

Clinical Management
of Mental, Neurological and Substance Use Conditions
in Humanitarian Emergencies

mhGAP Humanitarian Intervention Guide (mhGAP-HIG)



mental health Global Action Programme



World Health
Organization



UNHCR
The UN Refugee Agency

WHO Library Cataloguing-in-Publication Data

mhGAP Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies.

1.Mental Disorders. 2.Substance-related Disorders. 3.Nervous System Diseases. 4.Relief Work. 5.Emergencies. I.World Health Organization. II.UNHCR.

ISBN 978 92 4 154892 2

(NLM classification: WM 30)

© World Health Organization 2015

All rights reserved. Publications of the World Health Organization are available on the WHO website (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be addressed to WHO Press through the WHO website (www.who.int/about/licensing/copyright_form/en/index.html).

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Suggested citation: World Health Organization and United Nations High Commissioner for Refugees. *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*. Geneva: WHO, 2015.

Contact for feedback and communication: Department of Mental Health and Substance Abuse at WHO (mhgap-info@who.int) or the Public Health Section at UNHCR (HQPHN@unhcr.org)

Foreword

Today, the world is facing an unprecedented number of humanitarian emergencies arising from armed conflicts and natural disasters. The number of refugees and internally displaced persons has not been so high since the end of World War II. Tens of millions of people – especially in the Middle East, Africa and Asia – are in urgent need of assistance. This includes services that are capable of addressing the population's heightened mental health needs.

Adults and children affected by emergencies experience a substantial and diverse range of mental, substance use, and neurological problems. Grief and acute distress affect most people, and are considered to be natural, transient psychological responses to extreme adversity. However, for a minority of the population, extreme adversity triggers mental health problems such as depressive disorder, post-traumatic stress disorder, or prolonged grief disorder – all of which can severely undermine daily functioning. In addition, people with severe pre-existing conditions such as psychosis, intellectual disability, and epilepsy become even more vulnerable. This can be due to displacement, abandonment, and lack of access to health services. Finally, alcohol and drug use pose serious risks for health problems and gender-based violence. At the same time that the population's mental health needs are significantly increased, local mental health-care resources are often lacking. Within such contexts, practical and easy-to-use tools are needed more than ever.

This guide was developed with these challenges in mind. The *mhGAP Humanitarian Intervention Guide* is a simple, practical tool that aims to support general health facilities in areas affected by humanitarian emergencies in assessing and managing mental, neurological and substance use conditions. It is adapted from WHO's *mhGAP Intervention Guide (2010)*, a widely-used evidence-based manual for the management of these conditions in non-specialized health settings, and tailored for use in humanitarian emergencies.

This guide is fully consistent with the *Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings* and the *UNHCR Operational Guidance for Mental Health and Psychosocial Support in Refugee Operations*, which call for a multisectoral response to address the mental health and social consequences of humanitarian emergencies and displacement. It also helps realize a primary objective of the *WHO Comprehensive Mental Health Action Plan 2013-2020*, namely to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

We call upon all humanitarian partners in the health sector to adopt and disseminate this important guide, to help reduce suffering and increase the ability of adults and children with mental health needs to cope in humanitarian emergency settings.



Margaret Chan
Director-General
World Health Organization



António Guterres
United Nations High Commissioner for Refugees

Table of Contents

Acknowledgements	iv
Introduction	1
Advice for Clinic Managers	3
General Principles of Care for People with Mental, Neurological and Substance Use Conditions in Humanitarian Settings (GPC)	5
1. Principles of Communication	5
2. Principles of Assessment	6
3. Principles of Management	7
4. Principles of Reducing Stress and Strengthening Social Support.	8
5. Principles of Protection of Human Rights	10
6. Principles of Attention to Overall Well-being	11
Modules	
1. Acute Stress (ACU)	13
2. Grief (GRI)	17
3. Moderate-severe Depressive Disorder (DEP)	21
4. Post-traumatic Stress Disorder (PTSD)	27
5. Psychosis (PSY)	31
6. Epilepsy/Seizures (EPI)	35
7. Intellectual Disability (ID).	41
8. Harmful Use of Alcohol and Drugs (SUB)	45
9. Suicide (SUI)	49
10. Other Significant Mental Health Complaints (OTH)	53
Annexes	
Annex 1: UNHCR (2014) Health Information System (HIS) Case Definitions	56
Annex 2: Glossary	57
Annex 3: Symptom Index	60

Acknowledgements

Conceptualization

Mark van Ommeren (WHO), Yutaro Setoya (WHO), Peter Ventevogel (UNHCR) and Khalid Saeed (WHO), under the direction of Shekhar Saxena (WHO) and Marian Schilperoord (UNHCR)

Project Writing and Editorial Team

Peter Ventevogel (UNHCR), Ka Young Park (Harvard Kennedy School) and Mark van Ommeren (WHO)

WHO mhGAP Review Team

Nicolas Clark, Natalie Drew, Tarun Dua, Alexandra Fleischmann, Shekhar Saxena, Chiara Servili, Yutaro Setoya, Mark van Ommeren, Alexandra Wright and M. Taghi Yasamy

Other Contributors/Reviewers

Helal Uddin Ahmed (National Institute of Mental Health, Bangladesh), Corrado Barbui (WHO Collaborating Centre for Research and Training in Mental Health, University of Verona), Thomas Barrett (University of Denver), Pierre Bastin (International Committee of the Red Cross), Myron Belfer (Harvard Medical School), Margriet Blaauw (IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings), Boris Budosan (Malteser International), Kenneth Carswell (WHO), Jorge Castilla (ECHO-European Commission), Vanessa Cavallera (WHO), Elizabeth Centeno-Tablante (WHO), Lukas Cheney (University of Melbourne), Rachel Cohen (Common Threads), Ana Cuadra (Médecins du Monde, MdM), Katie Dawson (University of New South Wales), Joop de Jong (University of Amsterdam), Pamela Dix (Disaster Action), Frederique Drogoul (Médecins Sans Frontière, MSF), Carolina Echeverri (UNHCR), Rabih El Chammay (Ministry of Public Health Lebanon), Mohamed Elshazly (International Medical Corps, IMC), Michael First (Columbia University), Richard Garfield (Centers for Disease Control and Prevention, CDC), Anna Golaz (University of Geneva), David Goldberg (King's College London), Marlene Goodfriend (MSF), Margaret Grigg (MIND Australia), Norman Gustavson (PARSA Afghanistan), Fahmy Hanna (WHO), Mathijs Hoogstad (in non-affiliated capacity, the Netherlands), Peter Hughes (Royal College of Psychiatrists, United Kingdom), Takashi Izutsu (World Bank), Lynne Jones (Harvard School of Public Health), Devora Kestel (Pan American Health Association/WHO), Louiza Khourta (UNHCR), Cary Kogan (University of Ottawa), Roos Korste (in2mentalhealth, the Netherlands), Marc Laporta (McGill University), Jaak Le Roy (in non-affiliated capacity, Belgium), Barbara Lopes-Cardozo (CDC), Ido Lurie (Physicians for Human Rights-Israel), Andreas Maercker (University of Zürich), Heini Mäkilä (International Assistance Mission, Afghanistan), Adelheid Marschang (WHO), Carmen Martínez-Viciano (MSF), Jessie Mbwambo (Muhimbili University of Health and Allied Sciences, Tanzania), Fernanda Menna Barreto Krum (MdM), Andrew Mohanraj (CBM, Malaysia), Emilio Ovuga (Gulu University, Uganda), Sarah Pais (WHO), Heather Papowitz (UNICEF), Xavier Pereira (Taylor's University School of Medicine and Health Equity Initiatives, Malaysia), Pau Perez-Sales (Hospital La Paz, Spain), Giovanni Pintaldi (MSF), Bhava Poudyal (in non-affiliated capacity, Azerbaijan), Rasha Rahman (WHO), Ando Raobelison (World Vision International), Nick Rose (Oxford University), Cecile Rousseau (McGill University), Khalid Saeed (WHO), Benedetto Saraceno (Universidade Nova de Lisboa, Portugal), Alison Schafer (World Vision International), Nathalie Severy (MSF), Yasuko Shinazaki (MdM), Derrick Silove (University of New South Wales), Stephanie Smith (Partners in Health), Leslie Snider (War Trauma Foundation), Yuriko Suzuki (National Institute of Mental Health, Japan), Saji Thomas (UNICEF), Ana María Tijerino (MSF), Wietse Tol (Johns Hopkins University and Peter C Alderman Foundation), Senop Tschakarjan (MdM), Bharat Visa (WHO), Inka Weissbecker (IMC), Nana Wiedemann (International Federation of Red Cross and Red Crescent Societies) and William Yule (King's College London).

Funding

United Nations High Commissioner for Refugees (UNHCR)

Design

Elena Cherchi

Introduction

This guide is an adaptation of the *WHO mhGAP Intervention Guide (mhGAP-IG) for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings* for use in humanitarian emergencies. Accordingly, it is called the *mhGAP Humanitarian Intervention Guide (mhGAP-HIG)*.

What is mhGAP?

The *mental health Gap Action Programme (mhGAP)* is a WHO programme that seeks to address the **lack of care** for people suffering from mental, neurological and substance use (MNS) conditions. As part of this programme, the *mhGAP Intervention Guide (mhGAP-IG)* was issued in 2010. *mhGAP-IG* is a clinical guide on mental, neurological and substance use disorders for **general health-care providers** who work in **non-specialized health-care settings**, particularly in low- and middle-income countries.

These include general physicians, nurses, midwives and clinical officers, as well as physicians specialized in areas other than psychiatry or neurology.

In addition to clinical guidance, the *mhGAP* programme provides a range of tools to support programme implementation useful for situational analysis, adaptations of clinical protocols to local contexts, programme planning, training, supervision and monitoring.¹

Why is there a need for adaptation to humanitarian emergency contexts?

Humanitarian emergencies include a **broad range of acute and chronic emergency settings** arising from armed conflicts and both natural and industrial disasters. Humanitarian emergencies often involve mass displacement of people. In these settings, the population's need for basic services overwhelms local capacity, as the local system may have been damaged by the emergency. Resources vary depending on the extent and availability of local, national and international humanitarian assistance.

Humanitarian crises pose a set of challenges as well as unique opportunities for providers of health services. Opportunities include increased political will and resources to address and improve mental health services.²

Challenges include:

- » Heightened urgency to prioritize and allocate scarce resources
- » Limited time to train health-care providers
- » Limited access to specialists (for training, supervision, mentoring, referrals or consultations)
- » Limited access to medications due to disruption of usual supply chain.

The *mhGAP Humanitarian Intervention Guide* was developed in order to address these specific challenges of humanitarian emergency settings.

Contents of this guide

The *mhGAP Humanitarian Intervention Guide* contains **first-line management recommendations** for MNS conditions for non-specialist health-care providers in humanitarian emergencies where **access to specialists and treatment options is limited**.

This guide extracts essential information from the full *mhGAP-IG* and includes additional elements specific to humanitarian emergency contexts.

This guide covers:

- » Advice for clinic managers;
- » General principles of care applicable to humanitarian emergency settings, including:
 - ♦ Provision of multi-sectoral support in accordance with the *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007), *Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations* (UNHCR, 2013) and other emergency-related tools;
 - ♦ Instructions on stress reduction;
- » Brief modules on the assessment and management of:
 - ♦ Acute stress (ACU)
 - ♦ Grief (GRI)
 - ♦ Moderate-severe depressive disorder (DEP)
 - ♦ Post-traumatic stress disorder (PTSD)
 - ♦ Psychosis (PSY)
 - ♦ Epilepsy/seizures (EPI)
 - ♦ Intellectual disability (ID)
 - ♦ Harmful use of alcohol and drugs (SUB)
 - ♦ Suicide (SUI)
 - ♦ Other significant mental health complaints (OTH).

Other changes include the following:

- » Guidance on conduct disorder was rewritten as guidance on behavioural problems in adolescents, found in the module on other significant mental health complaints (OTH).
- » The module *Assessment and Management of Conditions Specifically Related to Stress: mhGAP Intervention Guide Module* (WHO, 2013) was separated into 3 modules: acute stress (ACU), grief (GRI) and post-traumatic stress disorder (PTSD).
- » A glossary has been added. Terms marked with the asterisk symbol * are defined in Annex 2.

This guide is considerably shorter in length compared with the *mhGAP-IG*. It does not contain guidance on:

- » Alcohol and drug intoxication and dependence* (however, alcohol withdrawal and harmful alcohol and drug use are covered in this guide);
- » Attention deficit hyperactivity disorder (however, adolescent behavioural problems are covered in this guide's module on other significant mental health complaints);
- » Autism-spectrum disorders;
- » Dementia (however, support for carers of people with any MNS condition is covered in this guide's *General Principles of Care*);
- » Non-imminent risk of self-harm;
- » Second-line treatments for most MNS conditions.

Guidance on these latter topics continues to be available in the full *mhGAP-IG*.

¹ Email mhgap-info@who.int to obtain a copy of these tools.

² See World Health Organization (WHO). *Building back better: sustainable mental health care after emergencies*. WHO: Geneva, 2013.

Advice for Clinic Managers

The integration of mental, neurological and substance use (MNS) conditions in general health care needs to be overseen by a leader (e.g. district-level public health officer, agency medical director, etc.) who is responsible for designing and coordinating care in a number of health facilities, based on relevant situation analyses (see *WHO & UNHCR [2012] assessment toolkit*). Each facility has a clinic manager (head of the health facility) with specific responsibilities. Clinic managers need to consider the following points.

Environment

- » Arrange for a **private space**, preferably a separate room, to do consultations for MNS conditions. If a separate room is not available, try to divide the room using curtains or other means in order to optimize privacy.
- » Consider having the room unmarked, in order to prevent avoidance of MNS services out of fear of social stigma.

Service model

- » Consider having at least one trained staff member be physically present at any given time on “MNS duty”, i.e. a person who is assigned to assess and manage people with MNS conditions.
- » Alternatively, consider holding a weekly or twice-weekly “MNS clinic” within the general health facility, at a time of the day when the clinic is less busy. If people show up during non-MNS clinic times, they could gently be asked to come back when the clinic is being held. Setting up such MNS clinics can be helpful in busy health facilities, especially for conducting initial assessments that typically take longer than follow-up visits.

Staffing and training

- » Brief all staff about providing a **supportive atmosphere** for people with MNS conditions.
- » Identify staff members to be trained on MNS care.
- » Ensure that resources are available not only for the training but also for supervision. Clinical **supervision** of staff is an essential part of good MNS care.
- » If only a few staff can be trained on the contents of this guide, then ensure that the rest of the clinical staff can offer psychological first aid (PFA)* at the least. Orientation on PFA can be provided in approximately half a day. *The Psychological First Aid Guide for Field Workers* and accompanying *Orientation materials* for facilitators can be found online.
- » Orient the receptionist (or person with similar role) on how to deal with agitated people who may demand or require immediate attention.
- » Train community workers and volunteers, if available, on how to (a) raise awareness about MNS care (see below), (b) help people with MNS conditions to seek help at the clinic and (c) assist with follow-up care.
- » Consider assigning someone in the health-care team (e.g. a nurse, a psychosocial worker, a community social worker) to be trained and supervised to provide **psychosocial support** (e.g. providing brief psychological treatments, running self-help groups, teaching stress management).
- » Orient all staff on **local protection arrangements**:
 - ♦ Requirements for and limitations of consent, including reporting around suspected child abuse, sexual and gender-based violence and other human rights violations;
 - ♦ Identifying, tracing and reuniting families. Separated children in particular must be protected and referred to appropriate temporary care arrangements, if needed.
- » If international mental health professionals are attached to the clinic to provide supervision, they should be briefed about the local culture and context.
- » Orient all staff on how to refer to available services.

Referral

- » Ensure that the clinic has an updated contact list for referrals for the care of MNS conditions.
- » Ensure that the clinic has an updated contact list for other available sources of support in the region (e.g. basic needs such as shelter and food aid, social and community resources and services, protection and legal support).

Raising awareness around available services

- » Prepare messages for the community about available MNS care (e.g. purpose and importance of MNS care, services available at the clinic, clinic location and hours).
- » Discuss the messages with community leaders.
- » Utilise various information distribution channels, e.g. radio, posters at health clinics, community workers or other community resources who can inform the general population.
- » Where appropriate, consider discussing the messages with local indigenous and traditional healing practitioners who may be providing care for people with MNS conditions and who may be willing to collaborate and refer certain cases (for guidance, see Action Sheet 6.4 of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* [IASC, 2007]).
- » Reach out to marginalized groups who may not be aware of or have access to the clinic.

Medicines

- » Work with relevant decision-makers to ensure a **constant supply of essential medicines**.
- » Ensure availability of:
 - ♦ at least one antipsychotic medicine (tablet and injectable forms)
 - ♦ at least one anti-Parkinsonian medicine (to deal with potential extrapyramidal side effects*) (in tablet form)
 - ♦ at least one anticonvulsant/antiepileptic medicine (tablet form)
 - ♦ at least one antidepressant medicine (tablet form) and
 - ♦ at least one anxiolytic medicine (tablet and injectable forms).
- » You may have access to the *Interagency Emergency Health Kit* (IEHK) (WHO, 2011), a large box with medicines and medical supplies designed to meet the expected primary health-care needs of 10 000 people exposed to major humanitarian emergencies for 3 months.
 - ♦ The following psychotropic medicines are included in the IEHK:
 - ▶ **Amitriptyline** tablets: 25 mg tablet x 4000
 - ▶ **Biperiden** tablets: 2 mg tablet x 400
 - ▶ **Diazepam** tablets: 5 mg tablet x 240
 - ▶ **Diazepam** injections: 5 mg/ml, 2 ml/ampoule x 200
 - ▶ **Haloperidol** tablets: 5 mg tablet x 1300
 - ▶ **Haloperidol** injections: 5 mg/ml; 1 ml/ampoule x 20
 - ▶ **Phenobarbital** tablets: 50 mg x 1000.
 - ♦ The quantity of medicines in the IEHK is not sufficient for programmes that proactively identify and manage epilepsy, psychosis and depression. Additional medicines will need to be ordered.
 - ♦ Over the long term, the necessary quantities of medicines should be informed by actual use.
- » In addition to psychotropic medicines, **atropine** should be available for the clinical management of acute pesticide intoxication, a common form of self-harm. Atropine is contained in the IEHK (1mg/ml, 1 ml/ampoule x 50).
- » Ensure that all medicines are **stored securely**.

Information management

- » **Ensure confidentiality.** Health records should be stored securely.
- » Identify data needed for input into the health information system.
 - ♦ Consider using the UNHCR Health Information System's 7-category neuropsychiatric component for guidance on documenting MNS disorders (see Annex 1).
 - ♦ In large, acute emergencies, public health decision-makers may not be ready to add 7 items to the health information system. In such a situation, at the very least an item labelled "mental, neurological or substance use problem" should be added to the health information system. Over time this item should be replaced with a more detailed system.
- » Collect and analyse the data and report the results to relevant public health decision-makers.

General Principles of Care for People with Mental, Neurological and Substance Use Conditions in Humanitarian Settings

GPC

1. Principles of Communication

In rapidly changing and unpredictable humanitarian environments, health-care providers are under enormous pressure to see as many people as possible in the shortest amount of time. Consultations in health facilities need to be brief, flexible and focused on the most urgent issues. Good communication skills will help health-care providers achieve these goals and will help deliver effective care to adults, adolescents and children with mental, neurological and substance use (MNS) conditions.

» Create an environment that facilitates open communication

- ♦ Meet the person in a **private space**, if possible.
- ♦ Position yourself to be at the **same eye level** as the person (e.g. if the person is sitting, sit down too).
- ♦ **Welcome** the person; introduce yourself and your position/role in a culturally appropriate way.
- ♦ **Acknowledge** everyone present.
- ♦ Ask the person whether he/she wants their carers or other people to stay.
 - Unless the person is a young child, suggest that you would like to talk to the person alone if possible. If the person wants others to stay, respect this.
 - If you see the person alone, seek permission to
 - ask the carers relevant assessment questions to find out their perspective, and
 - involve the carers when the management plan is discussed and agreed.
- ♦ Let the person know that information discussed during the visit will be kept **confidential** and will not be shared without their permission, except when you perceive a risk to the person or to others (note that this message may need to be adapted according to national legal limits on confidentiality).

» Involve the person with the MNS condition as much as possible

- ♦ Even if the person's functioning is impaired, always **try to involve them** in the discussion. This is also true for children, youths and elderly people with MNS conditions. Do not ignore them by talking only with their carers.
- ♦ Always try to **explain** to the person what you are doing (e.g. during physical examination) and what you are going to do.

» Start by listening

- ♦ Allow the person with an MNS condition to speak without interruption. Distressed people may not always give a clear history. When this happens, be patient and ask for clarification. Try not to rush them.
- ♦ Do not press the person to discuss or describe potentially traumatic events* if they do not wish to open up. Simply let them know that you are there to listen.
- ♦ Children may need more time to feel comfortable. Use language that they can understand. Establishing a relationship with children may require talking about their interests (toys, friends, school, etc.).

» Be clear and concise

- ♦ Use language that the person is familiar with. Avoid using technical terms.
- ♦ Stress can impair people's ability to process information. Provide one point at a time to help the person understand what is being said before moving on to the next point.

- ♦ **Summarize and repeat** key points. It can be helpful to ask the person or carers to write down important points. Alternatively, provide a written summary of the key points for the person.

» Respond with sensitivity when people disclose difficult experiences (e.g. sexual assault, violence or self-harm)

- ♦ Let the person know that you will respect the confidentiality of the information.
- ♦ Never belittle the person's feelings or preach or be judgemental.
- ♦ Acknowledge that it may have been difficult for the person to share.
- ♦ If referral to other services is necessary, explain clearly what the next steps will be. Seek the consent of the person to share information with other providers who may be able to help. For example:
 - *You have told me that your neighbour has done something very bad to you. I will not share this with anyone else but I can think of some people who may be able to help you. Is it OK if I discuss your experience with my colleague from agency X?*

» Do not judge people by their behaviours

- ♦ People with severe MNS conditions may demonstrate unusual behaviours. Understand that this may be because of their illness. Stay calm and patient. Never laugh at the person.
 - If the person behaves inappropriately (e.g. **agitated, aggressive, threatening**), look for the source of the problem and suggest solutions. Involve their carers or other staff members in creating a **calm, quiet space**. If they are extremely distressed or agitated, you may need to **prioritize** their consultation and bring them into your consulting space at once.

» If needed, use appropriate interpreters

- ♦ If needed, try to work with trained interpreters, preferably of the same gender as the person with the MNS condition. If a trained interpreter is not available, other health-care staff or carers may interpret, with the consent of the person.
- ♦ In situations where the carer interprets, be aware that the person with the MNS condition may not fully disclose. In addition, conflict of interest between the person and the carer may influence communication. If this becomes an issue, arrange for an appropriate interpreter for future visits.
- ♦ Instruct the interpreter to maintain confidentiality and translate literally, without adding their own thoughts and interpretations.

2. Principles of Assessment

Clinical assessment involves identifying the MNS condition as well as the person's own understanding of the problem(s). It is important also to assess the person's strengths and resources (e.g. social supports). This additional information will help health-care providers offer better care.

It is important to always pay attention to the overall appearance, mood, facial expression, body language and speech of the person with an MNS condition during assessment.

» Explore the presenting complaint

- ♦ *What brings you here today? When and how did the problem start? How did it change over time?*
- ♦ *How do you feel about this problem? Where do you think it came from?*
- ♦ *How does this problem impact on your daily life? How does the problem affect you at school/work or in daily community life?*
- ♦ *What kind of things did you try to solve this problem? Did you try any medication? If so, what kind (e.g. prescribed, non-prescribed, herbal)? What effect did it have?*

» Explore possible family history of MNS conditions

- ♦ *Do you know of anyone in your family who has had a similar problem?*

» Explore the person's general health history

- ♦ Ask about any previous physical health problem:
 - *Have you had any serious health problem in the past?*
 - *Do you have any health problem for which you are currently receiving care?*
- ♦ Ask if the person is taking any medication:
 - *Has a health-care provider prescribed any medication you are supposed to be taking right now?*
 - *What is the name of that medication? Did you bring it with you? How often do you take it?*
- ♦ Ask if the person has ever had an allergic reaction to a medication.

» Explore current stressors, coping strategies and social support

- ♦ *How has your life changed since the ... [state the event that caused the humanitarian crisis]?*
- ♦ *Have you lost a loved one?*
- ♦ *How severe is the stress in your life? How is it affecting you?*
- ♦ *What are your most serious problems right now?*
- ♦ *How do you deal/cope with these problems day by day?*
- ♦ *What kind of support do you have? Do you get help from family, friends or people in the community?*

» Explore possible alcohol and drug use

Questions regarding alcohol and drugs can be perceived as sensitive and even offensive. However, this is an essential component of MNS assessment. Explain to the person that this is part of the assessment and try to ask questions in a non-judgemental and culturally sensitive way.

- ♦ *I need to ask you a few routine questions as part of the assessment. Do you take alcohol (or any other substance known to be a problem in the area)? [If yes] How much per day/week?*
- ♦ *Do you take any tablets when you feel stressed, upset or afraid? Is there anything you use when you have pain? Do you take sleeping tablets? [If yes] How much/many do you take per day/week? Since when?*

» Explore possible suicidal thoughts and suicide attempts

Questions regarding suicide may also be perceived as offensive, but they are also essential questions in an MNS assessment. Try to ask questions in a culturally sensitive and non-judgemental way.

- ♦ You may start with: *What are your hopes for the future?* If the person expresses hopelessness, ask further questions (>> **Box 1** of **SUI** module), such as *Do you feel that life is worth living? Do you think about hurting yourself? or Have you made any plans to end your life? (>> SUI)*

» Conduct a targeted physical examination

- ♦ This should be a focused physical examination, guided by the information found during the MNS assessment. If any physical condition is found at this stage, either manage or refer to appropriate resources.



- » If an MNS condition is suspected, go to the relevant module for assessment.
- » If the person presents with features relevant to more than one MNS condition, then all relevant modules need to be considered.

3. Principles of Management

Many MNS conditions are chronic, requiring long-term monitoring and follow-up. In humanitarian settings, however, continuity of care may be difficult because mental health care is not consistently available or people have been or are about to be displaced. Therefore, it is important to recognize the carers of people with MNS conditions as a valuable resource. They may be able to provide consistent care, support and monitoring throughout the crisis. Carers include anyone who shares responsibility for the well-being of the person with an MNS condition, including family, friends or other trusted people. Increasing the person's and the carer's understanding of the MNS condition, management plan and follow-up plan will enhance adherence.

» Manage both mental and physical conditions in people with MNS conditions

- ♦ Provide information about the condition to the person
 - If the person agrees, also provide the information to the carer.
- ♦ Discuss and determine achievable goals, and develop and agree on a management plan with the person
 - If the person agrees, also involve the carer in this discussion
 - For the proposed management plan, provide information on:
 - expected benefits of treatment;
 - duration of treatment;
 - importance of adhering to treatment, including practising any relevant psychological interventions (e.g. relaxation training) at home and how carers could help;
 - potential side-effects of any medication being prescribed;
 - potential involvement of social workers, case managers, community health workers or other trusted members in the community (>> **Principles of Reducing Stress and Strengthening Social Support** below);
 - prognosis. Maintain a hopeful tone, but be realistic about recovery.
- ♦ Provide information about the financial aspects of the management plan, if relevant.

» Address the person's and the carer's questions and concerns about the management plan

If the person is pregnant or breastfeeding:

- » Avoid prescribing medications that may have potential risks to the fetus, and facilitate access to **antenatal care**.
- » Avoid prescribing medications that may have potential risks to the infant/toddler of a breastfeeding woman. Monitor the baby of a breastfeeding woman who is on any medication. Consider facilitating access to baby-friendly spaces/tents.

» Before the person leaves:

- ♦ Confirm that the person and the carer understand and agree on the management plan (e.g. you may ask both to repeat the essentials of the plan).
- ♦ Encourage self-monitoring of the symptoms and educate the person and carer on when to seek urgent care.
- ♦ Arrange a follow-up visit.
 - Create a follow-up plan, taking into consideration the current humanitarian situation (e.g. fleeing/moving population and disruptions in services).
 - If the person is unlikely to be able to access the same clinic:
 - Provide a brief written management plan and encourage the person to take this to any future clinical visits.
 - Provide contact information for other health-care facilities nearby.
- ♦ Initial follow-up visits should be more frequent until the symptoms begin to respond to treatment.
- ♦ Once the symptoms start improving, less frequent but regular appointments are recommended.
- ♦ Explain that the person can return to the clinic at any time in between follow-up visits if needed (e.g. when experiencing side-effects of medications).

» At each follow-up meeting, assess for:

- ♦ Response to treatment, medication side-effects and adherence to medications and psychosocial interventions. Acknowledge all progress towards the goals and reinforce adherence.
- ♦ General health status. Monitor physical health regularly.
- ♦ Self-care (e.g. diet, hygiene, clothing) and functioning in the person's own environment.
- ♦ Psychosocial issues and/or change in living conditions that can affect management.
- ♦ The person's and the carer's understanding and expectations of the treatment. Correct any misconceptions.
- ♦ Always check the latest contact information, as it can change frequently.

» During the entire follow-up period:

- ♦ Maintain regular contact with the person and their carer. If available, assign a community worker or another trusted person in the community to keep in touch with the person. This person may be a family member.
- ♦ Have a plan of action for when the person does not show up.
 - Try to find out why the person did not return. A community worker or another trusted person can help locate the person (e.g. home visits).
 - If possible, try to address the issue so that the person can return to the clinic.
- ♦ Consult a specialist if the person does not improve.

4. Principles of Reducing Stress and Strengthening Social Support

Reducing stress and strengthening social support is an integral part of MNS treatment in humanitarian settings, where people often experience extremely high levels of stress. This includes not only the stress felt by people with MNS conditions but also the stress felt by their carers and dependants. Stress often contributes to or worsens existing MNS conditions. Social support can diminish many of the adverse effects of stress; therefore, attention to social support is essential. Strengthening social support is also an essential component of protection (>> *Principles of Protection of Human Rights*) and overall well-being of the population affected by humanitarian crises (>> *Principles of Attention to Overall Well-Being*).

» Explore possible stressors and the availability of social support

- ♦ *What is your biggest worry these days?*
- ♦ *How do you deal with this worry?*
- ♦ *What are some of the things that give you comfort, strength and energy?*
- ♦ *Who do you feel most comfortable sharing your problems with? When you are not feeling well, who do you turn to for help or advice?*
- ♦ *How is your relationship with your family? In what way do your family and friends support you and in what way do you feel stressed by them?*

» Be aware of signs of abuse or neglect

- ♦ Be attentive to potential signs of sexual or physical abuse (including domestic violence) in women, children and older people (e.g. unexplained bruises or injuries, excessive fear, reluctance to discuss matters when a family member is present).
- ♦ Be attentive to potential signs of neglect, particularly in children, people living with disability and older people (e.g. malnourishment in a family with access to sufficient food, a child who is overly withdrawn).
- ♦ When signs of abuse or neglect are present, interview the person in a private space to ask if anything hurtful is going on.
- ♦ If you suspect abuse or neglect:
 - Talk immediately with your supervisor to discuss the plan of action.
 - With the person's consent, identify community resources (e.g. trusted legal services and protection networks) for protection.

» Based on information gathered, consider the following strategies:

- ♦ Problem-solving:
 - 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. In general, do not give direct advice. Try to encourage the person to develop their own solutions.
 - When working with children and adolescents, it is essential to assess and address the carer's sources of stress as well.
- ♦ Strengthen social support:
 - Help the person to identify supportive and trusted family members, friends and community members and to think through how each one can be involved in helping.
 - With the person's consent, refer them to other community resources for social support. Social workers, case managers or other trusted people in the community may be able to assist in connecting the person with appropriate resources such as:
 - social or protection services
 - shelter, food and non-food items
 - community centres, self-help and support groups
 - income-generating activities and other vocational activities
 - formal/informal education
 - child-friendly spaces or other structured activities for children and adolescents.

When making a referral, help the person to access them (e.g. provide directions to the location, operating hours, telephone number, etc.) and

provide the person with a short referral note.

♦ Teach stress management:

- Identify and develop positive ways to relax (e.g. listening to music, playing sports, etc.).
- Teach the person and the carers specific stress management techniques (e.g. breathing exercises (>> *Box GPC 2*)).
 - In some settings, you can refer to a health worker (e.g. nurse or psychosocial worker) who can teach these techniques.

» Address stress of the carers

♦ Ask the carer(s) about:

- worries and anxiety around caring for the person with MNS conditions in the current humanitarian emergency situation;
- practical challenges (e.g. burden on the carers' time, freedom, money);
- ability to carry out other daily activities, such as work or participation in community events;
- physical fatigue;
- social support available to the carers:
 - *Are there other people who can help you when you are not able to care for the person (for example, when you are sick or very tired)?*
- psychological well-being. If carers seem distressed or unstable, assess them for MNS conditions (e.g. >> *DEP, SUB*).

♦ After the assessment, try to address the carers' needs and concerns. This may involve:

- giving information;
 - linking the carer with relevant community services and supports;
 - discussing respite care. Another family member or a suitable person can take over the care of the person temporarily while the main carer takes a rest or carries out other important activities;
 - performing problem-solving counselling* and teaching stress management;
 - managing any MNS conditions identified in the carer.
- ♦ Acknowledge that it is stressful to care for people with MNS conditions, but tell the carer that it is important that they continue to do so. Even when this is difficult, carers need to respect the dignity of the people they care for and involve them in making decisions about their own lives as much as possible.

Box GPC 1: Strengthening community supports

In addition to clinical management, **encourage activities that enhance family and community support for everyone, especially marginalized community members.** For further guidance, see *Understanding Community-Based Protection* (UNHCR, 2013) and Action Sheet 5.2 of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007).

Box GPC 2: Relaxation exercise: instructions 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 practise 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.

5. Principles of Protection of Human Rights

People with severe MNS conditions need protection since they are at higher risk of human rights violations. They often experience difficulties in taking care of themselves and their families in addition to facing discrimination in many areas of life, including work, housing and family life. They may have poor access to humanitarian aid. They may experience abuse or neglect in their own families and are often denied opportunities to fully participate in the community. Some people with severe MNS conditions may not be aware that they have a problem that requires care and support.

People with MNS conditions may experience a range of human rights violations during humanitarian emergencies, including:

- » Discrimination in access to basic needs for survival such as food, water, sanitation, shelter, health services, protection and livelihood support;
- » Denial of the right to exercise legal capacity;
- » Lack of access to services for their specific needs;
- » Physical and sexual abuse, exploitation, violence, neglect and arbitrary detention;
- » Abandonment or separation from family during displacement;
- » Abandonment and neglect in institutional settings.

Unfortunately, community protection systems and disability programmes do not always include, and sometimes even actively exclude, protection of people with severe MNS conditions. Health-care providers should therefore actively advocate for and address the gap in protection of these people.

Below are key actions to address the protection of people with MNS conditions living in communities in humanitarian settings.

» Engage the key stakeholders

- ◆ Identify key stakeholders who should be made aware of the protection issues surrounding people with MNS conditions. These key stakeholders include:
 - ▶ people with MNS conditions and their carers;
 - ▶ community leaders (e.g. elected community representatives, community elders, teachers, religious leaders, traditional and spiritual healers);
 - ▶ managers of various services (e.g. protection/security, health, shelter, water and sanitation, nutrition, education, livelihood programmes);
 - ▶ managers of disability services (many disability services inadvertently overlook disability due to MNS conditions);
 - ▶ representatives of community groups (youth or women's groups) and human rights organizations; police and legal authorities.
- ◆ Organize awareness-raising activities for the key stakeholders:
 - ▶ Consider offering orientation workshops on MNS conditions.
 - ▶ Consult people with MNS conditions, their carers and the disability and social service sectors in the design and implementation of awareness-raising activities.
 - ▶ During the awareness raising activities:
 - Educate and dispel misconceptions about people with MNS conditions.
 - Educate on the rights of people with MNS conditions, including equal access to humanitarian aid and protection.
 - Dispel discrimination against people with MNS conditions.
 - Advocate for support for the carers of people with MNS conditions.

» Protect the rights of people with severe MNS conditions in health-care settings

- ◆ Always treat people with MNS conditions with respect and dignity.
- ◆ Ensure that people with MNS conditions have the same access to physical health care as people without MNS conditions.
- ◆ Respect a person's right to refuse health care unless they lack the capacity to make that decision (cf. signed international conventions).
- ◆ Discourage institutionalization. If the person is already institutionalized, advocate for their rights in the institutional setting.

» Promote the integration of people with severe MNS conditions in the community

- ◆ Advocate for the inclusion of people with MNS conditions in livelihood supports, protection programmes and other community activities.
- ◆ Advocate for the inclusion of children with epilepsy and other MNS conditions in mainstream education.
- ◆ Advocate for the inclusion of programmes for children and adults with intellectual disabilities/developmental delay in community disability support programmes.
- ◆ Advocate for maintaining, as far as possible, autonomy and independence for people with MNS conditions.

General principles of protection in humanitarian action are described in the *Sphere Handbook* (Sphere Project, 2011). For additional guidance on the protection of people in mental hospitals/institutions, see Action Sheet 6.3 of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007).

6. Principles of Attention to Overall Well-being

In addition to clinical care, people with MNS conditions need a range of other supports for their overall well-being. This is especially true in humanitarian settings where basic services, social structures, family life and security are often disrupted. People with MNS conditions face extra challenges to their daily routines and basic self-care. The role of health-care providers extends beyond clinical care to advocacy for the overall well-being of people with MNS conditions across multiple sectors, as shown in the IASC Guidelines pyramid (see figure GPC 1).

» **Support people with MNS conditions to safely access services necessary for survival and for a dignified way of living (e.g. water, sanitation, food aid, shelter, livelihoods support).** This may involve:

- ♦ advising about the availability and location of such services;
- ♦ actively referring and working with the social sector to connect people to social services (e.g. social work-type case management);
- ♦ advising about security issues when the person is not sufficiently aware of threats to security.

» **Arrange priority access to relevant activities for people with MNS conditions, such as helping children with such conditions to access child-friendly spaces.**

» **Support the general physical health of people with MNS conditions:**

- ♦ Arrange regular health assessments and vaccinations.
- ♦ Advise about basic self-care (nutrition, physical activity, safe sex, family planning, etc.).

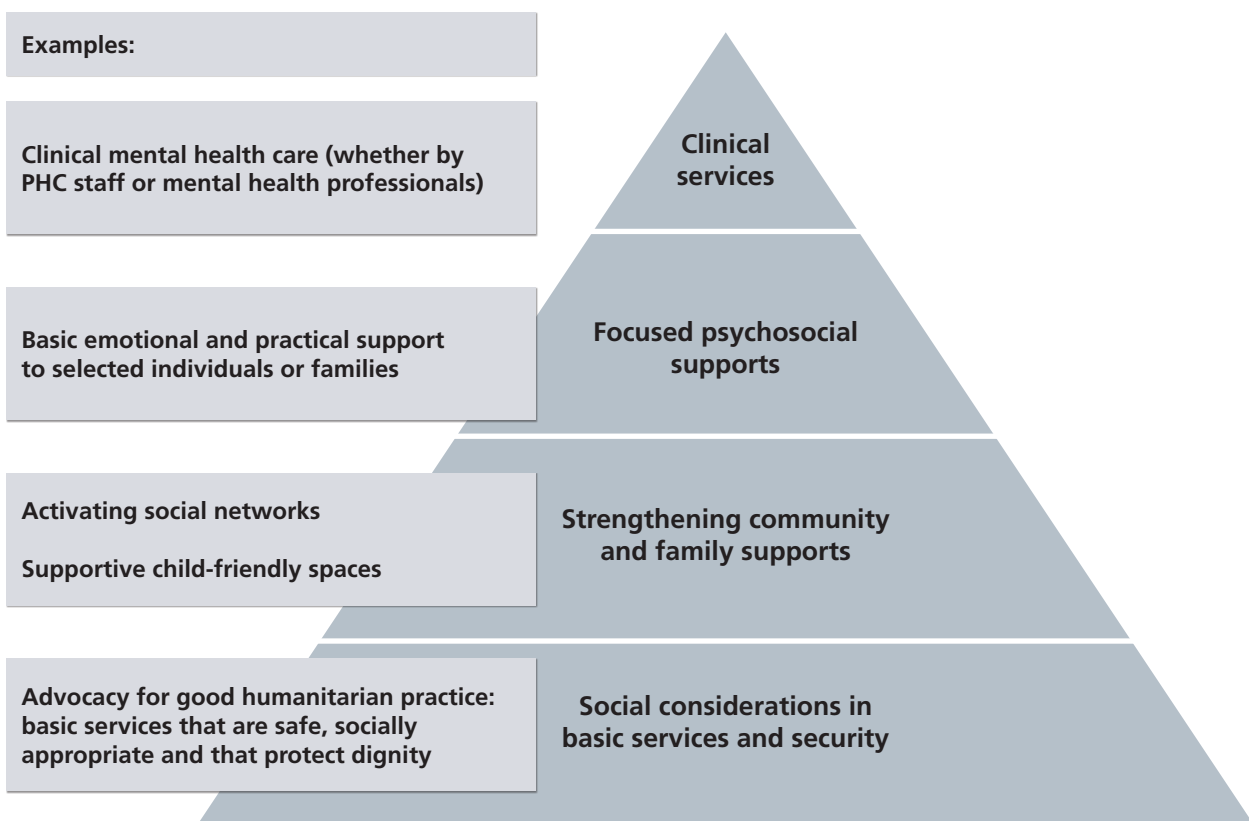


Figure GPC 1. The IASC intervention pyramid for mental health and psychosocial support in emergencies (adapted with permission)

In humanitarian emergencies, adults, adolescents and children are often exposed to potentially traumatic events*. Such events trigger a wide range of emotional, cognitive, behavioural and somatic reactions. Although most reactions are self-limiting and do not become a mental disorder, people with severe reactions are likely to present to health facilities for help.

In many humanitarian emergencies people suffer various combinations of potentially traumatic events and losses; thus they may suffer from both acute stress and grief. The symptoms, assessment and management of acute stress and grief have much in common. However, grief is covered in a separate module (>> *GRI*).

After a recent potentially traumatic event, clinicians need to be able to identify the following:

» Significant symptoms of acute stress (ACU).

People with these symptoms may present with a wide range of non-specific psychological and medically unexplained physical complaints. These symptoms include reactions to a potentially traumatic event **within the last month**, for which people seek help or which causes considerable difficulty with daily functioning, and which does not meet the criteria for other conditions covered in this guide. **The present module covers assessment and management of significant symptoms of acute stress.**

» Post-traumatic stress disorder (>> *PTSD*).

When a characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after a potentially traumatic event and if it causes considerable difficulty with daily functioning, the person may have developed post-traumatic stress disorder.

» Problems and disorders that are more likely to occur after exposure to stressors (e.g. potentially traumatic events) but that could also occur in the absence of such exposure.

These include: moderate-severe depressive disorder (>> *DEP*), psychosis (>> *PSY*), harmful use of alcohol and drugs (>> *SUB*), suicide (>> *SUI*) and other significant mental health complaints (>> *OTH*).

» Reactions that are not clinically significant and that do not require clinical management.

Of all reactions, these are the most common. They include transient reactions for which people do not seek help and which do not impair day-to-day functioning. In these cases, health providers need to be supportive, help address the person's needs and concerns and monitor whether expected natural recovery occurs.

Assessment question 1: Has the person recently experienced a potentially traumatic event?

- » Ask if the person has experienced a **potentially traumatic event**. A potentially traumatic event is any threatening or horrific event such as physical or sexual violence (including domestic violence), witnessing of atrocity, or major accidents or injuries. Consider asking:
 - ♦ *What major stress have you experienced? Has your life been in danger? Have you experienced something that was very frightening or horrific or has made you feel very bad? Do you feel safe at home?*
- » Ask **how much time** has passed since the event(s).
- » Go to assessment question 2 if a potentially traumatic event has occurred within the **last month**.
- » If a major loss (e.g. the death of a loved one) has occurred, also assess for grief (>> **GRI**).
- » If a potentially traumatic event has occurred more than 1 month ago, then consider other conditions covered in this guide (>> **DEP, PTSD, PSY, SUB**).

Assessment question 2: If a potentially traumatic event has occurred within the last month, does the person have significant symptoms of acute stress?

- » Check for:
 - ♦ anxiety about threats related to the traumatic event(s)
 - ♦ sleep problems
 - ♦ concentration problems
 - ♦ recurring frightening dreams, flashbacks* or intrusive memories* of the events, accompanied by intense fear or horror
 - ♦ deliberate avoidance of thoughts, memories, activities or situations that remind the person of the events (e.g. avoiding talking about issues that are reminders, or avoiding going back to places where the events happened)
 - ♦ being “jumpy” or “on edge”; excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements
 - ♦ feeling shocked, dazed or numb, or inability to feel anything
 - ♦ any disturbing emotions (e.g. frequent tearfulness, anger) or thoughts
 - ♦ changes of behaviour such as:
 - ▶ aggression
 - ▶ social isolation and withdrawal
 - ▶ risk-taking behaviours in adolescents
 - ▶ regressive behaviour* such as bedwetting, clinginess or tearfulness in children
 - ♦ hyperventilation (e.g. rapid breathing, shortness of breath)
 - ♦ medically unexplained physical complaints, such as:
 - ▶ palpitations, dizziness
 - ▶ headaches, generalized aches and pains
 - ▶ dissociative symptoms relating to the body (e.g. medically unexplained paralysis*, inability to speak or see, “pseudoseizures”*)
- » **Significant symptoms of acute stress** are likely if the person meets **all** of the following criteria:
 - ♦ a potentially traumatic event has occurred **within approximately 1 month**
 - ♦ the symptoms started **after** the event
 - ♦ considerable difficulty with daily functioning because of the symptoms or seeking help for the symptoms.

Assessment question 3: Is there a concurrent condition?

- » Check for any **physical conditions** that may explain the symptoms, and manage accordingly if found.
- » Check for any other **mental, neurological and substance use (MNS) condition (including depression)** covered in this guide that may explain the symptoms and manage accordingly if found.

Basic Management Plan



DO NOT prescribe medications to manage symptoms of acute stress (unless otherwise noted below).

1. In ALL cases:

- » Provide basic psychosocial support³
 - ♦ **Listen** carefully. DO NOT pressure the person to talk.
 - ♦ **Ask** the person about his/her needs and concerns.
 - ♦ **Help** the person to address basic needs, access services and connect with family and other social supports.
 - ♦ **Protect** the person from (further) harm.
- » Offer additional psychosocial support as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> **General Principles of Care**):
 - ♦ Address **current psychosocial stressors**.
 - ♦ Strengthen social support.
 - ♦ Teach stress management.
- » **Educate** the person about normal reactions to grief and acute stress, e.g.:
 - ♦ *People often have these reactions after such events.*
 - ♦ *In most cases, reactions will reduce over time.*
- » Manage concurrent conditions.

2. In case of sleep problems as a symptom of acute stress, offer the following additional management:

- » Explain that people commonly develop sleep problems (insomnia) after experiencing extreme stress.
- » Explore and address any environmental causes of insomnia (e.g. noise).
- » Explore and address any physical cause of insomnia (e.g. physical pain).
- » Advise on sleep hygiene, including regular sleep routines (e.g. regular times for going to bed and waking up), avoiding coffee, nicotine and alcohol late in the day or before going to bed. Emphasize that alcohol disturbs sleep.
- » Exceptionally, in extremely severe cases where psychologically oriented interventions (e.g. relaxation techniques) are not feasible or not effective, and insomnia causes considerable difficulty with daily functioning, short-term (3–7 days) treatment with benzodiazepines may be considered.
 - ♦ Dose:
 - ▶ For adults, prescribe 2–5 mg of diazepam at bedtime.
 - ▶ For older people, prescribe 1–2.5 mg of diazepam at bedtime.
 - ▶ Check for drug-drug interactions before prescribing diazepam.
 - ▶ Common side-effects of benzodiazepines include drowsiness and muscle weakness.
 - ▶ Caution: benzodiazepines can slow down breathing. Regular monitoring may be necessary.
 - ▶ Caution: benzodiazepines may cause dependence*. Use only for short-term treatment.
 - ♦ Note:
 - ▶ This treatment is for adults only.
 - ▶ Do not prescribe benzodiazepines to children or adolescents.
 - ▶ Avoid this medication in women who are pregnant or breastfeeding.
 - ▶ Monitor for side-effects frequently when using this medication in older people.
 - ▶ This is a temporary solution for an extremely severe sleep problem.
 - ▶ Benzodiazepines should not be used for insomnia caused by bereavement in adults or children.
 - ▶ Benzodiazepines should not be used for any other symptoms of acute stress or PTSD.

³ The approach described here is often referred to as psychological first aid (PFA) when applied in the immediate aftermath of an extremely stressful event (>> *WHO, WTF & WVI, 2013*).

3. In the case of **bedwetting** in children as a symptom of acute stress, offer the following additional management:

- » Obtain the history of bedwetting to confirm that it started **after** experiencing a stressful event. Rule out and manage **other possible causes** (e.g. urinary tract infection).
- » Explain:
 - ♦ Bedwetting is a **common**, harmless reaction in children who experience stress.
 - ♦ Children **should not be punished** for bedwetting because punishment adds to the child's stress and may make the problem worse. The carer should avoid embarrassing the child by mentioning bedwetting in public.
 - ♦ Carers should remain calm and emotionally supportive.
- » Consider training carers on the use of simple behavioural interventions (e.g. rewarding avoidance of excessive fluid intake before sleep, rewarding toileting before sleep, rewarding dry nights). The reward can be anything the child likes, such as extra playtime, stars on a chart or local equivalent.

4. In the case of **hyperventilation** (breathing extremely fast and uncontrollably) as a symptom of acute stress, offer the following additional management:

- » Rule out and manage **other possible causes**, even if hyperventilation started immediately after a stressful event. Always conduct necessary medical investigations to identify possible physical causes such as lung disease.
- » If no physical cause is identified, reassure the person that hyperventilation sometimes occurs after experiencing extreme stress and that it is unlikely to be a serious medical problem.
- » Be calm and remove potential sources of anxiety if possible. Help the person regain normal breathing by practising slow breathing (>> *Principles of Reducing Stress and Strengthening Social Support in General Principles of Care*) (do not recommend breathing into a paper bag).

5. In the case of a **dissociative symptom** relating to the body (e.g. medically unexplained paralysis, inability to speak or see, "pseudoseizures") as a symptom of acute stress, offer the following additional management:

- » Rule out and manage **other possible causes**, even if the symptoms started immediately after a stressful event. Always conduct necessary medical investigations to identify possible physical causes. See epilepsy module for guidance on medical investigations relevant to seizures/convulsions (>> *EPI*).
- » Acknowledge the person's suffering and maintain a respectful attitude. Avoid reinforcing any gain that the person may get from the symptoms.
- » Ask for the **person's own explanation** of the symptoms and apply the general guidance on the management of medically unexplained somatic symptoms (>> *OTH*).
- » Reassure the person that these symptoms sometimes develop after experiencing extreme stress and that it is unlikely to be a serious medical problem.
- » Consider the use of culturally specific interventions that do no harm.

6. Ask the person to return in 2–4 weeks if the symptoms do not improve, or at any time if the symptoms get worse.

In humanitarian emergencies, adults, adolescents and children are often exposed to major losses. Grief is the emotional suffering people feel after a loss. Although most reactions to loss are self-limiting without becoming a mental disorder, people with significant symptoms of grief are more likely to present to health facilities for help.

After a loss, clinicians need to be able to identify the following:

» Significant symptoms of grief (GRI).

As with similar to symptoms of acute stress, people who are grieving may present with a wide range of non-specific psychological and medically unexplained physical complaints. People have significant symptoms of grief after a loss if the symptoms cause considerable difficulty with daily functioning (beyond what is culturally expected) or if people seek help for the symptoms. **The present module covers assessment and management of significant symptoms of grief.**

» Prolonged grief disorder.

When significant symptoms of grief persist over an extended period of time, people may develop prolonged grief disorder. This condition involves severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months (and for a period that is much longer than what is expected in the person's culture). In these cases, health providers need to consult a specialist.

» Problems and disorders that are more likely to occur after exposure to stressors (e.g. bereavement) but that also occur in the absence of such exposure.

These include: moderate-severe depressive disorder (>> *DEP*), psychosis (>> *PSY*), harmful use of alcohol and drugs (>> *SUB*), self-harm/suicide (>> *SUI*) and other significant mental health complaints (>> *OTH*)

» Reactions that are not clinically significant and that do not require clinical management.

Of all reactions, these are the most common. They include transient reactions for which people do not seek help and which do not impair day-to-day functioning beyond what is culturally expected. In these cases, health providers need to be supportive, help address the person's needs and concerns and monitor whether expected natural recovery occurs; however, such reactions do not require clinical management.

Assessment

Assessment question 1: Has the person recently experienced a major loss?

» Ask if the person has experienced a **major loss**.

Consider asking:

- ♦ *How has the disaster/conflict affected you?*
- ♦ *Have you lost family or friends? Your house? Your money? Your job or livelihood? Your community?*
- ♦ *How has the loss affected you?*
- ♦ *Are any family members or friends missing?*

» Ask **how much time** has passed since the event(s).

» Go to assessment question 2 if a major loss has occurred within the **last 6 months**.

» If a major loss has occurred more than 6 months ago or if a potentially traumatic event has occurred more than 1 month ago, then consider other conditions covered in this guide (>> **DEP, PTSD, PSY, SUB**) or prolonged grief disorder.

Assessment question 2: If a major loss has occurred within the last 6 months,⁴ does the person have **significant symptoms of grief**?

» Check for:

- ♦ sadness, anxiety, anger, despair
- ♦ yearning and preoccupation with loss
- ♦ intrusive memories*, images and thoughts of the deceased
- ♦ loss of appetite
- ♦ loss of energy
- ♦ sleep problems
- ♦ concentration problems
- ♦ social isolation and withdrawal
- ♦ medically unexplained physical complaints (e.g. palpitations, headaches, generalized aches and pains)
- ♦ culturally specific grief reactions (e.g. hearing the voice of the deceased person, being visited by the deceased person in dreams).

» **Significant symptoms of grief** are likely if the person meets **all** of the following criteria:

- ♦ one or more losses within approximately 6 months
- ♦ any of the above symptoms that started after the loss
- ♦ considerable difficulty with daily functioning because of the symptoms (beyond what is culturally expected) or seeking help for the symptoms.

Assessment question 3: Is there a **concurrent condition**?

» Check for any **physical conditions** that may explain the symptoms, and manage accordingly if found.

» Check for any **other mental, neurological and substance use (MNS) condition (including depression)** covered in this guide that may explain the symptoms and manage accordingly if found.

⁴ This period may be longer than 6 months in cultures where the expected duration for mourning/bereavement is longer than 6 months.

Basic Management Plan



DO NOT prescribe medications to manage symptoms of grief.

1. Provide basic psychosocial support⁵

- » Listen carefully. DO NOT pressure the person to talk.
- » Ask the person about his/her needs and concerns.
- » Help the person to address basic needs, access services and connect with family and other social supports.
- » Protect the person from (further) harm.

2. Offer additional psychosocial support as described in the Principles of Reducing Stress and Strengthening Social Support (>> *General Principles of Care*)

- » Address current psychosocial stressors.
- » Strengthen social support.
- » Teach stress management.

3. Educate the person about common reactions to losses, e.g.:

- » People may react in different ways after major losses. Some people show strong emotions while others do not.
- » Crying does not mean you are weak.
- » People who do not cry may feel the emotional pain just as deeply but have other ways of expressing it.
- » You may think that the sadness and pain you feel will never go away, but in most cases, these feelings lessen over time.
- » Sometimes a person may feel fine for a while, then something reminds them of the loss and they may feel as bad as they did at first. This is normal and again these experiences become less intense and less frequent over time.
- » There is no right or wrong way to feel grief. Sometimes you might feel very sad, and at other times you might be able to enjoy yourself. Do not criticise yourself for how you feel at the moment.

4. Manage concurrent conditions.

5. Discuss and support *culturally appropriate* adjustment/mourning* processes

- » Ask if appropriate mourning ceremonies/rituals have occurred or have been planned. If this is not the case, discuss the obstacles and how they can be alleviated.
- » Find out what has happened to the body. If the body is missing, help trace or identify the remains.
- » If the body cannot be found, discuss alternative ways to preserve memories, such as memorials.

6. If feasible and culturally appropriate, encourage early return to previous, normal activities (e.g. at school or work, at home or socially).

7. For the specific management of sleep problems, bedwetting, hyperventilation and dissociative symptoms after recent loss, see the relevant sections in the module on acute stress (>> *ACU*).

⁵ The approach described here is often referred to as psychological first aid (PFA) when applied in the immediate aftermath of an extremely stressful event (>> *WHO, WTF & WVI, 2013*).

8. If the person is a young child:

- » Answer the child's questions by providing clear and honest explanations that are appropriate to the child's level of development. Do not lie when asked about a loss (e.g. *Where is my mother?*). This will create confusion and may damage the person's trust in the health provider.
- » Check for and correct "magical thinking" common in young children (e.g. children may think that they are responsible for the loss; for example, they may think that their loved one died because they were naughty or because they were upset with them).

9. For children, adolescents and other vulnerable persons who have lost parents or other carers, address the need for protection and ensure consistent, supportive caregiving, including socio-emotional support.

- » If needed, connect the person to trusted protection agencies/networks.

10. If *prolonged grief disorder* is suspected, consult a specialist for further assessment and management.

- » The person may have prolonged grief disorder if the symptoms of bereavement include severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months.⁶

11. Ask the person to return in 2–4 weeks if the symptoms do not improve or at any time if the symptoms get worse.

⁶ This period may be longer than 6 months in cultures where the expected duration for mourning/bereavement is longer than 6 months.

Moderate-severe Depressive Disorder

DEP

Moderate-severe depressive disorder may develop in adults, adolescents and children who have not been exposed to any particular stressor. In any community there will be people suffering from moderate-severe depressive disorder. However, the significant losses and stress experienced during humanitarian emergencies may result in grief, fear, guilt, shame and hopelessness, increasing the risk of developing moderate-severe depressive disorder. Nevertheless, these emotions may also be normal reactions to recently experienced adversity.

Management for moderate-severe depressive disorder should only be considered if the person has persistent symptoms over a number of weeks and as a result has considerable difficulties carrying out daily activities.

Typical presenting complaints of moderate-severe depressive disorder:

Low energy, fatigue, sleep problems

Multiple persistent physical symptoms with no clear cause (e.g. aches and pains)

Persistent sadness or depressed mood, anxiety

Little interest in or pleasure from activities.

Assessment

Assessment question 1: Does the person have moderate-severe depressive disorder?

» Assess for the following:⁷

A. The person has had at least one of the following core symptoms of depressive disorder for at least 2 weeks:

- ♦ **Persistent depressed mood**
 - ▶ For children and adolescents: either irritability or depressed mood
- ♦ **Markedly diminished interest in or pleasure from activities**, including those that were previously enjoyable
 - ▶ The latter may include reduced sexual desire.

B. The person has had at least several of the following additional symptoms of depressive disorder to a marked degree (or many of the listed symptoms to a lesser degree) for at least 2 weeks:

- ♦ **Disturbed sleep or sleeping too much**
- ♦ **Significant change in appetite or weight** (decrease or increase)
- ♦ Beliefs of **worthlessness** or excessive **guilt**
- ♦ **Fatigue** or loss of energy

- ♦ **Reduced ability to concentrate** and sustain attention on tasks
- ♦ **Indecisiveness**
- ♦ **Observable agitation or physical restlessness**
- ♦ **Talking or moving more slowly** than normal
- ♦ **Hopelessness** about the future
- ♦ **Suicidal thoughts or acts.**

C. The individual has considerable difficulty with daily functioning in personal, family, social, educational, occupational or other important domains.

- » If A, B and C – all 3 – are present for at least 2 weeks, then moderate-severe depressive disorder is likely.
 - ♦ Delusions* or hallucinations* may be present. Check for these. If present, treatment for depressive disorder needs to be adapted. Consult a specialist.
- » If the person's symptoms do not meet the criteria for moderate-severe depressive disorder, go to >> **OTH** module for assessment and management of the presenting complaint.

Assessment question 2: Are there other possible explanations for the symptoms (other than moderate-severe depressive disorder)?

» Rule out concurrent physical conditions that can resemble depressive disorder.

- ♦ Rule out and manage anaemia, malnutrition, hypothyroidism*, stroke and medication side-effects (e.g. mood changes from steroids*).

» Rule out a history of manic episode(s).

- ♦ Assess if there has been a period in the past when several of the following symptoms occurred **simultaneously**:
 - ▶ decreased need for sleep
 - ▶ euphoric, expansive or irritable mood
 - ▶ racing thoughts; being easily distracted
 - ▶ increased activity, feeling of increased energy or rapid speech
 - ▶ impulsive or reckless behaviours such as excessive gambling or spending, making important decisions without adequate planning
 - ▶ unrealistically inflated self-esteem.
- ♦ Assess to what extent the symptoms impaired functioning or were a danger to the person or to others. For example:
 - ▶ *Was your excessive activity a problem for you or your family? Did anybody try to hospitalize or confine you during that time because of your behaviour?*
- ♦ There is a history of manic episode(s) if both the following occurred:
 - ▶ Several of the above 6 symptoms were present for longer than 1 week.
 - ▶ The symptoms caused significant difficulty with daily functioning or were a danger to the person or to others.

- ♦ If a manic episode has ever occurred, then the depression is likely to be part of another disorder called **bipolar disorder*** and requires different management (>> **Box DEP 2** at the end of this module).

» Rule out **normal reactions** to major loss (e.g. bereavement, displacement) (>> **GRI**).

- ♦ The reaction is more likely to be a normal reaction to major loss if:
 - ▶ There is **marked improvement over time without clinical intervention**;
 - ▶ **None of the following symptoms is present**:
 - beliefs of worthlessness
 - suicidal ideation
 - talking or moving more slowly than normal
 - psychotic symptoms (delusions or hallucinations);
 - ▶ There is **no previous history of depressive disorder or manic episode**; and
 - ▶ **Symptoms do not cause considerable difficulty with daily functioning.**
 - Exception: impaired functioning can be part of a normal response after bereavement when it is within cultural norms.

- » **Rule out prolonged grief disorder**: symptoms include severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months (and for a period that is much longer than what is expected in that person's culture). Consult a specialist if this disorder is suspected.

Assessment question 3: Is there a concurrent mental, neurological and substance use (MNS) condition requiring management?

» Assess for **thoughts or plans of self-harm or suicide** (>> **SUI**).

» Assess for harmful alcohol or drug use (>> **SUB**).

- » If a concurrent MNS condition is found, manage the condition and moderate-severe depressive disorder at the same time.

⁷ This description of moderate-severe depressive episode is consistent with the current draft ICD-11 proposal.

Basic Management Plan

Psychosocial interventions

1. Offer psychoeducation

- » Key messages to the person and the carers:
 - ♦ Depression is a very common condition that can happen to anybody.
 - ♦ The occurrence of depression does not mean that the person is weak or lazy.
 - ♦ The negative attitudes of others (e.g. “You should be stronger”, “Pull yourself together”) may relate to the fact that depression is not a visible condition (unlike a fracture or a wound) and the false idea that people can easily control their depression by sheer force of will.
 - ♦ People with depression tend to have unrealistically negative opinions about themselves, their life and their future. Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression improves.
- ♦ Even if it is difficult, the person should try to do as many of the following as possible, as they can all help to improve mood:
 - ▶ Try to start again (or continue) activities that were previously pleasurable.
 - ▶ Try to maintain regular sleeping and waking times.
 - ▶ Try to be as physically active as possible.
 - ▶ Try to eat regularly despite changes in appetite.
 - ▶ Try to spend time with trusted friends and family.
 - ▶ Try to participate in community and other social activities as much as possible.
- ♦ The person should be aware of thoughts of self-harm or suicide. If they notice these thoughts, they should not act on them, but should tell a trusted person and come back for help immediately.

2. Offer psychosocial support as described in the Principles of Reducing Stress and Strengthening Social Support (>> *General Principles of Care*)

- » Address current psychosocial stressors.
- » Strengthen social supports.
 - ♦ Try to reactivate the person’s previous social networks. Identify prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychosocial support (e.g. family gatherings, visiting neighbours, community activities).
- » Teach stress management.

3. If trained and supervised therapists are available, consider encouraging people with moderate-severe depression to use one of the following brief psychological treatments whenever they are available:

- » problem-solving counselling*
- » interpersonal therapy (IPT)*
- » cognitive behavioural therapy (CBT)*
- » behavioural activation*.

There is increasing evidence that brief psychological treatments for depression can be done by trained and supervised lay/community workers.



Pharmacological interventions

1. Consider antidepressants

- » In children younger than 12:
 - ♦ Do not prescribe antidepressants.
- » In adolescents 12–18 years of age:
 - ♦ Do not consider antidepressants as first-line treatment. Offer psychosocial interventions first.
- » In adults:
 - ♦ If the person has a **concurrent physical condition** that can resemble depressive disorder (>> **Assessment question 2**), always manage that condition first. Consider prescribing antidepressants if the depressive disorder does not improve after managing the concurrent physical conditions.
 - ♦ If you suspect the symptoms are **normal reactions** to a major loss (>> **Assessment question 2**), do not prescribe antidepressants.
- ♦ Discuss with the person and decide together whether to prescribe antidepressants. Explain:
 - Antidepressants are not addictive.
 - It is very important to take the medication every day as prescribed.
 - Some side-effects (>> **Table DEP 1**) may be experienced within the first few days but they usually resolve.
 - It usually takes several weeks before improvements in mood, interest or energy can be noticed.
- ♦ Antidepressant medication usually needs to be continued for at least 9–12 months after the person feels well.
- ♦ Medications should not be stopped just because the person has experienced some improvement (it is not like a painkiller for headaches). Educate the person on the recommended timeframe for the medication.

2. If it is decided to prescribe antidepressants, choose an appropriate antidepressant (>> Table DEP 1)

- » Choose the antidepressant based on the person’s age, concurrent medical conditions and drug side-effect profile (>> **Table DEP 1**).
- » In adolescents 12 years and older:
 - ♦ Consider **fluoxetine** (but no other selective serotonin reuptake inhibitors (SSRI) or tricyclic antidepressants (TCAs)) only if symptoms persist or worsen despite psychosocial interventions.
- » In pregnant or breastfeeding women:
 - ♦ Avoid antidepressants if possible. Consider antidepressants at the lowest effective dose if there is no response to psychosocial interventions. If the woman is breastfeeding, avoid fluoxetine. Consult a specialist, if available.
- » In elderly people:
 - ♦ Avoid amitriptyline if possible.
- » In people with cardiovascular disease:
 - ♦ Do not prescribe amitriptyline.
- » In adults with thoughts or plans of suicide:
 - ♦ **Fluoxetine** is the first choice. If there is an imminent risk of self-harm or suicide (>> **SUI**), only give a limited supply of antidepressants (e.g. one week of supply at a time). Ask the person’s carers to keep and monitor medications and to follow up frequently to prevent medication overdose.

Table DEP 1: Antidepressants

	Amitriptyline ^a (a TCA ^b)	Fluoxetine (an SSRI ^c)
Starting dose for adults	25–50 mg at bedtime	10 mg once per day. Increase to 20 mg after 1 week
Starting dose for adolescents	Not applicable (do not prescribe TCAs in adolescents)	10 mg once per day
Starting dose for elderly and medically ill	25 mg at bedtime	10 mg once per day
Dose increment for adults	Increase by 25–50 mg per week	If no response in 6 weeks, increase to 40 mg once per day
Typical effective dose in adults	100–150 mg (max. dose 300 mg) ^d	20–40 mg (max. dose 80 mg)
Typical effective dose in adolescents, elderly and medically ill	50–75 mg (max. dose 100 mg) Do not prescribe in adolescents	20 mg (max. dose 40 mg)
Serious and rare side effects	Cardiac arrhythmia	Prolonged akathisia* Bleeding abnormalities in those who use aspirin or other non-steroid anti-inflammatory drugs* Ideas of self-harm (especially in adolescents and young adults)
Common side-effects	Orthostatic hypotension (risk of fall), dry mouth, constipation, difficulty urinating, dizziness, blurred vision and sedation	Headache, restlessness, nervousness, gastrointestinal disturbances, reversible sexual dysfunction
Caution	Stop immediately if the person develops a manic episode	Stop immediately if the person develops a manic episode

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

^b TCA indicates tricyclic antidepressant

^c SSRI indicates selective serotonin reuptake inhibitor

^d Minimum effective dose in adults: 75 mg (sedation may be seen at lower doses).

3. Follow-up

- » Offer **regular follow-up**.
 - ♦ Schedule and conduct regular follow-up sessions according to the Principles of Management (>> *General Principles of Care*).
 - ♦ Schedule the second appointment within 1 week and subsequent appointments depending on the course of the disorder.
- » Monitor response to antidepressants.
 - ♦ It may take a few weeks for antidepressants to show effect. Monitor the response carefully before increasing the dose.
 - ♦ If symptoms of a **manic episode** develop (>> *assessment question 2*), **stop the medication** immediately and go to >> *PSY* module for management of the manic episode.
 - ♦ Consider tapering off the medication 9–12 months after the resolution of symptoms. Reduce the dose gradually over at least 4 weeks.

Box DEP 2: Medical management of current depressive episode in a person with bipolar disorder



In people with bipolar disorder, never prescribe antidepressants alone without a mood stabilizer, because antidepressants can lead to a manic episode.

If the person has a history of manic episode:

- » Consult a specialist.
- » If a specialist is not immediately available, prescribe an antidepressant in combination with a mood stabilizer such as carbamazepine or valproate (>> *Table DEP 2*).
 - ♦ **Start the medicine at a low dose. Increase slowly over the following weeks.**
 - If possible, avoid carbamazepine and valproate in women who are pregnant or who are planning pregnancy, because of potential harm to the fetus from the medication. The decision to start mood stabilizers in a pregnant woman should be made in discussion with the woman. The severity and frequency of manic and depressive episodes should be taken into consideration.
 - ♦ Consult a specialist for ongoing treatment of bipolar disorder.
- » Tell the person and the carers to stop the antidepressant immediately and return for help if symptoms of manic episode develop.

Table DEP 2: Mood stabilizers in bipolar disorder

	Carbamazepine	Valproate
Starting dose	200 mg/day	400 mg/day
Typical effective dose	400–600 mg/day (max. dose 1400 mg/day)	1000–2000 mg/day (max. dose 2500 mg/day)
Dosing schedule	Twice daily, oral	Twice daily, oral
Rare but serious side-effects	<ul style="list-style-type: none"> ♦ Severe skin rash (Stevens-Johnson syndrome*, toxic epidermal necrolysis*) ♦ Bone marrow depression* 	<ul style="list-style-type: none"> ♦ Drowsiness ♦ Confusion
Common side-effects	<ul style="list-style-type: none"> ♦ Drowsiness ♦ Troubling walking ♦ Nausea 	<ul style="list-style-type: none"> ♦ Lethargy ♦ Sedation ♦ Tremor ♦ Nausea, diarrhoea ♦ Weight gain ♦ Transient hair loss (re-growth normally begins within 6 months) ♦ Impaired hepatic function

Post-traumatic Stress Disorder

PTSD

As mentioned in the Acute Stress (ACU) module, it is common for adults, adolescents and children to develop a wide range of psychological reactions or symptoms after experiencing extreme stress during humanitarian emergencies.

For most people, these symptoms are transient.

When a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after a potentially traumatic event*, the person may have developed post-traumatic stress disorder (PTSD).

Despite its name, PTSD is not necessarily the only or the main condition that occurs after exposure to potentially traumatic events. Such events can also trigger many of the other mental, neurological and substance use (MNS) conditions described in this guide.

Typical presenting complaints of PTSD

People with PTSD may be hard to distinguish from those suffering from other problems because they may initially present with non-specific symptoms, such as:

- » sleep problems (e.g. lack of sleep)
- » irritability, persistent anxious or depressed mood
- » multiple persistent physical symptoms with no clear physical cause (e.g. headaches, pounding heart).

However, on further questioning they may reveal that they are suffering from characteristic PTSD symptoms.

Assessment

Assessment question 1: Has the person experienced a potentially traumatic event more than 1 month ago?

- » Ask if the person has experienced a **potentially traumatic event**. This is any threatening or horrific event such as physical or sexual violence (including domestic violence), witnessing of atrocity, destruction of the person's house, or major accidents or injuries. Consider asking:
 - ♦ *How have you been affected by the disaster/conflict? Has your life been in danger? At home or in the community, have you experienced something that was very frightening or horrific or has made you feel very bad?*
- » If the person has experienced a potentially traumatic event, ask when this occurred.

Assessment question 2: If a potentially traumatic event occurred more than 1 month ago, does the person have PTSD?⁸

- » Assess for:
 - ♦ **Re-experiencing symptoms**. These are repeated and unwanted recollections of the event as though it is occurring in the here and now (e.g. through frightening dreams, flashbacks* or intrusive memories* accompanied by intense fear or horror).
 - In children this may involve replaying or drawing the events repeatedly. Younger children may have frightening dreams without a clear content.
 - ♦ **Avoidance symptoms**. These involve deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event (e.g. avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened).
 - ♦ Symptoms related to a **heightened sense of current threat** (often called "hyperarousal symptoms"). These involve excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements (e.g. being "jumpy" or "on edge").
 - ♦ Considerable **difficulty with daily functioning**.
- » If all of the above are present approximately 1 month after the event, then PTSD is likely.

Assessment question 3: Is there a concurrent condition?

- » Assess for and manage any **concurrent physical conditions** that may explain the symptoms.
- » Assess for and manage **all other MNS conditions** that are covered in this guide.

⁸ The description of PTSD is consistent with the current draft ICD-11 proposal for PTSD, with one difference: the ICD-11 proposal allows for classification of PTSD within 1 month (e.g. several weeks) after the event. The ICD-11 proposal does not include non-specific PTSD symptoms such as numbing and agitation.

Basic Management Plan

1. Educate on PTSD

- » Explain that:
 - ♦ Many people recover from PTSD over time without treatment while others need treatment.
 - ♦ People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they experienced when the event was actually happening. They may also have frightening dreams.
 - ♦ People with PTSD often feel that they are still in danger and may feel very tense. They are easily startled (“jumpy”) or constantly on the watch for danger.
 - ♦ People with PTSD try to avoid any reminders of the event. Such avoidance may cause problems in their lives.
 - ♦ (If applicable), people with PTSD may sometimes have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.
- » Advise the person to:
 - ♦ **Continue their normal daily routine** as much as possible.
 - ♦ **Talk to trusted people** about what happened and how they feel, but only when they are ready to do so.
 - ♦ **Engage in relaxing activities** to reduce anxiety and tension.
 - ♦ **Avoid using alcohol or drugs** to cope with PTSD symptoms.

2. Offer psychosocial support as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*)

- » Address current psychosocial stressors.
 - ♦ When the person is a victim of severe human rights violations, discuss with them possible referral to a trusted protection or human rights agency.
- » Strengthen social supports.
- » Teach stress management.

3. If trained and supervised therapists are available, consider referring for:

- » Cognitive behavioural therapy with a trauma focus*
- » Eye movement desensitization and reprocessing (EMDR)*.

4. In adults, consider antidepressants (selective serotonin reuptake inhibitors or tricyclic antidepressants) when cognitive behavioural therapy, EMDR or stress management do not work or are unavailable

- » Go to the module on moderate-severe depression for more detailed guidance on prescribing antidepressants (>> *DEP*).
- » DO NOT offer antidepressants to manage PTSD in children and adolescents.

5. Follow-up

- » Schedule and conduct regular follow-up sessions according to the *Principles of Management* (>> *General Principles of Care*).
- » Schedule the second appointment within 2–4 weeks and subsequent appointments depending on the course of the disorder.

Adults and adolescents with psychosis may firmly believe or experience things that are *not real*. Their beliefs and experiences are generally considered abnormal by their communities. People with psychosis are frequently unaware that they have a mental health condition. They are often unable to function normally in many areas of their lives.

During humanitarian emergencies, extreme stress and fear, breakdown of social supports and disruption of health-care services and medication supply can occur. These changes can lead to acute psychosis or can exacerbate existing symptoms of psychosis. During emergencies, people with psychosis are extremely vulnerable to various human rights violations such as neglect, abandonment, homelessness, abuse and social stigma.

Typical presenting complaints of psychosis

Abnormal behaviour (e.g. strange appearance, self-neglect, incoherent speech, wandering aimlessly, mumbling or laughing to self)

Strange beliefs

Hearing voices or seeing things that are not there

Extreme suspicion

Lack of desire to be with or talk with others; lack of motivation to do daily chores and work.

Assessment question 1: Does the person have psychosis?

- » Note that while people with psychosis may have abnormal thoughts, beliefs or speech, this does not mean that everything they say is wrong or imaginary. Careful listening is key to psychosis assessment. More than one visit may be necessary to ensure full assessment. Carers are often a source of helpful information.
- » Assess for:
 - ♦ **Delusions*** (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary)
 - Tip: Probe further by asking what the person means, and listen carefully.
 - ♦ **Hallucinations*** (hearing, seeing or feeling things that are not there)
 - *Do you hear or see things that others cannot?*
 - ♦ **Disorganized thoughts** that switch between topics without logical connection; speech that is difficult to follow
 - ♦ Unusual experiences such as believing that **others place thoughts** in one's mind, that **others withdraw thoughts** from one's mind or that one's **thoughts are being broadcast to others**
 - ♦ **Abnormal behaviour** such as odd, eccentric, aimless and agitated activity or maintaining an abnormal body posture or not moving at all
 - ♦ **Chronic symptoms that involve a loss of normal functioning**, including:
 - lack of energy or motivation to do daily chores and work
 - apathy and social withdrawal
 - poor personal care or neglect
 - lack of emotional experience and expressiveness.
- » **Psychosis** is likely if multiple symptoms are present. Always assess for **imminent risk of suicide (>> SUI)** and **harm to and from others**.

Assessment question 2: Are there acute physical causes of psychotic symptoms that can be managed?

- » Rule out **delirium*** from acute physical causes such as head injury, infections (e.g. cerebral malaria, sepsis* or urosepsis*), dehydration and metabolic abnormalities (e.g. hypoglycaemia*, hyponatraemia*).
- » Rule out **medication side-effects** (e.g. from certain antimalaria medications).
- » Rule out **alcohol or drug intoxication/withdrawal (>> SUB)**.
 - ♦ Ask about alcohol, sedative or other drug use.
 - ♦ Smell for alcohol.

Assessment question 3: Is this a manic episode?

- » Rule out mania. Assess for:
 - ♦ decreased need for sleep
 - ♦ euphoric, expansive or irritable mood
 - ♦ racing thoughts; being easily distracted
 - ♦ increased activity, feeling of increased energy or rapid speech
 - ♦ impulsive or reckless behaviours such as excessive gambling or spending, making important decisions without adequate planning
 - ♦ unrealistically inflated self-esteem.
- » **Manic episode** is likely if several of these symptoms are present for more than 1 week, and either the symptoms cause considerable difficulty with daily functioning or the person cannot be managed safely at home.

Basic Management Plan

A. Pharmacological interventions

1. For psychosis *without* acute physical causes

- » Initiate an **oral antipsychotic** medication. Consider intramuscular (i.m.) treatment only if oral treatment is not feasible. Check if the person has used an antipsychotic medication in the past that helped control the symptoms. If yes, resume the medication at the same dose. If the medication is not available, start a new medication. The involvement of a carer or health worker in keeping and giving out the medication will be essential at the start of treatment to ensure safe compliance.
 - ♦ Prescribe only **one antipsychotic** at a time (e.g. haloperidol >> **Table PSY 1**).
 - ♦ **“Start low, go up slow”**: start with the lowest therapeutic dose and increase slowly to achieve the desired effect at the **lowest effective dose**.
 - ♦ Try the medication for an adequate amount of time at a typical effective dose before considering it ineffective (i.e. for at least 4–6 weeks) (>> **Table PSY 1**).
 - Use the lowest effective oral dose in women who are planning **pregnancy**, are pregnant or are **breastfeeding**.
 - ♦ If agitation cannot be adequately managed by an antipsychotic alone, give a dose of **benzodiazepine** (e.g. **diazepam**, maximum 5 mg orally) and consult a specialist immediately.
- ♦ **Manage side-effects**.
 - In case of significant acute extrapyramidal side-effects* such as Parkinsonism (combination of tremors*, muscular rigidity and decreased body movements) or akathisia* (inability to sit still):
 - Reduce the dose of antipsychotic medication.
 - If **extrapyramidal side effects** persist despite reducing the dose, consider short-term use of **anticholinergics** (e.g. **biperiden** for 4-8 weeks (>> **Table PSY 2**)).
 - In case of acute **dystonia** (acute spasm of muscles, typically of neck, tongue and jaw):
 - **Stop** antipsychotic medication temporarily and provide **anticholinergics** (e.g. **biperiden** >> **Table PSY 2**). If these are not available, **diazepam** may be given to induce muscle relaxation.
- ♦ If possible, consult a specialist about the duration of treatment and when to discontinue antipsychotic medications.
 - In general, continue the antipsychotic medication for at least 12 months after the symptoms resolve.
 - Taper down slowly when discontinuing the medication over several months.
 - Never stop the medication abruptly.

2. For psychotic symptoms from acute physical causes (e.g. alcohol withdrawal or delirium)

- » **Manage the acute cause**.
 - ♦ For management of **alcohol withdrawal**, see **Box 1** in **SUB** module.
- ♦ In case of acute physical causes **other than alcohol withdrawal**, prescribe an **oral antipsychotic** medication as needed (e.g. **haloperidol**, initially 0.5 mg per dose up to 2.5–5 mg 3 times a day). **Only** prescribe antipsychotic medication at a moment when there is a need to control agitation, psychotic symptoms or aggression. Stop the medication as soon as these symptoms resolve. Consider intramuscular treatment only if oral treatment is not feasible.

3. For manic episode

- » Initiate an **oral antipsychotic** medication (>> #1 above under **Pharmacological interventions**).
- » When the person is **extremely agitated** despite antipsychotic treatment, consider adding a dose of **benzodiazepine** (e.g. **diazepam**, maximum 5 mg orally) and consult a specialist immediately.
- » A **manic episode** is part of **bipolar disorder***. Once the acute mania is managed, the person needs assessment and treatment for bipolar disorder with a **mood stabilizer** such as **valproate** or **carbamazepine**. Consult a specialist for management and/or follow instructions on **bipolar disorder** in the full **mhGAP Intervention Guide**.

Table PSY 1: Antipsychotic medications

Medication	Haloperidol ^a	Chlorpromazine	Risperidone
Starting dose	2.5 mg daily	50–75 mg daily	2 mg daily
Typical effective dose	4–10 mg/day (max. dose 20 mg)	75–300 mg/day ^b (max. dose 1000 mg)	4–6 mg/day (max. dose 10 mg)
Route	Oral/intramuscular	Oral	Oral
Significant side-effects:			
Extrapyramidal side-effects*	+++	+	+
Sedation (especially in elderly)	+	+++	+
Urinary hesitancy		++	
Orthostatic hypotension*	+	+++	+
Neuroleptic malignant syndrome*	Rare ^c	Rare ^c	Rare ^c

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

^b Up to 1 g may be necessary in severe cases.

^c Stop antipsychotic medicine immediately if this syndrome is suspected and keep the person cold and provide sufficient fluid.

Table PSY 2: Anticholinergic medications

Medication	Biperiden ^a	Trihexphenidyl
Starting dose	1 mg twice daily	1 mg daily
Typical effective dose	3–6 mg/day (max. dose 12 mg)	5–15 mg daily (max. dose 20 mg)
Route	Oral	Oral
Significant side-effects:		
Confusion, memory disturbance (especially in elderly)	+++	+++
Sedation (especially in elderly)	+	+
Urinary hesitancy	++	++

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



B. Psychosocial interventions

For all cases:

1. Offer psychoeducation

Key messages to the person and the carer(s):

- » Psychosis can be treated and the person can recover.
- » Stress can worsen psychotic symptoms.
- » Try to continue regular social, educational and occupational activities as much as possible, even if that may be difficult in the emergency setting.
- » Do not use alcohol, cannabis or other non-prescribed drugs, because they can make the psychotic symptoms worse.
- » People with psychosis need to take the prescribed medications and return for follow up regularly.
- » Recognize if the psychotic symptoms return or worsen. Return to the clinic as management may need to be changed accordingly.

Messages to the carer(s):

- » Do not try to convince the person that his or her beliefs or experiences are false or not real.
- » Try to be neutral and supportive even when the person shows unusual or aggressive behaviour.
- » Avoid getting into arguments or being hostile towards the person.
- » Try to give the person freedom to move about. Avoid restraining the person while ensuring that their basic security and that of others is met.
- » Psychosis is not caused by witchcraft or spirits.
- » Do not blame the person or others in the family or accuse them of being the cause of the psychosis.
- » If the person has **recently given birth**, do not leave her alone with the baby, in order to ensure the baby's safety.

2. Facilitate rehabilitation back into the community

- » Talk with community leaders to increase community acceptance and tolerance of the person.
- » Facilitate the inclusion of the person in community-based economic and social activities.
- » Connect with community resources such as community-based health workers, protection service workers, social workers and disability service workers. Ask for their help in assisting the person to resume appropriate social, educational and occupational activities.

3. Care for the carers according to the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*)

C. Follow-up

- » Schedule and conduct **regular follow-up sessions** according to the *Principles of Management* (>> *General Principles of Care*).
- » Schedule the second visit within 1 week and subsequent visits depending on the course of the condition.
- » Continue the antipsychotic treatment for **at least 12 months** after complete resolution of symptoms. If possible, consult a specialist regarding the decision to continue or discontinue the medication.

Epilepsy/Seizures

EPI



See **Box EPI 2** on page 40 for assessment and management of a person who is convulsing or is unconscious following a seizure*.

Epilepsy is the most frequently *treated* condition of all mental, neurological and substance use (MNS) conditions in humanitarian settings in low- and middle-income countries. Epilepsy affects all age groups including young children.

Epilepsy is a chronic neurological condition involving *recurrent unprovoked seizures* caused by abnormal electrical activity in the brain. There are various types of epilepsy and this module covers only the most prevalent type, **convulsive epilepsy**. Convulsive epilepsy is characterized by seizures that cause sudden *involuntary* muscle contractions alternating with muscle relaxation, causing the body and limbs to shake or become rigid. Seizures are often associated with *impaired consciousness*. A convulsing person may fall and suffer injuries.

The supply of antiepileptic medications is often disrupted during humanitarian emergencies. Without continuous access to these medications, people with epilepsy may begin experiencing seizures again, which can be life-threatening.

Typical presenting complaints of convulsive epilepsy

- A history of convulsive movements or seizures.

Assessment question 1: Does the person meet the criteria for convulsive seizure?

- » Ask the person, and carer, if the person has had any of the following symptoms:
 - ♦ **convulsive movements lasting longer than 1–2 minutes**
 - ♦ loss of or impaired consciousness
 - ♦ stiffness or rigidity of the body or limbs lasting longer than 1–2 minutes
 - ♦ bitten or bruised tongue or bodily injury
 - ♦ loss of bladder or bowel control during the episode.
 - ♦ After the abnormal movements, the person may demonstrate confusion, drowsiness, sleepiness or abnormal behaviour. The person may also complain of fatigue, headache, or muscle ache.
- » The person meets the criteria for a **convulsive seizure** if there are **convulsive movements and at least 2 other symptoms** from the above list.
- » Suspect **non-convulsive seizures or other medical conditions** if only 1 or 2 of the above criteria are present.
 - ♦ Consult a specialist if the person has had more than one non-convulsive seizure.
 - ♦ Manage accordingly if other medical conditions are suspected.
 - ♦ Follow up after 3 months to re-assess.

Assessment question 2: In the case of convulsive seizure, is there an acute cause?

- » Check for signs and symptoms of **neuroinfection**:
 - ♦ fever
 - ♦ headache
 - ♦ meningeal irritation* (e.g. stiff neck).
- » Check for **other possible causes** of convulsions:
 - ♦ head injury
 - ♦ metabolic abnormality* (e.g. hypoglycaemia*, hyponatraemia*)
 - ♦ alcohol or drug intoxication or withdrawal (>> **Box SUB 1 on page 48**).
- » If there is an **identifiable** acute cause of convulsive seizure, **treat the cause**.
 - ♦ Maintenance treatment with antiepileptic medications is **not** required in these cases.
- » **Refer to a hospital immediately** if neuroinfection*, head injury or metabolic abnormality is suspected.
 - ♦ Suspect neuroinfection in a **child** (aged 6 months to 6 years) with a **fever** if any of the following criteria for **complex febrile seizures** is present:
 - ▶ focal seizure – seizure starts in one part of the body
 - ▶ prolonged seizure – seizure lasts more than 15 minutes
 - ▶ repetitive seizure – more than 1 seizure during the current illness.
 - ♦ If none of the above 3 criteria are present in a febrile child, suspect simple febrile seizure. Manage the fever and look for its cause according to local **IMCI** guidelines. Observe the child for 24 hours.
- » Follow up in 3 months to re-assess.

Assessment question 3: In the case of convulsive seizure without an identified acute cause, is this epilepsy?

- » It is considered **epilepsy** if the person has had 2 or more unprovoked, convulsive seizures on 2 different days in the last 12 months.
- » If there was only 1 convulsive seizure in the last 12 months without an acute cause, then antiepileptic treatment is not required. Follow up in 3 months.

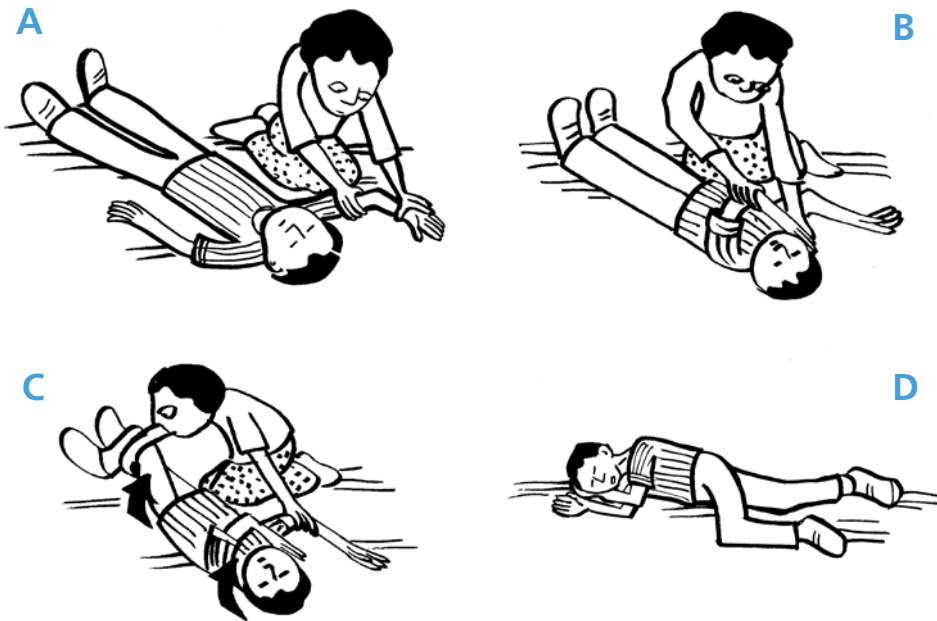
Basic Management Plan

1. Educate the person and carers about epilepsy

» Explain:

- ♦ What epilepsy is and **what causes it**:
 - ▶ Epilepsy is a chronic condition, but with medication three out of every four people can be seizure-free.
 - ▶ Epilepsy involves recurrent seizures. A seizure is a problem related to abnormal electrical activity in the brain.
 - ▶ Epilepsy is not caused by witchcraft or spirits.
 - ▶ Epilepsy is not contagious. Saliva does not transmit epilepsy.
- ♦ What the relevant **lifestyle issues** are:
 - ▶ People with epilepsy can lead normal lives:
 - They can marry and have healthy children.
 - They can work productively and safely at most jobs.
 - Children with epilepsy can go to school.
 - ▶ People with epilepsy should **avoid**:
 - jobs that require working near heavy machinery or fire
 - cooking over open fires
 - swimming alone
 - alcohol and recreational drugs
 - looking at flashing lights.
 - changing sleep patterns (e.g. sleeping much less than usual).
- ♦ **What to do at home** when seizures occur (message to carers):
 - ▶ If a seizure starts while the person is standing or sitting, help to prevent a fall injury by gently assisting them to sit or lie on the ground.
 - ▶ Make sure that the person is breathing properly. Loosen the clothes around the neck.
 - ▶ Place the person in the recovery position (see Figures A–D below).

Figures A–D: The recovery position



- A. Kneel on the floor on one side of the person. Place the arm closest to you at a right angle to their body with the person's hand upwards towards the head (see Figure A above).
- B. Place the other hand under the side of the person's head, so that the back of the hand is touching the cheek (see Figure B above).
- C. Bend the knee furthest from you to a right angle. Roll the person carefully onto his or her side by pulling on the bent knee (see Figure C above).
- D. The person's top arm should be supporting the head and the bottom arm will stop the person from rolling too far (see Figure D above). **Open the person's airway by gently tilting his or her head back and lifting the chin, and check that nothing is blocking the airway.** This manoeuvre moves the tongue out of the airway and helps the person breathe better and prevents choking from secretions and vomit.
 - ▶ Do not try to restrain or hold the person to the floor.
 - ▶ Do not put anything in the person's mouth.
 - ▶ Move any hard or sharp objects away from the person to prevent injury.
 - ▶ Stay with the person until the seizure stops and the person regains consciousness.

» Ask the person and the carers to keep a simple seizure diary (see *Figure EPI GPC 1*).

2. Initiate or resume antiepileptic drugs

- » Check if the person has ever used an antiepileptic medication that controlled the seizures. If yes, then resume the same medication at the same dose.
- » If the medication is not available, start a new medication.
- » Choose **only one** antiepileptic drug (see **Table EPI 1**).
 - ♦ Consider potential side-effects, drug-disease interactions* or drug-drug interactions*. Consult the **National or WHO Formulary**, as necessary.
 - ♦ Start with the **lowest dose** and **increase gradually** until complete seizure control is obtained.
- » **Explain to the person and carers:**
 - ♦ Medication dosing schedule (>> **Table EPI 1**)
 - ♦ Potential side-effects (>> **Table EPI 1**).
Most side-effects are mild and will resolve over time. If severe side-effects occur, the person should immediately stop the medication and seek medical help.
 - ♦ Importance of medication **adherence**. Missed doses or abrupt discontinuation can cause seizures to recur. The medications should be taken at the **same time each day**.
 - ♦ Time for the medication to start working. It usually takes a few weeks before the effect becomes clear.
 - ♦ Duration of treatment. Continue the medication until the person has not had a seizure for at least 2 years.
 - ♦ Importance of regular follow-up.

Table EPI 1: Antiepileptic medications

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

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

3. Follow-up

- » Ensure **regular follow-up**:
 - ♦ For the first 3 months or until seizures are controlled, schedule follow-up appointments at least once a month.
 - ♦ Meet every 3 months if seizures are controlled.
 - ♦ Refer to *Principles of Management* (>> **General Principles of Care**) for more detailed advice on follow-up.
- » **At each follow-up**:
 - ♦ Monitor for seizure control:
 - ▶ Refer to the **seizure diary** to see how well seizures are controlled.
 - ♦ Maintain or adjust the antiepileptic medication according to how well the seizures are controlled.
 - ▶ If seizures are still not controlled at the maximum therapeutic dose of one medication or the side-effects have become intolerable, change to another medication. Gradually increase the dose until seizures are controlled.
 - ▶ If seizures are very infrequent and a further increase in the dose may produce severe side-effects, then the current dose may be acceptable.
 - ▶ Consult a specialist if 2 medications were tried one after another and neither achieved adequate seizure control. Avoid treatment with more than one antiepileptic medication at a time.
- ♦ Consider **stopping the antiepileptic medication** if **no seizure** has occurred in the last **2 years**.
 - ▶ When stopping the medication, the dose should be *tapered down slowly* over several months to avoid seizures from medication withdrawal.
- ♦ Involve carers in monitoring for seizure control.
- ♦ Review lifestyle issues and provide further psychoeducation/support to the person and the carers (>> **Basic management plan step 1** described above).



Box EPI 1: Special management considerations for women with epilepsy

- » If the woman is of **childbearing age**:
 - ♦ Give folate 5 mg/day to prevent possible birth defects if she becomes pregnant.
- » If she is **pregnant**:
 - ♦ Consult with a specialist for management.
 - ♦ Advise more frequent antenatal visits and delivery in a hospital.
 - ♦ At delivery, give 1 mg **vitamin K** intramuscularly (i.m.) to the newborn.
- » The decision to start an antiepileptic medication in a pregnant woman should be made together with the woman. The severity and frequency of the seizures as well as the potential harm to the fetus from either the seizures or the medication should be considered. If the decision is made to start medication, then either **phenobarbital** or **carbamazepine** can be used. Valproate and polytherapy* should be avoided.
- » Carbamazepine can be used by women who are **breastfeeding**.

Figure EPI 1: Example seizure diary

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

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



Assessment and management of acute seizures should proceed simultaneously.

» Assessment of seizures

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

» Ask the carer:

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

» Refer urgently to a hospital:

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

» Management of seizures

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

Intellectual Disability

Intellectual disability⁹ is characterized by limitations across multiple areas of expected intellectual development (i.e. cognitive*, language, motor and social skills) that are not reversible. The limitations have existed from birth or started during childhood. Intellectual disability interferes with learning, daily functioning and adaptation to a new environment.

People with intellectual disability often have substantial care needs. They often experience challenges in accessing health care and education. They are extremely vulnerable to abuse, neglect and exposure to hazardous situations in chaotic emergency environments. For example, people with intellectual disability are more likely to walk into dangerous areas unknowingly. Moreover, they can be perceived as burdensome by their families and communities and may be abandoned during displacement. Therefore, people with intellectual disability require extra attention during humanitarian emergencies.

This module covers moderate, severe and profound intellectual disability in children, adolescents and adults.

Typical presenting complaints

- » **In infants: poor feeding, failure to thrive, poor motor tone, delay in meeting expected developmental milestones for appropriate age and stage such as smiling, sitting, standing.**
- » **In children: delay in meeting expected developmental milestones for appropriate age such as walking, toilet training, talking, reading and writing.**
- » **In adults: reduced ability to live independently or look after oneself and/or children.**
- » **In all ages: difficulty carrying out daily activities considered normal for the person's age; difficulty understanding instructions; difficulty meeting demands of daily life.**

⁹ The draft, proposed ICD-11 name for this condition is *Disorder of Intellectual Development*.

Assessment question 1: Does the person have intellectual disability?

» Review the person's skills and functioning:

- ♦ For **young children** and **toddlers**, assess whether the child has fully reached **age-appropriate milestones** across *all* developmental areas (>> **Box ID 1** with warning signs).
- ♦ Suggested questions to carers of children:
 - ▶ *Is your child behaving like others of the same age?*
 - ▶ *What kinds of things can your child do alone (sitting, walking, eating, dressing or toileting)?*
 - ▶ *How does your child communicate with you? Does the child smile at you? Does the child react to his/her name? How does the child talk to you? Is the child able to ask for what he/she wants?*
 - ▶ *How does your child play? Is your child able to play well with other children of the same age?*
- ♦ For **older children** and **adolescents**, ask whether they go to school and, if so, how they are managing schoolwork (learning, reading and writing) and everyday household activities.
 - ▶ *Are you going to school? How are you doing in school? Are you able to finish your schoolwork? Do you often have difficulties in school because you cannot understand or follow instructions?*
- ♦ For **adults**, ask whether they work and, if so, how they are managing their work and other daily activities.
 - ▶ *Do you work? What kind of work do you do? Do you often get into trouble at work because you cannot understand or follow instructions?*
- ♦ For **older children, adolescents** and **adults**, ask how much help the person is currently receiving to do daily activities (e.g. at home, school, work).

» If there is delay in reaching expected developmental milestones, rule out treatable or reversible conditions that can mimic intellectual disability.

♦ Rule out visual impairment:

- ▶ For a child >6 months, ask the carer if the child can do the following, while directly observing the child yourself:
 - if the child can follow a moving object with their eyes
 - if the child can recognize familiar people
 - if the child can grab an object with their hands.
- ▶ If any of the answers is **No**, inform the carer that the child may have impaired vision and consult a specialist, if available.

♦ Rule out hearing impairment:

- ▶ For a child >6 months, ask the carer if the child can do the following, while directly observing the child yourself:
 - if the child turns his/her head to see who is speaking from behind
 - if the child reacts to loud noises
 - if the child makes various vocal sounds (tata, dada, baba).
- ▶ If any of the answers is **No**, inform the carer that the child may have impaired hearing and consult a specialist, if available.

♦ Rule out problems in the environment:

- ▶ Moderate-severe depressive disorder in the mother or main carer (>> **DEP**)
- ▶ Lack of stimulation (stimulation is essential for brain development in young children).
 - *Who regularly interacts and plays with the child? How do you/they play with your child? How often?*
 - *How do you/they communicate with your child? How often?*

♦ **Rule out malnutrition** and other nutritional or **hormonal deficiencies** including iodine deficiency* and hypothyroidism*.

♦ **Rule out epilepsy (>> EPI)**, which can mimic or occur together with intellectual disability.

» Manage the identified treatable problems and follow up to reassess whether the person has intellectual disability.

- ♦ For confirmed cases of hearing and visual impairments, provide or advocate for necessary aids (glasses, hearing aid).
- ♦ Manage depressive disorder in the carer, if applicable.
- ♦ Teach the carer how to provide a more stimulating environment for young children. See **Counsel the Family for Care for Development: Counselling Cards** (UNICEF and WHO, 2012).
- ♦ Refer the person to Early Childhood Development (ECD) programmes, if appropriate.

» **Intellectual disability** is likely if a) there is a significant delay in reaching expected developmental milestones and difficulty meeting demands of daily life and b) treatable or reversible conditions have been ruled out or addressed.

Assessment question 2: Are there associated behavioural problems?

» Not listening to carers

» Temper tantrums. Aggression and self-harming behaviour when upset

» Eating non-organic materials

» Reckless sexual or other problematic behaviour.

Basic Management Plan

1. Offer psychoeducation

- » **Explain the disability** to the person and their carers. People with intellectual disability should not be blamed for the disability. The aim is for the carers to have realistic expectations and to be kind and supportive.
- » Provide parenting skills training. The aim should be to **improve positive interactions between parent/carer and child**. Teach the carers skills that can help reduce behaviour problems.
 - ♦ Carers should understand the importance of training the person to perform self-care and hygiene (e.g. toilet training, brushing teeth).
 - ♦ Carers should have very good knowledge of the person. Carers should know what stresses the person and what makes them happy, what causes behaviour problems and what prevents them, what the person's strengths and weaknesses are and how the person learns best.
 - ♦ Carers should keep the person's daily activities such as eating, playing, learning, working and sleeping as regular as possible.
- ♦ **Carers should reward the person** when the behaviour is good and withhold rewards when the behaviour is problematic. Use a balanced discipline:
 - ▶ Give clear, simple and short instructions on what the person should do rather than what the person should not do. Break complex activities into smaller steps so that the person can learn and be rewarded one step at a time (e.g. learning to put trousers on before buttoning them up).
 - ▶ When the person does something good, offer a reward. Distract the person from the things they should not do. However, such distraction should not be pleasurable and rewarding for the person.
 - ▶ **DO NOT** use threats or physical punishments when the behaviour is problematic.
- » Educate the carers that the person is more vulnerable to physical and sexual abuse in general, requiring extra attention and protection.
- » Educate carers to avoid institutionalization.

2. Promote community-based protection

- » Assess the availability of community-based protection (e.g. informal groups, local NGOs, governmental agencies or international agencies) and ask for relevant support for the person.

3. Advocate for inclusion in community activities

- » If the person is a child, keep them in normal schools as much as possible.
 - ♦ Liaise with the child's school to explore possibilities of adapting the learning environment to the child. Simple tips are available in *Inclusive Education of Children At Risk* (INEE).
- » Encourage participation in enjoyable social activities in the community.
- » Assess availability of community-based rehabilitation (CBR*) programmes and advocate to have the person with intellectual disability included in such programmes.

4. Care for the carers according to the Principles of Reducing Stress and Strengthening Social Support (>> *General Principles of Care*)

5. If possible, refer to a specialist for further assessment and management of possible concurrent developmental conditions

- » Irreversible motor impairment or cerebral palsy*
- » Birth defects, genetic abnormalities or syndromes (e.g. Down syndrome*).

6. Follow-up

- » Schedule and conduct follow-up sessions according to the Principles of Management (>> *General Principles of Care*).

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

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

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

Harmful Use of Alcohol and Drugs

SUB



See **Box SUB 1** on page 48 for assessment and management of life-threatening alcohol withdrawal.

Use of alcohol or drugs (e.g. opiates* (e.g. heroin), cannabis*, amphetamines*, khat*, diverse prescribed medications such as benzodiazepines* and tramadol*) can lead to various problems. These include *withdrawal* (physical and mental symptoms that occur upon cessation or significant reduction of use), *dependence** and *harmful use* (damage to physical or mental health and/or general well-being). Use of alcohol or drugs is harmful when it leads to physical or mental disorders, risky health behaviours, family/relationship problems, sexual and physical violence, accidents, child abuse and neglect, financial difficulties and other protection issues. The prevalence of harmful alcohol or drug use may increase during humanitarian emergencies as adults and adolescents may try to cope with stress, loss or pain by self-medicating*.

Acute emergencies can disrupt alcohol or drug supply, leading to unexpected life-threatening withdrawal symptoms in individuals who were using substances over a prolonged period of time at relatively high doses. This is particularly true for alcohol.

This module focuses on *harmful use of alcohol or drugs* and includes a box on *life-threatening alcohol withdrawal* (>> **Box SUB 1**). For other aspects of alcohol or drug use, see alcohol or drug use modules of the full *mhGAP Intervention Guide*.

Typical presenting complaints

- » **Appearing to be under the influence of alcohol or drugs** (e.g. smelling of alcohol, looking intoxicated, being agitated, fidgeting, having low energy, slurred speech, unkempt appearance, dilated/constricted pupils*)
- » **Recent injury**
- » **Signs of intravenous (i.v.) drug use** (injection marks, skin infection)
- » **Requests for sleeping tablets or painkillers.**

Assessment

Assessment question 1: Is there harm to physical or mental health and/or general well-being from alcohol or drug use?

- » Explore the use of alcohol or drugs, without sounding judgemental.
- » Ask:
 - ♦ **Amount and pattern of use**
 - ▶ *Do you drink alcohol? If so, in what form? How many drinks per day/week?*
 - ▶ *Do you use prescribed sleeping tablets/anxiety pills/painkillers? What kind? How many per day/week?*
 - ▶ *Do you use illegal drugs? What kind? How do you take them – by mouth, injection, snorting? How much/how often per day/week?*
 - ♦ **Triggers to alcohol or drug use**
 - ▶ *What makes you want to take alcohol or drugs?*
 - ♦ **Harm to self or others**
 - ▶ Medical problems or injuries **as a result of** alcohol or drug use
 - *Have you experienced health problems since you started drinking alcohol or using drugs?*
 - *Have you ever been injured while you were under the influence of alcohol or drugs?*
 - ▶ Continued use of alcohol or drugs despite advice to stop
 - When the person was pregnant or breastfeeding
 - When the person was told there is a problem with their stomach or liver because of drinking or drug use
 - When the person was on medications that have harmful interactions with alcohol or drugs, such as sedatives, analgesics or tuberculosis medications
 - ▶ Social problems **as a result of** alcohol or drug use:
 - Financial or legal problems
 - *Have you ever been in trouble with money or broken the law because of alcohol or drug use?*
 - Occupational problems
 - *Have you ever lost a job or done badly at work because of your alcohol or drug use?*
 - Difficulty caring for children or other dependants
 - *Have you ever found it hard to take care of your child/family because of alcohol or drug use?*
 - Violence towards others
 - *Have you ever hurt someone while taking alcohol or drugs?*
 - Relationship/marital problems
 - *Has your alcohol or drug use ever caused a problem with your partner?*
- » Perform a quick general **physical examination** to look for the signs of chronic alcohol or drug use
 - ♦ Gastrointestinal bleeding
 - ▶ abdominal pain
 - ▶ blood in vomit
 - ▶ blood in stool or black stool
 - ♦ Liver disease
 - ▶ Severe: jaundice, ascites*, enlarged and hardened liver and spleen, hepatic encephalopathy*
 - ♦ Malnutrition, severe weight loss
 - ♦ Evidence of infections associated with drug use (e.g. HIV, hepatitis B or C, injection site skin infections or tuberculosis).
- » Assess for **both** harmful alcohol and drug use in the same person as they often occur together.

Basic Management Plan

1. Manage the harmful effects of alcohol or drug use

- » Provide necessary **medical care** for physical consequences of harmful alcohol or drug use.
- » Manage any **concurrent mental conditions**, such as moderate-severe depressive disorder, PTSD and psychosis (>> **DEP, PTSD, PSY**).
- » Address **urgent social consequences** (e.g. liaise with protection services in case of abuse, such as gender-based violence).

2. Assess the person's motivation to stop or reduce the use of alcohol or drugs

- » **Assess whether the person sees alcohol or drug use as a problem and if the person is ready to do something about it.**
 - ♦ *Do you think you may have a problem with alcohol or drugs?*
 - ♦ *Have you thought about stopping or reducing your alcohol or drug use?*
 - ♦ *Have you tried stopping or reducing alcohol or drug use in the past?*

3. Motivate the person to either stop or reduce the use of alcohol or drugs

- » Initiate a **brief motivational conversation** about harmful use:
 - ♦ Ask about the **perceived benefits and harms** of alcohol or drug use. Do not be judgemental, but try to understand what motivates the person to use alcohol or drugs.
 - *What kind of pleasure do you get when taking alcohol or drugs?*
 - *Do you see any negative aspects of taking alcohol or drugs?*
 - *Did you ever regret using alcohol or drugs?*
 - ♦ **Challenge** any exaggerated sense of benefit from alcohol or drug use. For example, if the person uses alcohol or drugs to try to forget life problems, say:
 - *Is forgetting the problem really a good thing? Does that make the problem go away?*
 - ♦ **Highlight** some of the negative aspects of alcohol and drug use that may have been underestimated by the person.
 - *How much money do you spend buying alcohol or drugs? Per week? Per month? Per year? What else could you be doing with that money?*
- ♦ **Provide** additional information on the harmful effects of alcohol and drugs, both short-term and long-term.
 - *Alcohol or drugs may result in serious medical and mental health problems, including injuries and addiction.*
- ♦ **Acknowledge** that stopping alcohol or drug use is difficult. Let the person know you are willing to support them. Encourage people to *decide for themselves* if it is a good idea to stop alcohol or drugs.
- ♦ If the person is not ready to stop or reduce alcohol or drugs, respect the decision. Ask the person to come back another time to talk further.
- » **Repeat** the brief motivational conversations described above **over several sessions**.

4. Discuss various ways to reduce or stop harmful use

- » Discuss the following strategies:
 - ♦ Do not store alcohol or drugs at home.
 - ♦ Do not go near places where people may use alcohol or drugs.
 - ♦ Ask for support from carers and friends.
 - ♦ Ask carers to accompany the person to follow-up visits.
 - ♦ Encourage social activities without alcohol or drugs.
 - ♦ Consider referral to a self-help group for alcohol or drug use, if available.
 - » If the person agrees to stop using alcohol or drugs, then inform them of the possibility of developing transient withdrawal symptoms (i.e. <1 week). Describe the symptoms (e.g. anxiety and agitation after withdrawal from opiates, benzodiazepines and alcohol). Advise the person to return to the clinic if there are severe symptoms.

5. Offer psychosocial support as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*)

- » Address current psychosocial stressors.
- » Strengthen social support.
- » Teach stress management.

6. Offer regular follow-up

- » Continue to offer support, discuss and work together with the person and the carers about reducing or stopping alcohol or drug use.
- Schedule and conduct regular follow-up sessions (>> *Principles of Management in General Principles of Care*).



Box SUB 1 Assessment and management of life-threatening alcohol withdrawal

Typical presenting complaints of person with life-threatening alcohol withdrawal

- » Agitation, severe anxiety
- » Confusion or hallucinations* (seeing, hearing or feeling things that are not there)
- » Convulsions/seizures
- » Increased blood pressure (e.g. >180/100 mm Hg) and/or heart rate (e.g >100 bpm).

Assessment of life-threatening alcohol withdrawal

Assessment question 1: Is this alcohol withdrawal?

- » Rule out and manage other causes that can explain the symptoms, including:
 - ♦ Malaria, HIV/AIDS, other infections, head injury, metabolic abnormality* (e.g. hypoglycemia*, hyponatraemia*), hepatic encephalopathy, hyperthyroidism*, stroke, drug use (e.g. amphetamines), known history of psychosis and known history of epilepsy.
- » If the above causes are ruled out, take an alcohol history by asking the person and carers:
 - ♦ Does the person drink alcohol?
 - ♦ When was the last drink?
 - ♦ How much does the person usually drink?
- » Alcohol withdrawal is likely if the symptoms develop after the cessation of regular/heavy alcohol use. This happens typically 1–2 days after the last drink.
 - ♦ If the person has seizures or hallucinations and if alcohol withdrawal is not suspected, then assess for epilepsy (>> *EPI*) or psychosis (>> *PSY*).

Assessment question 2: If the person has alcohol withdrawal, is this life-threatening alcohol withdrawal?

- » Assess for life-threatening features:
 - ♦ Convulsions/seizures (typically within 48 hours)
 - ♦ Features of delirium* (typically within 96 hours)
 - ▶ acute confusion, disorientation
 - ▶ hallucinations.
- » Assess whether the person is at high risk of developing life-threatening features (convulsions or delirium) in the next 1–2 days:
 - ♦ Previous life-threatening features (convulsions or delirium) or
 - ♦ Current and severe withdrawal symptoms:
 - ▶ severe agitation, severe irritability, severe anxiety
 - ▶ excessive sweating, tremor of hands
 - ▶ increased blood pressure (e.g. >180/100 mm Hg) and/or heart rate (e.g. >100 bpm).



If delirium due to alcohol withdrawal is suspected, initiate the emergency management plan for life-threatening alcohol withdrawal (see below) and arrange accompanied transfer to the nearest hospital.

Emergency management plan for life-threatening alcohol withdrawal

1. Treat alcohol withdrawal immediately with diazepam (>> Table SUB 1)

- » The dose of diazepam treatment depends on the person's tolerance* for diazepam, the severity of the withdrawal symptoms and the presence of concurrent physical disorders.
 - ♦ Adjust the dose to the observed effect. The right dose is the one that gives slight sedation.
 - ▶ Too high a dose can cause over-sedation and depress respiration. Monitor the person's respiratory rate and level of sedation (e.g. sleepiness) frequently.
 - ▶ Too low a dose risks seizures/delirium.
- » Monitor the withdrawal symptoms frequently (every 3–4 hours). Continue to use diazepam until symptoms resolve (typically 3–4 days but no longer than 7 days).
- » In the case of a withdrawal seizure, DO NOT use antiepileptic drugs. Continue using diazepam.
- » Symptoms of delirium such as confusion, agitation or hallucinations can persist for several weeks after other alcohol withdrawal symptoms have resolved. In this case, consider using antipsychotics such as haloperidol 2.5–5 mg orally up to 3 times daily until confusion, agitation or hallucinations improve. In some cases it may take several weeks for hallucinations and confusion to resolve. Do not oversedate.

- » If possible, provide a quiet, non-stimulating and well-lit environment. Try to provide some light even at night to prevent falls if the person decides to get up in the middle of the night. Consider putting the person on a mattress on the floor to prevent injury. If possible, ask a carer to stay with the person and monitor. Avoid restraints if at all possible.

2. Address malnutrition

- » Give vitamin B1 (thiamine) 100 mg/day orally for 5 days.
- » Assess for and address malnourishment.

3. Maintain hydration

- » Start i.v. hydration if possible.
- » Encourage oral fluid intake (at least 2–3 litres/day).

4. When the life-threatening withdrawal is over, proceed to assessment and management of harmful alcohol or drug use (see main text of this module)

Table SUB 1: Diazepam for life-threatening alcohol withdrawal

	Diazepam ^a
Initial dose	10–20 mg up to 4 times/day for 3–7 days
Subsequent dose	Gradually decrease the dose and/or frequency as soon as the symptoms improve. Monitor frequently, as people respond differently to this medication
Route	Oral
Severe side-effects (rare)	Respiratory depression*, severely impaired consciousness Caution: monitor respiratory rate and level of sedation frequently
Common side-effects	Drowsiness, amnesia, altered consciousness, muscle weakness Caution: do not give another dose if the person is drowsy
Precautions in special groups	Use one quarter to half of the suggested dose in older people Do not use in people with respiratory problems

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

Mental disorder, acute emotional distress and hopelessness are common in humanitarian settings. Such problems may lead to *suicide** or acts of *self-harm**. Some health-care workers mistakenly fear that asking about suicide will provoke the person to attempt suicide. On the contrary, talking about suicide often reduces the person's anxiety around suicidal thoughts, helps the person feel understood and opens opportunities to discuss the problem further.

Adults and adolescents with any of the mental, neurological or substance use (MNS) conditions covered in this guide are at risk of suicide or self-harm.

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

Feeling extremely upset or distressed

Profound hopelessness or sadness

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

Assessment

Assessment question 1: Has the person recently attempted suicide or self-harm?

- » Assess for:
 - ♦ **Poisoning**, alcohol/drug intoxication, medication overdose or other self-harm
 - ♦ **Signs requiring urgent medical treatment**
 - Bleeding from self-inflicted wound
 - Loss of consciousness
 - Extreme lethargy.

Assessment question 2: Is there an imminent risk of suicide or self-harm?

- » Ask the person and/or carers about:
 - ♦ Thoughts or plans of suicide (currently or in past month)
 - ♦ Acts of self-harm in the past year
 - ♦ Access to means of suicide (e.g. pesticides, rope, weapons, knives, prescribed medications and drugs).
- » Look for:
 - ♦ Severely emotional distress or hopelessness
 - ♦ Violent behaviour or extreme agitation
 - ♦ Withdrawal or unwillingness to communicate.
- » The person is considered at **imminent risk** of suicide or self-harm if either of the following is present:
 - ♦ **Current thoughts**, plans or acts of suicide
 - ♦ **History of thoughts or plans** of self-harm in the past month or acts of self-harm in the past year in a person who is now extremely agitated, violent, distressed or uncommunicative.

Assessment question 3: Are there concurrent conditions associated with suicide or self-harm?

- » Assess and manage possible concurrent conditions:
 - ♦ Chronic pain or disability (e.g. due to recent injuries incurred during the humanitarian emergency)
 - ♦ Moderate-severe depressive disorder (>> **DEP**)
 - ♦ Psychosis (>> **PSY**)
 - ♦ Harmful alcohol or drug use (>> **SUB**)
 - ♦ Post-traumatic stress disorder (>> **PTSD**)
 - ♦ Acute emotional distress (>> **ACU, GRI, OTH**).

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

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

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

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

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

3. If the person has expressed suicidal ideas:

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

Basic Management Plan

1. If the person has attempted suicide, provide the necessary medical care, monitoring and psychosocial support

» Provide medical care:

- ♦ Treat those who have inflicted self-harm with the same care, respect and privacy given to others. Do not punish them.
- ♦ Treat the injury or poisoning.
 - For acute pesticide intoxication, see *Clinical Management of Acute Pesticide Intoxication* (WHO, 2008).
- ♦ In the case of a prescribed medication overdose where medication is still required, choose the least harmful alternative medication. If possible, prescribe the new medication for short periods of time only (e.g. a few days to 1 week at a time) to prevent another overdose.

» Monitor the person continuously while they are still at imminent risk of suicide (see below for guidance).

- » Offer psychosocial support (see below for guidance).
- » Consult a mental health specialist if available.

2. If the person is at imminent risk of suicide or self-harm, monitor and provide psychosocial support

» Monitor the person:

- ♦ Create a safe and supportive environment for the person. Remove all possible means of self-harm/suicide and, if possible, offer a separate, quiet room. However, do not leave the person alone. Have carers or staff stay with the person **at all times**.
- ♦ DO NOT routinely admit people to general medicine wards to prevent acts of suicide. Hospital staff may not be able to monitor a suicidal person sufficiently. However, if admission to a general ward for the medical consequences of self-harm is required, monitor the person closely to prevent subsequent acts of self-harm in the hospital.
- ♦ Regardless of the location, ensure that the person is monitored 24 hours a day until they are no longer at imminent risk of suicide.

» Offer psychosocial support:

- ♦ DO NOT start by offering potential solutions to the person's problems. Instead, try to instil hope. For example:
 - *Many people who have been in similar situations – feeling hopeless, wishing they were dead – have then discovered that there is hope, and their feelings have improved with time.*
 - ♦ Help the person to identify reasons to stay alive.
 - ♦ Search together for solutions to the problems.
 - ♦ Mobilize carers, friends, other trusted individuals and community resources to monitor and support the person if they are at imminent risk of suicide. Explain to them about the need for 24-hour-per-day monitoring. Ensure that they come up with a concrete and feasible plan (e.g. who is monitoring the person at what time of the day).
 - ♦ Offer additional psychosocial support as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> **General Principles of Care**).
- » Consult a mental health specialist if available.

3. Care for the carers as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> **General Principles of Care**)

4. Maintain regular contact and follow-up

- » Make sure there is a **concrete plan for follow-up sessions** and that the carers take responsibility for ensuring follow-up (>> *Principles of Management in General Principles of Care*).

- » Maintain regular contact (e.g. via telephone, text messages or home visits) with the person.

- » Follow up frequently in the beginning (e.g. weekly for the first 2 months) and decrease frequency as the person improves (every 2–4 weeks).

- » Follow up for as long as the suicide risk persists. At every contact, routinely assess suicidal thoughts and plans.

Other Significant Mental Health Complaints

OTH

While this guide has covered key mental, neurological and substance use (MNS) conditions relevant to humanitarian settings, it does not cover all possible mental health conditions that can occur. Therefore, this module aims to provide basic guidance on initial support for adults, adolescents and children who suffer from mental health complaints that are not covered elsewhere in this guide.

Other mental health complaints include

- (a) various physical symptoms that do not have physical causes and
- (b) mood and behaviour changes that cause concern but do not fully meet the criteria of the conditions covered in other modules of this guide.

These may include complaints involving *mild* depressive disorder and a range of subclinical conditions.

Other mental health complaints are considered *significant* when they impair daily functioning or when the person seeks help for them.

Assessment

Assessment question 1: Is there a physical cause that fully explains the presenting symptoms?

- » Conduct a general **physical examination** followed by appropriate medical investigations.
- » Manage any physical cause identified and recheck if the symptoms persist.

Assessment question 2: Is this an MNS condition discussed in another module of this guide?

- » Exclude:
 - ♦ **Significant symptoms acute stress (>> ACU)**
 - Core features:
 - potentially traumatic event within the last month
 - symptoms started after the loss
 - help-seeking to relieve symptoms or has considerable difficulty with daily functioning because of the symptoms.
 - ♦ **Significant symptoms grief (>> GRI)**
 - Core features:
 - major loss
 - symptoms started after the event
 - help-seeking to relieve symptoms or has considerable difficulty with daily functioning because of the symptoms.
 - ♦ **Moderate-severe depressive disorder (>> DEP)**
 - Core features (for at least 2 weeks):
 - persistent depressed mood
 - markedly diminished interest or pleasure in activities, especially those that were previously enjoyable
 - considerable difficulty with daily functioning because of the symptoms.
 - ♦ **Post-traumatic stress disorder (>> PTSD)**
 - Core features:
 - potentially traumatic event that happened more than a month ago
 - recurring frightening dreams, flashbacks* or intrusive memories* of the events accompanied by intense fear or horror
 - deliberate avoidance of reminders of the event
 - heightened sense of current threat (excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements)
 - Considerable difficulty with daily functioning because of the symptoms.
 - ♦ **Harmful alcohol or drug use (>> SUB)**
 - Core feature:
 - use of alcohol or drugs that is causing harm to self and/or others.
 - ♦ **Suicide/self-harm (>> SUI)**
 - Core features:
 - current acts of self-harm; current thoughts and plans of suicide, or
 - recent thoughts, plans and acts of self-harm in a person who is severely distressed, agitated, unwilling to communicate or withdrawn.
- » If any of the above conditions are suspected, then go to the appropriate module for assessment and management.
- » If 1) physical causes are excluded, 2) the above MNS conditions are excluded and 3) the person is seeking help to relieve symptoms or has considerable difficulty with daily functioning because of their symptoms, then the person has *another significant mental health complaint*.
 - ♦ It usually takes more than one meeting to exclude physical causes and the above MNS conditions.

Assessment question 3: If the person is an adolescent, is there a behavioural problem?

- » Interview both the adolescent and the carers to assess for persistent or concerning behavioural problems. Examples include:
 - ♦ Initiating violence
 - ♦ Drug use
 - ♦ Bullying or being cruel to peers
 - ♦ Vandalism
 - ♦ Risky sexual behaviour.
- » If the adolescent has a behaviour problem, ask further questions about:
 - ♦ Extreme stressors in the adolescent's past or current life (e.g. sexual abuse)
 - ♦ Parenting (inconsistent or harsh discipline, limited emotional support, limited monitoring, mental condition in the carer)
 - ♦ How the adolescent spends most of his or her time. Ask:
 - (if the adolescent works or goes to school) *How do you spend your time after work/school? Are there any regular activities that you do?*
 - *Are you often bored? What do you do when you are bored?*

Basic Management Plan



**DO NOT prescribe medicines for “other significant mental health complaints” (unless advised by a specialist).
DO NOT give vitamin injections or other ineffective treatments.**

1. In all cases (whether the person presents with emotional, physical or behavioural problems), provide basic psychosocial support as described in the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*)

- » Address current psychosocial stressors.
- » Strengthen social support.
- » Teach stress management.

2. When no physical condition is identified that fully explains a presenting somatic symptom, acknowledge the reality of the symptoms and provide possible explanations

- » DO NOT order more laboratory or other investigations unless there is a clear medical indication (e.g. abnormal vital signs).
 - ♦ Ordering unnecessary clinical investigations may reinforce the person’s belief that there is a physical problem.
 - ♦ Clinical investigations can have adverse side-effects.
- » Inform the person that no serious disease has been identified. Communicate the normal clinical and test findings.
 - ♦ *We did not find any serious physical problem. I do not see a need for any more tests at this point.*
- » If the person insists on further investigations, consider saying:
 - ♦ *Performing unnecessary investigations can be harmful because they can cause unnecessary worry and side-effects.*
- » Acknowledge that the symptoms are not imaginary and that it is still important to address symptoms that cause significant distress.
- » Ask for the person’s own explanation for the cause of the symptoms. This may give clues as to the cause, help build a trusting relationship with the person and increase the person’s adherence to management.
- » Explain that emotional suffering/stress often involves the experience of bodily sensations (stomach ache, muscle tension, etc.). Ask for and discuss potential links between the person’s emotions/stress and symptoms.
- » Encourage continuation of (or gradual return to) daily activities.
- » Remember also to apply the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*).

3. If the person is an adolescent who has behaviour problems

- » Take time to listen to the adolescent’s own perception of the problem (preferably do this without the presence of the carers).
- » Provide psychoeducation to the adolescent and their carers. Explain the following:
 - ♦ Adolescents sometimes develop problematic behaviours when they are angry, bored, anxious or sad. They need continuous care and support despite their behaviour.
 - ♦ Carers should make every effort to communicate with the adolescent, even that it is difficult.
 - ♦ Specific messages for the carers:
 - ▶ *Try to identify positive, enjoyable activities that you can do together.*
 - ▶ *Be consistent with respect to what the adolescent is allowed to do and not allowed to do.*
 - ▶ *Praise or reward the adolescent for good behaviours and correct only the most problematic behaviours.*
- ▶ *Never use physical punishment. Use praise for good behaviour more than punishment for bad.*
- ▶ *Do not confront the adolescent when you are very upset. Wait until you are calm.*
- ♦ Specific points for discussion with the adolescent:
 - ▶ There are healthy ways to deal with boredom, stress or anger (e.g. doing activities that are relaxing, being physically active, engaging in community activities).
 - ▶ It can be helpful to talk to trusted people about feeling angry, bored, anxious or sad.
 - ▶ Alcohol and other substance use can worsen feelings of anger and depression and should be avoided.
- » Promote participation in:
 - ♦ Formal and informal education
 - ♦ Concrete, purposeful, common interest activities (e.g. constructing shelters)
 - ♦ Structured sports programmes.
- » Remember also to apply the *Principles of Reducing Stress and Strengthening Social Support* (>> *General Principles of Care*) to this group of adolescents and their carers.

4. Follow-up

- » Advise the person to come back if the symptoms persist, worsen or become intolerable.
- » If no improvement is seen or the person or the carer insists on further investigations and treatment, consult a specialist.

1. Epilepsy/seizures

A person with epilepsy has at least 2 episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

2. Alcohol or other substance use disorder

A person with this disorder seeks to consume alcohol or other addictive substances and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol or other addictive substances despite these problems.

3. Intellectual disability

The person has very low intelligence, causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after themselves and/or dependants without support from others. When the disability is severe, the person may have difficulties speaking and understanding others and may require constant assistance.

4. Psychotic disorder (including mania)

The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused or incoherent and their appearance unusual. They may neglect themselves. Alternatively, they may go through periods of being extremely happy, irritable, energetic, talkative and reckless. The person's behaviour is considered "crazy"/highly bizarre by other people from the same culture. This category includes acute psychosis, chronic psychosis, mania and delirium.

5. Moderate-severe emotional disorder/depression

This person's daily normal functioning is markedly impaired for more than 2 weeks due to a) overwhelming sadness/apathy and/or b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.

This category includes people with disabling forms of depression, anxiety disorders and post-traumatic stress disorder (characterized by re-experiencing, avoidance and hyper-arousal). Presentations of milder forms of these disorders are classified as "other psychological complaint".

6. Other psychological complaint

This category covers complaints related to emotions (e.g. depressed mood, anxiety), thoughts (e.g. ruminating, poor concentration) or behaviour (e.g. inactivity, aggression, avoidance).

The person tends to be able to function in most day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder (e.g. mild forms of depression, of anxiety disorder or of post-traumatic stress disorder) or may represent normal distress (i.e. no disorder).

Inclusion criteria: This category should only be applied if a) if the person is requesting help for the complaint and b) if the person is not positive for any of the above 5 categories.

7. Medically unexplained somatic complaint

This category covers any somatic/physical complaint that does not have an apparent organic cause.

Inclusion criteria: This category should only be applied a) after conducting necessary physical examinations, b) if the person is not positive for any of the above 6 categories and c) if the person is requesting help for the complaint.

Ascites	Abnormal accumulation of fluid in the abdomen, from various causes.
Akathisia	A subjective sense of restlessness, often accompanied by observed excessive movements (e.g. fidgety movements of the legs, rocking from foot to foot, pacing, inability to sit or stand still).
Amphetamines	Group of drugs that have a stimulant effect on the central nervous system. They can heighten mental alertness and sense of being awake. They may be used as the basis of treatment for some health conditions but are also drugs of abuse that can produce hallucinations, depression and cardiovascular effects.
Behavioural activation	Psychological treatment that focuses on improving mood by engaging again in activities that are task-oriented and used to be enjoyable, in spite of current low mood. It may be used as a stand-alone treatment, and it is also a component of cognitive behavioural therapy.
Benzodiazepines	Class of medicines that have sedative (sleep-inducing), anti-anxiety, anticonvulsant and muscle-relaxing properties.
Bipolar disorder	Severe mental disorder characterized by alternation between manic and depressive episodes.
Bone marrow depression	Suppression of bone marrow function, which can lead to deficiencies in blood cell production.
Cannabis	General name for parts of the hemp plant, from which marijuana, hashish and hash oil are derived. These are either smoked or eaten to induce euphoria, relaxation and altered perceptions. They may reduce pain. Harmful effects include demotivation, agitation and paranoia.
Cerebral palsy	Disorder of motor and intellectual abilities caused by early permanent damage to the developing brain.
Cognitive	Mental processes associated with thinking. These include reasoning, remembering, judgement, problem-solving and planning.
Cognitive behavioural therapy (CBT)	Psychological treatment that combines cognitive components (aimed at thinking differently, for example through identifying and challenging unrealistic negative thoughts) and behavioural components (aimed at doing things differently, for example by helping the person to do more rewarding activities).
Cognitive behavioural therapy with a trauma focus (CBT-T)	Psychological treatment based on the idea that people who were exposed to a traumatic event have unhelpful thoughts and beliefs related to that event and its consequences. These thoughts and beliefs result in unhelpful avoidance of the reminders of the event and a sense of current threat. The treatment usually includes exposure to those reminders and challenging unhelpful trauma-related thoughts or beliefs.
Community-based rehabilitation (CBR)	Set of interventions delivered through a multi-sectoral strategy in community settings, using available community resources and institutions. It aims to achieve rehabilitation by enhancing the quality of life for people with disabilities and their families, meeting basic needs and ensuring inclusion and participation.
Delirium	Transient fluctuating mental state characterized by disturbed attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day. It is accompanied by (other) disturbances of perception, memory, thinking, emotions or psychomotor functions. It may result from acute organic causes such as infections, medication, metabolic abnormalities, substance intoxication or substance withdrawal.
Delusion	Fixed belief that is contrary to available evidence. It cannot be changed by rational argument and is not accepted by other members of the person's culture or subculture (i.e., it is not an aspect of religious faith).
Dependence	People are dependent on a substance (drugs, alcohol or tobacco) when they develop uncomfortable cognitive, behavioural and physiological symptoms in its absence. These withdrawal symptoms result in their seeking to take more of that substance. They cannot control their substance use and continue despite adverse consequences.
Dilated /constricted pupils	The pupil (black part of the eye) is the opening in the centre of the iris that regulates the amount of light getting into the eye. Pupils normally constrict (shrink) in light to protect the back of the eye and dilate (enlarge) in the dark to allow maximum light into the eye. Having dilated or constricted pupils can be a sign of being under the influence of drugs.
Down syndrome	A genetic condition caused by the presence of an extra chromosome 21. It is associated with varying degrees of intellectual disability, delayed physical growth and characteristic facial features.

¹⁰ Glossary terms are marked with the asterisk symbol * in the text.

¹¹ The operational definitions included in this glossary are for use only within the scope and context of the publication *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies* (WHO & UNHCR, 2015).

Drug-disease interaction	Situation where a drug prescribed to treat one health condition affects another health condition in the same person.
Drug-drug interaction	Situation where two drugs taken by the same person interact with each other, altering the effect of either or both drugs. Interactions can include lessening the effect of a drug, enhancing or speeding up an effect, or having a toxic effect.
Extrapyramidal side-effects	Abnormalities in muscle movement, mostly caused by antipsychotic medication. These include muscle tremors, stiffness, spasms and/or akathisia.
Eye movement desensitisation and reprocessing (EMDR)	Psychological treatment based on the idea that negative thoughts, feelings and behaviours result from unprocessed memories of traumatic events. The treatment involves standardized procedures that include focusing simultaneously on (a) associations of traumatic images, thoughts, emotions and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements.
Flashback	An episode where the person believes and acts for a moment as though they are back at the time of the event, living through it again. People with flashbacks briefly lose touch with reality, usually for a few seconds or minutes.
Hallucination	False perception of reality: seeing, hearing, feeling, smelling or tasting things that are not real.
Hepatic encephalopathy	Abnormal mental state including drowsiness, confusion or coma caused by liver dysfunction.
Hyperthyroidism	Condition in which the thyroid gland produces and secretes excessive amounts of thyroid hormones. Some of the symptoms of this condition such as delirium, tremors, high blood pressure and increased heart rate may be confused with alcohol withdrawal.
Hyperventilation	Breathing abnormally fast, resulting in hypocapnia (too little CO ₂ in the blood). This can produce characteristic symptoms of tingling or having a sensation of pins and needles in the fingers and around the mouth, chest pain and dizziness.
Hypoglycaemia	Abnormally low concentration of glucose (sugar) in the blood.
Hyponatraemia	Abnormally low concentration of sodium (salt) in the blood.
Hypothyroidism	Abnormally low activity of the thyroid gland. In adults, it can cause a range of symptoms such as fatigue, lethargy, weight gain and low mood that can be confused with depression. If present at birth and untreated, it may lead to intellectual disability and failure to grow.
Interpersonal therapy (IPT)	Psychological treatment that focuses on the link between depressive symptoms and interpersonal problems, especially those involving loss, conflict, isolation and major life changes.
Intrusive memories	Recurrent, unwanted, distressing memories of a traumatic event.
Iodine deficiency	Condition where the body lacks iodine required for normal production of thyroid hormone, affecting growth and development.
Khat	Leaves of the shrub <i>Catha edulis</i> , containing a stimulant substance. It is both a recreational drug and a drug of abuse and can create dependence.
Log-roll	Method of turning a person from one side to another without bending their neck or back, in order to prevent spinal cord damage.
Medically unexplained paralysis	Partial or total loss of strength in any part of the body without any identifiable organic cause.
Meningeal irritation	Irritation of the layers of tissue that cover the brain and spinal cord, usually caused by an infection.
Metabolic abnormality	Abnormality in the body's hormones, minerals, electrolytes or vitamins.
Mourning	The processes through which a bereaved person pays attention, bids farewell and memorialises the dead, both in private and in public. Mourning usually involves rituals such as funerals and customary behaviours such as changing clothing, remaining at home and fasting.
Neuroinfection	Infection involving the brain and/or spinal cord.
Neuroleptic malignant syndrome	A rare but life-threatening condition caused by antipsychotic medications, which is characterised by fever, delirium, muscular rigidity and high blood pressure.
Non-steroidal anti-inflammatory drugs (NSAIDs)	Group of drugs used to suppress inflammation. They are often used for pain relief (for example, ibuprofen is an NSAID).
Opiate	Narcotic drug derived from the opium poppy. Opiates are very effective painkillers but can be addictive and create dependence. Heroin is an opiate.
Orthostatic hypotension	Sudden drop of blood pressure that can occur when one changes position from lying to sitting or standing up, usually leading to feelings of light-headedness or dizziness. It is not life-threatening.

Polytherapy	Provision of more than one medicine at the same time for the same condition.
Potentially traumatic event	Any threatening or horrific event such as physical or sexual violence, witnessing of an atrocity, destruction of a person's house, or major accidents or injuries. Whether or not these kinds of event are experienced as traumatic will depend on the person's emotional response.
Problem-solving counselling	Psychological treatment that involves the systematic use of problem identification and problem-solving techniques over a number of sessions.
Problem-solving techniques	Techniques that involve working together with a person to brainstorm solutions and coping strategies for identified problems, prioritizing them, and discussing how to implement these solutions and strategies. In mhGAP the term "problem-solving counselling" is used when these techniques are used systematically over a number of sessions.
"Pseudoseizure"	An episode that appears to be an epileptic seizure but actually is not. They can mimic epileptic seizures closely in terms of changes in consciousness and movements, although tongue biting, serious bruising due to falling, and incontinence of urine are rare. Such episodes do not show the electrical activity of epileptic seizures. Symptoms are not due to a neurological condition or to the direct effects of a substance or medication. In ICD-11 proposals, these episodes are covered under dissociative motor disorder.
Psychological first aid (PFA)	Provision of supportive care to people in distress who have recently been exposed to a crisis event. The care involves assessing immediate needs and concerns; ensuring that immediate basic physical needs are met; providing or mobilizing social support; and protecting from further harm.
Regressive behaviour	Behaviour that is inappropriate to a child's actual developmental age but would be appropriate for someone younger. Common examples are bedwetting and clinginess in children.
Respiratory depression	Inadequate slow breathing rate, resulting in insufficient oxygen. Common causes include brain injury and intoxication (e.g. due to benzodiazepines).
Seizure	Episode of brain malfunction due to abnormal electrical discharges.
Self-harm	Intentional self-inflicted poisoning or injury to oneself, which may or may not have a fatal intent or outcome.
Self-medicating	Self-administering alcohol or drugs (including prescribed medicines) to reduce physical or psychological problems without consulting a health professional.
Sepsis	Life-threatening condition caused by severe infection, with signs such as fever, disruption of the circulatory system and dysfunction of organs.
Shock	Condition where a person's circulatory system collapses as a result of an infection or other toxins whereby the blood pressure may drop to a level unsustainable for survival. Signs include low or undetectable blood pressure, cold skin, a weak or absent pulse, troubled breathing and altered level of consciousness.
SSRI	Selective serotonin reuptake inhibitors: class of antidepressant drugs that selectively block the reuptake of serotonin. Serotonin is a chemical messenger (neurotransmitter) in the brain that is thought to affect a person's mood. Fluoxetine is an SSRI.
Steroids	A group of hormones available as medication that have important functions including suppressing inflammatory reactions to infections, toxins and other immune-related disorders. Examples of steroid medication include glucocorticoids (e.g., prednisolone) and hormonal contraceptives.
Stevens-Johnson syndrome	Life-threatening skin condition characterized by painful skin peeling, ulcers, blisters and crusting of mucocutaneous tissues such as mouth, lips, throat, tongue, eyes and genitals, sometimes associated with fever. It is most often caused by severe reaction to medications, especially antiepileptic drugs.
Suicide	The act of deliberately causing one's own death.
TCA	Tricyclic antidepressants: class of antidepressant drugs that block the reuptake of the neurotransmitters noradrenaline and serotonin. Examples include amitriptyline and clomipramine.
Tolerance	Diminishing effect of a drug when used at the same dose. It results from the body's habituation to the drug due to repeated consumption. Higher doses are then required to create the same effect.
Toxic epidermal necrolysis	Life-threatening skin peeling that is usually caused by a reaction to a medicine or infection. It is similar to but more severe than Stevens-Johnson syndrome.
Tramadol	Prescribed opioid used to relieve pain. It is sometimes misused because it can induce feelings of euphoria (feeling "high" or happy).
Tremor	Trembling or shaking movements, usually of the fingers.
Urosepsis	Sepsis caused by urinary tract infection.

Annex 3: Symptom Index

Anxiety	Acute Stress (ACU) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD) Psychosis (PSY) Harmful Use of Alcohol and Drugs (SUB)
Appetite problem	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP)
Bedwetting	Acute Stress (ACU) Intellectual Disability (ID)
Confusion	Psychosis (PSY) Epilepsy/Seizures (EPI) Harmful Use of Alcohol and Drugs (SUB)
Delusions	Psychosis (PSY)
Difficulty carrying out usual activities	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD) Psychosis (PSY) Intellectual Disability (ID) Harmful Use of Alcohol and Drugs (SUB)
Flashbacks	Acute Stress (ACU) Post-traumatic Stress Disorder (PTSD)
Hallucinations	Psychosis (PSY) Harmful Use of Alcohol and Drugs (SUB)
Hopelessness	Grief (GRI) Moderate-severe Depressive Disorder (DEP) Suicide (SUI)
Hyperventilation	Acute Stress (ACU)
Incontinence	Epilepsy/Seizures (EPI) Intellectual Disability (ID)
Insomnia	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD) Harmful Use of Alcohol and Drugs (SUB)
Intrusive memories	Acute Stress (ACU) Grief (GRI) Post-traumatic Stress Disorder (PTSD)
Irritability	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD) Harmful Use of Alcohol and Drugs (SUB)
Learning problem	Intellectual Disability (ID)
Loss of energy	Grief (GRI) Moderate-severe Depressive Disorder (DEP)

Low interest, pleasure	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP)
Poor hygiene	Psychosis (PSY) Intellectual Disability (ID) Harmful Use of Alcohol and Drugs (SUB)
Reduced concentration	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD) Harmful Use of Alcohol and Drugs (SUB)
Sad mood	Grief (GRI) Moderate-severe Depressive Disorder (DEP)
Seizures, convulsions	Epilepsy/Seizures (EPI) Harmful Use of Alcohol and Drugs (SUB)
Self-harm	Suicide (SUI)
Social withdrawal	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Psychosis (PSY)
Unexplainable physical symptoms	Acute Stress (ACU) Grief (GRI) Moderate-severe Depressive Disorder (DEP) Post-traumatic Stress Disorder (PTSD)

In every general health facility in humanitarian emergencies at least one supervised health care-staff member should be capable to assess and manage mental, neurological and substance use conditions.

The *mhGAP Humanitarian Intervention Guide (mhGAP-HIG)* is a simple, practical resource that aims to ensure this target.



mental health Global Action Programme

