal Menstrual Period, Parity, Family planning • Sexual practices • Sexual partners; history of sex work • Sexual orientation • Sexual abuse

2.3. Mental State Assessment

1. **Appearance**: How does the patient look? Neatly dressed in clear attention to detail. Well groomed?
2. **Attitude & Behavior:** Pleasant? Cooperative? Agitated? Appropriate for the situation? Any abnormal mannerisms?
3. **Speech:** Is it normal in tone, volume and quantity? Is it slow, very rapid, coherent or incoherent?
4. **Mood:** How do they feel? You may ask this directly (e.g. "Are you happy, sad, depressed, angry?"). Is it appropriate for their current situation?
5. **Affect:** How do they appear to you? This interpretation is based on your observation of their interactions during the interview. Do they make eye contact? Are they excitable? Does the tone of their voice change? Common assessments include flat (unchanging throughout), excitable, and appropriate.

6. **Thought Process**: This is a description of how they think. Are their comments logical and presented in an organized fashion? If not, how off-base are they? Do they tend to stray quickly to related topics? Are their thoughts appropriately linked or simply all over the map?
7. **Thought Content:** A description of what the patient is thinking about. Are they delusional (i.e. hold untrue beliefs)? If so, about what? Phobic? Hallucinating (you need to ask if they see or hear things that others do not)? Fixated on a single idea? If so, about what? Is the thought content consistent with their effect? If there is any concern regarding possible interest in committing suicide or homicide, the patient should be asked this directly, including a search for details (e.g. specific plan, time etc.).
    a) **Note:** These questions have never been shown to plant the seeds for an otherwise unplanned event and may provide critical information, so they should be asked!
8. **Perception:** do they hallucinate i.e. hear voices that others cannot hear (auditory), see, feel, taste or smell things without any obvious stimuli? Do they have illusions i.e. misinterpreting some stimuli like thinking a shadow of a tree is someone?
9. **Orientation:** Do they know where they are and what they are doing here? Do they know who you are? Can they tell you the day, date and year?
10. **Memory:** immediate recall is assessed by listing three objects, asking the patient to repeat them to you to ensure that they were heard correctly, and then checking recall at 5 minutes. Recent memory is tested by asking about events in the last few days/weeks while remote is testing memory of events in the distant past
11. **Attention & concentration** is tested by asking the person to do simple arithmetic such as serial 3 or 7 subtraction, and naming days of the week/months of the year backwards.
12. **Judgment:** Provide a common scenario and ask what they would do (e.g. "What would you do if you saw a child in a burning house?").
13. **Insight:** ask about the patient's awareness of his illness, whether he requires treatment and understanding of the nature of treatment.

2.4. Diagnostic Tests in Mental Health Conditions

Introduction

Diagnostic tests are an important part of the assessment process to ensure that the individual has a full physical workup to rule out any physical causes or underlying illnesses that may be related to the presenting mental health problem.

Although there are no specific laboratory or medical tests that can definitively determine the presence of the vast majority of psychological or psychiatric disorders, there are several physical conditions and diseases that either present very similarly to certain mental disorders or predispose to certain psychological disorders.

Tests can also be costly and hence they are only ordered when medically necessary and within justifiable rationale; additionally, not all or even most of these tests are ordered on every patient. Some patients may not require any tests, or the relevant laboratory studies may have been done recently enough to provide the necessary information. Some

investigations may result in many abnormal findings, most of which may be clinically insignificant and may not affect patient management and outcome.

Therefore, diagnostic tests are highly individualized and are based on a comprehensive evaluation with some cases requiring further tests beyond those listed here.

1.4.1 Purposes of diagnostic tests

- **Diagnosis**: To identify any underlying physiological, genetic, and environmental influences such as medical conditions or substance use that might be causing or contributing to a psychiatric presentation.
- **Comprehensive care:** To screen for comorbid medical problems that may not be linked to mental health symptoms as part of comprehensive care.
- **Safety and Medication monitoring:** To provide a baseline for the safe initiation of medication, determine the proper medication and dosage for treating mental health disorders and monitor blood levels of certain psychotropic medications.
- **Health outcome monitoring:** objectively measure the outcomes of specific treatment approaches for both psychological and physical disorders to determine the effectiveness and adjust them to suit the patient's needs.
- **Predictive diagnosis:** Genetic testing is a growing field in psychiatry where the genomic composition of persons at risk of mental illness is evaluated enabling early intervention and thus preventing severe mental illness.

1.4.2 Types of tests

1. **Neuroimaging techniques**: these look at the structure or functioning of the brain and include;
    a) **Structural neuroimaging** such as magnetic resonance imaging (MRI) focuses on changes in the structure of the brain.
    b) **Functional neuroimaging** such as positron emission tomography (PET) that focuses on blood flow and areas of activation in the brain during specific physical, cognitive, and emotional states.
2. **Psychophysiological assessment techniques**: these are procedures such as the electroencephalogram (EEG) and evoked potentials, that measure changes in the nervous system.
3. **Laboratory tests:** Tissue tests such as blood and urine tests, that are used to determine the presence of medical conditions, infections and substance use.
4. **Neuropsychological/Psychometric tests:** these are specialized tests administered by psychologists trained in brain behaviour relationships to determine the presence of cognitive strengths and weaknesses that may be the result of brain damage, a psychological disorder, a neurological disorder, or a developmental disorder.

Table 4: Commonly prescribed tests

TEST	DESCRIPTION/ RATIONALE
Full Blood Count	Routine tests can detect conditions like anaemia or infection which may present with delirium or other psychological symptoms. An

TEST	DESCRIPTION/ RATIONALE
	increase in WBC may indicate an infection or the development of neuroleptic malignant syndrome. Some psychiatric medications may cause low white cell and /or platelet count.
Thyroid function test	Hyperthyroidism can result in symptoms of anxiety, mania or psychosis, while hypothyroidism can be associated with symptoms of depression or psychosis.
Liver function test	Liver disease may affect the metabolism of psychiatric medication and lower plasma protein binding thus increasing their level of activity including both intended effects and side effects. Liver enzymes can be raised by alcohol-induced liver disease and severe liver disease can cause high levels of ammonia which may present as hepatic encephalopathy.
Kidney function test	Urinalysis, blood creatinine, urea, nitrogen and electrolytes monitoring can help identify any underlying physiological contributors to or complications of a patient's mental disorder and assess the safety of initiating certain medication.
Virological Tests	HIV testing, Hepatitis B & C testing are useful baseline tests, especially for persons who inject drugs and in cases of Sexual Violence. HIV may also result in AIDS dementia which presents with cognitive impairment.
Vitamin and Mineral deficiency tests	Essential vitamins and minerals are critical building blocks for brain health and deficiencies may worsen symptoms of mental illness or alter mood and cognition. Deficiencies in folate or vitamin B12 can manifest as depression, cognitive impairment, and persistent tiredness. Similarly, low levels of zinc, magnesium, and iron have been linked to anxiety and depression
Toxicology screening	Many substances of abuse can alter a person's perception or worsen a mental illness. Substance abuse is often a frequent comorbid condition with many psychiatric illnesses. Toxicology testing can determine if a person has drugs or toxins in their body
Medication level monitoring	Certain medications used in psychiatry such as lithium need continuous blood level monitoring to ensure dosage is within therapeutic ranges and avoid toxicity.
Liver Function Tests	Liver enzymes can be raised by alcohol-induced liver disease such as alcoholic cirrhosis as well as other causes. Liver disease resulting in high levels of ammonia can cause hepatic encephalopathy which includes lethargy and delirium. Liver disease which results in lowered plasma protein can cause some drugs to be less protein bound which increases their level of activity including both intended effects and side effects.

TEST	DESCRIPTION/ RATIONALE
VDRL	A VDRL test is performed in the case of dementia patients. This test is used to detect a syphilis infection. A long-standing syphilis infection can cause dementia-like symptoms
Blood Glucose testing	Altered blood sugar levels, either low or high, can be associated with delirium. Additionally, some antipsychotic agents cause metabolic syndrome with abnormal glucose tolerance and even lead to the development of diabetes mellitus. For this reason, patients on these drugs often have their fasting blood glucose levels monitored at regular intervals.
Biochemistry	For certain biomarkers for example CSF or blood tau or b-amyloid proteins in Alzheimer disease.
Neuroimaging	Neuroimaging with techniques like MRI, EEG, and fMRI helps to observe and study the structure and function of the brain. This technique is beneficial in identifying specific areas of the brain that do not function optimally in certain conditions. These tests can also be useful in detecting underlying disorders such as brain trauma and space-occupying lesions.
Psychometric tests	These can vary from personality tests such as the *Minnesota Multi-Phasic Personality Inventory* (MMPI), Intelligence tests such as *Wechsler Intelligence Scales,* tests specifically designed to measure aspects of an individual's mood e.g. *Patient Health Questionnaire* (PHQ-9) for depression, and other emotional states and psychological states e.g. GAD-9 for Anxiety)

2.5. Diagnostic Formulation

After completing the psychiatric assessment formulate the case summarizing the key features of the history, MSE and risk assessment, as well as (differential) diagnosis and management plan.

The case summary can be done using the 5Ps:

- Presenting symptom(s)
- Predisposing factor(s) – e.g. family history, circumstances in upbringing
- Precipitating factors(s) – e.g. any recent triggers
- Perpetuating factor(s) – e.g. on-going stressors
- Protective factor(s) – e.g. children, supportive family/friends, spiritual beliefs

SECTION 3: MANAGEMENT OF SPECIFIC COMMON MENTAL HEALTH CONDITIONS

Overview

This section will cover in detail the step-by-step management of the listed common mental disorders as per the format described below:

Introduction

This section gives a brief overview of the specific mental health condition.

Common Signs & Symptoms (Diagnostic features)

These refer to a particular disorder's generic characteristics, as the ICD 11 and DSM V TR indicates. It offers guidelines for making diagnoses, and clinical judgment should inform their use. A diagnostic feature follows a systematic criterion that helps identify the particular disorder. These signs and symptoms must cause significant distress to the individual because they cannot function well at school, work, or home.

Assessment

The Assessment section covers methods to diagnose mental health conditions by factoring in multiple clinical assessment points. A comprehensive clinical and psychiatric history is obtained, accompanied by a physical exam(s) and a mental status exam. Users of these guidelines must carry out a comprehensive assessment to develop a thorough clinical evaluation and management plan.

Diagnosis & Differential Diagnosis

There are no laboratory tests available for diagnosis of schizophrenia. Diagnosis is entirely based on clinical assessment and the fulfillment of a set of criteria.
A differential diagnosis means more than one possibility for a patient's diagnosis. The healthcare provider must then differentiate between the listed mental health conditions to arrive at the most plausible condition and make an appropriate treatment plan.

Management Plan

The Management section includes intervention details on managing the conditions assessed. This will include various investigations, and the proposed treatment, follow-up, and linkage plans.

Psychosocial Management

Psychosocial management focuses on a patient's mental, emotional, social, and spiritual aspects to help facilitate positive change in patients and improve the overall quality of their lives. This is achieved by assessment (history taking, MSE, Psychometrics (psychological test tools), suicide risk assessment tool), and psychoeducation.

Pharmacotherapy Management

Also known as pharmacological therapy, it refers to treating a mental health condition with medication.

Referral & Linkages

This section covers the biopsychosocial approach to treating a patient and the processes taken to ensure the holistic treatment of said patient. It also details procedures that need to be taken up to provide high-quality primary mental healthcare servibces.

3.1. Psychotic disorders

Introduction

These are conditions characterized by a loss of contact with reality, which manifest as altered thoughts, behaviour, or perceptions and cause significant impairment in various areas of functioning, including work, social relationships, and self-care.

3.1.1 Common Signs and Symptoms of Psychotic Disorders

The symptoms of a psychotic disorder can appear gradually or suddenly, can vary from person to person and can change over time. Patients may present with the following signs and symptoms:

- Unusual behaviour such as social withdrawal, violent or aggressive behaviour.
- Neglect of usual responsibilities related to work/school/domestic chores
- Neglected personal hygiene and unkempt appearance
- Disturbed sleep and appetite
- Cognitive disturbances presenting as problems with concentration or paying attention for long periods making it difficult to follow conversations or learn new things.
- Altered mood and effects include appearing indifferent to loved ones, disconnected or cut off from the world, bursting out laughing or getting angry for no reason.
- Hallucinations
- Delusions
- Formal thought disturbance
- Motor abnormalities such as being agitated, having difficulty with goal-directed behavior or abnormal body movements or posture.
- Negative symptoms such as reduced emotional expression, decreased motivation, diminished ability to feel pleasure, withdrawal from social interaction and difficulties in normal functioning.

3.1.2 Types of Psychotic Disorders

The main types of psychotic disorders include:

- **Schizophrenia:** a chronic illness that manifests with several symptoms of psychosis that last longer than six months leading to significant functional impairment
- **Schizoaffective disorder:** a chronic disorder that presents as a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder which may occur at the same time or at different times with episodes of severe symptoms often followed by periods of improvement.
- **Delusional disorder:** the main symptom of this condition is delusions, where individuals have one or more unshakeable false beliefs and ideas.
- **Brief psychotic disorder:** this condition presents with psychotic symptoms that appear suddenly, often triggered by a major stressor, and lasts for a short duration, no

longer than a month, after which the person may return to normal functioning after treatment.

- **Substance-induced psychotic disorder:** a condition in which individuals lose touch with reality while using or shortly after using substances such as alcohol, drugs, or medication.

For the purposes of this guideline, we shall focus on the management of schizophrenia.

3.1.2.1 Schizophrenia

This is a chronic mental illness that manifests with several symptoms of psychosis that last longer than six months leading to significant functional impairment.

3.1.2.2 Diagnostic criteria

Table 5: Diagnostic criteria for schizophrenia

Diagnostic Criteria for Schizophrenia
A. At least **two** or more of the following symptoms must have been present for a significant portion of time for one month (or less if successfully treated), with at **least one being** items **1, 2, or 3;** 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly disorganized or catatonic behavior. 5. Negative symptoms
B. The symptoms persist for at least six months (including the 1-month acute phase)
C. The symptoms are not attributable to the physiological effects of a substance, medications, or any other medical condition.
D. The symptoms are sufficiently severe to cause marked impairment in social or occupational functioning

3.1.2.3 Assessment

Assessment includes thorough history taking, physical examination and a mental state examination.

3.1.2.4 Management of Schizophrenia

Comprehensive investigations must be done to rule out organic causes of psychotic symptoms and identify comorbidities.

Investigation may include:

- Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test,
- Urine toxicology tests
- Imaging (ECG, CT scan and MRI).

Other investigations may be considered based on the patient's presentation.

In case a patient tests positive for any of the above tests, manage as per medical condition and consider the possibility of co-morbidity in the background of mental illness.

Comprehensive treatment, which is delivered either at an outpatient or inpatient setting, should include psychological, social, and pharmacological management and based on the illness stage (either acute or maintenance).

3.1.2.5 Treatment Setting Consideration

Outpatient setting for: –

- Mild to moderate symptoms
- Good social support

Inpatient treatment should be considered for

- Severe psychotic symptoms
- Aggressive behaviour that puts self or others at risk
- Persistence of significant symptoms not responding during outpatient care.
- Poor social support
- Lack of insight
- Need to evaluate for or manage underlying medical conditions

3.1.2.6 Pharmacological Management

Pharmacological management with antipsychotic medication forms the cornerstone of treating schizophrenia. Treatment can be broadly divided into acute and maintenance phases. The acute phase of treatment aims to reduce symptoms, prevent harm to self/others and improve biological functioning. The goal of the maintenance phase of treatment is to prevent relapse and help patients improve their level of functioning.

Two classes of antipsychotic drugs are available, typical antipsychotics and atypical antipsychotics as oral formulations, fast-acting or depot injections. Both groups are equally effective but differ in their side-effect profiles. Antipsychotic medications should be started depending on clinical status.

Factors to Consider when Choosing Medication

- Age of the patient – Oral medication is preferred for extreme ages
- If the patient has responded well to a particular drug in the past, use that drug again.

- Cost and availability of the drug
- Presence of co-morbid illness - If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side effects.
- Side effects of the drug
- Adverse drug reactions of the drug
- Start with the lowest effective dose, and build up to the maximum effective dose based on response and tolerability.
- Continue antipsychotics for at least two years after the condition improves
- Lifelong treatment may be considered for patients with chronic psychotic disorders such as schizophrenia

Consider appropriate use of medicine guided by assessment, start with a low dose, and titrate depending on clinical response and tolerability. Choose any **ONE** of the following medications and avoid switching medications unless there is poor tolerance to side effects and poor response to treatment after at least six weeks with adequate dosage and adherence.

Table 6: Antipsychotic Medication Dosage

	Acute Phase	**Maintenance Phase**
Haloperidol	Start 1.5-3 mg daily. Increase as needed (maximum 20 mg daily). Route: oral or intramuscular	Start at 5 mg OD. Increase by 5mg every two weeks. Max dose 20 mg Daily dose. Extreme ages start at 2.5mg Route: Oral
Chlorpromazine	Start at 100-200mg to a maximum of 400mg daily Route: Oral or IM	Start 25-50mg daily. Increase to 75mg-300mg daily dose. Route: Oral
Fluphenazine Decanoate		Start 12.5 mg. Use 12.5-50 mg every 2-4 weeks. Route: IM
Flupentixol Injection		20–40 mg after at least 7 days, then 20–40 mg every 2–4 weeks Route: IM
Zuclopenthixol Injection- Acute phase	Adult: 100 mg Elderly/physically ill: A quarter to half usual starting dose to be used Route: IM	
Zuclopenthixol decanoate		Start dose 100mg Then 200mg - 500 mg every one to four weeks Route: Deep IM Gluteal or thigh Injection

	Acute Phase	Maintenance Phase
Olanzapine	2.5 to 10 mg Route: IM	Adult: 5-10 mg daily, adjusted according to response, usual dose 5–20 mg. Max dose 20 mg per day Route: Oral
Risperidone		Start 1 mg daily. Increase to 2-6 mg OD Route: Oral
Quetiapine		Start 25mg, then increase by 25mg over one week to a Maximum dose of 300mg-400mg in divided doses a day Route: Oral
Aripiprazole		Start 10 -15mg OD Maximum dose 30mg OD Route: Oral
Paliperidone palmitate	Start 234mg Day 1; Then 156mg Day 8. 117mg -234 IM MONTHLY	After four months of treatment, maintain on 117mg-234mg monthly or convert to the 3 monthly at a dose of 273mg -819mg Route: IM

3.1.2.7 Treatment Resistance Schizophrenia

Treatment Resistance Schizophrenia (TRS) is defined as failure to respond to at least two antipsychotic medications given at an adequate dose, with sufficient adherence and for a minimum duration of six weeks.

Clozapine is approved for use in TRS and is prescribed by a psychiatrist.

Before initiation, conduct the following baseline tests/ assessment:

FBC, body weight and BMI, fasting glucose, lipid profile, liver function tests, blood pressure, and ECG.

Dose: titrate the dose gradually over 2-4 weeks to reduce the incidence of adverse effects such as hypotension, neutropenia, and myocarditis.

Day 1: 12.5 mg, days 2–3: 25 mg, days 3–4: 50 mg and so on until a clinically effective, well-tolerated dose is reached. The usual maintenance dose lies between 300 and 600 mg per day

Monitoring: FBC weekly for the first 18 weeks of treatment, fortnightly for the next 34 weeks, and monthly thereafter.

3.1.2.8 Managing Side Effects

There should be ongoing monitoring of common side effects and appropriate management initiated when they occur.

1. For Extrapyramidal side effects (drooling of saliva, rigidity, fine tremors, acute dystonia): reduce antipsychotic dosage or give oral anticholinergic drugs, e.g.,

benzhexol or trihexyphenidyl. If symptoms are severe or persistent, switch to lower-risk atypical antipsychotics such as quetiapine.

2. Cardiovascular side effects (hypotension, bradycardia, QTc prolongation in ECG): These side effects require reducing dosage or switching to other agents.

3.1.2.9 Nonpharmacological Management

Electroconvulsive Therapy (ECT)

ECT is an effective treatment for some types of severe mental illness. ECT uses an electric current to cause a seizure in the brain and is one of the fastest ways to treat severe symptoms of mental illness. ECT is done with the informed consent of the patient or following the patient's advance directives.

The procedure is done under anaesthesia by a team of specialists with a prior comprehensive evaluation of patients for any medical contraindication to ECT.

ECT is a safe and effective treatment with indications of its use in patients with schizophrenia including:

- Treatment-resistant schizophrenia
- To augment pharmacotherapy
- Management of catatonia
- Presence of Suicidal behavior
- Severe agitation
- Clozapine-resistant schizophrenia

ECT should be administered 2 to 3 times a week for a total of 6-12 sessions.

Psychosocial Management

Evaluate psychosocial needs and make appropriate management plans and linkages. The interventions should include:

- Psychoeducation to the individual and family about the illness and treatment
- Establishing social support that can include support groups.
- Social skills training
- Occupational therapy and rehabilitation to improve the activities of daily living.
- Vocational and recreational support
- Appropriate psychotherapy

3.1.3 Follow-up care.

People with schizophrenia require regular follow-up. Once a patient is in remission or stable, follow-up can continue at the nearest facility and be referred to mental health clinics on a need basis.
In the acute phase, review can be once or twice weekly; in the maintenance phase, follow-up can be every one to three months.

The following should be assessed during follow-up visits:

- Level of symptoms
- Side-effects of medications
- Treatment adherence
- Concurrent medical conditions
- Psychosocial needs

3.1.4 Referral and Linkages

When to refer to specialized mental health services:

a) Based on the severity of illness:
   - Severe and persistent symptoms
   - Suicide behaviour
   - Risk of harm to others
   - Catatonic symptoms

b) Based on the nature of treatment:
   - Poor adherence to medication
   - Partial or no response to treatment after adequate duration
   - Need for electroconvulsive therapy.
   - Need to start clozapine.
   - Need for specific psychological therapies

When to refer to support systems:

- Poor social support system (e.g., homelessness)
- Family needs psychoeducation about the nature of illness and the need for treatment.
- Vocational rehabilitation.

Note:

Caution should be taken when managing

a) Children and adolescents
b) Pregnant and breastfeeding mothers
c) Older persons
d) Patients with other medical conditions.

This is due to varied symptoms, occasioned by other factors. Kindly refer to the section on special populations for further details.

3.2. Depression

Introduction

Depression is a mood disorder that causes persistent feelings of sadness and loss of interest or pleasure in previously rewarding or enjoyable activities. The effects of depression can be long-lasting or recurrent and can dramatically affect a person's ability to function and live a rewarding life.

The signs and symptoms are covered in diagnostic criteria A.

3.3.1 Diagnostic Criteria

Diagnosis of depression is based on clinical assessment whereby a person's symptoms must fit the following criteria:

Table 6: Diagnostic Criteria for Depression

Diagnostic Criteria for Depression
An individual must be experiencing at least five or more of the symptoms below during the same 2-week period and at least one of the symptoms should be either: 1) Low /sad mood 2) Diminished interest or pleasure in activities • Significant unintentional weight loss or weight gain • Decrease or increase in appetite. • Disturbed sleep pattern: insomnia or hypersomnia • Fatigue or loss of energy, • Decreased libido. • Feeling of worthlessness or guilt • Impaired cognitive functioning- Difficulty thinking, concentrating, or making decisions. • Recurrent thoughts of death or suicidal ideation with or without suicidal plans or attempts. • Agitation or slowing of movement or speech. • Self-neglect • Self-isolation **Irritability:** The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note:

Responses to a significant loss, such as bereavement, financial losses, a serious medical illness or disability, may include intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode.

Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode and the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for expressing distress in the context of loss.

The patient may present initially with one or more physical symptoms, e.g.; (fatigue, body aches) PHQ-9 can classify depression as mild, moderate, or severe (refer to appendixes).

3.3.2 Assessment for Depression

Assessment helps identify specific symptoms and explore medical and family histories and cultural and environmental factors to arrive at a diagnosis and plan a course of action. It includes;

- Comprehensive history taking obtained from all sources, including the family members.
- Mental status examination
- Physical examination
- Suicide risk assessment
- Investigations:

  There is no laboratory or radiological test to diagnose depression. However, it is important to conduct baseline tests to ensure the depression is not due to a medical condition like a thyroid disease or a vitamin deficiency.

  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test,
  - Specific test (toxicology),
  - Imaging (ECG, CT scan and MRI),
  - Other investigations may be considered based on the patient's presentation,

If a patient tests positive for any of the above tests, manage as per medical condition and consider the possibility of co-morbidity in the background of mental illness.

3.3.3 Differential Diagnosis

- Psychosis
- Bipolar mood disorder
- Mood disorder due to other medical conditions
- Alcohol and/or Substance-induced depressive disorders.
- Medications that may produce symptoms of depression (e.g., Antihypertensives, e.g., beta-blockers, H2 blockers, oral contraceptives, corticosteroids).

Management of Depression

Management is guided by the severity of depression. A combination of medication and psychotherapy has been associated with significantly higher improvement rates in more severe, chronic, and complex presentations of depression. Psychotherapy alone is effective in managing mild depression.

Consider inpatient management for:

- Suicidal behavior
- Refusal to eat
- Severe malnutrition
- Catatonia
- Comorbid medical or psychiatric condition that is significant
- Poor social support or unsafe home environment

3.3.4 Pharmacotherapy

Many types of antidepressants are available, including **Selective serotonin reuptake inhibitors (SSRIs), Serotonin-norepinephrine reuptake inhibitors (SNRIs), Tricyclic antidepressants** (TCAs)**, Monoamine oxidase inhibitors (MAOIs)**.

All antidepressants have been shown to have nearly equal efficacy in managing depression. Selective serotonin reuptake inhibitors (e.g. Fluoxetine) are considered the first-line antidepressants, with other preferred options being tricyclic antidepressants (e.g. Amitriptyline), mirtazapine and venlafaxine. The medication must be started in lower doses and titrated, depending on the response and the side effects experienced.

Factors to consider when prescribing medication

- The choice of antidepressants must be guided by the aim to relieve the patient's symptoms, particularly sleep, appetite, and libido
- Sometimes, different antidepressant medications may have to be tried before finding the one that works best for the individual
- Antidepressants may take about 2-4 weeks to take full effect therefore, avoid changing medication too soon unless due to severe side effects.
- Some medications need several weeks or longer for side effects to be tolerated
- Medications that have worked for patients in the past may be the preferred first choice.
- If medications are effective, they should be continued for 6-12 months and then reduced gradually if only one episode of depression has occurred.
- Longer duration of treatment, sometimes lifelong, may be considered for patients with recurrent episodes.
- Fluoxetine and Amitriptyline are the preferred first-line medication.
- All patients on antidepressants should be monitored for suicidal ideations.
- Avoid Fluoxetine in patients with suicidal ideations, especially in teenagers and young adults

The following are different types of antidepressants. Choose **ONE** and start with lower doses and titrate depending on response:

- P.O Fluoxetine -Initial dose 20mg/day in the morning. One can gradually increase the dose by 20mg weekly. Maximum dose 40mg. Preferable use in hypersomnia
- P. O Amitriptyline -Initial dose 25mg. One can increase by 25mg weekly. Maximum dose 75mg daily
- P. O Mirtazapine-Initial dose 15mg/day. Gradually increase the dose by 15mg weekly. Maximum dose 45mg. Avoid overweight patients.
- P.O Venlafaxine - Initial dose 75mg. One can increase the dose by 75mg weekly. Maximum dose 150mg OD.

3.3.5 Electroconvulsive Therapy (ECT)

ECT is found to be beneficial and efficient on its own or together with antidepressants in severe cases of depression and is indicated for the following;

- Suicidal behavior
- Refusal to eat
- Catatonia
- Treatment-resistant depression
- Medications not tolerated
- When ECT has been successful in the past
- Depression with psychotic symptoms

ECT should be administered 2 to 3 times a week for a total of 6-12 sessions.

3.3.6 Psychotherapeutic Management

Psychotherapy may be considered the first treatment line for patients with mild to moderate depressive disorder. Other factors that may suggest using specific psychotherapy as a first line include the presence of significant psychosocial stressors, intrapsychic conflict, and patient preference. Psychotherapy should nonetheless be used alongside medication in severe depression or as a follow-up upon recovery.

Different psychotherapy techniques, such as cognitive behavioural and interpersonal therapy, apply depending on assessment and needs.

Psychotherapy can help a patient to:

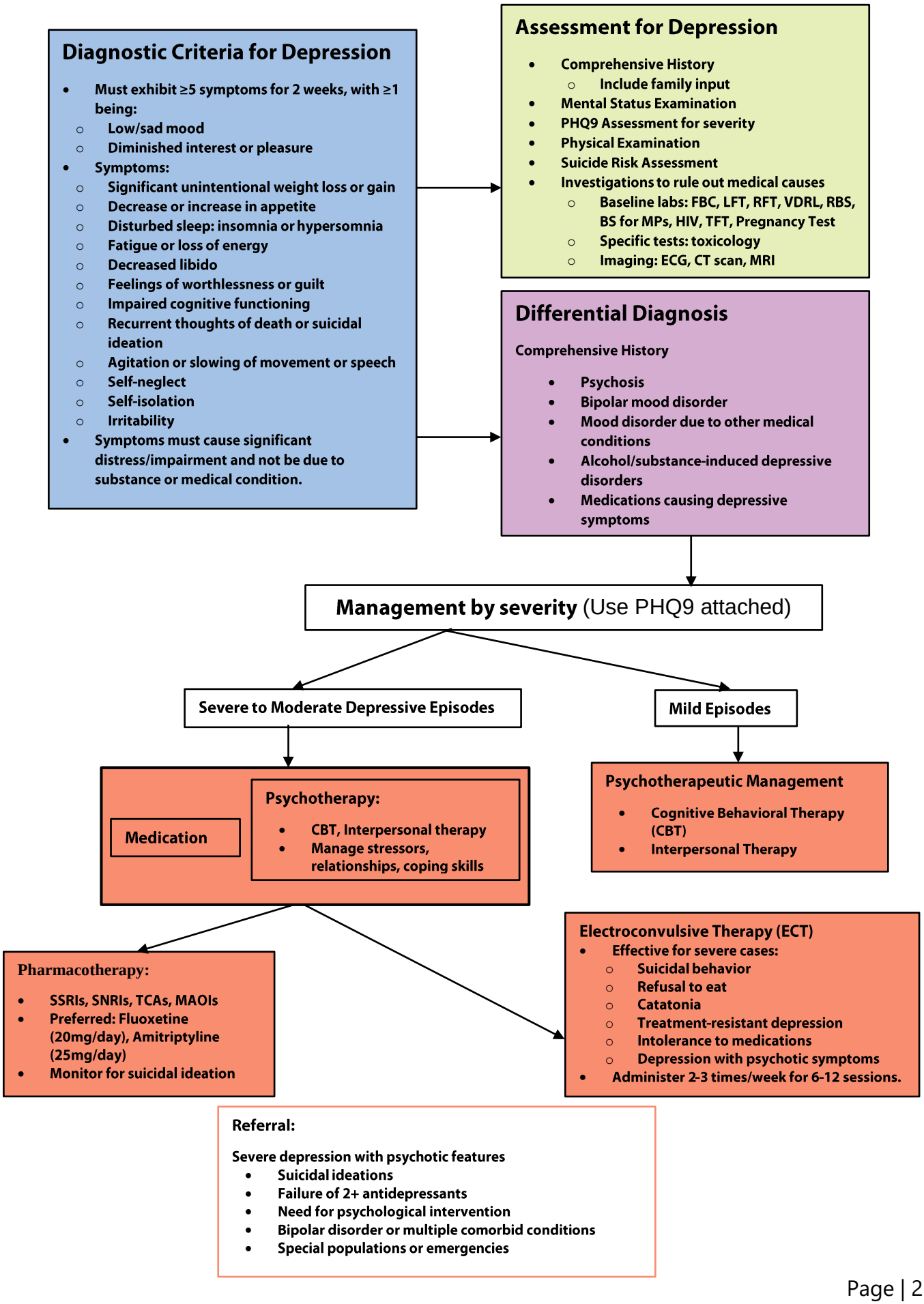
- Manage and adjust to a crisis or other current stressors
- Identify negative beliefs and behaviours and replace them with healthy, positive ones
- Explore relationships and experiences, and develop positive interactions with others
- Develop better coping and problem-solving skills
- Identify issues that contribute to depression and change behaviours that make it worse
- Regain a sense of satisfaction and control.
- Ease feelings of hopelessness, guilt or anger.
- Learn to set realistic goals.
- Develop the ability to tolerate and accept distress using healthier behaviours.

3.3.7 Referral and Linkage

Refer to a mental health specialist when;

- Patient has severe depression with psychotic features
- Suicidal ideations
- Failure of 2 or more antidepressants
- Psychological intervention needed (lack of resources)
- Bipolar affective disorder
- Multiple comorbid conditions
- Special population if not manageable.
- Any other emergency comorbid with mood disorder.

Algorithmic Summary Flow Diagram for Depression Treatment Protocol



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	___0___	+_____	+_____	+_____
				=Total Score: _____

If you checked off any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with others?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

3.3. Bipolar Disorder

Introduction

This disorder is characterized by extreme mood changes that alternate between high moods (mania or hypomania) and Low moods(depression).
The manic episode consists of high moods and excessive energy not consistent with the person's typical behaviour over one week or less if treatment is initiated.
At least one lifetime manic episode is required for the diagnosis of bipolar disorder.
The signs and symptoms are covered in the diagnostic criteria (B).

3.3.8 Diagnostic criteria for bipolar mood disorder

Table 7: DSM 5 Diagnostic Criteria for Manic Episode

DSM 5 Diagnostic Criteria for Manic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary). **B.** During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behaviour: 1) Inflated self-esteem or grandiosity. 2) Decreased need for sleep (e.g., feeling rested after only 3 hours). 3) More talkative than usual or pressure to keep talking. 4) Flight of ideas or subjective experience that thoughts are racing. 5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6) Increase goal-directed activity (either socially, at work or school, or sexually) or 7) psychomotor agitation (i.e., purposeless non-goal-directed activity). 8) Excessive involvement in activities with a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or poor business investments). **C.** The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features. **D.** The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition.

Note:

- Depressive episodes are as described in the depression section. At least one lifetime manic episode is required for the diagnosis of bipolar disorder.
- An episode during antidepressant treatment should be considered a manic episode if the symptoms are persistent even after stopping the treatment and the effects of the treatment are considered to have receded.
- Manic Episodes may or may not include delusions, hallucinations, or other psychotic symptoms.
- In children, the symptoms may border normal childhood behaviour or disruptive mood/ and must be assessed by a professional mental health provider.

3.3.9 Assessment

- History taking and mental status exam
- Vital signs and physical examination
- Suicide risk assessment

3.3.10 Differential diagnosis

- Major Depressive disorders
- Other bipolar disorders, e.g., Hypomania
- Anxiety disorders
- Substance /medication-induced bipolar disorder
- ADHD
- Other medical conditions that may cause bipolar-like mood symptoms, e.g., Hyperthyroidism HIV, Head injury, CNS Infections, CNS tumours, and Epilepsy among others.

Management plan for bipolar disorder

3.3.11 Investigations

- Investigate as necessary, mainly to rule out comorbid medical conditions, baseline for medication safety and any contraindication. They may include:
    - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test,
    - Urine toxicology
    - Imaging (ECG, CT scan and MRI).
- Other investigations may be considered based on the patient's presentation.
- If a patient tests positive for the above tests, manage as per medical condition and consider the possibility of co-morbidity in the background of mental illness.

The treatment of bipolar disorder is directly related to the phase of the episode (i.e., depression or mania) and the severity of that phase.

The goal of treatment is to manage the current acute episode, prevent relapse through medical and psychosocial interventions, and refer as appropriate.

3.3.12 Pharmacotherapy

This mainly targets control of behaviour in the acute stage and prevention of relapses in the long term. Medication is also helpful in improving psychosocial functioning.

Medication should be continued for at least two years after the condition improves and for a longer duration (sometimes lifelong) for patients with recurrent episodes.

a) Acute Manic Episode:

Antipsychotics and mood stabilizers effectively treat acute mania.

Mood stabilizers can be used as monotherapy; however, due to their delayed acute impact on symptom resolution, a combination with antipsychotics is recommended, especially in the presence of risky behavior, psychotic symptoms, and poor medication compliance. Medication should be started at a low dose and titrated gradually based on clinical response and side effects.

Stop all antidepressants that the patient may be taking.

Consider the following medications:

- Mood Stabilizer: either Lithium, Carbamazepine, or Valproate,
    - Lithium is preferably prescribed by a psychiatrist where baseline FBC must be done, and serum levels monitored (Recommended serum Lithium levels 0.9-1.2mmol/l). Avoid combining it with typical antipsychotics due to the increased risk of side effects.
    - Valproate should be avoided in women of child-bearing potential.
- Oral Antipsychotic: Chlorpromazine, Haloperidol, Olanzapine, Risperidone, Quetiapine, or Aripiprazole.
    - Typical antipsychotics may be fast-acting and effective but are more associated with somnolence and EPSEs.
- Parenteral Antipsychotic: Haloperidol, Chlorpromazine, Zuclopenthixol.
    - These are beneficial in the acute manic phase for those who are non-compliant with oral medication or have severe agitation but only for a short duration, then replaced by oral formulations.

Table 8: Table showing medication and its dosage for acute manic episode

Drug	Route	Dosage
Lithium carbonate	P. O	Starting dose: 400mg – 800mg /day in 2 or 3 divided doses, Titration: increase by 300mg/day every 3–4 days according to plasma levels Target dosages: 600-1500mg/day (not to exceed 1800mg/day).

Drug	Route	Dosage
Sodium Valproate	P. O	Starting dose: 750 mg/day in 3 divided doses Titration: increase by 250mg/day every 3–4 days as necessary and tolerated. Target dosages: 20–30mg/kg/day.
Carbamazepine		Starting dose: 200–400 mg/day, Titration: increase by 200 mg/day every 2–4 days. Target dosages: 600-1,200 mg/day
Aripiprazole	P. O	15mg/day increasing up to 30mg/day
Olanzapine	P. O	Starting dose: 5-10 mg once daily Titration: increase by 5-mg Max dose: 20 mg once daily
Risperidone	P. O	Starting dose: 2–3 mg daily in 1 or 2 divided doses, Titration: increase by 1 mg every 4-5 days Max dose up to 6 mg daily
Quetiapine	P. O	Day 1: 100mg/day Day 2: 200mg/day Day 3: 300mg/day Day 4: 400mg/day Further dose increase: no more than 200 mg/day to as high as 800 mg/day by day 6
Haloperidol	P. O	5–10mg/day increasing to 15mg if required
Haloperidol	I.M	5-10mg
Chlorpromazine	P. O	Starting dose: 75-150mg in 3 divided doses Titration: Increase by 25-50mg daily Maximum 400mg daily
Chlorpromazine	I.M	25-100mg
Zuclopenthixol acute phase	I.M	50-100mg

b) Acute presentation-depressive episode:

The patient presents with signs and symptoms meeting diagnostic criteria for a major depressive episode.

Treatment options include:

1. Quetiapine at a dosage of 300 mg/day, higher doses have no evidence of greater antidepressant efficacy
2. Combination of Olanzapine 5mg and Fluoxetine 20mg OD lurasidone as monotherapy or adjunctive therapy with lithium or divalproex.

3.3.13 Bipolar Maintenance Treatment

Note:

Antidepressants are not very useful in bipolar depression. They can cause mood destabilization (i.e., induction or exacerbation of mania symptoms or acceleration of cycling frequency).

You can choose to use either mood stabilizers or antipsychotics, as outlined in the table below.

Table 9: Covering medications used in treatment maintenance

Drug	Route	Dosage
Mood Stabilizers		
Lithium carbonate	P. O	Start with 400mg – 800mg /day in 2 or 3 divided doses, increasing every by 300mg/day every 3–4 days according to plasma levels (not to exceed 1800mg/day).
Sodium Valproate	P. O	Start with 250 mg three times a day(750mg/day), increase by 250mg/day every 3–4 days as necessary and tolerated. The dose is 20–30mg/kg/day.
Lamotrigine	P. O	50-100 mg O.D(preferred for in women of childbearing potential and, bipolar associated with depressive episodes).
Second Generation Antipsychotics		
Aripiprazole	P. O	15mg/day increasing up to 30mg/day as required34
Olanzapine	P. O	In adult monotherapy: initiate 10–15 mg once daily, increase by 5-mg as necessary and tolerated. Max 20 mg once daily. In adolescent monotherapy: start at 2.5–5 mg once daily and increase by 2.5- to 5 mg as necessary and tolerated, with a target dose of 10 mg once daily.
Risperidone	P. O	Start with 2–3 mg daily, increase by 1 mg daily to 6 mg daily. In children and adolescents, start at 0.5 mg daily, and increase by 0.5–1 mg daily up to 2.5 mg daily.
Quetiapine	P. O	100 mg/day on day 1, then increase to 200 mg/day on day 2, 300 mg/day on day 3, and 400 mg/day on day 4, and further increasing the dosage by no more than 200 mg/day to as high as 800 mg/day by day 6

Note:

Carbamazepine and Sodium Valproate: Due to the risk of teratogenicity, avoid in women or advice on birth control before initiating.
Quetiapine 50-300mg PO daily-best used for mixed episodes.

Long-acting injectable Antipsychotics for non-compliant patients. Use ONE

- Haloperidol decanoate 50–200mg IM monthly **OR**
- Fluphenazine decanoate 25–50mg IM monthly **OR**
- Zuclopenthixol decanoate 200mg IM monthly **OR**

Drugs for managing extrapyramidal effects (EPSE)

These refer to the various side effects caused by medication on the extrapyramidal system of the brain commonly caused by antipsychotic medicines.

The healthcare worker must monitor the causes of EPSE.

To manage EPSE:

- Reduce dosage.
- Change medication e.g., typical antipsychotics to atypical antipsychotics
- Use medication only when necessary:
    - P.O Benzhexol 5-10 mg PRN
    - P.O Biperiden 2-4 mg PRN

3.3.14 Psychological and Psychosocial Care

Involve family members in management.

See *Section 4* for **psychosocial care/management**

3.3.15 Electroconvulsive therapy (ECT)

ECT can be used for bipolar for patients who are resistant to medication treatment at adequate doses and with adherence for a sufficient duration or in manic episodes with severe agitation, and contraindications for medication in elderly or pregnant patients.

3.3.16 Referral and Linkages

When to refer:

- Episode is severe and not being controlled at the primary health care level
- A patient with bipolar depression
- Comorbid medical emergencies
- Special populations such as the elderly and pregnant women
- Need for medication serum monitoring

Who to refer to:

- To a psychiatrist in case of non-response to treatment
- Psychologist for psychotherapy
- Social worker for social economic assessment and support.
- Linkage with community resource persons

When to refer:

- If an acute episode is severe and not being controlled at a primary health care setting
- A patient with bipolar depression
- Medical emergencies comorbid with Bipolar mood disorder
- Special populations like the elderly, pregnant women and children and adolescent
- Toxicity with drugs

Algorithmic Summary Flow Diagram for Bipolar Treatment Protocol

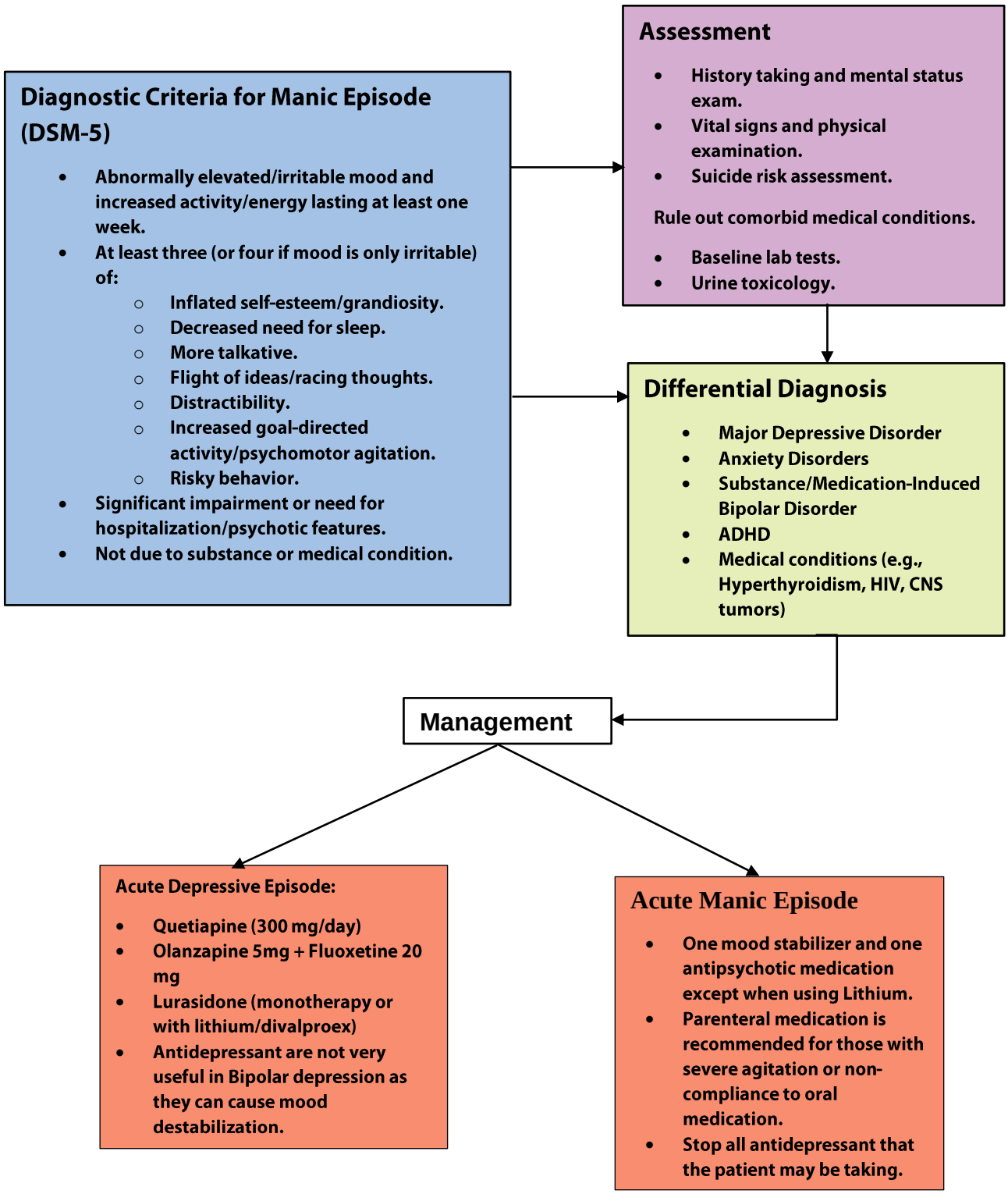


Table 10: Medication and Dosages for Acute Manic Episode

Drug	Route	Dosage
Lithium carbonate (Gold Standard, used as monotherapy)	P. O	Starting dose: 400mg – 800mg /day in 2 or 3 divided doses, Titration: increase by 300mg/day every 3–4 days according to plasma levels Target dosages: 600-1500mg/day (not to exceed 1800mg/day).
Sodium Valproate (Avoid in women of childbearing age)	P. O	Starting dose: 750 mg/day in 3 divided doses Titration: increase by 250mg/day every 3–4 days as necessary and tolerated. Target dosages: 20–30mg/kg/day.
Carbamazepine	P. O	Starting dose: 200–400 mg/day, Titration: increase by 200 mg/day every 2–4 days. Target dosages: 600-1,200 mg/day
Aripiprazole	P. O	15mg/day increasing up to 30mg/day
Olanzapine	P. O	Starting dose: 5-10 mg once daily Titration: increase by 5-mg Max dose: 20 mg once daily
Risperidone	P. O	Starting dose: 2–3 mg daily in 1 or 2 divided doses, Titration: increase by 1 mg every 4-5 days Max dose up to 6 mg daily
Quetiapine	P. O	Day 1: 100mg/day Day 2: 200mg/day Day 3: 300mg/day Day 4: 400mg/day Further dose increase: no more than 200 mg/day to as high as 800 mg/day by day 6
Haloperidol	P. O	5–10mg/day increasing to 15mg if required
Haloperidol	I.M	5-10mg
Chlorpromazine	P. O	Starting dose: 75-150mg in 3 divided doses Titration: Increase by 25-50mg daily Maximum 400mg daily
Chlorpromazine	I.M	25-100mg
Zuclopenthixol acuphase	I.M	50-100mg

Maintenance Treatment:

One can use either Mood Stabilizer or Antipsychotics

- **Mood Stabilizers: Lithium, Sodium Valproate, Lamotrigine.**
- **Antipsychotics: Aripiprazole, Olanzapine, Risperidone, Quetiapine.**

Long-acting injectables can be used for non-compliant patients (Haloperidol decanoate, Fluphenazine decanoate, Zuclopenthixol decanoate).

Monitor for extrapyramidal side effects and manage appropriately as outlined in the Section on Psychosis.

ECT: Indication

- **Those resistant to medication despite adequate dosages and adherence**
- **Manic episodes with severe agitation.**
- **Contraindication for medication in elderly or pregnant patients.**

Psychotherapy interventions are considered at this stage

- **Psychoeducation to both the patient and caregiver.**
- **Other therapies are recommended by the Psychologist.**

Referral and Linkages

When to refer:

- **Severe episodes not controlled at primary care level.**
- **Bipolar depression.**
- **Comorbid medical emergencies.**
- **Special populations (elderly, pregnant women, children).**

Who to refer to:

- **Psychiatrist for non-response to treatment.**
- **Psychologist for psychotherapy.**
- **Social worker for socio-economic support.**
- **Community resource persons for linkage.**

3.4. Anxiety disorders

Introduction

These are mental health disorders characterized by a feeling of worry or fear that is strong enough to interfere with daily activity.

Types of Anxiety Disorders

- Generalized anxiety disorder
- Panic disorder
- Social anxiety disorder
- Agoraphobia
- Specific phobias
- Separation anxiety disorder
- Selective mutism
- Substance/medication-induced anxiety disorder,

In this guideline, we shall focus on Generalized Anxiety Disorder, Specific Phobia, and panic disorders. The signs and symptoms are covered in diagnostic criteria A section

3.3.17 Generalized Anxiety Disorder (GAD)

This condition is characterized by constant persistent and excessive worry about several different everyday things when there is no apparent reason for concern.

Table 11: Diagnostic Criteria for Generalized Anxiety Disorder

Diagnostic Criteria for Generalized Anxiety Disorder
A) An individual must present with excessive anxiety and worry (apprehensive expectation), occurring on most days, for at least six months, which they find difficult to control. The worry can be about several events or activities (such as work or school performance). The anxiety is also associated with three or more symptoms for at least six months: • Restlessness or feeling keyed up or on edge. • Being easily fatigued. • Difficulty concentrating or mind going blank. • Irritability. • Muscle tension. • Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). **B)** The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C) The symptoms are not attributable to the effects of a drug, another medical condition or another mental disorder.

3.3.18 Panic Disorder

This disorder is characterized by recurrent unexpected panic attacks.

A **panic attack** is an abrupt rush of intense fear or sense of terror accompanied by intense physical and mental symptoms that occur suddenly for no apparent reason reaching a peak within minutes.

3.3.19 Diagnostic criteria

Table 12: Diagnostic criteria for panic disorder

Diagnostic Criteria for Panic Disorder
1. This disorder is characterized by recurrent unexpected panic attacks, during which four or more symptoms occur: • Palpitations • Sweating. • Trembling or shaking. • Shortness of breath. • Feeling of choking. • Chest pain/ discomfort. • Nausea/ abdominal distress. • Feeling dizzy, light-headed, or faint. • Fear of losing control. • Depersonalization (being detached from oneself). • Fear of Dying. • Paresthesia (numbness or tingling sensations). • Chills or heat sensations. **2.** At least one of the attacks has been followed by one month (or more) of one or both of the following: • Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”). • A significant maladaptive change in behaviour related to the attacks (e.g., behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations). **3.** The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. **4.** The disturbance is not better explained by another mental disorder.

3.3.20 Specific Phobias

Introduction

Specific phobias involve uncontrollable, unrealistic, persistent, intense fear and anxiety about a specific object, situation, circumstance, or activity. Some of the common phobias include fear of heights (acrophobia), being in confined spaces (Claustrophobia), animals (zoophobia), spiders (arachnophobia), flying (aerophobia)and fear of injuries related to blood.

3.3.20.1 Diagnostic Criteria

Table 13: Diagnostic criteria for specific phobic disorder

Diagnostic Criteria for Specific Phobic Disorder
• The individual suffers from a persistent fear that is either unreasonable or excessive, caused by the presence or anticipation of a specific object or situation • Exposure to the stimulus usually results in an anxiety response, often as a panic attack in adults, or a tantrum, clinging, crying or freezing in children • The person recognizes that their fear is disproportionate to the perceived threat or danger (not always present in children) • The phobic situation(s) is avoided or endured with intense anxiety or distress. • Fear, anxiety, or avoidance causes clinically significant distress, impairment, social occupation, or normal functions. • The fear is persistent, typically lasting for at least six months • The disturbance is not better explained by the symptoms of another mental disorder

3.3.20.2 Assessment

This involves taking a thorough history, mental state examination and a physical examination which help rule out any comorbid physical or mental disorders.

Laboratory investigations should be conducted at baseline to rule out medical conditions with similar presentations.

3.3.20.3 Differential Diagnosis

The common differential diagnosis for anxiety disorders that should be investigated include:

- Acute cardiac syndromes like anaemia, cardiac failure, arrhythmias, or angina
- Respiratory emergencies like asthma
- Endocrine disorders like thyrotoxicosis, Pheochromocytoma, hypoglycemia, and menopausal or premenstrual syndromes.
- Drug intoxication or withdrawal states.
- Allergic states like anaphylaxis should be ruled out.

Management plans specific phobias.

3.3.21 Pharmacotherapy

The use of medications should be done alongside psychotherapeutic techniques and should be considered for moderate to severe anxiety disorders or where psychotherapy does not work for mild disorders.

Selective Serotonin Reuptake Inhibitors (SSRIs) and Selective Serotonin Norepinephrine Reuptake Inhibitors (SNRIs are recommended as first-line drugs.

The onset of the anxiolytic effect of this medication has a latency of 2 to 4 weeks (in some cases, up to 6 weeks), and the dosage should be titrated gradually.

Tricyclic Antidepressants (TCAs) are equally effective in treating anxiety disorders. However, the frequency of adverse events is higher for TCAs than for SSRIs or SNRIs.

Choose **ONE** of the following medications:

Table 14: Table showing the medication used in the treatment of anxiety disorders

Medication for Anxiety Disorders		
Class	**Medication**	**Dose range**
SSRIs	Fluoxetine	20-40mg once daily
	Citalopram	20-40mg
	Escitalopram	10-20mg
	Sertraline	50-100mg
SNRIs	Venlafaxine	75-225mg
	Duloxetine	60-120mg
TCAs	Clomipramine	75-250mg
	Imipramine	75-200mg
	Amitriptyline	25-75mg

Use of Benzodiazepines in anxiety disorders

Current guidelines **DO NOT** recommend benzodiazepines as first-line treatments of anxiety disorders due to the association with impaired cognitive functioning especially in the elderly, Central Nervous System (CNS) depression and dependency. The risks and benefits should be carefully considered before treatment with benzodiazepine.

They may **ONLY** be used in exceptional cases (such as contraindications for the standard drugs, suicidality, and other conditions) and only for a very **LIMITED** period. They may also be used in combination with SSRIs/ SNRIs during the first weeks before the onset of efficacy of the antidepressants or for immediate management of acute panic attacks. Lorazepam at a dose of 1.0 to 2.5 mg (up to a maximum of 7.5 mg/day) may be given in such cases as needed.

Use of Beta Blockers in Anxiety Disorders

These medications can be used off-label in the short term to help reduce acute anxiety attacks' physical signs and symptoms. Use Atenolol 10-40mg per day or Propranolol 10-40mg per day.

3.3.22 Psychotherapy

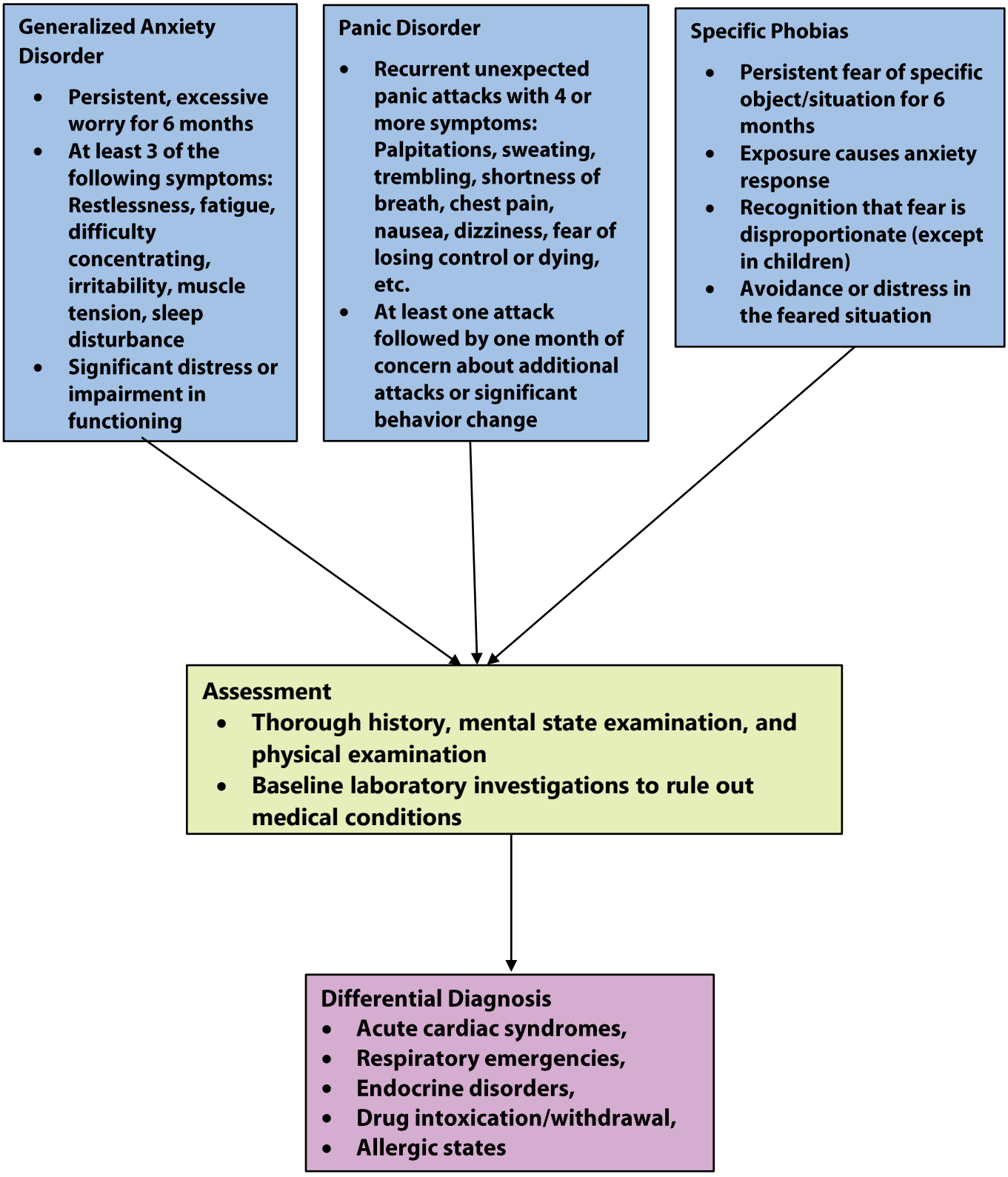
Psychotherapy is the mainstay of management for anxiety disorders especially for mild cases though moderate to severe may require a combination with medication.

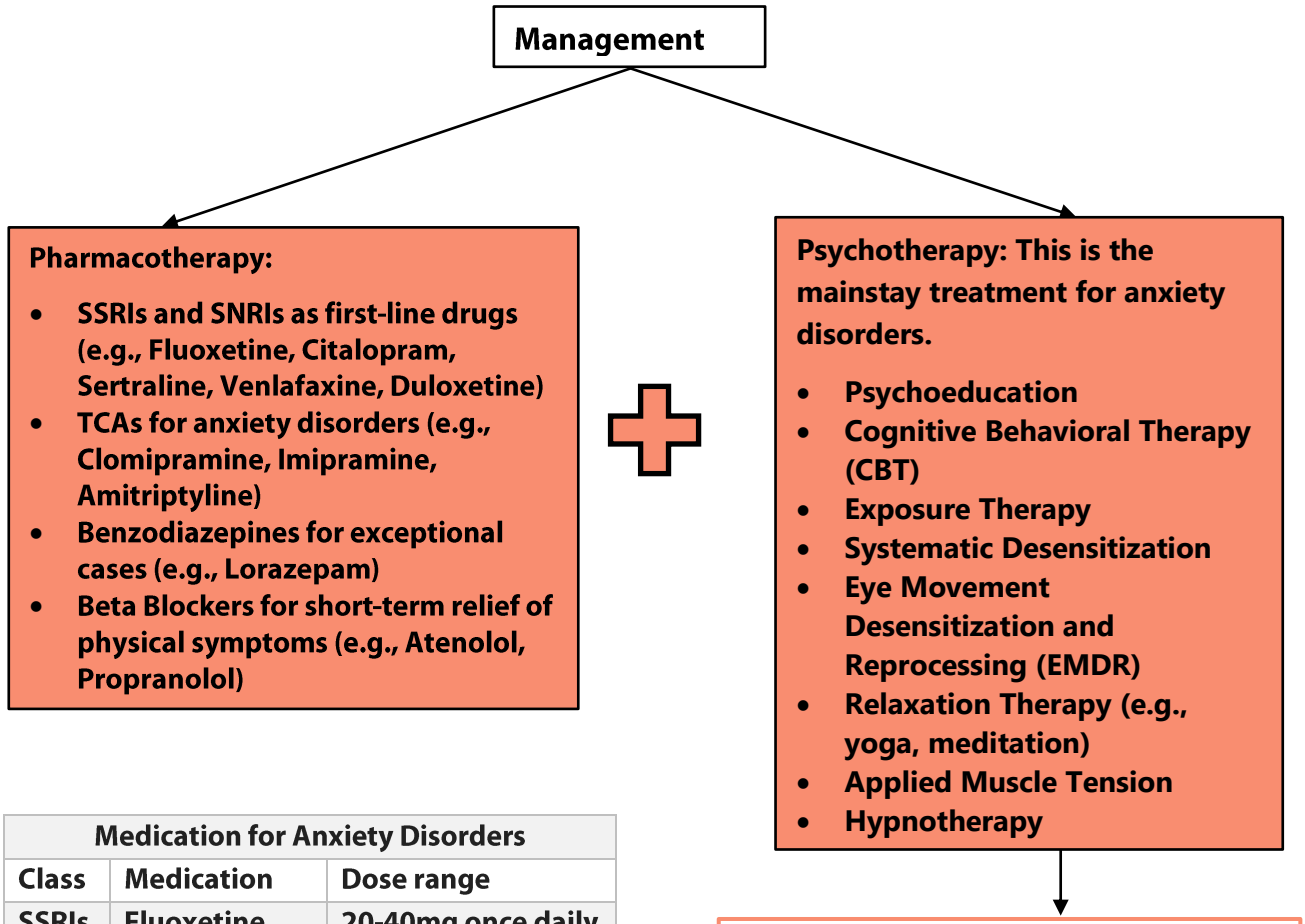
- Cognitive behavioral therapy (CBT): involves helping people learn to identify and change the automatic negative thoughts contributing to anxiety reactions.
- Exposure therapy: exposure therapy involves exposing people gradually and repeatedly, in their imagination or sometimes in reality, to whatever triggers their fear. People are also taught relaxation and/or breathing techniques before and during exposure. Exposure therapy is repeated until people become very comfortable with anxiety-provoking situations.
- Psychoeducation: provide patients and their relatives with information about the physiology of the symptoms of anxiety and the rationale of available treatment options
- Systematic desensitization
- Eye movement desensitization and reprocessing (EMDR)
- Relaxation therapy, yoga, meditation, exercise, and biofeedback techniques
- Applied muscle tension
- Hypnotherapy

3.3.23 Referral and Linkages

1. To a psychiatrist in case of non-response to medication
2. To a psychologist for psychotherapy
3. A social worker for socio-economic assessment and support.
4. Linkage with community resource persons

Algorithmic Summary Flow Diagram for Anxiety Disorder Treatment Protocol





Medication for Anxiety Disorders		
Class	**Medication**	**Dose range**
SSRIs	Fluoxetine	20-40mg once daily
	Citalopram	20-40mg
	Escitalopram	10-20mg
	Sertraline	50-100mg
SNRIs	Venlafaxine	75-225mg
	Duloxetine	60-120mg
TCAs	Clomipramine	75-250mg
	Imipramine	75-200mg
	Amitriptyline	25-75mg

Use of Benzodiazepines in Anxiety Disorders

Not First-Line Treatment: Benzodiazepines are not recommended as first-line treatments for anxiety disorders due to:

- **Impaired cognitive functioning, especially in the elderly**
- **Central Nervous System (CNS) depression**
- **Dependency risks**

Exceptional Use: Only for limited periods in exceptional cases, such as:

- **Contraindications for standard drugs**
- **Suicidality**
- **Other specific conditions**

Temporary Combination Therapy: Can be combined with SSRIs/SNRIs during the first weeks before antidepressants take effect or for immediate management of acute panic attacks.

Dosage: Lorazepam 1.0 to 2.5 mg (up to a maximum of 7.5 mg/day) as needed.

3.5. Post-Traumatic Stress Disorder

Introduction

Posttraumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have been exposed to or witnessed a traumatic event or near-death experience such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence, or serious injury.

It can also occur after learning that the traumatic event(s) happened to a close family member or close friend and was violent or accidental.

Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., paramedics, journalists, or police officers also poses a risk for this disorder. This does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work-related.

The symptoms must be present for over 1 month and cause significant dysfunction in daily living.

Table 15: Common Signs and Symptoms

Intrusive	Avoidance	Negative cognition and mood	Arousal /Reactivity
Intrusive thoughts	Avoiding reminders of the event	Blocking Important Aspects of the Trauma	Irritability and anger
Nightmares	Avoidance of memories, thoughts and feelings related to the event	Negative thoughts about self and the world	Self-destructive behaviour
Flashbacks		Casting blame upon themselves or others	Hyper-vigilance
Marked psychological distress at exposure to similar events		Persistent negative emotional state e.g., guilt, shame, anger, and fear	Exaggerated startle reflexes
Marked physiological reactions to similar cues		Diminished interest in favorite activities	Poor concentration
		Self-isolation and feeling distant	Sleep disturbances

Intrusive	Avoidance	Negative cognition and mood	Arousal /Reactivity
		Difficulty in experiencing positive emotions	

Note:

In children less than 6 years, the symptoms may present in play reenactment.

Table 16: Diagnostic criteria for children above 6 years and adults

Diagnostic criteria for children above 6 years and adults
A. **Exposure** to actual or threatened death, serious injury, or sexual violence with the duration of symptoms persistent for more than 1 month. **Intrusion** symptoms are associated with the traumatic event(s), beginning after the traumatic event(s) occurs, as above. **Persistent avoidance** of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, either 1 or both symptoms described above. **Negative cognition or mood** presenting with 2 or more symptoms described above. Marked alterations in **arousal and reactivity** associated with the traumatic event(s), beginning, or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the symptoms. **B.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. **C.** The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

3.3.24 Assessment

- History taking especially on traumatic events and mental status exam.
- Vital signs and physical examination
- Suicide risk assessment
- Investigations:
    - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test,
    - Specific test (toxicology)

    - Imaging (ECG, CT scan and MRI).
- Other investigations may be considered based on the patient's presentation.
- In case a patient tests positive for any of the above tests, manage as per medical condition and consider the possibility of co-morbidity in the background of mental illness.

3.3.25 Differential diagnosis

- Major Depressive disorder
- Anxiety disorder
- Adjustment disorder
- Acute stress disorder

Management plan for Post-Traumatic Stress Disorder

3.3.26 Psychological

MAINSTAY of treatment is psychotherapy:

- Trauma Focused Cognitive Behavioral therapy
- Exposure therapy
- Individual therapy

3.3.27 Social

- Psychoeducation to patients and caregivers
- Linkage to Social support
- Support groups
- See annex for further management.

3.3.28 Pharmacotherapy

- Antidepressants mainly Selective Serotonin Reuptake Inhibitors e.g., P.O Fluoxetine 20mg am.

3.3.29 Referral and Linkages

- To a psychiatrist in case of non-response to medication.
- Psychologist for psychotherapy.
- Social worker for social economic assessment and support.
- Linkage with community resource persons.

Algorithmic Summary Flow Diagram for PTSD Treatment Protocol

Introduction

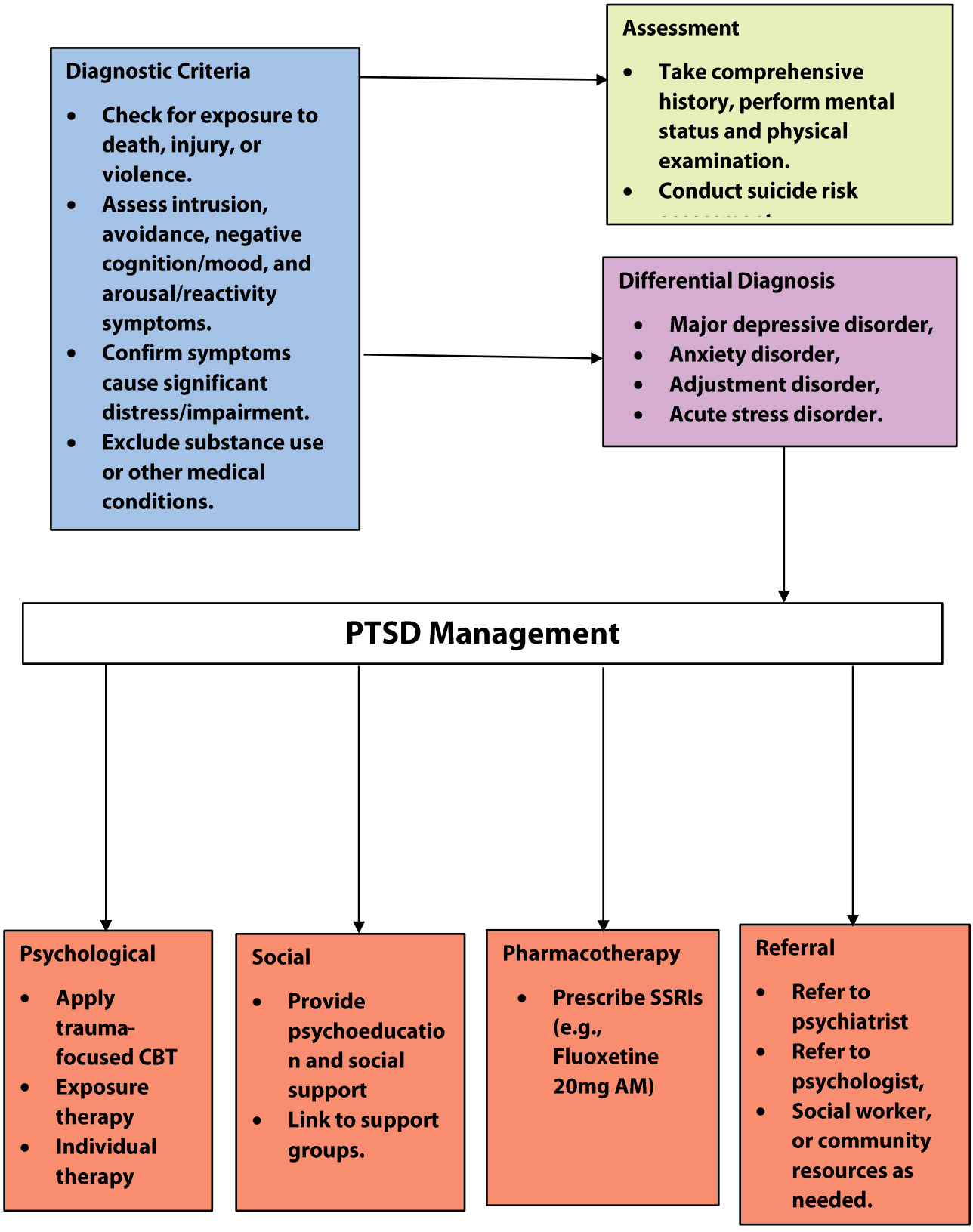
Post Traumatic Stress Disorder may occur:

- After Exposure to or witnessing a traumatic event or near-death experience
- In a person threatened with death, sexual violence, or serious injury
- After learning that the traumatic event(s) occurred to a close family member or close friend and were violent or accidental.
- After repeated or extreme exposure to aversive details of the traumatic event(s)

This does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work-related.

Table 17: Signs and symptoms can be classified as below

Intrusive	Avoidance	Negative cognition and mood	Arousal /Reactivity
Intrusive thoughts	Avoiding reminders of the event	Blocking Important Aspects of the Trauma	Irritability and anger
Nightmares	Avoidance of memories, thoughts and feelings related to the event	Negative thoughts about self and the world	Self-destructive behaviour
Flashbacks		Casting blame upon themselves or others	Hyper-vigilance
Marked psychological distress at exposure to similar events		Persistent negative emotional state e.g., guilt, shame, anger, and fear	Exaggerated startle reflexes
Marked physiological reactions to similar cues		Diminished interest in favorite activities	Poor concentration
		Self-isolation and feeling distant	Sleep disturbances
		Difficulty in experiencing positive emotions	


Diagnostic Criteria
Check for exposure to death, injury, or violence.
Assess intrusion, avoidance, negative cognition/mood, and arousal/reactivity symptoms.
Confirm symptoms cause significant distress/impairment.
Exclude substance use or other medical conditions.
Assessment
Take comprehensive history, perform mental status and physical examination.
Conduct suicide risk
Differential Diagnosis
Major depressive disorder,
Anxiety disorder,
Adjustment disorder,
Acute stress disorder.
PTSD Management
Psychological
Apply trauma-focused CBT
Exposure therapy
Individual therapy
Social
Provide psychoeducation and social support
Link to support groups.
Pharmacotherapy
Prescribe SSRIs (e.g., Fluoxetine 20mg AM)
Referral
Refer to psychiatrist
Refer to psychologist,
Social worker, or community resources as needed.

3.6. Neurocognitive disorders

Introduction

These are a category of mental conditions that impair cognition, cause neuropsychiatric disturbances, and progressively limit an individual's ability to meet the demands of everyday life flexibly and adaptively. They include:

- Delirium
- Major and mild neurocognitive disorder (NCD), previously called dementia.

The neurocognitive disorders can be a result of;

- Alzheimer's disease
- Frontotemporal lobar degeneration
- Lewy body disease
- Vascular disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson's disease
- Huntington's disease
- Another medical condition
- Multiple etiologies

3.3.30 Diagnostic Criteria

Table 18: DSM-5 Diagnostic Criteria for Major Neurocognitive Disorder

DSM-5 Diagnostic Criteria for Major Neurocognitive Disorder
A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on: 1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and 2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment. **B.** The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications). **C.** Cognitive deficits do not occur exclusively in the context of delirium. **D.** The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

3.3.31 Neurocognitive Disorder Due to Alzheimer's Disease

This guideline will focus on Alzheimer's as the commonest cause of mild and major neurocognitive disorders.

Table 19: DSM-5 Diagnostic Criteria for Major Neurocognitive Disorder

DSM-5 Diagnostic Criteria for Neurocognitive Disorder Due to Alzheimer's Disease
A. The criteria met for major or mild neurocognitive disorder. **B.** There is the insidious onset and gradual progression of impairment in one or more cognitive domains (for a major neurocognitive disorder, at least two domains must be impaired). **C.** Criteria are met for either probable or possible Alzheimer's disease as follows: *For major neurocognitive disorder:* Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, possible Alzheimer's disease should be diagnosed. 1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing. 2. All three are present: a. Clear evidence of the decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing). b. Steadily progressive, gradual decline in cognition without extended plateaus. c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular diseases or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline). ***For mild neurocognitive disorder:*** Probable Alzheimer's disease is diagnosed if there is evidence of a causative Alzheimer's disease or genetic mutation from either genetic testing or family history. Possible Alzheimer's disease is diagnosed if there is no evidence of causative Alzheimer's disease or genetic mutation from either genetic testing or family history, and all three of the following are present: 1. Clear evidence of a decline in memory and learning. 2. Steadily progressive, gradual decline in cognition without extended plateaus. 3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular. **D.** The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

3.3.32 Assessment

- Detailed history from patient and caregiver:
  - Assess for problems with memory and orientation, e.g., forgetting what happened the previous day, orientation of place.

  - Assess for difficulty performing key roles and activities, e.g., shopping, and cooking.
  - Assess the onset duration -slowly progressive for at least six months.
- Mental state Examination
- Vital signs and physical examination
- Suicide risk assessment
- Investigations:
  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT,
  - Vitamin levels – B12, Folate and thiamine,
  - Radiological investigations – EEG, MRI, CT SCAN, Amyloid PET scan
  - Biomarkers-CSF, Amyloid proteins
- Other investigations may be considered based on the patient's presentation.
- If a patient tests positive for the above tests, manage accordingly and refer where appropriate.

3.3.33 Differential diagnosis

- Delirium
- Major depressive disorder

Management plan Neurocognitive Disorder

Currently, there are limited options for definitive treatment of dementia, but the management should aim at reducing distress and improving the quality of life.

The management plan depends on holistic assessments and the application of multidisciplinary approaches/interventions to address the various needs and changing features across the course of the disease.

3.3.34 Pharmacotherapy

These medications may temporarily delay or slow down the cognitive decline in dementia and improve quality of life.

Table 10: Neurocognitive Medication Disorder

Drug	Initial dose	Target dose
Donepezil	5 mg/day	10 mg/day
Galantamine	4 mg bid (immediate release) or 8 mg/day (extended-release)	8 - 12 mg bid (immediate release) or 16 - 24mg/day (extended-release)
Rivastigmine	1.5 mg bid (oral) or 4.6 mg/day (transdermal)	3–6 mg bid (oral) or 9.5 mg/day (transdermal)
Memantine	5 mg/day	10nmg/day

- Refer to a Mental health professional for other mental disorders for appropriate diagnosis and management.
- Manage comorbidities, e.g., Diabetes Mellitus and hypertension appropriately.

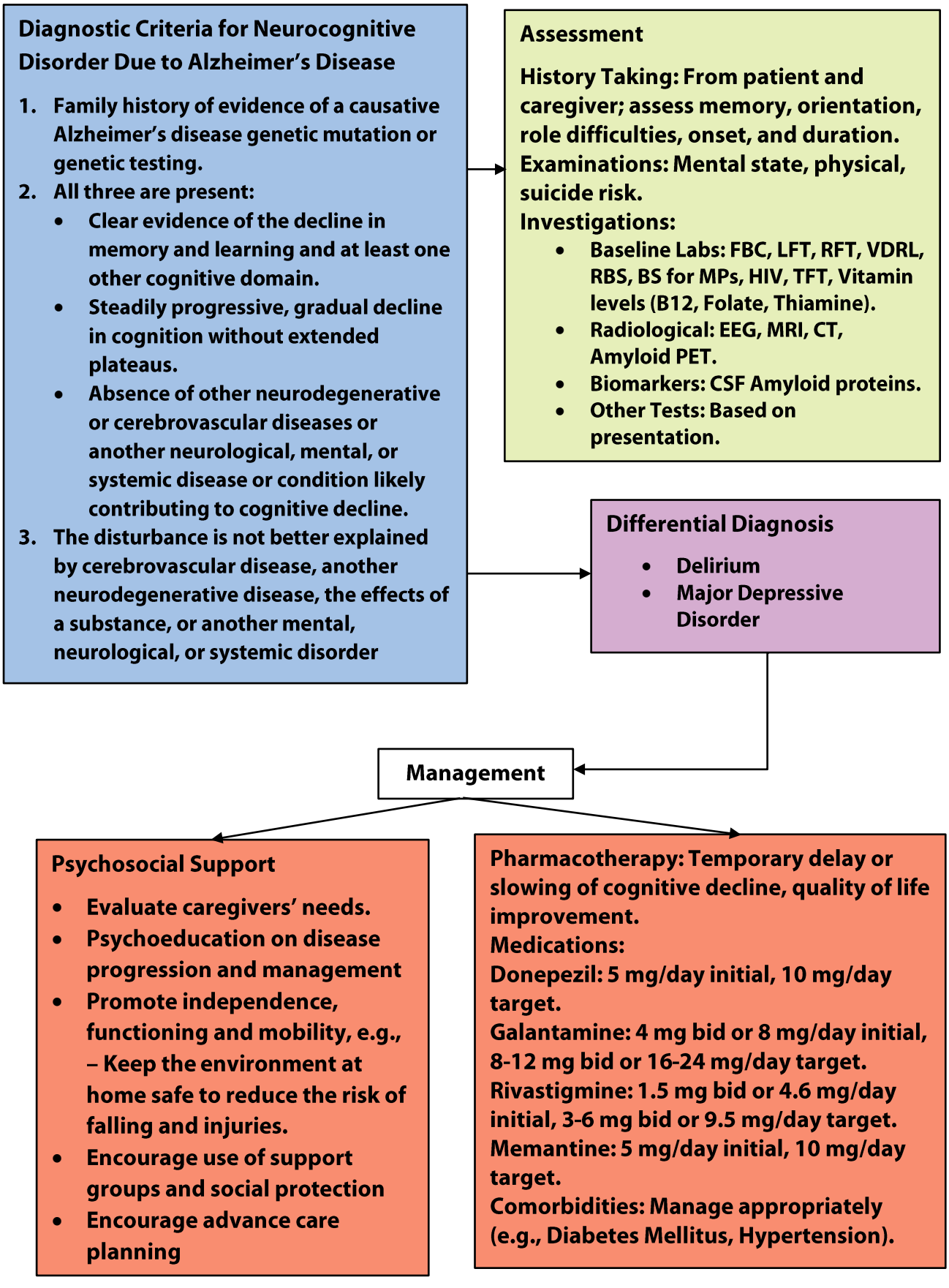
3.3.35 Psychosocial Support

- Evaluate caregivers' needs.
- Psychoeducation on disease progression and management.
- Promote independence, functioning and mobility, e.g., – Keep the environment at home safe to reduce the risk of falling and injuries.
- Stigma reduction, human rights protection, dementia-friendly communities.
- Evaluate the caregiver's needs and promote psychosocial support.
- Rehabilitation and palliative care.
- Support groups and social protection.
- Advance care planning.
- See annex for further management.

3.3.36 Referral and Linkages

1. To a specialist as guided by the assessment, e.g., Psychiatrist, Physician, Neurologist, among others.
2. Refer to a psychologist for psychotherapy.
3. Refer to a social worker for social and economic assessment and support.
4. Linkage with community resource persons.

Algorithmic Summary Flow Diagram for Neurocognitive Disorders Treatment Protocol



Referral and Linkages

- **Specialist Referral: Psychiatrist, Physician, Neurologist.**
- **Psychotherapy: Referral to a psychologist.**
- **Social Worker: Economic assessment and support.**
- **Community Resources: Linkage and support.**

3.7. Common Mental Disorders in Children and Adolescents

Mental disorders in children are common but inadequately addressed by the healthcare system. Children can develop the same mental health conditions as adults, but their symptoms may differ. Most present serious changes in how children typically learn, behave, or handle their emotions, resulting in distress and difficulties getting through the day.
Conducting a thorough assessment, and considering various factors, is essential to differentiate between typical developmental phases and potential mental health or neurodevelopmental problems. Early identification and intervention can significantly improve outcomes for children facing these challenges.
Some of the common mental illnesses in children include:

- Anxiety
- Depression
- Oppositional Defiant Disorder,
- Conduct Disorder
- Attention Deficit/Hyperactivity Disorder
- Posttraumatic Stress Disorder
- Eating Disorders
- Neurodevelopmental Disorders: Autism Spectrum Disorder, Disorders of Intellectual Development

Box 1: Warning signs for mental illness in children

- Persistent sadness
- Persistent boredom
- Withdrawing from or avoiding social interactions
- Hurting oneself or talking about hurting oneself
- Talking about death or suicide
- Outbursts of anger or extreme irritability
- More risk-taking behaviors
- Drastic changes in mood, behavior, or personality
- Changes in eating habits
- Weight changes
- Sleep problems like sleeping too much or too little, nightmares, sleepwalking.
- Frequent physical symptoms such as headaches or stomachaches
- Difficulty concentrating
- Changes in academic performance
- Regressive behavior such as bedwetting, throwing tantrums or clinginess.
- Avoiding or missing school

General Guidelines on the Assessment of Children

It is important to note the following about the assessment of children:

1) Children are unlikely to have initiated the consultation or may not agree with it.
2) A consultation may or may not be pursued for the most debilitating problem.
3) While children may be able to report the nature of symptoms, they may not be very good at reporting the timing and duration of their problems.
4) Children may refrain from reporting problems if they feel embarrassed or fear being portrayed negatively.
5) Clinical assessments should be elaborate with corroboration of information from multiple sources and in various settings.
6) Assessment should be multidisciplinary.
7) Information may also be gathered and staged to not overwhelm the child and family.
8) Information gathered must be shared among all professionals involved in caring for the child and family.
9) The role of writing, drawing, painting, and play should be considered in assessing children, as children may express themselves better this way than in oral interviews.

The purpose of assessment is to establish presenting behavioural and emotional problems, level of current and previous functioning in various settings, and strengths/assets of the child and the family.

Information may be gathered from non-family members such as teachers and caregivers, especially in cases where these non-family members spend more time with the child than the parents.

Assessment should include:

A. Thorough history, which covers:
- History of presenting complaints
- Past medical history
- History of physical or emotional trauma
- Family history of physical and mental illness
- Review of symptoms and general concerns with parents
- Timeline of child's developmental milestones
- Schooling/academic history
- Conversations with and observations of the child

B. Mental state assessment in children

This can be obtained by observations and specific questioning:

1. **Physical appearance;** observe for size, grooming, nutritional state, facial expressions, physical signs of anxiety and mannerisms.
2. **Parent-child interaction;** note this interaction and the emotional overtones.

3. **Separation and reunion:** observe for either a lack of effect or severe distress during separation and reunion.
4. **Orientation in time, place and person:** impairments may indicate intellectual disability (keep in mind the child's chronological age).
5. **Speech and language;** is it appropriate for age? Spontaneous? What is the rate of speech? Articulation? Echolalia? Repetitive stereotypic phrases, etc.
6. **Mood:** looking for sadness, lack of appropriate smiling, tearfulness, anxiety and anger may indicate a mood disorder. Persistent themes in play and fantasy may also reflect the child's mood.
7. **Affect:** note the child's range of emotional expressivity, appropriateness of affect to thought content, ability to move smoothly from one affect to another and sudden labile emotional shifts.
8. **Thought process;** look for loosening of associations, excessive magical thinking, echolalia, perseverations, and the ability to reason logically.
9. **Thought content:** delusions, obsessions, preoccupations, suicidal and homicidal ideations and aggressive thoughts.
10. **Social relatedness;** assess the appropriateness of the child's responses, their general level of social skills and eye contact.
11. **Motor behaviour:** observe the child's coordination and activity level and how they carry out age-appropriate tasks. Also, take note of any involuntary movements, such as tremors and motor hyperactivity.
12. **Cognition:** assessing the child's intellectual functioning and problem-solving abilities.
13. **Judgment and insight:** the child's view of the problems, reaction to them, and suggested solutions may indicate their judgement and insight

C. Complete physical exam

- Do a thorough head-to-toe examination to rule out any medical conditions.
- Check for any features suggestive of a syndrome such as Down syndrome, or cerebral palsy.
- Check for any marks of trauma.

3.3.37 Follow-up and Care for Mental Illness in Children and Adolescents

Children and adolescents with mental illness require regular follow-up. In the acute phase, review can be once or twice weekly; in the maintenance phase, follow-up can be every one to three months.

During follow-up visits, assess for the following:

- Level of symptoms
- Side-effects of medications
- Treatment adherence
- Psychosocial needs
- Function, especially school and milestones

3.3.38 Referral and Linkages

When to refer to specialized mental health services:

Based on the severity of the illness:

- Severe and persistent symptoms.
- Self-injurious or suicidal behaviour.
- Risk of harm to others.

Based on the nature of the treatment:

- Poor medication adherence.
- Partial or no response to treatment following sufficient duration.
- Need for specific psychological therapies.

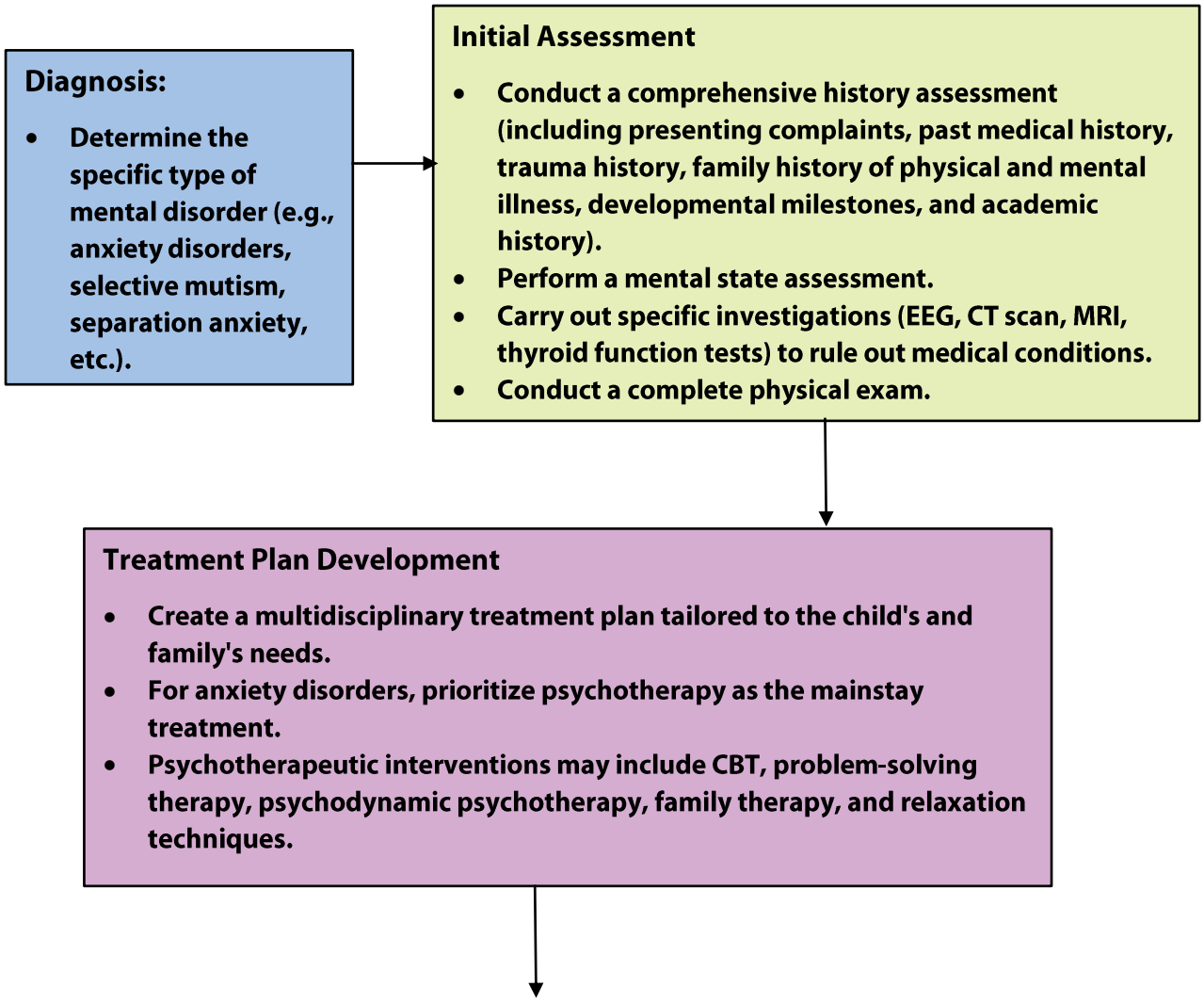
When to refer to support systems:

- When there are signs of neglect or abuse- link to the children's office for protection.
- Poor social support systems (e.g., homelessness)- link to existing community resources.
- Family needs psychoeducation about the nature of illness and the need for treatment.
- Difficulties with school – consider special schools and vocational centres.

Algorithmic Summary Flow Diagram for Common Mental Disorders in Children Treatment Protocol

Introduction

Mental disorders in children are common but inadequately addressed by the healthcare system. Children can develop the same mental health conditions as adults, but their symptoms may differ. Most present serious changes in how children typically learn, behave, or handle their emotions, resulting in distress and difficulties getting through the day.



Psychosocial Management

- **Implement supportive therapy strategies such as:**
  - **For anxiety disorders, prioritize psychotherapy as the mainstay treatment.**
  - **Cognitive-behavioral therapy (CBT) including psychoeducation and cognitive restructuring.**
  - **Mindfulness and relaxation techniques.**
  - **Expressive arts therapy.**
  - **Behavioral interventions like systematic desensitization and positive reinforcement.**
  - **Parental involvement and support including parent training and family therapy.**
  - **School-based interventions.**
  - **Normalization and validation of anxiety.**
  - **Problem-solving skills and gradual exposure.**
  - **Goal setting with achievable milestones.**

Pharmacotherapy (If needed)

Create a multidisciplinary treatment plan tailored to the child's and family's needs.

- **Prescribe medication only for severe anxiety.**
- **Use a combination of medication and psychotherapy for better outcomes.**
- **Commonly prescribed drugs:**
  - **Fluoxetine (10-40mg/day)**
  - **Sertraline (25-50mg/day)**
  - **Venlafaxine (37.5-225mg/day)**
  - **Amitriptyline (25-100mg/day) [Note: Amitriptyline is not preferred unless cost is a hindrance or other drugs cause side effects. Benzodiazepines are to be avoided due to addiction risks].**

Follow-up and Monitoring

- **Schedule regular follow-up visits:**
  - **Acute phase: once or twice weekly.**
  - **Maintenance phase: every one to three months.**
- **During follow-up, assess:**
  - **Level of symptoms.**
  - **Side effects of medications.**
  - **Treatment adherence.**
  - **Psychosocial needs.**
  - **Functional status (school performance and developmental milestones).**

Initial Assessment

- **Refer to specialized mental health services if:**
  - **Symptoms are severe and persistent.**
  - **Self-injurious or suicidal behavior is present.**
  - **There is a risk of harm to others.**
  - **There is poor adherence to medication or partial/no response to treatment.**
  - **Specific psychological therapies are needed.**
- **Link to support systems if:**
  - **There are signs of neglect or abuse.**
  - **Social support systems are poor (e.g., homelessness).**
  - **Family needs psychoeducation about the illness and treatment.**
  - **There are difficulties with school (consider special schools and vocational centers).**

3.3.39 Anxiety disorders in children

Anxiety disorders in children are persistent fears or worries that disrupt their ability to participate in play, school, or typical age-appropriate social situations.

Common symptoms of anxiety disorders in children:

- Irritability
- Trouble sleeping or waking with bad dreams.
- Restlessness
- Outbursts of anger
- Difficulty concentrating
- Being tense or fidgety or using the toilet often
- Being too clingy, which is not age-appropriate.
- Physical symptoms like fatigue, headaches, or stomachaches

Table 11: Types of Childhood Anxiety Disorders

Anxiety Disorder	Manifestation
Separation Anxiety	At least three of these symptoms: • Recurrent excessive fear when anticipating or experiencing separation from a major attachment figure (e.g., parents or guardians). • Excess worry about losing a major attachment figure. • Persistent Refusal to go to school or away. • Excess fear of being alone or away from loved ones. • Nightmares involving themes of separation. • Recurrent body symptoms e.g. headaches when separation occurs or is anticipated. • Being excessively afraid and worried when away from parents. • Symptoms last for at least four weeks. • Symptoms result in impairment in social occupational functioning e.g. challenges in school.
Selective Mutism	Consistent failure to speak in specific social situations. Symptoms have lasted at least one month. Failure to speak is not due to language challenges or lack of knowledge. Mutism is not best explained by a communication disorder. Ability to speak freely in familiar situations but become mute in specific situations or around certain people.

3.3.40 Assessment

a) Conduct a comprehensive history assessment.

b) Conduct a mental state assessment.
c) Selected investigations may be performed to rule out any other medical conditions, such as EEG, brain CT scan, MRI, thyroid function tests to rule out hyperthyroidism, and other routine baseline blood tests.

3.3.41 Management of Anxiety Disorders in Children

A treatment plan that works best for the child and family should be developed with a multidisciplinary approach. In the treatment of very young children, involving parents and other important caregivers is crucial, and when appropriate, the school can also be included in the management process.

3.3.42 Psychosocial Management

The Mainstay of treatment of mild to moderate anxiety disorders in children is psychotherapy.

Various psychotherapeutic interventions are effective, including:

- Cognitive behaviour therapy (CBT),
- Problem-solving therapy,
- Psychodynamic psychotherapy,
- Family therapy,
- Relaxation techniques.

It's important to tailor the supportive therapy approach to each child's unique needs and consider the severity of their anxiety symptoms. Additionally, involving parents and caregivers in the therapeutic process enhances the overall effectiveness of anxiety management strategies for children.

3.3.43 Pharmacotherapy

Medication is only prescribed for severe anxiety.
A combination of medication and psychotherapy has better outcomes than either of the interventions alone.

Table 12: Common drugs prescribed for anxiety in children

Drug	Min Dose per day	Max dose
Fluoxetine	10mg	40mg
Sertraline	25mg	50mg
Venlafaxine	37.5mg	225mg
Amitriptyline	25mg	100mg

Note:

Amitriptyline is not preferred unless its cost is a hindrance or where a child has side effects from the other options. In the same breadth, benzodiazepines are to be avoided due to the risk of addiction.

3.3.44 Autism Spectrum Disorder

Autism spectrum disorder is diagnosed only when the characteristic deficits of social communication are accompanied by excessively repetitive behaviours, restricted interests, and insistence on sameness.

Table 213: DSMV Criteria for diagnosing Autistic spectrum Disorders

DSMV Criteria for diagnosing Autistic spectrum Disorders
A child must have persistent deficits in three areas of social communication and interaction plus at least two of four types of restricted repetitive behaviours. **A.** Persistent deficits in social communication and social interaction 1) Deficits in social-emotional reciprocity, e.g., failure of normal back-and-forth conversation; and failure to initiate or respond to social interactions. 2) Deficits in nonverbal communication, e.g., abnormalities in eye contact, a lack of facial expressions and nonverbal communication. 3) Deficits can range from challenges in developing, maintaining, and understanding relationships, such as difficulties in sharing imaginative play or making friends, to a complete absence of interest in peers. **B.** Restricted, repetitive patterns of behaviour, interests, or activities, e.g. 1) Stereotyped or repetitive motor movements, 2) Insistence on sameness, inflexible adherence to routines, 3) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests). Hyper- or hyperreactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement). **C.** Symptoms must be present in the early developmental period. However, they may fully manifest once social demands exceed limited capacities or be masked by learned strategies later in life. **D.** Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. **E.** These disturbances aren't explained by intellectual disability (intellectual developmental disorder) or global developmental delays.

Severity is based on social communication impairments and restricted repetitive behaviour patterns.

For either criterion, severity is described in 3 levels:

- Level 3 – Requires very substantial support
- Level 2 – Requires substantial support
- Level 1 – Requires minimal support.

3.3.45 Assessment

NB: Despite exhibiting symptoms since childhood, autism spectrum disorder can sometimes be initially diagnosed in adulthood.

- Detailed history from a caregiver and educational institutions.
- Vital signs and physical examination.
- Suicide risk assessment.
- Investigations:
  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for M.P.s, HIV, TFT, Pregnancy Test,
  - specific test, e.g.(toxicology)
  - imaging (C.T. scan and MRI).
- Other investigations may be considered based on the patient's presentation.
- If a patient tests positive for any of the above tests, manage accordingly and refer where appropriate

3.3.46 Differential Diagnosis

- Intellectual disability
- ADHD
- Schizophrenia
- Stereotypic movement disorder
- Selective mutism
- Language disorders
- Social communication disorders

3.3.47 Management of Autism Spectrum Disorder

Management of autistic spectrum disorders follows the Biopsychosocial approach.

Psychosocial interventions are the mainstay treatment for this condition.

3.3.48 Psychosocial Support

Several therapeutic interventions may be provided based on the child's and family-specific needs. They include:

- Behavioral therapy
- Occupational and speech therapy
- Special and remedial education
- Social skills training and therapy
- Caregiving skills training

3.3.49 Pharmacotherapy

Aims to manage behavioural or emotional symptoms, e.g., aggression, anxiety, irritability, mood swings and sleep disturbances.

Medications may also manage comorbid conditions like attention problems and hyperactivity.

Table 14: Medications that are Considered in Autistic Spectrum Disorder

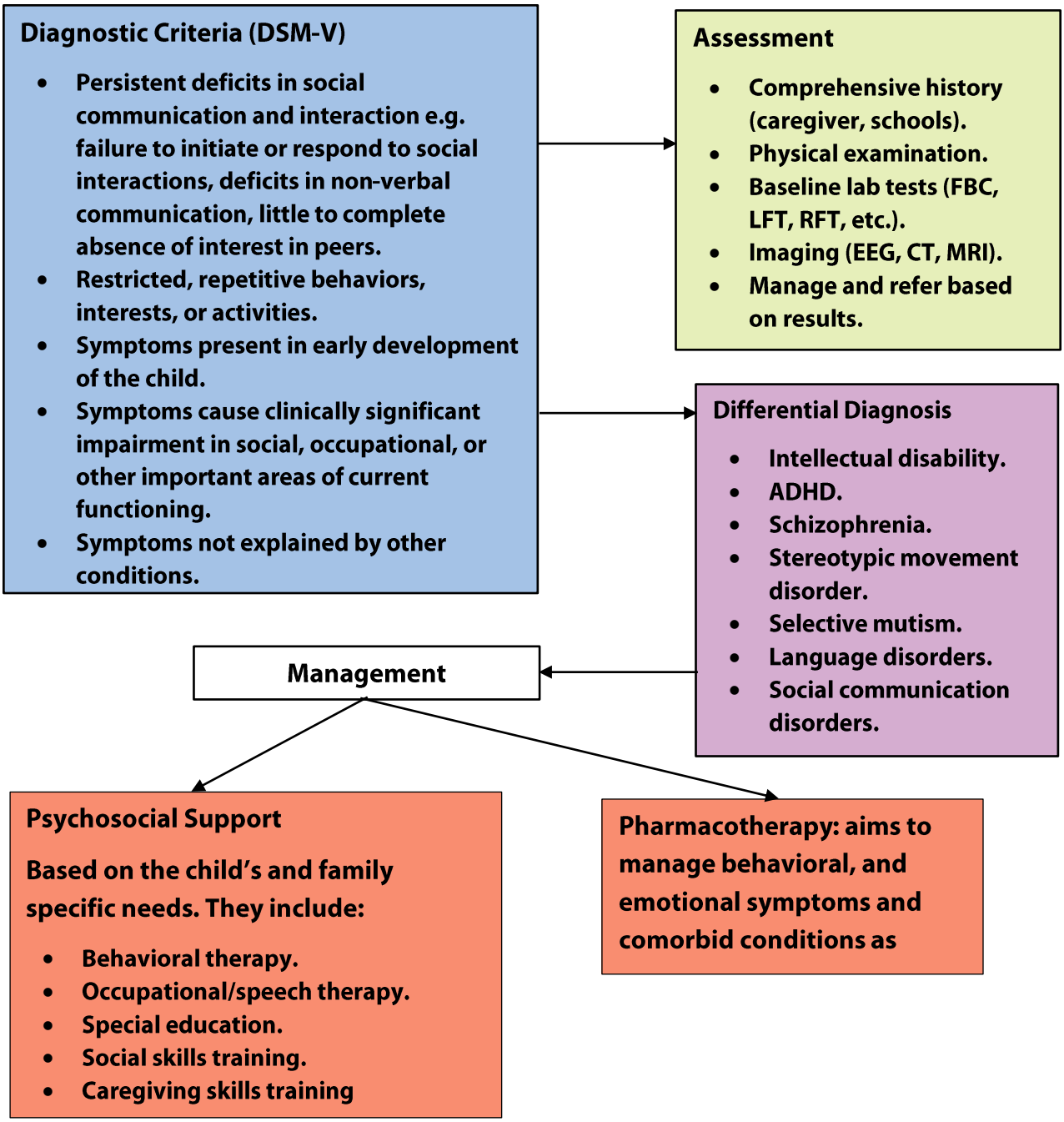
Drug	Daily Dose	Indication
Risperidone	0.5- 4 mg	Tantrums, aggressive episodes, self-injurious behaviours, hyperactivity
Methylphenidate	5-15mg (immediate release) Or. 18-36mg for extended-release.	For comorbid hyperactivity
Atomoxetine	40-80 mg	Hyperactivity
Haloperidol	2.5- 30mg	Aggressive behaviour, irritability, and uncooperativeness
Aripiprazole	2-15mg	Irritability
Clozapine	25-400mg	Disruptive behavior
Venlafaxine	37.5-225Mg	Aggression, self-injurious behaviour, and hyperactivity
Fluoxetine	10-80 mgs	Repetitive behaviors
Mirtazapine	7.5-45 mg	Insomnia
Melatonin	3- 6mg	Insomnia

Algorithmic Summary Flow Diagram for Autism Spectrum Disorder in Children Treatment Protocol.

Introduction

Autism spectrum disorder is diagnosed only when the characteristic deficits of social communication are accompanied by excessively repetitive behaviours, restricted interests, and a strong preference for routine.

Despite exhibiting symptoms since childhood, autism spectrum disorder can sometimes be initially diagnosed in adulthood.



Drug	Daily Dose	Indication
Risperidone	0.5- 4 mg	Tantrums, aggressive episodes, self-injurious behaviours, hyperactivity
Methylphenidate	5-15mg (immediate release) Or. 18-36mg for extended-release.	For comorbid hyperactivity
Atomoxetine	40-80 mg	Hyperactivity
Haloperidol	2.5- 30mg	Aggressive behaviour, irritability, and uncooperativeness
Aripiprazole	2-15mg	Irritability
Clozapine	25-400mg	Disruptive behavior
Venlafaxine	37.5-225Mg	Aggression, self-injurious behaviour, and hyperactivity
Fluoxetine	10-80 mgs	Repetitive behaviors
Mirtazapine	7.5-45 mg	Insomnia
Melatonin	3- 6mg	Insomnia

3.3.50 Attention Deficit and Hyperactivity Disorder

This condition is characterized by a persistent pattern of inattention and/ or hyperactivity or impulsivity.

The symptoms first develop in childhood (before the age of 12 years), but it is sometimes first recognized in adulthood.

3.3.51 Common Signs and Symptoms

Over 6 signs and symptoms for each category must be observed to make a diagnosis of ADHD.

Table 15: Common Signs and Symptoms for ADHD

No.	Symptoms of Inattention	Hyperactivity Impulsivity symptoms
1	Difficulty giving close attention to details	Restlessness
2	Difficulty in sustained attention/focus in tasks	Often standing in situations where remaining seated is required e.g., in class or office
3	Seems not to listen when spoken to	Often running or climbing inappropriately
4	Often does not follow through on instructions	Noisy play or engagement in leisure activities
5	Difficulty organizing tasks and activities	Often on the go
6	Avoidance of activities requiring sustained mental effort	Frequently engages in excessive talking
7	Often loses things necessary for tasks / activities	Blurting out answers before questions are completed /completing people's sentence
8	Easy distractibility	Difficulty waiting for his or her turn
9	Forgetfulness	Interrupting /intruding on others

Table 16: Diagnostic criteria DSM 5 for ADHD

Diagnostic criteria DSM 5 for Attention Deficit and Hyperactivity Disorder (ADHD)
A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by any six of the above symptoms over six months. **Note:** The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or failure to understand tasks or instructions. At least five symptoms are required for adolescents and adults (age 17 and older). **B.** Several symptoms were present before the child attained 12 years. **C.** Several symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during schizophrenia or another psychotic disorder and are not better explained by another mental disorder.

3.3.52 Assessment

1) Detailed history from a caregiver and educational institutions
2) Observation of symptoms
3) Examination: physical and mental state examination
4) Psychometric tools: conners comprehensive behavioural rating scale
5) Screen for comorbidities, e.g., Anxiety and Depression
6) Routine blood work: FBC, LFTs, UECs, Thyroid Function Test, Calcium levels, Urinalysis
7) EEG to rule out seizures
8) Imaging- CT scan or MRI brain

3.3.52.1 Differential Diagnosis

- Age-appropriate behaviour.
- Side effects of various medication
- Autism spectrum disorder
- Anxiety disorder
- Depressive disorder
- Bipolar Mood Disorder
- Substance use disorder
- Oppositional Defiant Disorder,
- Conduct Disorder.

3.3.52.2 Pharmacotherapy

Age above six years:

a) CNS stimulants are used to improve the ability to sustain attention and academic sufficiency
    a. Methylphenidate 5mg to 10mg BD taken after breakfast and after lunch. **OR**
    b. Methylphenidate extended-release (XL) 18-36mg OD.
b) Non- stimulants, e.g., Atomoxetine (0.5mg/kg OD for the first three days and then increase to 1.2mg/kg according to the response).
c) Medications may also be used to manage comorbid conditions.

3.3.52.3 Psychosocial Intervention

a) Psychoeducation
b) Behavioral therapy
c) Family therapy
d) Group therapy
e) Individual therapy
f) Couples therapy
g) Social support

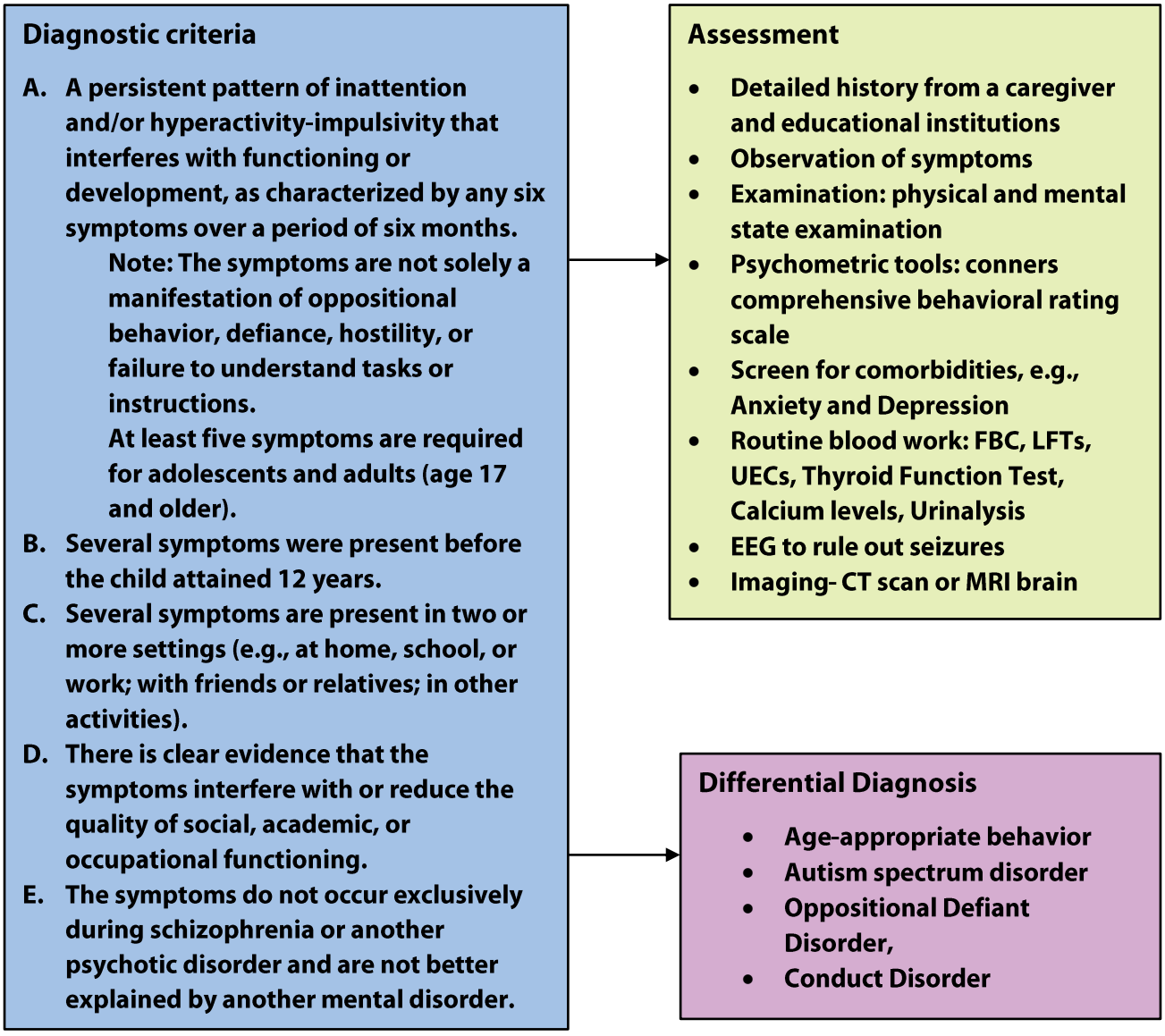
Algorithmic Summary Flow Diagram for Attention Deficit and Hyperactivity Disorder in Children Treatment Protocol

Introduction

This condition is characterized by a persistent pattern of inattention and/ or hyperactivity or impulsivity.

The symptoms first develop in childhood (before the age of 12 years), but it is sometimes first recognized in adulthood.

Common Signs and Symptoms: (See Table 18 below)



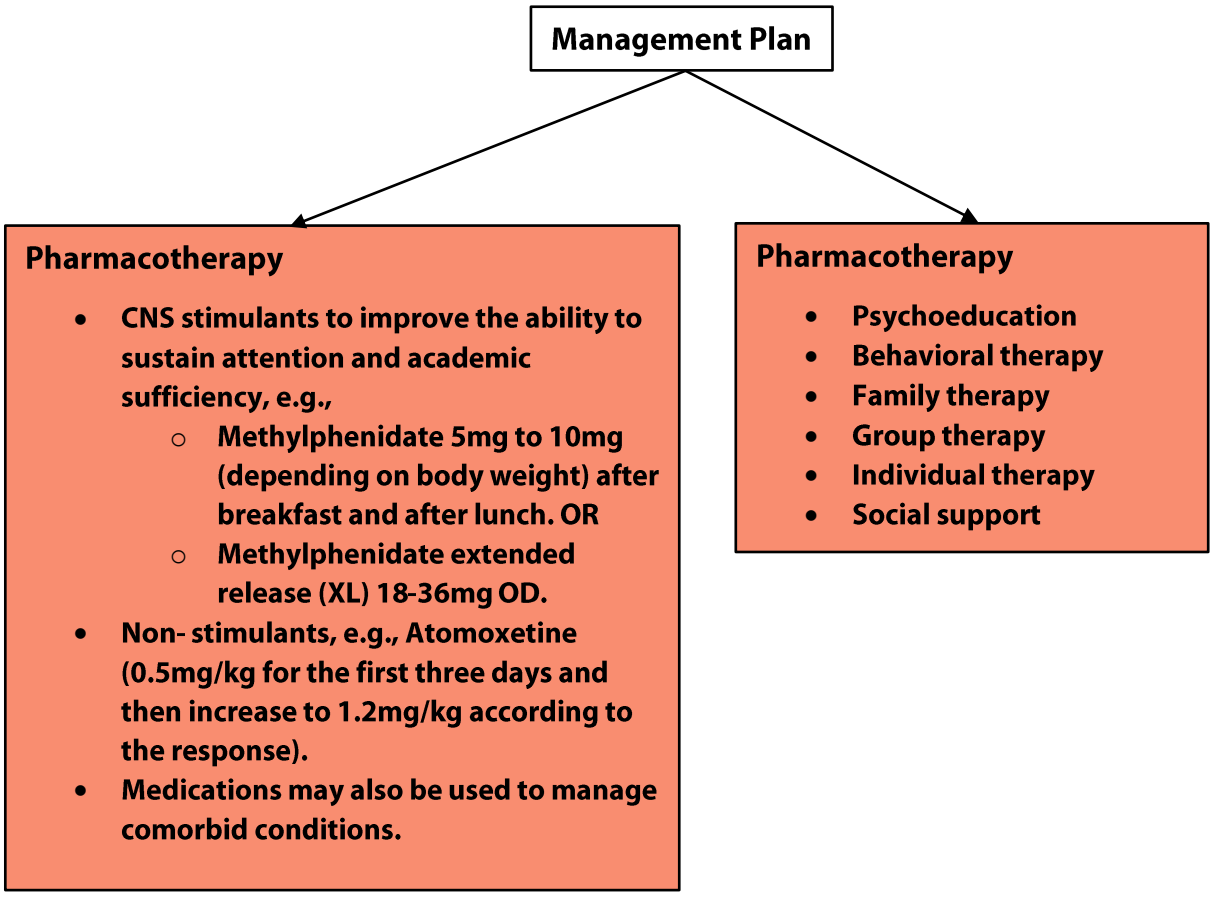


Table 17: Common Signs and Symptoms

Common Signs and Symptoms		
No	**Symptoms of Inattention**	**Hyperactivity Impulsivity symptoms**
1	Difficulty giving close attention to details	Restlessness
2	Difficulty in sustained attention/focus in tasks	Often standing in situations where remaining seated is required e.g., in class or office
3	Seems not to listen when spoken to	Often running or climbing inappropriately
4	Often does not follow through on instructions	Noisy play or engagement in leisure activities
5	Difficulty organizing tasks and activities	Often on the go
6	Avoidance of activities requiring sustained mental effort	Frequently engages in excessive talking
7	Often loses things necessary for tasks/activities	Blurting out answers before questions are completed /completing people's sentence
8	Easy distractibility	Difficulty waiting for his or her turn
9	Forgetfulness	Interrupting /intruding on others

3.8. Sleep-Wake Disorders

Sleep-wake disorders are changes in sleeping patterns or habits that can negatively affect health.

There are many types of sleeping disorders which include:

- Insomnia disorder
- Hypersomnolence disorder
- Narcolepsy
- Sleep-related breathing disorders
- Circadian rhythm sleep-wake disorders
- Parasomnia
- Substance/medication-induced sleep disorders.

This guideline will focus on the management of Insomnia.

Insomnia

Insomnia refers to difficulty in getting to sleep or staying asleep, occurring at least three nights per week, is present for at least three months, and occurs despite adequate opportunities for sleep.

There are two types of insomnia:

1. Transient or short-term insomnia
2. Chronic insomnia

3.3.53 Transient or Short-Term Insomnia.

This type of insomnia often occurs in the aftermath of a stressful life event — for example, losing a loved one or going through relationship issues. It can also happen if you work shifts or have jet lag. One might be unable to relax, experience disturbed sleep, and may be unable to pinpoint any real reason for their inability to sleep.

3.3.54 Chronic Insomnia.

Chronic insomnia is characterized by experiencing non-restorative sleep, difficulty falling asleep and maintaining sleep for at least one month, leading to daytime exhaustion.

With chronic intermittent insomnia, one experiences a sleeping pattern with a few nights of good sleep alternating with many nights of insomnia.

3.3.55 Causes

- Poor sleep hygiene
- Sleep-related breathing disorders
- Medical conditions
- Disrupted sleep-wake schedule
- Hormonal changes
- Limb movements during sleep
- Circadian rhythm disorder.

Table 18: Signs and Symptoms

Signs and Symptoms	
1	Inability to initiate sleep resulting in significant distress or impairment.
2	Difficulty initiating or maintaining sleep.
3	Anxiety or depression commonly coexist with insomnia.
4	Waking up early in the morning.
5	Difficulty falling asleep at night.
6	Difficulty in paying attention, focusing on tasks, or remembering.
7	Not feeling well rested after a night's sleep.
8	Increased errors or accidents.
9	Daytime tiredness or sleepiness

Table 19 : Diagnostic Criteria for Insomnia

Diagnostic Criteria for Insomnia
A. A predominant complaint of dissatisfaction with sleep quantity or quality associated with one (or more) of the following symptoms: i) Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.) ii) Difficulty maintaining sleep is characterized by experiencing frequent awakenings or facing challenges in returning to sleep after waking up. (In children, this may manifest as difficulty returning to sleep without the caregiver's intervention.) iii) Experiencing early-morning awakening without the ability to return to sleep. **B.** The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioural, or other important areas of functioning. **C.** The insomnia is not better explained by and does not occur exclusively in the course of another sleep-wake disorder: it is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or any coexisting mental disorders and medical conditions.

3.3.56 Assessments

It is mainly done to rule out any physical or mental illness that would present with similar sleep disturbances.

- History taking, especially on the sleep schedule and sleep hygiene
- Mental status exam
- Vital signs and physical examination
- Suicide risk assessment
- Investigations:

  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test.
  - Specific test (toxicology).
  - Imaging (CT scan and MRI).
- Other investigations may be considered based on the patient's presentation.
- If a patient tests positive for any of the above tests, manage accordingly and refer where appropriate.

3.3.57 Differential Diagnosis

- Normal sleep variations
- Other sleep disorders:
  - Central sleep apnea (primary or due to drug or substance), in which the breathing repeatedly stops and starts during sleep.
  - Cheyne-Stokes breathing pattern (associated with heart failure).
  - High-altitude periodic breathing.
  - Jet lag disorder is *a temporary sleep problem that can affect anyone who* quickly travels across multiple time zones.
- Substance/ medication induced-sleep disorder insomnia type.

Note:

It's important to identify the secondary cause

3.3.58 Management of Insomnia

Insomnia management utilizes various interventions, including managing underlying conditions (for non-primary insomnia) and psychosocial &pharmacotherapy interventions.

Psychosocial interventions are the first line of treatment with CBT being the most effective psychotherapeutic technique.

3.3.59 Psychosocial Management

This is the mainstay of treatment.

3.3.60 Psycho-educational interventions

Providing information about the connection between thoughts, feelings, behaviour, and sleep is central to cognitive behavioural therapy.

3.3.60.1 Good Sleep Hygiene

This describes a series of healthy sleep habits that can improve your ability to fall and stay asleep. It is noted that behaviours during the day, especially before bedtime, can significantly impact sleep. They can promote healthy sleep or contribute to sleeplessness. Good sleep hygiene ensures a good night's sleep and rest.

Educate the patient on the following tips on sleep hygiene:

- To be consistent. Go to bed at the same time each night and get up at the same time each morning, including on the weekends.

- Make sure your bedroom is quiet, relaxing, and at a comfortable temperature.
- Remove electronic devices such as televisions, computers, and smartphones from the bedroom.
- Avoid large meals with caffeine and alcohol before bedtime.
- Get some exercise. Being physically active during the day can help you fall asleep more easily at night.

Some steps for good sleep hygiene are captured in the table below.

Table 20: Sleep hygiene Do's and Don'ts

✓ Do:	✕ Don't:
Establish a regular bedtime and rise time	Take daytime naps
Exercise in the late afternoon or early evening	Use stimulants such as caffeine and nicotine
Take a hot bath a couple of hours before bedtime	Drink alcohol before bedtime
	Eat offensive foods, such as spicy or acidic foods (e.g., orange juice before bed)
Establish a comfortable sleep environment (e.g., bed and bedding)	Try too hard to fall asleep
Sleep in a dark, quiet area that is temperature and humidity-controlled.	"Watch the clock"
Establish a relaxing pre-sleep routine that you use every night before sleep, such as washing your face, getting into pajamas, reading or listing to soft music before turning the lights out.	Take prescript and over-the-counter medications that might be stimulating (check with your doctor)

3.3.61 Cognitive Behavioral Therapy:

This helps to identify thoughts, feelings, and behaviors that contribute to insomnia symptoms. Thoughts and feelings are examined to determine if they are accurate, while behaviours are examined to determine if they promote sleep. The provider will then clarify or reframe the misconception and address challenges to promote restful sleep.

3.3.62 Pharmacotherapy:

Insomnia may be treated using several medication classes, including benzodiazepines, antidepressants, and antipsychotics. Depending on availability, affordability and comorbidities, the following actions can be taken for insomnia:

3.3.62.1 Benzodiazepines:

These are used in the acute management period, with a **maximum duration of two weeks**, as the drugs have a strong propensity for addiction. They can also be used for a maximum of one week if used in combination with antidepressants to allow for the antidepressant medication to take effect.

Ensure to taper off the medication gradually when stopping.

- Alprazolam at 0.25 mg – 0.5mg at night. It can go up to 1mg at night. Give for a maximum of two weeks.

Short-acting benzodiazepines are often preferred for insomnia because they theoretically produce less next-day drowsiness, although many patients still experience these effects.

Benzodiazepines should not be taken with alcohol or with opioids commonly found in prescription pain medications and cough syrups, as this can have serious side effects, including slowed or difficult breathing and even death.

3.3.62.2 Sedative Antidepressants

These can be prescribed for more than four weeks and have a lower propensity to addiction. Therefore, they are used for long-term management of insomnia in combination with other psychological interventions.

Sedating antidepressants is a good option if the patient has comorbid depression and anxiety disorders; however, Avoid in the elderly and patients with medical comorbidities. their use should be avoided in elderly persons and patients with medical comorbidities.

One can use one of the following medications:

- P.O Amitriptyline: initial dose 25mg, increase by 25mg weekly with a maximum of 50mg/day.
- Mirtazapine at 15-30mg at night.
- Zolpidem at 5-10 mg at night. Suitable for long-term management of insomnia and usage by in-patients with multiple medical comorbidities and older patients. It has fewer side effects compared to benzodiazepines and less addictive potential.

3.3.62.3 Antipsychotics

This is a good option if the patient has comorbid mood or psychotic symptoms.

- Quetiapine at 50 mg nocte and increase by 25 mg every two days, titrated against response, a maximum dose of 100mg per day.

Note:

Combination pharmacotherapy may be used in certain situations where one mode of treatment is ineffective or side effects limit dose optimization for the initial medication. Combination medication should consider patient comorbidities and drug-drug interactions.

3.3.63 Referral and Linkage

1. To a psychiatrist in case of non-response to medication
2. Psychologist for other psychotherapy techniques
3. Refer to a social worker for social and economic assessment and support.
4. Linkage with community resource persons

5. Refer to an occupational therapist to promote the person's ability to fulfill their daily routines and roles.

Algorithmic Summary Flow Diagram for Sleep Wake Disorder Treatment Protocol

Introduction

Sleep-wake disorders are changes in sleeping patterns or habits that can negatively affect one's health.

In this guideline, we shall focus on insomnia.

Insomnia

Insomnia refers to difficulty in getting to sleep or staying asleep, occurring at least three nights per week, is present for at least three months, and occurs despite adequate opportunities for sleep.

There are two types of insomnia:

- Transient or short-term insomnia: This can occur after a stressful life event.
- Chronic insomnia

Diagnostic Criteria

A. A predominant complaint of dissatisfaction with sleep quantity or quality associated with one (or more) of the following symptoms:
   1. **Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.)**
   2. **Difficulty maintaining sleep is characterized by experiencing frequent awakenings or facing challenges in returning to sleep after waking up. (In children, this may manifest as difficulty returning to sleep without caregiver's intervention.)**
   3. **Experiencing early-morning awakening without the ability to return to sleep.**

B. The sleep disturbance causes clinically significant distress or impairment in important areas of functioning.

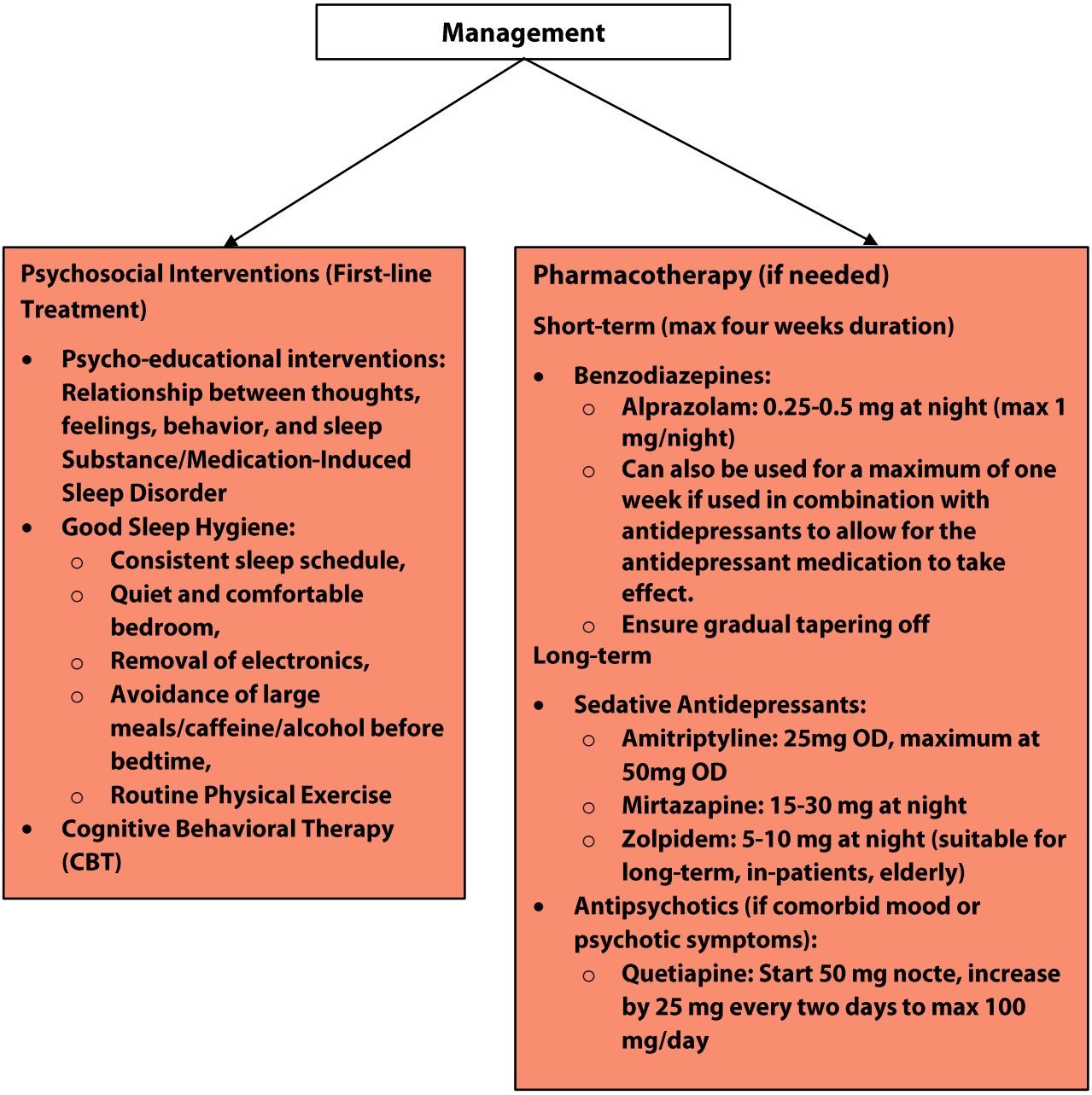
C. The insomnia is not better explained by and does not occur exclusively in the course of another sleep-wake disorder: it is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or any coexisting mental disorders and medical conditions.

Assessment

- **History Taking: Sleep schedule, sleep hygiene,**
- **Examinations: Mental state, Physical examination, suicide risk assessment**
- **Investigations:**
  - **Baseline lab tests: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT, Pregnancy Test**
  - **Specific tests: Toxicology**
  - **Imaging: EEG, CT scan, MRI**

Differential Diagnosis

- **Normal sleep variations**
- **Other Sleep Disorders: Central sleep apnea, Cheyne-Stokes breathing, high-altitude periodic breathing, jet lag disorder**
- **Substance/Medication-Induced Sleep Disorder**



Referral and Linkage

- To Psychiatrist: Non-response to medication
- To Psychologist: Other psychotherapy techniques
- To Social Worker: Social and economic assessment and support
- Community Resource Persons: Linkage
- To Occupational Therapist: Promote daily routines and roles

3.9. Psychiatric Emergencies

A psychiatric emergency is a disturbance in thought, mood, and/or action which causes sudden distress to the individual/others and sudden disability or death, thus requiring immediate management.

Common psychiatric emergencies include:

- Extrapyramidal Side Effects (EPSE) e.g., acute dystonia, acute akathisia, neuroleptic malignant syndrome.
- Acute Psychosis with bizarre behaviour and violence
- Postpartum (puerperal) psychosis
- Delirium
- Self-harm
- Suicide
- Post Partum Psychosis
- Substance use disorders- Overdose and withdrawal crisis
- Panic disorder with panic attacks.

3.3.63.1 Assessment of psychiatric emergencies

History: –

- Obtain detailed history from the patient and the informants.
- Determine overdose or withdrawal of drugs and or alcohol.

Examination: –

- Conduct a detailed physical and systemic examination to rule out or diagnose any organic problems such as head injury and or delirium tremens.
- Glasgow Coma Scale to determine the level of consciousness if required.
- Assess suicidal or homicidal intent as soon as possible.
- Formulate a psychiatric diagnosis.

Table 21: General management of psychiatric emergencies

General management of psychiatric emergencies	
Secure the safety of patient	Target: Patients who are at high risk for suicide and violence Appropriate measures: • Keep family as attendants if available. • Otherwise, mobilize hospital staff or other patients to observe the patient closely.
Nutrition and hydration	Target: Patients are at high risk of dehydration and starvation due to self-neglect. Appropriate measures: • Patients receive adequate hydration and nutrition.
Psycho-social support	Educate the patient and family about the illness and your plan of management so that they understand the disorder.
Medication	Prescribed as per the assessment findings

General management of psychiatric emergencies	
Investigations	As per assessment findings
Notification	Inform the patient's family, hospital administrator or other agencies as necessary.
Consult a senior colleague	If in doubt
Refer if necessary	after giving psychological first aid and medical treatment.
Criteria for emergency treatment through supported decision-making or advance directives	Unlike patients with physical disorders, psychiatric patients pose a unique challenge as they may not accept treatment or admission to a hospital due to a lack of insight. Nevertheless, the following conditions warrant treatment: Presence of a mental disorder (as defined by internationally accepted standards) and needing treatment. Loss of insight and unable to provide for own basic needs. Serious likelihood of immediate or imminent danger to oneself (suicide) or others (homicide).

3.3.63.2 Specific Management

This guideline will focus on specific management of:

- Extrapyramidal Side Effects (EPSE)
- Acute Psychosis
- Delirium
- Self-harm
- Suicide
- Post Partum Psychosis
- Substance use disorders- Overdose and withdrawal crisis

3.3.64 Extra-Pyramidal Side Effects (EPSE)

These are adverse extra-pyramidal effects that may occur due to antipsychotic medication, e.g., haloperidol and chlorpromazine.

They include:

- Dystonia - characterized by intermittent spasmodic or sustained involuntary contractions of muscles in the face, neck, trunk, pelvis, and extremities
- Akathisia - characterized by a subjective feeling of internal restlessness and presents as repetitive movements of the legs, e.g., crossing, swinging, or shifting from one foot to another.
- The onset is usually within four weeks of starting or increasing the dosage of the offending medication.
- Drug-induced parkinsonism presents as tremor, rigidity, and slowing motor function in the truncal region and extremities. Patients are mostly present with a slow shuffling gait, difficulty rising from a seated position, masked facies, and a stooped posture.

- Tardive dyskinesia manifests as involuntary choreoathetoid movements affecting oral, facial, and tongue muscles and less commonly, the truncal region and extremities.

3.3.64.1 Management of EPSE

- Gradually withdraw the offending medication
- Change medication e.g., typical antipsychotics to atypical antipsychotics.
- May add:
    - P.O Benzhexol 5-10 mg PRN **OR**
    - P.O Biperiden 2-4 mg PRN

3.3.65 Acute psychosis

- This refers to a sudden onset of a change of behaviour from a nonpsychotic state to a psychotic state within 2 weeks.
- Refer to the section on Psychosis for the diagnostic features.
- In this section we shall emphasize the management of Acute Psychosis.

3.3.65.1 Management of Acute Psychosis

- Comprehensive investigations must be done to rule out organic causes of psychotic symptoms and identify comorbidities.
- Acute psychosis is preferably treated in an inpatient setting to allow for observation of symptom relief.
- Once the symptoms have reduced, maintenance treatment is initiated as per the guidelines on treatment of psychosis above.

3.3.65.2 Pharmacological Management

Pharmacological management with antipsychotic medication forms the cornerstone of treating acute psychosis and aims to reduce symptoms, prevent harm to self/others and improve biological functioning.

Factors to Consider when Choosing Medication

- Age of the patient – Oral medication is preferred for extreme ages
- If the patient has responded well to a particular drug in the past, use that drug again.
- Cost and availability of the drug
- Presence of co-morbid illness - If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side effects.
- Side effects of the drug
- Adverse drug reactions of the drug
- Start with the lowest effective dose, and build up to the maximum effective dose based on response and tolerability.

Medication	Dosage
Haloperidol	Oral: 1.5mg-5mg stat **Or** IM: 5mg Maximum daily dosage of 20mg **NB:** Extreme ages start at 2.5mg
Chlorpromazine	Oral 100-200mg stat **Or** IM:100-200mg stat Max daily dose of 400mg
Zuclopenthixol Acetate (Acuphase)	Adult: 50mg-150mg Stat Elderly/ physically ill: 25mg -50mg Route: IM
Olanzapine	Oral dispersible tablets:2.5-10mg IM: 2.5-10mg

3.3.66 Post-partum psychosis

Introduction

Post-partum psychosis (also called puerperal psychosis) is the most severe form of perinatal mental illness and carries a high suicide risk or risk of infanticide if untreated

It is a syndrome associated with:

- Pregnancy or puerperium (commencing within about 6 weeks after delivery)
- Involves significant mental and behavioral features: including delusions, hallucinations, or other psychotic symptoms.
- Rapidly changing mood, disorientation, poor concentration, screaming or muteness and impaired memory of recent events
- Mood symptoms (depressive and/or manic) are also typically present.

Clinical features are similar to psychosis as previously explained in the sub-section on Psychosis.

3.3.66.1 Differential diagnosis

- Bipolar mood disorder
- Psychotic disorder secondary to a general medical condition
- Delirium
- Schizoaffective disorder
- Schizophrenia

Management EPSE

3.3.66.2 Investigations

There are no specific diagnostic laboratory or radiological tests for puerperal psychosis.

MRI, CT scan EEG and other laboratory investigations may be considered to rule out medical causes of psychosis.

3.3.66.3 Treatment

Puerperal psychosis in a psychiatric emergency that typically requires in-patient treatment.

Ensure safety: Prevent patients from harming themselves or others.

Table 22: Showing medication used in the treatment of puerperal psychosis

Medication	Dosage
Haloperidol	Oral: 1.5mg-5mg stat **Or** IM: 5mg Maximum daily dosage of 20mg
Chlorpromazine	Oral 100-200mg stat **Or** IM:100-200mg stat Max daily dose of 400mg
Zuclopenthixol Acetate (Acuphase)	Adult: 50mg-150mg Stat Route: IM
Olanzapine	Oral dispersible tablets:2.5-10mg IM: 2.5-10mg

Electroconvulsive therapy (ECT) is also effective in symptoms refractory to medication

Note:

All psychotropic medications are secreted into breast milk.

Maintenance treatment is initiated as per management of psychosis

3.3.66.4 Psychosocial support:

Supportive care of the infant while his/her mother undergoes acute treatment.

Individual and family psychotherapy is necessary to cope with stressors and improve self-esteem and confidence.

3.3.66.5 Psychoeducation

3.3.66.6 Referral and Linkages

Refer to a mental health specialist for follow-up and maintenance treatment.

3.3.66.7 Delirium:

Introduction

This is an acute confusional state characterized by fluctuating cognitive abilities or a worsening of cognitive abilities associated with behavioural changes. This is common in patients with medical conditions e.g. severe infection or post-surgery.

3.3.66.8 Diagnostic criteria

Table 23: Delirium Diagnostic criteria

Delirium Diagnostic criteria
A. Reduced attention and awareness **B.** Develop over a short period (hours to few days) and tend to fluctuate in severity during the day, worsening at night **C.** An additional disturbance in cognition (memory, disorientation, language, perception, or visuospatial ability) **D.** Exclude that disturbances in A & C are not better explained by another preexisting neurocognitive disorder or do not occur in the context of severely reduced level of arousal (coma). **E.** Evidence that the disturbance is a direct physiological consequence of another medical condition, substance/medication intoxication, withdrawal, or multiple aetiologies.

3.3.66.9 Assessment

As delirium is commonly caused by other medical conditions, collaborative history from other healthcare workers is key in assessment

- Assess the onset of duration key being a sudden onset of change in behaviour.
- Assess for fluctuation of symptoms with rapid worsening and severe during the night.
- Assess for hallucinations with visual hallucinations commonly reported.
- Asses for any previous history of a similar condition, a psychotic illness, drug or alcohol use.
- Assess for the duration of illness in case of a comorbid condition
- Mental state Examination
- Vital signs and physical examination
- Suicide risk assessment
- Investigations:
  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT,
  - Vitamin levels – B12, Folate and thiamine,
  - Radiological investigations – EEG, MRI, CT SCAN, Amyloid PET scan
  - Biomarkers-CSF, Amyloid proteins
- Other investigations may be considered based on the patient's presentation.

- If a patient tests positive for the above tests, manage accordingly and refer where appropriate.

3.3.66.10 Differential diagnosis

- Acute Psychosis
- Acute stress disorder
- Dementia

Management Plan

- The mainstay of treatment is to identify and treat the underlying medical condition.
- Avoid sedation unless the patient is severely agitated.
- Benzodiazepines worsen delirium therefore oral antipsychotics are preferred.
- Use single medication starting at a low dose:
    - P.O Haloperidol 5mg OD **OR**
    - P.O Risperidone 2mg OD with a maximum of 6 mg OD

Reassess 2 - 4 hourly.

3.3.67 Suicide

Introduction

Suicide is the act of deliberately killing oneself and is a serious public health problem affecting families, communities and entire countries.

Suicides are preventable with timely, evidence-based and often low-cost intervention.

3.3.67.1 Suicidal behaviour

Suicidal behaviour refers to any thoughts, actions or behaviour that indicates an individual's intent or desire to end their own life. It encompasses a spectrum of behaviour from suicidal ideation to suicide attempts and death.

It includes the following components:

- Suicidal ideation
- Suicide plan
- Suicide attempt
- Completed suicide

3.3.67.2 Warning signs of suicidal behaviour

Suicidal behaviour emerges from a diverse range of factors, spanning individuals, interpersonal, communal and societal.

Box 2: Warning signs to look out for
• Feeling like a burden • Being isolated • Increased anxiety

- Talking about feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness and having no reason to live
- Sleeping too little or too much
- Talking or posting about wanting to die or to kill self
- Making plans for suicide
- Giving away prized possessions
- Showing rage or talking about seeking revenge
- Suddenly, coming out from being hopeless
- Not wanting to complete projects, one has started

Table 24: Diagnostic Features of Suicidal Behavior

Diagnostic Features of Suicidal Behavior
A. The act: 1) Has been attempted within the last 24 months. 2) Does not meet criteria for non-suicidal self-injury to produce a positive mood. 3) Is not applied to suicidal ideation or preparatory acts. 4) Was not initiated during a state of delirium or confusion. 5) Was not undertaken solely for a political or religious objective. **B.** The behaviour or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning. **C.** The behaviour does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal.

3.3.67.3 Assessments of Patients with Suicidal Behavior

- Previous suicidal attempts.
- Look out for signs of poisoning or intoxication, loss of consciousness, bleeding from self-inflicted wounds or extreme lethargy.
- Previous history of self-harm/suicidal thoughts or plans in the past two weeks – one year.
- For a person who is extremely agitated, violent, distressed or lacks communication, inquire if, in the past two weeks to one month, they have had thoughts or plans to self-harm/suicidal ideations, or if in the past year, they have self-harmed.

- Presence of mental, neurological & substance abuse (MNS) conditions, e.g., depression, child & adolescent mental and behavioural disorders, psychoses, disorders due to substance use, epilepsy, and chronic pain.
- Severity of emotional symptoms:
  - Is the person having difficulty carrying out usual work, school, domestic or social activities?
  - Is the person on repeated self-medication for emotional distress or unexplained physical symptoms?
  - Is the person experiencing marked distress or repeated help-seeking behaviour?

3.3.67.4 Differential diagnosis

- Self-harming behavior.

Management of Suicide

- Assess the physical condition of the patient to ensure that the patient is medically stable by stabilizing the vital signs and appropriately managing any emergencies.
- When medically stable, calm the patient to do a risk assessment.
- Evaluate for underlying psychiatric illness by taking history and mental status examinations.
- A multidisciplinary approach including the role of physicians in medical management of injuries
- It is best to admit the patient for at least 24 hours with strict vigilance to prevent another suicidal attempt or completion.
- Remove all potentially harmful objects or means near the patient.
- All medication given should be supervised.

3.3.67.5 Pharmacotherapy

The choice of medication administered depends on the specific circumstances and the psychiatric diagnosis determined during the assessment of suicidal behavior.

3.3.67.6 Psychosocial management

This approach can be dual-focused, addressing both the individual and the available caregivers.

Ensure the person is placed within a secure and nurturing environment at a healthcare facility (avoid leaving them unattended). Additionally, take measures to eliminate access to potential means of self-harm.

If the person must wait for treatment, offer an environment that minimizes distress; if possible, in a separate, quiet room with constant supervision and contact with a designated staff or family member to always ensure safety.

Consult a mental health specialist, if available.

Offer psychoeducation. Some key messages to the person and the caregivers can include:

- If one has thoughts of 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 a suicidal episode is an indicator of severe emotional distress. The person does not see an alternative or a solution. Therefore, getting the person immediate support for emotional problems and stressors is essential.
- Suicidal means (e.g., pesticides, firearms, medications) should be removed from the home.
- Social networks, including the family and significant others, are important for providing social support.

Mobilize active engagement of family, friends, and other concerned individuals, along with available community resources, to oversee and provide support to the individual throughout imminent risk.

Follow the guidelines outlined below:

Offer Support to the Person:

- Explore reasons and ways to stay alive.
- Focus on the person's strengths by encouraging them to discuss how earlier problems have been resolved.
- Consider problem-solving therapy to help people with suicidal behavior within the last year.

Activate Psychosocial Support

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

Provide emotional support to caregivers and family members if they need it.

Ensure continuity of care.

3.3.67.7 Referral & Linkages, and Follow-Up

It is important to follow up on the patient.

The healthcare worker should maintain regular contact (via telephone and home visits). This will initially be frequent (e.g., daily, weekly) for the first two months. This should continue for as long as the risk of suicide persists and decreases as the person improves.

If the person does not show signs of improvement, they should be referred to a specialist for further management as required.

At each point of contact during follow-up, the healthcare worker should regularly assess for thoughts and plans for self-harm/suicide.

Algorithmic Summary Flow Diagram for Psychiatric Emergencies Disorder Treatment Protocol

Introduction

A psychiatric emergency is a disturbance in thought, mood, and/or action which causes **sudden distress** to the individual/others and **sudden disability or death**, thus requiring immediate management.

Common psychiatric emergencies include:

- Suicidal attempt, deliberate harm to self or others.
- Acute psychotic episode with bizarre behaviour and violence.
- Alcohol & drug withdrawal syndrome, e.g., delirium tremens.
- Stupor or catatonic syndrome.
- Acute stress reaction with dissociative conversion disorder.
- Panic disorder with panic attacks.
- Extrapyramidal side effects of psychotropic drugs. e.g., acute dystonia, acute akathisia, neuroleptic malignant syndrome.

In this guideline, we shall cover management of:

- Suicidal Attempt
- Aggressive/Violent patients

Suicide

This describes the act of deliberately killing oneself.

Suicidal behaviour refers to any thoughts, actions or behaviour that indicates an individual's intent or desire to end their own life. It encompasses a spectrum of behaviour from suicidal ideation, plans, attempts and death.

Warning Signs to Look Out for Include:	
• **Feeling like a burden** • **Being isolated** • **Increased anxiety** • **Talking about feeling trapped or in unbearable pain** • **Increased substance use** • **Looking for a way to access lethal means** • **Increased anger or rage** • **Extreme mood swings** • **Expressing hopelessness and having no reason to live**	• **Sleeping too little or too much** • **Talking or posting about wanting to die or to kill self** • **Making plans for suicide** • **Giving away prized possessions** • **Showing rage or talking about seeking revenge** • **Suddenly, coming out from being hopeless** • **Not wanting to complete projects, one has started**

Diagnostic Features of Suicidal Behavior

A. The act:
   1) Has been attempted within the last 24 months.
   2) Does not meet criteria for non-suicidal self-injury to produce a positive mood.
   3) Is not applied to suicidal ideation or preparatory acts.
   4) Was not initiated during a state of delirium or confusion.
   5) Was not undertaken solely for a political or religious objective.
B. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.
C. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal.

Assessments of Patients with Suicidal Behavior

- Previous suicidal attempts.
- Previous history of self-harm/suicidal thoughts or plans in the past two weeks – one year
- If a person is extremely agitated, violent, distressed or lacks communication, inquire if, in the past two weeks to one month, they have had thoughts or plans to self-harm/ suicidal ideation, or if in the past year, they have self-harmed.
- Presence of mental, neurological & substance abuse (MNS) conditions
- Severity of emotional symptoms
  - Difficulty in daily activities
  - Repeated self-medication or help-seeking behavior

Management

Pharmacotherapy

The choice of medication administered depends on the findings of the assessment done.

Psychosocial Management:

- Provide a secure and supportive environment.
- Remove means of self-harm.
- Consult a mental health specialist.
- Provide psychoeducation.
- Psychosocial support

Referral and Linkages

- Maintain regular contact (daily/weekly initially) for the first one month.
- Regularly assess for self-harm/suicidal thoughts during follow-up.
- Refer to a mental health specialist if no improvement.

Management of Aggressive/Violent Patients

DEFINITIONS

Aggression refers to a range of behaviours that can result in both physical and psychological harm to oneself/others or objects in the environment.

Violence is harmful behaviour inflicted upon another person or property involving the use of force. Violence is also defined as an act that leads to physical harm or destruction.

In this guideline, we recommend 3 phases for dealing with aggressive or violent patients

1. De-escalation
2. Sedation
3. Post Sedation/Transfer

De-escalation

De-escalation involves diffusing potentially violent situations without resorting to physical restraint, which can pose risks to both patients and staff.

Instead, verbal interventions are emphasized to reduce aggression and restore calm.

In de-escalation, healthcare workers are encouraged to:

- Express concern and empathy.
- Speak calmly and clearly, avoiding arguments.
- Assist the patient in maintaining control.
- Set clear limits **without** making threats.
- Provide additional personal space.
- Address the immediate issue.
- Ensure a safe environment by removing potential weapons and alerting authorities if necessary.
- Identify safe exits for staff.
- Encourage the patient to communicate and utilize active listening skills.
- Offer oral medication initially to manage the situation.
- Support the patient in finding a resolution.
- Consult with the patient's relatives regarding any advance directives that the patient has provided for emergencies.

Sedation (*See flow chart*)

For sedation, consider the following steps:

- Offer oral medication initially.
- If oral therapy is refused and de-escalation fails, consider intramuscular or intravenous options.

- Administer a Benzodiazepine e.g. Lorazepam 2mg – 4mg IM/IV slowly over 3 minutes after dilution, avoiding needlestick injuries if IV access is challenging.
- If sedation is inadequate after 20 minutes, administer Haloperidol 5mg IM, with additional 5mg doses hourly up to 20mg maximum
- Gather collateral information from family or accompanying individuals.

Post Sedation

After sedation:

- Assign staff to monitor the patient and preferably nurse them in a safe environment.
- Conduct history taking, mental state examinations, and necessary investigations as per the obtained history.
- Monitor vital signs closely every 15 minutes for the 1st Hour, then adjust the frequency as the patient stabilizes.
- Manage patients as guided by the vital signs and investigation reports.
- Accurately document all care and medication administered.

INITIAL CONSIDERATIONS

1. DE-ESCALATION – Talking down, time out, provide a distraction, privacy and quiet.

2. MEDICATIONS – Note any Psychotropic medication received in last few hours.

3. ADVANCE DIRECTIVES – Patient preferred treatment choices.

↓

OFFER ORAL THERAPY

CHLORPROMAZINE (Max 300mg /24hrs) 25 – 75mg initially

(Sedation in 30 minutes, peaks in 1 –3 hours, lasts 3 – 4 hours)

Take special note of contraindications for use e.g. epilepsy, elderly, alcohol abuse, liver disease, CVS disease, coma or CNS depression, etc.

↓

INTRAMUSCULAR THERAPY

Lorazepam 2 – 4 mg (Max 6mg/24hrs)
(Sedation in 30 – 45 minutes; peaks in 1 – 3 hours, lasts 4 – 6 hours)
+ / -
Haloperidol 5mg (Max 18mg / 24hrs)
(Sedation in 10 minutes; peaks in 20 minutes)
OR
Olanzapine 5 – 10mg (Max 20mg/24 hrs. with 2-hour interval between injections)
(Peaks within 15 – 45 minutes)
Zuclopenthixol Acuphase 50 – 150mg
(Sedation in 1 – 2 hrs., peaks in 36 hours, lasts 72 hours)

↓

IF THE ABOVE FAILS, SEND FOR REVIEW OR CONSULT A PSYCHIATRIC

NB: For elderly patients, halve doses and titrate according to response.

3.3.68 Substance Use Disorder: Management of Withdrawal Symptoms (Medical Detoxification)

Medical Detoxification is the management of withdrawal drug use to arrest or reduce acute physical and psychiatric symptoms.

Treatment of withdrawal is of the foremost concern if a patient has had a protracted and severe recent history of alcohol, opioid, benzodiazepine, or barbiturate use.

Stabilization of acute withdrawal problems is typically complete within 3-5 days but may be extended for patients with co-morbidities.

Psychological interventions and education must be initiated during the detoxification process.

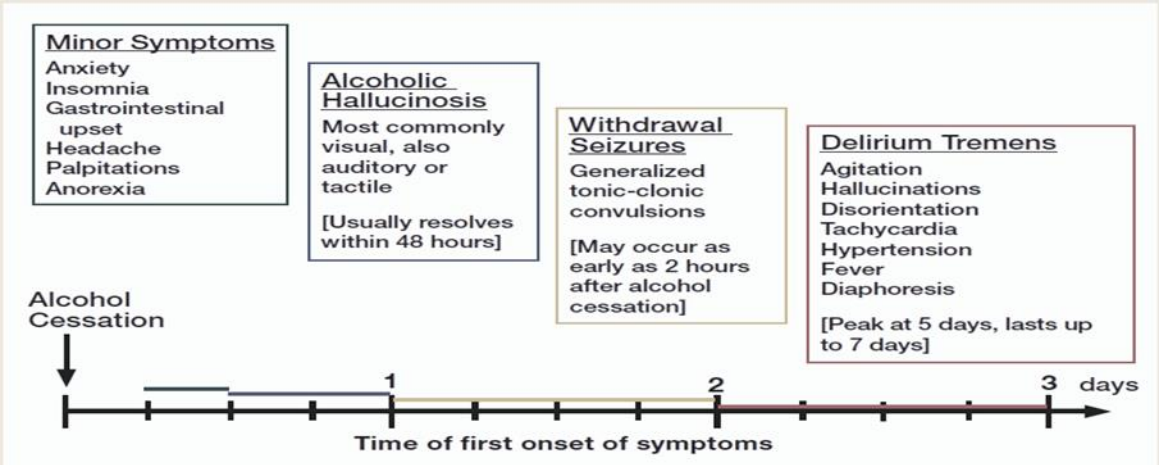
This guideline will focus on Alcohol withdrawal.

3.3.68.1 Alcohol Withdrawal

3.3.68.2 Signs and symptoms include:

No.	Signs and symptoms
1	Tremors, sweating, nausea and vomiting, increased pulse and blood pressure, agitation, headache, anxiety, hallucinations, seizures.
2	Severe withdrawal (delirium tremens) is characterized by tremors, hallucinations, agitation, confusion, disorientation, hypertension, hyperthermia, excessive sweating and altered sensorium.
3	Delirium tremens is a life-threatening condition that should be managed as a medical emergency.

3.3.68.3 Alcohol withdrawal progress



3.3.68.4 Pharmacological management

Withdrawal management

Mild withdrawal can be managed at outpatient but severe withdrawal and delirium tremens must be managed in an inpatient hospital setting.

Medication	Dosage	Remarks
Benzodiazepines: Diazepam: Or Lorazepam Or Chlordiazepoxide	Tapered dose over 7 to 10 days: 10-20mgs QID for 3 days 10-20 mg TID for 3 days 10- 20 mg BD for 2 days 10-20mgs nocte for 2 days. 100mgs stat then 100mgs every 12 hours for 5 days then 100mgs every other day for 2 days.	Benzodiazepines may cause intoxication and physical dependence therefore should not be continued after the withdrawal management period. During the administration of benzodiazepines, patients should be constantly monitored for signs of over-sedation or cognitive impairment and the dosage adjusted appropriately.
Thiamine	IV Vitamin B complex and Vitamin C combination given once daily on alternate days for 5 to 7 doses as a slow IV infusion with 100mls Dextrose/Normal Saline (DNS) Oral thiamine is given 100mgs once daily for at least 1 month	Used as prophylaxis for Wernicke's Korsakoff Syndrome (WKS)
Haloperidol Or Olanzapine Or Risperidone	P.O 2.5-5mg (max of 10mg daily) P.O 5-10mg P.O 1-4mg	Used in management of the psychotic symptoms and should not be prescribed for prolonged periods unless there is a comorbid psychotic illness Chlorpromazine and depot antipsychotics are not recommended initially as they may lower the seizure threshold.
Carbamazepine	200mg P.O qid.	May be used as an alternative anticonvulsant

Medication	Dosage	Remarks
Propranolol (β-blockers) Or Clonidine (alpha-blocker)	40mg P.O PRN 0.1-0.2mg P.O given every 2-4 hours	Given in severe hyperadrenergic activity or to reduce benzodiazepine requirements.

Symptomatic management: Antiemetic, Analgesia (e.g., paracetamol), Antidiarrheal

3.3.68.5 Post Withdrawal Management

- Detoxification is a precursor of treatment because it is designed to treat the acute physiological effects of stopping drug use but does not usually produce lasting changes.
- Post-withdrawal management should include strategies that retain the patient in treatment either at an outpatient or residential facility for ongoing management. This should be based on the patient's treatment goals (abstinence or reduced consumption) and the severity of problems.
- When post-withdrawal treatment care is not available, seek appropriate referral.

*Refer to **The National Protocol for Substance Use Management for Residential and Non-residential treatment programs** for mild and moderate withdrawal*

3.3.68.6 Substance Use Disorder: Management of Overdose

The term drug overdose (OD) describes the ingestion or use of a drug or other substances in quantities greater than are recommended.

Signs and symptoms vary depending on the substance exposure.

Overdose may result in a toxic state or death.

Management includes:

- Stabilization of the victim's airway, breathing and circulation (ABCs)
- Ventilation when there is low respiratory rate or when blood gases show the person to be hypoxic.
- Continued monitoring of the patient before and throughout the treatment process, paying attention to temperature, pulse rate, respiratory rate, blood pressure, urine output and oxygen saturation.
- Certain overdoses have specific antidotes:
    - Opiate/Opioid overdose managed with Naloxone.
    - Benzodiazepine overdose managed by Flumazenil.

- Activated charcoal can be used as a non-specific antidote if available within one hour of the ingestion or if the ingestion is significant.

This guideline will focus on the management of opioid overdose.

3.3.68.7 Opioid overdose

Opioids are a class of drugs chemically similar to alkaloids found in the opium poppy plant.

They are commonly used as analgesics, but they also have great potential for misuse.

Repeated use greatly increases the risk of developing an opioid use disorder.

Examples of Opiates/ Opioids are:

- Morphine
- Codeine
- Heroine
- Oxycodone
- Methadone
- Pethidine
- Fentanyl

To ascertain opioid overdose, perform a quick assessment as follows:

- Is the person breathing? Is the respiratory rate below 10 breaths per minute and oxygen saturation below 92%?
- Is the person responsive (do they answer when you shake them and call their name)?
- Does he/she respond to stimulation (such as sternum rub)?
- Can the person speak? Is the speech slurred?
- Is the color of his/her skin pale?

The following steps (best remembered by the acronym "SCARE ME") are used in the management of opioid overdose.

S – Stimulation (wakening):

Try to wake the person by shouting their name, shaking their body or pressing the breastbone with your knuckles.

C – Call for additional medical help: If the client doesn't respond to noise, movement or pain, immediately call for help, and put the person in a recovery position to prevent choking in case of vomiting.

A – Airway: Make sure the airway is clear of blockage.

R – Rescue Breathing: Assess for breathing and connect oxygen support

E – Evaluate: check whether the client has improved and is breathing properly.

M-Muscular Injection of Naloxone: Naloxone is a non-selective, short-acting opioid receptor antagonist.

I.M or Sub cutaneous 0.4-0.8 mg dose of Naloxone on the upper arm or thigh.

E – Evaluate and Support: The effect of Naloxone should be evident within 1-5minutes and may last for 60-90 minutes.

Repeat Naloxone administration (maximum daily dose of 10mg) if the patient is not awake or able to take a deep breath after 5 minutes.

Note:

Initial doses of Naloxone above 2 mg can induce severe withdrawal, with the risk of vomiting and aspiration; very high doses above 10 mg may even be life threatening.

Repeat the above steps if signs of overdose return.

OVERDOSE DON'TS

- Do not leave the person alone by him/herself as they could stop breathing
- Do not induce vomiting or feed orally as the client may aspirate

Admit for continued observation for a minimum of 4 hours after administration of Naloxone.

The client should be advised to avoid using any opioids or other drugs that may cause CNS depression for at least 24 hours and to ensure they do not stay alone during that period.

Refer to a mental health specialist for maintenance and opioid replacement therapy.

Refer to The **National Protocol for Substance Use Management for further opioid management.*

3.10. Considerations for specific patient groups

Health care workers should strive to understand the needs of special populations including issues related to access to care and treatment. These considerations are key to providing patient-centred, effective mental health services that maximize rapport, treatment engagement and clinical outcomes.

When possible, the services should be tailored in a multidisciplinary manner to accommodate the particular needs of special populations such as having patient-oriented treatment programs for women, children and adolescents, older persons, persons with disability and co-occurring medical conditions.

For purposes of this guideline, this section will focus on:

1. Perinatal mental health
2. Older persons
3. Persons with co-morbid physical conditions

3.3.69 Perinatal Mental Health

Perinatal mental health refers to a woman's mental health during pregnancy and the postpartum period.

Perinatal mental illness is a group of mental disorders characterized as occurring

- During the period from conception to delivery (pregnancy),
- During labour and delivery (childbirth) or
- During the approximately six weeks after delivery

Perinatal mental illness impairs a woman's functioning and hence her ability to look after herself with resultant suboptimal fetal or newborn development.

These disorders include anxiety, depression, birth-related post-traumatic stress disorder and post-partum psychosis. Postpartum blues are a common but lesser manifestation of postpartum mood disturbance.

Risk factors for perinatal mental health problems include:

- History of depression, anxiety, or bipolar disorder,
- Psychosocial factors, such as ongoing conflict with the partner, poor social support, and ongoing stressful life events.

Screening during pregnancy and the postpartum period is crucial for detecting early symptoms of depression, anxiety, and mania. Timely identification and management of perinatal psychiatric disorders are essential for positive outcomes for both the mother and child.

The table below outlines essential guidelines for addressing the needs of women seeking mental health services:

- If the woman is of child-bearing age, ask about:
  - –Breastfeeding
  - –Possible pregnancy
  - –Last menstrual period, if pregnant
- Liaise with maternal health specialist to organize care.
- Manage the mental health condition accordingly and consider consultation with mental health specialist if available.
- Exercise caution with pharmacological interventions – check toxicity to fetus and passage into breast milk. Consult a specialist as needed.
- Women treated with valproic acid/sodium valproate/divalproex sodium and carbamazepine should avoid breastfeeding where possible because these agents have been associated with hepatotoxicity in the infant.
- Breastfeeding in women treated with lithium should be pursued with caution because lithium is secreted at high levels in breast milk and may cause significant toxicity in the nursing infant. If the breastfed infant is exposed to lithium in the breast milk, periodic monitoring of lithium levels and thyroid function is indicated
- In general, it is recommended that women who need to take an antipsychotic during pregnancy continue the antipsychotic that has been most effective for symptom remission.
- Avoid clozapine in pregnancy and lactation due to possible agranulocytosis, keeping in mind that pregnancy can be an immunosuppressive state.

For purposes of this guideline, this section will focus on:

- Postpartum depression
- Birth-related post-traumatic stress disorder

Postpartum depression

Postpartum depression is characterized as intense sadness, anxiety or despair which interferes with the woman's ability to function and may cause harm to the mother or infant.

The disorder can have an acute onset or develop insidiously over the first 3 postpartum months.

Maternal depression (antepartum or post-partum) has been linked to negative health-related behaviours and adverse outcomes, including psychological and developmental disturbances in infants, children, and adolescents

Clinical features

Signs and symptoms of postpartum depression are clinically indistinguishable from depression that occurs in women at any other time and may include specific fears such as excessive preoccupation with the child's health or intrusive thoughts of harming the infant.

At least five of the following depressive symptoms in addition to the anxiety symptoms towards the child.

Depressive symptoms:

- Depressed mood
- Diminished interest or loss of pleasure in almost all activities (anhedonia)
- Significant weight change or appetite disturbance
- Sleep disturbance (insomnia or hypersomnia)
- Fatigue or loss of energy
- Feelings of worthlessness
- Diminished ability to think or concentrate, indecisiveness

Anxiety symptoms towards the child:

- Worry or obsessions about the infant's health and well-being.
- Ambivalent or negative feelings toward the infant.

3.3.69.1 Screening

The Edinburgh perinatal/Postnatal Depression Scale (EPDS) can be used between 28-32 weeks in all pregnancies and 6-8 weeks postpartum to screen for symptoms of depression and anxiety.

3.3.69.2 Assessment

- Comprehensive history taking obtained from all sources, including the family members.
- Mental status examination
- Physical examination
- Suicide risk assessment and infanticide risk assessment
- Investigations:

  It is important to conduct baseline tests to ensure the depression is not due to a medical condition like thyroid disease or a vitamin deficiency.

  - Baseline lab Investigations: FBC, LFT, RFT, VDRL, RBS, BS for MPs, HIV, TFT
  - Specific test (toxicology),
  - Imaging (ECG, CT scan and MRI),
  - Other investigations may be considered based on the patient's presentation.

If a patient tests positive for any of the above tests, manage as per medical condition and consider the possibility of co-morbidity in the background of mental illness.

Management of Postpartum depression

Management is similar to the management of a major depressive episode

Healthcare workers attending to the patient should:

- Listen with empathy without criticizing the patient
- Help her to organize help to assist with childcare.
- Encourage her to join a support group
- Encourage her to be active, for example, go for a walk together with a family member
- Encourage the patient to have good nutritional status
- Remind her often that the illness is temporary and that she will get better

3.3.69.3 Psychosocial interventions

Nonpharmacological treatment strategies are useful for women with mild to moderate depressive symptoms.

Different psychotherapy techniques, such as cognitive behavioural and interpersonal therapy, apply depending on assessment and needs.

3.3.69.4 Pharmacotherapy

Pharmacologic strategies are indicated for moderate to severe depressive symptoms or when a woman's condition does not respond to non-pharmacological treatment.

Medication may also be used in conjunction with non-pharmacological therapies.

Use one of the following:

- P.O Fluoxetine -Initial dose 20mg/day in the morning. One can gradually increase the dose by 20mg weekly. Maximum dose 40mg. Preferable use in hypersomnia
- P.O Sertraline 50mg OD with Maximum of 100mg OD
- P. O Amitriptyline -Initial dose 25mg. One can increase by 25mg weekly. Maximum dose 75mg daily especially for those with sleep disturbances.

3.3.69.5 Referral and Linkages

- A Psychologist for psychosocial interventions
- A Psychiatrist if there has been non-response to medication at maximal dosages
- Inpatient hospitalization may be necessary for severe postpartum depression.
- A consideration of electroconvulsive therapy (ECT), which is rapid, safe, and effective for women with severe postpartum depression, especially those with active suicidal ideation.

3.3.70 Birth-related post-traumatic stress disorder

PTSD includes two key elements:

1) Experiencing or witnessing an event involving actual or threatened danger to the self or others, and
2) Responding with intense fear, helplessness or horror to the event or memories of the event.

After childbirth, women may also experience post-traumatic stress disorder (PTSD) which may be caused by having a traumatic birthing experience, miscarriage or neonatal death.

3.3.70.1 Clinical features

Symptoms of birth-related PTSD may include:

- Obsessive thoughts about the birth
- Feelings of panic when near the site where the birth occurred
- Feelings of numbness and detachment
- Disturbing memories of the birth experience
- Nightmares
- Flashbacks
- Sadness, fearfulness, anxiety or irritability

3.3.70.2 Management principles

Treatment follows the same principles of management for post-traumatic stress disorder.

3.3.70.3 Psychotherapy

- Trauma-focused psychotherapy (such as trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing; also known as EMDR) are first line in the treatment of post-traumatic stress disorder

3.3.70.4 Pharmacotherapy

- Antidepressants mainly Selective Serotonin Reuptake Inhibitors e.g., P.O Fluoxetine 20mg am.

3.3.71 Older persons

Mental health conditions among older people are often under-recognized and under-treated, and the stigma surrounding these conditions can make people reluctant to seek help.

3.3.71.1 Risk factors for mental health conditions among older adults

- Stigma related to mental illness: Reluctance to seek help due to stigma surrounding mental health issues.
- Cumulative impact of earlier life experiences, loss of intrinsic capacity, and decline in functional ability.
- Significant life changes such as bereavement, reduced income after retirement, and loss of purpose.
- Negative stereotypes and discrimination based on age, can affect mental health despite older adults' contributions to society.
- Social Isolation and Loneliness: About a quarter of older people experience social isolation, which is a key risk factor for mental health conditions.
- Abuse: Physical, verbal, psychological, sexual, or financial abuse, often perpetrated by caregivers or within family settings.
- Caregiving Burden: Overwhelming responsibilities of caring for spouses with chronic health conditions, such as dementia, impacting caregivers' mental health.
- Chronic illnesses (e.g., heart disease, cancer, stroke), neurological conditions (e.g., dementia), and substance use problems increase the risk of depression and anxiety in older adults.
- Dire living conditions, poor physical health, and lack of access to quality support and services.

Management of mental health conditions among older adults

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

3.3.72 Persons with co-morbid conditions

Managing mental health conditions in individuals with physical comorbidities requires healthcare workers to be mindful of several special considerations and cautions. Integrating a holistic approach to care that addresses both the mental and physical aspects of health is crucial.

Key considerations include:

1. **Interconnected Nature of Health:** Recognize the bidirectional relationship between mental and physical health. Physical health conditions can contribute to or exacerbate mental health issues, and vice versa. Treatments and interventions should address both aspects simultaneously
2. **Communication and Collaboration:** Encourage open communication between mental health professionals and other medical professionals. Collaborative care involving a multidisciplinary team ensures a comprehensive understanding of the individual's overall health and facilitates coordinated treatment plans.
3. **Medication Interactions:** Be cautious of potential interactions between medications for physical and mental health. Some medications may affect mood or cognitive function, and it's essential to monitor for adverse effects or drug interactions.
4. **Screening and Assessment:** Conduct thorough assessments to identify mental health conditions early, especially in individuals with chronic physical conditions. Regular screening for depression, anxiety, and other mental health disorders can help in prompt intervention.
5. **Adapted Treatment Plans:** Tailor mental health interventions to accommodate physical limitations or challenges associated with comorbidities. For example, consider alternative therapeutic modalities for individuals with mobility issues.
6. **Education and Empowerment:** Provide education to patients about the relationship between mental and physical health. Empower them with information on self-management strategies, stress reduction techniques, and lifestyle modifications that support both aspects of their well-being.
7. **Support Networks:** Recognize the importance of social support networks. Encourage patients to engage with friends, family, or support groups, as social connections can positively impact mental health and contribute to overall well-being.
8. **Risk Assessment:** Conduct thorough risk assessments, considering the increased vulnerability of individuals with both mental health and physical conditions. Be vigilant for signs of suicidal ideation or self-harm and develop safety plans accordingly.
9. **Cultural Sensitivity:** Be culturally sensitive in your approach to care. Consider the cultural beliefs, values, and practices that may impact how individuals perceive and cope with mental health issues and physical illnesses.
10. **Regular Follow-ups:** Implement regular follow-up appointments to monitor the progress of both mental health and physical conditions. Adjust treatment plans as needed based on the individual's response to interventions.

11. **Patient-Centered Care:** Prioritize patient-centred care by involving individuals in decision-making processes related to their treatment. Consider their preferences, values, and goals when developing care plans.
12. **Holistic Well-being:** Emphasize the importance of holistic well-being, addressing not only symptoms but also quality of life, functional capacity, and overall life satisfaction.

By adopting a comprehensive and integrated approach, healthcare workers can effectively manage mental health conditions in individuals with physical comorbidities, improving overall outcomes and quality of life for these patients.

SECTION 4: PSYCHOSOCIAL INTERVENTIONS

Introduction

Psychosocial interventions are structured psychological or social interventions used to address mental health problems a person could be experiencing.

These interventions include certain forms of psychotherapy (also known as "talk therapy"), psychoeducation, occupational and sociological therapy as well as spiritual therapy.

The rationale behind the use of psychosocial interventions is that, for individuals experiencing distress due to mental health challenges, once engaged in a therapeutic arrangement, these interventions promote a sense of safety, calm, Self and community efficacy, social connectedness, and Hope.

For these interventions to be effective, there needs to be a strong therapeutic alliance, that is, the relationship between the mental healthcare provider and client. Mental healthcare providers can achieve this relationship by being empathic, genuine, and truly believing in their clients.

This section will explain some psychosocial interventions.

Psychosocial interventions can be delivered in various formats, including individual, group, marital/couple, family, and community settings. There are various methods or approaches to delivering these interventions as indicated below:

4.1. Psychoeducation

Psychoeducation is a type of intervention whereby, the mental healthcare worker provides information to client(s) with mental health conditions, and their kin, the causes, symptoms, prognosis, and treatments of their diagnosed condition, to better understand and cope with the illness.

The goals of psychoeducation include:

a) **Giving information**

The patient needs to know the name of their diagnosed condition, as well as to learn what the diagnosis means for them with regards to factors that contribute to the cause of the condition, symptoms that people with the condition may have, types of treatment available, what patient can expect in the future (the prognosis).

b) **Allowing the patient to release emotions (next of kin as well)**

Psychoeducation allows the patient to process feelings about the diagnosis. As the patient releases these uncomfortable emotions, they may reveal gaps in their understanding of the condition and its treatment.

It is at this point that the mental health provider helps them understand the condition better by providing relevant facts. With time the patient can come to terms with all aspects of the mental health condition.

c) Adherence to treatment

The patient is taught how the medication works, how it will affect the body, and how it will help the mind. Carers/ next of kin are also taught what they can do to help the person adhere to treatment.

They also learn about potential side effects (short and long-term) of any prescribed medication that the person (and their carers) needs to monitor.

Additionally, they are taught about any restrictions they may have when taking the medication e.g. avoiding driving or operating machinery, avoiding caffeine, tobacco and alcohol, drinking plenty of fluids etc.

d) Deepening the patients' role as an "expert"

As the patient learns about helping themselves, they can learn how to recognize negative symptoms as soon as possible and when to report them.

Additionally, the mental health provider can teach the patient self-help skills to diminish or alleviate symptoms, and lifestyle changes, as well as give strategies to accomplish the changes that can positively impact their well-being by suggesting books to read about the condition, websites to visit, or support groups to attend.

4.2. Psychotherapy

Also known as talk therapy, is a type of treatment aimed at relieving emotional distress and mental health problems and utilizes a range of techniques.

For this guideline, we shall discuss

- Cognitive behavior therapy,
- Problem-solving,
- Group therapy
- Brief intervention

4.3. Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is a psycho-social intervention that aims to reduce symptoms of various mental health conditions. It is a combination of cognitive and behavioural strategies aimed at the identification and restructuring of maladaptive thoughts while also providing opportunities to utilize more effective thought patterns through exposure-based experiences.

The cognitive model proposes that distorted or dysfunctional thinking (which influences the patient's mood and behaviour) is common to all psychological disturbances. Realistic evaluation and modification of thinking produce an improvement in mood and behaviour.

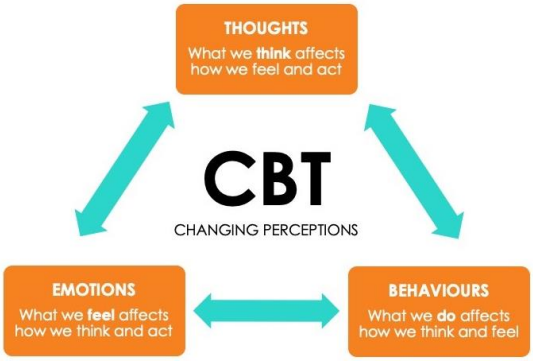
Treatment is based on cognitive formulation, beliefs, and behavioural strategies that characterize a specific disorder. It is also based on a conceptualization or understanding of individual patients.

The principles of treatment in CBT are:

1. An ever-evolving formulation of patients' issues, incorporating an individualized conceptualization of each patient in cognitive terms.
2. A strong therapeutic alliance characterized by a positive rapport between the client and therapist, with the therapist providing unconditional positive regard towards the client.
3. Emphasizes collaboration and active participation. That there is teamwork in the process of therapy.
4. Goal-oriented and problem-focused.
5. Initially emphasizes the present. Treatment focuses on current problems and specific situations that are distressing to them.
6. Educational, aiming to empower the patient to become their therapist while emphasizing relapse prevention.
7. Time-limited.
8. Sessions are structured.
    - An ***introductory*** part (mood check, briefly reviewing week, collaboratively setting session agenda)
    - ***middle*** part (reviewing homework, discussing problems on the agenda, setting new homework, summarizing),
    - ***final*** part (eliciting feedback).
9. Teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
10. Uses a variety of techniques to change thinking, mood and behaviour.

4.4. CBT Triad

A central principle of cognitive theory is that our thinking influences our emotional and behavioural experiences and vice versa. The basic model depicting the interrelationships among thoughts, emotions, and behaviours is indicated below.



Source: https://www.cdchk.org/parent-tips/enhancing-emotional-regulation-with-cbt/

For example:

> "If I like being outside near water and enjoy swimming, the thought of going to a pool makes me feel happy. These thoughts and feelings are going to lead me to plan activities that include swimming. However, if the thought of being near water scares my friend, she will avoid swimming. The same experience (swimming) viewed differently by each of us (thoughts) causes different emotions (happiness or fear) which leads to different behaviours (going to the pool or not)."

4.1.1 CBT session structure

A recommended structure for the CBT session:

- Setting the session agenda (and providing a rationale for doing so).
- Doing a mood check, including objective scores.
- Briefly reviewing the presenting problem and obtaining an update (since evaluation).
- Identifying problems and setting goals.
- Educating the patient about the cognitive model. (during the initial session)
- Eliciting the patient's expectations for therapy. (during the initial session)
- Educating the patient about the disorder. (during the initial session)
- Setting homework.
- Providing a summary.
- Eliciting feedback from patients.

4.1.2 Problem-Solving Techniques

Problem-solving techniques generally involve a process by which an individual attempts to identify effective means of coping with problems of everyday living.

This often involves a set of steps for analyzing a problem, identifying options for coping, evaluating the options, deciding upon a plan, and developing strategies for implementing the plan.

Problem-solving techniques teach skills that help the patient gain increased control over issues that previously felt overwhelming or unmanageable. In so doing, problem-solving can help with practical problem resolution and emotion-focused coping (e.g., increasing control, decreasing stress, and increasing hopefulness).

An effective strategy for the problem could include the **SOLVED** technique as below:

S (Selecting a Problem) the patient would like to solve. Ask the patient to think about situations when they feel distressed or have difficulty problem-solving.

O (Opening Your Mind to All Solutions) encourages the patient to brainstorm all possible solutions.

L (Listing the Potential Pros and Cons of Each Potential Solution) For each option considered, ask the patient to list the potential advantages and disadvantages. This will help them in choosing an option.

V (Verifying the Best Solution) Once a solution has been identified, the patient chooses the best solution for themselves and can rank the answers selected.

E (Enacting the Plan) identifies the steps needed to implement the selected solution. Patients may need to break down actions into small steps to facilitate achieving goals.

D (Deciding if the Plan Worked) Follow up with patients to see how well the solution picked worked for them. If it did, give positive reinforcement. If it does not work, return to the options generated at O and L for potential solutions.

See Annex 7 for the SOLVED template

4.5. Group Therapy

Group therapy is a type of psychotherapy in which carefully selected patients are placed in a group facilitated by a psychotherapist to stimulate the patients to help each other as well as cause changes to the patient's personality and behaviour.

The objectives of group therapy include:

- Describe the elements of group therapy that can increase the chance of patients benefiting from the treatment process.
- Review the presence and management of issues of patient confidentiality during group therapy sessions.
- Summarize the management of internal issues that disrupt group therapy sessions.
- Explain the importance of collaborative efforts when providing treatment in a group setting.

The mental healthcare provider decides on which patients will benefit the most from the group therapy and makes the selection.

It is necessary to include patients in different stages of treatment/recovery to help facilitate individual recovery.

By comparing themselves to other patients in the recovery process, they (patients) can see themselves in the recovery process. Furthermore, seeing patients worse off than them but still contributing to the group can provide motivation, keeping patients committed to the treatment process.

The mental health provider should ensure the group members range between 10 to 12 for ease of facilitating the treatment sessions. The sessions can last between one to two hours once a week.

Structure of group therapy session:

1. Members introduce themselves and share why they are in the group
2. Set some group ground rules (during the initial group therapy session)

3. Set the meeting objectives- Before each group therapy session, it's crucial to define the objectives you want to achieve. Whether it's building trust among group members, promoting self-reflection, or addressing specific issues, having clear objectives will guide the flow of the meeting and help participants understand what they can expect.
4. Prepare discussion topics- it's essential to have relevant topics ready for each meeting. Based on the objectives you've set, brainstorm discussion topics that will encourage group participation and foster a supportive environment. Consider including topics related to coping mechanisms, personal growth, or specific challenges that group members may be facing.
5. Allocate time for each agenda item- This will help you manage the flow of the session and make sure that all important topics are covered within the designated time frame.
6. Document meeting outcomes and action items- After each group therapy session, it's crucial to document the outcomes and action items discussed during the meeting. This will help you track progress, identify recurring themes, and provide a reference point for future sessions.

4.6. Brief Intervention (BI)

Brief intervention therapy is a solutions-focused, short counseling treatment usually delivered to patients who are not actively seeking treatment for their unhealthy behaviors, addiction or substance abuse. These are appropriate for individuals who are at an increased risk of developing substance use disorder or health-risk behavior. It’s a helpful tool for them to see the benefits of treatment and the need for a change in their behavior.

BIs are time-limited, patient-centered conversations structured to facilitate effective behavior change. These work by addressing an individual's internal unsureness toward behavior change and connecting this change to individual values.

While brief intervention therapy is often used for alcohol addiction or other substance use disorders, it can be used for various unhealthy or health-risk behavior including unsafe sexual practices, non-adherence to prescribed medical regimens.

Approach used in brief intervention

BIs use the approach commonly known as FRAMES. **F, A**, and **M** describe what is provided in brief intervention; **R, E** and **S** describe how brief intervention is provided (Beyer, Lynch, & Kaner, 2018).

F- FEEDBACK about personal risk or level of current harm, as indicated by the screening process.

R-RESPONSIBILITY for choices and change sit with the person. It is not the role of the professional to confront or persuade. Respect the person's autonomy.

A-ADVICE: increase the person's awareness of the costs and consequences of their behavior and provide advice to support positive change.

M-MENU: outline options or strategies to support positive change; help with goals and action planning if appropriate to the person.

E-EMPATHY: listen and reflect; maintain rapport; use an empathic communication style.

S-SELF-EFFICACY: convey optimism and strengthen the person's self-belief in their ability to change.

Steps in Brief Intervention.

Introduce the subject- in a general setting where a person is not expecting to talk about their issue, introducing the subject can be the biggest hurdle for the HCW. The key is for the HCW to be clear, confident, and relaxed in talking about these issues and to normalize the process.

Screening - A standardized screening tool provides more accurate information for the person being screened and can be useful for a healthcare worker who does not have specialist knowledge.

Provide feedback and advice - the HCW provides individualized information about the level of risk and harm by interpreting the screening results. This could help the patient reflect and review behavior and advice to assist with reducing risk and/or harm.

Listen for readiness and confidence - the HCW pays attention to what the patient says which indicates their willingness level to change their behavior. They can do this by asking questions such as:

- *Their thoughts about the screening results*
- *Concerns they could be having and whether making a change is worthwhile*
- *Benefits for or against making changes*
- *Eliciting change talk e.g. "On a scale of 1-10, if 1 is not ready at all and 10 is ready, how ready are you to make changes to your (issue)? What are some of your reasons for giving this rating? OR "why did you rate 5 instead of 3?"*

If the patient is not ready to change, thank him or her for checking their (issue), and offer to speak with them again if they ever want to change.

Providing further information as appropriate - the HCW gives options to the patient. This can be in the form of leaflets, a book to read or a website to visit.

See the annex for sample summary of BI intervention for addictive behaviors.

Table 25: More Psychotherapy Techniques…

More Psychotherapy Techniques…	
Crisis intervention Therapy	This approach provides emergency psychological care, assisting individuals in returning to normal levels of functioning and preventing or alleviating potential psychological trauma. It is indicated for acute stress, anxiety, fear of the unknown, abuse or life events such as death, divorce, separation, assaults, rape and imprisonment, common with drug users.
Motivational Interviewing (MI)	Motivational Interviewing (MI) techniques are good at encouraging behavior change to support one's well-being. The focus is on intrinsic motivation, which is important in eliciting individual focus, efforts and energy to move through the change process. In MI, the therapist first engages with the patient, then focuses on an issue or goal for their work together. Lastly, the therapist evokes the patients' motivation to change. Once a decision to change has been made, the therapist assists the patient in making plans while strengthening their commitment to change and carrying out their change plans.
Interpersonal Therapy (IPT)	Interpersonal Psychotherapy initially was used to treat major depression but has been adapted to treat other mental illnesses. It focuses on helping the patient effectively deal with social and life events while reducing depression symptoms. At the same time, the counselor serves as a supportive component in the patient's life by helping the client understand the symptoms of their disease and assist in problem-solving.
Eye Movement Desensitization and Reprocessing (EMDR)	In the treatment of trauma-related disturbances, the therapy combines eye movements with cognitive processing and exposure with the goal of numbing traumatic experiences, as well as reprocessing them to reduce distress. Intrusive memories are reduced and made ambiguous by focusing on rhythmic directed eye movement and images of traumatic events.
Family Therapy	This is a therapeutic space where preferentially, all family members attend the therapy session. A therapist gets to listen and observe family relations as he/she deciphers the interpersonal causes of distress. This may also involve individual interviews with each family member and observations within the home environment. The therapists then postulate the reason for distress within the family, which the family discuss, shapes the problem together, and agrees on management. The therapist then follows up on the agreed behavior changes. The integration of family is resourceful in determining the course and outcomes of treatment.

More Psychotherapy Techniques...	
Social Support	Social support ensures that people who are overwhelmed by certain adverse situations can overcome their stressful situations because the community can work with them by accepting them and supporting the family members to take care of the affected people. For instance, the community can assist the family in taking the person with the mental illness to the hospital and assisting financially when needed.
Social Skills Training (SST)	SST generally begins with assessing a client's specific skill deficits and impairments. The therapist may then ask which social interactions a client finds most challenging or which skills they want to improve. The goal is to identify the best targets for social skills training for a particular situation. Some examples of skills targeted in SST programs include: initiating conversations, greetings, appropriate eye contact, social interaction, and how to behave in specific social and community settings. Once specific target areas are identified, techniques for improving social skills are introduced. Usually, changes are made in one area at a time to ensure the client is calm. Caregivers of children with Autism would benefit from this
Referral and linkage	This is a psycho-social intervention that is applied when the service provider cannot handle some of a client's needs. For the intervention to work successfully, the referring provider needs to call the recipient provider at the other end of the service to inform them that he/she is referring a client to them. A follow up call should be made to ensure the client reached the place and was received.
Sensitization and awareness creation	This entails talking to the community members about mental health issues that are prevalent in the community. This encourages the involvement of community members in efforts to fight these issues as opposed to them being bystanders. Service providers work with the local administrators and community health volunteers in barazas to sensitize the community and create awareness of mental health issues, the services available and where they can be accessed. The community then actively supports people with mental illness and survivors of sexual and gender-based violence to fit in the community by showing them love and not stigmatizing them.

Table 26: Brief Intervention/Recommendation

Intervention:	Recommended for:
Behavioral Activation	Depression
Relaxation Training	Depression, Anxiety

Intervention:	Recommended for:
Problem Solving Treatment	Depression
Cognitive Behavioral Therapy (CBT)	Depression, Child mental health conditions, substance use disorders, psychoses
Contingency Management Therapy	Substance use disorders
Family Counseling or Therapy	psychoses, substance use disorders
Interpersonal Therapy (IPT)	Depression
Motivational Enhancement Therapy	Substance use disorders
Parent Skills Training, Social skills training	Child mental health conditions

4.7. Occupational therapy approach.

The occupational therapy approach refers to interventions carried out by occupational therapists (OTs). These interventions address the physical, mental, developmental, and emotional ailments of individuals, which interfere with or prevent them from carrying out activities and routines in their personal and professional life on a day-to-day basis.

Occupational therapists involve the psychiatric patient in meaningful activities that focus on aspects of individual functioning including self-care, productivity through work, education, leisure, and social and occupational skills training to reintegrate the client into mainstream society.

OTs work with patients to build skills and adapt their environment in ways that make it easier for them to do the things they both need and want, helping patients regain a sense of accomplishment and pleasure from taking action to help themselves.

Focus is mainly on the performance areas that include:

1. Activities of daily living.
2. Work and productive activities,
3. Play or leisure activities.

OTs involve performance components in the intervention plan to improve the performance areas.

Performance components are:

1. The sensorimotor component- It includes, sensory processing, range of motion, muscle strength, endurance, postural control, etc. for example: manipulating small objects, such as beads, buttons, or pegs, to improve hand-eye coordination, precision, and dexterity.
2. The cognitive/ cognitive integration component- Attention and concentration exercises, memory enhancement activities, problem-solving, and breaking down

complex activities into smaller, manageable steps to facilitate learning and successful completion of tasks.
3. The psychosocial/ psychological components – It includes interest, role performance, social interaction, coping skills, vocational rehabilitation among others.

4.8. Sociological therapy approach

Sociological approaches regard mental health and illness as aspects of social circumstances. This approach recognizes that an individual's mental health is shaped by various societal factors and emphasizes the importance of social context in both understanding and treating mental health challenges.

This approach focuses on how processes such as life events, social conditions, social roles, social structures, and cultural systems of meaning affect states of mind.

Some examples of how a patient with mental illness is treated using this approach may include:

1. Analyzing, assessing and understanding how various social systems, such as family, community, workplace, and broader societal structures, contribute to a patient's mental health. This looks to improve areas such as communication, address conflicts, and create a supportive environment for the individual's mental health.
2. Recognizing the influence of culture on mental health perceptions, coping mechanisms, and help-seeking behaviours of a patient
3. Conducting community-based interventions such as support groups, and community psychiatry clinics to address shared social challenges contributing to mental health issues.
4. Engaging in advocacy and awareness creation on mental health to address systemic issues such as discrimination, inequality, and lack of access to resources. This can involve collaborating with community organizations, participating in public awareness campaigns, or advocating for policy changes.
5. Encouraging the strengthening of the patient's social support networks, emphasizing the importance of positive relationships and connections in promoting mental well-being.
6. Recognizing the impact of societal trauma by acknowledging the role of systemic violence, discrimination, or historical trauma in mental health struggles in the provision of trauma-informed care.
7. Encouraging individuals to explore and reframe their narratives within a social context, considering societal influences on identity, self-perception, and life experiences.
8. Referring the patient to other services such as legal, educational, and social services as appropriate

By adopting a sociological approach in mental health therapy, not only individual symptoms are addressed but also the social factors that contribute to and maintain mental health challenges. Thus, aiming for a holistic change at both the individual and societal levels.

4.9. Spiritual Therapy Approach

Spirituality is a deep well upon which many people draw in times of crisis, unrest, or personal challenge. It reinforces inner peace and provides a sense of connection to a force greater than ourselves. Even people who do not practice religion can take comfort in spirituality since it is a prevalent concept among secular communities.

Spirituality is a way of integrating our own experiences with the idea of something more overarching and more timeless than ourselves.

People use spirituality to:

- Deepen their relationships with themselves and others
- Find purpose in life
- Find comfort in difficult times—as in illness, bereavement, breakups, and unemployment
- Understand the idea of the afterlife (even if one's belief is that there is no life after death)
- Gain and cultivate hope

Spirituality and religion are not the same thing. Religion is a type of codified spirituality in which all followers practice the same faith and pray to the same deity.

4.10. Psychosocial interventions for children

When working with children, it is important to consider their age, developmental stage as well as their individual needs. Additionally, the role a parent or caregiver as well as any other significant person such as teachers, should not be overlooked as they can offer input as well as implement an intervention plan that will help the child resolve their psychosocial issues.

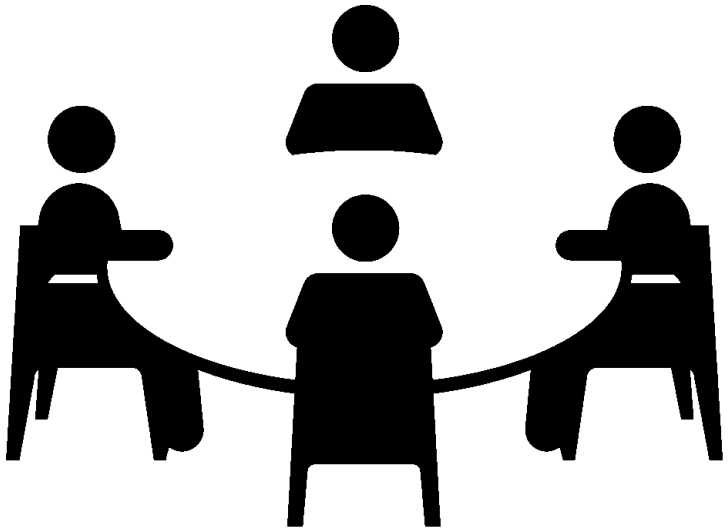
Building a trusting and positive therapeutic relationship with the child is core, for the success of psychosocial interventions. Always prioritize the child's well-being and actively involve parents or guardians in the therapeutic process when appropriate.

Special considerations when providing psychosocial support to children may include:

- Upholding ethical standards in working with children, ensuring informed consent, confidentiality, and respect for their rights and autonomy.
- Tailoring interventions to the child's developmental stage.
- Use of language and activities that are age-appropriate thus ensuring children can understand and engage in the intervention effectively.
- Recognizing and respecting the individual differences among children, including temperament, personality, learning styles, and cultural background.
- Involving parents, caregivers or other significant persons such as teachers in the intervention process to address academic and social challenges that may impact the child's well-being.

- Cultural sensitivity and awareness of the diverse backgrounds and beliefs of children and their families. Consider cultural factors that may influence the child's worldview and approach to mental health.
- Awareness of the potential impact of trauma on a child's mental health. Implement trauma-informed approaches that prioritize safety, trust-building, and sensitivity to the child's experiences.
- Recognize the importance of play in a child's development. Incorporate play-based interventions to facilitate expression, communication, and emotional regulation.
- Teach and reinforce age-appropriate coping skills to help children manage stress, anxiety, and other emotions. This can include breathing exercises, relaxation techniques, or creative outlets.
- Be flexible and adaptable in your approach, considering the child's changing needs and preferences. Modify interventions as necessary to ensure they remain engaging and effective.
- Foster a sense of empowerment and autonomy in the child. Involve them in decision-making when appropriate and encourage the development of self-efficacy.
- Assess and address social skills development. Interventions may include activities that promote positive peer interactions, communication, and conflict resolution.
- Explore the use of technology as a tool for engagement. Age-appropriate digital resources and platforms can enhance intervention effectiveness, especially for tech-savvy children.
- Establish clear goals and regularly assess the child's progress. Use age-appropriate methods to measure changes in behaviour, emotional well-being, and other relevant outcomes.

SECTION 5: ANNEXES



Annex 1: Relevant Policies and Guidance Documents

- Constitution of Kenya, 2010
- Kenya Mental Health Policy, 2015-2030
- Kenya Health Act 2017
- National Protocol for Treatment of Substance Use Disorders in Kenya, 2016
- Pharmacy and Poisons Act, 2009
- Narcotics and Psychotropics Act, 1994
- WHO Quality Rights in Mental Health Care
- Suicide Prevention Strategy
- Kenya Essential Medicines List
- Kenya Mental Health (Amendment) Act 2022

Annex 2: Mental Status Examination in Adults

When conducting a mental status exam, lookout for changes or abnormalities in the following areas

a) Behavior and Appearance

Lookout for how the patient behaves towards the examiner:

- Is the patient cooperative, defensive, engaging, evasive, hostile, guarded?
- Is there rapport established between patient and the examiner?
- Is eye contact made and is it maintained?
- How are the clothes, grooming, hair, nails?
- Are the patients old/ young looking, sickly/ healthy, apathetic, frightened, confused?
- Have signs of anxiety such as perspiring forehead, restlessness.
- How is the patients' gait and posture?
- Does the patient have mannerisms, stereotypical twitches, tics, clumsiness?
- Have psychomotor activity and disturbances like hyperactive, rigid, clumsy, waxy, agile and retarded.

b) Emotion

Mood

- How does the patient say he/ she feels (subjective mood)?
- Assess for intensity, duration, and fluctuation.
- Here are some descriptions; depressed, anxious, angry, guilty, sad, euphoric, empty, no feelings and lack of pleasure.

Affect

- What the examiner observes as the patient's feelings (objective).
- Assess the amount and range of expressions and if the affect is congruent to the mood and appropriate to the setting.
- Possible descriptors; broad, restricted, shallow, and blunted/ flat

c) Speech

Look for changes in speech in rhythm, rate, volume, and tone. This includes patterns such as rapid, slow, monotonous, emotional, loud, whispered, mumbled, slurred, spontaneous, and echolalia.

d) Thought

Thought Process

Here, we are looking out for whether the patient's thought process is normal in rate, form and flow.

1) *Productivity:* Does the patient think spontaneously or only when questions are asked? Is there an overabundance of ideas or paucity of ideas? Here are some descriptors - Rapid thinking, slow thinking, hesitant thinking, and stream of thinking.
2) *Continuity of thought:* Does the patient answer questions? Are the answers goal-directed? Are the answers relevant or irrelevant? Possible descriptors: circumstantiality, tangential, loosening of associations, flight of ideas, thought blocking and perseveration.
3) *Language impairments:* Is there any deficiency that reveals disordered mentation? Is there incoherent or incomprehensible speech? Descriptors include word salad, clang associations and neologisms.

Thought Content

Here we are looking at what the patient is thinking about.

- Is the patient preoccupied with thoughts of a certain topic?
- Are there any obsessions, compulsions, or phobias?
- Are there any thoughts of suicide or homicide?
- Any hypochondriacal symptoms?
- Any antisocial urges or impulses?

Here are some disturbances in thought content that you can find with a patient:

1) *Delusions:* A belief that is held persistently despite that it conflicts with reality. Check on how the delusions affect the patients' life? Are the delusions mood congruent or mood incongruent? Types of delusions may include persecutory, grandiose and jealousy.
2) *Ideas of reference:* A belief that innocuous and irrelevant things refer to the person directly or have a special personal significance.
3) *Ideas of influence:* A false belief that the person's thoughts, movements or actions are controlled by external forces.
4) *Thought broadcasting:* Person believes that their thoughts are being heard by others.
5) *Thought insertion:* Person believes that thoughts are being put into their mind by others.

Assess how these ideas began, what is their content and what is their meaning to the patient?

e) Perception

Hallucinations: This is a perception in a sensory modality that appears real but is not there. They may be auditory, visual, olfactory, gustatory, and tactile. Assess the content of the hallucinations and the circumstances under which they occur. Illusions: This is a misinterpretation of an experienced sensation. Assess the content and context.
Derealization and depersonalization: A feeling of being disconnected or detached from one's surroundings or one's body.

f) Insight

Is the person aware that they have a mental illness? To what level is this awareness?

- *Level 1:* Complete denial of disease.

- *Level 2:* Slight awareness of the illness and needing help but denying it at the same time.
- *Level 3:* Awareness of the illness but blaming others or external factors like physical illness.
- *Level 4:* Awareness that illness is caused by something unknown.
- *Level 5:* Intellectual insight; awareness that there is a mental illness without applying this knowledge to future experiences.
- *Level 6:* Emotional insight; Awareness into the feelings and illness and ability to modify.

g) Cognition

1. *Level of consciousness:* Does the patient have clouding of consciousness? Are they aware of their surroundings? Is there fluctuation in alertness? Possible descriptors - sleepiness, stupor and coma.
2. *Orientation*
    a. Time: Does the person know the date, and can they approximate the time? Does the person behave as if they are oriented in the present? If they have been in hospital, do they know how long they have been there?
    b. Person: Can the patient identify the people they are with? Does the patient know who the examiner is?
    c. Place: Does the person know where they are?

Concentration and Attention

Serial 7 test: The patient subtracts 7 from 100 and keeps subtracting up to the 5th time or they are unable to continue. If unable, apply serial 3, then serial 5.

Can the person spell 'world' or any other word forwards and backwards?

Memory

Check for the patient's immediate, short-term, and long-term.

What are the patients' coping strategies for memory loss? Is there confabulation, denial, catastrophic reaction, or circumstantiality? Are the processes of registration, retention and recall present?

PS: To check for immediate memory, name three things that you would like the patient to remember. Do this before you start the MSE.

h) Knowledge, Abstract Thinking and Judgement

Check for general knowledge. For example, is the person able to name 5 counties in Kenya or former presidents?

Check for abstract thinking. For example, can the person interpret a proverb such as '*haraka haraka haina baraka.*'

Check for judgment. Is the person able to figure out how to run away from a burning building.

Mental Status Examination in Children

This can be obtained through observations and specific questioning:

- **Physical appearance;** observe for size, grooming, nutritional state, facial expressions, physical signs of anxiety and mannerisms.
- **Parent-child interaction;** note this interaction and the emotional overtones.
- **Separation and reunion:** observe for either lack of effect at separation and re-union or severe distress at separation and reunion.
- **Orientation in time, place and person;** impairments may indicate for example intellectual disability (keep in mind the child's chronological age).
- **Speech and language;** is it appropriate for age? spontaneous? what is its rate of speech? Articulation? echolalia? repetitive stereotypic phrases, etc.
- **Mood:** Observing for sadness, lack of appropriate smiling, tearfulness, anxiety and anger may indicate a mood disorder. Persistent themes in play and fantasy may also reflect the child's mood.
- **Affect:** note the child's range of emotional expressivity, appropriateness of affect to thought content, ability to move smoothly from one affect to another and sudden labile emotional shifts. Thought process; look for loosening of associations, excessive magical thinking, echolalia, perseverations, and the ability to reason logically.
- Thought content, delusions, obsessions, preoccupations, suicidal and homicidal ideations and aggressive thoughts.
- **Social relatedness;** assess the appropriateness of the child's responses, general level of social skills and eye contact.
- **Motor behaviour:** observe the child's coordination and activity level and how they carry out age-appropriate tasks. Also take note of any involuntary movements, tremors, and motor hyperactivity.
- **Cognition;** assess child's intellectual functioning and problem-solving abilities.
- **Judgment and insight;** the child's view of the problems, reaction to them, and suggested solutions may indicate the child's judgement and insight.

Annex 3: Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health illness. Do not include impairment in functioning due to physical (or environmental) limitations.	
Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)	
100 - 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 - 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities. socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).
80 - 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g., temporarily failing behind in schoolwork).
70 - 61	Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 - 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).
50 - 41	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 - 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., a depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 - 21	Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 - 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears faeces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 - 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death. 0 Inadequate information.

Annex 4: CAGE- AID: Substance Abuse Screening Tool

Patient Name _____ **Date of Visit** _____

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to

cast a wider net and identify more patients who may have substance abuse disorders. Several other screening tools are available.

Annex 5: GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Column totals	_____ +	_____ +	_____ +	_____ +

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr.Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety 15–21: severe anxiety

Annex 6: ASQ Suicide Screening Tool

1. In the past few weeks, have you wished you were dead?	○ Yes	○ Yes
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?	○ Yes	○ Yes
3. In the past week, have you been having thoughts about killing yourself?	○ Yes	○ Yes
4. Have you ever tried to kill yourself?	○ Yes	○ Yes

If yes, how? _____

When? _____

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?	○ Yes	○ Yes

If yes, please describe: _____

Next steps:

- If the patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5).
  No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:

"Yes" to question #5 = acute positive screen (imminent risk identified)

- The patient requires a STAT safety/full mental health evaluation. The patient cannot leave until evaluated for safety.
- Keep patient in sight. Remove all dangerous objects from the room. Alert physician or clinician responsible for patient's care.

"No" to question #5 = non-acute positive screen (potential risk identified)

- The patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. The patient cannot leave until evaluated for safety.
- Alert the physician or clinician responsible for the patient's care.

Source: https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit.pdf

Annex 7: Problem-solving template

Specific Problem: _____

_____

Open Your Mind **L**ist

To Possible Solutions	PROS AND CONS
1.	
2.	
3.	
4.	

Verify the best solution by circling your choice.

Enact the Solution.

Steps and Time Frame of Solution:

1._____Time:_____
2._____Time:_____
3._____Time:_____

Decide if Your Solution Worked: **[ ] YES [ ] NO**

Source: https://depts.washington.edu/dbpeds/therapists_guide_to_brief_cbtmanual.pdf

Annex 8: BI Intervention for Addictive Behaviour

Brief Intervention for Addictive Behavior – Summary

1. Introduce the Topic

"Is it okay if we briefly talk about (issue) and how it affects your life? We can go over a few quick questions together."

2. Screen

"Have you ever felt the need to be dishonest with those close to you about how much you (issue)?"

"Have you ever experienced the urge to engage in (issue) more frequently?"

3. Offer Feedback and Advice

"The screening suggests that you are engaging in (issue) at a harmful level. This could negatively impact your mental health, finances, and relationships. The best course of action is to try and stop. I know it's challenging, but some resources can help support you."

4. Gauge Readiness and Confidence

"Quitting (issue) can be tough, but many avenues for help and support are available."

5. Provide Additional Resources

"Would you like to explore some options (give examples)?"

Note: *The person can exit at any stage if they prefer not to continue.*

Annex 9: Toll-Free Lines for Psychosocial Support:

1199	Kenya Red Cross
1192	NACADA For Substance Abuse Counselling
21094	Gender-Based Violence
1195	Gender-Based Violence
1196	Gender-Based Violence for Men
1190	LVCT For General Counselling Services
116	Child Help Line
911	Police
112	Police

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REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL CLINICAL GUIDELINES FOR MANAGEMENT OF COMMON MENTAL DISORDERS

PEPFAR

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION