

SOP for Management of Patients with Mental Disorders

Management of Substance-Induced Psychosis

1.0 PURPOSE

- To provide standardized procedures for the identification, assessment, immediate management, treatment, referral, and follow-up of patients presenting with Substance-Induced Psychosis (SIP) in order to ensure safe, ethical, and evidence-based care aligned with WHO mental health and patient safety principles.

2.0 SCOPE

This SOP applies to all patients presenting with suspected or confirmed substance-induced psychosis in the following hospital areas:

- Emergency Department (ED)
- Psychiatry Unit
- Medical Wards
- Intensive Care Unit (ICU)
- Outpatient Department (OPD)

This SOP applies to all healthcare workers involved in patient care including doctors, nurses, mental health professionals, social workers, and security staff.

3.0 POLICY STATEMENT (WHO-ALIGNED)

The hospital is committed to managing Substance-Induced Psychosis using the following principles:

- Patient dignity, human rights, and non-discrimination
- Confidentiality and privacy
- Informed consent where clinically possible
- Early detection and rapid stabilization
- Safety of patient, staff, and the public
- Least restrictive care approach
- Restraint and seclusion only as a last resort and for the shortest duration
- Continuity of care through referral, discharge planning, and follow-up

4.0 DEFINITIONS

Substance-Induced Psychosis (SIP): A psychotic episode (hallucinations and/or delusions) directly caused by intoxication, withdrawal, or exposure to a psychoactive substance.

Psychosis: A condition characterized by impaired reality testing, hallucinations, delusions, and disorganized thinking.

Delirium: Acute disturbance of attention, awareness, and cognition usually due to medical illness or substance intoxication/withdrawal.

Agitation: Excessive motor activity associated with emotional tension that may lead to aggressive behavior.

Restraint: Physical or mechanical restriction used to limit movement to prevent harm.

5.0 RESPONSIBILITIES

5.1 Emergency Physician / Attending Doctor

- Conduct immediate medical stabilization and assessment
- Rule out medical emergencies (hypoglycemia, head injury, overdose)
- Request urgent psychiatry consult
- Prescribe emergency sedation if indicated

5.2 Psychiatrist / Mental Health Specialist

- Conduct mental status examination and confirm diagnosis
- Develop treatment plan (medication + admission/referral)
- Evaluate suicide/violence risk
- Determine need for involuntary admission based on local law

5.3 Nurses (ED/Medical/Psychiatric)

- Continuous observation and monitoring of vital signs
- Implement de-escalation strategies
- Administer prescribed medications
- Document behavior, interventions, and patient response

5.4 Social Worker / Counselor

- Conduct psychosocial assessment
- Provide brief intervention and counseling
- Coordinate family involvement with consent
- Arrange referral to rehabilitation/addiction services

5.5 Security Staff

- Support staff in maintaining safety
- Assist in controlling aggressive situations without unnecessary force
- Follow hospital violence prevention procedures

6.0 REQUIRED MATERIALS / RESOURCES

- Triage and risk assessment form
- Mental Status Examination (MSE) form
- Suicide risk assessment checklist
- Toxicology screening access (urine/blood)
- Emergency sedation medications (as per hospital protocol)
- Restraint equipment (if permitted)
- Observation room / safe area
- Incident reporting forms
- Referral forms for psychiatry and substance rehabilitation services

7.0 PROCEDURE

7.1 Patient Reception and Triage

1. Register patient and identify referral source (self, family, police, ambulance).
2. Perform rapid triage and assign priority level.
3. Assess immediate threats (violence, suicide risk, severe confusion).
4. Place patient in a safe observation area.
5. Remove potential harmful objects if feasible.

7.2 Immediate Safety Measures

1. Ensure safety of staff and other patients.
2. Maintain calm environment and reduce noise/stimulation.
3. Assign staff for close monitoring.
4. Do not leave high-risk patient unattended.
5. Request security support if there is risk of aggression.

7.3 Clinical Assessment (Medical Stabilization)

1. Record vital signs (BP, pulse, temperature, oxygen saturation).
2. Check random blood sugar.
3. Assess airway, breathing, circulation (ABC).
4. Identify signs of overdose, withdrawal, or trauma.

5. Perform neurological assessment.
6. Conduct physical examination focusing on head injury and infection.

7.4 Substance Use History

Obtain history from patient and/or relatives (if possible):

- Substance used (alcohol, cannabis, methamphetamine, cocaine, opioids, hallucinogens, inhalants)
- Quantity and route (smoking, injection, oral)
- Time of last use
- Previous psychotic episodes
- Previous psychiatric diagnosis
- Current medications
- History of withdrawal symptoms
- Past overdose or seizures

7.5 Mental Status Examination (MSE)

Perform and document the MSE including:

- Appearance and behavior
- Speech
- Mood and affect
- Thought process
- Thought content (delusions, paranoia)
- Perception (hallucinations)
- Cognition and orientation
- Insight and judgment

7.6 Differential Diagnosis (Rule Out Delirium and Medical Causes)

The clinician must rule out medical conditions that may mimic psychosis, including:

- Hypoglycemia
- CNS infection (meningitis/encephalitis)
- Head trauma
- Seizure disorder
- Electrolyte imbalance
- Thyroid disorders
- Delirium tremens (alcohol withdrawal)
- Medication-induced psychosis (steroids, anticholinergics)

7.7 Required Investigations

Investigations should be ordered as clinically indicated:

- CBC
- Electrolytes, renal function tests
- Liver function tests
- Blood glucose
- Urine toxicology screen
- Blood alcohol level (if available)
- ECG (especially if stimulant intoxication suspected)
- CT brain (if trauma, seizures, or neurological signs)
- Pregnancy test (for females of reproductive age)

7.8 Risk Assessment (Suicide and Violence)

Assess risk level and document findings.

Suicide risk screening questions:

- Have you thought about harming yourself?
- Do you have a plan?
- Have you attempted suicide before?

Violence risk indicators:

- severe agitation
- command hallucinations
- paranoia and suspiciousness
- intoxication with stimulants
- access to weapons

7.9 Management Plan (Non-Pharmacological)

1. Use verbal de-escalation as first-line management.
2. Provide reassurance and clear instructions.
3. Avoid confrontation or arguing with delusions.
4. Maintain adequate lighting and orientation cues.
5. Allow presence of trusted family member if safe and with consent.
6. Encourage hydration and rest when medically appropriate.

7.10 Emergency Pharmacological Management

General principles:

- Use the lowest effective dose.
- Monitor airway, breathing, and circulation.

- Monitor ECG when antipsychotics are used (QT prolongation risk).

Common medication classes used (depending on protocol):

- Benzodiazepines for acute agitation
- Antipsychotics for severe psychosis

Patients must be monitored for adverse effects such as respiratory depression, hypotension, dystonia, and neuroleptic malignant syndrome.

7.11 Management of Specific Substance Presentations

A. Stimulant-induced psychosis (methamphetamine/cocaine):

- prioritize sedation, hydration, cooling if hyperthermia
- monitor ECG and blood pressure

B. Alcohol withdrawal with psychosis:

- manage withdrawal protocol and monitor seizures

C. Cannabis-induced psychosis:

- supportive care and psychiatric monitoring

D. Hallucinogen-induced psychosis:

- quiet room, reassurance, sedation if required

7.12 Use of Restraint (Last Resort)

Restraint must only be used when:

- the patient poses immediate danger to self or others
- all de-escalation attempts have failed

Requirements:

1. Must be authorized by a physician.
2. Must be time-limited.
3. Continuous monitoring is mandatory.
4. Patient dignity must be preserved.
5. Documentation must include reason, start/stop time, and monitoring chart.

7.13 Admission, Referral, and Transfer Criteria

Admit patient if:

- persistent psychosis after intoxication resolves

- high suicide risk or self-harm attempt
- aggressive behavior requiring monitoring
- severe withdrawal symptoms
- no reliable family support

Refer outpatient if:

- symptoms resolved and patient stable
- low risk of harm
- follow-up appointment arranged

Transfer to higher-level facility if:

- ICU support required
- severe medical complications (respiratory depression, seizures)
- specialized psychiatric services unavailable

7.14 Discharge Planning and Follow-Up

Before discharge:

1. Ensure patient is clinically stable and oriented.
2. Provide brief counseling on substance risks.
3. Provide relapse warning signs and crisis plan.
4. Arrange follow-up with psychiatry/addiction services within 7 days.
5. Provide emergency contact numbers.
6. Document discharge summary and referral.

8.0 DOCUMENTATION REQUIREMENTS

The following documentation is mandatory:

- Triage form and risk categorization
- Medical assessment findings
- Mental Status Examination record
- Substance use history documentation
- Toxicology and laboratory results
- Treatment and medication chart
- Restraint/seclusion documentation (if used)
- Incident report (if violence occurred)
- Discharge summary and referral form

9.0 CONFIDENTIALITY AND ETHICAL CONSIDERATIONS

1. Maintain confidentiality of all patient information.
2. Obtain informed consent before involving relatives, except in emergencies.
3. Provide non-discriminatory care regardless of substance use.
4. Follow national laws for involuntary admission and mandatory reporting.
5. Ensure respect for patient dignity at all times.

10.0 REFERENCES

- World Health Organization (WHO) mhGAP Intervention Guide
- WHO Quality Rights Toolkit
- WHO Mental Health Action Plan
- National Mental Health and Substance Use Guidelines
- Hospital Emergency and Patient Safety Policies

Management of Substance Use Disorder

1. Purpose

To provide standardized guidelines for the identification, assessment, treatment, referral, and follow-up of patients with substance use disorder (SUD) in the hospital setting to ensure safe, ethical, and evidence-based care.

2. Scope

This SOP applies to all healthcare professionals including physicians, nurses, psychiatrists, psychologists, social workers, emergency department staff, and administrative personnel involved in patient care.

3. Definitions

Substance Use Disorder (SUD): A medical condition characterized by uncontrolled use of substances despite harmful consequences.

Withdrawal: Clinical symptoms occurring after reduction or cessation of substance use.

Detoxification: Medically supervised management of withdrawal symptoms.

4. Screening and Identification

4.1 All patients should be screened using validated tools (e.g., AUDIT, DAST, CAGE) during admission or emergency presentation.

4.2 Positive screenings must be documented in the medical record.

4.3 High-risk patients must be referred to the treating physician immediately.

5. Assessment

5.1 Conduct comprehensive history including substance type, duration, last use, previous treatments, and co-morbid psychiatric or medical conditions.

5.2 Perform physical examination and necessary laboratory investigations.

5.3 Assess risk of withdrawal using standardized scales (e.g., CIWA-Ar for alcohol).

6. Management

6.1 Initiate withdrawal management protocol as per substance type.

6.2 Provide pharmacological treatment as indicated (e.g., benzodiazepines for alcohol withdrawal, buprenorphine or methadone for opioid use disorder).

6.3 Provide supportive care including hydration, nutrition, and monitoring of vital signs.

6.4 Ensure suicide risk assessment where indicated.

7. Behavioral and Psychosocial Interventions

7.1 Provide brief intervention and motivational interviewing.

7.2 Refer to psychiatry services.

7.3 Initiate discharge planning with referral to rehabilitation services.

8. Documentation

8.1 Document screening results, assessment findings, treatment plan, medications administered, and patient response.

8.2 Maintain confidentiality in accordance with hospital policy and legal requirements.

9. Discharge and Follow-Up

9.1 Provide written discharge instructions including warning signs of relapse or withdrawal.

9.2 Schedule follow-up appointments prior to discharge.

Management of Alcohol Use Disorder (AUD)

1. Purpose

To establish standardized procedures for screening, assessment, medical management, withdrawal management, referral, discharge planning, and follow-up of patients with Alcohol Use Disorder (AUD) in a general hospital setting.

2. Scope

This SOP applies to Emergency Department, Inpatient Wards, ICU, Psychiatry, Internal Medicine, Nursing Staff, Social Workers.

3. Definitions

Alcohol Use Disorder (AUD): A problematic pattern of alcohol use leading to clinically significant impairment or distress.

Alcohol Withdrawal Syndrome (AWS): Symptoms occurring after reduction or cessation of heavy alcohol intake.

Delirium Tremens (DT): Severe form of alcohol withdrawal characterized by confusion, agitation, hallucinations, and autonomic instability.

4. Screening Procedure

4.1 All adult patients should be screened at admission using validated tools (e.g., AUDIT, CAGE).

4.2 Positive screening results must be documented in the medical record.

4.3 High-risk patients should be flagged for physician review.

5. Assessment

5.1 Obtain detailed history: quantity, duration, last drink, prior withdrawals, seizures, DT, comorbidities.

5.2 Perform physical examination including vital signs and mental status.

5.3 Order baseline investigations: CBC, LFT, RFT, electrolytes, blood glucose, ECG if indicated.

5.4 Assess withdrawal severity using CIWA-Ar scale.

6. Management of Alcohol Withdrawal

6.1 Initiate CIWA-Ar based benzodiazepine protocol (e.g., diazepam/lorazepam).

6.2 Administer Thiamine 100 mg IV/IM before glucose to prevent Wernicke's encephalopathy.

6.3 Provide multivitamins, folate, and electrolyte correction as needed.

6.4 Monitor vital signs every 4 hours or as clinically indicated.

6.5 Severe cases (DT, seizures) require ICU admission and continuous monitoring.

7. Long-Term AUD Treatment

7.1 Offer brief intervention and motivational interviewing.

7.2 Consider anti-craving medications (e.g., naltrexone, acamprosate, disulfiram) as appropriate.

7.3 Refer to Psychiatry/Addiction specialist.

7.4 Encourage participation in rehabilitation programs and support groups.

8. Psychiatric & Suicide Risk Assessment

8.1 Screen for depression, anxiety, and other psychiatric disorders.

8.2 Conduct suicide risk assessment in high-risk individuals.

8.3 Initiate psychiatric referral when indicated.

9. Documentation

9.1 Document screening results, CIWA-Ar scores, medications administered, and patient response.

9.2 Record counseling provided and referrals made.

9.3 Maintain confidentiality as per hospital policy.

10. Discharge Planning

10.1 Ensure patient is clinically stable before discharge.

10.2 Provide discharge summary including medications and follow-up plan.

10.3 Schedule follow-up appointment before discharge.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

- 0 none
- 1 very mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.

- 0 no tremor
- 1 not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 moderate, with patient's arms extended
- 5
- 6
- 7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

- 0 not present
- 1 very mild harshness or ability to frighten
- 2 mild harshness or ability to frighten
- 3 moderate harshness or ability to frighten
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.

- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 2
- 3
- 4 beads of sweat obvious on forehead
- 5
- 6
- 7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

- 0 not present
- 1 very mild sensitivity
- 2 mild sensitivity
- 3 moderate sensitivity
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.

- 0 no anxiety, at ease
- 1 mild anxious
- 2
- 3
- 4 moderately anxious, or guarded, so anxiety is inferred
- 5
- 6
- 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0 not present
- 1 very mild
- 2 mild
- 3 moderate
- 4 moderately severe
- 5 severe
- 6 very severe
- 7 extremely severe

AGITATION -- Observation.

- 0 normal activity
- 1 somewhat more than normal activity
- 2
- 3
- 4 moderately fidgety and restless
- 5
- 6
- 7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask

- "What day is this? Where are you? Who am I?"
- 0 oriented and can do serial additions
- 1 cannot do serial additions or is uncertain about date
- 2 disoriented for date by no more than 2 calendar days
- 3 disoriented for date by more than 2 calendar days
- 4 disoriented for place/or person

Total **CIWA-Ar** Score _____
 Rater's Initials _____
 Maximum Possible Score 67

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

CIWA-Ar Based Alcohol Withdrawal Medication Dosing Chart

1. CIWA-Ar Scoring Interpretation

CIWA-Ar Score	Withdrawal Severity	Recommended Action
0–7	Minimal	No medication required. Monitor every 4–6 hours.
8–15	Mild	Symptom-triggered benzodiazepine dosing.
16–20	Moderate	Scheduled or symptom- triggered benzodiazepines. Close monitoring.
>20	Severe	High-dose benzodiazepines. Consider ICU admission.

2. Symptom-Triggered Benzodiazepine Protocol

CIWA Score	Diazepam (PO/IV)	Lorazepam (PO/IV)	Monitoring
8–10	5 mg	1 mg	Reassess in 1 hour
11–15	10 mg	2 mg	Reassess in 1 hour
16–20	10–20 mg	2–4 mg	Reassess in 1 hour
>20	20 mg (repeat every 1 hr as needed)	4 mg (repeat every 1 hr as needed)	Consider ICU
Seizure	10–20 mg IV immediately	4 mg IV immediately	Continuous monitoring

Repeat diazepam every 1–2 hours as required until CIWA < 10.

3. Fixed-dose diazepam regimen (Alternative)

Why diazepam?

- Long half-life – smoother withdrawal control
- Active metabolites – “auto-taper” effect
- Rapid onset
- Reduce risk of seizures & delirium tremens

Avoid or use caution in:

- Severe liver impairment (consider lorazepam instead)
- Severe respiratory disease
- Elderly

Standard Fixed dose diazepam regimen (for moderate withdrawal)

- Day 1: Diazepam 10 mg four times daily.
- Day 2: Diazepam 10 mg three times daily.
- Day 3: Diazepam 5 mg four times daily.
- Day 4: Diazepam 5 mg three times daily.
- Day 5: Diazepam 5 mg twice daily, then stop

For severe withdrawal or high risk of DT/seizures

Loading option (first 6-12 hrs)

Diazepam 20mg every 1-2hrs until

- light sedation achieved
- CIWA < 10
- Max 60-80 mg (varies by protocol)

Then continue fixed taper as above

4. Adjunctive Treatment

Thiamine 100 mg IV/IM daily (before glucose)

Multivitamin supplementation

Folic Acid 1 mg daily

Electrolyte correction (Mg, K, Phosphate)

IV fluids as required

Haloperidol 0.5–5 mg for severe agitation or hallucinations (use cautiously)

5. ICU Indications

Delirium Tremens

Refractory seizures

Persistent CIWA >20 despite treatment

Hemodynamic instability

Severe electrolyte imbalance

Management of Heroin (Opioid) Use Disorder

Purpose

To provide a standardized approach for identification, assessment, acute management, withdrawal treatment, overdose management, and referral of patients with heroin (opioid) use disorder in a general hospital setting.

Scope

Applies to all adult inpatients and emergency department patients with suspected or confirmed heroin/opioid use disorder.

Initial Assessment

- History: type of opioid, route, quantity, last use, polysubstance use.
- Assess withdrawal using Clinical Opiate Withdrawal Scale (COWS).
- Screen for overdose risk, suicidality, infection (HIV, hepatitis), pregnancy.
- Physical exam: vital signs, pupil size, injection sites.
- Baseline labs: FBC, U&E; LFTs, CRP, viral screen as appropriate.

Management of Opioid Withdrawal

- Mild (COWS <8): Symptomatic treatment (antiemetics, loperamide, NSAIDs).
- Moderate–Severe (COWS ≥8): Initiate buprenorphine when objective withdrawal present.
- Initial buprenorphine 2–4 mg SL, repeat 2–4 mg after 1–2 hrs if needed.
- Typical Day 1 total: 8–12 mg; titrate to control symptoms.
- Alternative: Methadone 10–20 mg PO if buprenorphine contraindicated.
- Monitor sedation, respiratory rate, and blood pressure.

Opioid Overdose Management

- Airway, breathing, circulation assessment.
- Administer naloxone 0.4–2 mg IV/IM; repeat every 2–3 minutes as needed.
- Consider infusion if recurrent respiratory depression.
- Observe at least 4–6 hours after last naloxone dose.

- Assess for polysubstance overdose.

Harm Reduction & Support

- Offer take-home naloxone where appropriate.
- Screen and vaccinate for hepatitis B if required.
- Provide wound care advice for injection-related injuries.
- Offer blood-borne virus screening and referral.
- Engage hospital addiction team if available.

Discharge Planning

- Arrange follow-up with community drug and alcohol services.
- Continue opioid substitution therapy where initiated.
- Provide written information and crisis contacts.
- Assess safeguarding and social support needs.

Management of Schizophrenia

1. Purpose

To provide standardized guidelines for assessment, diagnosis, treatment, and follow-up of patients with schizophrenia in a general hospital setting.

2. Scope

Applicable to Psychiatry Department, Emergency Department, Medical Wards, and ICU (if required). Applies to adult patients aged 18 years and above.

3. Definition

Schizophrenia is a chronic psychiatric disorder characterized by disturbances in thought, perception, behavior, and functioning.

4. Initial Assessment

- Detailed psychiatric history
- History of substance use
- Past psychiatric treatment and adherence
- Risk assessment (suicide, violence, self-neglect)
- Mental Status Examination (MSE)
- Physical examination
- Baseline investigations: CBC, LFT, RFT, Blood glucose, Lipid profile, Thyroid profile

5. Admission Criteria

- Acute psychosis with risk to self or others
- Severe agitation or aggression
- Poor self-care or inability to function
- non-response to outpatient treatment

6. Pharmacological Management

First-line: Second-generation antipsychotics

Examples:

- Risperidone
- Olanzapine
- Aripiprazole

Start low and titrate based on response and tolerability.

Monitor for side effects (EPS, metabolic syndrome, sedation).

7. Management of Acute Agitation

- Verbal de-escalation
- Short-acting antipsychotics or benzodiazepines
- Continuous monitoring after IM/IV medication

8. Monitoring

- Daily mental status assessment (inpatient)
- Monitor vitals
- Weight, BMI, blood glucose, lipids periodically
- Assess medication adherence

9. Non-Pharmacological Management

- Psychoeducation (patient and family)
- Cognitive Behavioral Therapy (CBT) if stable
- Social skills training
- Occupational rehabilitation

10. Discharge Planning

- Ensure symptom stabilization
- Provide prescription and adherence counseling
- Schedule follow-up within 1–2 weeks
- Provide emergency contact information
- Consider long-acting injectable antipsychotics if poor adherence

11. Documentation

- Diagnosis and clinical findings
- Risk assessment
- Medications prescribed and dose
- Side effects
- Counseling provided

Management of Psychosis Due to Another Medical Condition

1. PURPOSE

To provide standardized guidelines for the assessment, diagnosis, management, and follow-up of patients presenting with **psychosis due to another medical condition** in a general hospital setting, ensuring patient safety and timely treatment of the underlying cause.

2. SCOPE

This SOP applies to:

- Emergency Department
- Internal Medicine Department
- Psychiatry Department
- Intensive Care Unit (ICU)
- Nursing Staff
- Allied Health Professionals

3. DEFINITION

Psychosis due to another medical condition refers to the presence of hallucinations, delusions, or disorganized thinking that is directly attributable to a medical illness (e.g., neurological, metabolic, infectious, endocrine, autoimmune conditions), and not primarily caused by a psychiatric disorder.

4. RESPONSIBILITIES

4.1 Emergency Physician / Attending Physician

- Initial medical assessment and stabilization
- Rule out life-threatening causes
- Initiate investigations

4.2 Psychiatrist

- Conduct psychiatric evaluation
- Differentiate from primary psychiatric disorders
- Recommend psychotropic medications if needed

4.3 Nursing Staff

- Monitor vitals and mental status
- Ensure patient safety
- Administer medications as prescribed

4.4 Laboratory & Radiology Team

- Perform required investigations promptly

5. CLINICAL PRESENTATION

Common symptoms include:

- Visual or auditory hallucinations
- Delusions (often persecutory or bizarre)
- Disorganized speech or behavior
- Agitation or aggression
- Fluctuating consciousness (suggesting delirium)
- Cognitive impairment

Red flags suggesting medical cause:

- Acute onset
- Fluctuating symptoms
- Abnormal vital signs
- New neurological signs
- No prior psychiatric history
- Age >40 years with first episode

6. INITIAL ASSESSMENT

6.1 Immediate Safety

- Assess risk of harm to self or others
- Use de-escalation techniques
- Apply restraints only (if necessary)

6.2 ABC Assessment

- Airway
- Breathing
- Circulation

6.3 Vital Signs

- Blood pressure
- Heart rate
- Temperature
- Oxygen saturation
- Blood glucose

7. MEDICAL EVALUATION

7.1 History

- Onset and duration of symptoms
- Past medical history
- Medication history
- Substance use
- Family psychiatric history

7.2 Physical Examination

- General examination

- Neurological examination
- Signs of infection or metabolic disturbance

8. INVESTIGATIONS

Minimum recommended tests:

- CBC
- Electrolytes
- Renal function test
- Liver function test
- Thyroid function test
- Blood glucose
- Vitamin B12
- Urinalysis
- Toxicology screen

If indicated:

- CT Brain
- MRI Brain
- EEG
- Lumbar puncture
- Autoimmune panel
- Infectious disease screening (HIV, syphilis, etc.)

9. DIFFERENTIAL DIAGNOSIS

- Delirium
- Primary psychotic disorders (e.g., Schizophrenia)
- Bipolar disorder with psychotic features

- Substance-induced psychosis
- Medication-induced psychosis

10. MANAGEMENT

10.1 Treat Underlying Cause

Examples:

- Infection → Antibiotics
- Hypoglycemia → IV glucose
- Thyroid disorder → Endocrine management
- Electrolyte imbalance → Correction
- Autoimmune encephalitis → Immunotherapy

10.2 Symptomatic Psychiatric Treatment

If severe agitation or psychosis:

- Low-dose antipsychotics (e.g., Haloperidol, Risperidone)
- Avoid high doses
- Monitor QT interval if using IV antipsychotics

Benzodiazepines may be used cautiously if indicated.

10.3 Non-Pharmacological Measures

- Quiet room
- Orientation cues (clock, calendar)
- Family involvement
- Sleep regulation

11. MONITORING

- Vital signs every 4–6 hours (or as clinically indicated)
- Mental status monitoring

- Monitor medication side effects
- Repeat labs as needed

12. ADMISSION CRITERIA

Admit if:

- Unstable medical condition
- Severe agitation
- Risk of harm
- Need for close monitoring
- Diagnostic uncertainty

ICU admission if:

- Hemodynamic instability
- Reduced consciousness
- Severe metabolic disturbance

13. DISCHARGE CRITERIA

- Underlying medical condition stabilized
- Psychotic symptoms significantly improved
- Risk assessment completed
- Follow-up plan arranged

14. FOLLOW-UP

- Psychiatry follow-up within 1–2 weeks
- Medical specialist follow-up as needed
- Medication review
- Family education

15. DOCUMENTATION

Must include:

- Mental status examination
- Risk assessment
- Medical findings
- Diagnostic reasoning
- Treatment plan
- Consent and family discussion

Management of Major Depressive Disorder (MDD)

1. PURPOSE

- ❖ To provide standardized guidelines for the screening, diagnosis, treatment, referral, and follow-up of patients with Major Depressive Disorder (MDD) in a general hospital setting.

2. SCOPE

This SOP applies to:

- ❖ Emergency Department
- ❖ Outpatient Department (OPD)
- ❖ Inpatient Wards
- ❖ Intensive Care Unit (ICU)
- ❖ Psychiatry Department
- ❖ General Physicians and Nursing Staff

3. DEFINITIONS

Major Depressive Disorder (MDD):

- ❖ A psychiatric disorder characterized by persistent low mood and/or loss of interest or pleasure lasting at least 2 weeks, associated with cognitive and physical symptoms affecting daily functioning, as defined in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition**.

4. RESPONSIBILITIES

4.1 Treating Physician

- ❖ Conduct clinical assessment
- ❖ Rule out medical causes
- ❖ Initiate treatment
- ❖ Refer to Psychiatry when required

4.2 Psychiatrist

- ❖ Confirm diagnosis
- ❖ Initiate/adjust pharmacotherapy
- ❖ Provide psychotherapy
- ❖ Assess suicide risk

4.3 Nursing Staff

- ❖ Monitor mood and behavior

- ❖ Ensure medication compliance
- ❖ Observe suicide precautions

4.4 Clinical Psychologist (if available)

- ❖ Provide psychotherapy (CBT, IPT, etc.)
- ❖ Perform psychological assessments

5. SCREENING AND IDENTIFICATION

5.1 Screening Tools (OPD / IPD)

- ❖ PHQ-9 (Patient Health Questionnaire-9)
- ❖ HADS (Hospital Anxiety and Depression Scale)

Screening should be performed in:

- ❖ Patients with chronic illness
- ❖ Patients with unexplained somatic complaints
- ❖ Postpartum patients
- ❖ Patients with substance use
- ❖ Any patient expressing low mood

6. DIAGNOSTIC CRITERIA (DSM-5-TR)

Diagnosis requires:

At least 5 of the following symptoms for 2 weeks:

- ❖ Depressed mood
- ❖ Loss of interest/pleasure
- ❖ Significant weight/appetite change
- ❖ Sleep disturbance
- ❖ Psychomotor agitation/retardation
- ❖ Fatigue
- ❖ Feelings of worthlessness/guilt
- ❖ Poor concentration
- ❖ Recurrent thoughts of death or suicide
- ❖ Symptoms must cause significant distress or impairment.

7. SUICIDE RISK ASSESSMENT

7.1 Assess:

- ❖ Suicidal ideation

- ❖ Plan
- ❖ Intent
- ❖ Means availability
- ❖ Past attempts

7.2 High-Risk Management

- ❖ Immediate psychiatric consultation
- ❖ Do not leave patient unattended
- ❖ Remove harmful objects
- ❖ Consider admission

8. INVESTIGATIONS

To rule out organic causes:

- ❖ CBC
- ❖ Thyroid function tests
- ❖ Vitamin B12
- ❖ Blood glucose
- ❖ Liver and renal function
- ❖ Toxicology screening (if indicated)

9. MANAGEMENT

9.1 Mild Depression

- ❖ Psychoeducation
- ❖ Lifestyle modification
- ❖ Psychotherapy (CBT preferred)
- ❖ Follow-up in 24 weeks

9.2 Moderate Depression

- ❖ SSRI (e.g., Sertraline, Escitalopram, fluoxetine)
- ❖ Psychotherapy
- ❖ Follow-up in 2 weeks

9.3 Severe Depression

- ❖ SSRI/SNRI (vanlafaxine, duloxetine)
- ❖ Consider augmentation
- ❖ Psychiatric referral mandatory
- ❖ Consider inpatient admission if suicidal

9.4 Psychotic Depression

- ❖ Antidepressant + Antipsychotic
- ❖ Urgent psychiatric management
- ❖ Consider ECT where indicated

10. INPATIENT MANAGEMENT

Admit if:

- ❖ Active suicide risk
- ❖ Severe functional impairment
- ❖ Refusal to eat/drink
- ❖ Psychotic symptoms
- ❖ Failure of outpatient treatment

Monitoring:

- ❖ Daily mood chart
- ❖ Suicide precautions
- ❖ Medication adherence
- ❖ Nutritional intake

11. FOLLOW-UP PROTOCOL

- ❖ First follow-up: 12 weeks
- ❖ Assess symptom improvement
- ❖ Monitor side effects
- ❖ Continue treatment minimum 6 months after remission
- ❖ Long-term maintenance if recurrent episodes

12. DOCUMENTATION

- ❖ Ensure proper documentation of:
- ❖ History
- ❖ Mental status examination
- ❖ Suicide risk assessment
- ❖ Treatment plan
- ❖ Consent
- ❖ Follow-up plan

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 these problems 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Management of Bipolar I Disorder (Manic Episode)

1. PURPOSE

- ❖ To provide standardized guidelines for the identification, diagnosis, emergency stabilization, treatment, referral, and follow-up of patients presenting with Manic Episode in Bipolar I Disorder in a general hospital.

2. SCOPE

This SOP applies to:

- ❖ Emergency Department
- ❖ Outpatient Department (OPD)
- ❖ Inpatient Wards
- ❖ ICU (if severe agitation or medical instability)
- ❖ Psychiatry Department
- ❖ Medical Officers and Nursing Staff

3. DEFINITIONS

3.1 Bipolar I Disorder

- ❖ A psychiatric disorder characterized by at least one manic episode, as defined in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition**.

3.2 Manic Episode

- ❖ A distinct period of abnormally elevated, expansive, or irritable mood and increased energy lasting at least 1 week (or any duration if hospitalization is required), associated with marked functional impairment.

4. RESPONSIBILITIES

4.1 Treating Physician

- ❖ Initial medical assessment
- ❖ Rule out organic causes
- ❖ Start emergency management
- ❖ Refer to Psychiatry

4.2 Psychiatrist

- ❖ Confirm diagnosis
- ❖ Initiate mood stabilizers/antipsychotics
- ❖ Assess risk (harm to self/others)

- ❖ Decide on admission

4.3 Nursing Staff

- ❖ Monitor behavior and safety
- ❖ Administer medications
- ❖ Maintain observation chart
- ❖ Implement safety precautions

5. CLINICAL FEATURES OF MANIA

Diagnosis requires:

- ❖ Elevated/irritable mood plus 3 or more (4 if irritable only):
- ❖ Inflated self-esteem or grandiosity
- ❖ Decreased need for sleep
- ❖ Increased talkativeness/pressured speech
- ❖ Flight of ideas
- ❖ Distractibility
- ❖ Increased goal-directed activity
- ❖ Excessive involvement in risky activities
- ❖ Symptoms must cause:
- ❖ Marked impairment
- ❖ Need for hospitalization
- ❖ Or psychotic features

6. INITIAL ASSESSMENT (EMERGENCY / OPD)

6.1 Immediate Evaluation

- ❖ Vital signs
- ❖ Level of agitation
- ❖ Risk of aggression
- ❖ Substance use history
- ❖ Medication history

6.2 Risk Assessment

- ❖ Harm to self
- ❖ Harm to others
- ❖ Impulsive behaviors
- ❖ Financial/social risk
- ❖ High-risk patients require immediate psychiatric consultation and possible admission.

7. DIFFERENTIAL DIAGNOSIS

- ❖ Substance-induced mood disorder
- ❖ Hyperthyroidism
- ❖ Delirium
- ❖ Schizophrenia
- ❖ Steroid-induced mood symptoms

8. INVESTIGATIONS

To rule out medical causes:

- ❖ CBC
- ❖ Thyroid function test
- ❖ Liver function test
- ❖ Renal function test
- ❖ Blood glucose
- ❖ Urine toxicology
- ❖ ECG (before certain medications)

9. MANAGEMENT PROTOCOL

9.1 Acute Agitation (Emergency Management)

- ❖ Ensure safety
- ❖ De-escalation techniques
- ❖ IM antipsychotic (haloperidol 5mg stat) & IV diazepam 10mg (slowly) can be given.
- ❖ Continuous monitoring

9.2 Pharmacological Treatment

- ❖ First-Line Options:
- ❖ Mood stabilizer (Lithium / Valproate)
- ❖ Atypical antipsychotic (Olanzapine, Risperidone, Quetiapine)
- ❖ Severe Mania:
- ❖ Combination therapy (Mood stabilizer + Antipsychotic)
- ❖ Psychotic Mania:
- ❖ Mandatory antipsychotic
- ❖ Consider ECT if severe or treatment-resistant

9.3 Inpatient Admission Criteria

Admit if:

- ❖ Severe agitation/aggression
- ❖ Psychotic symptoms
- ❖ Poor insight
- ❖ Risk to self/others
- ❖ Severe functional impairment
- ❖ Noncompliance with treatment

10. INPATIENT MANAGEMENT

- ❖ Structured low-stimulus environment
- ❖ Monitor sleep pattern
- ❖ Daily behavioral chart
- ❖ Monitor medication side effects
- ❖ Ensure hydration and nutrition
- ❖ Regular psychiatric review

11. DISCHARGE CRITERIA

- ❖ Stabilized mood
- ❖ Reduced agitation
- ❖ Adequate sleep
- ❖ No active risk
- ❖ Family education completed

12. FOLLOW-UP PROTOCOL

- ❖ First follow-up: within 1 week
- ❖ Monitor mood symptoms
- ❖ Monitor Lithium/Valproate levels (if applicable)
- ❖ Psychoeducation
- ❖ Long-term maintenance therapy
- ❖ Maintenance treatment typically continues long term to prevent relapse.

13. DOCUMENTATION

- ❖ Ensure documentation of:
- ❖ Mental status examination
- ❖ Risk assessment
- ❖ Diagnosis
- ❖ Medication chart
- ❖ Consent
- ❖ Family counseling

❖ Follow-up plan

Management of Bipolar I Disorder – Current Episode Depressive

1. Purpose

To provide standardized guidelines for assessment, diagnosis, treatment, referral, safety management, and follow-up of patients diagnosed with Bipolar I Disorder – Current Episode Depressive in a general hospital setting.

2. Scope

This SOP applies to Emergency Department, Outpatient Department (OPD), Inpatient units, Psychiatry Department, and all healthcare professionals involved in the management of adult patients with Bipolar I Disorder.

3. Definition

Bipolar I Disorder is characterized by at least one lifetime manic episode. The current episode depressive phase involves persistent depressed mood or loss of interest with associated cognitive, behavioral, and somatic symptoms causing functional impairment.

4. Responsibilities

- Emergency Physician/Medical Officer: Initial assessment, medical stabilization, and referral.
- Psychiatrist: Diagnostic confirmation and pharmacological management.
- Clinical Psychologist: Psychological assessment and psychotherapy.
- Nursing Staff: Monitoring safety, medication administration, and patient education.
- Medical Social Worker: Family counseling and discharge planning.

5. Procedure

A. Initial Assessment:

- Assess airway, breathing, circulation (ABCs) if in emergency setting.
- Record vital signs.
- Conduct detailed psychiatric history including past manic/hypomanic episodes.
- Assess for suicidal ideation, intent, or plan.
- Screen for substance use and comorbid medical conditions.

B. Diagnostic Evaluation:

- Detailed Mental Status Examination (MSE).
- Confirm diagnosis as per ICD/DSM criteria.

- Baseline laboratory investigations before initiating mood stabilizers (CBC, LFT, RFT, thyroid function tests as indicated).

C. Risk Assessment:

- Evaluate suicide risk using structured assessment tools if available.
- Assess risk of self-neglect, psychosis, or catatonia.
- Determine need for inpatient admission.

D. Management:

1. Pharmacological Treatment:

- Mood stabilizers (e.g., lithium, valproate) as first-line treatment.
- Atypical antipsychotics if indicated.
- Antidepressants only in combination with mood stabilizer and under psychiatric supervision.
- Monitor serum levels (e.g., lithium) as per protocol.

2. Psychotherapy:

- Cognitive Behavioral Therapy (CBT).
- Psychoeducation for patient and family.
- Interpersonal and Social Rhythm Therapy (if available).

3. Safety Measures:

- Remove access to means of self-harm.
- Close monitoring in high-risk cases.
- Consider admission for severe depression or suicidal risk.

E. Referral Criteria:

- High suicide risk.
- Psychotic symptoms.
- Severe functional impairment.
- Poor response to outpatient management.

F. Follow-Up:

- First follow-up within 1 week after discharge or medication initiation.
- Monitor medication adherence and side effects.
- Regular mood monitoring.
- Long-term maintenance therapy planning.

6. Documentation

- Document detailed assessment findings.
- Record diagnosis with episode specification.
- Maintain medication chart and monitoring records.
- Record informed consent and safety planning.

7. Emergency Red Flags

- Active suicidal intent or plan.
- Psychotic symptoms.
- Severe agitation or refusal to eat/drink.
- Lithium toxicity symptoms (if on lithium).

Mood Disorder Due to Another Medical Condition

1. Purpose

To establish a standardized protocol for the identification, assessment, diagnosis, management, and referral of patients presenting with mood disturbances that are direct physiological consequences of another medical condition in a general hospital setting.

2. Scope

This SOP applies to all healthcare professionals including physicians, psychiatrists, nurses, psychologists, and allied health staff involved in patient care within the hospital.

3. Definition

Mood Disorder Due to Another Medical Condition is characterized by a prominent and persistent disturbance in mood (depressed mood, elevated mood, or irritability) that is judged to be the direct pathophysiological consequence of another medical condition.

4. Responsibilities

- Attending Physician: Initial identification and medical evaluation.
- Psychiatrist: Diagnostic confirmation and psychiatric management.
- Nursing Staff: Monitoring, documentation, and patient safety.
- Clinical Psychologist: Psychological assessment and therapy as indicated.
- Medical Social Worker: Family education and discharge planning.

5. Procedure

5.1 Identification and Screening

- Screen patients with known neurological, endocrine, infectious, autoimmune, or metabolic disorders for mood changes.
- Assess for new onset depressive or manic symptoms following diagnosis of a medical illness.
- Use standardized screening tools where appropriate.

5.2 Assessment

- Detailed medical and psychiatric history.
- Review of current medications.
- Physical and neurological examination.
- Relevant laboratory and imaging investigations.
- Mental Status Examination (MSE).

5.3 Diagnostic Criteria

Diagnosis should be made when:

- Prominent mood disturbance is present.
- There is evidence that the disturbance is a direct consequence of a medical condition.
- The disturbance is not better explained by another psychiatric disorder.
- The symptoms cause significant distress or impairment.

5.4 Management

A. Treat Underlying Medical Condition:

- Optimize treatment of the primary illness.

B. Pharmacological Management:

- Antidepressants, mood stabilizers, or antipsychotics as clinically indicated.
- Monitor for drug interactions.

C. Non-Pharmacological Management:

- Psychoeducation.
- Supportive psychotherapy.
- Family counseling.

5.5 Safety Measures

- Assess risk of self-harm or harm to others.
- Ensure close monitoring if high risk.
- Follow hospital suicide prevention protocols where applicable.

5.6 Referral Criteria

- Severe mood symptoms.
- Diagnostic uncertainty.
- Poor response to initial management.
- Need for specialized psychiatric intervention.

6. Documentation

All assessments, diagnosis, management plans, informed consent, and follow-up recommendations must be clearly documented in the patient's medical record.

7. Discharge and Follow-Up

- Ensure stability of both medical and psychiatric conditions prior to discharge.
- Provide clear medication instructions.
- Schedule follow-up appointments with relevant departments.
- Provide emergency contact information.

Management of Generalized Anxiety Disorder (GAD)

1. Purpose

- To establish a standardized protocol for the identification, assessment, diagnosis, treatment, referral, and follow-up of patients presenting with Generalized Anxiety Disorder (GAD) in a general hospital setting.

2. Scope

This SOP applies to:

- Emergency Department (ED)
- Outpatient Department (OPD)

- Inpatient Wards
- Psychiatry Department
- Primary Care Physicians
- Nursing Staff
- Clinical Psychologists
- Medical Social Workers

3. Definition

- Generalized Anxiety Disorder (GAD) is characterized by excessive anxiety and worry occurring more days than not for at least 6 months, about various events or activities, that is difficult to control and causes clinically significant distress or impairment.

4. Diagnostic Criteria (As per DSM-5-TR guidelines)

- A. Excessive anxiety and worry occurring more days than not for at least 6 months
- B. Difficulty controlling the worry
- C. Associated with ≥ 3 of the following:
 - Restlessness
 - Fatigue
 - Difficulty concentrating
 - Irritability
 - Muscle tension
 - Sleep disturbance
- D. Causes functional impairment
- E. Not due to substance/medical condition

5. Responsibilities

5.1 Medical Officer / Primary Physician

- Initial screening and assessment
- Rule out medical causes
- Initiate first-line management
- Refer to Psychiatry when required

5.2 Psychiatrist

- Confirm diagnosis
- Risk assessment (suicidal ideation, comorbidities)
- Pharmacological management
- Ongoing supervision

5.3 Clinical Psychologist

- Conduct structured assessments
- Provide CBT and other psychotherapies
- Monitor psychological progress

5.4 Nursing Staff

- Monitor vital signs
- Medication compliance
- Provide supportive care
- Document behavioral observations

6. Procedure

6.1 Screening

- Use standardized tools:
 - GAD-7 Scale
 - HAM-A (if required)
- Identify red flags:
 - Panic attacks

- Suicidal thoughts
- Substance abuse

6.2 Clinical Assessment

- Detailed psychiatric history
- Medical history (thyroid disorders, anemia, cardiac issues)
- Substance use history
- Family psychiatric history
- Mental Status Examination (MSE)

6.3 Investigations (If indicated)

- CBC
- Thyroid Function Test (TFT)
- Blood sugar
- ECG (before certain medications)
- Vitamin B12 (if indicated)

6.4 Risk Assessment

- Suicidal ideation
- Self-harm risk
- Severe functional impairment
- Psychosis or severe depression

If high risk → Immediate psychiatric referral/admission.

7. Management

7.1 Non-Pharmacological Management

- Psychoeducation

- Cognitive Behavioral Therapy (CBT)
- Relaxation techniques
- Breathing exercises
- Sleep hygiene counseling
- Lifestyle modification (exercise, caffeine reduction)

7.2 Pharmacological Management

First-line:

- SSRIs (e.g., Escitalopram, Sertraline)
- SNRIs (e.g., Venlafaxine)

Short-term (if severe anxiety):

- Benzodiazepines (short course only, 2–4 weeks max)

Alternatives:

- Buspirone
- Pregabalin (if indicated)

7.3 Emergency Management

If patient presents with:

- Severe agitation
- Panic with autonomic instability
- Suicidal ideation

→ Stabilize in ED

→ Psychiatric consultation

→ Consider admission

8. Follow-Up Protocol

- First follow-up: 2 weeks after initiation
- Subsequent visits: Every 4–6 weeks
- Monitor:
 - Symptom improvement
 - Side effects
 - Medication adherence
 - Functional recovery

Minimum treatment duration: 6–12 months after remission.

9. Referral Criteria

Refer to higher center or specialist if:

- Treatment resistance (no response after 8–12 weeks)
- Severe comorbid psychiatric disorders
- Active suicidality
- Diagnostic uncertainty

10. Documentation

Maintain:

- GAD-7 scores
- Medication chart
- Progress notes
- Risk assessment record
- Consent for treatment

Management of Hyperventilation Syndrome (HVS)

1. PURPOSE

- To provide a standardized approach for the assessment, diagnosis, and management of patients presenting with Hyperventilation Syndrome (HVS) in a general hospital setting.

2. SCOPE

This SOP applies to:

- Emergency Department physicians
- General physicians
- Nurses
- Respiratory therapists
- Mental health professionals

3. DEFINITION

- Hyperventilation Syndrome (HVS) is a condition characterized by rapid or deep breathing exceeding metabolic demand, leading to decreased arterial carbon dioxide (hypocapnia), which results in respiratory alkalosis and associated symptoms.

4. COMMON CAUSES

- Anxiety or panic attacks
- Emotional distress
- Acute stress reaction
- Pain
- Fever
- Asthma exacerbation
- Metabolic acidosis (compensatory hyperventilation)
- Pulmonary embolism
- Cardiac conditions

5. CLINICAL PRESENTATION

Symptoms:

- Rapid breathing (tachypnea)
- Shortness of breath

- Chest tightness
- Dizziness
- Tingling in hands, feet, or around mouth
- Lightheadedness
- Palpitations
- Anxiety

Severe Cases:

- Carpopedal spasm
- Syncope

6. INITIAL ASSESSMENT (ABCDE APPROACH)

A Airway

Ensure airway patency.

B Breathing

- Assess respiratory rate
- Pulse oximetry
- Observe breathing pattern

C Circulation

- Check pulse, blood pressure
- Cardiac monitoring if indicated

D Disability

- Assess mental status (GCS)
- Check blood glucose

E Exposure

- Look for trauma, infection signs

7. INVESTIGATIONS (AS INDICATED)

- To exclude serious causes:
- Pulse oximetry
- Arterial Blood Gas (ABG)
- ECG
- Chest X-ray
- D-dimer (if PE suspected)

- Cardiac enzymes (if cardiac cause suspected)
- Serum electrolytes

8. DIAGNOSTIC CRITERIA

- Diagnosis of HVS is made after excluding organic causes.
- Typical ABG findings:
 - Low PaCO₂
 - Elevated pH (respiratory alkalosis)
 - Normal oxygen saturation unless underlying pathology exists.

9. MANAGEMENT

9.1 Immediate Management

- Reassure the patient calmly.
- Position patient upright.
- Encourage slow, controlled breathing:
 - Inhale through nose for 4 seconds
 - Hold for 2 seconds
 - Exhale slowly through mouth for 6 seconds
- Do NOT use paper bag rebreathing (risk of hypoxia).

9.2 If Anxiety/Panic Related

- Provide psychological support
- Consider short-acting benzodiazepine (e.g., Lorazepam) if severe anxiety (as per hospital protocol)
- Refer to psychiatry if recurrent

9.3 If Secondary Cause Identified

- Treat underlying condition:
 - Asthma Bronchodilators
 - Pulmonary embolism Anticoagulation
 - Metabolic acidosis Treat cause

10. ADMISSION CRITERIA

Admit if:

- Uncertain diagnosis
- Abnormal vital signs
- Suspected cardiac/pulmonary cause

- Recurrent unexplained episodes
- Severe electrolyte imbalance

11. DISCHARGE CRITERIA

- Stable vital signs
- Organic causes excluded
- Symptoms resolved
- Patient educated about breathing control techniques
- Follow-up arranged

12. PATIENT EDUCATION

- Teach breathing exercises
- Stress management techniques
- Avoid caffeine and stimulants
- Follow-up with primary care or mental health provider

13. DOCUMENTATION

- Record:
 - Time of onset
 - Vital signs
 - Investigations performed
 - Differential diagnoses considered
 - Treatment provided
 - Response to treatment
 - Discharge advice

Management of Panic Disorder

1. Purpose

To provide standardized guidelines for identification, assessment, management, referral, and follow-up of patients presenting with panic disorder in a general hospital setting.

2. Scope

This SOP applies to Emergency Department, Outpatient Department (OPD), Inpatient units, Psychiatry Department, and all healthcare professionals involved in patient care.

3. Definition

Panic Disorder is characterized by recurrent unexpected panic attacks accompanied by persistent concern about additional attacks or maladaptive changes in behavior related to the attacks.

4. Responsibilities

- Emergency Physician/Medical Officer: Initial assessment and rule out medical causes.
- Psychiatrist: Diagnostic confirmation and treatment plan.
- Nursing Staff: Monitoring, reassurance, and medication administration.
- Clinical Psychologist: Psychotherapy interventions.
- Medical Social Worker: Counseling and family support.

5. Procedure

A. Initial Assessment:

- Assess airway, breathing, circulation (ABCs).
- Record vital signs.
- Rule out medical emergencies (cardiac, respiratory, endocrine, neurological).
- Conduct brief mental status examination.

B. Diagnostic Evaluation:

- Detailed psychiatric history.
- Substance use history.
- Relevant laboratory investigations if indicated.

C. Acute Management:

- Provide reassurance and calm environment.
- Breathing exercises and grounding techniques.
- Short-term benzodiazepines if clinically indicated.

D. Long-Term Management:

- Initiate SSRI/SNRI as first-line pharmacotherapy.
- Cognitive Behavioral Therapy (CBT).
- Lifestyle modification and stress management.

E. Referral Criteria:

- Severe functional impairment.
- Suicidal ideation.

- Poor response to initial treatment.

F. Follow-Up:

- First follow-up within 1–2 weeks.
- Monitor medication adherence and side effects.
- Ongoing psychotherapy sessions as scheduled.

6. Documentation

- Document assessment findings.
- Record diagnosis as per ICD/DSM criteria.
- Maintain treatment plan and follow-up notes.
- Incident reporting if required.

7. Emergency Red Flags (Require Immediate Medical Attention)

- Chest pain suggestive of cardiac origin.
- Loss of consciousness.
- Seizures.
- Severe suicidal intent.

Management of Social Phobia (Social Anxiety Disorder)

1. Purpose

To provide standardized guidelines for identification, assessment, management, referral, and follow-up of patients presenting with Social Phobia (Social Anxiety Disorder) in a general hospital setting.

2. Scope

This SOP applies to Emergency Department, Outpatient Department (OPD), Inpatient units, Psychiatry Department, and all healthcare professionals involved in patient care.

3. Definition

Social Phobia (Social Anxiety Disorder) is characterized by marked and persistent fear of one or more social or performance situations in which the individual is exposed to possible scrutiny by others, leading to significant distress or impairment.

4. Responsibilities

- Medical Officer/Primary Physician: Initial screening and referral.
- Psychiatrist: Diagnostic confirmation and pharmacological management.
- Clinical Psychologist: Psychological assessment and psychotherapy.
- Nursing Staff: Monitoring, psychoeducation, and medication administration.
- Medical Social Worker: Family counseling and rehabilitation support.

5. Procedure

A. Screening and Initial Assessment:

- Obtain detailed history of symptoms, duration, and triggers.
- Assess functional impairment (academic, occupational, social).
- Screen for comorbid depression, substance use, or other anxiety disorders.
- Rule out medical conditions causing anxiety symptoms.

B. Diagnostic Evaluation:

- Detailed psychiatric evaluation as per ICD/DSM criteria.
- Mental Status Examination (MSE).
- Use standardized rating scales if available (e.g., LSAS).

C. Risk Assessment:

- Assess for suicidal ideation or self-harm risk.
- Evaluate severity and level of avoidance.

D. Management:

1. Psychoeducation:

- Explain nature of disorder and treatment options.
- Involve family when appropriate.

2. Pharmacological Treatment:

- SSRIs/SNRIs as first-line treatment.
- Beta-blockers for performance-related anxiety (if indicated).
- Short-term benzodiazepines only when necessary.

3. Psychotherapy:

- Cognitive Behavioral Therapy (CBT) including exposure therapy.
- Social skills training if required.

E. Referral Criteria:

- Severe functional impairment.

- Comorbid psychiatric disorders.
- Poor response to first-line treatment.

F. Follow-Up:

- First follow-up within 2–4 weeks after initiation of treatment.
- Monitor adherence, side effects, and symptom progression.
- Continue psychotherapy sessions as scheduled.

6. Documentation

- Record detailed assessment findings.
- Document diagnosis as per ICD/DSM classification.
- Maintain treatment plan and follow-up notes.
- Record informed consent for treatment.

7. Emergency Red Flags (Require Immediate Psychiatric Evaluation)

- Active suicidal ideation or intent.
- Severe depressive symptoms.
- Substance dependence.
- Marked functional decline.

Obsessive–Compulsive Disorder (OCD)

1. Purpose

To guide health workers in the **identification, assessment, and management of Obsessive–Compulsive Disorder (OCD)** to reduce distress, improve functioning, and prevent complications.

2. Definition

Obsessive–Compulsive Disorder (OCD) is a mental disorder characterized by **obsessions, compulsions, or both** that are **time-consuming or cause significant distress or impairment in functioning**.

Obsessions

- Recurrent, persistent **thoughts, urges, or images**

- Experienced as **intrusive and unwanted**
- Cause **anxiety or distress**

Examples:

- Fear of contamination
- Harm coming to self or others
- Excessive doubts
- Need for symmetry or order

Compulsions

- **Repetitive behaviours or mental acts** performed in response to obsessions
- Aimed at **reducing anxiety or preventing feared events**

Examples:

- Repeated handwashing
- Checking doors, locks, appliances
- Counting, praying, repeating words
- Arranging objects symmetrically

3. Epidemiology

- Lifetime prevalence: **2–3%**
- Usually begins in **adolescence or early adulthood**
- Slightly more common in **females in adulthood**

4. Risk Factors

- Family history of OCD
- Genetic vulnerability
- Stressful life events
- Neurobiological factors

- Comorbid anxiety or depression
-

5. Assessment

5.1 Clinical History

Assess:

- Nature of **obsessions and compulsions**
 - **Frequency, duration, and severity**
 - Level of **distress and functional impairment**
 - Patient's **insight** into symptoms
 - Avoidance behaviours
 - Time spent on rituals
-

5.2 Screen for Comorbid Conditions

Common comorbidities include:

- Major depressive disorder
- Anxiety disorders
- Tic disorders
- Substance use disorders

Assess **suicidal thoughts**, especially if severe distress or depression is present.

5.3 Mental Status Examination

Assess:

- Thought content (obsessions)
- Repetitive behaviors
- Insight and judgment
- Mood and anxiety levels

5.4 Differential Diagnosis

Rule out:

- Generalized anxiety disorder
 - Psychotic disorders (delusions)
 - Autism spectrum disorder
 - Obsessive–compulsive personality disorder
 - Substance-induced symptoms
-

6. Management

6.1 Psychoeducation

Explain to patient and family:

- OCD is a **treatable mental disorder**
- Symptoms are related to **anxiety and intrusive thoughts**
- Treatment may require **both psychological therapy and medication**

Encourage **family support and understanding**.

6.2 Psychological Treatment

Cognitive Behavioural Therapy (CBT)

First-line treatment

Key technique:

Exposure and Response Prevention (ERP)

Steps:

1. Gradual exposure to feared situations
2. Prevention of compulsive behaviour
3. Anxiety gradually decreases through habituation

6.3 Pharmacological Treatment

First-line medications

Selective Serotonin Reuptake Inhibitors (SSRIs)

Examples:

- Fluoxetine
- Sertraline
- Fluvoxamine
- Paroxetine

SSRIs usually require **higher doses and longer duration** than for depression.

Alternative medication

If inadequate response:

- **Clomipramine** (tricyclic antidepressant effective for OCD)
-

Treatment duration

- Continue treatment for **at least 12 months after improvement**
 - Gradual dose reduction when stable
-

6.4 Severe or Resistant OCD

Consider:

- Combination of **CBT + medication**
 - Referral to specialist
 - Augmentation with **antipsychotics** in resistant cases
-

7. Follow-Up

Regular follow-up should include:

- Monitoring symptom severity
 - Assessing medication adherence
 - Monitoring side effects
 - Evaluating functional improvement
 - Assessing suicide risk
-

8. Referral

Refer to a **psychiatrist or specialist service** if:

- Severe OCD
 - Poor response to first-line treatment
 - Diagnostic uncertainty
 - Significant suicide risk
 - Complex comorbid conditions
-

References

- Diagnostic and Statistical Manual of Mental Disorders
 - Oxford Handbook of Psychiatry
 - Shorter Oxford Textbook of Psychiatry
 - Mental Health Gap Action Programme (mhGAP) by the World Health Organization
-

Anxiety Disorder Due to Another Medical Condition

1. Definition

Anxiety disorder due to another medical condition is characterized by **prominent anxiety symptoms that are directly caused by a medical illness or physiological condition**.

The anxiety is **not better explained by a primary psychiatric disorder**, substance use, or psychological stress alone.

Common anxiety symptoms include:

- excessive worry or fear
- restlessness
- palpitations
- sweating
- tremor
- sleep disturbance
- difficulty concentrating.

2. Common Medical Causes

Anxiety symptoms may occur due to:

Endocrine disorders

- Hyperthyroidism
- Hypoglycaemia
- Pheochromocytoma
- Cushing syndrome

Cardiovascular conditions

- Arrhythmias
- Heart failure
- Hypertension

Neurological disorders

- Epilepsy
- Brain tumours
- Stroke
- Parkinson disease

Respiratory diseases

- Asthma
- Chronic obstructive pulmonary disease (COPD)

Metabolic and systemic conditions

- Anaemia
- Vitamin B12 deficiency
- Electrolyte imbalance
- Infection or fever

Medication-related causes

- Steroids
- Bronchodilators
- Thyroid medications
- Stimulants
- Withdrawal from alcohol or sedatives

Box 8.6 Medical conditions associated with anxiety-like symptoms

- **Cardiovascular system (CVS):** arrhythmias, ischaemic heart disease (IHD), mitral valve disease, cardiac failure.
- **Respiratory:** asthma, COPD, HVS, PE, hypoxia.
- **Neurological:** TLE, vestibular nerve disease.
- **Endocrine:** hyperthyroidism, hypoparathyroidism, hypoglycaemia, pheochromocytoma.
- **Miscellaneous:** anaemia, porphyria, SLE, carcinoid tumour, pellagra.

Box 8.7 Prescribed medications causing anxiety-like symptoms

- **CVS:** antihypertensives, anti-arrhythmics.
- **Respiratory:** bronchodilators, α 1/ β -adrenergic agonists.
- **CNS:** anaesthetics (pre-med and post-general anaesthetic syndrome), anticholinergics, anticonvulsants, anti-Parkinsonian agents, antidepressants, antipsychotics (akathisia), disulfiram reactions, withdrawal from BDZs and other sedatives and hypnotics.
- **Miscellaneous:** levothyroxine, NSAIDs, antibiotics, chemotherapy.

3. Assessment

Assessment Question 1: Are anxiety symptoms present?

Assess for:

- excessive fear or worry
- palpitations
- sweating

- trembling
- shortness of breath
- restlessness
- sleep problems
- impaired daily functioning

Determine **severity and impact on functioning**.

Assessment Question 2: Is there evidence of a medical condition causing anxiety?

Take a **detailed medical history** including:

- current medical illnesses
- recent infections
- endocrine disorders
- neurological conditions
- medication history
- substance use

Conduct **physical examination**.

Perform relevant **laboratory investigations** when indicated:

- thyroid function tests
- blood glucose
- complete blood count
- electrolytes
- ECG if cardiac symptoms present.

Anxiety disorder due to medical condition is likely if:

- a **medical condition is present**, and
 - anxiety symptoms **developed after the onset of the medical illness**.
-

Assessment Question 3: Exclude other psychiatric conditions

Rule out:

- generalized anxiety disorder
- panic disorder
- depression
- substance use disorders
- post-traumatic stress disorder

Assess for **suicide risk** if severe distress is present.

4. Basic Management Plan

4.1 Treat the underlying medical condition

Management should primarily focus on **treating the medical cause**, for example:

- treat hyperthyroidism
- correct hypoglycaemia
- manage cardiac arrhythmias
- treat infections or metabolic abnormalities.

Improvement of the medical condition usually reduces anxiety symptoms.

4.2 Provide Psychoeducation

Explain to the patient and family that:

- anxiety symptoms are **related to the medical illness**
- symptoms may improve when the medical condition is treated
- stress management can help reduce symptoms.

Reassurance is important.

4.3 Psychosocial Support

Provide supportive interventions:

- stress management techniques
- relaxation exercises
- breathing exercises
- sleep hygiene advice
- encourage social support

Encourage continuation of normal daily activities when possible.

4.4 Pharmacological Treatment (If Needed)

Medication may be considered if anxiety symptoms are **severe or persistent**.

Possible options:

Short-term treatment

- Benzodiazepines (short course only)

Long-term treatment

- Selective serotonin reuptake inhibitors (SSRIs)

Medication choice should consider:

- the underlying medical illness
 - possible drug interactions.
-

5. Follow-Up

Regular follow-up is required to:

- monitor improvement of anxiety symptoms
- monitor treatment of the medical condition
- assess medication side effects
- reassess diagnosis if symptoms persist.

Follow-up interval: **2–4 weeks initially**, then according to clinical progress.

6. Referral

Refer to a specialist if:

- diagnostic uncertainty
 - severe anxiety symptoms
 - poor response to treatment
 - complex medical conditions
 - suicide risk present.
-

PTSD

Assessment and Basic Management of Post-Traumatic Stress Disorder (PTSD)

1. Purpose

To provide a standardized procedure for the **assessment, diagnosis, and initial management of Post-Traumatic Stress Disorder (PTSD)** in individuals presenting to healthcare services.

2. Scope

This SOP applies to **healthcare providers, mental health workers, and trained clinicians** involved in the assessment and management of individuals who may have experienced traumatic events.

3. Definition

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that develops after exposure to a **traumatic event** such as violence, disaster, accident, or conflict, and is characterized by **re-experiencing, avoidance, hyperarousal, and functional impairment lasting more than one month after the event.**

4. Typical Presenting Complaints

Individuals with PTSD may initially present with **non-specific symptoms**, which may make the condition difficult to recognize.

Common presenting complaints include:

- Sleep problems (e.g., insomnia)
- Irritability
- Persistent anxiety or depressed mood
- Multiple physical symptoms without clear medical cause
 - Headaches
 - Palpitations or pounding heart
 - General body discomfort

Further questioning may reveal **characteristic PTSD symptoms**.

5. Assessment Procedure

5.1 Assessment Question 1: Exposure to Traumatic Event

Determine whether the person has experienced a **potentially traumatic event more than 1 month ago**.

Examples of traumatic events include:

- Physical violence
- Sexual violence
- Domestic violence
- Witnessing atrocities
- Destruction of home
- Serious accidents or injuries
- Exposure to disasters or armed conflict

Suggested Assessment Questions

- “How have you been affected by the disaster or conflict?”
- “Has your life been in danger?”
- “Have you experienced something very frightening or horrific at home or in the community?”

If a traumatic event occurred, determine **when the event took place**.

5.2 Assessment Question 2: Presence of PTSD Symptoms

If the traumatic event occurred **more than one month ago**, assess for the following symptoms.

1. Re-experiencing Symptoms

Repeated and intrusive recollections of the traumatic event, such as:

- Frightening dreams
- Flashbacks
- Intrusive memories
- Feeling as if the event is happening again
- Intense fear or horror during recollections

In children:

- Repeated play or drawings about the event
- Frightening dreams without clear content

2. Avoidance Symptoms

Avoiding reminders associated with the traumatic event, including:

- Avoiding thoughts or memories related to the event
- Avoiding discussions about the trauma
- Avoiding people, places, or activities that trigger memories

3. Hyperarousal Symptoms (Heightened Sense of Threat)

- Being constantly alert or “on edge”
- Being easily startled by loud noises or sudden movements
- Excessive concern about danger

4. Functional Impairment

Assess whether symptoms are causing **significant difficulty in daily functioning**, such as:

- Work problems
- Social withdrawal
- Difficulty performing normal daily activities

If **all above symptoms are present at least one month after the event**, PTSD is likely.

5.3 Assessment Question 3: Concurrent Conditions

Assess for other conditions that may contribute to the symptoms.

Physical Conditions

Evaluate for physical illnesses that may explain symptoms.

Other Mental Health Conditions

Assess for additional **mental, neurological, or substance use disorders**, including:

- Depression
- Anxiety disorders
- Substance use disorders

Manage any identified conditions accordingly.

6. Basic Management Plan

6.1 Psychoeducation

Provide education about PTSD.

Explain that:

- Many people recover from PTSD over time without treatment.
- Some individuals require professional treatment.
- PTSD symptoms include repeated unwanted memories of the traumatic event.
- People may experience fear, horror, or distress similar to the original event.
- Nightmares and frightening dreams may occur.
- Individuals may feel constantly in danger and become easily startled.

- Avoiding reminders of the event is common but may interfere with daily life.

People with PTSD may also experience:

- Body aches and pains
- Fatigue and low energy
- Irritability
- Depressed mood

Advice to the Person

Encourage the individual to:

- Continue normal daily routines as much as possible
 - Talk with trusted people when they feel ready
 - Practice relaxation activities to reduce stress and anxiety
 - Avoid alcohol or drugs as coping strategies
-

6.2 Psychosocial Support

Provide psychosocial support following general mental health care principles.

Address Psychosocial Stressors

Identify and manage current stressors affecting the individual.

If the person is a **victim of severe human rights violations**, discuss referral to trusted protection or human rights agencies.

Strengthen Social Support

Encourage:

- Family support
- Community support
- Peer support

Teach Stress Management

Provide simple stress management techniques such as:

- Breathing exercises
 - Relaxation techniques
 - Structured daily routines
-

6.3 Psychological Therapy

If trained and supervised therapists are available, consider referral for:

- Trauma-focused **Cognitive Behavioural Therapy (CBT)**
- **Eye Movement Desensitization and Reprocessing (EMDR)**

These therapies are effective for treating PTSD.

6.4 Pharmacological Treatment

In adults, consider antidepressant medication when:

- Psychological therapy is unavailable
- Psychological therapy is ineffective
- Stress management alone is insufficient

Recommended medications include:

- **Selective Serotonin Reuptake Inhibitors (SSRIs)**
- **Tricyclic Antidepressants (TCAs)**

Refer to **moderate-severe depression treatment guidelines** for prescribing details.

Important:

- **Do not prescribe antidepressants for PTSD in children and adolescents.**
-

6.5 Follow-Up

Regular follow-up is essential.

- Schedule the **second appointment within 2–4 weeks.**

- Arrange further appointments depending on symptom progression and treatment response.

During follow-up:

- Monitor symptom improvement
- Assess daily functioning
- Reinforce coping strategies
- Adjust management if necessary

Acute stress disorder

Assessment and Basic Management of Acute Stress Disorder (ASD)

1. Purpose

To help field health workers **identify and support people who develop significant stress reactions within 1 month after a traumatic event.**

2. Identify Possible Acute Stress Disorder

Suspect **acute stress disorder** if a person presents with:

- Anxiety or fear after a traumatic event
- Sleep problems
- Poor concentration

- Physical symptoms without clear medical cause (e.g., dizziness, headache, palpitations)
- Emotional distress or difficulty functioning

Symptoms usually appear **within 1 month after the traumatic event**.

3. Assessment Steps

Step 1: Ask About Recent Traumatic Events

Ask if the person experienced a **frightening or life-threatening event within the last month**.

Examples include:

- Physical or sexual violence
- Domestic violence
- Witnessing death or atrocities
- Serious accidents or injuries
- Disaster or conflict

Example questions:

- “What major stress have you experienced recently?”
- “Was your life in danger?”
- “Have you experienced something very frightening or horrific?”
- “Do you feel safe at home?”

If the event occurred **more than 1 month ago**, consider other conditions such as depression or PTSD.

If there was a **death of a loved one**, also assess for grief.

Step 2: Check for Symptoms of Acute Stress

Ask if the person has:

Emotional and psychological symptoms

- Anxiety or fear related to the event

- Recurring dreams or flashbacks
- Feeling shocked, numb, or emotionally blank
- Crying frequently or feeling angry

Avoidance

- Avoiding reminders of the event
- Avoiding places or discussions related to the event

Hyperarousal

- Being easily startled
- Feeling constantly “on edge”

Cognitive symptoms

- Difficulty concentrating
- Confusion or feeling dazed

Behavior changes

- Aggression
- Social withdrawal
- Risk-taking behaviour (especially in adolescents)

Physical symptoms

- Rapid breathing (hyperventilation)
- Palpitations
- Dizziness
- Headache
- Body aches

Children may show

- Bedwetting
- Clinginess
- Tearfulness

- Regressive behaviour

Acute stress disorder is likely if:

- The traumatic event occurred **within 1 month**
 - Symptoms started **after the event**
 - The symptoms cause **significant difficulty in daily life**
-

Step 3: Check for Other Conditions

Also assess for:

- Physical illness
- Depression
- Other mental health conditions
- Substance use

Manage or refer if needed.

4. Basic Management

1. Provide Immediate Psychosocial Support

Field health workers should:

- Listen carefully and calmly
 - **Do not pressure the person to talk**
 - Ask about the person's **needs and concerns**
 - Help the person access **basic needs and services**
 - Encourage connection with **family and social support**
 - Protect the person from **further harm**
-

2. Educate the Person

Explain that:

- Stress reactions after traumatic events are **common**
 - Most people **recover gradually with support**
 - Symptoms usually **improve over time**
-

3. Strengthen Social Support

Encourage:

- Support from family and friends
 - Community support
 - Safe and stable environments
-

4. Teach Simple Stress Management

Teach basic techniques such as:

- Slow breathing
 - Relaxation exercises
 - Maintaining daily routines
-

5. Special Situations Management

Sleep Problems

Advise:

- Regular sleep schedule
- Avoid coffee, nicotine, and alcohol before bedtime
- Reduce noise or environmental disturbances

Medication **should generally not be used.**

In very severe cases, doctors may prescribe **short-term medication.**

Bedwetting in Children

Explain to caregivers:

- Bedwetting can occur after stress
- **Do not punish the child**
- Provide emotional support

Encourage:

- Toilet before sleep
 - Reduced fluid intake before bedtime
 - Positive rewards for dry nights
-

Hyperventilation (Rapid Breathing)

First rule out medical causes.

If caused by stress:

- Reassure the person
- Encourage **slow breathing**
- Stay calm and reduce anxiety triggers

Do not recommend breathing into a paper bag.

Dissociative Symptoms

Examples:

- Temporary inability to speak
- Unexplained paralysis
- “Pseudoseizures”

Actions:

- Rule out physical illness
- Reassure the person
- Provide supportive care

- Refer if symptoms persist
-

6. Follow-Up

- Ask the person to return in **2–4 weeks**
- Review symptoms and functioning
- Refer for specialized care if symptoms **worsen or do not improve**

Adjustment disorder

Assessment and Basic Management of Adjustment Disorder

1. Purpose

To guide field health workers in **identifying and supporting people who develop emotional or behavioral problems after a stressful life event** that affect daily functioning.

2. Identify Possible Adjustment Disorder

Suspect **adjustment disorder** if a person develops emotional or behavioral symptoms **after a stressful life event** such as:

- Loss of job or income
- Family or relationship problems
- Divorce or separation
- Financial difficulties
- Migration or displacement
- Illness of self or family member
- Major life changes

Common symptoms include:

- Persistent sadness or worry
- Feeling stressed or overwhelmed
- Sleep problems
- Difficulty concentrating
- Irritability
- Reduced ability to work or perform daily activities

Symptoms usually start **within 1–3 months after the stressful event**.

3. Assessment Steps

Step 1: Ask About Recent Stressful Events

Ask whether the person experienced a **major stressful life event** recently.

Example questions:

- “Have you experienced any major stress or change in your life recently?”

- “What difficulties have you been facing in your life?”
- “When did these problems begin?”

Confirm that the symptoms **started after the stressful event**.

Step 2: Assess Emotional and Behavioral Symptoms

Check whether the person has:

Emotional symptoms

- Sadness or low mood
- Anxiety or excessive worry
- Feeling hopeless or overwhelmed
- Frequent crying

Behavioral symptoms

- Social withdrawal
- Irritability or anger
- Reduced work performance
- Avoiding responsibilities

Physical symptoms

- Headache
- Fatigue
- Sleep disturbance
- Body aches

Assess whether the symptoms **cause significant difficulty in daily life**.

Step 3: Rule Out Other Conditions

Check whether symptoms may be caused by other conditions such as:

- **Acute Stress Disorder** (recent traumatic event within 1 month)

- **Post-Traumatic Stress Disorder (PTSD)** (trauma more than 1 month ago with re-experiencing symptoms)
- **Depression**
- **Physical illness**
- **Substance use**

Refer for further assessment if these conditions are suspected.

4. Basic Management

1. Provide Psychosocial Support

Field health workers should:

- Listen carefully and show empathy
 - Allow the person to share their problems
 - Do not judge or blame the person
 - Encourage discussion of coping strategies
-

2. Address Current Stressors

Help the person:

- Identify the main sources of stress
- Explore practical solutions
- Access community resources or services if needed

Examples:

- Social support
 - Financial assistance programs
 - Community organizations
-

3. Strengthen Social Support

Encourage the person to:

- Seek support from family and friends
- Participate in community activities
- Maintain supportive relationships

Social support helps reduce emotional distress.

4. Teach Stress Management

Encourage simple coping strategies:

- Relaxation exercises
- Deep breathing
- Regular daily routine
- Physical activity
- Healthy sleep habits

Advise the person to **avoid alcohol or drugs as coping methods.**

5. Provide Education

Explain that:

- Emotional distress after stressful life events is **common**
 - Many people **recover with support and time**
 - Learning healthy coping strategies can help recovery
-

5. Referral to Specialized Care

Refer the person to a **mental health professional** if:

- Symptoms are severe
- Symptoms persist for a long time
- The person cannot perform daily activities

- There are suicidal thoughts
 - There is suspicion of depression, PTSD, or other mental disorders
-

6. Follow-Up

- Arrange follow-up within **2–4 weeks**
- Monitor emotional wellbeing and daily functioning
- Continue support and referral if needed

References;

1. **World Health Organization – mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings (Version 2.0)**
2. **World Health Organization – Psychological First Aid: Guide for Field Workers**
3. **American Psychiatric Association – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition**

Epilepsy

Assessment and Basic Management of Epilepsy (Convulsive Epilepsy)

1. Purpose

To guide field health workers in **identifying, assessing, and managing people with convulsive epilepsy**, and to provide **education and follow-up care**.

2. Identify Possible Epilepsy

Suspect **convulsive epilepsy** if a person has a **history of convulsive seizures**, including:

- Sudden shaking of body or limbs
- Body stiffness or rigidity
- Loss of consciousness
- Falling during seizures

- Injury during seizures

Epilepsy involves **recurrent seizures caused by abnormal electrical activity in the brain.**

3. Assessment Steps

Step 1: Confirm Convulsive Seizure

Ask the person or caregiver if the following occurred during the episode:

- Convulsive movements lasting **more than 1–2 minutes**
- Loss or impairment of consciousness
- Body or limb stiffness lasting **more than 1–2 minutes**
- Tongue biting or body injury
- Loss of bladder or bowel control

After the seizure, the person may have:

- Confusion
- Drowsiness or sleepiness
- Abnormal behaviour
- Fatigue, headache, or muscle pain

A **convulsive seizure is likely** if:

- Convulsive movements are present **plus at least two other symptoms.**

If only **1–2 symptoms** are present, consider **non-convulsive seizures or other medical conditions** and follow up in **3 months.**

Step 2: Check for Acute Causes

Check whether the seizure is caused by an **acute medical condition** such as:

Possible neuroinfection

- Fever
- Severe headache

- Stiff neck

Other possible causes

- Head injury
- Metabolic problems (e.g., low blood sugar, low sodium)
- Alcohol or drug intoxication or withdrawal

If an **acute cause is found**, treat the cause.

Long-term antiepileptic medication **is not required**.

Refer to hospital **immediately** if:

- Neuroinfection is suspected
- Head injury is present
- Metabolic abnormality is suspected

Step 3: Determine if the Person Has Epilepsy

Diagnose **epilepsy** if:

- The person had **two or more unprovoked convulsive seizures**
- Occurring on **different days within the last 12 months**

If the person had **only one seizure**, do not start medication yet.

Follow up after **3 months**.

4. Basic Management**1. Educate the Person and Caregivers**

Explain that:

- Epilepsy is a **chronic brain condition**
- Seizures occur due to **abnormal electrical activity in the brain**
- **Most people can control seizures with medication**
- Epilepsy is **not contagious**
- It is **not caused by spirits or witchcraft**

People with epilepsy can:

- Marry and have children
 - Work safely in most jobs
 - Attend school
-

2. Lifestyle Advice

People with epilepsy should avoid:

- Working near **heavy machinery or fire**
- **Cooking over open fire**
- **Swimming alone**
- **Alcohol and recreational drugs**
- **Flashing lights**
- **Irregular sleep patterns**

Encourage **regular sleep and healthy lifestyle.**

5. What to Do During a Seizure

Teach caregivers the following steps:

Protect the person

- Help the person **sit or lie on the ground**
- Prevent injuries from falling

Ensure breathing

- Loosen tight clothing around the neck

Place in recovery position

- Turn the person on their **side**
- Keep airway open
- Allow saliva or vomit to drain

Important precautions

Do **NOT**:

- Restrain the person
- Put anything in the mouth

Remove **sharp or hard objects** nearby.

Stay with the person **until consciousness returns**.

6. Medication Management

If epilepsy is confirmed:

- **Start or resume antiepileptic medication**
- If a previous medication worked, **restart the same medication**
- If not available, start **one appropriate antiepileptic drug**

Principles:

- Start with **low dose**
- Increase **gradually until seizures are controlled**
- Use **only one medication at a time**

Explain to the person:

- Importance of **taking medication regularly**
- Medication should be taken **at the same time each day**
- Stopping medication suddenly can cause seizures

Treatment should continue **until the person has been seizure-free for at least 2 years.**

Table EPI 1: Antiepileptic medications

	Phenobarbital*	Carbamazepine	Phenytoin	Valproate
Starting dose in children	2–3 mg/kg/day	5 mg/kg/day	3–4 mg/kg/day	15–20 mg/kg/day
Typical effective dose in children	2–6 mg/kg/day	10–30 mg/kg/day	3–8 mg/kg/day (max. dose 300 mg/day)	15–30 mg/kg/day
Starting dose in adults	60 mg/day	200–400 mg/day	150–200 mg/day	400 mg/day
Typical effective dose in adults	60–180 mg/day	400–1400 mg/day	200–400 mg/day	400–2000 mg/day
Dosing schedule	Once daily at bedtime	Twice daily	In children, give twice daily; in adults, it can be given once daily	Usually 2 or 3 times daily
Rare but serious side-effects	<ul style="list-style-type: none"> Severe skin rash (Stevens-Johnson syndrome*) Bone marrow depression* Liver failure 	<ul style="list-style-type: none"> Severe skin rash (Stevens-Johnson syndrome*, toxic epidermal necrolysis*) Bone marrow depression* 	<ul style="list-style-type: none"> Anaemia and other haematological abnormalities Hypersensitivity reactions including severe skin rash (Stevens-Johnson syndrome*) Hepatitis 	<ul style="list-style-type: none"> Drowsiness Confusion
Common side-effects	<ul style="list-style-type: none"> Drowsiness Hyperactivity in children 	<ul style="list-style-type: none"> Drowsiness Trouble walking Nausea 	<ul style="list-style-type: none"> Nausea, vomiting, constipation Tremor Drowsiness Ataxia and slurred speech Motor twitching Mental confusion 	<ul style="list-style-type: none"> Lethargy Sedation Tremor Nausea, diarrhoea Weight gain Transient hair loss (regrowth normally begins within 6 months) Impaired hepatic function
Precautions	<ul style="list-style-type: none"> Avoid phenobarbital in children with intellectual disability or behavioural problems 			<ul style="list-style-type: none"> Avoid valproate in pregnant women

* Available in the Interagency Emergency Health Kit (WHO, 2011)



Box EPI 1: Special management considerations for women with epilepsy

» If the woman is of childbearing age:

- Give folate 5 mg/day to prevent possible birth defects if she becomes pregnant.

» If she is pregnant:

- Consult with a specialist for management.
- Advise more frequent antenatal visits and delivery in a hospital.
- At delivery, give 1 mg **vitamin K** intramuscularly (i.m.) to the newborn.

» The decision to start an antiepileptic medication in a pregnant woman should be made together with the woman. The severity and frequency of the seizures as well as the potential harm to the fetus from either the seizures or the medication should be considered. If the decision is made to start medication, then either **phenobarbital** or **carbamazepine** can be used. Valproate and polytherapy* should be avoided.

» Carbamazepine can be used by women who are **breastfeeding**.

7. Seizure Diary

Ask the person or caregiver to **keep a simple seizure diary**, including:

- Date of seizure
- Duration

- Possible triggers
- Medication adherence

This helps monitor treatment effectiveness.

Figure EPI 1: Example seizure diary

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

8. Follow-Up

First 3 months

Follow up **every month** until seizures are controlled.

After seizures are controlled

Follow up **every 3 months**.

During follow-up:

- Review seizure diary
- Assess seizure control
- Adjust medication if needed
- Check medication side effects
- Reinforce education and lifestyle advice

9. Referral

Refer to a specialist if:

- Seizures are **not controlled after two medications**
- Severe side effects occur
- Diagnosis is uncertain

Box EPI 2: Assessment and management of a person who is convulsing or is unconscious following a seizure



Assessment and management of acute seizures should proceed simultaneously.

» **Assessment of seizures**

- Stay calm. Most seizures will stop after a few minutes.
- Check **airway, breathing and circulation**, including blood pressure, respiratory rate and temperature.
- Check for **signs of head or spinal injury** (e.g. dilated pupils may be a sign of serious head injury).
- Check for **stiff neck or fever** (signs of meningitis).

» **Ask the carer:**

- *When did this seizure start?*
- *Is there a past history of seizures?*
- *Is there a history of head or neck injury?*
- *Are there other medical problems?*
- *Did the person take any medication, poison, alcohol or drugs?*
- *If female: Is she in the second half of pregnancy or first week after delivery?*

» **Refer urgently to a hospital:**

- If there is any sign of **major injury, shock* or breathing problem**
- If the person may have had a **serious head or neck injury**:
 - › Do not move the person's neck.
 - › Log-roll* the person when transferring them.
- If the person is a woman in the **second half of pregnancy or less than 1 week after delivery**
- If **neuroinfection** is suspected
- If it has been **more than 5 minutes** since the seizure started.

» **Management of seizures**

- Put the person on their side in the **recovery position** (see *Basic management plan and Figures A–D above*).
- If the seizure does not spontaneously stop after 1–2 minutes, insert an intravenous (i.v.) line as quickly as possible and give **glucose and benzodiazepines** slowly (30 drops/minute).
 - › If an i.v. line is difficult to establish, give the benzodiazepines through the rectum.
 - › Caution: **benzodiazepines can slow down breathing**. Give oxygen if available and monitor the person's respiratory status frequently.
 - › **Child glucose dose:** 2–5 ml/kg of 10% glucose
 - › **Child benzodiazepines dose:**
 - diazepam rectally 0.2–0.5 mg/kg or
 - diazepam i.v. 0.1–0.3 mg/kg or
 - lorazepam i.v. 0.1 mg/kg.
 - › **Adult glucose dose:** 25–50 ml of 50% glucose
 - › **Adult benzodiazepines dose:**
 - diazepam rectally 10–20 mg or
 - diazepam i.v. 10–20 mg slowly or
 - lorazepam i.v. 4 mg.
 - › **Do not give benzodiazepines intramuscularly (i.m.).**
- Give the **second dose** of benzodiazepines if the seizure continues for 5–10 minutes after the first dose.
- Use the same dose as the first dose.
- **Do not give more than 2 doses of benzodiazepines.** If the person needs more than 2 doses, they should be sent to a hospital.
- Suspect **status epilepticus** if:
 - › Seizures occur frequently and the person does not recover in between episodes, or
 - › Seizures are not responsive to 2 doses of benzodiazepines, or
 - › Seizures last for more than 5 minutes.
- » **Refer urgently to a hospital:**
 - If status epilepticus is suspected (see above)
 - If the person does not respond to the first 2 doses of benzodiazepines
 - If the person is having breathing problems after receiving benzodiazepines.

Assessment and Basic Management of Intellectual Disability

1. Purpose

To guide field health workers in **identifying, assessing, and supporting people with intellectual disability**, especially in humanitarian or community settings.

2. Identify Possible Intellectual Disability

Intellectual disability is a condition where a person has **limitations in intellectual development** such as:

- Cognitive skills (thinking and understanding)
- Language and communication
- Motor skills
- Social skills

These limitations:

- Start **from birth or childhood**
- Are **not reversible**
- Affect **learning, daily functioning, and adaptation**

People with intellectual disability may require **additional care and protection**, especially during emergencies.

3. Assessment Steps

Step 1: Assess Development and Daily Functioning

Evaluate the person's **developmental milestones and daily functioning**.

For young children

Check whether the child has reached **age-appropriate milestones**.

Ask carers:

- "Is your child behaving like other children of the same age?"
- "What can your child do alone (sit, walk, eat, dress, use toilet)?"

- “How does your child communicate with you?”
 - “Does the child smile or respond to their name?”
 - “How does your child play with other children?”
-

For older children and adolescents

Ask about **school performance**.

Example questions:

- “Do you go to school?”
 - “Are you able to understand lessons?”
 - “Can you finish your schoolwork?”
 - “Do you have difficulty following instructions?”
-

For adults

Assess **work and daily activities**.

Example questions:

- “Do you work?”
- “What kind of work do you do?”
- “Do you have difficulty understanding instructions at work?”

Also ask **how much help the person needs** for daily activities.

Step 2: Rule Out Treatable or Reversible Conditions

Before diagnosing intellectual disability, rule out other conditions.

Visual impairment

For children older than 6 months check if the child can:

- Follow a moving object with eyes
- Recognize familiar people

- Grab objects

If not, refer for **vision assessment**.

Hearing impairment

Check if the child can:

- Turn head toward someone speaking
- React to loud sounds
- Make sounds like “dada” or “baba”

If not, refer for **hearing assessment**.

Environmental factors

Assess for:

- Severe depression in the mother or caregiver
- Lack of stimulation or interaction

Ask:

- Who plays with the child?
 - How often does the child interact with others?
-

Nutritional or medical conditions

Check for:

- Malnutrition
- Iodine deficiency
- Thyroid problems
- Epilepsy

Manage these conditions and reassess later.

Step 3: Confirm Intellectual Disability

Intellectual disability is likely if:

- There is **significant delay in developmental milestones**
 - The person has **difficulty with daily functioning**
 - Other treatable causes have been **ruled out or treated**
-

4. Assess Behavioural Problems

Check whether the person has:

- Temper tantrums
 - Aggressive behaviour
 - Self-harm
 - Not listening to carers
 - Eating non-food items
 - Risky sexual or social behaviour
-

5. Basic Management

1. Provide Psychoeducation

Explain to carers that:

- Intellectual disability is **not the person's fault**
- The person should **not be blamed or punished**
- Supportive care and training can improve functioning

Encourage carers to have **realistic expectations**.

2. Parenting Skills and Behaviour Support

Teach carers to:

- Train the person in **self-care skills**

- toileting
- brushing teeth
- dressing
- Keep **daily routines consistent**

Carers should:

- Understand what causes the person's behaviour
 - Know what makes the person happy or stressed
 - Recognize the person's strengths and weaknesses
-

Behaviour management

Encourage carers to:

- Give **simple and clear instructions**
- Break tasks into **small steps**
- Reward good behaviour
- Distract from inappropriate behaviour

Avoid:

- Physical punishment
 - Threats
-

6. Protection and Safety

Explain to carers that people with intellectual disability are **more vulnerable to abuse**.

Encourage:

- Close supervision
- Protection from physical or sexual abuse

Avoid **institutionalization** whenever possible.

7. Promote Community Inclusion

Encourage the person to participate in **community life**.

For children

- Encourage attendance in **regular schools**
- Work with teachers to **adapt the learning environment**

For adults

- Encourage participation in **social and community activities**

Refer to **community-based rehabilitation programs** if available.

8. Support for Caregivers

Caregivers may experience **stress and burden**.

Provide support by:

- Listening to their concerns
 - Helping them connect with community support
 - Strengthening social support networks
-

9. Referral

Refer to a specialist if there are:

- Severe developmental delays
 - Motor impairment or cerebral palsy
 - Genetic conditions (e.g., Down syndrome)
 - Complex behavioural problems
-

10. Follow-Up

Arrange **regular follow-up visits** to:

- Monitor development and functioning

- Support caregivers
- Review behavioural management
- Ensure access to community services

Box ID 1: Developmental milestones: warning signs to watch for

By the age of 1 MONTH	<ul style="list-style-type: none"> • Poor suckling at the breast or refusing to suckle • Little movement of arms and legs • Little or no reaction to loud sounds or bright lights • Crying for long periods for no apparent reason • Vomiting and diarrhoea, which can lead to dehydration
By the age of 6 MONTHS	<ul style="list-style-type: none"> • Stiffness or difficulty moving limbs • Constant moving of the head (this might indicate an ear infection, which could lead to deafness if not treated) • Little or no response to sounds, familiar faces or the breast • Refusing the breast or other foods
By the age of 12 MONTHS	<ul style="list-style-type: none"> • Does not make sounds in response to others • Does not look at objects that move • Listlessness and lack of response to the caregiver • Lack of appetite or refusal of food
By the age of 2 YEARS	<ul style="list-style-type: none"> • Lack of response to others • Difficulty keeping balance while walking • Injuries and unexplained changes in behaviour (especially if the child has been cared for by others) • Lack of appetite
By the age of 3 YEARS	<ul style="list-style-type: none"> • Loss of interest in playing • Frequent falling • Difficulty manipulating small objects • Failure to understand simple messages • Inability to speak using several words • Little or no interest in food
By the age of 5 YEARS	<ul style="list-style-type: none"> • Fear, anger or violence when playing with other children, which could be signs of emotional problems or abuse
By the age of 8 YEARS	<ul style="list-style-type: none"> • Difficulties making and keeping friends and participating in group activities • Avoiding a task or challenge without trying, or showing signs of helplessness • Trouble communicating needs, thoughts and emotions • Trouble focusing on tasks, understanding and completing schoolwork • Excessive aggression or shyness with friends and family

Source: UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and World Bank (2010)

ADHD

Assessment and Basic Management of ADHD (Attention-Deficit/Hyperactivity Disorder) for Field Health Workers

1. Purpose

To guide field health workers in **identifying, assessing, and providing basic support for children, adolescents, and adults with ADHD**, based on standard psychiatric guidelines.

2. Identify Possible ADHD

ADHD is a **neurodevelopmental disorder** characterized by **persistent patterns of inattention, hyperactivity, and impulsivity** that are **inconsistent with developmental level** and interfere with **social, academic, or occupational functioning**.

Key features:

1. Inattention

- Often fails to pay close attention to details
- Difficulty sustaining attention in tasks or play
- Does not follow through on instructions
- Avoids tasks that require mental effort
- Frequently loses items
- Easily distracted

2. Hyperactivity-Impulsivity

- Fidgets or squirms in seat
- Leaves seat when expected to stay seated
- Runs or climbs inappropriately
- Unable to play quietly

- “On the go” or “driven by a motor”
- Talks excessively
- Blurts out answers
- Difficulty waiting turn
- Interrupts or intrudes on others

DSM-5 criteria (simplified for field use):

- Symptoms **present before age 12**
 - Symptoms **persist for at least 6 months**
 - Symptoms occur in **two or more settings** (home, school, community)
 - Clear evidence that symptoms **interfere with daily functioning**
 - Symptoms **not better explained** by another mental disorder
-

3. Assessment Steps

Step 1: Gather History

Ask carers, teachers, or colleagues about:

- Patterns of **inattention and hyperactivity**
- **Onset and duration** of symptoms
- Impact on **school, work, or social life**
- Previous interventions or strategies tried

Use **examples of behaviour**:

- Difficulty completing schoolwork
 - Forgetting daily routines
 - Interrupting conversations
 - Trouble sitting still for meals or meetings
-

Step 2: Rule Out Other Conditions

Check for conditions that may mimic ADHD:

- **Learning disabilities**
- **Anxiety or depression**
- **Sleep disorders**
- **Thyroid problems**
- **Hearing or vision impairment**
- **Traumatic brain injury**

Manage or refer as needed.

Step 3: Assess Functional Impairment

Determine whether ADHD symptoms **interfere with daily life**:

- Academic difficulties or school failure
 - Problems at work or with colleagues
 - Social relationship problems
 - Safety issues (e.g., impulsive behaviour, accidents)
-

4. Basic Management

1. Psychoeducation

Explain to parents, caregivers, and the person:

- ADHD is a **real neurodevelopmental condition**, not due to poor parenting or laziness
 - Symptoms can **persist into adulthood**
 - With support and treatment, **functional outcomes can improve**
 - Provide guidance on **daily routines, structure, and supervision**
-

2. Behavioural and Educational Interventions

For children and adolescents:

- **Structured environment** at home and school
- **Clear rules and routines**
- **Positive reinforcement** for desirable behaviour
- Break tasks into **small, achievable steps**
- Encourage **physical activity** to reduce hyperactivity
- Use **visual aids** and reminders

For adults:

- Time management strategies
- Organisational tools (calendars, apps)
- Structured work environment

3. Medication (if available and under supervision)

Based on **Maudsley Guidelines**:

- **First-line:** Stimulants (e.g., methylphenidate, lisdexamfetamine)
- **Alternative:** Non-stimulants (e.g., atomoxetine, guanfacine)
- **Start low, titrate gradually** based on response and side-effects
- Monitor **blood pressure, heart rate, appetite, sleep**
- Educate on **adherence and potential side-effects**
- Avoid abrupt discontinuation

Important: Medications are prescribed only if **available, safe, and supervised by a trained clinician**.

4. Support for Families and Caregivers

- Teach **parenting strategies** to manage hyperactivity and impulsivity
- Encourage **family participation in therapy**
- Provide **social support and stress reduction strategies** for caregivers

5. Referral

Refer to a **specialist** if:

- Symptoms are **severe or complex**
 - Functional impairment is significant
 - There are **comorbid conditions** (e.g., epilepsy, depression, anxiety)
 - Medication initiation is required but not supervised locally
-

6. Follow-Up

- Regular follow-up to monitor:
 - Symptom improvement
 - School or work performance
 - Medication response and side-effects
 - Adjust interventions as needed
 - Reinforce behavioural strategies and routines
-

References

1. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, 2013.
2. Maudsley Prescribing Guidelines in Psychiatry, Taylor D, Paton C, Kapur S.
3. Oxford Textbook of Psychiatry, Gelder M, Andreasen N, Lopez-Ibor J, Geddes J.

Suicide and Self-harm

Assessment and Basic Management of Suicide and Self-Harm

1. Purpose

To guide field health workers in **identifying, assessing, and supporting individuals at risk of suicide or self-harm**, especially in **humanitarian or community settings**.

2. Identify Individuals at Risk

Adults and adolescents with **mental, neurological, or substance use conditions** are at higher risk of suicide or self-harm.

Common risk factors:

- **Mental disorders:** depression, psychosis, PTSD, acute stress
- **Substance use:** harmful alcohol or drug use
- **Chronic pain or disability**
- **Recent emotional crises or hopelessness**

Do not avoid asking about suicide; talking about it can **reduce distress and open support opportunities**.

Typical presenting complaints of a person at risk of suicide or self-harm

Feeling extremely upset or distressed

Profound hopelessness or sadness

Past attempts of self-harm (e.g. acute pesticide intoxication, medication overdose, self-inflicted wounds).

3. Assessment Steps

Step 1: Recent Suicide Attempt or Self-Harm

Ask or observe for:

- Poisoning, medication overdose, alcohol or drug intoxication
- Other self-harm behaviours (cutting, burns, etc.)

Red flags requiring urgent medical care:

- Bleeding from self-inflicted wounds
 - Loss of consciousness
 - Extreme lethargy
-

Step 2: Imminent Risk of Suicide or Self-Harm

Ask the person or carers about:

- Current thoughts or plans of suicide (past month)
- Acts of self-harm in the past year
- Access to means (pesticides, rope, knives, firearms, medications)

Observe for:

- Severe emotional distress or hopelessness
- Agitation or violent behaviour
- Withdrawal or uncommunicative behaviour

Imminent risk is present if:

- Current thoughts, plans, or acts of suicide
 - Past month thoughts/plans or acts in a person who is now extremely distressed, agitated, violent, or uncommunicative
-

Step 3: Concurrent Conditions

Assess and manage any **concurrent conditions** that increase risk:

- Moderate-severe depression
- Psychosis
- PTSD or acute stress
- Harmful alcohol or drug use
- Chronic pain or disability

Box SUI 1: How to talk about suicide or self-harm

1. Create a safe and private atmosphere for the person to share thoughts.

- » Do not judge the person for being suicidal.
- » Offer to talk with the person alone or with other people of their choice.

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

- » [Start with the present] *How do you feel?*
- » [Acknowledge the person's feelings] *You look sad/ upset. I want to ask you a few questions about it.*
- » *How do you see your future? What are your hopes for the future?*
- » *Some people with similar problems have told me that they felt life was not worth living. Do you go to sleep wishing that you might not wake up in the morning?*
- » *Do you think about hurting yourself?*
- » *Have you made any plans to end your life?*
- » *If so, how are you planning to do it?*
- » *Do you have the means to end your life?*
- » *Have you considered when to do it?*
- » *Have you ever attempted suicide?*

3. If the person has expressed suicidal ideas:

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

4. Basic Management

1. Immediate Care for Suicide Attempt

- Provide **medical care for injuries or poisoning**
 - Treat with same **care, respect, and privacy** as for any patient
- Monitor the person continuously if **still at imminent risk**
- Offer **psychosocial support**
- Consult a **mental health specialist** if available

2. Support for Persons at Imminent Risk

Monitoring

- Create a **safe environment**: remove possible means of self-harm
- Ensure **24-hour monitoring** by carers or staff
- **Do not leave the person alone**
- Hospital admission only if medically necessary; continue monitoring

Psychosocial Support

- Start by **instilling hope**, not offering solutions immediately
 - Help the person **identify reasons to stay alive**
 - Work together to **find practical solutions** to problems
 - Mobilize **trusted carers, friends, community resources** for continuous support
 - Offer **additional psychosocial support** per stress-reduction principles
-

3. Care for Carers

- Support carers as described in the **Principles of Reducing Stress and Strengthening Social Support**
 - Help carers understand **24-hour monitoring responsibilities**
-

4. Follow-Up

- Develop a **concrete follow-up plan** with carers
 - Maintain **frequent contact** (e.g., weekly for first 2 months, then every 2–4 weeks)
 - Continue follow-up **as long as risk persists**
 - At each contact, **assess suicidal thoughts and plans**
-
-

Insomnia

Assessment and Management of Insomnia

1. Purpose

To guide field health workers in **identifying, assessing, and managing insomnia**, ensuring basic support, sleep hygiene education, and referral when necessary.

2. Definition

Insomnia: Persistent difficulty (≥ 3 nights/week for ≥ 1 month) with:

- Falling asleep (sleep initiation)
- Staying asleep (sleep maintenance)
- Poor sleep quality
- Daytime impairment (fatigue, concentration difficulties, mood changes)

Patients are often **preoccupied with their sleep problems** and distressed.

Prevalence: ~30% of general population, higher in females and older adults; clinically significant insomnia affects 9–12%.

Box 10.2 Common medication causes of insomnia

- Antidepressants (e.g. MAOIs, SSRIs, venlafaxine, reboxetine).
- Anti-Parkinsonian medication.
- Bronchodilators (e.g. aminophylline, theophylline, pseudoephedrine).
- Cardiovascular medication (e.g. β -blockers, clonidine, high-dose digoxin, verapamil).
- Chemotherapy agents.
- Corticosteroids/anabolic steroids.
- NSAIDs (high dose).
- Stimulants (e.g. dexamfetamine, methylphenidate, amphetamine cocaine, caffeine, nicotine).
- Levothyroxine.
- Withdrawal (e.g. hypnotics, opiates, alcohol, or cannabis).

3. Assessment Steps

Step 1: Rule Out Physical Causes

- Perform **physical examination** and basic investigations.
- Treat any identified physical causes.
- Reassess if insomnia persists.

Step 2: Exclude Other MNS Conditions

- Acute stress disorder, PTSD, grief, moderate-severe depression
- Harmful alcohol or drug use
- Suicide/self-harm risk

Refer to specialized module if any of the above is suspected.

Step 3: Identify Behavioral/Environmental Contributors

- Stress, irregular routines, excessive screen time

- Caffeine, alcohol, nicotine
 - Inadequate or inconsistent sleep environment
-

4. Basic Management Plan

1. Psychosocial Support

- Address **stressors** and strengthen **social support**
- Encourage **continuation of daily activities**
- Discuss healthy coping strategies for anxiety or tension

2. Sleep Education

- Explain **normal sleep cycles and age-related changes**
- Correct **misconceptions** about sleep

3. Sleep Hygiene

- **Environmental control:** Reduce noise, light, maintain comfortable temperature
- **Wind-down routine (~1 hour before sleep):** Reading, warm bath, calm activities
- **Avoid stimulants:** Caffeine after 4 p.m., nicotine 1 hour before bed, alcohol close to bedtime
- **Exercise:** Regular but not late at night
- **Daytime naps:** Short (<40 min), early afternoon only
- **Reflect on stress:** Allocate quiet time during day for problem-solving

4. Stimulus Control

- Go to bed only when sleepy
- Avoid non-sleep activities in bed (except sex)
- If unable to sleep after 10–20 minutes, get up, return when sleepy
- Maintain **consistent wake-up time** (± 1 hour)

5. Relaxation Training

- Practice **progressive relaxation, deep breathing** during day and before bed

- Use relaxation techniques in bed if needed

6. Sleep Restriction (If Fragmented Sleep)

- Limit total time in bed to consolidate sleep
- Gradually adjust sleep/wake schedule
- Requires motivation and encouragement

Box 10.3 Sleep restriction

- Keep a sleep diary for 5–14 days to allow the calculation of TST and SE.
- $TST = (\text{total time spent in bed}) - (\text{time spent awake during the night})$.
- $SE = (TST \times 100) / \text{total time spent in bed}$.

- For the first few nights of a sleep restriction programme, spend only the same number of hours in bed as the average TST for the past week. No naps allowed during the day (despite initial tiredness).
- Continue to keep sleep diary. When the calculated mean SE for five nights reaches 85% or better, go to bed 15min earlier.
- Repeat the procedure with increases of 15min if mean SE remains 85% or better, or decreases of 15min if the mean SE falls below 85%, until a satisfactory amount of night-time sleep is achieved.

7. Medication (Last Resort)

- Only if insomnia is **severe, disabling, or distressing**
- Treat underlying causes first
- Use **short-term hypnotics** or adjunct therapy
- Avoid prolonged use (>4 weeks)
- Interrupted courses (5 nights with medication, 2 nights off) to avoid tolerance

- Options may include:
 - Benzodiazepines (BDZs)
 - “Z-drugs” (zopiclone, zolpidem)
 - Certain antidepressants (e.g., mirtazapine)
 - Others: trazodone, melatonin agonists

Table 10.1 Pharmacokinetic data for drugs used as hypnotics (in order of decreasing $T_{1/2}$)

Drug	Availability (%)	Plasma-bound (%)	Time to T_{max} (hr)	$T_{1/2}$ (hr)
Mirtazapine	50	85	0.25–2	16.3–40
Nitrazepam	78	85–87	0.5–5	15–40
Olanzapine	60	93	5–6	24–30
Temazepam	91	96–98	0.75–3	2–25
Promethazine	12.3–25	–	4.39	18.6
Trazodone	60–80	89–95	1–2	6–15
Lormetazepam	70–80	92	2	7.9–12
Chloral hydrate	–	35	0.76–8.2	9.3–10.9
Quetiapine	–	83	1–2	5.3–7
Zopiclone	70–80	45–80	0.25–1.5	3.5–6.5
Zolpidem	70	90–92	0.5–2.6	1.5–4.5
Agomelatine	<5	95	1–2	1–2
Zaleplon	30	60	0.25–1.5	0.9–1.1
Melatonin	15	–	0.83	0.75

5. Follow-Up

- Monitor **sleep patterns, daytime function, and stress levels**
- Advise patient to return if:
 - Symptoms persist or worsen

- Severe distress occurs
 - Reassess need for specialist referral if standard measures fail
-

Somatic Symptom Disorder (SSD) / Other Significant Mental Health Complaints

1. Purpose

To guide health workers in the **assessment and basic management** of individuals presenting with **physical symptoms without a clear medical cause**, and mild emotional or behavioral problems that **do not meet full criteria for other mental, neurological, or substance use (MNS) disorders**.

2. Definition

Somatic Symptom Disorder (SSD):

- Persistent physical symptoms (e.g., pain, fatigue, gastrointestinal complaints) **without a fully explainable medical cause**.
 - May include mild **mood or behavior changes** that cause concern.
 - Considered **significant** when the symptoms **impair daily functioning** or the person **seeks help**.
-

3. Assessment

Step 1: Exclude Physical Causes

- Conduct **general physical examination**.
- Perform appropriate **medical investigations**.
- Treat any **identified physical condition**.
- Reassess **after treatment** to see if symptoms persist.

Step 2: Exclude Other MNS Conditions

Check for the following and **refer to the relevant module if suspected**:

Condition	Core Features
Acute Stress Disorder	Traumatic event in last month; symptoms started after event; functional impairment
Grief	Symptoms after a major loss; functional impairment
Moderate-Severe Depression	≥2 weeks; persistent low mood, loss of interest, functional impairment
PTSD	Traumatic event >1 month ago; flashbacks, nightmares, avoidance, hypervigilance; functional impairment
Harmful Alcohol/Drug Use	Use causing harm to self or others
Suicide/Self-Harm	Current self-harm, suicidal thoughts/plans, or recent acts with severe distress or agitation

If any of these are present, follow the **specific module for management**.

Step 3: Confirm Somatic Symptom Disorder / Other Mental Health Complaint

- If **physical causes are excluded**,
- **Other MNS conditions are excluded**, and
- The person **seeks help or experiences functional impairment**,
- Then the person likely has **SSD or another significant mental health complaint**.

May require **multiple consultations** to fully exclude other causes.

4. Management Plan

4.1 Psychosocial Support

- Listen actively and acknowledge the **reality of symptoms**.
- Avoid implying the symptoms are **“imaginary”**.
- Encourage **daily activity and engagement**.
- Strengthen **social support** and address psychosocial stressors.

4.2 Education

- Explain that **emotional distress can cause physical sensations** (e.g., stomach aches, headaches, muscle tension).
- Help the person identify possible links between **stress/emotions and symptoms**.

4.3 Avoid Unnecessary Investigations

- Only order tests when **clinically indicated**.
- Over-testing may **reinforce the belief of a physical disease** and increase distress.

4.4 Referral

- Refer to a **specialist** if:
 - Symptoms persist or worsen,
 - Functional impairment increases, or
 - Other MNS conditions emerge.

4.5 Follow-Up

- Schedule **regular follow-ups**.
 - Monitor for emergence of **other MNS conditions**.
 - Support the person and carers in maintaining **daily routines and social engagement**.
-

5. Key Points for Field Health Workers

- Symptoms are **real and distressing**, even without a medical explanation.
- Focus on **support, education, and functional improvement**.
- Avoid unnecessary testing.
- Persistent or worsening cases require **referral to mental health specialists**.

Acute Excitement / Acute Behavioral Disturbance

1. Purpose

To guide health workers in **assessment, risk management, and immediate intervention** for individuals presenting with **acute behavioral disturbance**, including shouting, aggression, threats to self or others, or other antisocial behaviors.

Note: In extreme situations involving weapons, potential suicide from height, or hostage situations, **call police/security immediately**. Do **not** risk your own or others' lives.

2. Definition

Acute excitement:

- Sudden **qualitative change** in normal behavior.
 - May manifest as: shouting, screaming, aggressive outbursts, disruptive activity, or threatening violence.
 - Causes can be **psychiatric, neurological, substance-related, or situational**.
-

3. Common Causes

- **Acute confusional states / delirium**
 - **Drug/alcohol intoxication**
 - **Acute psychiatric symptoms** (anxiety, panic, mania, psychosis)
 - **Challenging behavior** in brain-injured or intellectually disabled individuals
 - Situational stressors, personality traits, or antisocial tendencies
-

4. Assessment

Step 1: Context & Information Gathering

- Identify **setting and triggers**: ward, outpatient, emergency, or community
- Seek **collateral information** from carers, staff, or family
- Look for **physical causes** (infection, intoxication, metabolic disorder)
- Look for **psychiatric causes** (mania, psychosis, panic, delirium)

Step 2: Immediate Risk Assessment

- Assess for **risk to self or others**
 - Check for **access to weapons** or dangerous objects
 - Determine **ability to safely manage** the patient on-site
-

5. Management

Step 1: Address Physical Causes

- If a **physical cause is suspected** (delirium, intoxication, infection):
 - Follow **delirium / medical management protocols**
 - Ensure **monitoring and supportive care**

Step 2: Behavioral and Psychiatric Causes

- Attempt **verbal de-escalation first**: calm tone, clear instructions, safe distance
- **PRN (as-needed) sedative medication** may be used if verbal de-escalation fails
- Consider **rapid tranquillization (RT)** if urgent:

Rapid Tranquillization Protocol

Before RT:

- Ensure **patient and staff safety**
- Check for **physical conditions** (renal, liver, cardiac, respiratory, pregnancy)
- Review **recent medications and maximum doses**
- Offer **oral medication first**, if possible

Non-psychotic context:

- IM lorazepam 1–2mg (or IM promethazine 50mg if respiratory risk or BDZ sensitivity)
- Wait 30 min, reassess

Psychotic context:

- IM lorazepam 1–2mg (or IM promethazine 50mg)
- Wait 30 min, reassess
- If insufficient:
 - IM haloperidol 5mg (wait 1 hr to assess response)
 - OR IM olanzapine 5–10mg (do **not** give lorazepam within 1 hr of IM olanzapine)
 - OR IM aripiprazole 9.75mg (wait 2 hrs to assess response)

Alternative options (with senior consultation):

- IM clonazepam 0.5–2mg/hr (max 4mg/24hr)
- IM chlorpromazine 25–100mg every 30–60min (monitor closely; avoid IV)

Repeat if necessary **up to BNF limits**.

If no response: **urgent team review / senior consultation**.

Table 23.2 Pharmacokinetics of RT injectables

Drug	Usual dose ^a	Max/24hrs	Pharmacokinetics		
			Onset	Peak	t1/2
Lorazepam	1/2mg 30mins	4mg	15– 30mins	60– 90mins	12–15 hrs
Haloperidol	5mg hourly	18mg ^b	15– 30mins	20– 45mins	21hrs
Olanzapine ^c	5/10mg 2-hourly	20mg	15– 30mins	15– 45mins	30– 50hrs
Aripiprazole ^c	9.75mg 2-hourly	Three doses/30mg	30mins	1–3hrs	75– 146hrs
Promethazine	50mg 30mins	100mg	1–2hrs	2–6hrs	7– 15hrs

^a As a general rule, doses in adults aged >65yrs, those with ID, and other groups sensitive to side effects of medication will be 25–50% of the usual adult dose—always check the *BNF* for guidelines.

^b The bioavailability of PO and IM haloperidol is different—when considering the total dose per 24hrs, 5mg PO = 3mg IM. IV use has a high risk of arrhythmias and is not recommended.

^c Not approved for the treatment of dementia-related psychosis or behavioural disturbance.

Step 3: Physical Monitoring During and After RT

- Record **vitals**: temperature, pulse, BP, O2 saturation, respiratory rate
 - Every 15 min for 1 hr
 - Then hourly for 4 hrs
 - Then every 4 hrs for 12 hrs (or as clinically needed)
- Monitor **sleeping patient** at minimum for **pulse and respiratory rate**
- Watch for **side effects**:
 - Extrapyramidal symptoms (dystonia)
 - Neuroleptic malignant syndrome (NMS)
 - Hypotension (lie flat, raise legs)
 - Respiratory depression (O2, ventilatory support, flumazenil for BDZ overdose)

Step 4: Dangerous or Irresponsible Behavior Without Clear Cause

- If **no physical or psychiatric cause** is identified and behavior is **dangerous**:
 - Contact **security or police** for safe removal
 - Document clearly
-

6. Documentation

- Record:
 - **Assessment findings**
 - **Triggers identified**
 - **Medication administered** (dose, time, route)
 - **Patient response and side effects**
 - **Follow-up plans**
-

7. Key Points

- **Safety first**: patient, staff, and public
 - **Identify cause**: physical vs psychiatric vs situational
 - **Use verbal de-escalation first**
 - **Rapid tranquilization** only if urgent or dangerous
 - **Close monitoring** is mandatory after medication
 - **Escalate to senior staff or police** if situation exceeds scope
-

Perimenopausal Syndrome**1. Purpose**

To guide health workers in the **assessment and management of perimenopausal syndrome**, including psychological, physical, and behavioral symptoms occurring during the menopausal transition.

2. Definition

Perimenopausal syndrome refers to the **cluster of physical, psychological, and hormonal symptoms** that occur during the transition period before menopause due to **declining ovarian estrogen production**.

The perimenopausal period usually occurs **between 40–50 years of age** and may last **several years before the final menstrual period**.

3. Common Symptoms

Physical symptoms

- Hot flushes
- Night sweats
- Palpitations
- Fatigue
- Headaches
- Sleep disturbances
- Irregular menstruation

Psychological symptoms

- Irritability
- Anxiety
- Low mood or depressive symptoms
- Emotional lability
- Poor concentration
- Memory difficulties

Sexual and genitourinary symptoms

- Vaginal dryness
- Reduced libido

- Dyspareunia

Table 10.20 Menopause symptoms.

Vasomotor	Physical	Genitourinary	Psychological
Hot flushes/flushes	Sleep disturbance	Urinary frequency	Anxiety
Night sweats	Muscular aches and pains	Nocturia	Low mood
Excessive sweating	Period changes – flow, duration, frequency	Vaginal dryness/irritation	Loss of motivation
Cold chills	Headaches/migraines	Vulval itching and irritation	Mood swings
	Weight gain	Frequent UTIs	Tearfulness
	Tinnitus	Low libido	Increased PMS
	Breast tenderness	Loss of sexual pleasure	Poor concentration and focus
	Heart palpitations	Vaginal discomfort	Brain fog
	Acne		Poor word-finding and short-term memory
	Fatigue and low energy		Irritability

PMS, premenstrual syndrome; UTIs, urinary tract infections.

4. Risk Factors

- Age 40–50 years
- Family history of early menopause
- Surgical menopause
- Smoking
- Chronic stress
- Previous history of depression or anxiety

5. Assessment

Step 1: Clinical History

Assess:

- Menstrual history (irregular cycles, amenorrhea)
- Vasomotor symptoms (hot flushes, night sweats)

- Sleep disturbances
 - Mood symptoms
 - Sexual symptoms
 - Impact on **daily functioning**
-

Step 2: Physical Examination

- Blood pressure
 - Weight and BMI
 - Thyroid examination
 - General physical examination
-

Step 3: Rule Out Other Conditions

Exclude conditions that may mimic perimenopausal symptoms:

- Thyroid disorders
- Major depressive disorder
- Anxiety disorders
- Anemia
- Medication side effects

Laboratory tests may include:

- FSH (follicle stimulating hormone)
 - Thyroid function tests
 - CBC if indicated
-

6. Management

6.1 Psychoeducation

Explain:

- Perimenopause is a **normal biological transition**
- Symptoms may fluctuate
- Lifestyle changes can significantly improve symptoms

Provide reassurance and encourage discussion of concerns.

6.2 Lifestyle Management

Encourage:

- Regular physical exercise
 - Balanced diet
 - Adequate sleep
 - Stress reduction techniques
 - Smoking cessation
 - Limiting caffeine and alcohol
-

6.3 Psychological Support

For emotional symptoms:

- Supportive counseling
 - Stress management techniques
 - Cognitive behavioral strategies
 - Encourage social support
-

6.4 Pharmacological Treatment

Hormone Replacement Therapy (HRT)

May be considered for **moderate to severe vasomotor symptoms**.

Benefits:

- Reduces hot flashes

- Improves sleep
- Improves mood symptoms

Contraindications must be assessed.

Non-Hormonal Treatment

If HRT is contraindicated:

Antidepressants (low dose):

- SSRIs
- SNRIs

These may improve:

- mood symptoms
 - hot flushes
-

Sleep Management

For insomnia:

- Sleep hygiene
 - Short-term sedative medication if necessary
-

7. Follow-Up

- Review symptoms every **3–6 months**
 - Monitor treatment response
 - Adjust medications if necessary
 - Screen for **depression or anxiety disorders**
-

8. Referral

Refer to a **specialist (gynecologist or psychiatrist)** if:

- Severe mood symptoms
- Treatment-resistant symptoms
- Uncertain diagnosis
- Complicated medical history

Dementia

Definition

Dementia is a **chronic and progressive syndrome caused by brain disease** characterized by decline in **memory, thinking, orientation, comprehension, and ability to perform daily activities**. It mainly affects older adults but **is not a normal part of ageing**. The most common cause is **Alzheimer's disease**.

1. Assessment

Assessment Question 1: Are there symptoms of dementia?

Ask the person and a reliable informant (family/carer):

Memory and orientation problems

- Forgetting recent events
- Forgetting where they are
- Forgetting where items are placed

Functional decline

- Difficulty managing daily activities such as:
 - cooking
 - shopping
 - paying bills
 - social functioning

If **memory problems + decline in daily functioning** are present → suspect dementia.

Assessment Question 2: Are there other explanations for symptoms?

Check if symptoms:

- Have been **progressive**
- Present for **at least 6 months**

Rule out other causes.

Rule out delirium

Look for:

- sudden onset
- fluctuating symptoms
- disturbed consciousness
- confusion at night

If suspected:

- investigate infection
 - review medications
 - check metabolic causes
 - treat medical cause.
-

Rule out depression (pseudodementia)

Check for:

- persistent depressed mood
- loss of interest
- reduced motivation

If present:

- treat depression
 - reassess cognition after treatment.
-

Assessment Question 3: Evaluate other medical causes

Look for:

Early onset (<60 years)

History of:

- head injury
- stroke
- loss of consciousness

Medical conditions:

- hypothyroidism
- malnutrition
- anaemia
- HIV or other infections

Cardiovascular risk factors:

- hypertension
- diabetes
- smoking
- obesity
- previous stroke

If present → refer or manage accordingly.

Assessment Question 4: Assess carers' situation

Identify:

- main caregiver
- level of caregiver stress
- financial or social difficulties
- caregiver depression

Provide support if carers are struggling.

Assessment Question 5: Are behavioural or psychological symptoms present?

Common symptoms include:

Behavioural symptoms

- wandering
- agitation
- aggression
- sleep disturbance

Psychological symptoms

- hallucinations
- delusions
- anxiety
- emotional outbursts

These are called **Behavioural and Psychological Symptoms of Dementia (BPSD)**.

Box 19.4 Behavioural and psychological symptoms of dementia

Behaviours

Agitation
Shouting
Wandering
Apathy
Inappropriate sexual behaviour
Impaired sleep

Symptoms

Delusions
Hallucinations
Depression
Anxiety

Contributory factors

Constipation
Pain
Superimposed delirium
Sensory deficits

2. Basic Management Plan

2.1 Psychoeducation

Explain to the patient and family:

- Dementia is a **brain illness that gradually worsens**
- It is **not caused by normal ageing**
- There is **no cure**, but supportive care can improve quality of life
- Many symptoms can be managed.

2.2 Manage Behavioural and Psychological Symptoms

First identify and treat physical causes such as:

- pain

- infection
- constipation
- medication side effects

Identify triggers such as:

- crowded environments
- unfamiliar places
- stress

Modify these triggers when possible.

2.3 Non-pharmacological Interventions

Recommended approaches include:

- calm environment
- simple communication
- structured daily routines
- exercise
- music therapy
- activities and schedules
- massage or relaxation

These should be **first-line management**.

2.4 Promote Functioning in Daily Activities

Encourage independence in:

- toileting
- dressing
- eating
- mobility

Home safety measures:

- remove floor clutter
- install handrails
- use clear signs for rooms
- adapt the house for safety.

Encourage:

- regular exercise
 - social activities
 - recreational activities.
-

2.5 Cognitive Stimulation

Carers should:

- regularly orient the patient (time, date, place)
 - use photos, TV, newspapers for memory stimulation
 - use short and simple sentences
 - reduce background noise
 - maintain consistent routines.
-

2.6 Support for Carers

Provide:

- education about dementia
 - emotional support
 - training in behaviour management
 - respite care if available
 - information on social or financial assistance.
-

2.7 Pharmacological Treatment

Medication is **not required for all patients**.

Consider medication only when:

- Alzheimer's disease diagnosis is likely
- specialist supervision is available.

Possible medications:

Cholinesterase inhibitors

- donepezil
- rivastigmine
- galantamine

Memantine

- particularly in vascular dementia.

Summary of NICE guidance for the treatment of Alzheimer's disease^{78,79}

- The three AChE-Is donepezil, galantamine and rivastigmine are recommended for managing mild-to-moderate AD.
- Memantine is recommended for managing moderate AD for people who are intolerant of or have a contraindication to AChE-Is, or for managing severe AD.
- For people with an established diagnosis of AD who are already taking an AChE-I:
 - consider memantine in addition to an AChE-I if they have moderate disease;
 - offer memantine in addition to an AChE-I if they have severe disease.
- Treatment should be under the following conditions:

For people who are not taking an AChE-I or memantine, prescribers should only start treatment with these on the advice of a clinician who has the necessary knowledge and skills.

This could include:

 - secondary care medical specialists such as psychiatrists, geriatricians and neurologists; and
 - other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating AD.
- Once a decision has been made to start an AChE-I or memantine, the first prescription may be made in primary care.
- For people with an established diagnosis of AD who are already taking an AChE-I, primary care prescribers may start treatment with memantine without taking advice from a specialist clinician.
- Ensure that local arrangements for prescribing, supply and treatment review follow the NICE guideline on medicines optimisation.⁸⁰
- Do not stop AChE-Is in people with AD because of disease severity alone.
- Therapy with AChE-I should be initiated with a drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). An alternative may be considered on the basis of adverse effects profile, expectations about adherence, medical co-morbidity, possibility of drug interactions and dosing profiles.

Summary of NICE guidance for the treatment of non-AD dementia^{78,79}

- Offer donepezil or rivastigmine to people with mild-to-moderate DLB.
- Only consider galantamine for people with mild-to-moderate DLB if donepezil and rivastigmine are not tolerated.
- Consider donepezil or rivastigmine for people with severe DLB.
- Consider memantine for people with DLB if AChE-Is are not tolerated or are contraindicated.
- Only consider AChE-Is or memantine for people with vascular dementia if they have suspected co-morbid AD, Parkinson's disease dementia or DLB.
- Do not offer AChE-Is or memantine to people with frontotemporal dementia.
- Do not offer AChE-Is or memantine to people with cognitive impairment caused by multiple sclerosis.
- For guidance on pharmacological management of Parkinson's disease dementia, see Parkinson's disease dementia in the NICE guideline on Parkinson's disease.

Medicines that may cause cognitive impairment¹

Medicines that may cause cognitive impairment¹

- Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment.
- Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:
 - when assessing whether to refer a person with suspected dementia for diagnosis
 - during medication reviews with people living with dementia.
- Be aware that there are validated tools for assessing anticholinergic burden but there is insufficient evidence to recommend one over the others (see section 'Safer prescribing for physical health conditions in dementia').
- For guidance on carrying out medication reviews, see medication review in the NICE guideline on medicines optimisation.

NB: The Anticholinergic Effect on Cognition (AEC) scale can be accessed at www.medicheck.com

Antipsychotics for severe behavioural symptoms

Use **only when there is risk of harm** to patient or others.

Principles:

- start low, go slow
- use lowest effective dose
- review regularly
- monitor for extrapyramidal side effects.

Box 19.6 Daily doses of drugs used to treat behavioural and psychological symptoms of dementia

For mild agitation

Trazodone 50–100 mg
 Benzodiazepines, e.g. lorazepam 0.5–4 mg
 SSRIs, e.g. citalopram 10–20 mg
 Carbamazepine 50–300 mg
 Sodium valproate 250–1000 mg
 Rivastigmine (for Lewy body dementia) 1.5–6 mg

For severe agitation with psychosis

Quetiapine 25–200 mg
 Risperidone 0.5–3 mg
 Olanzapine 2.5–10 mg

For depression

SSRI, as above
 Mirtazapine 15–45 mg

For severe behavioural problems

Consider haloperidol in small doses (0.5–4 mg), for a limited time

Reproduced from British Medical Journal, 338, Burns A, Iliffe S. Dementia. b75. Copyright (2009), with permission from BMJ Publishing Group Ltd.

3. Follow-Up

Frequency

- Every 3 months if stable.

At each follow-up assess:

- cognitive decline
- behavioural symptoms
- medication side effects
- daily functioning
- safety risks (driving, cooking)
- depression or suicide risk
- caregiver burden.

Adjust management accordingly.