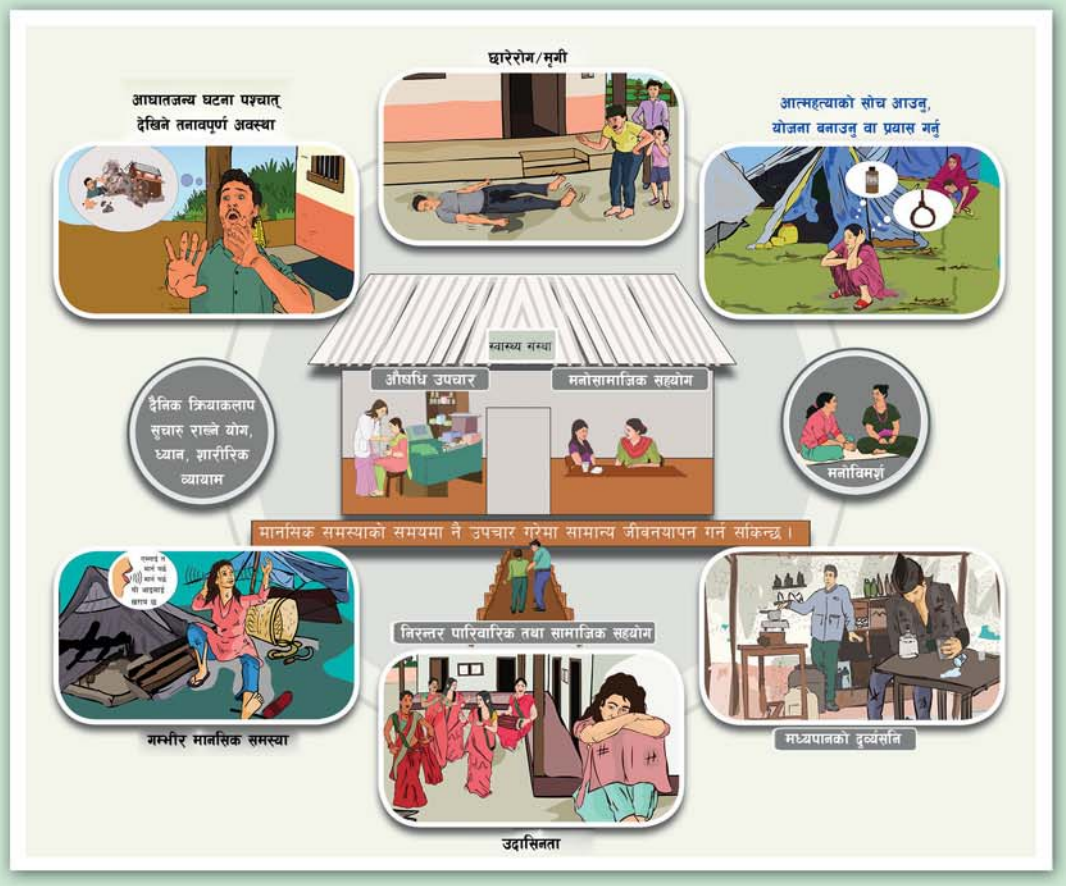
Standard Treatment Protocol (STP) for Mental Health Services into the Primary Health Care System

नेपाल सरकार स्वास्थ्य मन्त्रालय अन्तर्गतका स्थानीय स्तरमा भएका स्वास्थ्य संस्थाहरुमा मानसिक स्वास्थ्य सेवाका लागी स्तरिय उपचार पद्धति



नेपाल सरकार

स्वास्थ्य मन्त्रालय

स्वास्थ्य सेवा विभाग

प्राथमिक स्वास्थ्य सेवा पुनर्जागरण महाशाखा

Standard Treatment Protocol (STP) for Mental Health Services into the Primary Health Care System

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Ministry of Health

Department of Health Services

Primary Health Care Revitalization Division

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नेपाल सरकार स्वास्थ्य मन्त्रालय अर्न्तगतका स्थानिय स्तरमा भएका स्वास्थ्य संस्थाहरुमा मानसिक स्वास्थ्य सेवाका लागी स्तरिय उपचार पद्धति

प्रकाशक : **नेपाल सरकार, स्वास्थ्य मन्त्रालय, स्वास्थ्य सेवा विभाग, प्राथमिक स्वास्थ्य सेवा पुनर्जागरण महाशाखा, टेकु, काठमाडौं**

प्रकाशन मिति : २०७३ पौष

संस्करण : **प्रथम**

संस्करण प्रति : ११०० प्रति

प्रकाशन सहयोग : टी. पि. ओ नेपाल

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मुद्रण : दाहाल प्रिन्टीङ्ग सपोर्ट

कभर फोटो © : टी.. पि. ओ नेपाल

नेपाल सरकार

स्वास्थ्य मन्त्रालय

(.....शाखा)

फोन नं. ४२६२५९०
४२६२८०२
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४२२३५८०

रामशाहपथ,
काठमाडौं, नेपाल ।

प्राप्त पत्र संख्या :-
पत्र संख्या :-
चलानी नं. :-

मिति : २०७३।०८।२९.....

विषय :- शुभकामना

नेपाल लगायत विश्वमा नसर्ने रोगको प्रकोप दिन प्रतिदिन बढ्दै गईरहेको छ । विश्व स्वास्थ्य संगठनले समेत जनताको आधारभूत अधिकारको रुपमा रहेको स्वास्थ्य सेवा मध्ये नसर्ने रोगहरुको रोकथाम तथा नियन्त्रणका लागि उच्च प्राथमिकताका साथ विभिन्न कार्यक्रमहरु संचालनमा ल्याएको छ । नसर्ने रोगहरु अन्तर्गत नै पर्ने मानसिक रोग पनि प्रमुख रोग हो र यसले नसर्ने रोगको ठुलो हिस्सा ओगटेको छ । यसै उद्देश्य अनुरुप जनताले निश्चित मापदण्डमा गुणस्तरीय सेवा दिलाउने मानसिक स्वास्थ्य सेवाको एउटा Standard Treatment Protocol (STP) तयार पारीएको छ ।

विश्व स्वास्थ्य संगठनको तर्फबाट समेत यसै कार्यक्रममा सहयोग प्राप्त भएको अवस्थामा यसैसंग सम्बन्धित मानसिक स्वास्थ्य संगका थुप्रै समस्या तथा रोगहरु रहेको कारण मानसिक स्वास्थ्य सेवालाई बढी भन्दा बढी प्रभावकारी एवम व्यवस्थित बनाउन बृहत छलफल तथा अन्तक्रिया पश्चात सरल एवम् व्यबहारिक Standard Treatment Protocol (STP) for Mental Health Services into the Primary Health Care Services नामक पुस्तक कार्य क्षेत्रमा काम गर्न सजिलो हुने गरि तयार पारिएको छ । जस अनुसार यो पुस्तकले मानसिक रोगीहरुको समयमै गुणस्तरीय उपचार गर्ने कार्यमा स्वास्थ्यकर्मिहरुको लागि अति नै उपयोगी हुने कुरामा विश्वास लिएको छु ।

अन्त्यमा, यो पुस्तक तयार गर्न सहयोग गर्ने सम्बन्धित सबैमा कार्यको उच्चमुल्याकंन गर्दै हार्दिक धन्यवाद व्यक्त गर्दछु ।

.....
(डा. सेनेन्द्र राज उप्रेती)
सचिव

नेपाल सरकार
स्वास्थ्य मन्त्रालय
स्वास्थ्य सेवा विभाग

४२६१७१२,४२६१४३६
फ्याक्स : ४-२६२६८
पचली,टेकु
काठमाडौं, नेपाल ।

पत्र संख्या :- ०७३/७४
चलानी नम्बर:

प्राक्कथन

मलाई यो Standard Treatment Protocol (STP) for Mental Health Services into the Primary Health Care Services तयार भएकोमा अत्यन्त खुशि लागेको छ । नेपालमा अहिले नसर्ने रोगको कारणले ६० प्रतिशत भन्दा बढि मानिस मरिरहेको तथ्याङ्कहरुले देखाई रहेको सन्दर्भमा मानसिक रोग पनि नसर्ने खालको रोग भएको र यसको लागि यो Standard Treatmernt Protocol (STP) बन्नु खुशीको कुरा हो ।

राष्ट्रिय मानसिक स्वास्थ्य निति सन् १९९६ मा बनिसके पछि यसले नेपालमा मानसिक स्वास्थ्य ले उब्जाएका समस्याहरुलाई सम्बोधन गर्न सहज भएको छ ।

मानसिक रोग को केहि बिषय बस्तुहरु स्वास्थ्य चौकिहरुको लागि स्तरीय उपचार पद्धतिमा पनि समोवश भएका छन् । तर यसलाई अझ परिमार्जित गर्दै मानसिक स्वास्थ्यको परिभाषा सहीत Axiety Disorder,Alcohol Use Disorders हरु जस्ता नयाँ बिषय वस्तुहरु थप गरि बिस्तृत रुपमा निदान तथा उपचारमा सहज हुने गरि तयार पारिएको छ । हाल यो कार्यक्रमको लागि एघार थरिको औषधिहरु निशुल्क रुपमा कार्यक्रम संचालित जिल्लाहरुका स्वास्थ्य संस्थाहरु बाट पाउने ब्यवस्था गरिएको छ ।

मानसिक स्वास्थ्यको लागि नेपाल सरकार एक्लैले मात्र काम गर्न गाह्रो हुने र समुदाय लगायत बहु क्षेत्रीय सहयोगको आवश्यकता अपरिहार्य रहेको छ । यसको लागि सबै क्षेत्रको सहयोग एवंम सहकार्य जरुरी छ । यस पुस्तिका तयार पार्ने कार्यमा आफनो अहम भूमिका निर्वाह गर्ने स्वास्थ्य सेवा विभाग प्राथमिक स्वास्थ्य सेवा पुनर्जागरण मशाशाखाका निर्देशक मोहम्द दाउद लगायत अन्य सम्पूर्ण कर्मचारीहरु का साथै वहुसांस्कृतिक मनोसामाजिक संस्था (Transcultural Psychosocial Organization (TPO) Nepal) तथा अन्य सहयोगि संघ संस्थाहरु समेत लाई धन्यवाद दिन चाहन्छु र यो पुस्तकको प्रयोग गरी गुणस्तरिय सेवा पुऱ्याउनु हुने स्वास्थ्यकर्मिलाई बिशेष शुभकामना प्रदान गर्दछु ।

डा.पुष्प चौधरी
महानिर्देशक

नेपाल सरकार
स्वास्थ्य मन्त्रालय
स्वास्थ्य सेवा विभाग
प्राथमिक स्वास्थ्य सेवा पुनर्जागरण महाशाखा

फोन ४१०००८०
फ्याक्स : ४१०००५२
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पचली, टेकू
काठमाडौं,

पत्र संख्या :- ०७३/७४
चलानी नम्बर:

प्राक्कथन

स्वस्थ्य नागरीक नै देशको महत्वपूर्ण कर्णधारको रुपमा रहने कुरालाई नेपाल सरकारले मनन गरि सबै रोगहरुको एउटा निश्चित मापदण्डमा गुणस्तरीय सेवा पाउन भन्ने उद्देश्यले मानसिक स्वास्थ्य सेवाको एउटा Standard Treatment Protocol (STP) तयार पारीएको छ।

नेपाल लगायत विश्वमा नसर्ने रोगको प्रकोप दिन प्रतिदिन बढ्दै गईरहेको विभिन्न अध्ययन प्रतिवेदेनहरुले पुष्टि गरेका छन्। नेपालमा पनि नसर्ने रोगहरुका कारण ६० प्रतिशत भन्दा बढि मानिसहरुको मृत्युको परिदृश्यलाई मध्यनजर गरी नसर्ने रोगहरु सम्वन्धि कार्यक्रमहरु संन्चालन गर्न अवश्यक ठानी प्रस्ताव गरे अनुरुप स्वास्थ्य सेवा विभाग प्राथमिक स्वास्थ्य सेवा पुनर्जागरण मशाशाखाको अगुवाईमा आ.व. ०७३।०७४ मा स्वीकृत बार्षिक कार्यक्रम तथा बजेटमा नसर्ने रोग सम्बन्धि २ जिल्लामा कार्यक्रम संन्चालन गर्न प्रकृया शुरु भइसकेको र आगामी बर्षहरु देखि क्रमशः मुलुकका सबै जिल्लाहरुमा विस्तार गर्दै लैजान सम्वद्ध निकायको ध्यानकर्षण भैसकेको छ।

यसै परिप्रेक्ष्यमा विभिन्न नसर्ने रोगहरु अन्तर्गत मानसिक स्वास्थ्य समस्या पनि एउटा प्रमुख स्वास्थ्य समस्या को रुपमा रहेको छ। विभिन्न अध्ययनहरुले देखाए अनुसार मानिसलाई अंगभंग गराउने कारणमा कुष्ठरोग पछि दोस्रो मानसिक रोग नै पर्न आउछ भने प्रत्यक्ष परोक्ष रुपमा सामाजिक जीवनमा मानसिक स्वास्थ्य समस्याले बढी नै प्रभावित पारिरहेको अवस्थाले गर्दा पनि मानसिक स्वास्थ्य सेवाको Standard Treatment Protocol आवश्यक देखि प्राथमिक स्वास्थ्य सेवा पुनर्जागरण मशाशाखाको अगुवाईमा सरकारी तथा गैरसरकारी संस्थाहरुको प्रतिनिधी समेतको उपस्थितीमा मिति २०७३।०४।२० गते बसेको बैठकले मानसिक स्वास्थ्य कार्यक्रम Mental Health Program अन्तर्गत Depression,Epilepsy/Seizure,Psychosis,Anxiety disorder,Alcohol Use disorder को परिचय लक्षण चिन्ह,निदान उपचार र व्यवस्थापन तथा सो को Protocol मा छलफल गरी प्राप्त सुझावहरु को आधारमा तयार गरिएको Draft STP लाई सम्वन्धित विज्ञहरु कहाँ पठाई थप परिमार्जन गर्ने निर्णय गरे अनुरुप पुनः मिति २०७३।०७।०५ गते आयोजित मानसिक स्वास्थ्य (Mental Health) को क्षेत्रमा कार्यरत विभिन्न निकायका प्रतिनिधी,सरोकारवाला एवं मानसिक रोग विशेषज्ञहरुको उपस्थितीमा तयार पारिएको Draft Standard Treatment Protocol (STP) FOR Mental Health Services into Primary Health Care Services लाई स्वास्थ्य मन्त्रालयले मिति २०७३।०८।०३ मा स्विकृती प्रदान गरेपछि अहिलेको यो रुपमा प्रस्तुत गर्न पाएको मा धेरै खुशि लागेको छ।

यो पुस्तक सबै स्वास्थ्य कर्मीहरुको लागि ज्यादै उपयोगी हुने छ भन्ने विश्वास लिएको छु। यो पुस्तक तयार पार्ने क्रममा खटी सहयोग गर्नु हुने स्वास्थ्य सेवा विभाग प्राथमिक स्वास्थ्य सेवा पुनर्जागरण मशाशाखाका सम्पूर्ण कर्मचारीहरुका साथै वहुसांस्कृतिक मनोसामाजिक संस्था (Transcultural Psychosocial Organization (TPO), Nepal) लगायतका अन्य सहयोगी सबै संघ संस्थाहरुलाई हार्दिक धन्यवाद दिन चाहन्छु।

मोहम्मद दाउद
निर्देशक

Table of content

How to use this Standard Treatment Protocol

यो स्तरीय उपचार पद्धति पुस्तिका कसरी प्रयोग गर्ने ?

यो स्तरिय उपचार पद्धति (protocol) पूस्तिकाको प्रयोग सम्बन्धमा प्रयोगकर्ताको सुविधा तथा यसको अधिकतम उपयोगको लागि यहाँ सामान्य जानकारी प्रस्तुत गरिएको छ । यस पुस्तिकाको सम्पूर्ण बिषय सूचिलाई छ भागमा बिभाजित गरी सोको प्रयोग सम्बन्धमा निम्नानुसार जानकारी दिइएको छ ।

भाग एक मानसिक स्वास्थ्य (Mental Health)

यस भागमा मानसिक स्वास्थ्यका विषयमा सामान्य जानकारी समेटिएको छ । यसबाट स्वास्थ्यकर्मीहरूले मानसिक स्वास्थ्यको महत्व तथा आवश्यकतालाई बुझ्न सक्नु हुनेछ ।

भाग दुई देखी भाग छ मानसिक स्वास्थ्य समस्या, उपचार पद्धतिहरू (Treatment Protocol for mental illness)

यस खण्डमा चारबटा मानसिक स्वास्थ्य समस्याका बारेमा विशिष्टकृत रूपमा परिभाषित गरिएको छ । ति स्वास्थ्य समस्या/डिसअर्डरहरूको लक्षणे, उपचारपद्धतिहरू, औषधिको मात्रा (dose), पटक र अवधि (Frequency), स्पष्ट रूपमा उल्लेख गरिएको छ भने मनोसामाजिक हेरचाहको बारेमा समेत स्पष्ट खुलाइएको छ । त्यसको साथसाथै सारांसमा फ्लो चार्टमा समेत खुलाइएको हुनाले चार्टमात्र हेरेर पनि सेवा पुऱ्याउन सकिन्छ । चार्ट आफैले प्रिन्ट गरेर राखेर वा चिन्ह लगाएर सजिलै हेर्न सकिन्छ ।

भाग सात औषधि तथा अभिलेखिकरण सम्बन्धमा जानकारी (Information on Medication and Documentation):

यस खण्डमा औषधि सेवा (Pharmacological) को सम्बन्धमा महत्वपूर्ण जानकारीहरू निम्नानुशार दिइएका छन् ।

१. औषधि तथा मात्रा सम्बन्धमाः औषधिको नाम, बनावट र मात्रा (बयस्क तथा बालक) तथा सेवनबिधि (Name, dose frequency, Route of Administration) बारे जानकारी रहेका छन् ।

२. औषधिबाट हुन सक्ने सम्भावित प्रतिक्रियाहरू (Side Effects) र औषधिको प्रयोग बञ्चित गर्नुपर्ने अवस्था (Contraindications) औषधिको नकारात्मक असर (Adverse Drug Reaction-ADR) र अन्त्यमा स्वास्थ्यकर्मिहरूले प्रयोग गर्ने अभिलेखिकरण फाराम /प्रिस्किप्सन समेत दिईएको छ ।

Part One:
MENTAL HEALTH

Mental Health

Mental, neurological, and substance use disorders are common in all regions of the world, affecting every community and age group across all income countries. Round 14% of the global burden of disease is attributed to these disorders. Around 75% of the people affected live in low-income countries and do not have access to the treatment they need.[1] Similar is the case in Nepal. Since mental health is not integrated into primary health care system in our country, majority of patients with mental illnesses remain undiagnosed in the community creating a big widening treatment gap.

National Mental Health Policy (NMHP) was formulated in 1996 to address the burden of mental illnesses in Nepal. NMHP includes-

- To ensure the availability and accessibility of minimum mental health services for all the population of Nepal.
- To prepare human resources in mental health.
- To protect the fundamental human rights of the mentally ill in Nepal.
- To improve awareness about mental health, mental disorders and healthy lifestyles.

However, delay in the promulgation and implementation of Mental Health Legislation has led to difficulty in addressing the national mental health problems.

Mental health needs multi-sectorial initiatives from many community development programs. Awareness raising activities plays a crucial role for reducing public stigma and discrimination. So, mainstreaming of mental health services at PHC level is an effective approach in providing mental health care to the rural and disadvantaged people.

The exact cause of mental illness is not known. However studies suggest interplay of

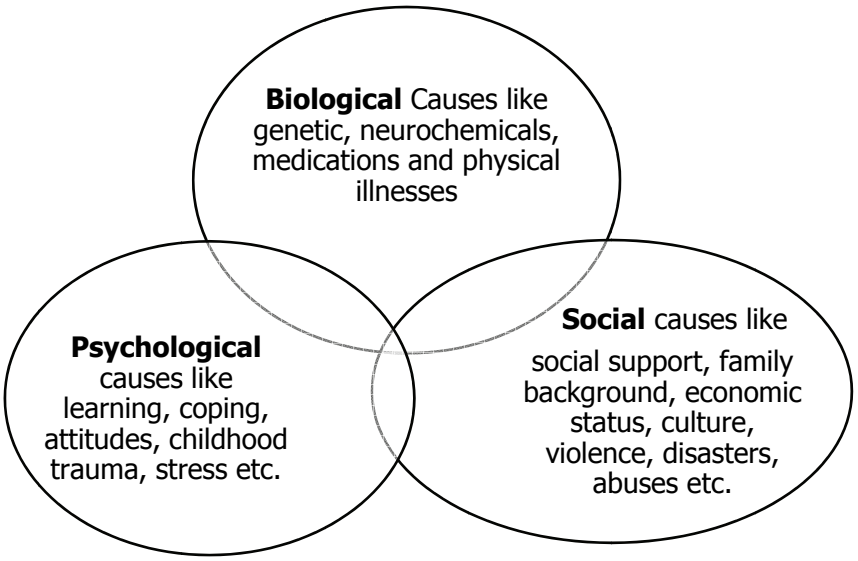


Figure : Bio-psychosocial model of Mental Illness

biological, psychological and social factors as a cause.

General guideline for evaluation and treatment of people with mental illness:

1. Whenever possible, arrange for a private, comfortable setting to talk to the patient.
2. Provide enough time to hear about the patient's problems and listen attentively.
3. Ensure that the communication is clear, non- judgmental, empathic, and respectful.
4. Be sensitive when private and distressing information (suicide, abuse) is provided.
5. Maintain confidentiality. Confidentiality can only be broken when there is risk of harm to self or others.
6. Information provided by the family members should also be taken into consideration while making a diagnosis.
7. Always evaluate for the possibility of physical illness.
8. Always perform general physical evaluation.
9. Manage or refer for any concurrent medical conditions.
10. Enquire about psychosocial stressors and assist in providing psychosocial support.
11. Explain about the nature of illness, side effects of the drugs and total treatment duration to the patient and family members (when appropriate).
12. After initiating treatment, advise for frequent follow up visits as drug dose needs to be adjusted based on the efficacy and side effect of drugs.
13. Maintain records of the patients seen accordingly in the HMIS forms.

What to advise both the patient and family members of people with mental illness:

1. Mental illness is caused by the interplay of biological, psychological and social factors. It can happen to anybody. Having mental illness does not indicate laziness, lack of will power, being possessed by evil spirits, or being punished for their sins.
2. Mental illnesses are not communicable.
3. Mental illness is an illness like any other and can be treated effectively in large portion of the ill population.
4. Marriage is not a treatment for any kind of mental illness.
5. Family and social support improve the chances of recovery.
6. Maintaining a daily routine especially for sleep, eating and physical exercise is very helpful.
7. Involvement in family and social activities is beneficial.
8. Regular follow up in health center is very essential to provide quality care. Medications are largely safe and can be taken regularly as prescribed. Except diazepam (a benzodiazepine drug) no other drugs mentioned in this protocol are addictive in nature.
9. Continue with regular educational and occupational activities as far as possible.

Advice to family members:

1. They need to provide constant support to the patient, especially for regular follow up and treatment adherence.
2. If there is risk of self-harm and suicide, it should be taken seriously and brought to the health center/ hospital. Suicidal precautions should be well explained.
3. If medications are prescribed, family members should ensure the intake of medications by patients. When there is risk of suicide, medications should be kept securely preferably locked.

Psychosocial management:

1. Family can play an important role in the treatment of people with mental illness.
2. General care and support provided by the family and community is beneficial for the patient.
3. Even when formal support groups are not available, getting involved in community events, local club activities, and local community groups can boost patient's morale.

When to refer to the nearest health facility with psychiatric care:

1. When patients are of older age, children (except epilepsy), pregnant, and lactating mothers).
2. When recommended drug dosing is not effective.
3. When there are other co-morbid illnesses.
4. When there are side effects for which treatment is not possible at the health center/hospital.

Part Two:
DEPRESSION

Depression

There are many types of disorders of mood (emotion) like unipolar depression, bipolar affective disorder, etc. Among them, unipolar depression is a very common presentation in primary health care set-up. For the sake of simplicity, unipolar depression will be referred as depression from this point on.

Core symptoms:

1. Depressed mood for most time of the day for most of the days
2. Loss of interest or pleasure in previously pleasurable activities
3. Easy fatigue or decreased energy

Other features:

1. Feelings of guilt
2. Feelings of worthlessness
3. Poor attention and concentration
4. Low confidence and self-esteem
5. Negative view of the future
6. Ideas or attempts of suicide
7. Poor sleep
8. Poor appetite

To diagnose a case of depression:

At least 2 core symptoms and at least 3 other symptoms need to be present for at least 2 weeks.

Rule out other physical conditions that can mimic symptoms like depression, such as- anemia, malnutrition, thyroid disorders, and medication reaction (steroids, Oral Contraceptive Pills, statins, some anti-hypertensives). If any of these are present, manage them first before starting medication for depression. Refer when management for this condition is not possible from the health center.

Rule out the presence of manic episode in the past. If there are symptoms like extremely expansive, elated or irritable mood, increased activity and extreme talkativeness, flight of ideas, decreased need for sleep, grandiosity, extreme distractibility or reckless behavior for a duration of at least a week, mania should be suspected and the patient should be referred for further management.

Special considerations:

It is very common in general health clinics for patient with depression to present with multiple physical complaints like non-specific aches and pains, dizziness, tingling *(jham-jham)* sensation of body. Prescription of multi-vitamins without elaborate history taking is not fruitful for the patient.

Depression can also be seen in children and old age population. These cases need to be referred whenever possible as special considerations need to be taken during management.

If the symptoms of depression start during pregnancy, within a month of delivery of a child (post-partum depression) or in a lactating mother, they need to be referred for further management. When people are currently exposed to severe adversity (eg. grief), symptoms may be similar to depression, there should be **impairment in daily functioning** to make a diagnosis of depression.

Risk of suicide:

Risk of suicide needs to be assessed in every person suspected of having mental health issues. It should **always** be asked when depression is suspected as a large portion of suicide is caused due to underlying depression. It is not true that asking about suicide initiates a person to commit suicide. Always ask about suicidal ideas/thoughts, plan or previous suicide attempts. Inform family members about risk of suicide and ask for close monitoring of the patient, including removal of harmful objects. Serious risk of suicide is an indication for admission, so refer to a hospital with psychiatric care.

Management of depression:

Note: Re-confirm that there is no past history of mania before starting anti-depressants

Management with antidepressants (SSRI- Selective Serotonin Reuptake inhibitor):

Capsule Fluoxetine 10 mg should be started **in the morning, after food** and increased to 20 mg after a week. Evaluate after 6 weeks and continue same dose if symptom of depression start decreasing. If there is no change in the symptoms even after 6 weeks, patient should be referred.

For MBBS doctors: Dose of Fluoxetine can be gradually increased by 10 mg every 6 weeks for a **maximum up to 40 mg.** It is important to wait for 6 weeks at every dose to assess the effectiveness of the dose. Refer if treatment seems ineffective even at 40 mg/day.

- When insomnia or severe restlessness is present: Add Tab. Diazepam 5mg PO HS along with fluoxetine. Decrease the dose to 2.5mg after 1 week and then stop Diazepam within 2 weeks. Do not give diazepam for more than 2 weeks.
- Stop the medication and refer whenever there are symptoms of mania.

Total duration of treatment:

Medication should be given for 9 more months after the symptoms improve significantly.

Decrease the dose by 10 mg every 4 weeks and stop the medication. If symptoms restart, refer.

Side effects of Fluoxetine:

Common Side effects	Restlessness, nervousness, insomnia, anorexia gastrointestinal disturbances, headache, sexual dysfunction
Serious side –effects	marked / prolonged akathisia , bleeding abnormalities in those who regularly use aspirin and other non-steroidal anti-inflammatory drug

Refer in case of prolonged or serious side-effects.

Psychosocial management:

If symptoms are present but not enough to make a diagnosis of depression, psychosocial support itself may be enough for treatment. Even when medications are started, psychosocial support needs to be provided to the patient.

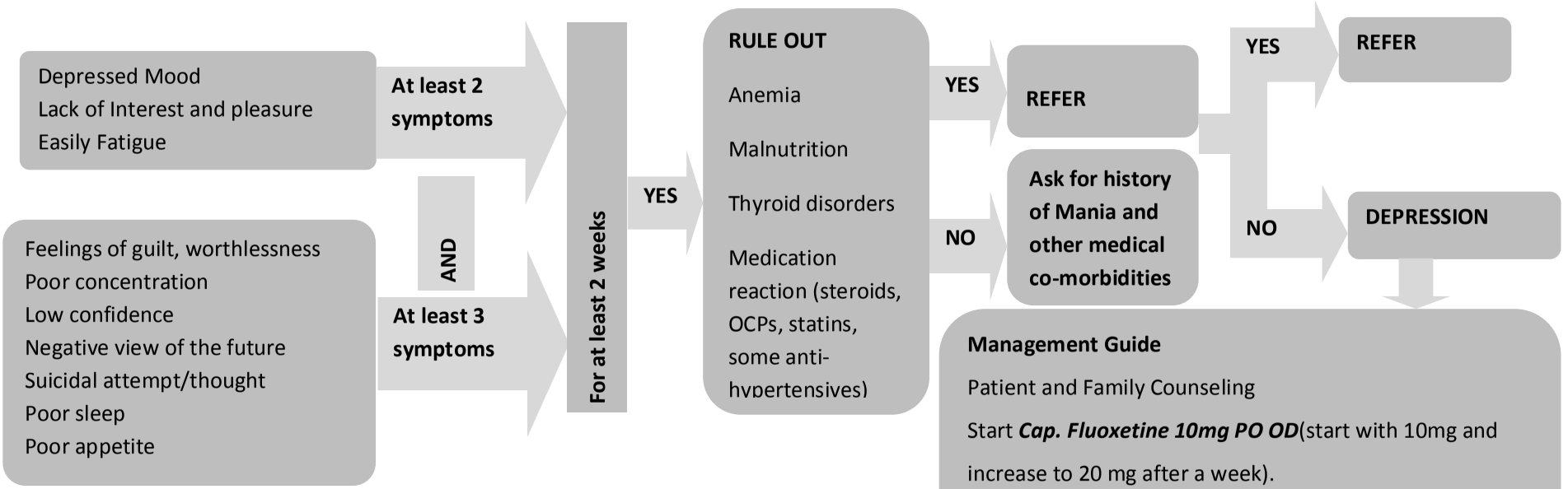
Advice to patient and family members relating to depression:

1. Symptoms of depression are not a result of patient's laziness or lack of effort. It is a disease and the symptoms cannot be controlled by patient's will-power.
2. Mention of suicidal ideation should always be taken seriously and immediately followed up.
3. Patient should be encouraged to continue regular sleep routine and physical activity routine.
4. Patient should also be encouraged to take part in activities that they used to enjoy even if they do not currently do so.
5. Treatment is effective in most of the patients, but will take a few weeks to show the desired effects.
6. Ensure the intake of medications

Addressing the current psychosocial stressors:

1. Provide the opportunity for the patient to talk about their current stressors. Ask them about their understanding of the cause of the stressors.
2. If there are issues of abuse, contact local centers/ resources to try to manage it.
3. Help the patient to cope with the current stressors. Involve the support system that the patient already has, such as- friends, family or local groups.
4. Encourage moderate physical activity (Example: 45 minute walk, 3 times a week). Find out the daily activity of the patient and advice physical activity accordingly. It can be started with shorter duration of activity which can gradually be increased.

Flowchart for the case management of Depression



Management Guide

Patient and Family Counseling

Start ***Cap. Fluoxetine 10mg PO OD***(start with 10mg and increase to 20 mg after a week).

For MBBS doctors: If no signs of improvement even after 4-6 weeks of 20mg/day, it can be increased gradually up to 40 mg. If still not improved, REFER

If insomnia or severe restlessness is present:

Cap Fluoxetine + ***Tab. Diazepam 5-10mg PO HS***, gradually taper and **stop Diazepam, within 2 weeks**

Treatment Duration

Continue the medicine for 9 **months after the symptoms have improved. Gradually taper and stop.**

More than one episode – Refer for evaluation.

Maintenance treatment can be done from the health

SUICIDE:

There is a significant risk of suicide in a patient with mental health issues, especially depression.

Risk of suicide should be assessed in every patient.

If there is serious risk of suicide, family member should be advised to remove harmful objects and keep constant vigilance.

Note: If a Patient on Fluoxetine presents withsymptoms of Mania, then **HOLD** Fluoxetine and **REFER**

REFER IF CHILDREN, OLD AGE, PREGNANT OR LACTATING FEMALE

Part Three:
EPILEPSY

Epilepsy

Epilepsy is a chronic condition, characterized by recurrent unprovoked seizures in a timeframe of longer than 24 hours. It has several causes; it may be genetic or may occur in people with past history of birth trauma, brain infection or head injury. In many cases no specific cause may be identified.

Seizures are caused by abnormal, excessive electrical activity in a group of brain cells. Seizures can be convulsive or non-convulsive. Non convulsive seizure may have symptoms like change in awareness, behavior, emotion or senses (such as taste, smell, vision or hearing) which are similar to mental health conditions and may be confused with them.

Convulsive seizure is associated with greater morbidity and mortality. **This section will only deal with Generalized Tonic Clonic Seizures (GTCS)** which are easier to diagnose and treat at primary care level.

Symptom profile of Generalised Tonic Clonic Seizure (GTCS):

Pre-ictal stage: Aura might be present in some cases with some uneasiness, autonomic or sensory symptoms which precedes the ictal stage, usually few minutes before the seizure starts.

Ictal stage: Tonic muscle contraction of whole body with loss of consciousness may cause the person to fall. It is followed by a clonic phase with alternating rigidity and relaxation of muscles. There will be jerky movement of muscles associated with frothing of saliva, and sometimes bowel and bladder incontinence. There will be up-rolling of eye and injuries may be sustained in the tongue and lip. This stage will last for a few minutes. It the duration exceeds 5 minutes, status epilepticus needs to be considered and referral advised.

Post-ictal phase: After the tonic, clonic phase the patient may sleep or have a period of confusion and drowsiness. Patient may wake up with headache or bodyache. Post ictal phase may usually last up to an hour.

To diagnose epilepsy:

There should be at least 2 episodes of unprovoked seizures. Fever, meningeal signs, head trauma, metabolic abnormality and substance use or withdrawal should have been evaluated and ruled out (Referral is needed for seizure due to such acute causes).

Special considerations:

At least one specialist visit and neuro-imaging is recommended if feasible. Focal Seizures: Any seizure involving a focal part of the body needs to be referred for thorough evaluation.

Febrile Seizure: Febrile seizure should be managed conservatively.

Pregnancy: Look for signs of eclampsia and then refer.

Absence seizures: Some children may have episodes of seizure where they will look as if they are daydreaming for few seconds with alteration of consciousness. Refer if absence seizure is suspected.

Refer when: FOCAL SEIZURE, younger than 2 years of age, or regression of developmental milestones seen in children, and pregnant females.

Pharmacological management:

Acute Seizure Management:

1. Check and maintain airway, breathing and circulation of the patient.
2. Protect the person from injury (Holding and restraining the patient tightly to prevent convulsive movement can cause fracture so should not be done).
3. Put the patient in left lateral position to prevent aspiration
4. Do not put anything in the patient's mouth
5. Give IV Glucose slowly: 30 drops/min

For Adults – Start IV Diazepam 10mg slowly (Over 10 minutes)

For Children– *IV Diazepam 0.2-0.5mg/kg* slowly, for a maximum up to 10mg

If there is no IV access DO NOT GIVE IM, instead give the same dose PER RECTAL (Push the drug per rectal after removing the needle from the syringe which has been prepared for IV administration).

Status Epilepticus (Seizure lasting more than 5 minutes, or recurrent seizures without regaining of consciousness in between the episode of seizures):

Dose of Diazepam can be repeated after 10 minutes of first dose, then referral is advised.

Maintenance with anti-epileptic medication:

1. Initiate treatment with only one drug.
2. Start with low dose and slowly increase to the maintenance dose (start low, go slow)
3. Ask the patient and family members to maintain a record of seizure events in systematic manner (seizure diary)

Maintenance can be done with **Tablet carbamazepine:**

Dose given 2 times a day

Starting dose:

Children: 5 mg /kg /day

Adult: 200 mg / day

Maintenance dose: (Gradually increase from the starting dose to reach the maintenance dose over a week)

Children: 10 – 30mg / kg / day (**Refer to MBBS doctors** if dose needs to exceed 800mg/day)

Adult: 400 – 800 mg / day (**For MBBS doctors**: Can be increased up to 1400mg/day)

Maintenance can be done with **Tablet sodium valproate:**

Dose given 2 times a day

Starting dose:

Children: 15-20 mg /kg /day

Adult: 400 mg / day

Maintenance dose: (Gradually increase from the starting dose to reach the maintenance dose over a week)

Children: 15- 30 mg / kg / day (**Refer to MBBS Doctors** if dose needs to exceed 1200mg/day)

Adult: 400 – 1200 mg / day (**For MBBS Doctors:** Can be increased to a maximum of 2000mg/day)

NOTE: Prescribe tablet Folic acid 5mg daily along with anti-epileptics especially if it is women of childbearing age

If there is recurrence of seizure when maintenance dose has been reached:

Ask about any missed drug doses, alteration in sleep or eating pattern, any other physical illness or stressful life events.

If no such events have taken place, drug dose can be increased within the range of maintenance dose.

If seizure does not stop with the upper range of maintenance dose, refer.

Treatment duration:

Continue for at least 2 more years from the date of last seizure.

While discontinuing the drug after 2 years, medication can be gradually decreased in dose every 2-4 weeks and stopped within 2 months.

If patient had already been treated with antiepileptic drugs in the past too, longer duration of treatment is needed, referral may be needed. Some need lifelong treatment.

Side effects of carbamazepine:

Common Side effects	Blurred vision, diplopia (double vision), ataxia (staggering gait), gastrointestinal side effects
Serious side –effects	**Bone Marrow depression:** If patient gets fever or repeated infections, anemia, bleeding problems, stop drug immediately and **refer** to hospital. **Skin Rashes**: Stop the drug immediately and **refer.**

Side effects of sodium valproate:

Common Side effects	Nausea, Sedation, tremor (dose dependent), transient hair loss, weight gain, hepatic dysfunction, gastrointestinal side effects
Serious side –effects	**Confusion, Thrombocytopenia, leucopenia, red blood hypoplasia, pancreatitis, appearance of jaundice/ fulminant hepatic failure: refer**

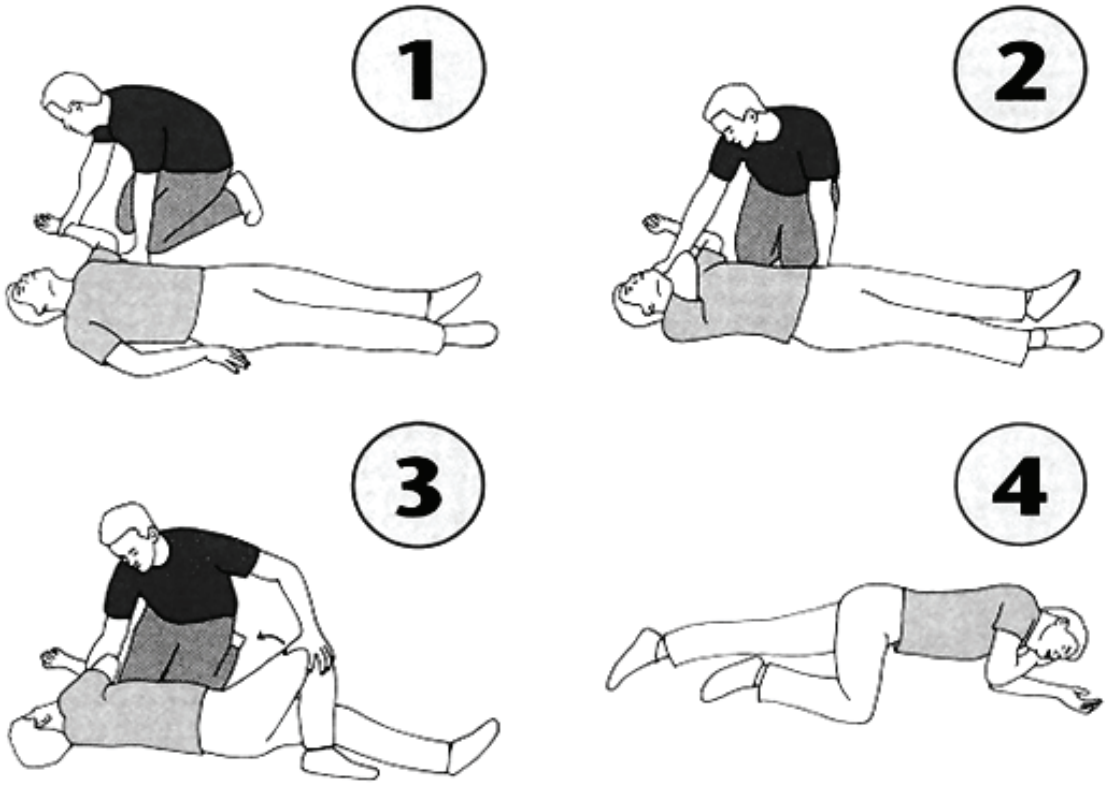
Advice to patient and family members relating to epilepsy:

1. Epilepsy is a neurological condition. It is not contagious.
2. Medicine should be taken regularly and at the same time every day without missing a single dose.
3. Activities like cooking in open fire, swimming alone, driving, climbing high up, working with heavy machinery and going to places with flash lights should be avoided.
4. Children with epilepsy should be allowed to continue school.
5. Using alcohol or any addictive substances should be avoided. Sleeping and eating routinely is advised.

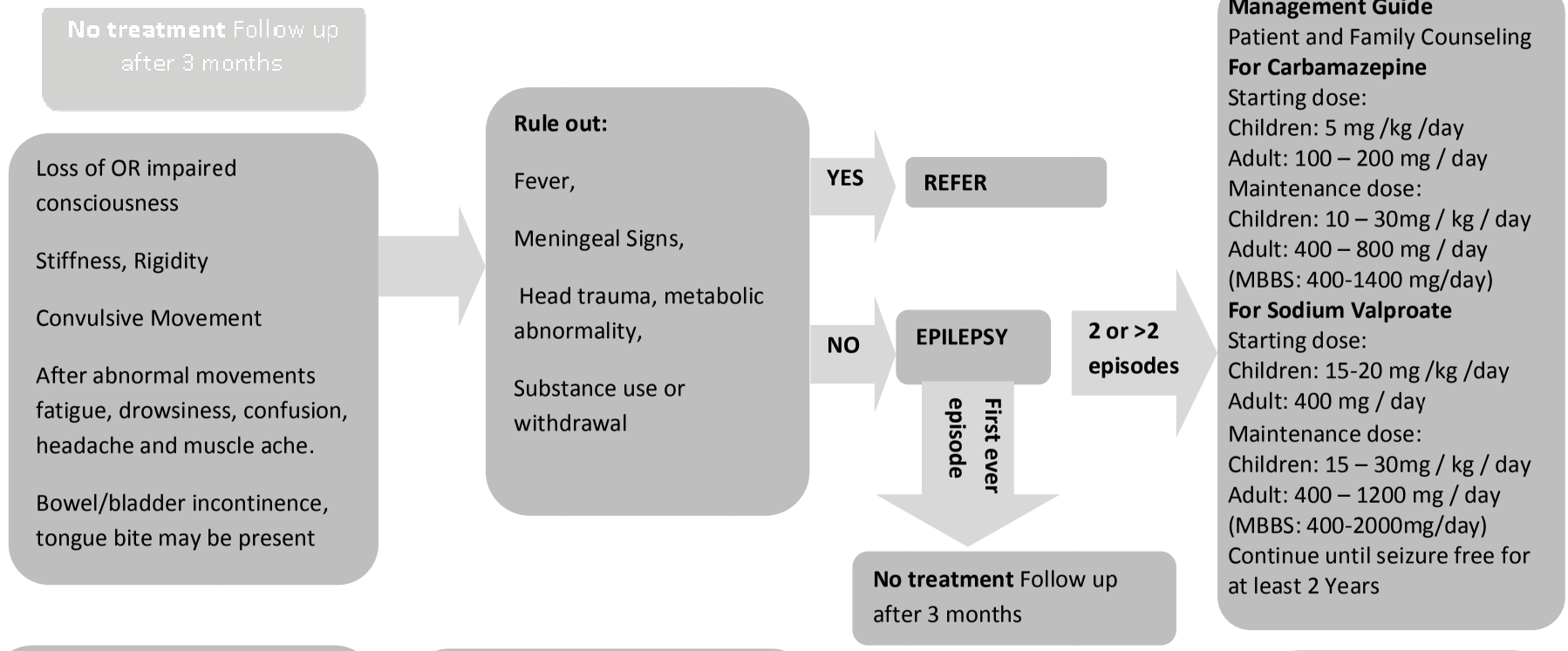
Precaution to be taken at home in case a seizure occurs

1. Lay the person down, on their side and in a safe space (recovery position/ left lateral position).
2. Make sure that the person is breathing properly.
3. Do not try to restrain or put anything in the person during seizure
4. Stay with the person until he/she gains consciousness.

Illustration of Recovery Position to be kept in case of Acute Seizure:



Flowchart for the case management of Epilepsy



Simple Febrile Seizure: Assess the severity, manage fever and follow up.

Complex Febrile Seizure: Secure ABC, **REFER**

Pregnancy: Look for signs of Eclampsia, **REFER**

ALWAYS EXPLAIN THE RISK AND BENEFIT OF MEDICATION BEFORE PRESCRIBING.

Acute Seizure Management:
IV Glucose slowly, 30 drops/min
Adult - IV Diazepam 10mgslowly
Children– *IV Diazepam 0.2-0.5mg/kg* slowly, max 10mg
If there is no IV access DO NOT GIVE IM, instead give PER RECTAL.
Status Epilepticus:
Repeat the first dose of Diazepam after 10 minutes, REFER

Side Effects of Carbamazepine:

Life-threatening side effects:
Bone Marrow depression: If patient gets fever or repeated infections, anemia, bleeding problems, stop drug immediately and **REFER** to hospital.

Skin Rashes: Stop the drug immediately and **REFER.**

Referral to a specialist at least once is advised (maintenance treatment should be started when indicated).
Neuroimaging is needed when: less than 2 years of age, developmental regression, onset after 30 years of age.

Part Four:
PSYCHOSIS

Psychosis

It is a kind of severe mental disorder which is characterized by distortion of thinking and sensory perceptions. It can also have inappropriate or narrow range of emotion. There is a loss of touch with reality.

Symptoms:

- Delusion: These are false beliefs which are so fixed that the patient will continue believing in them even when proofs are provided against it. These beliefs cannot be explained on the basis of patient's socio-cultural or educational background. For example: Belief that people are trying to harm him/her, belief that the spouse is unfaithful to them, belief that people are spying on them, etc.
- Hallucination: These are sensory perceptions even in the absence of a stimuli (while awake and conscious). For example: hearing voices when no-one is speaking, seeing things when nothing is actually present.
- Incoherent or disorganized speech
- Disorganized behavior
- Social withdrawal and neglect of usual responsibilities at home, work or social activities

To diagnose a case of psychosis:

At least 2 or more symptoms from the above list should be present persistently

Special considerations:

Delirium, drug/alcohol intoxication or withdrawal, head trauma, side effects of medicines, infectious disease (such as- malaria, encephalitis, HIV etc.) should always be ruled out as acute organic causes can also show psychotic symptoms. Treatment of the primary medical condition should be done immediately and referred when needed.

Referral is needed in:

Children, elderly, pregnant or lactating mother.

Psychotic symptoms present with depression or mania.

Pharmacological management with antipsychotic medication:

Start with *Tab Risperidone 1mg PO HS, increase to 1mg PO BD after 2 days.* Evaluate the improvement after 4 weeks. If symptoms have started improving, continue the same dose.

If symptoms are not improved, dose can be improved up to 2mg PO BD. (Typical effective dose is 2-4 mg per day).

Refer if symptoms still not improved.

Treatment Duration

If it is the first episode of psychosis: Continue treatment with regular follow-ups for at least 1-2 years after the resolution of symptoms.

Risperidone can be tapered gradually and stopped. Current dose is decreased to half the dose for 2 more weeks, then stopped if no significant distress is noticed. If possible, it is advised to consult with a psychiatrist while attempting to decrease or discontinue the drug.

If it is a case of recurrence of psychosis or chronic psychosis, treatment for longer duration is needed. Consultation with a psychiatrist is needed. Follow up at the primary health care level during routine maintenance can be done.

Side effects of Risperidone:

Common Side effects

Dry mouth, dizziness, weight gain G.I disturbance,
EPS (Tremor, rigidity, akathsia) weight gain, increased prolactin level (breast engorgement, galactorrhoea, amenorrhoea, gynaecomastia), Sexual dysfunction

Serious side –effects

Acute dystonia, Tardive dyskinesia

For the treatment of Extra Pyramidal Syndrome (EPS) or Acute Dystonic Reaction:

If possible, dose can be slightly reduced.

Add Tablet Trihexyphenidyl 2mg TDS immediately. Continue for 6 weeks. After 6 weeks decrease the dose to BD for 1 week, then stop.

If symptoms recur or are severely distressing, refer to higher center.

For acutely agitated patients:

Tablet/Injection Diazepam 5-10 mg can be given for symptom control.

Severely agitated and violent patients usually require admission and hence need referral to a hospital with psychiatric care.

Psychosocial management:

Patient with psychosis are at high risk of human rights violation. They need constant psychosocial support for a good recovery.

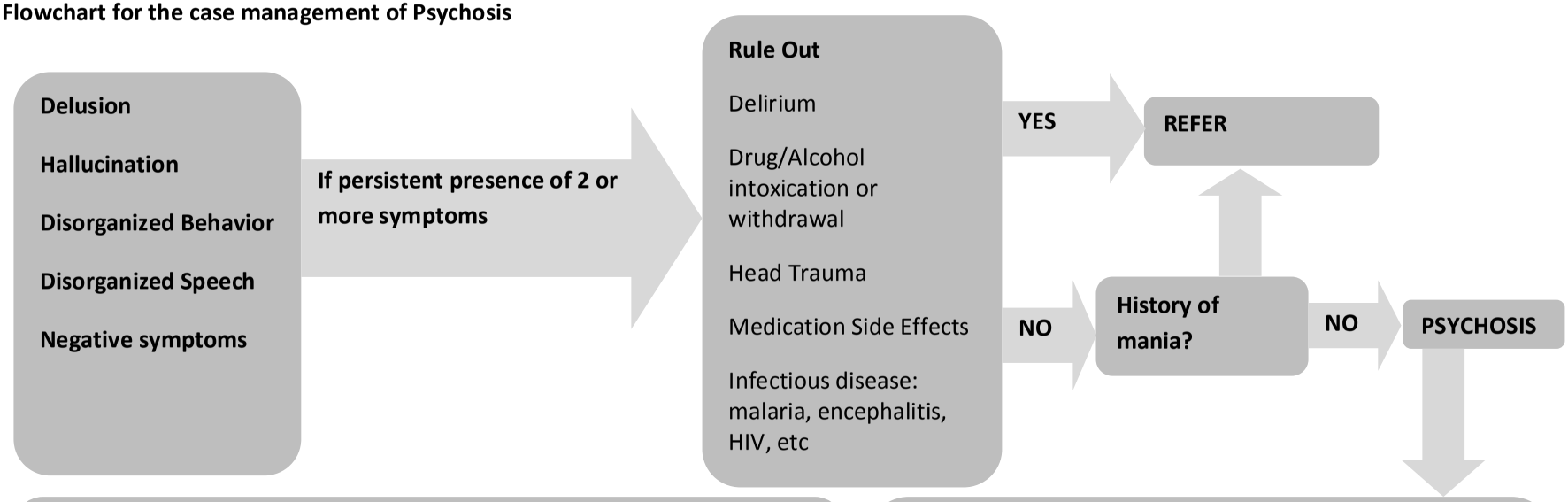
Advice to patient and family members:

1. This is a disorder like any other and people can recover with the aid of medication.
2. Following routine activities and being involved in family and social activity helps in the recovery process.
3. Physical activity should be done regularly.
4. Medication needs to be taken regularly.
5. Follow up needs to be done regularly.

Advice to family members relating to psychosis:

1. Delusional beliefs and unusual experiences of patients should neither be challenged nor supported. Doing so might increase chances of confrontation and increase agitation in patients.
2. Patients with psychosis may not believe that they are ill.
3. Patients' actions are a result of illness and not under their control.
4. Risk of self-harm, harm to others and suicide should be considered seriously during acute stage. Admission might be needed in some.
5. Family should avoid expressing constant criticism and hostility towards the patient. This hampers recovery process severely.
6. Involving in community and social activity is very beneficial for the patient.
7. Being involved in a job or meaningful activity is advised. But high stress working or living environment may hamper recovery.

Flowchart for the case management of Psychosis



Side Effect of Risperidone
Weight gain
Dry mouth
Increased prolactin: changes in menstrual cycle, galactorrhoea
Extra Pyramidal Syndrome (EPS) or Acute Dystonic Reaction: - Muscle stiffness, rigidity, -->start ***trihexyphenidyl 2mg TDS*** immediately
Tardive dyskinesia (involuntary uncontrollable movements especially of the mouth, tongue, trunk, and limbs →**REFER**

IF IT IS A CHILD, ELDERLY, PREGNANT OR LACTATING FEMALE: REFER

Management Guide

Patient and Family Counseling
Start ***Tab Risperidone 1mg PO OD*** increased to ***1mg PO BD*** after 2 days and evaluate the improvement after 4-6 weeks. If symptoms not improved, dose can be improved up to **2mg PO BD**.(Typical effective dose is 2-4 mg per day). Refer if symptoms still not improved.

Treatment Duration
Continue treatment with ongoing monitoring for at least 1-2 years after the resolution of symptoms. It is advised to consult with a psychiatrist (if possible) while attempting to

Part Five:

ANXIETY DISORDER

Anxiety disorder

Anxiety Disorder is one of the most common disorder with which patients present to a primary health care set-up. We are referring to Generalized Anxiety Disorder in this document which is the most common type of anxiety disorder.

Symptoms of anxiety disorder:

- Generalised and persistent anxiety (i.e. anxiety occurring everywhere "free floating")
- Apprehension (worries about future misfortunes, feeling "on edge", difficulty in concentrating, etc.)
- Motor tension (restless fidgeting, tension headaches, trembling, inability to relax)
- Autonomic overactivity (lightheadedness, sweating, tachycardia or tachypnoea, epigastric discomfort, dizziness, dry mouth, etc.).
- May be accompanied by irritability, disturbed sleep, increased emotional sensitivity etc.

To diagnose a case of anxiety disorder:

Most of the symptoms listed above should be present on **most days** for at least **several weeks** at a time, and **usually for several months** affecting daily activity and behavior.

Neurological disorders, cardiac diseases, anemia, thyroid disorders, nutritional deficiency states, hypoglycemia, febrile illness/chronic conditions, alcohol and drug withdrawal should be ruled out. If any physical cause is suspected, referral needs to be considered.

Special considerations:

It is very common in general health clinics for patient with anxiety disorder to present with multiple physical complaints like non-specific aches and pains, dizziness, tingling *(jham-jham)* sensation of body. If a patient has multiple healthcare center visits, has been evaluated multiple times with all the relevant investigations which are normal, anxiety disorder needs to be considered and thorough evaluation done.

Management of anxiety disorder

Psychosocial management:

1. If only few of the symptoms are present and it has not caused impairment in daily functioning, psychosocial support and relaxation techniques itself may be enough for treatment.
2. Even when medication is started, psychosocial support needs to be provided to the patient.

Advice to patient and family members:

1. Continuing daily routine activities is helpful.
2. Physical exercise should also be done regularly.
3. Learning relaxation techniques and doing them in stressful situation helps relieve the symptom. See below for further details.

Pharmacological management with anti-depressant drugs:

Start ***Cap. Fluoxetine 10mg PO OD***. If there are no signs of improvement even after 4-6 weeks, dose can be increased to 20 mg/day. If still not improved with 20 mg/day after 4-6 weeks, referral may be needed**.**

For MBBS doctors: Dose can be increased up to 40 mg/day, with careful assessment of drug efficacy every 4-6 weeks

Consultation with psychiatrist can be done to increase dose more than 20 mg, after which regular follow up for maintenance phase can be done from primary health care set-up itself.

For more information on fluoxetine, refer to the section on depression.

Diazepam can also be added for initial 2 weeks as in depression when insomnia or restlessness is present.

Total duration of treatment:

Treatment for **4-6 weeks** then follow up, if symptoms have started improving continue same dose.

Continue the medicine for **at least 9-12 months after the symptoms have improved significantly.**

Conversion disorder

Sometimes symptoms resembling neurological disorders may have psychological etiology. Among them Psychogenic Non Epileptic Seizures (PNES) are very common in Nepal. Patient will become unresponsive- sometimes for hours, but physical evaluation and investigations will show everything to be normal. These kind of unresponsive episodes usually DO NOT occur after falling asleep and will rarely have injury associated. They usually occur in specific set-up, for example only at school, only after stressful situations, etc.

Different set of symptoms might be present like

- Paralysis, blindness and mutism are most common symptoms.
- Sensory symptoms: anesthesia and paresthesia Unilateral or Bilateral
- Motor symptoms: abnormal movement, gait disturbance, weakness, paralysis.
- Seizure like episode
- Depression and anxiety disorder symptoms often accompany the symptoms of Conversion Disorder.

- Secondary gain: miss/avoid work, gain attention/ sympathy but unconsciously

Special considerations:

It is advisable to rule out any neurological condition from a higher center when there is doubt. Subsequent management can be done from the primary health care set-up when neurological conditions have been ruled out.

Differences between true seizure and PNES (Conversion Disorder)

Seizure	**PNES (Conversion Disorder)**
Typical symptom presentation that is similar in every episode	Symptom presentation may change from episode to episode
Lasts mostly for a number of minutes	Lasts mostly for a number of hours
Can occur even during sleep	Does not usually occur after during sleep
Bowel, bladder incontinence may be present	Bowel, bladder incontinence is usually not present
Injuries may be sustained during the episodes	Injuries are generally not sustained

Management of conversion disorder:

Psychosocial management:

Conversion disorders are mostly managed by counseling and psychological methods.

Conversion disorders have some underlying stressors of life which the patient is having difficulty managing. In case of vulnerable groups like women and children, sometimes collaboration with welfare organizations may be needed. In most of the cases, we can help the patients by talking about problem solving techniques and relaxation techniques.

Advice to patient and family members relating to conversion disorder:

1. This is a non-lethal disorder and cannot by itself cause any long term consequence or disability.
2. If any such episodes occur, the patient should be kept in a private and peaceful area. Crowd should not be allowed to disturb the patient and no interactions or discussions should be attempted with the patient during such episodes. However, when the patient is able to communicate, a conversation with trusted family members or care-takers should be initiated to know about the stressor and what needs to be done about such stressors. Secondary gain should be cut down.
3. When it occurs in a group of people like in school children, the management steps are the same as for individual cases. It should be kept in mind that whenever possible, in cases of such mass conversion disorder, individual cases need to be kept in a separate private space and the primary caregivers should avoid panicking and creating an anxious

environment. The parents and the teachers should be educated about this condition and stressor can be brought out from any of the sources. Interview and counselling of the cases should be done on individual basis. The stressor should be addressed and secondary gains should be cut down. After the event subsides group education about the illness can be given.

4. Regular sessions of psychosocial support are required

Note: As anxiety disorder is frequently associated with conversion disorder, it needs to be evaluated for and treated with medication when necessary.

Specific psychosocial techniques that help in stress management:

Problem solving techniques:

1. We can use problem-solving techniques to help the person address major stressors. When stressors cannot be solved or reduced, problem-solving techniques may be used to identify ways to cope with the stressor.
2. In general, we should not give direct advice. We should try to encourage the person to develop their own solutions.

Stress management:

1. Ventilation is important.
2. Identify and develop positive ways to relax (e.g. listening to music, playing sports, etc.).
3. Teach the person and the carers specific stress management techniques (e.g. breathing exercises)

Relaxation exercise: instruction for slow breathing technique

I am going to teach you how to breathe in a way that will help relax your body and your mind. It will take some practice before you feel the full benefits of this breathing technique.

The reason this strategy focuses on breathing is because when we feel stressed our breathing becomes fast and shallow, making us feel tenser. To begin to relax, you need to start by changing your breathing.

Before we start, we will relax the body. Gently shake and loosen your arms and legs. Let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.

Now place one hand on your belly and the other hand on your upper chest. I want you to imagine you have a balloon in your stomach and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach. [Demonstrate breathing from the stomach – try and exaggerate the pushing out and in of your stomach]

Ok, now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out; then breathe in. If you can, try and breathe in through your nose and out through your mouth.

Great! Now the second step is to slow the rate of your breathing down. So we are going to take three seconds to breathe in, then two seconds to hold your breath, and three seconds to breathe out. I will count with you. You may close your eyes or keep them open.

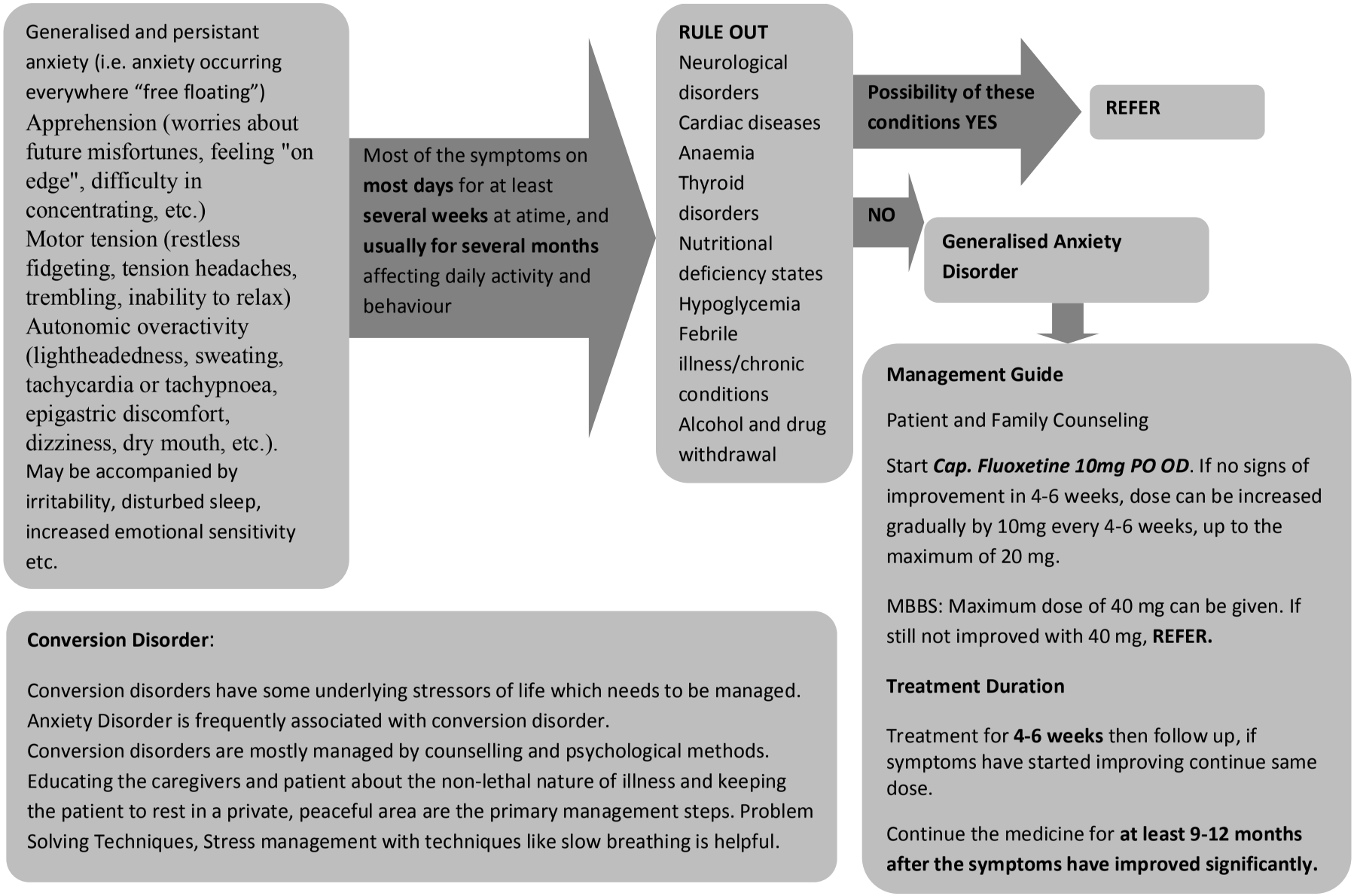
Ok, so breathe in, 1, 2, 3. Hold, 1, 2. And breathe out, 1, 2, 3. Do you notice how slowly I count?

[Repeat this breathing exercise for approximately one minute]

That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down when you are stressed.

Ok, now try on your own for one minute.

Flowchart for the case management of Generalised Anxiety Disorder



Conversion Disorder:

Conversion disorders have some underlying stressors of life which needs to be managed. Anxiety Disorder is frequently associated with conversion disorder.
Conversion disorders are mostly managed by counselling and psychological methods. Educating the caregivers and patient about the non-lethal nature of illness and keeping the patient to rest in a private, peaceful area are the primary management steps. Problem Solving Techniques, Stress management with techniques like slow breathing is helpful.

Part Six:

ALCOHOL USE DISORDER

Alcohol use disorder

Alcohol Use disorder is fairly common in our society. Though it is a big public health concern, alcohol use disorder is still taken as a moral flaw rather than a disease condition, because of which many people who could be treated even from a primary health care set-up are being deprived of basic care. This section will deal with methods to help people who have alcohol use disorder.

Criteria to diagnose alcohol dependence:

1. Craving: A strong compulsion to take alcohol
2. Loss of control: drinking longer and more than intended
3. Development of tolerance (increased amount of alcohol is required to achieve effects previously produced by lesser amount)
4. Withdrawal symptoms when alcohol use has ceased or reduced
    - Tremor
    - Headache
    - Nausea and vomiting
    - Sweating
    - Palpitation
    - Seizure
    - Disorientation
    - Hallucination
5. Continued use of alcohol despite harm: liver damage, mental illness, etc.
6. Progressive neglect of alternate activities or interests due to alcohol use

To diagnose alcohol dependence:

If a person taking alcohol has 3 or more features from the criteria listed above for at least 1 month within previous year, it can be diagnosed as alcohol dependence.

Special considerations:

If seizure, acute confusion, disorientation, hallucination, meningeal signs, head injury, metabolic abnormality, acute wernicke's encephalopathy (confusion, ataxia, ophthalmoplegia) , respiratory rate > 22/min or less than 10/min, heart Rate>120 or <60, BP: systolic blood pressure > 160mmHg or < 90mmHg; diastolic Blood Pressure > 100mgHg or < 40mmHg, severe Headache, asterixis, violent behavior toward self or others, thoughts of suicide or self-harm are present, patient should be referred to higher center.

If the person consumes alcohol but does not meet the criteria for dependence, we should evaluate whether their alcohol use puts them at risk of harm by taking history about the quantity and frequency of drinking. If the patient has consumed 5 or more standard drinks (or 60g alcohol) on any given occasion in the last 12 months, drinks on average more than

two drinks per day, drinks every day of the week then it can be taken as **harmful or hazardous use of alcohol** and should be provided with counselling and kept on regular follow up.

There are high chances of co-morbid physical and mental illness with alcohol use disorders. Evaluation should be thorough and referral should be done when needed.

Management of alcohol use disorder:

Psychosocial management:

While talking to the patient:

1. Talk about whether or not alcohol use seems like a problem to the patient
2. Talk about what the patient regards as the pros and cons of drinking alcohol
3. Repeat the consultation many times till the patient acknowledges the need to get help for alcohol use disorders.
4. Once the patient decides to stop alcohol intake, continue follow up consultations to maintain his motivation
5. Advise the patient to avoid situation and scenarios which tempts him to take alcohol.
6. Teach him/her how to say no if there is significant social/peer pressure on him/her to drink. Role play to teach him/her to say no if needed.

Advice to patient and family members relating to alcohol use disorders:

1. Biological mechanisms play a role in Alcohol use disorders and should not be seen as moral failure of the patient.
2. Suddenly stopping or decreasing the amount of alcohol intake can cause withdrawal symptoms, so it is better to consult health workers while stopping alcohol intake.
3. It is advised to avoid situation and scenarios in which the person starts taking alcohol
4. Frequent follow up and support from family members are essential in the treatment process.
5. Involvement in community and social activity should be encouraged.

Pharmacological management for alcohol dependence:

Note: Admission for detoxification between 7-10 days is the ideal option. However, following management can be initiated even when admission is not possible after warning the patient about the risk of taking medication and alcohol together and arranging follow-up visit every 2 days (at least).

Start Tab. Thiamine 100 mg PO OD or BD and continue for 3- 6 months

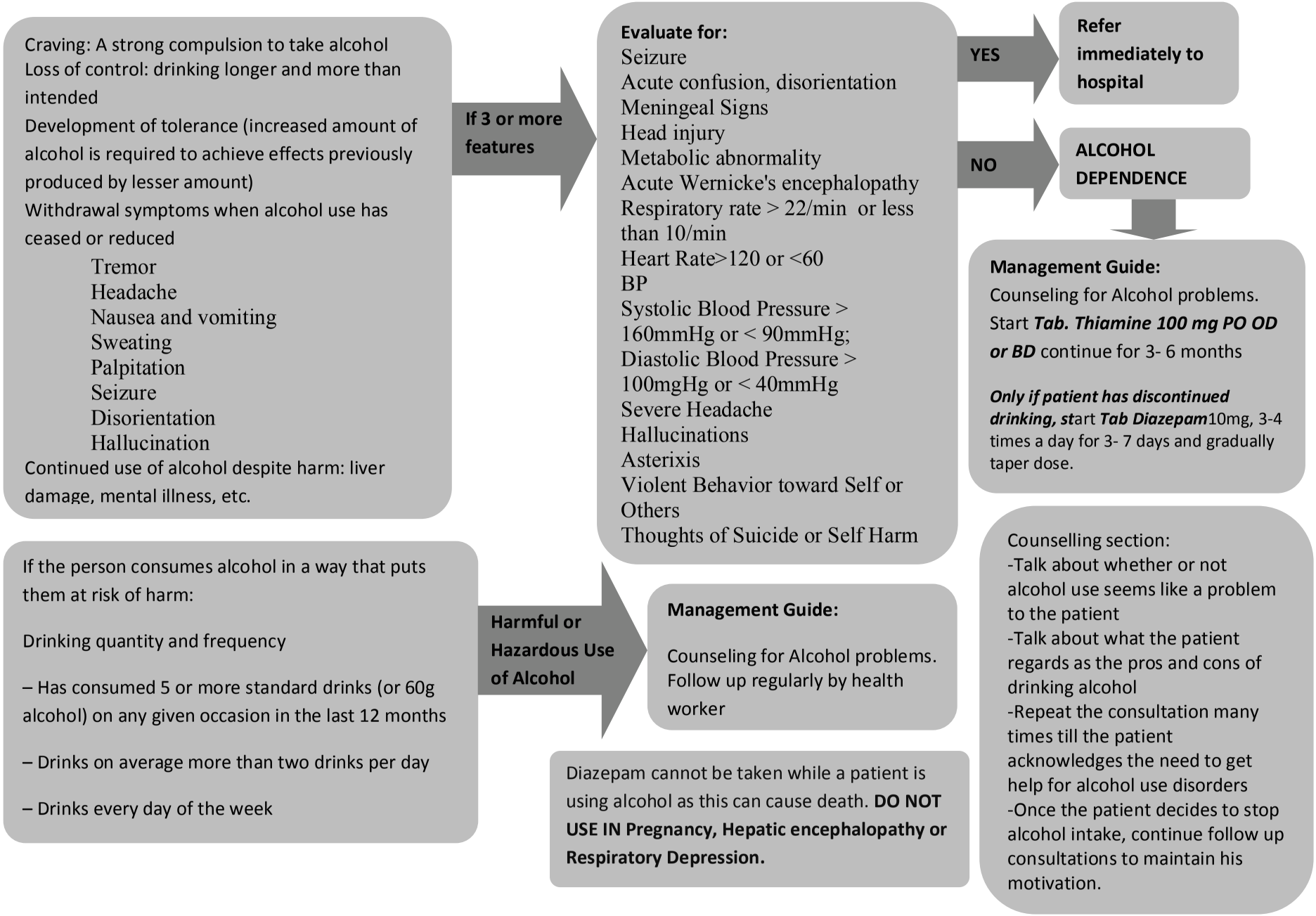
As there will be withdrawal symptoms in patients with alcohol dependence, diazepam can be used to decrease withdrawal symptoms and assist in easy detoxification.

- Start Tab Diazepam 10mg, 3 times a day (Do not start diazepam when the patient is already in an intoxicated state as it increases the chance of respiratory depression).
- Decrease the dose to 10 mg BD after 2 days, then 10 mg HS for next 2 days and then stop. If the patient is still distressed with the recommended dose, refer to the nearest health facility with psychiatric care.

Side effects of Diazepam

Common Side effects	Sedation, muscle pain, amnesia
Serious side –effects	Respiratory distress, Clouding of consciousness
Contraindications	Known respiratory disease, Hepatic encephalopathy (characterized by confusion), Pregnancy

Flowchart for the case management of Alcohol Use Disorder



Part Seven:

INFORMATION ON MEDICATION AND DOCUMENTATION

Medications for Mental Disorders

	Fluoxetine	**Risperidone**	**Carbamazepine**	**Sodium Valproate**	**Diazepam**	**Trihexyphenidyl**
Start with	10 mg per day	1 mg per day	Children: 5 mg /kg /day Adult: 100 – 200 mg / day	Children: 15-20mg/ kg/ day Adult:400 mg/day	10 mg 3-4 times a day	2mg 2-3 times a day
Maintain at	20-mg per day MBBS: up to 40mg/day	2-4 mg per day	Children: 10 – 30mg / kg / day Adult: 400 – 800 mg / day MBBS: 400-1400mg/day	Children: 15-30mg/kg/day Adult: 400-1200mg/day MBBS: 400-2000mg/day	Gradually taper within 1 week	4-6mg
How to take the drug	In the morning, after food. Total duration: 9-12 months after symptoms start improving significantly	1-2 times a day after food	Twice a day after food **Note:** Add prophylactic folate(Tablet Folate 5mg) for women of child bearing age Total Duration: 2 years after the last day of seizure	2-3 times a day after food **Note:** Add prophylactic folate(Tablet Folate 5mg) for women of child bearing age Total Duration: 2 years after the last day of seizure	3-4 times a day after food	2-3 times a day after food
Common Side effects	Restlessness, nervousness, insomnia, anorexia gastrointestinal disturbances, headache, sexual dysfunction	Dry mouth, dizziness, weight gain G.I disturbance, EPS (Tremor, rigidity, akathisia) weight gain, Increased serum prolactin level	Blurred vision, diplopia (double vision), ataxia (staggering gait) and nausea	Nausea, Sedation, tremor (dose dependent), transient hair loss, weight gain, hepatic dysfunction	Sedation, muscle pain, amnesia	Sedation, Confusion, Memory disturbance (especially in elderly)

Serious side - effects	marked / prolonged akathisia , bleeding abnormalities in those who regularly use aspirin and other non-steroidal anti-inflammatory drug	Acute dystonia Tardive dyskinesia	Allergic skin reactions Bone Marrow Depression	Confusion, Thrombocytopenia, leucopenia, red blood hypoplasia, pancreatitis, fulminant hepatic failure	Respiratory distress, Clouding of consciousness	Angle closure glaucoma, Myasthenia gravis, Gastrointestinal obstruction
Contraindications	Risk of Mania in Bipolar depression		Known skin reaction	Known hepatic dysfunction **Note:** Advised to perform full blood count and liver function test before starting medication	Known respiratory disease, Hepatic encephalopathy (characterized by confusion), Pregnancy	Confusion, Disorientation, Delirium
	Refer when it is a child (except in epilepsy), pregnant female or someone with multiple co-morbid diseases					

Psychiatry referral form for tertiary care

Patient Information **Date:** _____

Name: _____ Age: _____Sex: _____

Address: _____ Marital Status: _____

Phone: _____

Provisional Diagnosis:

Reason for Referral:

If treatment given, please list the patient's past/ current psychiatric medications

Does the patient have any current or past safety issues?

☐None ☐Suicidal ☐Homicidal ☐Violent ☐Other safety issues

Any adverse drug reaction? ☐Yes ☐No

Current or past substance abuse or dependence?☐Alcohol ☐Other drugs

Mention if patient has other medical problems? ☐Yes ☐No

If "Yes" mention the problems

Referred to

Signature and Date

Name
Phone
Designation

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The Final Workshop on Draft of Standard Treatment Protocol was successfully completed on 2073/07/05 focusing on feedback collection. The officials who attended the workshop are as follows:

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3	Dr. Jaya Regmee	TPO Nepal
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14	Balkrishna Khakurel	DDA
15	Dr. Suman Aryal	Mental Hospital

विशेष अनुरोध

१. यो पुस्तक मानसिक स्वास्थ्य कार्यक्रम संचालन भएका सबै स्वास्थ्य संस्थाहरुलाई सम्बन्धित जिल्ला जन-स्वास्थ्य कार्यालय मार्फत उपलब्ध गराइने छ । यसरी उपलब्ध गराईएको सो पुस्तकमा आफ्नो स्वास्थ्य संस्थाको नाम र छाप भित्रि पानामा प्रष्टसंग लेख्नु पर्नेछ । यसरी उपलब्ध गराइएको पुस्तक सम्बन्धित स्वास्थ्य संस्थामा अनिवार्य रुपमा राख्नु पर्नेछ ।माथिल्लो निकायबाट सुपरिवेक्षण तथा अनुगमन गर्न आएको समयमा यो पुस्तक स्वास्थ्य संस्थामा उपलब्ध हुनुपर्नेछ ।

२. यो पुस्तकको विषयबस्तु सम्बन्धमा केही प्रतिक्रिया भएमा यस महाशाखामा पत्राचार गरी जानकारी गराउन हुन अनुरोध गरिन्छ । साथै यस महाशाखाको इमेल phcrd.teku@gmail.com वा smdaud61@gmail.comमा इमेल पठाईदिनु हुन समेत अनुरोध गरिन्छ । तपाईको प्रतिक्रियाबाट यस पुस्तकको परिमार्जनमा थप सहयोग पुग्न जाने विश्वास लिइएको छ ।