

Government of Punjab,
Health Department

MENTAL HEALTH

IN

PRIMARY CARE

Guidelines

FOR

**PRIMARY HEALTH CARE PHYSICIANS, GENERAL
PRACTITIONERS AND DOCTORS IN OTHER
DISCIPLINES OF MEDICINES**

**Prepared BY: Punjab Institute of Mental Health
(PIMH), Lahore**



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Foreword & Acknowledgment

With rapid advancements in the medical field, communicable diseases are being eliminated and chronic non communicable diseases are becoming a major threat. A large number of population in Pakistan is suffering from mild to moderate psychiatric illnesses and an estimated number of mentally disturbed people in Pakistan is even higher. Department of Health Promotion (HP) was established in Directorate General of Health Punjab in May-2009. One of its main concerns is to design and launch appropriate Health Promotion strategies for addressing non communicable diseases (NCDs).

Mental health is an integral part of health and after a lengthy and exhaustive process; we have been able to develop this manual to be used for the capacity building of health care providers. The availability of a contemporary response to the need of developing healthcare providers' skills and knowledge on mental illnesses had been a dream and we acknowledge the commitment and hard work of following colleagues to make this dream come true;

1. Dr. Nusrat Habib Rana Chief Executive PIMH
2. Dr. Simon Azariah, Project Director CIDA-SOHIP
3. Dr. Syeda Zahida Sarwar, Health Promotion Coordinator, CIDA-SOHIP
4. Dr. Babar Aalam, MNCH Officer WHO
5. Dr. Fida Ali, Director Health Promotion
6. Dr. Shamsa Shafee, Friends of PIMH
7. Technical Team for PIMH

And my special thanks and acknowledgments are for Prof. Dr. Hussain Mubashar Malik Vice Chancellor, University of Health Sciences, Lahore Punjab whose foundational work and support proved very effective for contemporary writers to complete this task.

Dr. Muhammad Aslam Chaudhary
Director General Health Services
Punjab

Introduction

Health Promotion has been globally recognized as a comprehensive approach for enhanced health gains. Among a large contingent of health promotion roles and strategies one of its main foci is the prevention and control of non communicable diseases (NCDs). With the development of a new Department of Health Promotion at office of Director General Health Services Punjab, new avenues for adapting appropriate measures for primary and secondary prevention of NCDs have been opened and for the first time a strategic approach to prevention of NCDs is being adopted. Four major groups of NCDs namely Mental Illnesses, Cancers, Cardiovascular Diseases and Diabetes have been selected for building capacity of health care providers (HCPs) and also for raising public awareness on these issues in order to affect enhanced awareness and prevention.

The occurrence of mental illnesses are on the rise. However it has been observed that most of the frontline healthcare providers do not have adequate firsthand knowledge and skills to either build mental illnesses in their differential diagnosis: practitioners typically overlook most of the times the somatization of mental illnesses and continue treating the presenting symptoms which neither helps the client nor the practitioner. Therefore building capacity of healthcare providers mental health issues becomes imperative as a first step to start improving the situation.

The CIDA-funded Systems-Oriented Health Investment Program (SOHIP) in collaboration with Department of Health Promotion and Punjab Institute of Mental Health (PIMH) collected and reviewed the existing material already developed by Institute of Psychiatry and WHO. During this process WHO was recognized as a critical partner as mental health is a strong mandate of WHO. Also considerable work had also been done already by WHO and it was only prudent to build upon the existing resources. Extensive additional work has been put in by PIMH.

With the arrangement that SOHIP would assist in the development and production of this manual and training of 100 provincial level trainers while WHO would take on the downstream training of healthcare providers in the districts in a phased manner we are pleased to present this training manual on mental illnesses prevention to you.

We are extremely grateful to Dr. Muhammad Aslam Chaudhary, Director General Health Services Punjab for his support and guidance for the completion of this noble task. We appreciate the untiring efforts of Dr. Fida Ali, Director Health Promotion and Dr. Nusrat Habib Rana Chief Executive PIMH and her team for their technical inputs and hard work for the development of this manual and of course acknowledge the great work done by Prof. Dr. Hussain Mubashar Malik (presently Vice Chancellor, University of Health Sciences, Punjab) which provided a firm foundation for the development of this manual.

Dr. Simon Azariah

Project Director

CIDA: Systems-Oriented Health Investment Program

PREFACE

Psychiatric diseases have been declared as the fifth common illness afflicting the general population all over the world. People with mental health problem often suffer in silence because of the stigma attached with mental illness. Mental health promotion will provide comprehensive approach to bring the change in attitude & behaviour of the health providers and the community at large.

In Pakistan the incidences of psychiatric illnesses is very high and also positive mental health contributes to human, social and economic capital of the nation. In order to reduce the number of people suffering from this illness, it is important that the health care providers be given guidelines, how to recognize the case, i.e. differentiate from other medical and surgical illnesses, and to treat them with simple, available resources, so as to prevent them from going into the hands of non medical practitioners (quacks and soothers) and to help the patient in rehabilitation process.

This curriculum gives a brief outline, on how to handle a psychiatric patient once it has been identified and where to seek advice and reference if improvement not seen.

This curriculum is especially designed for doctors serving in the rural areas where diagnostic facilities are not available and advice from Psychiatrists is not within reach. Besides, theoretical training of the doctors will also be given practical / clinical demonstration. They will also be apprised with counseling and rehabilitation techniques by Psychologists and Medical Social Officers.

It is hoped that this curriculum will enable the doctors to manage psychiatric patients close to their homes and help in de-mystifying psychiatric diseases and save the people from faith healers, thus bridging the gap between the primary and tertiary health care. It will help in integration of mental health in health delivery system.

DR. NUSRAT HABIB RANA
Executive Director
Punjab Institute of Mental
Health, Lahore

INTRODUCTION OF MENTAL HEALTH

Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity (WHO).

Mental health is an integral part of health and plays an important role in the overall health of individuals, families, communities & nations. Indeed there is no health without mental health. It is therefore necessary to include mental health in promotive, preventive, curative and rehabilitative health care services in every stage of human life.

Advances in medical field has eliminated infectious disease and now the leading causes of disability and deaths are chronic disease like cancer, diabetes, mental illnesses etc. bringing a shift in management focus from treatment to preventions.

Health maintenance depends upon active promotion of positive thinking, attitude and behaviors, proper diet, exercise and reduction of stress, methods how to cope with stresses leading to better quality of life.

Health promotion is the process of enabling people to increase control over their health and its determinants which are: -

- Living and working conditions.
- Personal habits and level of education.
- Socio economic and environmental factors.
- Climate that respects basic civil, political and cultural norms.

MAGNITUDE OF PSYCHIATRIC DISEASES

- 13% of total population in Pakistan is suffering from mild to Moderate Psychiatric illness in Pakistan (Iqbal, 1996). 1% having severe incapacitating mental disorders (WHO Report).

*population suffering from these ailments is as under: -

--	Pakistan	21.27 million
--	Punjab	11.83 million
--	Lahore (District)	0.57 million

*Projected by 2.69% (G.R) on population of 1998 (Census of Pakistan 1998)

- About 2% of children (>0.1 million) have severe mental retardation.

- Depression will on 1st at ranking order of leading causes of disabilities between the age of 15-45 by 2020 (WHO Report 2001)
- Worldwide 1:4 people suffer from mental health problem at some point in their lives (WHO 2001) “Mental Health: New Understanding, New Hope”
- By 2020 Depression will be the leading cause of disability in Asia. Already mental illness account for 5 of the top disability reasons in Asia.
- World Health Report (WHR 2001) “Neuropsychiatric Disorders are a bigger burden than AID, TB and Malaria combine worldwide”.

STATUS OF PSYCHIATRIC SERVICES IN PAKISTAN

- In Pakistan the estimated number of mentally disturbed people is more than 20-25 Million out of population 152 Million.
- 01 Psychiatrist for 10000 People.
- 01 Child Psychiatrist for 04 Million Children
- Only 03 major hospital and 20 such units dealing with psychiatric patients.
- There are no psychiatric facilities available at some districts.
- 46 to 66 % of women and 15% of men in Pakistan suffer from Anxiety & Depressive Disorders (Mental Health Atlas WHO 2005)

RATIONALE / SIGNIFICANCE OF MENTAL HEALTH, IT CONSTITUTES A HEAVY BURDEN.

- Suffering, disability and mortality.
- Family burden, loss of bread winner of the family, untreated childhood disorders lead to educational failure hence unemployment and illness in adult life.
- Loss of economic productivity leading to poverty and illnesses.

MISSION

- Enhance value and visibility of mental health at national, local and individual levels.
- Protect, maintain and improve mental health.
- Main streaming mental health promotion into policies and programs.
- No health without mental health.

COMPONENTS OF HEALTH PROMOTION

- Build healthy public policy.
- Create supportive environment.
- Strengthen community actions.
- Develop personal skills.
- Reorient health services.

STRATEGIES

- Health education
- Health communication
- Community development
- Organizational development and change
- Healthy public policy
- Advocacy
- Inter sectoral collaboration
- Self help and mutual aid

APPROACH IN MENTAL HEALTH PROMOTION

- Increase emotional resilience through interventions.
- Design to promote self esteem.
- Strengthening individuals, communities & society, increase social support.
- Social inclusion and participation.
- Campaign against stigma
- Reducing structural barriers to mental health.
- Demystification of mental illnesses.

GOALS OF MENTAL HEALTH PROMOTION

- Promote mental health in the general population specially schools and workplaces.
- Prevent people from getting mentally sick.
- Treat people quickly and effectively.
- Treat people near to their homes, saving time and money.
- Encourage people with mental disorders to participate in normal life with their families and friends once treated and stable.

- Reduce stigma and discrimination surrounding people with mental illnesses and women.
- Protect the human right and dignity of people with mental illnesses.
- Socio economic empowerment of women.
- To raise the level of tolerance, acceptance and respect among the diverse groups in community.

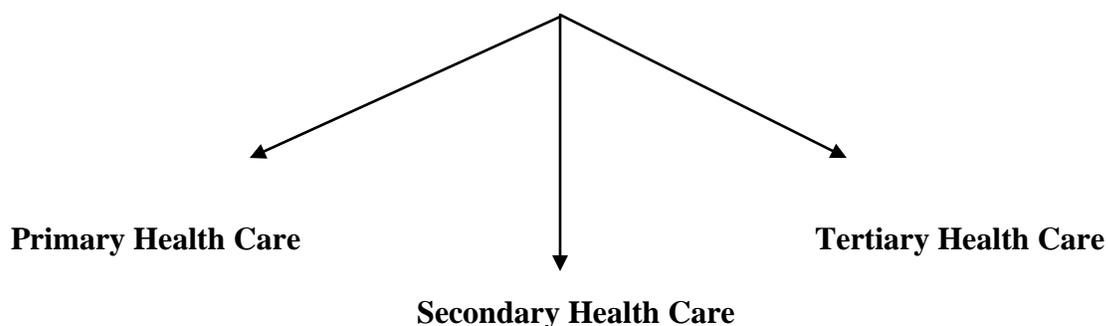
VULNERABLE GROUPS (Need special attention and focus in Health Promotion)

- Women neglected in society
- Children / street children
- Orphanage
- Prisons
- Intellectual handicaps
- Older people (dementia, A.D)
- Sensory impairment, blind, deaf, speech defects
- Refugees and internally displaced people due to natural calamities, political or economical conditions
- Care giver in these homes and centers are very important and need special trainings.

SUMMARY OF MENTAL HEALTH PROMOTION & PREVENTIONS

- Value mental health as same way as physical health.
- Value social supports.
- Create / facilitate social settings which enhance social network.
- Give practical information and guidelines to health workers and carers.
- Inter-sectoral dialogue, linkages and cooperation.

IMPLEMENTATION OF MENTAL HEALTH PROMOTION AT 3 LEVELS IN HEALTH CARE DELIVERY SYSTEM



At Primary Level	Medium (Through)	Aim	How
Community based villages' first contact between patients and health care providers.	<ul style="list-style-type: none"> • Community midwives • Lady health workers • Dispensers • Vaccinators • Union councilor • Khateeb (Mosque) • Sanitary inspectors • School teachers • Social workers 	<ul style="list-style-type: none"> • Identify psychiatric cases • Case history • Find factors leading to illness • Solve issues by advice and counseling • Support family in handling violence and aggression • Take patient to Secondary Health Care Centre (Doctor). 	<ul style="list-style-type: none"> • Training of personnel • Raising awareness on mental health in general public • Field visits / reaching out at community level / holding talks and discussions to change prevailing mental health beliefs and practices. • Bridging the gap at all levels.
Secondary Level			
Districts, Towns & Cities	<ul style="list-style-type: none"> • Staff Health Centers • DHQ hospitals • Social Welfare 	<ul style="list-style-type: none"> • Early diagnosis • Exclusion of other illness (T.B, Malaria, Reproductive Health) • Treatment • Screening test 	

	Officers <ul style="list-style-type: none"> • School Teachers • N.G.Os • Religious leaders. • Workplace Managers 	<ul style="list-style-type: none"> • Counseling and advice to family • Follow up • Record keeping • Referral to Tertiary Health Care Centre. 	// //
Tertiary Level			
Provincial, Specialized Treatment Centers.	<ul style="list-style-type: none"> • Health care providers of Govt. hospitals & Private Clinics • Medical Social Officers • Psychologists • Religious Leaders • School Teachers • Police 	<ul style="list-style-type: none"> • Reduce duration of illness • Reduce stress for the family and community • Prevent further breakdown • Referred back to home at Primary Care Level for follow up 	

All strategies and components of health care promotion are included in this integrated health care system.

TRAINING OF PERSONNELS

- 1- Health Care Providers from Primary, Secondary & Tertiary Level (Health Facilities).
- 2- From other sectors like education, social welfare, police, religious sectors.
- 3- Care providers of centers/homes for children and adults.

Training program includes: -

- Learning symptoms of psychiatric illness for identification of patients.
- Factors, predisposing and precipitating mental disorders.
- Case history of psychiatric patients.
- First aid management of aggressive and violent patients.
- Developing co-ordination & understanding between patient's family and community.
- Generating support to the family.
- Monitor side-effects.
- Monitor compliance of medicines.
- Develop referral system with community efforts (Transport).
- Acceptance of psychiatric illness as a disease like other organic disorders and not stigma.
- Work for rehabilitation of patients with family and community.

DEVELOPING PUBLIC HEALTHY POLICIES

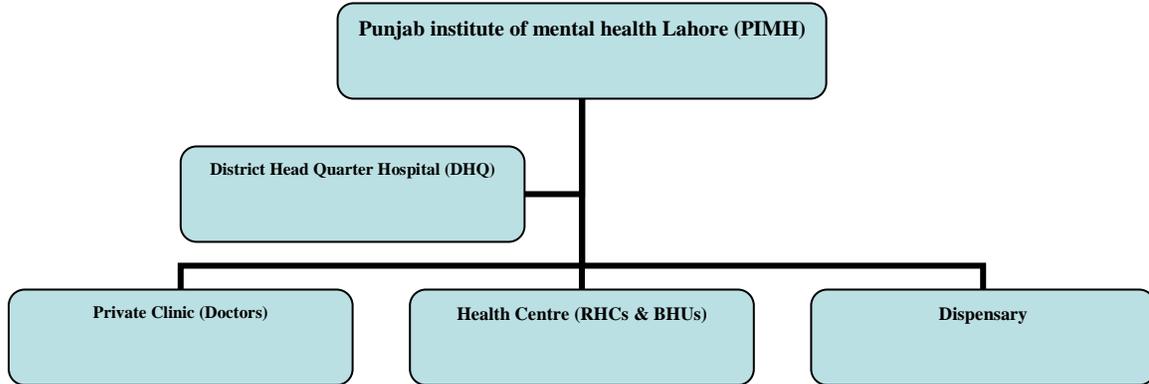
- 1- District Headquarter Hospitals for record maintenance of psychiatric patients which are identified and referred to tertiary hospitals.
- 2- Posting of Psychiatrist in all District Headquarter Hospitals.
- 3- Provision of psychiatric medicine at District Headquarter Hospitals.
- 4- Mental Health Promotion team to be established at two levels: -
 - a. District Health Development Centers.
 - Training of health care providers from Primary Health Care Centers and provision of guidelines and management charts for psychiatric patients.
 - Monitoring staff

b. Punjab Institute of Mental Health, Lahore.

- Training of health care providers from Secondary / District Health Care Centers and provision of guidelines and management charts for psychiatric patients.
- Monitoring staff
- Research on community health promotion
- Guidance on new techniques in psychiatric management.



PRESENT SETUP IN HEALTH SYSTEM



PIMH

- PIMH will act as focal institute for Mental Health Promotion in Punjab.
- Mental Health Promotion Team
 - i. Dr. Nusrat Habib Rana, Executive Director Focal Person
 - ii. Dr. Shamsa Shaffi, Secretary General, Friends of PIMH
- Mental Health Promotion Committee at PIMH
 - i. Dr. Hamid Nawaz Consultant Psychiatrist
 - ii. Dr. Zulfiqar Ali Rizvi Consultant Psychiatrist
 - iii. Dr. Tariq Aziz Consultant Psychiatrist
 - iv. Dr. Riaz Ahmad Senior Medical Officer
 - v. Abia Nazim Clinical Psychologist
 - vi. Rukhsana Nafees Social Medical Officer
 - vii. Mr. M. Umair Naeem Data Operator

MENTAL HEALTH ACT 2001 (VIII OF 2001)

An Act to consolidate and amend the Law relating to the mentally disordered persons with respect to the care and treatment, the management of their property and other related matters.

GUIDING PRINCIPAL

- This Act is called Mental Health Act 2001.
- It extends to the whole of Pakistan since February 2001.
- Regulates mental health care environment in the best interest of the patient / client / consumer / user.
- Protection of human rights of mentally ill patients.
- Court of protection is there to safeguard the interest of psychiatric patients.
- Federal Mental Health Authority, Court of Protection, Board of Visitor are the regulating bodies.

OVERALL PROVISIONS OF MENTAL HEALTH ACT 2001

- Admission and discharge procedure of mentally ill patient is regulated and made easier.
- Provision of emergency holding made possible.
- Decriminalize mental illness
- Demystified mental illness
- Treat all patients with dignity and respect

IDENTIFICATION AND MANAGEMENT OF COMMON PSYCHIATRIC ILLNESSES

(1)

ANXIETY DISORDER: - Persistent or recurrent anxiety (worrisome, anxious, apprehensive & palpitation) with no low mood.

Presenting Complaints	<ul style="list-style-type: none"> • Tense or anxious • Worrying unnecessarily • Intense fear, pounding heart • Headache, dizziness, shortness of breath, insomnia. • Apprehension, fear of dying, sweating
Diagnostic Features	<ul style="list-style-type: none"> • Dry mouth, stomach pain, palpitation, headache, sweating, chest pain, choking, poor concentration, unable to relax, worry, fear of attack, tremors • physical illness to be excluded, B.P. asthma, heart disease while taking history • When symptoms persist for more than 06-Months then known as anxiety disorder, when occurring in episodes known as “Panic” disorder • Irrational persistent fear, cued by the presence or anticipation of a specific object or situation i.e. Phobic Disorder e.g. flying animals, receiving injection, open spaces, speaking in public, height, water etc.
Differential Diagnosis	<ul style="list-style-type: none"> • Rule out depressive illness. • Schizophrenia • PTSD • Thyrotoxicosis • Arrhythmias • Bronchial Asthma • Angina Pectoris / M.I. • Hypoglycemia
Advice for Patients and Family	<ul style="list-style-type: none"> • It is quite common and can be treated • Skills to reduce the effects of stress, are easy to learn and give effective relief • Chest pain etc. not necessarily heart disease. • Encourage patients to use relaxation techniques. • Daily physical exercise to reduce physical symptoms • Avoid Alcohol & Cigarette Smoking • No diazepam to be given, causes addiction.
Treatment	<ul style="list-style-type: none"> • Reassurance and counseling in mild cases • Anti depressant (SSRI) • Benzodiazepines(for short term only)

REFERRAL

Referral to District Hospital / Punjab Institute of Mental Health, Lahore, if unmanageable

(2)

DEPRESSIVE ILLNESS: - A disorder of persistent low mood.

Presenting Complaints	<ul style="list-style-type: none">• Headache, tiredness all the time• Irritability• Sadness• Suicidal thoughts• Anxiety, insomnia, worried about social problems e.g. financial, marital• Increased Alcohol use by male member, fear for children.
Diagnostic Features	<ul style="list-style-type: none">• Low, sad mood, fatigue• Loss of interest, loss of self confidence• Disturb sleep, appetite, speech• Pessimism, decreased libido.
Differential Diagnosis	<ul style="list-style-type: none">• Medical conditions e.g. thyroid dysfunction, organic brain disease, diabetes and hepatitis, cardiovascular diseases.• Bipolar affective disorder• Substance induced disorder• Schizophrenia
Advice for Patients and Family	<ul style="list-style-type: none">• Depressive illness is a treatable psychiatric problem not otherwise (Jaddu Tona)• Depressive illness is not due to any personal weakness or laziness, so there is no need to be guilty about it.• Regular follow up to psychiatric hospital.• Assess risk of suicide and take it seriously and bring your patient to the psychiatrist.• Help the patient in overcoming social stresses.• Encourage him to take balanced diet and sleep.• Spouse has to be helpful and less demanding.• Encourage the patient to visit psychiatric hospital regularly and take prescribed medicines along with other advices.
Treatment	<p><u>PHARMACOLOGICAL</u></p> <ul style="list-style-type: none">• SSRI e.g. Fluoxetine, Es-citalopram, Paroxetine, Sertraline.• SNRIs e.g. Venlafaxine• Tricyclics / Serotonine modulators• Benzodiazepine e.g. alprazolam, bromazepam• Hybnotic for e.g. temazepam.• ECT• Minimum 6 months to 1 year after stabilization of symptoms.• Tricyclics start imipramine / clomfranil / oral 25mg daily then 75 mg build upto 250 mg a day.• Explain treatment and sideeffect to the family and patient e.g. dryness of mouth, drowsiness, blurring of vision etc.• Basic screening is essential before initiating this drug therapy. <p><u>PSYCHOLOGICAL</u></p> <ul style="list-style-type: none">• Counseling• Cognitive Behavioural Therapy• Family Therapy• Regular Follow-ups

REFERRAL

If symptoms persist or patient is suicidal or psychotic symptoms developed refer him immediately to Punjab Institute of Mental Health, Lahore.

(3)

OBSESSIVE COMPULSIVE DISORDER: Persistent repetitive, intrusive, illogical thoughts and rituals leading to anxiety if not acted upon 2% of the population suffer from this disorder.

Presenting Complaints	<ul style="list-style-type: none">• Slow performance of every day activities.• Repeated washing of hands• Anxiety-provoking repeated thoughts (i.e. obsession) or repetition of the particular behaviors that reduce anxiety (i.e. compulsion).• Common obsession is about contamination, doubt, guilt, symmetry.• Common compulsion is hand washing arranging things, checking, counting and praying.
Diagnostic Features	<ul style="list-style-type: none">• Persistent thoughts, impulses or images which are acknowledged to be silly and ridiculous but recur despite resistance.• The most prominent feature is a repetitive feeling of subjective compulsion to carry out such action, or stick to an idea which cannot be got rid of, although it is perceived to be senseless or inappropriate.
Differential Diagnosis	<ul style="list-style-type: none">• GAD (Panic and Phobic Disorder)• Schizophrenia• Depressive illness• Delusional Disorder
Advice for Patients and Family	<ul style="list-style-type: none">• Patient and family has to be informed about nature of illness.• Consider this as a very painful disease process, instead of supernatural things.• Reassurance and emotional support from the family• Patient is advised to work on diversion skills.• Encourage the patient to ignore the obsessional thoughts.
Medication	<ul style="list-style-type: none">• Clomipramine 75mg to 250mg per day divided doses build up gradually.• Fluoxetine 20mg to 40mg O.D.

REFERRAL

If symptoms persist refer the patient to District Hospital / Punjab Institute of Mental health for expert advice.

(4)

PTSD (Post Traumatic Stress Disorder): - This disorder follows a traumatic event / calamity: -

Presenting Complaints	<ul style="list-style-type: none">• After the exposure to a traumatic event a person can present with disturbed sleep, irritability, out bursts of anger, intense fear, horror and distressing dreams.
Diagnostic Features	<ul style="list-style-type: none">• A person experienced witnessed or confronted with traumatic event.• Traumatic event is persistently re-experienced.<ul style="list-style-type: none">a. Images / Thought & Perceptionb. In children themes of the playc. Frightening Dreams• Persistence avoidance of any one associated with trauma.• Numbness of feelings and mood.• Unable to perform / loss of sleep / disturbed appetite.• Above said symptoms continued for more than 1 month.
Differential Diagnosis	<ul style="list-style-type: none">• Rule out all other psychiatric illnesses e.g. Depressive illness, GAD & Acute psychosis etc.
Advice for Patients and Family	<ul style="list-style-type: none">• Be supportive with the patient• Regular follow-up• Help him If patient is not taking his medicines regularly or not eating.
Treatment	<p><u>PHARMACOLOGICAL</u></p> <ul style="list-style-type: none">• Treatment according to the presentation of symptoms. e.g. anti depressants when person is depressed along with anxiolytics <p><u>PSYCHOLOGICAL</u></p> <ul style="list-style-type: none">• Supportive Psychotherapy• Encourage patient to face avoided activities and situations.• Explain to the patient that traumatic event can lead to psychological discomfort and is manageable without medication

REFERRAL

If symptoms persist or patient is dangerous to himself for others refer him immediately to Punjab Institute of Mental Health, Lahore.

(5)

Unexplained Somatic Complaints: Preoccupation with bodily discomforts not coinciding with particular signs of that disease.

Presenting complaints	<ul style="list-style-type: none">• Patient's complaints may be single or multiple• Complaints may change with the passage of time• Symptoms may vary widely• Symptoms may be distension (Gola formation), palpitation, headache, chest pain, difficulty in breathing, difficulty in swallowing, nausea vomiting, abdominal pain, low back pain, skin rashes, frequent urination, diarrhea & skin and muscle discomfort etc.
Diagnostic Features	<ul style="list-style-type: none">• Most of physical complaints are medically unexplained.• Hypochondriasis: - worrying about having a physical illness and be unable to believe that no physical condition is present.• For medically unexplained psychological symptoms a full history and physical examination are necessary
Differential Diagnosis	<ul style="list-style-type: none">• Drug abuse• Generalized anxiety disorder• Depression
Advise for patient and family	<ul style="list-style-type: none">• Try to decrease stresses which often exacerbate physical symptoms.• All the symptoms may not be cured.• Explain the links between stress and physical symptoms
Treatment	<ul style="list-style-type: none">• If depression or anxiety, treat accordingly• Relaxation exercise may help to relief symptoms• Encourage physical exercises• To encourage positive and pleasurable activities

REFERRAL

If symptoms are not relief refer to District Hospital / Punjab Institute of Mental Health, Lahore.

(6)

DISSOCIATIVE (Conversion) Disorder: - (Hysteria) Disorder in which patient experiences Physical symptoms that have psychological causes rather than organic cause and patient has excessive emotions, dramatic and attention seeking behaviour, essentially not malingering. There are two types: -

- 01) Somatoform / Conversion
- 02) Dissociative.

SOMATOFORM / CONVERSION

Conversion reaction such as paralysis, pains and fits are presented with no neurological cause. Symptoms are psychological rather than biological.

Disorder of sudden dramatic symptoms which are inconsistent with known disease, but are stress induced. It can present either singly or en mass e.g.. in high school students.

DISSOCIATIVE

Patient experiences loss of identity to some degree and changes in personality are present to some extent.

Presenting Complaints	<ul style="list-style-type: none">• Patient exhibit unusual, dramatic physical symptoms such as seizure, amnesia, trance, loss of sensation, visual disturbance, paralysis, aphonia, identity confusion
Diagnostic Features	<ul style="list-style-type: none">• Onset is sudden and related to psychological stress and personal circumstances e.g. marital difficulties, school related problems• Look for physical symptoms, unusual not consistent with disease, change from time to time to gain attention• Chronic patient appear calm unrelated to the seriousness of complains.• Secondary gain
Differential Diagnosis	<ul style="list-style-type: none">• Rule out Epilepsy and other psychiatric, somatic illness.
Information for Patients and Family	<ul style="list-style-type: none">• Physical symptoms have no physical causes but due to stress• Symptoms not permanent, disappear with time• Encourage patient to accept, adopt to the stress factors• Take rest then return to work• Try not to stay away from work for long period• Try to solve and lesson the stress factors• Seek treatment only for medical practitioners do not seek treatment from spiritual healers.• Take good diet and exercise.
Treatment	<ul style="list-style-type: none">• Psychotherapy• <u>PHARMACOLOGICAL</u>• Inj. Diazepam SOS to terminate acute, dissociative state.• Anit depressant if required• Psychosocial support

REFERRAL

If simple method of counseling does not work or in case of severe psychiatric complication refer to Punjab Institute of Mental Health, Lahore / DHQ Hospitals.

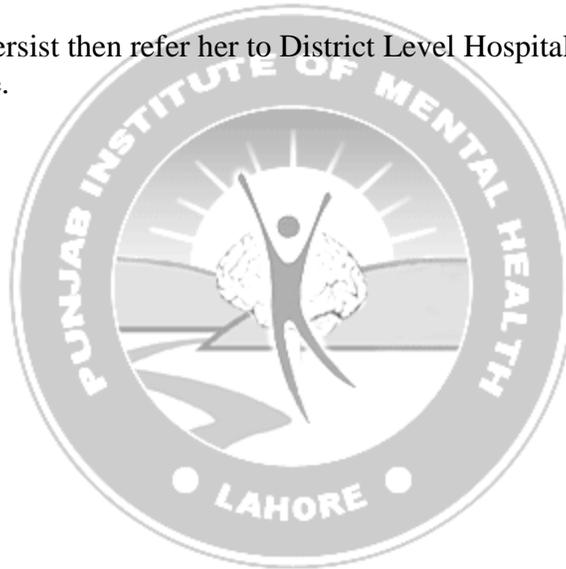
(7)

POST PARTUM DISORDER: - This disorder occurs after child birth: -

- Onset of episode within 04 weeks of post partum.
- Symptoms can be of depressive illness / bipolar illness (Manic episode) / Schizophrenic episode.
- Management is according to the presenting complaints after excluding all other psychiatric problems.

REFERRAL

If symptoms persist then refer her to District Level Hospital or Punjab Institute of Mental Health, Lahore.



(8)

BIPOLAR DISORDER (Manic depressive disorder)- patient experiences symptoms of mania / hypomania in alternation with depression. Between the two phases patient is symptom free. Usual age of onset is between 15-25 years.

Epidemiology: lifetime risk is about 1%. Lifetime risk in first degree relatives is from 7-10% Equally prevalent in men and women.

Presenting Complaints	<ul style="list-style-type: none">• Patients may have a period of mania or excitement or severe depression• Patient may be brought in by relative or police or community leader because lack of insight about his illness
Diagnostic Features	<p>a) Period of mania (excitement, activity energy)</p> <ul style="list-style-type: none">• Elevated mood, aggressive behaviour, decreased need to sleep, increase self importance, over talkative, pressure of speech, delusions of grandeur or sometimes hallucinations symptoms persists for more than 01 Month <p>b) Period of depression</p> <ul style="list-style-type: none">• Low or sad mood, poor concentration, anhedonia, worthlessness, disturbed sleep, fatigue, poor appetite, suicidal acts.• Severe cases may have hallucination (hearing voices)• Delusions (strange belief)• Symptoms persists for 02-Weeks
Differential diagnosis	<ul style="list-style-type: none">• Schizoaffective disorder• Drug induced psychosis• Psychotic depression• Brief reactive psychosis• Organicity
Advice for Patients and Family	<ul style="list-style-type: none">• These are symptoms of illness• Effective treatment is present• Long term treatment can prevent further episodes• If untreated mania become dangerous and lose job, marital problems & financial problems, must be taken to doctor at once.
Treatment	<p>According to bio psycho social model Treatment is related to phase of episode-mania or depression.</p> <p><u>PHARMACOLOGICAL:</u></p> <p><i>Drugs for mania</i> antipsychotics (haloperidol, risperidone, olanzapine) and mood stabilizers (carbamazepine, sodium valporoate, lithium carbonate)</p> <p><i>Drugs for depression</i> antidepressants(SSRIs, SNRIs, tricyclics) and mood stabilizers</p> <p><u>PSYCHOLOGICAL:</u></p> <ul style="list-style-type: none">• identifying and removing conflicts/stressors, removing high expressed emotions, family counseling• Social intervention: involving family members and caregivers.• About early identification of symptoms.

REFERRAL

Referral to District Hospital / Punjab Institute of Mental Health, Lahore if symptoms persists.

(9)

DRUG ABUSE DISORDER: - A disorder of repeated consumption of illegal drugs, leads to psychological and physical dependence.

Presenting Complaints	<ul style="list-style-type: none">• Patient may come up with list of drug he has been taking, asking for help to get rid of drugs• State of intoxication or withdrawal or physical complication of drug use e.g. abscess or bruises scars, thrombosis.• Has depressed mood, loss of sleep, nervousness, irritable misses work.
Signs & Symptoms of Drug Withdrawal	<ul style="list-style-type: none">• Nausea, vomiting, aches and pains, shaking, sweating, lacrimation, diarrhea, palpitation, confusion & Anxiety, Irritability and other psychiatric symptoms like delusion and hallucination,
Diagnostic Features	<ul style="list-style-type: none">• Physical harm: injuries when intoxicated e.g. thrombophelbitis, Hepatitis C & HIV etc.• Psychological harm acute psychotic breakdown or aggressive odd behaviour and homicidal.• Social: loss of job, family problems• Strong desire: cannot resist• Tolerance Level High• On withdrawal signs like anxiety & tremor etc.
Differential Diagnosis	<ul style="list-style-type: none">• Generalized Anxiety Disorder / Depressive Illness / Delirium & other psychotic disorders.
Advise for Patients and Family	<ul style="list-style-type: none">• Drug misuse: chronic, relapsing & can take a long time in controlling• Stopping drug use has its own benefits: leads to good health, social, and family benefits. Drug use during pregnancy has harmful effects on new born.• I/V drug users develop Hepatitis, HIV.• Family to adopt preventive measures, no sharing of needles, blades, scissors, shaving instruments, spoons, condoms.• Good diet exercise
Treatment	<ul style="list-style-type: none">• Detoxification• Rehabilitation (12 Steps N.A programme may be followed)• Follow up

REFERRAL

If there is underlying physical complication problem then refer him to District Level Hospital or if patient develop psychotic symptoms refer him to Punjab Institute of Mental Health, Lahore.

(10)

SCHIZOPHRENIA: - It is common serious mental illness characterized by disturbed thinking and perception and usually accompanied by blunted emotions: -

- Thought Disturbance / Detachment from Reality
- Delusions & Hallucinations
- Disturbed & Bizzare Behaviour, Lack of Insight

INCIDENCE 1 in 1000 per year **LIFE TIME RISK** 0.9% **AGE** 18 years to 35 years

Presenting Complaints	<ul style="list-style-type: none">• Strange behaviour e.g. behaving against social norms like taking off clothes in public etc / hostile & aggressive behaviour without any reason• Hearing voices• Strange belief e.g. supernatural powers• Problem managing work, studies• Difficulty with thinking and cooperation• Apathy and poor hygiene• Loss of contact with reality• Disturbed sleep and appetite
Diagnostic Features	<ul style="list-style-type: none">• Social withdrawal, bizarre behaviour• Low motivation• Self neglect• Thought Disorder• Hallucination (hearing voices)• Delusion (firm belief that he is special important person - prophet)
Differential Diagnosis	<ul style="list-style-type: none">• Rule out depressive illness• Bipolar affective disorder• Substance abuse disorder
Advise for Patients and Family	<ul style="list-style-type: none">• Symptoms may come and go over time• Medication reduces difficulties continue to prevent relapse• Stable living conditions for recovery• Support of the relatives essential for recovery and rehabilitation• Discuss treatment with family members• Minimize stress and stimulation• Take care of patient's physical health• Community action and support for rehabilitation and compliance of treatment very essential• Identification of side effect of medicines
Treatment	<p><u>PHARMACOLOGICAL</u></p> <ul style="list-style-type: none">• Haloperdol 10mg to 15mg per day in divided doses• Risperidone 2mg to 8mg per day in divided doses• Continue for 06-Months after remission of symptoms• Common side effect is EPS (tremors, akithesia, dystonia etc.)• Procycladine 5mg TDS / Inj. SOS• Promethazine 50mg TDS / Inj. SOS <p><u>PSYCHOSOCIAL</u></p> <ul style="list-style-type: none">• Support by the family / community• Rehabilitation• Compliance of treatment

REFERRAL

If patient is not responding to the treatment refer him to Punjab Institute of Mental Health, Lahore for expert advise or to a District Psychiatrist.

The Mini-Mental State Exam (MMSE) – Dementia / Alzheimer Disease

Patient _____ Examiner _____ Date ____ / ____ / ____

Orientation	Score	Maximum
What is the (year) (season) (date) (day) (month)?	()	5
Where are we (state) (country) (hospital) (floor)?	()	5

Registration

Name 3 objects : 1 second to say each. Then ask the patient all 3 after you have said them. Give one point for each correct answer. Then repeat () 3
 Then unit he/she learns all 3. Count trials and record.
 Trails _____

Attention and Calculation

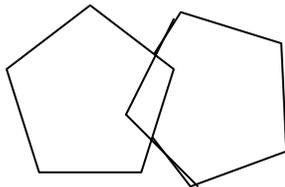
Serial 7's, 1 point for each correct answer. Stop after 5 answer. () 5
 Alternatively spell "world" backward.

Recall

Ask for the 3 objects repeated above. Give 1 point for each correct answer. () 3

Language

Name a pencil and watch. () 2
 Repeat the following "No ifs, ands, or buts" () 1
 Follow a 3-stage command: () 3
 "Take a paper in your hand, fold it in half, and put it on the floor."
 Read and obey the following: CLOSE YOUR EYES () 1
 Write a sentence. () 1
 Copy the design shown. () 1



Total Score

ASSESS level of consciousness along a continuum _____
 Alert Drowsy Stupor Coma _____

24-30: within normal limits; ≤ 23: cognitive impairment
 (further formal testing recommended)

(12)

EPILEPSY: - is a neurological disorder, characterized by tendency to recurrent seizures. Seizure is the result of abnormal excessive neuronal discharges of a group of neurons.

Epidemiology: life time prevalence is 5-10 %. However, incidence of active epilepsy is 1-2 %. More in developing countries due to poor perinatal services, CNS infections, head trauma.

Presenting Complaints	<ul style="list-style-type: none">• Loss of consciousness, drop attacks• Staring of eyes for few seconds• Jerky movements of face, body, limbs• Tongue bite, froth from mouth• Incontinence of urine, faeces• Headache confusion, memory disturbance• Irritability, seeing spot of light• Afraid, abnormal smell, taste• Walk around picking objects• Strange feeling in stomach
Diagnostic Features(according to ILAE 1981)	<p><i>Partial Seizures-Originate from a focal area in one hemisphere, may become secondarily generalized.</i></p> <ul style="list-style-type: none">• Aura, change perception• Automatic movement, lip smacking, chewing• Impaired consciousness confusion or amnesia• Jerking of a limb or a part of a limb• Seizures may last from few seconds to 1-2 minutes <p><i>Generalized Seizures-originate and spread in both hemispheres at one time</i></p> <ul style="list-style-type: none">• Complete loss of consciousness• Sudden onset• Jerky movements, tongue bite, incontinence, eyes rolling upward and amnesia• If seizures remain for more than 5 minutes, call emergency.
Differential diagnosis	<ul style="list-style-type: none">• Pseudofits and concersion disorder• Tetany• TIAs• Brain tumors• CNS infections
Management issues	<ul style="list-style-type: none">• Can be controlled successfully in up to 70 to 80 % cases• Drugs have to be taken regularly for many year• Discontinuation without doctor's advice leads to recurrence
Advise and support to patients and families	<ul style="list-style-type: none">• Not caused by punishment of sin or possession by jin• Don't go close to fire and water tank• Avoid putting something in patient's mouth during fit• Not a contagious (infectious) disorder• Child go to school and spend normal life• Don't over protect child• Patient with epilepsy can marry• Talk about epilepsy in family and community-no more stigma• Treatable and effective on regular medication
Treatment	<ul style="list-style-type: none">• Carbimazapine• Sodium Valproate

REFERRAL

Referral to District Hospital for consultation and follow up by health workers.

(13)

MENTAL RETARDATION: It is not disease it a disorder characterized by significantly impaired cognitive functioning and deficits in two or more adoptive behaviors which are communications, self care, home living, social interpersonal skills, functional academic skills health and safety.

Presenting complaints	<ul style="list-style-type: none">• Disturbed behavior.• Self neglect.• Unable to manage his/her routine activities• Delayed milestones Laughing (6-8 weeks normally) Sitting (6-8 months normally) Crawling (9 month normally) Walking (1 year to 1 ½ year) Talking (first words 9 month to 1 year)
Diagnostic Features	<ul style="list-style-type: none">• IQ below average Mild (50% to 70%) Moderate (35% to 50%) Severe (20% to 35%) Profound (<20%)• No toilet training possible or delayed.• Poor school performance• Unable to take care him / herself.
Differential Diagnosis	<ul style="list-style-type: none">• Rule out physical diseases• Learning disabilities• Attention Deficit Hyperactive Disorder• Epilepsy can be present with MR
Advise for patient and family	<ul style="list-style-type: none">• Information about illness and prognosis. (Don't promise anything what cannot be done, tell the truth)• The child may develop but with a low pace• His training about proper feeding, self care and healthy diet.• Teach child should be trained step by step to cop with normal daily life routine work.
Treatment	<ul style="list-style-type: none">• If child has epileptic fits treat them• If having behavior problems and restlessness then haloperidol 1.5mg to 10 mg.

REFERRAL

If child is not manageable then refer him / her to district level hospital / children hospital

CHILDHOOD CONDUCT DISORDERS: - Impaired functional behaviour characterized by constant conflict with adults, other children, anti social behaviour leading to exclusion from school or trouble.

Causes	<ul style="list-style-type: none"> • Traumatic life experiences • Rejection or emotional abuse • Harsh punishment • Broken relationship • School failure • Insufficient praise • Lack of positive joint activities with child
Presenting Complaints	<ul style="list-style-type: none"> • Often stays out at night • Runs away from school • Takes drug (gang)
Diagnostic Features	<ul style="list-style-type: none"> • Anti social, aggressive behaviour, persistent more than six months • Loss of temper, refuses to obey • Hitting, destructive • Stealing, criminal acts • Bullying, lying, cruelty to animals
Information for Patients and Family	<ul style="list-style-type: none"> • Educate parents and child on “effective communication” • Combine activities with child • Praise child, avoid arguments • Educate child on anger control
Advise and support to patients and families	<ul style="list-style-type: none"> • Interaction with child to be preferred

REFERRAL

- Referral to District Hospital for consultation and follow up health workers.
- Referral to Child Protection Officer and Educational Services.

SLEEP DISORDER: A **sleep disorder** (somnipathy) is a medical disorder of the sleep patterns of a person. Some sleep disorders are serious enough to interfere with normal physical, mental and emotional functioning.

Presenting Complaints	<ul style="list-style-type: none"> • Difficulty in falling into sleep. • Frequent awakening during sleep. • Early morning awakening. • Disturbed sleep. • Difficulty at work and in social and family life • It becomes difficult to carry out routine works • Sleep-restricted state can cause fatigue, daytime sleepiness, clumsiness and weight gain.
Causes	<p>PSYCHOLOGICAL</p> <ul style="list-style-type: none"> • Acute Stress • Anxiety • Depression • Mania • Schizophrenia • Sleep Apnoea • Narcolepsy <p>PHYSICAL / MEDICAL PROBLEMS</p> <ul style="list-style-type: none"> • Nose, throat and lung diseases • Heart failure • Pains <p>MEDICATIONS</p> <ul style="list-style-type: none"> • Steroids • Decongestants • Others <p>LIFE STYLE</p> <ul style="list-style-type: none"> • Tea, Coffee & Alcohol before sleep • Day time naps • Irregular sleep schedule <p>ENVIRONMENTAL</p> <ul style="list-style-type: none"> • Noise • Lack of privacy • Over crowding
Advise for Patients and Family	<ul style="list-style-type: none"> • Family is advised not to bother him/her before going to bed. • Before going to sleep follow some relaxation techniques
Treatment	<ul style="list-style-type: none"> • Treat the cause • Reassurance • Supportive therapy for Anxiety, Depression & other illnesses • Use of hypnotics for a short period of time to avoid dependence.

REFERRAL

Referral to District Hospital / Punjab Institute of Mental Health, Lahore when a simply method of management does not work

MANAGING VIOLENT PATIENTS:

What is Violence	<ul style="list-style-type: none"> • Behaviour that intentionally inflicts physical harm. • Behaviour that is hostile, threatening, damaging a non physical way.
Causes of Violence / Aggression	<p>Impulsive aggression could be due to: -</p> <ul style="list-style-type: none"> • Environmental influences e.g. long standing childhood victimization, violent life style • Biological abnormality, head injury • Genetically transmitted
Mental Illness Associated with Violence / Aggression	<ul style="list-style-type: none"> • Personality disorders • Substance abuse • Schizophrenia • Bipolar Effective Disorder • Depressive illness • Epilepsy • Mental retardation • Dementia • Head injuries – personality changes
What to do?	<p>Brief history from relative, friends to identify: -</p> <ul style="list-style-type: none"> • Cause of violence • Rate of onset • Precipitating factors • Type of hallucination – maladjustment • Delusion
Management Guidelines	<ul style="list-style-type: none"> • Get help, exercise caution, allow for escape, identify yourself • Try to calm the patient, speak softly, no sudden action • Listen to the patient • Do not argue the patient • Do not make false promises • Try to persuade surrendering weapon • For controlling him at least 2 to 3 people to over power and hold all limbs of patient • Cover patient with blanket • Approach from behind

REFERRAL

Referral to District Hospital when a simply method of counseling does not work.

MEDICATION GUIDELINES

DISORDER	MEDICATION	DOSAGES	SIDE-EFFECTS
Epilepsy	Carbamazapine 200mg Sodium valproate 250-500mg	Daily 400-1600mg divided doses Daily 200mg- 2000mg Divided doses	<ul style="list-style-type: none"> • Drowsiness, dizziness, ataxia, diplopia, nausea, agranulocytosis, skin rash Nausea, vomiting, tremors, sedation, weight gain, hepatotoxicity, thrombocytopenia,
Delirium	Haloperidol 1.5 mg and 5 Diazepam 5mg	<p>First treat underlying cause of delirium!</p> <p>1.5 to 15mg in 3 divided doses. Half dose to elderly!</p> <p>Alcohol withdrawal, only for admitted patients: 10-50 mg a day in divided doses</p>	<ul style="list-style-type: none"> • Dry mouth • Blurred vision • Constipation • EPS • galactorrhea Drowsiness, confused thinking, ataxia, dependence,
Dementia	Haloperidol 1.5 mg Memantine hydrochloride	<p>1.5mg in divided doses per day.</p> <p>Daily doses 5-20mg</p>	<ul style="list-style-type: none"> • Dry mouth, blurred vision, constipation, tremor. Dizziness, headache, somnolence, hallucinations, seizures,

DISORDER	MEDICATION	DOSAGES	SIDE-EFFECTS
Schizophrenia	Haloperidol 5mg Trifluoperazine 5mg Levosulpiride 100mg Risperidone 1, 2, 3 mg	1.5 mg to 10mg in 2 divided doses 1.5-10mg in divided doses 100mg-600mg divided doses 2-8 mg daily in divided doses	<ul style="list-style-type: none"> • See above <p>Dry mouth, retention urine, blurred vision, EPS</p> <p>Raised prolactin level EPS and TD with lesser intensity</p> <p>Dry mouth, constipation,</p> <p>Insomnia, agitation, anxiety, headache, raised serum prolactin level, EPS, seizures</p>
Acute psychotic disorder	Injection Haloperidol 5mg Injection promethazine 50mg Injection flupenthixol acuphase 50mg-100mg	5 mg to 10 mg as required, can be repeated 8 hourly along with injection haloperidol not less than 72 hours	<ul style="list-style-type: none"> • See above <p>Dry mouth, EPS, drowsiness, hypotension, blurring of vision,</p>
Bipolar disorder	Haloperidol 5 mg Risperidone 1, 2, 3 mg Carbamazapine 200mg Sodium valproate 250-500mg	5 mg to 10 mg in two divided doses 2-8 mg daily in divided doses Daily 400-1600mg divided doses Daily 200mg-2000mg Divided doses	<p>Insomnia, agitation, anxiety, headache, raised serum</p> <p>Prolactin level, EPS, seizures</p> <p>Drowsiness, dizziness, ataxia, diplopia, nausea, agranulocytosis, skin rash</p> <p>Nausea, vomiting, tremors, sedation, weight gain, hepatotoxicity, thrombocytopenia,</p>

	Clonazepam 0.5 mg, 2mg	Daily Dose 0.5 mg to 2 mg B.D	Drowsiness, confusion, ataxia, dependence with drawl symptoms
Depression	Amitriptyline 25mg Fluoxetine hydrochloride 20 mg	50 to 100 mg in 2 divided doses 20 mg to 60 mg O.D	Sedation, orthostatic hypotension, Dryness of mouth, constipation, blurring of vision, retention of urine, cognitive interment, Nausea, headache, anxiety, insomnia, fatigue, treamers, skin rash.
Sleep Disorders	Benzodiazepines Temazepam 15 mg, 30 mg Lormetazepam 1mg, 2mg Non- Benzodiazepines Zolpidem 10mg	15 mg to 30mg at bed time 1 mg to 2mg at bed time 10mg at bed time	Ataxia, Drowsiness, confuse thinking, amnesia, dependence withdrawal symptoms Bitter taste, confusion, depressed mood, slowness, rebound insomnia, tolerance

GENERAL GUIDELINES OF MANAGEMENT FOR MILD TO MODERATE PROBLEMS

REASSURANCE

- Stresses often produce physical symptoms or makes them worse.
- You can benefit from learning strategies to reduce the impact of your symptoms.
- Symptoms can be reduced or minimized by acting upon learning strategies.

RELAXATION TECHNIQUES

- Slow and deep breathing reduces common physical symptoms for example muscle tension hot and cold flushes, headaches, chest tightness.
- Breathe in deeply and breathe out slowly and then take pause for next breath.
- Practice this exercise ten minutes for morning and ten minutes at night
- This practice should be exercised during any situation that makes you anxious.

CHANGE OF THINKING AND ATTITUDES

NEGATIVE THOUGHT	POSITIVE THOUGHT
I can't understand why the tests are negatives. I feel the pain. It probably something really unusual pains	The pain is real but I have been checked out physically and I have had all the relevant test, many other things such as worry and stress, can cause these pains
Maybe a doctor has missed something I should try another doctor or better specialist	It is very unlikely that these doctors have missed something. Maybe I should examine whether stress tension or my life style is contributing to the pain. It is unlikely that a specialist would say anything different
Why won't this pain go away I am not feeling well. I have probably got cancer	I should learn to relax and focus my thoughts on other things to distract myself from the pains

FOCUS ON PHYSICAL ACTIVITY

Gradually built up physical activities

COMMUNITY MENTAL HEALTH PROGRAMME

Name _____ Clinic No. _____

Age _____ Yrs _____ Sex _____ Date _____

Father's/Husband's Name _____

Village/Address _____

Distance from Health Centre _____

Mode of Referred Health Worker Other Patient Faith healer Teacher, Student Health Committee

Sell Other

Working/Not

Working _____

(Since when)

Main Complaints & Duration _____

SYMPTOMS & SIGNS

- | | |
|--|---|
| <input type="checkbox"/> Unconsciousness
<input type="checkbox"/> Clouded consciousness*
<input type="checkbox"/> Injury/tongue bite
<input type="checkbox"/> Tonic/Clinic movement
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Attack in sleep / when alone
<input type="checkbox"/> Delayed milestones
<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Physical handicaps
<input type="checkbox"/> Poor school performance
<input type="checkbox"/> Limited social skills
<input type="checkbox"/> Fear / Anxiety
<input type="checkbox"/> Palpitation
<input type="checkbox"/> Giddiness / Tinnitus
<input type="checkbox"/> Headache
<input type="checkbox"/> Tremors of hands
<input type="checkbox"/> Fainting attacks with Abnormal*
Movements
<input type="checkbox"/> Difficulty to concentrate / Remember
<input type="checkbox"/> Body aches and pains*
<input type="checkbox"/> Weakness
<input type="checkbox"/> Gas / Gola formation | <input type="checkbox"/> Sexual problems
<input type="checkbox"/> Possession*
<input type="checkbox"/> Excess Activity*
<input type="checkbox"/> Dull/Withdrawn*
<input type="checkbox"/> Excess understandable speech
<input type="checkbox"/> Hallucination*
<input type="checkbox"/> Elation / excessive happiness
<input type="checkbox"/> Violence and aggressing
<input type="checkbox"/> Anger/Irritability
<input type="checkbox"/> Sadness/Weeping episodes
<input type="checkbox"/> Suicidal ideation / attempt
<input type="checkbox"/> Delusion*
<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Sleep disturbance
<input type="checkbox"/> Appetite disturbance
<input type="checkbox"/> Self neglect
<input type="checkbox"/> Brief episodic abnormal behaviour

<input type="checkbox"/> Drug abuse-Herion/Cannabis/other
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> |
|--|---|

Family History

:Mental Illness/M.R./Epilepsy

Past History

:Mental Illness/Epilepsy

Associated events

:Fever/Head injury/Drug Abuse/Psychological stress/Significant physical illness

Physical Examination

:Normal/Abnormal (Specify) _____

- Psychosis (Schizophrenia/Hypomania)*
 Depression
 Epilepsy
 Mental Retardation
 Drug dependence (Heroin, Cannabis / Others)
 Others

Treatment _____

Referral

Signature of M.O

TRAINING OUTLINE FOR TRAINEES

(One Week)

THEORY TRAINING

Part-I

Presentation of Mental Disorders

- Sign & Symptoms
- Confirmation of Disease

Part-II

Management

- Pharmacological
- Psychological

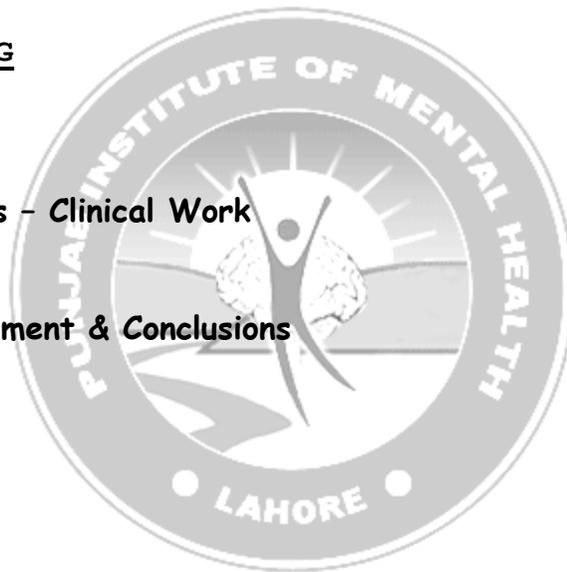
CLINICAL TRAINING

Part-III

- Role Model
- Case Studies – Clinical Work

Part-IV

Training Assessment & Conclusions



GLOSSARY

Abnormal personality

- A personality with traits deviating markedly from what is generally accepted as normal.

Addiction

- A state of physiological and psychological dependence on some substance, usually a drug, resulting in tolerance of the drug such that progressively larger doses are required to obtain the same effect.

Affect

- The subjective and immediate experience of emotion with outward manifestations.

Agitation

- Excessive motor activity usually non purposeful.

Aggression

- Forceful physical, verbal or symbolic action, may be appropriate and self protective (Self assertiveness) or inappropriate as in hostile and destructive behaviour.

Agnosia

- Inability to understand the importance of sensory stimuli even though the sensory pathways and sensorium are sufficiently intact for the patient to be able to do so.

Akathisia

- Physical restlessness

Akinesia

- Reduced physical activity of the person

Ambivalence

- Presence of strong and often overwhelming simultaneous contrasting attitude, ideas, feelings and drives toward an object, person or goal.

Amnesia

- **Pathological loss of memory.**

Anhedonia

- **Lack of enjoyment in pleasurable activities.**

Aphasia

- **A disturbance in language function.**

Apraxia

- **Inability to perform a voluntary purposeful motor activity.**

Attitude

- **A mental set up held by an individual which affects the ways that person responds to events and organizes his cognitions. Its three components are: cognitive dimension, affective dimension and conative dimension.**

Automatism

- **Automatic and apparently undirected non purposeful behaviour not consciously control.**

Catalepsy

- **Condition in which a person maintains the body position in which he is placed.**

Catatonia

- **A state of increased muscle tone affecting extension and flexion and abolished by voluntary movement.**

Circumstantiality

- **Disturbance in associative thoughts and speech processes in which patient goes into unnecessary and inappropriate details before communicating the central idea.**

Cognition

- **Mental process of knowing and becoming aware.**

Compulsion

- **Uncontrollable, repetitive and unwanted urge to perform an act.**

Confabulation

- Unconscious filling of the gaps in memory by imaginary experiences or events that took place at other times.

Confusion

- A state of impaired consciousness.

Consciousness

- The awareness of one's own mental processes and having orientation about place, person and time.

Delusions

- False, fixed, unshakable beliefs held on inadequate grounds contrary to the social and cultural backgrounds.

Depersonalization

- Change of self awareness such that the person feels unreal, detached from his own experience and unable to feel emotion.

Derealization

- Change in awareness about the environment such that objects and people appear unreal.

Dystonia

- Motor disturbance consisting of slow, sustained contractions of axial or appendicular musculature leading to sustained postural deviations.

Echolalia

- Patient repeats words of the interviewer

Echopraxia

- Patient repeats the actions of the interviewer

Empathy

- The intellectual and emotional awareness and understanding of an other persons state of mind.

E.C.T

- Electro Convulsive Therapy.

E.E.G

- Electro Encephalography.

Flight of Ideas

- A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable association.

Hallucinations

- Percept in the absence of stimulus and related to sense organs

Ictus

- State of fit

Incoherent Speech

- Speech that is not understandable due to lack of logical and meaningful connection between words, phrases or sentences.

Insight

- Patient awareness about his illness

IQ

- Intelligence quotient

Interictal Period

- Period between two fits

Judgment

- Mental act of comparing and reevaluating choices within the framework of a given set of values for the purpose of electing a course of action.

Loosening of Association

- Loss of normal structure of thinking. Patient jumps from one topic to another without any logical connection.

Mood

- A long lasting state of emotions

Neologism

- Use of new words or phrases.

Neurosis

- **Mental disorders that are generally less severe and characterized by symptoms of anxiety, fearfulness etc.**

Obsession

- **Recurrent persistent thoughts, images or impulses that enter the mind despite efforts to exclude them**

Overvalued Ideas

- **An isolated preoccupying belief, neither delusional nor obsessional in nature which comes to dominate a person's life having roots in social and cultural background.**

Passivity Phenomena

- **False belief that one's actions and thoughts are controlled by an outside force or agency.**

Perseveration

- **Persistent and inappropriate repetition of the same thoughts.**

Phobia

- **Irrational fear which is out of proportion to the situation.**

Post Ictal Period

- **Period immediately after the fit**

Posturing

- **Adoption of unusual bodily postures continuously for a long time.**

Stereotypies

- **Repeated movements that are regular and without obvious significance.**

Substance abuse

- **Inappropriate use of substance in a way that is harmful to the individuals.**

Thought Disorder

- **Disorganized thinking.**

Tics

- **Irregular repeated movements involving a group of muscles, apparently purposeful**

