



स्वास्थ्य विभाग
Ministry of Health and Family Welfare
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**Training Manual on Mental, Neurological and
Substance Use (MNS) Disorders Care for Staff Nurse**
at Ayushman Bharat – Health and Wellness Centres



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INTRODUCTION TO THE MODULE



As part of Ayushman Bharat- Health and Wellness Centre roll out, there is expansion in package of services delivered at primary care level. One of the additional service packages is related to Mental, Neurological and Substance use disorders.

Mental health disorders are prevalent in the community. The National Mental Health Survey (NMHS) conducted in 2017 in India, reported the prevalence of any mental health condition as 10.6% (point prevalence) and 13.7% (lifetime prevalence). Suicide is also the third leading cause of Years of Lives Lost (YLL) in several states in India.

There are peculiar challenges in service delivery for these conditions due to various causes such as myths and misconceptions about conditions, stigma and discrimination against the individuals with disorders, and limited information regarding the disease and treatment availability. Nationally, the treatment gap for mental disorders ranged between 70% and 92% for different disorders: common mental disorder - 85.0%, severe mental disorder - 73.6%, psychosis - 75.5%, alcohol use disorder - 86.3% and tobacco use - 91.8%. (as per NMHS 2017).

The treatment gap is also due to shortage of trained human resources and specialists. Nevertheless, it has been demonstrated that care can be delivered efficiently by training of frontline workers and nurses, who are closer to the community. These trained service providers can facilitate early detection and appropriate referral of persons in mental distress and will provide community based psychosocial interventions and rehabilitation. Therefore, it is critical to integrate these services within primary health care.

You might have come across or heard about mental health disorders in your community. This can include people with complaints of unusual constant fear or long-lasting sad mood or some who might exhibit symptoms like hearing voice when no one is talking. The objective of Comprehensive Primary Health Care is to provide appropriate and quality services to all these individuals, presenting with any signs of mental distress and more importantly promote mental health and prevent mental health disorders.

ROLE OF STAFF NURSE IN MENTAL NEUROLOGICAL AND SUBSTANCE USE DISORDER CARE

You have been posted at PHC-HWCs to facilitate provision of Comprehensive Primary Health Care along with the Medical Officer. As a skilled service provider, you would have a key role in provision of services related to MNS disorders.

This module will tell you in detail about mental health related topics, especially the application of the knowledge and skills in your Primary health centre and community. It will guide you on how you can help people in the community who are suffering from any of these disorders. It would also help you to facilitate prevention of mental disorders, early detection of the individuals with mental disorders and reduce the stigma.

TRAINING IN THIS MODULE WILL HELP YOU

- ▶ Build your knowledge of mental, neurological and substance use disorders, risk factors, symptoms and signs and management at PHC-HWC level
- ▶ Identify emergencies in MNS disorders and how to manage them
- ▶ Provide clinical support to the Medical Officer and help arrive at treatment plan together.
- ▶ Build your general and specific counselling skills and ability to match counselling strategies to the needs of the patient
- ▶ Know when, where, how and whom to refer (identify red flags)
- ▶ Provide follow up care and treatment adherence support as and when required at the PHC-HWC.
- ▶ Conduct monitoring and supportive supervision visits along with MOs to SHC-HWCs
- ▶ Serve as mentors and trainers to Primary Health Care Team
- ▶ Understand vulnerabilities and stigma and discrimination faced by persons with mental disorders and rights violations associated with mental health disorders (legal, ethical issues)

CHAPTER 1

INTRODUCTION TO MENTAL HEALTH AND MENTAL HEALTH DISORDERS

Mental Illness are classified in many ways based on the characteristics of the illness, severity, duration and the disability it causes to an individual. Mental disorders can affect women and men differently. Understanding mental illness in human being is essential role of Community Health Officers.

WHAT IS MENTAL HEALTH?

As per the definition of World Health Organization (WHO), health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Thus, for an individual to stay healthy, apart from physical health, mental well-being is equally important. It has been proposed by WHO 'that there can be no physical health without mental health'.

Mental well-being of an individual implies that an individual is able to:

- ▶ realize his or her own potentials,
- ▶ cope with the normal stresses of life,
- ▶ work productively and fruitfully, and
- ▶ make a contribution to her or his community.

Few major components influencing the mental health include:

Resilience: Life poses various short- and long-term challenges. Dealing with them effectively and not getting overwhelmed by them is crucial for mental health. Various life skills such as critical thinking, problem solving and stress tolerance can help us in this.

Self-esteem: Self-esteem refers to our perception towards ourselves; for example, in our own evaluation how valuable we are to others and how confident we are in our own abilities. Positive self-esteem helps us in realization of our potentials and having a sense of control.

Emotional Well-being: Regulations of emotions in constructive manner and dealing with emotional upheavals so that they do not affect us negatively are important for our emotional well-being.

Spiritual Well-being: It refers to having sense of purpose in life and our connectedness with others. Spirituality does not mean religiosity but religious beliefs can be one of the means for our spiritual well-being. Apart from this, sharing, helping etc. boosts our spiritual well-being.

Social Connectedness: Last but not least, having a wider perspective towards society, respect for others and acceptance of other's beliefs and values are important for positive mental health.

BIO-PSYCHO-SOCIAL CAUSE OF MENTAL ILLNESS

Patients / caregivers/ general public will often ask you the reasons for development of mental illnesses. It is very important to make them understand that in contrary to the popular belief, mental illnesses are not the result of possession by evil spirits, curses, astrological influences, character weakness, laziness, karma or black magic. There are many factors that play a vital role in the onset and course of the mental illnesses. Most mental illnesses are caused by a combination of factors including: stressful life events, biological factors, individual psychological factors (e.g. poor self-esteem, negative thinking), adverse life experiences during childhood (e.g. abuse, neglect, death of parents or other traumatic experiences), social factors like poverty, migration, access to health and sanitation etc. These can be diagrammatically depicted as follows:



Fig. 1: Bio-psycho-social Model of Mental Illnesses

FACTORS AFFECTING MENTAL HEALTH

Mental illnesses are often caused by a combination of biological, psychological and social factors. It is important to identify the contributing risk factors at various levels and also the

protective factors which can be leveraged upon for patient care. A brief description is as follows:

Most mental health disorders are caused by a combination of factors (figure 2) including:

- ▶ Stressful life events
- ▶ Biological factors
- ▶ Individual psychological factors e.g. poor self-esteem, negative thinking
- ▶ Adverse life experiences during childhood e.g. abuse, neglect, death of parents or other traumatic experiences

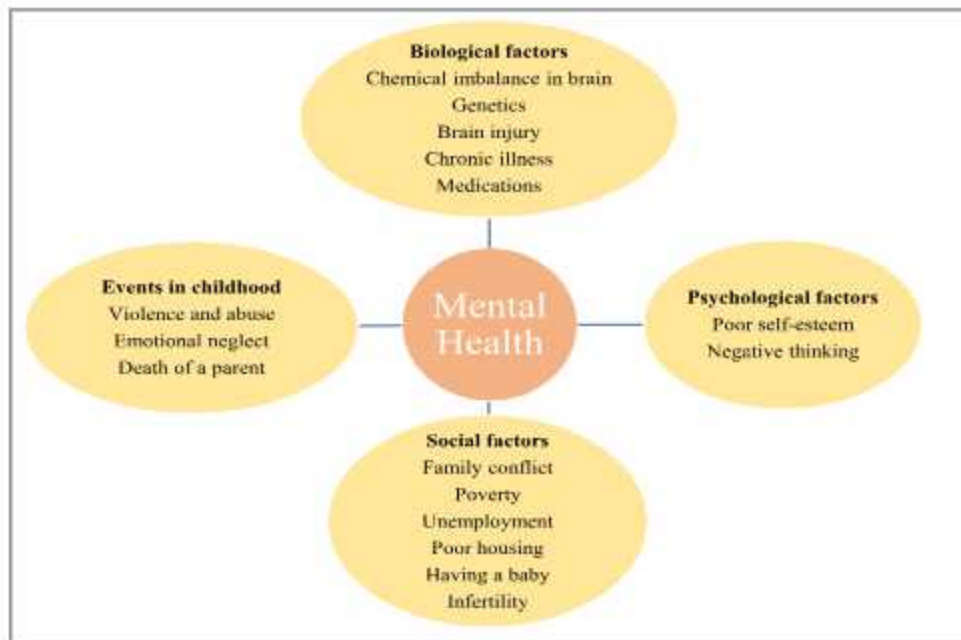


Fig. 2: Mental Health Disorders are Caused by a Combination of Factors

Some people may be more vulnerable to mental health disorders than others but may not develop an illness until they are exposed to stressful life events.

Biological factors can include genetics, brain injury, and chemical imbalance in the brain. Sometimes people experiencing chronic medical problems such as heart, kidney and liver failure, and diabetes may develop mental health problems such as depression, as living with a chronic illness can be very stressful.

Stressful life events can contribute to the development of mental health disorders e.g. family conflicts, unemployment, death of a loved one, money problems, infertility and violence. A lot of stress may also contribute to an imbalance of chemicals in the brain.

Poverty can place a person at risk of mental health disorders because of the stresses associated with low levels of education, poor housing and low income. Mental health disorders are also more difficult to cope with in conditions of poverty.

Difficulties in Childhood: such as sexual or physical violence, emotional neglect, or early death of a parent can sometimes lead to a mental health disorder later in life.

Unhealthy behaviors such as **drug and alcohol abuse** can lead to the development of a mental health disorder as well as being the result of a mental health disorder.

RISK FACTORS FOR MENTAL HEALTH DISORDERS

Table 1 shows level of acting of these risk factors and what could be protective factors against them.

Table 1: Risk Factors for Developing Mental Health Disorders and their Protective Factors

Risk Factors	Level	Protective Factors
<ul style="list-style-type: none"> • Pessimistic attitude, • Low self-esteem, • Substance abuse, • Poor lifestyle 	Individual	<ul style="list-style-type: none"> • Hobbies, • Physical activity, • Meditation/ yoga
<ul style="list-style-type: none"> • Broken families, • Harsh discipline styling, • f/h/o mental illness/ substance abuse 	Family	<ul style="list-style-type: none"> • Supportive parents/ caregivers, • Family harmony and stability, • Strong family values
<ul style="list-style-type: none"> • Discrimination, • Isolation, • Lack of access to support services, • Socio-economic disadvantage 	Community/ society	<ul style="list-style-type: none"> • Participation in community networks, • Access to support services, • Cultural identity and pride/ acceptance, • Economic security

COMMON MYTHS AND MISCONCEPTIONS RELATED TO MENTAL ILLNESSES

Being a key member of the primary health care team, you can play a significant role in addressing the myths and stigma associated with mental illnesses, by disseminating the right knowledge.

Some of the common myths and the facts are as follows:

Myth	Fact
Mental illness is caused by evil spirit or supernatural power.	Biological, psychological and social factors are responsible for the causation of mental illness.
Mental illnesses are untreatable.	Mental illnesses are treatable with proper treatment and counselling.
Lack of willpower causes mental illness.	Willpower does get affected due to mental illness but is not a cause of mental illness.
Marriage can cure mental illness.	Marriage cannot cure mental illness; it can act as a stressor.

Table (Contd.)...

... Table (Contd.)

Mentally ill patients belong to hospitals.	Majority of persons with mental illness can be treated at out-patient settings or primary care settings.
Mental health problems are only seen in illiterate, poor people.	Mental health problems may occur to anybody, irrespective of caste, education or class.
People with mental illness can never be productive or do normal work like normal people.	People with mental illness on regular treatment and supervision, can very well lead a productive and qualitative life like any other normal person.
Mental illness is unlike physical illness; the illness is really all in the person's head.	Mental illness is just like physical illness since both are biologically based.
Mentally ill people have weak characters since they can't cope with the world in the same way that the rest of us do.	The Development of mental illness has nothing to do with person's character. Mental illness strikes people with all kinds of backgrounds, beliefs, temperament and morals.
Once a psychiatric patient, always a psychiatric patient.	A psychiatric patient, with proper treatment, can improve and function well enough in society, if given the right conditions and opportunities.
Children don't suffer from psychiatric illnesses.	Children too get affected by mental illness.
Mental health disorders are a result of bad parenting.	Bad parenting does not lead to mental illness but may have some role in relapse, and can be a risk factor.
Mental illnesses are contagious.	Mental illnesses are not contagious.
Attempting suicide is a sign of cowardice.	Suicide usually is attempted by someone who is depressed and not because he/she is a coward.
Mentally ill patients are violent and dangerous.	Few patients with severe psychotic illness may become violent at times, but otherwise not all patients are violent.

COMMON SYMPTOMS OF MENTAL DISORDERS

Activity:

- ▶ Can you describe a person with mental illness?
- ▶ If yes, what would be the particular signs?
- ▶ If no, why?

It should be understood that not all persons with mental illnesses will show signs. Most of the signs they may show are seen to be normal and may not alarm you. It should be kept in mind that not all of them will be visible. Also, just showing one of the symptoms does NOT mean that the person has mental illness.

Here are few typical symptoms that are shown by person suffering from mental disorders. If you notice any of these, you should be able to facilitate conversation with the person about the issues they could be facing. This way, you would be able to help and prevent mental illness by intervening early.

1. Physical Symptoms

Involve the physical functioning of the body like aches and pains, pounding heart, weakness, tiredness, sleep disturbance, and increased or decreased appetite, excessive sweating, weight loss etc.

2. Psychological Symptoms

Involve the **mental functioning of the body** that involve our emotions or feelings like persistent sadness, fear and worry, increased or decreased self-esteem, mood swings, excess of fear, loss of motivation, lack of will to work

3. Thinking Symptoms

These involve those that affect **the way a person thinks** e.g. problems in understanding, concentrating, memory, and judgment (decision-making). Thinking about ending your life (suicide) or fixed false belief, someone else is going to harm you /kill / follow, letting you down are examples of thinking symptoms.

4. Behavioural Symptoms

These include those that affect the way people act or what they do. Behaviours are what we actually see others doing e.g. being aggressive, increased or decreased talking, withdrawal from family and friends, self-harm e.g. cutting the skin, and attempting suicide.

5. Imagining Symptoms

These include those that involve the person perceiving or experiencing things that are not actually real (although they seem very real to the person experiencing them). For example, the person may be hearing voices or seeing things that are not real, feeling that are not there. e.g.: imaginary voices ordering the person to do something, seeing imaginary people etc.

As one can observe, first four types of symptoms may seem common. They often are seen in a daily life as a response to the situations that arise around us. This particularly is a reason why Mental Health Disorders are difficult to identify.

As a Community Health Officer, you should know that everyone may show different symptoms and there are different signs for mental health disorder. You should be able to have a healthy conversation with the person and talk about issues if they are facing any. Such conversations might give you an idea about possibility of the person suffering from mental health disorder.

TYPES OF MENTAL DISORDERS

In this module you will learn about six groups of disorders related to mental health, neurological health and substance use.

1. Common Mental Disorders

These disorders may present with symptoms that we all experience from time to time like, feelings of fear, worry or sadness. People with Common Mental Disorders usually experience physical, emotional, thinking and behaviour symptoms, but not imagining symptoms. Out of these symptoms, people may get treatment for physical symptoms associated with their illness (like poor sleep or appetite), but neglect the cause of these physical problems such as underlying depression or anxiety.

2. Severe Mental Disorders

These are often difficult for the general community to understand, for example, hearing voices or expressing strange or unusual beliefs. People with Severe Mental Disorders usually experience a mixture of physical, emotional, thinking and behaviour symptoms, as well as symptoms of abnormal perception.

Severe Mental Disorders are rare and usually involve noticeable behavioural problems and the expression of strange or unusual ideas, often called psychosis. Psychosis is sometimes described as 'losing touch with reality'.

3. Child and Adolescent Mental Health Disorders

These include Attention Deficit Hyperactivity Disorder, Intellectual Development Disability etc. These are specific to the age group, for example, some children can develop slower than other children or show behaviours causing problems.

4. Neurological Conditions

These conditions affect the brain such as epilepsy and dementia, including Alzheimer's' disease.

5. Substance Use Disorder &

A person may consume too much harmful substances like alcohol, tobacco or other illegal substances like ganja, hashish etc.

6. Suicide Ideation/Behaviours

An individual who is feeling unusually sad or has prolonged feeling of sadness and hopelessness may to end his/her life. This is called suicide ideation or behaviour.

IMPORTANT!

As you can see, the presentations of common mental disorders are difficult to recognise and are normalised. People with Common Mental Disorders are often not treated as it is more difficult for family members and health workers to recognise that they are suffering from a mental disorder. Case identification is difficult but not impossible.

CHAPTER 2

MENTAL HEALTH PROMOTION

Mental health promotion is a positive, effective approach involving any practice that enhances capacity for good mental health for the whole population through action at the individual, community and societal levels following an integrated approach. Mental health promotion focuses on personal and social development and on life skills such as coping strategies, adaptability, help-seeking or communication skills, self-efficacy, resiliency, parenting, etc. Individual-level interventions work to reduce risk factors and increase protective factors, improving mental health and behavioural outcomes.

It is very important that mental health promotion strategies and programs be adapted to the local needs of the members and the communities by taking into account differing social, cultural and economic systems.

STIGMA AND DISCRIMINATION

Stigma is a mark of shame, disgrace or disapproval, which results in an individual being shunned or rejected by others (WHO). Discrimination is the unfair and less favourable treatment towards those who are stigmatized. People may be discriminated for different reasons, e.g. their race, gender or caste. Stigma and discrimination may lead to isolation and humiliation.

HOW DOES STIGMA ARISE?

Stigma arises when someone sees a person in a negative way because of a particular characteristic or attribute that they associate when they come to know that the person has a mental health issue. E.g., the image they have created in their mind due to the false depictions shown in movies about persons suffering from mental health disorder. When someone treats people in a negative way because of their mental illness, this is discrimination e.g. talking to the person rudely or in a harsh manner or depriving the person of a job though he/she is qualified and capable can be an act of discrimination because of the stigma.

For people with mental health issues, the social stigma and discrimination they experience can make their problems worse and can predispose them to frequent relapses and turning their illness chronic.

STIGMA AND DISCRIMINATION IN MENTAL HEALTH DISORDERS

Poor awareness about the symptoms of mental illness, stigma associated with mentally ill persons and the lack of mental health services available has resulted in a massive treatment gap, with inadequate numbers of trained mental health care professionals.

Why is there stigma and discrimination?

- ▶ People with mental health disorder are sometimes stigmatised and discriminated against because they think and behave differently.
- ▶ Not knowing the facts about mental health disorders sometimes makes people afraid of those having any symptoms of mental disorders.

How does stigma and discrimination affect a person with a mental health disorder?

- ▶ A person suffering from a mental health disorder may be rejected by friends, relatives, neighbours and employers.
- ▶ A person who is rejected may then feel more lonely and unhappy and this will make recovery even more difficult.

Although stigmatizing attitudes are not limited to mental illness, the community seems to discriminate persons with psychiatric illnesses more than other physical illness

The impact of stigma is two fold, as outlined in Table 1. Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination.

Table 1: Stigma and its Impact

Public Stigma	
Stereotype	Negative belief about a group (e.g., dangerousness, incompetence, character weakness)
Prejudice	Agreement with belief and/or negative emotional reaction (e.g., anger, fear)
Discrimination	Behaviour response to prejudice (e.g., avoidance, withhold employment and housing opportunities, withhold help)
Self-stigma	
Stereotype	Negative belief about the self (e.g., character weakness, Incompetence)
Prejudice	Agreement with belief, negative emotional reaction (e.g., low self-esteem, low self-efficacy)
Discrimination	Behaviour response to prejudice (e.g., fails to pursue work and housing opportunities)

HOW CAN YOU MINIMISE STIGMA AND DISCRIMINATION?

To begin with, you should counsel and convince the patient and the caregivers to change their stance and educate that mental illness needs to be treated just like any other physical illness.

1. **Educate the person with mental illness and their caregivers:** Provide adequate education to the person who is coming to get treated for mental health issues and for his or her family members. Staying mentally fit can empower the person and help him or her lead a good quality of life.
2. **Be non-judgemental:** As a Staff Nurse, avoid being judgemental towards the person taking treatment and his family members. The support and care that we show to them will ensure that they come regularly for treatment and follow ups. Highlight the positive milestones that the patient has reached in his or her efforts to get better.
3. **Educate public to stop believing negative news about stigma:** A change in public attitude towards the persons with mental illness is the key to bringing down stigma. Educating the public that visit your PHC-HWC about the myths and misconceptions, negative bias and stereotypes that they hold will make the community be more informed about how they treat persons with mental illness.

HOW TO SUPPORT THE FAMILY OF INDIVIDUALS WITH MENTAL HEALTH DISORDERS?

In most cases the family provides the majority of support and care for a person with a mental health disorder. Living with and caring for someone with a mental disorder can be very stressful, therefore it is important that the family receives help and support to care for their ill relative (like for someone with a physical illness). The family usually will provide you with important information about the person with the mental health disorder. Families often don't understand the symptoms of a mental health disorder; therefore, the family members may unintentionally increase the stress for the person with the mental illness.

Family members' behaviour has positive or negative impact on the person with mental health disorder. Certain behaviours can increase the stress of the individual, such as calling the person lazy or an embarrassment to the family, shouting or using critical tone of voice, or being over-protective, such as doing everything for the person or treating him/her like a child.

On the other hand, if family members are communicating in a clear and calm way and discussing the problems openly, giving the person space, especially when he/she is tense and allowing or encouraging the person to take responsibility of their own affairs can decrease the stress of the individual.

You can encourage involvement of family during treatment of the individual with mental health disorder. In many cases the person with mental health disorder will be accompanied by a family member. Sometimes the family member has taken the initiative to seek help. If a family member wants to talk to you confidentially always ask the person with the mental health disorder for permission. If a person comes by him/herself ask him/her if you may call a close family member for further information and collaboration (who is there to help the person?).

At the same time, it is important that the family members are maintaining some of their own interests and not devoting their lives exclusively to the person (this will make the family feel less stressed).

SUPPORTING FAMILY MEMBERS

Family members also feel stress while taking care of persons with mental health disorders. You should also address their stressors and provide psychosocial support for them. Caregiving depending on the kind of mental illness the patient has, could range from a few months to years of care. Relapse of mental illness is also a reality that caregivers face. Caregiving can be demanding in several ways and if its challenges and associated stress is not addressed, it could affect the caregivers' physical health, mental health, relationships, work functioning and also the ability to provide care to the patient.

Explain to the caregivers that caregiving could be demanding and may lead to strain. For those who experience caregiver stress, there may be a risk of physical and mental health problems as well as a negative impact on work, leisure, and relationships. Therefore, it is essential that the caregiver does not ignore taking care of oneself.

Common signs of caregivers stress include:

- ▶ Feeling sad and low
- ▶ Aches and pains in body
- ▶ Constantly worried
- ▶ Getting tired easily
- ▶ Easily irritable and angry
- ▶ Difficulty in concentration
- ▶ Problems in sleep with it being either too much or not enough
- ▶ Losing interest in activities that used to enjoy earlier
- ▶ Harmful use of alcohol, nicotine or other substance

How to Support the Family Members?

- ▶ Listen carefully.
- ▶ Give reassurance and information.
- ▶ Tell them where to get professional help (as you would do it for the person with mental health disorder).
- ▶ Assure your support.
- ▶ Tell about the behaviours increasing and decreasing the stress for the family member with a mental health disorder.
- ▶ Encourage the family to maintain own interests and other social contacts.
- ▶ If available, provide information on support groups for family members in the area.
- ▶ Suggest them the self-help strategies as mentioned before.

POSITIVE PARENTING

As we have learnt in previous section, family environment could be a major risk factor for mental health disorder or may also act as protective factor for a person. It is thus important to educate parents about how their behaviour affects children and their mental health.

The way parents treat their children affects the children deeply. It is well known that children with nurturing and loving parents have better mental health. However, children with over protective, over caring parents or neglecting parents are often more at risk to develop mental health disorders in later part of their life.

Another reason why parents that accompany their sick child to the PHC-HWC need to be sensitised is they themselves becoming aware of mental health and sensitise their children regarding the same. Parents whose children might have some mental health disorder will also need support and guidance on how to take care of their children. They will also need to be told about their children's specific needs.

Management, diagnosis and referral for children and adolescent mental health disorders will be discussed in later chapters.

It is important that children are also made aware about their mental well-being. They should also be informed about mental health and their feelings. This can be done directly by you opportunistically wherever possible or through teachers.

YOGA FOR PROMOTION OF MENTAL HEALTH



What is Yoga?

Yoga is a traditional practice that focusses on overall health:

- ▶ Body health through Asanas
- ▶ Energy balance through Pranayama
- ▶ Mind Health through Meditation and Mantra Chanting
- ▶ Social behaviour through niyama (truthfulness, non-violence, control of senses, non-stealing, non-hoarding)

- ▶ Individual behaviour through niyama (cleanliness, contentment, introspection, dedicated practice of yoga and spiritual observance, surrender to God)

Why Yoga?

- ▶ Yoga reduces mental tension.
- ▶ Yoga makes body fit and flexible.
- ▶ Yoga improves relationship of individual with himself and with society.
- ▶ Yoga helps manage problems of obesity, Blood pressure and Sugar (Diabetes); yoga reduces depression and stress (mental tension).

When to Do Yoga?

- ▶ Early morning before breakfast, or afternoon before lunch or evening before snacks. At least 3 hours after full meal.

What Yoga to Practice for Improving Overall Health? What Precautions to Take?

- ▶ Twenty-minute yoga module. (Annexure 1)

How Many Times a Day?

- ▶ Minimum twenty minutes per day. Two times in one day. Five times in a week as a part of daily lifestyle.

COMMON SELF-CARE ACTIVITIES FOR MAINTAINING ONE'S MENTAL HEALTH

Self-care activities can help the individual maintain his/her mental health. It is important to have a healthy lifestyle, adequate sleep, good nutrition, regular physical activity, practice relaxation techniques, talk to loved ones and avoid substance use such as tobacco and alcohol in order to maintain good physical and mental health. As a Staff Nurse, you could include educating the patients and caregivers regarding some common and easy to practice self-care activities in your routine management of cases. Please refer to Annexure 2 for details.

MENTAL HEALTH DISORDERS AND VULNERABLE GROUPS IN THE COMMUNITY

There are certain social groups who are more likely to experience mental disorders and have limited access to care due to vulnerability.

Poverty and Mental Health Disorders

People living in poverty are more likely to experience mental health disorders due to the stresses associated with being poor, and mental health disorders are likely to worsen poverty, so that it becomes a vicious cycle. (Figure 3)

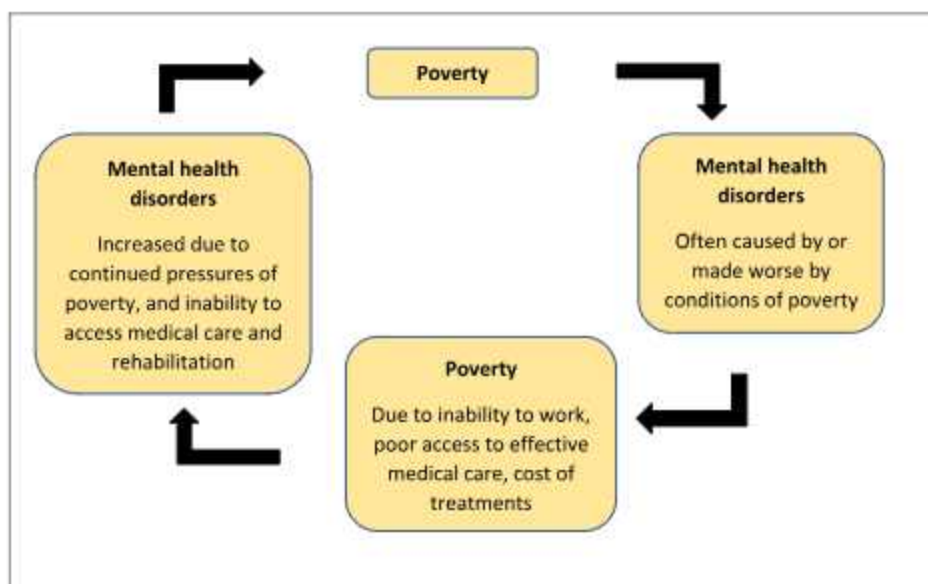


Fig. 3: Poverty and Mental Health Disorders

Women, Gender Inequality and Violence

As you know, there are inequalities between men and women in society. These are observed in different fields such as access to health services, jobs, violence. You have also learnt about this in your module on 'Gender based Violence'. Most common form of violence against women occurs in domestic context. The violence can be physical, verbal, sexual, emotional and financial. Violence leads to physical and mental health problems in women.

How is gender related to health? Can the reasons include any of the following?

- ▶ Men do not discuss their problems with friends and find solutions as much as women.
- ▶ It is more acceptable for men to drink alcohol leading to more problem drinking in men and more stigma for women who have a drinking problem.
- ▶ Domestic violence and rape can place great stress on the life of a woman.
- ▶ Women's income is often lower than that of men, and they have less control over household finances.
- ▶ Women may not be able to independently access treatment unless there is agreement from senior members (whether male or female) of the household.
- ▶ A woman cannot receive needed health services because norms in her community prevent her from travelling alone to a clinic.
- ▶ Families may be more reluctant to spend money on treatment for females compared to males.
- ▶ Women are more prone to mental illness following stress like diabetics, child birth, menopause

What can be done to promote mental health for men and women?

Two actions to help promote mental health for men and women include:

- ▶ Empowering men and women to make decisions that influence their own lives.
- ▶ Educating people about the need for equal rights for men and women.

"Gender equality means women and men have equal opportunities to realise their individual potential, to contribute to their country's economic and social development and to benefit equally from their participation in society."

IMPORTANT!

- ▶ Mental illnesses are often invisible because its symptoms often go unnoticed. It is also difficult for people to find a space to talk about their feelings. It is important to continue and openly discuss about mental health. It is important that mental health promotion also includes everyone in the community.
- ▶ You should understand that mental health is not limited to mental health disorders. It is just like physical health. Various self-care strategies like timely food, regular sleep, regular exercises, talking with loved ones, taking long walks help maintaining mental health.
- ▶ As a health worker you should understand that identifying a person with mental disorder is an important task but providing support to anyone who is in distress is also equally important. They need not be showing any symptoms but timely support will help them for maintaining their mental health.



CHAPTER 3

APPROACH TO A PERSON WITH MENTAL ILLNESS

It is important to understand that health-seeking behaviour of people suffering from mental health illnesses is different as compared to other illnesses, owing to the stigma and discrimination associated with them. Often these individuals continue to suffer in silence or visit healthcare institutions with vague, differing complaints, leading to a further delay in diagnosis and treatment. Hence, it is very important to approach a patient with mental illness with utmost care.

APPROACHING PATIENT WITH MENTAL HEALTH ILLNESS

Some salient features of approaching a patient with mental health illness are as follows:

STEP 1: INITIAL ASSESSMENT OF AN INDIVIDUAL SUSPECTED BE SUFFERING FROM MENTAL ILLNESSES

Physical Settings

Ideally the assessment should be made in a quiet place, free from any major distractions. The arrangement should be such that it ensures utmost privacy, dignity and comfort of the person.

Building a Rapport

Ask the person's name and address him/her by name. Culturally appropriate tags, such as adding 'ji' at the end of the name may be used. Make the person sit comfortably before beginning to interview him/her. It is important to note that the patient may not open up and give you all the relevant history and information at the first visit itself. Hence it is necessary to have patience and not be in a haste to reach to a probable diagnosis. In some/ doubtful cases, you may also try and get additional relevant information from the CHO (if the case is a referred case) or the close family members.

Interviewing Skills

Some important points which must be kept in mind while interviewing persons with probable mental health illness are:

- ▶ Face the patient upfront or adopt a posture that indicates your involvement.
- ▶ Try to maintain good eye contact with the patient, indicating attention and interest.

- ▶ Do not be in a haste to ask about the problems of the patient. Beginning the interview with some brief neutral or casual conversation (e.g., what is the usual daily schedule of the patient and how does his/ her start routinely?) relaxes the environment and the patient feels more comfortable in interaction.
- ▶ Ask open ended questions initially; for example, 'when you are not able to work, how do you feel?' Do not ask 'when you are not able to work, do you feel sad?' Do not ask multiple options at a time. Thus, instead of asking 'Do you feel sad or angry?', Ask them separately – 'Do you feel sad?' wait for answer and then ask 'Do you feel angry?'
- ▶ Listen carefully. Avoid obstructing a conversation in order to ask any other question or giving suggestions to the patient half-way when he is talking about something else.

Summarize in your own words what they have said to reflect what you have understood.

Based on the information obtained from the patient/ care givers, you may arrive at a probable diagnosis for the person.

STEP 2: ENLISTING THE PROBABLE RISK FACTORS AND PROTECTIVE FACTORS

As mentioned previously, mental illnesses are often caused by a combination of biological, psychological and social factors. It is important to identify the contributing risk factors at various levels and also the protective factors which can be leveraged upon for patient care. A brief description is as follows:

Table 1: Probable Risk Factors and Protective Factors

Risk Factors	Level	Protective Factors
Pessimistic attitude Low self-esteem Substance abuse Poor lifestyle	Individual	Hobbies Physical activity Meditation/ yoga
Broken families Harsh discipline styling f/h/o mental illness/ substance abuse	Family	Supportive parents/ caregivers Family harmony and stability Strong family values
Discrimination Isolation Lack of access to support services Socio-economic disadvantage	Community / society	Participation in community networks Access to support services, Cultural identity and pride/ acceptance, Economic security

STEP 3: OFFER APPROPRIATE PSYCHO-EDUCATION/ PSYCHOLOGICAL FIRST AID

Psycho-education

Psycho-education is a process to offer education to individuals suffering from mental illness and their families to help them to deal with their condition in a better way. The basic goal of psycho-education is to make the patients and their family members understand the illness (including nature of illness and availability of treatment) and support their capability to

deal with the illness. It also helps in addressing the myths and stigma associated with various mental illnesses.

Thus Psycho-education with Family, Peer or caregivers would focus on the following:

- i. Understanding the nature of the illness
- ii. The main symptoms of the disorder and its identification (early signs and symptoms)
- iii. Identification of the triggering factors
- iv. Treatment Adherence- and their role as a caregivers how to help the patient to adhere to the schedule in managing the condition.

Psychological First Aid

This should be offered to any individual who reports experiencing psychosocial distress. It consists of five essential steps

- i. Listening non-judgmentally
- ii. Assessing risk of harm to self or others
- iii. Giving reassurance and information
- iv. Encouraging the person to get appropriate help if needed
- v. Encouraging self-help strategies.

Key Points in Psychological First Aid Initial Management of Mental Disorder

1. **Listen without judgement:** Listen to what the person describes without being critical or thinking they are weak. Don't give advice such as 'just cheer up' or 'pull yourself together'. It is important that you should understand that whatever the person is saying is a part of illness and not their personality. It is important that you stay patient with them and not get overwhelmed yourselves. Avoid getting into an argument with the person.
2. **Give reassurance and information:** Provide hope for the person and their family and talk about a good outcome for that person. Tell the person that he/she has an illness that can be treated, and it doesn't mean that he / she is a bad person. Let them know that you want to help.
3. **Encourage the person to get appropriate professional help:** You should discuss every case with the MO to come up with appropriate treatment plan. . Then, if need be, referral should be made by giving ongoing support to the person and their family. If the person is very unwell i.e. you think they are suicidal or psychotic, (harmful to self/ others) and he/she is refusing to get any help from you or the doctor, encourage the family to consult with the doctor so that they can explain the situation and get professional support.
4. **Assess the risk of suicide and harm to self or others:** People with mental disorders sometimes feel so overwhelmed and helpless about their life, the future appears hopeless. Engage the person in conversation about how they are feeling and let them describe why they are feeling this way. Ask the person if they are having thoughts of suicide. If they are,

find out if they have a plan for suicide. This is not a bad question to ask someone who is mentally unwell. It is important to find out if he/she is having these thoughts in order to arrive at probable help. If you believe the person is at risk of harming him/herself then:

- Don't leave the person alone, alert the family members and MO immediately about what you have found out.
- Try to remove the person from access to the means of taking their own life
- Try to communicate to the person, the need to discontinuing the use alcohol or drugs.

Some Important Do's and Don'ts for Counselling

Table 2: Do's and Don'ts

Do's	Don'ts
Try to find a quiet place to talk, and minimize outside distractions.	Don't pressure someone to tell their story.
Respect privacy and keep the person's story confidential, if this is appropriate.	Don't interrupt or rush someone's story (for example, don't look at your watch or speak too rapidly).
Stay near the person but keep an appropriate distance depending on their age, gender and culture.	Don't touch the person if you're not sure it is appropriate to do so.
Let them know you are listening; for example, nod your head or say "hmmmm."	Don't judge what they have or haven't done, or how they are feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived."
Be patient and calm.	Don't make up things you don't know.
Provide factual information, if you have it. Be honest about what you know and don't know. "I don't know, but I will try to find out about that for you."	Don't use terms that are too technical.
Give information in a way the person can understand – keep it simple.	Don't tell them someone else's story.
Acknowledge how they are feeling and any losses or important events they tell you about, such as loss of their home or death of a loved one. "I'm so sorry. I can imagine this is very sad for you."	Don't talk about your own troubles.
Acknowledge the person's strengths and how they have helped themselves.	Don't give false promises or false reassurances.
Allow for silence.	Don't think and act as if you must solve all the person's problems for them.
	Don't take away the person's strength and sense of being able to care for themselves.
	Don't talk about people in negative terms (for example, don't call them 'crazy' or 'mad').

STEP 4: ASSESS THE NEED FOR REFERRAL TO APPROPRIATE HIGHER CENTRE OF CARE/ REHABILITATIVE SERVICES, ETC.

Based on the above parameters and some other clinical assessment scales described later, you should be able to assess the need for referral for further evaluation and management. However, no referral should be made without approval and consultation of the PHC MO.

STEP 5: PROVISION OF FOLLOW-UP CARE THROUGH HWCs

After the initial assessment and cross-referral (if needed), you should update the same to the CHO at the SHC-HWC about who will then provide the patient with follow-up care near his/her house i.e. at the HWC.

REHABILITATION

Psychiatric rehabilitation, also known as psychosocial rehabilitation is the process of restoring a mentally ill person into the community and to make him as independent as possible. Every patient suffering from severe and persistent mental illness needs rehabilitation. The primary goal of psychiatric rehabilitation is to help disabled individuals to develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support.

NEED FOR PSYCHIATRIC REHABILITATION

Rehabilitation work should start from the beginning itself, which helps to:

1. Prevent Chronicity
2. Restore residual abilities
3. Improves quality of life
4. Maximises the functional abilities within the limits of disabilities

KEY ACTIVITIES OF THE REHABILITATION PROGRAM

- ▶ Ensuring home visit
- ▶ Educating family about expressed emotion and their role to maintain positive environment at home
- ▶ Creating awareness about availing of welfare benefits that will be a support to the patient as well as family
- ▶ Emphasizing on community-based rehabilitation or identifying strength of the patient as well as opportunity available in the community
- ▶ Sensitizing community towards patients with mental illness

CHAPTER 4

COMMON MENTAL DISORDERS (CMD)

CASE VIGNETTES

A 47-year-old Mr. A was diagnosed two years back with chronic kidney disease due to accelerated hypertension. He has also asthma and is Hepatitis C positive. You have not seen Mr. A for around six months and he is now coming for routine check-up at your PHC-HWC.

Mr. A is not currently working because of his medical problems. He has been separated from his wife since 2015. During his routine check-up visits, he mentioned that he is feeling tired to the point of weariness. His memory has been affected recently and lack of interest for his hobbies. He is finding it difficult to be able to enjoy everyday activities such as watching television or sharing the meal with his family.

Questions

- ▶ What can be the probable disorder in the above-mentioned scenario?
- ▶ What are the sign and symptoms you have observed in the above scenario?
- ▶ What is your role in managing the case?

Common Mental Disorders (CMDs) include:

1. Depressive disorder
2. Anxiety disorder
3. Obsessive compulsive disorder
4. Dissociative disorder and
5. Somatization disorder

The main symptoms of CMDs are psychological in nature, however, they tend to manifest as physical symptoms. As a result, patients seek help from general medical practitioners, who also may find it difficult to make a correct diagnosis.

IDENTIFYING INDIVIDUALS SUFFERING FROM CMIs: SIGNS AND SYMPTOMS

DEPRESSIVE DISORDERS

Main Symptoms

- ▶ Sad mood
- ▶ Loss of interest or pleasure in activities which the individual used to find pleasurable before
- ▶ Fatigue, decreased energy

Additional Symptoms

- ▶ Headache, body pains and aches
- ▶ Reduced or increased appetite, weight loss
- ▶ Sleep disturbances – sleeping too much or too little
- ▶ Feeling irritable/anxious/nervous
- ▶ Unable to concentrate
- ▶ Decrease in self-confidence & self-esteem
- ▶ Feeling of unworthiness and guilt
- ▶ Having a negative view of the future
- ▶ Suicidal thoughts

ANXIETY DISORDERS

- ▶ Physical symptoms: Headache, sleep disturbances (especially difficulty in falling sleep), palpitations, dry mouth, dizziness, sweating, abdominal discomfort
- ▶ Restlessness, trembling, inability to relax, excessive worries about future misfortunes

OBSESSIVE-COMPULSIVE DISORDER (OCD)

It is an anxiety disorder majorly characterized by two kinds of symptoms:

1. Obsessive Symptoms (Obsessions are repeated thoughts, urges, or mental images that the person feels compelled to perform causing anxiety)
 - ▶ Repeated thoughts, repeated urges, mental images etc.
 - ▶ Uncontrollable, unwanted thoughts
2. Compulsive Symptoms (Compulsions often occupy a large portion of the person's day, leading to marked occupational and social impairment)
 - ▶ Repetitive, Ritualized Behaviours (like repeating a few simple actions such as washing hands, checking the door's lock or whether the light is turned off)
 - ▶ OCD as a disorder is difficult to diagnose since the symptoms may appear common as mostly everyone double checks things. However, OCD is when the person is unable to control his/her thoughts, repetitive behaviour etc.

Trance and Possession Disorders/ Dissociative Disorders

Individuals seem to experience a temporary loss of personal identity, while being fully aware of their surroundings. Sometimes, they may act as though they are taken over by a spirit/deity/ some force.

SOMATIZATION DISORDERS

Individuals mainly present with various physical symptoms, which may be single or multiple, involving any part of the body:

- ▶ Nausea, vomiting, belching, pain in the abdomen
- ▶ Skin symptoms such as itching, burning, tingling, numbness, soreness
- ▶ Pain at multiple sites (such as abdomen, back, chest, joints, pain during menstruation).
- ▶ Sexual and menstrual complaints (e.g. ejaculatory or erectile dysfunction, irregular menstruation or excessive bleeding)

Often, individuals visit different doctors repeatedly, but no abnormality can be found on medical examination and investigation.

SCREENING TOOL FOR CMD

The Self-Reporting Questionnaire with 20 items (SRQ-20) can be used to identify common mental disorders. Items are scored 0 (symptom absent) or 1 (symptom present). The scores are summarized to obtain a total score. A score above a cut-off point of 11 and above indicates the presence of a common mental disorder (Annexure 3). The Patient Health Questionnaire 9-item scale (PHQ-9) is used to screen for depression (Annexure 4).

ROLE AND RESPONSIBILITIES OF STAFF NURSE IN IDENTIFYING CMDs

Table 1: Responsibilities of Staff Nurse in Identifying CMDs

Depressive Disorders	Anxiety, Somatization, Obsessive-Compulsive, Trance and Possession Disorders
<ul style="list-style-type: none"> • Listen and offer emotional support. • Ask for specific symptoms. Many do not express their complaints until you ask. • Ask for thoughts of suicide. If present, discuss with the Medical Officer immediately. Also tell the family members to keep the individual under close supervision. • Advise the individual to engage in activities/ hobbies which can give him/her enjoyment, build confidence, or at least divert the mind. • Help the person to set realistic expectations and not blame self for things which are beyond control. 	<ul style="list-style-type: none"> • Let the individual know that you understand that his/her physical symptoms are real, and that he/she is not lying or inventing them. • Explain that the symptoms are not being caused by an underlying disease (e.g. abdominal pain does not indicate cancer). • Direct his/her attention towards the stressors or problems which may be causing the symptoms. Offer practical advice to the individual and family to cope with them. • Check if the individual is using harmful ways of coping with anxiety, such as using alcohol or sleeping pills. Let him/her know that using alcohol or any drugs without prescription will only increase problems and damage health.

Table 1 (Contd.)...

...Table 1 (Contd.)

Depressive Disorders	Anxiety, Somatization, Obsessive-Compulsive, Trance and Possession Disorders
<ul style="list-style-type: none"> Identify current life problems, offer practical advice which can help the individual to cope with them. Involve the family members as needed, in resolving family stressors/problems 	<ul style="list-style-type: none"> Encourage a healthy lifestyle: Balanced diet, adequate rest and sleep, time management, regular exercise, recreation.

MANAGEMENT OF CMDs AT PHC-HWC

Table 2: Management of CMDs at PHC-HWC

PSYCHOSOCIAL MANAGEMENT	
Correcting Negative Thinking	<p>In this, help the individual to:</p> <ul style="list-style-type: none"> identify negative thoughts; develop alternate positive ways of thinking; practice positive ways of thinking <p>E.g. The patient's low energy may be the result of his/her expectation of failure in all areas of life. Challenge such thoughts: e.g. what is the basis of such thoughts? What proof is there that he/she will face failure in life? Instead, what are the resources that he has – family, friends, past positive experiences?</p>
Family Interventions	<ul style="list-style-type: none"> Let the individual know that CMDs need to be treated, just like any other medical illness.. Help the family to identify stressors which may be contributing to the symptoms and discuss how they can limit their effect. Try and identify the individual's current interpersonal problems, and then try to address the existing symptoms and problems in this context. Address caregiver burden <p>E.g. The patient's depressive symptoms may be due to a work-related conflict. He/she is then guided in making necessary changes in communication and adjustments in the relationship, in order to reduce the symptoms.</p>
MEDICAL MANAGEMENT	
<p>Medicines for CMDs can only be prescribed by a Medical Officer (MBBS) or Psychiatrist. If you suspect CMD in a patient, discuss it with the MO at your PHC. Drugs used to treat depression are called Antidepressants (e.g. Fluoxetine) and drugs used to treat anxiety disorders are called Anxiolytics (e.g. Clonazepam). These may be prescribed by the MO/specialist if needed. Antidepressants and anxiolytics may have side effects like increased drowsiness, cognitive impairment and dependence. You along with the Medical Officer prescribing the drugs, will inform the patient about possible side effects and provide the CHO with follow-up schedule.</p>	

RED FLAGS IN CMDs

- When the symptoms appear severe
- If the individual expresses death wishes
- If there is use of alcohol/ tobacco/sleeping pills
- When the individual/ family appears significantly distressed
- In case the PHQ-9 tool score is more than 9.
- When the SRQ-20 score is 11 or more.

CHAPTER 5

SEVERE MENTAL DISORDERS (SMD)

CASE VIGNETTE

SCENARIO 1

A 20-year-old man presents to the psychiatry ward accompanied by his parents, with complaints of unnecessary quarrels, excessive laughing, excessive talking, insomnia, tells that he is God etc. For the past 2 weeks, he was not attending college classes, staying awake most nights till 4 or 5 a.m., writing some things continuously. When asked by parents, he reports that he is writing 2 story books at the same time. Sometimes he roams around in the locality talking to strangers, cracking jokes. He also spent Rs 10,000 in shopping that was very unusual of him.

SCENARIO 2

Mrs T, 30-year-old female, housewife presented with chief complaint of headache manifesting as heaviness of head throughout the day. She had consulted a general practitioner earlier and was diagnosed as a case of hypothyroidism for which she was on Thyroxin but still the headache persisted. All other investigations were normal. While interviewing, the patient appeared tearful. On being inquired, patient started crying and reported that she does not feel happy anymore. This happened after she lost her job 6 months before. She reported that she does not feel happy even if something good happened. World did not seem interesting anymore and she had lost interest in her old hobbies. Household work seemed like a burden now and she barely managed it and she was slower than before in her routine chores. She stopped visiting her friends and was having frequent altercations with husband as he felt she was not interested in home like before. She felt she would never improve again and that she was burden on her family now. She used to hold herself responsible for the same. On being asked proactively, patient reported contemplating suicide once, but never acted on it. Along with this she was hardly able to sleep for 2-3 hours at night and felt fatigued in daytime. Husband reported she seemed to have lost weight in past 3 months.

Questions

1. What are the signs and symptoms you have observed in the case scenarios?
2. What can be the probable disorder in the above case scenarios?
3. What are the main features that point to the disorder?
4. What is your role in managing the cases?

Severe Mental Disorders (SMDs) include:

1. Schizophrenia
2. Bipolar disorder

1. SCHIZOPHRENIA

Schizophrenia is a major mental disorder characterized by the changes in thinking, emotions, in the presence of conscious state, which usually leads to social isolation.

Etiology

- ▶ **Genetic Factors:** A family relative with schizophrenia increases the chance of developing the illness.
- ▶ **Biological Causes:** exposure to infection during prenatal period.
- ▶ **Biochemical Causes:** The most prominent cause may be imbalance of dopamine (brain chemical or neurotransmitter) in the brain.
- ▶ **Stress:** Significant stressful life events such as the loss of someone close, business loss or change in place of living, can be stressful and lead to relapse.
- ▶ **Coping Skills:** Mal-adaptive coping skills to life events.
- ▶ **Poor and Ineffective Social Skills:** Can effect forming rewarding relationships and lead to difficulties in resolving conflicts

Signs and Symptoms

The symptoms of schizophrenia mainly fall into three categories: positive, negative, and cognitive.

a. Positive Symptoms



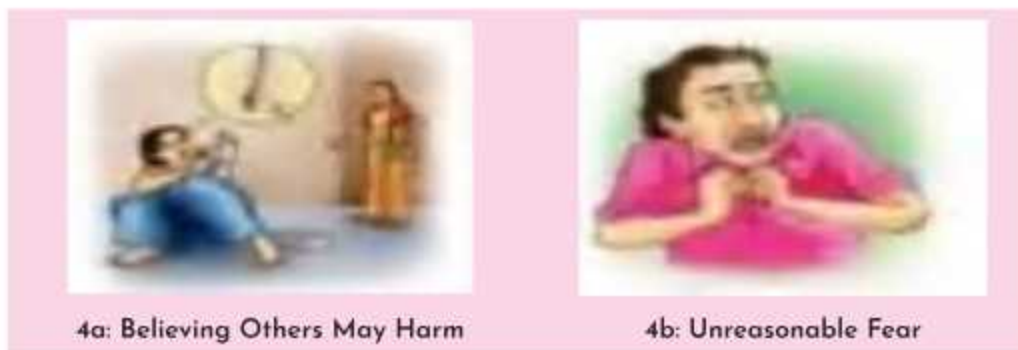


Fig. 1: Delusions: Delusions are Firm, False, and Fixed Unshakable Beliefs that are not based on Reality.

b. Negative Symptoms: "Negative" symptoms are associated with disturbances to normal emotions and behaviours.



c. Cognitive Symptoms: Disturbances in memory or thinking. E.g., poor concentration, poor judgement

Role of Staff Nurse in Assessment of Schizophrenia

Obtain the history from person, their relative and assess relevant patient records. The following questions can be asked for the assessment:

- Is there any history of co-morbid medical illness?
- Are there any recent significant life-events?
- Any history of substance use?
- Does the patient's past behavior identify any psychological issues? e.g. irritability, isolation?
- Is there a family history of psychiatric illness?

Probable Diagnosis of Schizophrenia

Remember that you shall not arrive at a diagnosis in isolation. The diagnosis should only be undertaken by the medical officer whom, you may help in the same. The person may have schizophrenia if there are more than two symptoms from those mentioned below for more than 1 month which causes disturbance in functioning:

1. Delusions
2. Hallucinations
3. Change in speech
4. Disorganized behaviour
5. Negative symptoms

Management of Schizophrenia at PHC-HWC

A comprehensive treatment plan should include:

1. Medical management
2. Family psycho-education
3. Rehabilitation

Medical Management

Medicines for SMDs can only be prescribed by a Medical Officer (MBBS) or Psychiatrist. If you suspect schizophrenia in a patient, discuss it with the MO at your PHC. Drugs used for treatment of schizophrenia are called Antipsychotics (commonly prescribed antipsychotics are Chlorpromazine, Haloperidol, Olanzapine, etc.). These may be prescribed by the MO/specialist if needed.

Antipsychotic drugs may have some side effects which might interfere with the functioning of the person like tremors, twitching of muscles, rigidity, postural hypotension, etc. You along with the Medical Officer prescribing the drugs, will inform the patient about possible side effects and provide the CHO with follow-up schedule.

Psychosocial Management



Fig. 1

ROLE OF STAFF NURSE IN PSYCHOSOCIAL MANAGEMENT

Psycho-education

Discuss with the person and their family regarding:

- ▶ The importance of taking medicines on regular basis.
- ▶ Involve the patient in decision making in treatment.
- ▶ Importance of healthy lifestyle (e.g. healthy diet, physically activity).
- ▶ Address caregiver burden/stress.

The family caregivers take care of the day-to-day needs of the patient with severe mental illness such as monitoring the mental state, identifying the early signs of illness, relapse and deterioration, and helping the patient access services. The family caregiver also supervises medication adherence and provides emotional support to the patient. Since the illness is chronic in nature, the family caregiver often feels overburdened or stressed. The family care giver needs emotional support from the mental health providers to maintain their physical as well as mental health.

Rehabilitation

Schizophrenia usually develops during early adulthood. Therefore, rehabilitation must focus to increase the individual's ability to function normally. Rehabilitation needs to include vocational training and preparing them to solve problems in daily life including managing own finances.

BIPOLAR DISORDERS

Bipolar disorder is characterized by episodes of mania and depression, which can appear in phases, alternating with each other.

Etiology

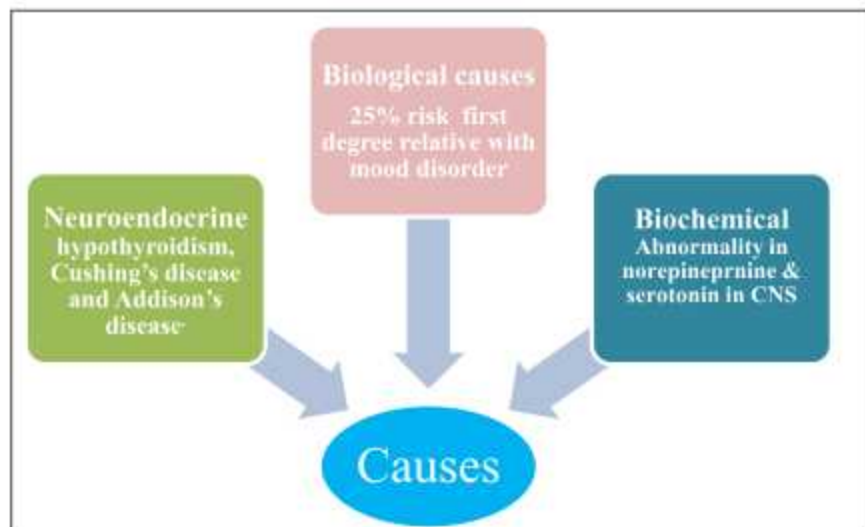


Fig. 2

Manic Episode

It is characterized by the following clinical picture which should be present for at least 1 week and cause disruption in daily living.

Signs and Symptoms

- Elevated, Expansive Mood:** It can range from euphoria to irritability
- Psychomotor Activity:** Characterized by over-activity, restlessness, & excitement.
- Speech and Thought:** Person is more talkative, increased pressure of speech (fast and incoherent speech), use of playful language such as rhyming, joking, teasing.
- Goal Directed Activity:** There is marked increase in daily activity with more planning and at times execution of many activities.

Depressive Episode

The depressive state is mainly characterized by the following clinical features, which should be present for at least 2 weeks for the diagnosis.

Signs and Symptoms

- Depressed Mood:** Sadness, no interest in daily activities.
- Depressed Cognition:** Hopelessness, Helplessness & Worthlessness can lead to difficulty in thinking & concentration.
- Psychomotor Activity:** Slowed thinking & activity, decreased energy.
- Physical Symptoms:** Heaviness of head, body aches, easy fatigability.
- Biological Symptoms:** Insomnia, loss of appetite and weight, loss of sexual drive, risk of suicide and death wishes.
- Psychotic Symptoms:** Delusion & hallucinations, and inappropriate behaviour

Role of Staff Nurse in Assessment of Bipolar Disorder

Assessment of bipolar disorder at the PHC-HWC is based on symptoms of mania and depression, present for at least 2 weeks.

Management of Bipolar Disorder at PHC-HWC

This includes Medical management and Psychosocial treatment.

Medical Management

Medicines for SMDs can only be prescribed by a Medical Officer (MBBS) or Psychiatrist. Drugs used for treatment of bipolar disorders are Mood stabilizers for mania and Antidepressants for depressive episodes. If you suspect bipolar disorders in a patient, discuss it with the MO at your PHC. The MO will prescribe required drugs if needed.

The prescribed drugs may have side effects like increased drowsiness, cognitive impairment and dependence. You along with the Medical Officer prescribing the drugs, will inform the patient about possible side effects and provide the CHO with follow-up schedule.

Psychosocial Treatment



Fig. 3

ROLE OF STAFF NURSE IN PSYCHOSOCIAL MANAGEMENT

Psycho-education forms the mainstay of psychosocial management of SMDs. The family caregivers can be educated on the following:

FOR MANIA

- ▶ Violence and aggressive behaviour patient to be handled with caution.
- ▶ Set limits for manipulative behaviour, give positive reinforcement for non-punitive behaviour.
- ▶ Never take care of violent patient alone. If the patient has sharps such as knife, blade ask him to keep it on the table or floor instead of fighting to take away.
- ▶ Provide diet with high protein, nutritious finger foods and drinks that can be taken when walking or running.
- ▶ Walk or sit with the patient when he eats.
- ▶ Give prescribed medications.

FOR DEPRESSION

- ▶ Ask the patient about suicidal ideas, create and maintain the safe environment.
- ▶ Remove all potentially dangerous objects from the person's environment.

- ▶ Plan daytime activities according to patient interest & closely monitor the patient's food and fluid intake.
- ▶ Ensure the patient's hygienic needs are met or assist the patient to complete the tasks.
- ▶ Provide the medications as appropriately.

Addressing Caregiver Burden

Caregivers taking care of person with mental illness may have the following problems, they are: Caregivers often find they have less time for themselves and other family members, emotional and physical stress, lack of privacy, financial strain, sleep deprivation, lack of help, depression and isolation. These problems should be identified and managed properly to avoid caregiver burden.

RED FLAGS IN SMDs

1. When there is risk of suicide or harm to others
2. Catatonic behaviour symptoms (abnormal movements - no movement/speech/response to stimuli or excessive movements)
3. Poor general health condition
4. Refusal to take orally (meals & medications)

CHAPTER 6

CHILD AND ADOLESCENT MENTAL HEALTH DISORDERS (C&AMHD)

CASE VIGNETTE

SCENARIO 1

Santosh is about 20 years from lower socio-economic background. His mother had obstructed labour during delivery. Now she needs to help him for brushing his teeth, bathing or dressing. He spills while taking food. He talks in sentences, needs repeated instructions to carry out simple tasks. He went to a school and attended class I. He had been in the same class for the last four years and has learnt to write a few alphabets and numbers without understanding. If given money and instructed several times, he can buy one or two things from shop but cannot calculate and get balance. His father brought him to hospital for the first time.

SCENARIO 2

A. Chhotu, 8-year-old, is always quiet in class. He sits and fantasizes in the class room and shows less interest with poor academic performance.

B. Babu, 7-year-old, is always the centre of attention. He will make lot of noise and tell an answer in class before teachers complete the question, whether he knows the correct answer or not. He often distracts students around him and talks loudly, gets up, jumps, runs around, wriggles his hand, and taps his pencil loudly.

SCENARIO 3

Sasikumar is about 9-year-old from lower socio-economic background. His father had history of mood disorder and received treatment few years ago from hospital. While Sasikumar interacts well with peers his own age, his parents noted that he can be easily led and influenced by others. They also report that Sasikumar gets upset and irritable when he does not receive recognition or feels that he has been ignored. His teacher notes that he sometimes acts 'socially immature, aggressive', and that he often demonstrates attention-seeking behaviour and shows stubborn attitude.

Questions

1. What are the signs and symptoms you have observed in the case scenarios?
2. What can be the probable disorder in the above case scenarios?
3. What can be the possible risk factors for the disorders?
4. What is your role in managing the cases?

Child and Adolescent Health Disorders (C&AMHDs) include:

1. Conduct Disorder
2. Attention Deficit Hyperactive Disorder
3. Oppositional Defiant Disorder
4. Intellectual Disability

1. CONDUCT DISORDERS

Conduct Disorder (CD) is a childhood externalizing behaviour problem characterized by violent, aggressive and maladaptive behaviour that leads to problems in the child's family, neighbourhood and school. Research shows that conduct disorder is more common in boys than girls.

DEFINITION

The term 'conduct disorder' is generally used to describe a pattern of repeated and persistent misbehaviour in which the basic rights of others and major age-appropriate societal norms and rules are violated (American Psychiatric Association, 2000).

CLASSIFICATION

- 1) Child Onset Type: Occur before the age of 10 years.
- 2) Adolescent-Onset Type: The problems of conduct disorder in adolescent period only.

Etiology

- ▶ **Biological Influences:** Temperament (personality traits) and Genetic factors
- ▶ **Biochemical Factors:** Alterations in the neurotransmitters, norepinephrine, serotonin and possibility of testosterone.
- ▶ **Organic Factors:** Head injury and epilepsy
- ▶ **Psychosocial Issues in Family**
- ▶ **Co-morbid Conditions:**
 - ▶ Attention-Deficit/ Hyperactivity Disorder
 - ▶ Substance Use Disorders
 - ▶ Learning Disabilities

Signs and Symptoms

1. Shows aggressive and cruel behaviour with people and animals.
2. Bullies and threatens others & is easily annoyed by others

3. Physically fights with family members, siblings and others.
4. Uses weapons and makes serious physical harm to others.



Fig. 1

5. Involvement in robbery and stealing things (including purse-snatching, extortion, mugging).
6. Early involvement in sexual activity and may lead to unwanted pregnancy, Syphilis, HIV/AIDS.
7. Deliberate fire setting, breaks or destroys other's things.
8. Significant impairment in social, academic, or occupational functioning.
9. Refuses adults' requests or disobeys rules.
10. Repeatedly blames others for his or her own mistakes or misbehaviour.
11. Is angry or resentful most of the time.
12. Frequently lies or breaks promises & runs away from home.
13. Often stays out after dark (beginning before 13 years of age).
14. Frequently becomes absent from school (beginning before 13 years of age).

Management of Conduct Disorder at PHC-HWC

Non-Pharmacological Management

1. **Counselling and Guidance:** Parents of the affected children must be explained about the condition and counselled to be patient with their child. The need for psychotherapy has to be explained. After consultation with the PHC Medical Officer, the child and his/her parents must be referred to a psychiatrist or child psychologist. There are many forms of psychological and behavioural therapy which may be prescribed by the psychiatrist/mental health specialist.

2. Psychosocial Management

a. *For violent behaviour towards others*

- ▶ Continuous observation of the behaviour
- ▶ Redirect the violent behaviour with constructive physical activity
- ▶ Encourage for appropriate expression of anger
- ▶ Use restraints if it necessary order by mental health practitioner

b. *For impaired social interaction*

- ▶ Maintain trustful relationship
- ▶ Accept the person
- ▶ Clearly explain about acceptable and non-acceptable behaviours
- ▶ Arrange group interactions to express the thoughts
- ▶ Provide social skill training and behaviour modification training

c. *For Low self-esteem and defensive coping*

- ▶ Explain relationship between inadequacy feelings and provocation of defensive feeling like blaming others for own mistakes
- ▶ Help to identify the unacceptable behaviours and acceptable behaviours
- ▶ Explain the way to show appropriate behaviours through role play
- ▶ Set limit for maladaptive behaviour and consequences (punishment)
- ▶ Give opportunity for realistic goal and success
- ▶ Provide unconditional acceptance and positive regard

3. Psychological therapies: Behaviour modification technique such as positive reinforcement (Token economy) and structured rules and activity schedule.

Guidance and Counselling for Parents

Encourage the positive relationship among child and parents Family oriented Life skill management program can be arranged

Conduct training programs towards guidelines for discipline (how to follow time out and removal of privileges)

Enhance the skill in parents towards planning structures activity schedule for child (Parent management training) Encourage the parents to spend quality time with children.

Guidance for Teachers

Training program for teachers towards behavioural correction
Conduct training programs towards guidelines for discipline

Encourage individual program plan for children with conduct disorder.

Pharmacological Management

Medicines may be prescribed by the Psychiatrist in some cases.

RED FLAGS IN CHILDREN/ADOLESCENTS WITH CONDUCT DISORDER

1. When the child/adolescent continuously violates rule
2. When the symptoms appear severe and unmanageable at home
3. Injurious to self and others
4. Severe decline in academic performance

REMEMBER

1. Conduct disorder is an externalizing behavioral disorder.
2. Early identification and treatment are necessary to prevent other mental illness and complications.
3. Parent management training is essential treatment program.

2. ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) is an externalizing Neuro chemical disorder characterized by a continuous inattention and/or hyperactivity-impulsivity, which disturbs functioning and/or development. Most of the time this problem is found in children, during their school age. Moreover, this disorder occurs more frequently in boys than girls.

CLASSIFICATION

- ▶ Inattentive type
- ▶ Hyperactive-impulsive type
- ▶ Combined type

Etiology

Even though the exact cause of ADHD is not known, some possible factors associated with the disorder are as follows:

- ▶ Genetic factors
- ▶ Environmental factors: Lead exposure, food additives and preservatives
- ▶ Psychosocial factors: Family disharmony and emotional disturbance
- ▶ Biochemical theory: Deficit of dopamine and norepinephrine
- ▶ Perinatal factors: Infection, drug and radiation exposure during pregnancy

Sign and Symptoms

These can be grouped into symptoms of inattention, hyperactivity and impulsivity.

Table 1

Inattention	Hyperactivity Impulsivity
<ul style="list-style-type: none"> • Poor connection and attention, • Lack of determination, • Easily distracted, • Not following instructions, • Does not seem to listen, • Poor time management, • Fails to complete assigned work, • Problems in organizing tasks and activities, • Making 'careless mistakes' in schoolwork, • Failing to meet deadlines, • Lose things such as pencils, books, play things, keys, eye glasses, • Forgetfulness in daily activities 	<p>Hyperactivity</p> <ul style="list-style-type: none"> • Restlessness, • Making lot of noise, • Excessively fidgety, • Frequently getting up from a seat, running here and there and jumping around, • Unable to play quietly, • Talks excessively and continuously, • Often disturbs others. <p>Impulsivity</p> <ul style="list-style-type: none"> • Answers before the question is completed, • Does not wait for their turn, • Rapid actions without initial thinking, • Craving for immediate rewards, • Can't postpone gratification.

Management of ADHD at PHC-HWC

If you suspect ADHD in a child, firstly inform and consult with the MO, and then counsel the parents regarding the disorder. The PHC Medical Officer may refer the child and the parents to a psychiatrist or child psychologist. There are many forms of psychological and behavioural therapy which may be prescribed by the psychiatrist/mental health specialist. The psychiatrist can also train and guide parents on various aspects of managing conduct disorder in their child, including parenting management.

Non-Pharmacological Management

This includes psychotherapy which will be prescribed by the mental health specialist.

- ▶ Social skill training
- ▶ Behaviour modification technique
- ▶ Cognitive behaviour therapy
- ▶ The following can be advised to the parents:

Table 2

To Prevent Injury	To Improve Social Interaction	To Improve Low Self Esteem	To Improve Attention
<ul style="list-style-type: none"> • Keep away sharp instruments • Provide safe environment for the child 	<ul style="list-style-type: none"> • Develop a trusting relationship. • Explain about unwanted behaviours 	<ul style="list-style-type: none"> • Keep realistic goals, • Provide opportunity for success, • Convey unconditional regard, • Give positive reinforcement for achievement 	<ul style="list-style-type: none"> • Ensure the child's attention by calling his/her name and make eye to eye contact, • Assign simple steps and avoid giving complex work at a time • Enhance attention through colouring, grain sorting • Allow short breaks between work • Reward each step completion, • Reward for independent achievement based on Token economy

Guidance and Counselling for Parents

- ▶ Parents should accept the child.
- ▶ Help the child to complete given work
- ▶ Shouldn't compare the child with another child.
- ▶ Always provide unconditional love and support
- ▶ Help the child to face the criticism.
- ▶ Help the child to understand their strength and weakness.
- ▶ Provide positive reinforcement and social rewards for acceptable and adaptive behaviours by using Token economy

Guidance for Teachers

- ▶ Create trust with child, communicate clearly, Give one instruction at a time
- ▶ Observe and listen, maintain eye contact Be specific & brief
- ▶ Use simple and easy assignment and games
- ▶ Make frequent checks to ensure that child is following Instructions correctly.
- ▶ Teacher should set behaviour goals, recognize suitable behaviour, and offer rewards.
- ▶ Help the students to learn to solve the problems.
- ▶ Encourage students to develop their interest-based activities.
- ▶ Utilize reminders (e.g. Write down in the diary or board)

Pharmacological Management

Medicines may be prescribed by the Psychiatrist in some cases.

RED FLAGS IN CHILDREN/ ADOLESCENTS WITH ADHD

Child looks very dull, talk self, frequent complaints on child, continuous poor school performance and involvement in social issues

REMEMBER

ADHD in children is a common disorder but it is very important to identify and treat as early as possible, so that we can reduce potential problems like school related problems, parent's stress towards children and social issues.

3. OPPOSITIONAL DEFIANT DISORDER

Oppositional Defiant Disorder (ODD) is a behavioural disorder in children that is defined by a pattern of hostile, disobedient and defiant behaviours directed at adults and other authority figures. ODD is frequently comorbid with other psychiatric conditions and often precedes the development of conduct disorder (CD), substance abuse, and severely delinquent behaviour. Treatment of ODD may be particularly problematic and often demands multimodal treatment, involving psychosocial and, occasionally, medication therapy.

RISK FACTORS

a. Biological Influences

- ▶ A parent with a history of attention-deficit/ hyperactivity disorder (ADHD), ODD, or Conduct Disorder
- ▶ A parent with a mood disorder (such as depression or bipolar disorder)
- ▶ A parent who has a problem with drinking or substance abuse
- ▶ Temperament (personality traits) and Genetic factors

b. Biochemical Factors

Alterations in the neurotransmitters, norepinephrine, serotonin and possibility of testosterone.

c. Organic Factors

Head injury and epilepsy

d. Social Factors

- ▶ Poverty
- ▶ Chaotic environment
- ▶ Abuse and neglect
- ▶ Lack of supervision & uninvolved parents
- ▶ Inconsistent discipline
- ▶ Family instability (such as divorce or frequent moves)

PSYCHOSOCIAL ISSUES IN FAMILY

- ▶ Poor relationship with one or more parent
- ▶ Neglectful or absent parent
- ▶ Difficulty or inability to form social relationships or process social cues
- ▶ A mother who smoked during pregnancy

CLINICAL FEATURES

- ▶ Often being angry or losing one's temper
- ▶ Often arguing with adults or refusing to comply with adults' rules or requests
- ▶ Often resentful or spiteful
- ▶ Deliberately annoying others or becoming annoyed with others
- ▶ Often blaming other people for one's own mistakes or misbehaviour

Role of Staff Nurse in Assessment of ODD

To be diagnosed to have ODD, a child must have at least 4 symptoms from the following:

- ▶ **Angry and irritable mood:**
 - Often loses temper
 - Is easily annoyed by others
 - Is often angry and resentful
- ▶ **Argumentative and defiant behaviour:**
 - Often argues with adults or people in authority
 - Often actively defies or refuses to comply with adults' requests or rules
 - Often deliberately annoys people
 - Often blames others for his or her mistakes or misbehaviour
- ▶ **Vindictiveness:**
 - Is often spiteful or vindictive
 - Has shown spiteful or vindictive behaviour at least twice in the past six months

The persistence and frequency of these behaviours should be used to distinguish a behaviour that is within normal limits from a behaviour that is symptomatic.

- ▶ For children younger than 5 years, the behaviour should occur on most days for a period of at least 6 months.
- ▶ For individuals 5 years or older, the behaviour should occur at least once per week for at least 6 months. Symptoms may be present at home, in the community, at school, or in all three settings.

Management of ODD at PHC-HWC

Children with early onset of ODD are more likely to develop Conduct Disorder (CD) later in life which is more severe form of behavioural problems. Therefore, early identification and treatment of ODD is very important.

Non-Pharmacological Management

If you suspect ODD in a child, firstly consult the MO and inform and counsel the parents regarding the disorder. The PHC Medical Officer may refer the child and the parents to a psychiatrist or child psychologist. There are many forms of psychological and behavioural therapy which may be prescribed by the psychiatrist/mental health specialist. The psychiatrist can also train and guide parents on various aspects of managing conduct disorder in their child, including parenting management.

Some of the psychosocial management techniques include:

- ▶ Cognitive problem-solving skills training
- ▶ Family therapy
- ▶ Parent management training
- ▶ School-based programs
- ▶ Social skills programs

Monitoring of Down Referral Cases of Substance Use

Watch for dehydration, maintain fluid and electrolyte balance, and observe level of consciousness. Provide a calm, non-threatening environment. Towards evening/night, the patient may become agitated and requires close monitoring, and needs to be protected from injuring self.

Emphasize on medication compliance and regular follow-up.

If the individual is prescribed long-term medication (e.g. Acamprosate/Naltrexone): Watch for allergic reactions (e.g. skin rash), adverse effects such as headache, nausea, sedation, hepatotoxicity. Ask the individual to report any such effects immediately. Monitor vitals regularly during follow up.

If the individual is prescribed disulfiram:

- (a) Warn that he should NOT drink any alcohol, otherwise life-threatening reactions can occur, which can continue for up to 2 weeks following the last dose.
- (b) Warn him NOT to use any alcohol-containing products such as cough syrups or any medicines without doctor's prescription. Also tell him not to use alcohol-based after shave lotions, inhalation of paints, varnishes.

Pharmacological Management

The management of children and teens with ODD is based on identifying and assessing the person's needs. Though overall psychosocial approach is used, sometime specific treatment is needed. Any required medication will be prescribed by the Specialist

RED FLAGS IN CHILDREN/ADOLESCENTS WITH ADHD

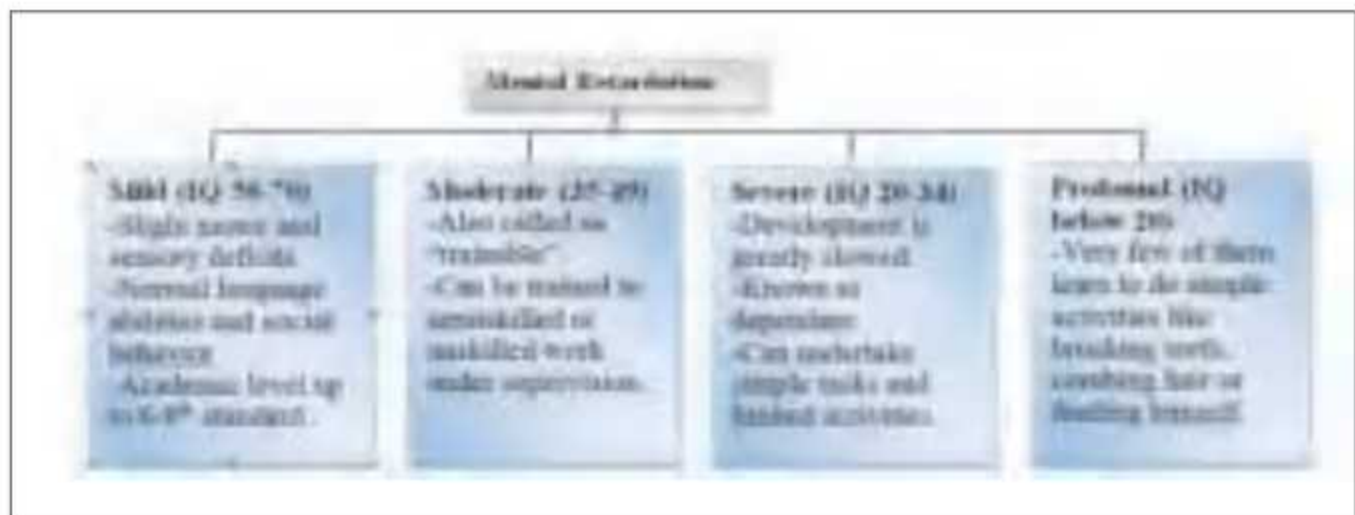
- ▶ Aggressive behaviour
- ▶ Causing physical harm to others
- ▶ Frequent violation of the rules

4. INTELLECTUAL DISABILITY

Intellectual Disability is a state of developmental disability that begins in childhood and results in significant difficulties for performing activities of everyday life. This can be found anywhere in any family, irrespective of caste, creed, race or religion. It is characterized below-average intelligence and difficulty in age-appropriate functioning since childhood.

CLASSIFICATION

Based on the level of IQ:



RISK FACTORS OF INTELLECTUAL DISABILITY

- ▶ **Before birth of a child:** Infections, placental dysfunction, hormonal disturbances, exposure to certain drugs, radiation or nutritional deficiencies during pregnancy
- ▶ **During delivery:** Prolonged labour or obstructed labour, prematurity, lack of respiration immediately after birth, instrumental delivery, low birth weight
- ▶ **After delivery:** Injury, malnutrition, infection, etc.
- ▶ **Other factors:** Chromosomal abnormalities (Down's syndrome), metabolic disorders, etc.
- ▶ **Other co-morbidities:** Epilepsy, hyperactivity, mood disorders, personality disorders, autism, and sensory problems like difficulty in hearing or vision

Clinical Features



Management of Intellectual Disability Disorders at PHC-HWC

If you suspect IDD in a child, firstly consult the MO and inform and counsel the parents regarding the disorder. The PHC Medical Officer may refer the child and the parents to a psychiatrist or child psychologist. There are many forms of psychological and behavioural therapy which may be prescribed by the psychiatrist/mental health specialist. The psychiatrist can also train and guide parents on various aspects of managing the disorder in their child, including parenting management.

Though many cases of intellectual disability are untreatable (e.g., Down's syndrome), there are psychosocial management techniques which can help.

Non-Pharmacological Management



Fig. 6

Pharmacological Management

The management of individuals with Intellectual Disability is based on identifying and assessing the person's needs. Though overall psychosocial approach is used, sometime specific treatment is needed. Any required medication will be prescribed by the Specialist.

PREVENTION OF INTELLECTUAL DISABILITY DISORDERS

Most cases of intellectual disability in children can be prevented. Many times, these disorders are caused due to various factors (risk factors) described above. Preventing these risk factors can help prevent Intellectual Disability Disorder.

- ▶ Precaution should be taken during pregnancy to avoid any drug intake without prescription, and avoid exposure to any radiation (like x-rays) and any injury.
- ▶ Good nutrition during pre-pregnancy and pregnancy period.
- ▶ Institutional delivery by trained health provider.
- ▶ Universal immunization of children with BCG, polio, DPT, and MMR.
- ▶ Creating awareness among public to remove the misconceptions.

REHABILITATION

- ▶ Vocational rehabilitation
- ▶ Training the child in activities of daily living (menstrual hygiene for girls)
- ▶ Training the child about safe touch so that sexual abuse does not occur
- ▶ Institutionalization if needed
- ▶ Address caregiver burden

Legislation: The Rights of Persons with Disabilities Act 2016 ensures various facilities and welfare benefits for the intellectually disabled individuals.

CHAPTER 7

NEUROLOGICAL DISORDERS

CASE VIGNETTE

SCENARIO 1

A 72-year-old hypertensive man, was seen at 5:30 am in the morning by his wife, having abnormal posturing of all four limbs with head turning to the left and frothing from the mouth. The movements lasted for around 2 minutes following which the patient lost consciousness. There was no history similar episode in the past. On examination, patient was unconscious and non-responsive even 10 mins after the seizure stopped.

SCENARIO 2

A four-year-old child is brought by the parents with recurrent episodes for episodes of sudden onset blank staring that occur abruptly and lasts for 10-15 seconds and occurs 10-15 times a day since last 2-3 months. Patient is unresponsive and stops all activities during the episodes. Patient occasionally have rapid eye blinking during these episodes. He resumes the activity immediately after that and stays unaware of the episode. There are no convulsions. There is no similar history in family member.

SCENARIO 3

A 70-years-old male, a retired teacher, presented with complaints of forgetfulness in day-to-day activities. He had noticed these symptoms around three years ago, and the complaints had been progressive since. This had led to problems such as forgetting where he placed his spectacles or car keys, and also forgetting to lock the house after him. He felt bothered by these issues and was worried. His wife also reported that he sometimes got confused about the routes while driving, a problem that he never had before. On examination, he was alert and oriented to time, place and person. His general knowledge was intact. On Mini Mental State Examination, he had difficulty with recall of two items. He also made three errors in calculation. The rest of his examination was normal. Detailed cognitive testing showed problems in naming, memory and visuospatial function. He had no other significant past medical or family history. He had no history of substance use or the use of any regular medications.

Questions

1. What are the possible diagnoses in the above case scenarios?
2. What are the clinical features that made you think of these diagnoses?
3. What is the role of CHO in management of these cases at the SHC-HWC?

The neurological disorders that will be discussed in this module are:

1. Epilepsy
2. Dementia

A. EPILEPSY

Epilepsy is a disease where a person tends to have recurrent seizures or 'fits'. Seizures are caused by abnormal nerve signals in the brain and can cause a variety of symptoms. Epilepsy is one of the most common neurologic conditions and about 1% of the population suffers from epilepsy. Approximately 75% of epilepsy begins during childhood usually before the age of 20 years. To diagnose epilepsy the person must have at least 2 seizures per month.

RISK FACTORS OF EPILEPSY

Epilepsy can occur due to many causes that lead to brain damage. In 60%-70% of cases, no cause is found.

The causes may be different for different age groups. These include:

- ▶ Difficult birth causing low oxygen supply to the brain of the newborn.
- ▶ Head injuries
- ▶ Brain tumours
- ▶ Genetic conditions where other family members can also be affected
- ▶ Brain infections
- ▶ Stroke (most common cause in elderly)

CLINICAL FEATURES OF EPILEPSY

The signs and symptoms depend on the type of seizures experienced by the patient. The seizures can be of the following types:

1. Generalized Seizures

These occur without warning and hence are commonly associated with injuries. The patient can have sudden onset jerking/ shaking with stiffness/ tightening of the whole body, which can be associated with:

- a. Cry out.
- b. Loss of consciousness.
- c. Fall to the ground.
- d. Passage of urine or stools.
- e. Tongue bite
- f. Excessive salivation from mouth
- g. Difficult breathing
- h. Up rolling of eyes
- i. Pale skin colour

The person may feel tired, confused, or sleepy and may have headaches after the seizure. They may or may not remember the seizure afterward.

Sometimes during the seizure, the patient's body may suddenly become stiff or the patient's muscles suddenly relax and become floppy. If they are standing, they often fall and develop injuries. In another type of seizure, the patient can have rapid blinking of eyes, and may seem confused or look like they are staring at something that is not there (absence seizure). This is usually seen in children and adolescents.

2. Focal Seizures

In this type of seizure, there can be:

- ▶ Muscle twitching, or abnormal jerking of one limb
- ▶ Abnormal sensation over some part of the body
- ▶ Feeling of strange taste or smell.

Patients with focal seizures may become confused or be unable to respond to questions for up to a few minutes.

Sometimes seizures occur secondary to causes other than abnormalities in the brain.

- ▶ Seizures can occur due to changes in body electrolytes. These seizures generally do not recur if the electrolytes are corrected.
- ▶ Alcohol withdrawal seizures can occur in chronic alcoholics when they do not drink alcohol for a few days.
- ▶ Pseudo-seizures may be caused by mental stress or a physical condition and are not actual seizures.

What can Precipitate Seizures in Epilepsy Patients who are Already on Treatment?

- ▶ Missing medication doses.
- ▶ Lack of sleep (a common cause of seizures in patients with juvenile myoclonic epilepsy)
- ▶ Fever
- ▶ Intake of other drugs that cause seizures
- ▶ Heavy alcohol intake

Management of Epilepsy/ Seizures at the PHC-HWC

Although seizures can be frightening to see, they are not usually a medical emergency. Usually, the seizures are self-limiting and stop within 1 to 2 minutes. Once the seizure stops, the person recovers and goes back to normal after some time. However, in case the seizures last for more than 5 minutes, it is an emergency called 'status epilepticus', and the person must be immediately referred to a hospital. The following points must be followed when helping a patient who has an active seizure.

Seizure First Aid

1. Stay calm. Note the time when the seizure started.
2. Look around: is the person in a dangerous place like in a swimming pool or near the fire? If not, do not move them. Move objects like furniture away from them.
3. Position: Keep the patient in a lateral position to allow draining of saliva outside the mouth.
4. Cushion their head with something soft if they have collapsed to the ground.
5. Rescue therapy: There are a few drugs that can be given to abort a seizure at home.
 - ▶ In a patient with known epilepsy, Midazolam nasal spray can be given during the seizure to abort the seizure. Give 5 mg (1 spray) into one nostril. An additional 5 mg (1 spray) into the opposite nostril may be administered after 5 minutes if the patient has not responded to the initial dose. Do not administer the second dose if the patient has breathing trouble or if excessive sedation occurs.
6. Stay with the patient. If the patient does not collapse but seems blank or confused, gently guide them away from any danger. Speak quietly and calmly.
7. Recheck the time. If the seizure continues for more than 5 minutes, take the patient to the hospital's emergency department.
8. If possible, try to record the video.
9. After the seizure has stopped, gently put the patient into the recovery position and check if breathing is returning to normal. Gently check their mouth to see that nothing is blocking their airways, such as food, tongue, or broken teeth. If their breathing sounds difficult after the seizure has stopped, call for an ambulance.
10. Stay with the patient until fully recovered.

What Not to Do in the Event of a Seizure?

- ▶ Do not hold them down. This can lead to injuries and fractures.
- ▶ Do not put anything to eat or drink in their mouth.
- ▶ Do not make them smell shoes or onions.

Precautions to be Taken in Epilepsy Patients

1. General precautions to prevent seizures:

- a. Do not skip medications
- b. Adequate sleep for at least 8 hours
- c. Early treatment of fever

2. Precautions to prevent seizure-related injuries

- a. **Do not Drive:** Driving is not permitted in patients with epilepsy as per Indian laws.
- b. **Avoid Swimming:** Patients should avoid swimming or should be supervised while swimming. Patients with frequent seizures should not swim to avoid drowning. Taking a shower in running water is better than with a bucket full of water to avoid drowning if a seizure occurs during bathing.
- c. **The patient should avoid going at height alone.**
- d. **Patients with frequent drop attacks** can be given a helmet to avoid head injuries.

Pharmacotherapy

Medicines for treatment and control of epilepsy or seizures can only be prescribed by a Medical Officer. You should be aware of the common side-effects of these medicines educate the patient/family regarding the same.

Non-Pharmacological Intervention

All non-pharmacological interventions are used in addition to the pharmacological therapy. These include:

- ▶ **Diet Therapy:** Special high-fat, low-carbohydrate diets (ketogenic diet and modified Atkin's diet) can be given to drug resistant epilepsy patients in addition to the anti-seizure drugs.
- ▶ **Alternative Therapies:** Yoga, exercise, music therapy have been tried in patients with epilepsy. Though these can be advised to patients with epilepsy, these cannot be relied upon for epilepsy control.

FOLLOW UP CARE, FREQUENCY AND FOLLOW UP ASSESSMENT

Since epilepsy is a chronic disease, long term follow-up is required. Generally, in a patient with well controlled epilepsy 3-6 monthly follow up is adequate. In other epilepsy patients, a more frequent follow up should be done. During each follow up visit:

- ▶ Ask for the last seizure episode
- ▶ Ask for the compliance
- ▶ Ask if patient had any reaction/ side-effects to the drug (especially if a new drug is introduced)
- ▶ Ask for sleep duration
- ▶ Preferably patients should maintain the seizure diary to record all this information.
- ▶ Patients immediate relative/ witness of the seizures should be interviewed for the seizure episodes
- ▶ Ask for use of any alternate medications
- ▶ In females, the drug changes may be required before conceiving, proper counselling is needed for this issue

WHEN TO REFER A PATIENT WITH EPILEPSY TO A HIGHER REFERRAL CENTRE?

- ▶ The epilepsy is not controlled with medication within 2 years despite good compliance.
- ▶ Management is unsuccessful after two drugs given in adequate dose.
- ▶ Patient experiences unacceptable immediate or long-term side-effects from medication.
- ▶ There is psychological and/or psychiatric co-morbidity.
- ▶ Seizures are associated with other symptoms like declining school performance, behavioural disturbances, difficulty in walking, frequent falls, visual disturbances etc.
- ▶ Patients with strong family history of seizures.

B. DEMENTIA

Dementia is a syndrome—usually of a chronic or progressive nature—in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing (WHO). It affects:

- ▶ Memory
- ▶ Thinking
- ▶ Orientation
- ▶ Comprehension
- ▶ Calculation
- ▶ Learning capacity
- ▶ Language
- ▶ Judgement and social interaction

Consciousness is not affected. Dementia is one of the major causes of disability and dependency among older people worldwide. It can be overwhelming, not only for the people who have it, but also for their careers and families. There is often a lack of awareness and understanding of dementia, resulting in stigmatization and barriers to diagnosis and care.

RISK FACTORS OF DEMENTIA

Potentially Non-Modifiable Factors:

- ▶ Genetic factors

Modifiable Factors:

- ▶ Illiteracy
- ▶ Hearing Loss
- ▶ Diabetes
- ▶ Hypertension
- ▶ Obesity
- ▶ Smoking
- ▶ Depression
- ▶ Physical Inactivity
- ▶ Social Isolation
- ▶ Stroke

CLINICAL FEATURES OF DEMENTIA

Dementia affects each person in a different way, depending upon the impact of the disease and the person's personality before becoming ill. Dementia might sometimes mimic depression since depression may lead to loss of interest in surroundings and usual activities, which may appear as if the patient has developed features of memory loss. The signs and symptoms linked to dementia can be understood in three stages.

Stages of Dementia			Sign & Symptoms
1	Early stage/Mild Dementia	The early stage of dementia is often overlooked, because the onset is gradual.	<ul style="list-style-type: none"> • Forgetfulness • Losing track of the time • Becoming lost in familiar places
2	Middle stage/Moderate Dementia	As dementia progresses to the middle stage, the signs and symptoms become clearer and more restricting.	<ul style="list-style-type: none"> • Becoming forgetful of recent events and people's names • Becoming lost at home • Having increasing difficulty with communication • Needing help with personal care • Experiencing behaviour changes, including wandering and repeated questioning.

Table (Contd.)...

...Table (Contd.)

3	Late stage/Severe Dementia	The late stage of dementia is one of near total dependence and inactivity. Memory disturbances are serious and the physical signs and symptoms become more obvious.	<ul style="list-style-type: none">• Becoming unaware of the time and place• Having difficulty recognizing relatives and friends• Having an increasing need for assisted self-care• Having difficulty walking• Experiencing behaviour changes that may escalate and include aggression.
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RED FLAGS IN DEMENTIA

A patient suspected to have dementia should be referred to a specialist in the presence of the following features:

- ▶ Rapidly progressive cognitive dysfunction
- ▶ Worsening impairment in activities of daily living
- ▶ Presence of focal neurological deficits such as paralysis of one half of the body
- ▶ Headache and vomiting
- ▶ Fever
- ▶ Involuntary weight loss and loss of appetite
- ▶ Incontinence of bowel or bladder
- ▶ Self-injury or injury to a caregiver
- ▶ Recent history of head trauma
- ▶ Associated seizures

CHAPTER 8

SUBSTANCE USE DISORDERS

In this module we will learn about the following substance use disorders:

1. Alcohol
2. Tobacco
3. Other psychotropic drugs

Substance abuse is defined as a maladaptive pattern of use indicated by continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use [or by] recurrent use in situations in which it is physically hazardous.

Classification

Psychoactive substances are classified according to their pharmacological properties into 3 main groups:

- ▶ Substances that cause sedation (suppress the Central Nervous System) also known as Sedatives, for example- alcohol, opium and opioid drugs, cannabis, volatile solvents like petrol, paint thinners, glue, etc.
- ▶ Substances that cause stimulation (arouse the Central Nervous System) also known as Stimulants, for example- nicotine in cigarettes and chewing tobacco, caffeine, cocaine, etc.
- ▶ Substances that cause hallucinations also known as Hallucinogens, for example- Lysergic acid diethylamide (LSD), Psilocybin present in some varieties of mushrooms, etc.

ALCOHOL

By pharmacological definition, alcohol is a drug and may be classified as a sedative, tranquillizer, hypnotic or anaesthetic, depending upon the quantity consumed.

The impact of alcohol consumption on chronic and acute health outcomes in populations is largely determined by 2 separate but related dimensions of drinking:

- (i) Total volume of alcohol consumed,
- (ii) Pattern of drinking

The different patterns of drinking include:

- ▶ Social drinking: occasional drinking in social rounds and not causing any medical or social problems
- ▶ Harmful drinking: The drinking can cause damage to the person's physical or mental health and is associated with adverse social consequences
- ▶ Alcohol dependence: The person has a sense of compulsion to drink alcohol daily and needs to gradually increase the amount of alcohol to feel physically and mentally well; the person will usually neglect his/her responsibilities and other interests

WHY DO PEOPLE DRINK TOO MUCH?

- ▶ Many people start drinking when they are teenagers because their friends drink and they want to be social (peer pressure).
- ▶ Alcohol is easily available and quite cheap.
- ▶ Some people start to drink more alcohol when they feel stressed or can't sleep.
- ▶ Some people work hard and drink more to reduce their pains.
- ▶ When people start to use alcohol to cope better with their problems, they are already in danger to develop an alcohol use disorder.

According to WHO, the only safe limit for amount of alcohol to be consumed is 'Zero' and that it is harmful in either way, whether consumed as binge drinking or in small amount over shorter or longer duration. Alcohol has many ill effects and can cause general health problems, mental health disorders and social problems.

General health problems caused by too much alcohol include:

- ▶ Liver problems (alcohol damages the liver which can later cause death, you may recognize the person having a yellowish skin or eyes)
- ▶ Stomach aches, nausea, vomiting (alcohol damages the stomach)
- ▶ Sensation of numbness in the feet or experience of sexual impotence (alcohol damages the nerves)
- ▶ A higher risk of injuries or accidents (alcohol disturbs the ability of appropriate reaction and concentration)
- ▶ Development of a physical dependence (with withdrawal symptoms when not drinking)

What are withdrawal symptoms?

- ▶ Withdrawal symptoms occur when the dependent person doesn't get his/her drink
- ▶ They occur as a sign that a person has become physically dependent on alcohol and can't be without alcohol anymore
- ▶ Dependent people often have to get their first drink early in the morning to avoid withdrawal symptoms

Typical withdrawal symptoms are:

- ▶ Restlessness and irritability sweating
- ▶ Shaking or trembling of hands
- ▶ Fast heartbeat
- ▶ High blood pressure (red face)

And in severe cases:

- ▶ Seeing things not there (hallucinations)
- ▶ Disorientation (the person doesn't know where he/she is)
- ▶ Seizures

MENTAL HEALTH PROBLEMS CAUSED BY TOO MUCH ALCOHOL

- ▶ Psychological dependency (the person will start to think that he/she can only perform well with alcohol, the mind starts to become preoccupied with thoughts about alcohol)
- ▶ Experience of typical symptoms of a common mental disorder (e.g. sleeping problems, sad or irritable moods, fears)
- ▶ Experience of hallucinations (e.g. hearing voices or seeing things) or unreasonable jealousy
- ▶ In chronic cases: loss of memory and orientation and become a 'helpless person' (alcohol damages the brain)
- ▶ Epileptic fits
- ▶ Increased risk of suicide

SOCIAL PROBLEMS CAUSED BY TOO MUCH ALCOHOL

Problems in the Family

- ▶ Arguments about spending too much money on alcohol and not fulfilling household duties when drunken
- ▶ Aggressive or violent behaviors (domestic violence is often associated with alcohol use disorders)
- ▶ To avoid arguments some people with Alcohol Use Disorder may drink secretly, e.g. hide bottles somewhere in the house

Problems at Work

- ▶ Appearing drunken at work
- ▶ Having problems with concentration
- ▶ Becoming unreliable
- ▶ The person may lose his/ her job

TOBACCO

Tobacco is in legal use globally, yet it causes far more deaths than all other psychoactive substances combined together. It is available in various forms such as beedis, cigarettes, hooka, hookli, chhutta, dhumti, chillum, etc. for smoking, and as betel quids, mishri, khaini, gutka, snuff, for chewing and as Electronic nicotine delivery systems (ENDS) also known as 'E-cigarettes'. All of these different forms of tobacco are harmful; they pose increased risk of development of following:

- ▶ Increased risk of respiratory infections
- ▶ Chronic obstructive pulmonary diseases including asthma and emphysema
- ▶ High blood pressure and diabetes mellitus
- ▶ Heart disease, stroke and vascular diseases
- ▶ Cancers of lung, bladder, breast, mouth, throat and oesophagus
- ▶ Miscarriage, premature labour and low birth weight babies are a result of smoking during pregnancy

Table 1

Myths	Facts
Alcohol/ tobacco cause health problems only when used in large quantities.	There is no known safe limit for alcohol/tobacco use. Health problems can set in with any quantity or at any time.
Alcohol and tobacco make a person attractive and enhance sexual performance.	Alcohol and tobacco damage the skin and cause a person to age rapidly, so they cannot make anyone look attractive. Alcohol and tobacco also damage the reproductive system and blood vessels, causing infertility
Alcohol makes a person brave.	Alcohol affects the nervous system and makes a person say or do inappropriate things which he/ she would never do when sober. So the person just appears to be out of his/her mind to others, rather than brave.
Alcohol and tobacco improve work performance.	In people who have been using alcohol/ tobacco for a long time, they become dependent on it, so that they are unable to concentrate if they do not use.
Alcohol induces good sleep.	Alcohol disrupts the natural sleep cycle. Therefore, following alcohol-induced sleep, the person will still feel tired and drowsy in the morning.
Smokeless (chewing) forms of tobacco are not dangerous	Smokeless forms of tobacco are also harmful; they harm and erode into the oral tissues causing ulcers and may develop into oral cancer. Tobacco, in ANY form, is harmful and deadly.

OTHER PSYCHOACTIVE SUBSTANCES

These are substances that affect how the brain works and leads to changes in mood, feelings, thoughts, perception and behaviour. Like alcohol and tobacco, addiction to these substances can start with experimental use in social situations or due to peer pressure and, for some people, can slowly cause dependence. Examples of some psychoactive drugs that cause addiction are cannabis products, benzodiazepines, cocaine, LSD, opioid painkillers and inhalants.

Use of these substances can result in different symptoms based on the chemical composition of the drug, but some serious side effects include:

- ▶ Increased blood pressure and heart rate
- ▶ Decreased coordination and muscle control
- ▶ Anxiety and paranoid thinking
- ▶ Impaired judgement
- ▶ Hallucinations
- ▶ Delirium
- ▶ Psychotic and violent behaviour

CLINICAL FEATURES WHICH CAN INDICATE POSSIBLE SUBSTANCE USE DISORDERS

1. Loss of interest in sports and daily routine
2. Loss of appetite and body weight
3. Unsteady gait, clumsy movements, tremors
4. Reddening and puffiness of eyes, unclear vision, slurring of speech
5. Fresh, numerous injection marks on body and blood stains on clothes
6. Nausea, vomiting and body pain
7. Drowsiness or sleeplessness, lethargy and passivity
8. Acute anxiety, depression, profuse sweating
9. Changing mood, temper, tantrums
10. Emotional detachment
11. Impaired memory and concentration
12. Presence of needles, syringes and strange packets at home

RISK FACTORS FOR SUBSTANCE USE DISORDER

Although certain chemical changes in the brain (neurobiology) play a role in addiction, the precursors of substance abuse are also environmental and include family, school, community, and peer factors. These multiple factors make the control and prevention of substance abuse very difficult. The environmental risk factors include:

Table 2: Environmental Risk Factors

(a) Family Factors	(b) School Factors
i. Sexual or physical abuse ii. Parental or sibling substance abuse iii. Parental approval or tacit approval of child's substance use iv. Disruptive family conflict v. Poor communication discipline and supervision vi. Parental rejection	i. Lack of involvement in school activities ii. Poor school climate iii. Norms that accept substance use iv. Unfair rules v. School failure
(c) Community Factors	(d) Peer Factors
i. Poor community bonding ii. Disorganized neighbourhoods iii. Crime iv. Drug use v. Poverty vi. Low employment vii. Community norms that condone substance use	Bonding to peer group that engages in substance use or other antisocial behaviours

ROUTES OF ADMINISTRATION

Psychoactive substances can be administered in many ways. They can be injected, chewed, dissolved slowly in the mouth, or swallowed, smoked or inhaled, rubbed into the skin, placed under the eyelid, or inserted in the anus or vagina, etc. Some of the health risks of substance use (e.g. local or general infection, HIV transmission, hepatitis B and C transmission, nasal sepsis, cancer of the airways, etc.) are related directly to the route of administration. Not all drugs can be taken by all routes.

Identifying Dependence

Dependence on any substance can be assessed when at least 3 of the following symptoms are reported to be present together in the past year.

1. Strong desire to use (craving)
2. Unable to reduce the amount used
3. Withdrawal symptoms when they don't use or use less than usual amount (e.g. hands shaking, feeling irritable, not able to sleep)
4. Needing more and more quantities of the substance to get the desired effect
5. Neglecting responsibilities and spending more time using the substance or with related activities
6. Continuing to use although aware of the negative effects

Management of SUDs at PHC-HWC

Non-Pharmacological Management

Counselling

Educate individuals about the harmful health effects of the substance: e.g. second-hand smoke (smoke from someone else's beedi/cigarette) effects on pregnant women and children, and the dangers of drunken driving. Use this information to motivate them to quit use.

Psychosocial Management

- a. Help individuals to overcome specific situations in which they may be using:
 - ▶ Ask to identify specific situations in which they use, e.g. using to relax, forget problems, control hand tremors, sleep.
 - ▶ Explain that use only increases problems by damaging health and finances.
 - ▶ Help them to identify other sources of relaxation and other ways of dealing with problems, e.g. spending time with family/friends, reading, exercise, gardening, etc.
 - ▶ When craving is strong, ask them to eat something, or drink hot milk/fruit juice/water.
- b. Some people say they are drinking/ smoking due to pressure from friends. In that case, advise them to stay away from such friends, or tell those friends firmly not to insist that he should drink/ smoke along with them.
- c. Combine anti-substance messages into your routine health care activities, e.g.:
 - ▶ If a person is coughing/ has abdominal pain, ask: does he/she use tobacco/cannabis/ alcohol? If yes, explain that the use may be contributing to their health complaints, and that he/she needs to cut down.
 - ▶ Ask pregnant women: do they use alcohol/chew tobacco or cannabis? Or does anyone in the family smoke? Help them as well as their spouses understand that using alcohol/ tobacco, and second-hand smoke can harm the unborn baby.
- d. Help to organize public awareness programs (e.g. at schools) and help to put up anti-substance use messages in public places. Use local leaders (e.g. teachers, sarpanch) to spread these messages.
- e. Encourage affiliation with self-help groups available locally for mutual sharing and support.

Pharmacological Management

- ▶ Delirium tremens is a serious syndrome associated with alcohol withdrawal which can occur in some individuals, usually within 48 to 72 hours after sudden stopping or significant reduction in quantity of alcohol intake. It is characterized by disturbances of consciousness and confusion, vivid hallucinations in any sensory modality (auditory, visual, tactile hallucinations), severe tremors, insomnia, sweating, palpitations, fear, agitation. There can be withdrawal convulsions.

- ▶ Delirium tremens is a medical emergency with a high mortality risk if untreated. Benzodiazepines, multivitamin supplementation (especially high dose thiamine) and symptomatic treatment is the mainstay of management. Diazepam tablet or slow IV injection 20 mg or Lorazepam tab/IM/IV 4mg is administered as loading dose. The patient is referred to a secondary or tertiary care hospital at the earliest.
- ▶ Correcting fluid and electrolyte imbalance; supplementing vitamins and minerals.
- ▶ Treatment of co-existing medical problems (e.g. hepatitis).
- ▶ Medications to reduce craving/cause aversion to alcohol will be started by the Medical Officer (E.g. Acamprosate, Disulfiram, Naltrexone).

RED FLAGS IN SUBSTANCE USE DISORDERS

- ▶ When the person is unable to stop substance use with simple advice
- ▶ If there are seizures
- ▶ If there are physical health problems, e.g. fever, mouth patches, yellowness of eyes, any other
- ▶ If the individual appears confused/ claims to hear or see what others cannot
- ▶ When the individual/family appear significantly distressed

CHAPTER 9

SUICIDE IDEATION AND BEHAVIOUR

CASE VIGNETTE

Mrs. S, a 60-year-old elderly person works as a helper in the school, enjoys her work and also gets appreciation from peers and superiors for her good job. She has four sons and all are living separately with their wife and children. She has lost her husband two years back, she has no friends and she has withdrawn from the contacts of her relatives after her husband's death. Of late she feels very disturbed, lonely and helpless and also feels life is not worth living. At times she cries very bitterly and looks sad most of the day.

Questions

1. What do you think Mrs. S is suffering from?
2. What is the level of risk for suicide?
3. What immediate help would you provide?
4. How will you manage this situation?
5. How will you plan the referral?

Suicide is a preventable cause of death. Every 40 seconds a person dies by suicide somewhere in the world. Close to 8,00,000 people die due to suicide every year. For every suicide there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population. Suicide is the third leading cause of death in 15-19-year-olds. 79% of global suicides occur in low- and middle-income countries and India is one among them. Ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally.

RISK FACTOR OF SUICIDAL IDEATION

The link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established. Many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness.

In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTQIA+) persons; and prisoners. The strongest risk factor for suicide is a previous suicide attempt.

Identifying Suicidal Person

- ▶ History of earlier attempts
- ▶ Suffering from Mental disorders
- ▶ Co-occurring substance mis-use
- ▶ History of suicide in their relatives
- ▶ Violence
- ▶ Difficulties in getting help from professionals
- ▶ Unwillingness to seek help because of stigma
- ▶ Withdrawing from relationships at family, social and work
- ▶ Financial loss
- ▶ Physical illness or medical problems
- ▶ Easy access to lethal means
- ▶ Modelling the suicidal behaviours of significant people.
- ▶ Cultural and religious beliefs

Clinical Features or Warning Signs of Suicide

Clinical features are usually seen as warning signs for suicide. It can be seen as verbal or behavioural signs.

Verbal Warning Signs

- ▶ Talking about wanting to die
- ▶ Talking about feeling guilty or having committed a sin
- ▶ Talking about feeling hopeless or having no reason to live
- ▶ Talking about feeling trapped or in unbearable pain
- ▶ Talking about being a burden to others

Behavioural Warning Signs

- ▶ Drinking more alcohol than usual or using other substances.
- ▶ Being restless, agitated (getting angry easily), anxious (very worried/ fearful)

- ▶ Feeling sad and dejected
- ▶ Showing extreme rage or talking about seeking revenge (gets into arguments and physical fights with others)
- ▶ Sleeping or eating too little or too much (less or more than usual for the person)
- ▶ Withdrawing/ becoming or feeling isolated (Outgoing or social persons interaction with family/friends decreases or stops completely)
- ▶ Stops using usual social media or is inactive on social media platforms
- ▶ Excessive internet use or posting negative content (personal thoughts /feelings as stated in list or sharing content related to death and suicide)
- ▶ Expressing Verbal and behavioural signs on Internet via platforms or sudden reduction or withdrawal from internet platforms
- ▶ Stops attending work/ misses classes or work/ gets late/ doesn't complete jobs assigned or homework
- ▶ Displaying extreme mood swings (suddenly crying/reckless/hyperactive)
- ▶ Preparatory behaviours (giving away belongings, collecting medicines or pesticides)

ROLE OF STAFF NURSE IN SUICIDE RISK ASSESSMENT

If any person is suspected to be/ informed to you as being at risk of suicidal behaviour, assess for the following along with the MO:

1. Present mental status and thoughts about killing self
2. How detailed is the plan and method?
3. What protective factors/the support system is available for the individual such as family, friends, relatives etc.

A common myth is - asking somebody about suicide will increase chances of him/ her committing suicide. However, this is not true. The best way to know if the person is having the suicidal thoughts is by asking them directly, talking about this can give the individual other alternatives or the time to change the decision. Better to start with leading questions such as: Do you feel:

1. Unhappy?
2. Nobody bothers about you?
3. Life is not worth living?
4. Helpless and trapped?
5. Like harming yourself?
6. Like ending your life?
7. Like committing suicide?

The suicidal questions can be asked only when the individual begins to trust and feels that he is been understood. These must be asked carefully, without being judgmental. The **Suicidal Ideation Attributes Scale (SIDAS)** (Refer to Appendix) is used to assess the risk of suicide in a person who is suspected to show suicidal risk factors.

- ▶ While interacting with anyone who is suspected to be at risk of suicide, it is very important to keep in mind the following: Being a good listener and paying full attention to the patient
- ▶ Being non-judgmental
- ▶ Being supportive and instilling hope
- ▶ Offering help by asking 'Can I help you?'
- ▶ Building a contract by asking 'Will you promise me not to kill yourself till I find a help for you?'
- ▶ As a part of the contract, provide a crisis plan as a safety net by discussing with the MO.

Management of Persons with Suicidal Behaviour

All persons who are suspected to be at risk of suicide will be referred to the Medical Officer by the CHO at the SHC-HWC. You shall help the MO provide treatment or refer the patient further as deemed fit.

If the Person is at Low Risk

Thoughts of self-harm come once in a while, but there are no plans. However, they will have thoughts like "I can't take it anymore", "I wish I was dead and gone".

Interventions:

1. Support and instil hope.
2. Work on the suicidal feelings with the help of the Medical Officer. Identify the strengths in the person by talking about their past experiences and how they had resolved their issues in the past without thinking of suicide.

If the Person is at Medium Risk

There are thoughts of self-harm and plans but he/she is still in the thinking stage and does not plan to act on the thought.

Interventions:

1. Offer emotional support and instil hope. Identify the positive strengths in the person.
2. Usually, the suicidal person will have the ambivalent feelings about committing suicide, use this opportunity to gradually instil hope.
3. Finding solutions: it might not be possible to solve all their problems but explore alternatives to suicide hoping that the person might consider at least one of the options provided.

4. Contracting: Building a contract by asking 'Will you promise me not to kill yourself till I find a help for you?'
5. Refer to psychiatrist, counsellor, doctor or any mental health professional as early as possible.
6. Involve the support system such as family members, friends, colleagues etc.

If the Person is at High Risk

When the person has definitely decided about a method to commit suicide immediately.

Interventions:

1. Never allow the person to be alone and provide vigilant supervision.
2. Talk to the person gently and remove the access to means such as sharps, pills, rope etc.
3. Write out a statement that the person will not commit suicide and get it signed by him/her.

SOME POINTS TO REMEMBER

1. Explain the person why the referral is made.
2. Plan and organize for the appointment.
3. Inform them you will be available for them even though the referral is made.
4. Follow up the person after the consultation is made.
5. Follow up and community support: Recently discharged patients often lack social support and can feel isolated once they leave care. Follow-up and community support have been effective in reducing suicide deaths and attempts among patients who have been recently discharged.
6. The intervention can involve the use of postcards, telephone calls or brief in-person visits (informal or formal) to make contact and encourage continued contact.

Involving available community support—such as family, friends, colleagues, crisis centres or local mental health centres—in aftercare is important as these can regularly monitor people and encourage treatment adherence.

RED FLAGS FOR SUICIDAL CASES

- ▶ Presence of any known psychiatric illness
- ▶ History of previous suicide attempt
- ▶ Family history of suicide, alcoholism or mental illness
- ▶ Chronic physical illness
- ▶ No social support

CHAPTER 10

SERVICE DELIVERY FRAMEWORK FOR MNS DISORDERS

As part of expansion of services under Comprehensive Primary Health Care, care for mental, neurological and substance use disorders has been included in service package at HWCs.

Integration of mental health care in primary health care is enabled through following approaches-

- i. Community level Health Promotion interventions and improving mental health literacy that enables an understanding of mental health, common symptoms, risk factors/causes of disorders, treatment, reduction of stigma and discrimination, and of techniques such as psychological first aid, and self-care.
- ii. Early identification, referral to CHO for screening and home & community based follow up by frontline worker team and use of the Community Based Assessment Checklist (Annexure 8) by ASHA and Community Informant Decision Tool (CIDT) (Annexure 9) by MPW.
- iii. Screening by Community Health Officer (CHO) through the use of a standard screening tool, psychosocial management and enabling referral.
- iv. Diagnosis and initiation of treatment by the Medical Officer at the HWC-PHC/UPHC levels or by specialists at secondary/tertiary care facilities.
- v. Reduction of treatment gap (psychosocial and pharmacological) by facilitating access to treatment by referral to higher level centres (CHC and other referral centres), initiation of treatment and ensuring regular supplies and treatment adherence at HWCs.

As the staff nurse at the PHC-HWC, you need to know about the services available at PHC and referral facilities and roles of different service providers at community and health facilities.

1. SERVICE DELIVERY FRAMEWORK

The following table describes in brief the service delivery framework for MNS care.

Table

Care at Community Level	Care at SHC-HWC	Care at PHC-HWC	Care at Secondary/ Tertiary Care Facility
<p>IEC and Community mobilization (MPW, CHO and ASHAs)</p> <ul style="list-style-type: none"> Promotion of mental health- through family enrichment programs, school health programs, positive parenting, and physical activities initiative including yoga, balanced diet, exercise, sleep hygiene, and stress management. (CHO and MPWs) Screening and Early Detection using Community Informant Decision Tool (CIDT) (CHO/MPW) Screening using Patient Health Questionnaires 2 (PHQ 2) as part of CBAC form administered by ASHAs Follow up care at home: Ensuring treatment compliance, providing treatment adherence support and checking for side effects by ASHAs, MPW Improving psychosocial competencies at individual and family level- Basic psychoeducation, psychological first aid, basic suicide risk assessment/ management by MPW, CHO 	<p>Community Health Officer</p> <ul style="list-style-type: none"> Conducting individual level awareness and stigma reduction activities Delivering Psychosocial Interventions Identification/screening of MNS conditions Referral to PHC or higher facilities for diagnosis and treatment Administering Patient Health Questionnaire (PHQ) 9 for screening of depression. Tracking for improvement in PHQ 9 score during follow up care. Emergency care for seizure/status epilepticus Developing and implementing comprehensive life plan for Persons with dementia. Dispensation of medicines prescribed by PHC-MO and specialists Follow up care- checking for side effects and toxicities, for prescribed medications, monitoring for relapses and recurrences, checking for red flag signs, signs of abuse and neglect in patients with dementia 	<p>Medical Officer (MBBS)</p> <ul style="list-style-type: none"> Conduct individual level awareness and stigma reduction activities Identification and screening for MNS conditions Identification/diagnosis, and developing management plan for CMDs, Epilepsy and Dementia Identification/diagnosis and referral for confirmed diagnosis and initiation of treatment for SMDs, SUDs and C&AMHDs. Suicide risk assessment and basic management Initiation of pharmacological treatment for CMD, Epilepsy and Dementia Basic management of drug overdose/ intoxication Emergency care for seizure/status epilepticus Emergency management of poisoning Follow up care and continuation of treatment initiated by specialists 	<p>Specialists</p> <ul style="list-style-type: none"> Confirmed diagnosis of SMDs, SUDs and C&AMHDs Providing multidisciplinary care upon referral at the secondary level Clinical support and supervision for continued management by specialists

Table (Contd.)...

...Table (Contd.)

	<ul style="list-style-type: none"> • Facilitating community-based rehabilitation, family-based interventions, organising meetings of self-help groups. • Establish linkages with other programs, departments and NGOs for referral services 		
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2. PSYCHOLOGICAL FIRST AID (MENTAL HEALTH FIRST AID)

It is similar to first aid for any physical illness. When a person has an acute physical illness, it can be addressed in the short-term with first aid treatments, such as treatment for snake bite. Mental health disorders can also be addressed initially with first aid.

Mental Health First Aid is the help you give to a person with a mental health problem until treatment by a trained doctor/mental health specialist is available or a mental health crisis is resolved. This would particularly be useful in situations where there may be momentary unavailability of the MO at the PHC-HWC. The purpose of this first aid is to:

- ▶ Preserve life when a person may be a danger to him/herself or others
- ▶ Provide comfort to the person and relieve for some symptoms
- ▶ Ensure further professional treatment

3. PSYCHOLOGICAL FIRST AID SHOULD BE DELIVERED TO ANY INDIVIDUAL WHO REPORTS EXPERIENCING PSYCHOSOCIAL DISTRESS.

Essential Steps in Psychological First Aid are:

1. Listen without judgement
2. Give reassurance and information
3. Encourage the person to get appropriate professional help
4. Encourage self-help treatments, follow ups, maintaining compliance
5. Assess the risk of suicide and harm to self or others



After diagnosis of a disorder, you, along with the MO will come up with a treatment plan which will include psychosocial interventions, including community-based rehabilitation and this plan shall then be shared with the CHO at the SHC-HWC.

4. REFER AS APPROPRIATE

After the initial treatment of the individual, you shall discuss with the MO and refer him/her to appropriate higher referral facility- CHC or secondary care facility depending upon the condition.

5. FOLLOW-UP SCHEDULE

A treatment plan will be shared by PHC-MO to the CHO. You will help the MO to plan the frequency for follow-up visits and this shall then be shared with the CHO at the SHC-HWC for maintaining continuum of care.

6. MAINTAINING OF RECORDS

Records for probable/at risk cases based on CBAC forms and CIDT tools would be maintained at SHC-HWC by the CHO.

You will maintain records of screening, treatment and referrals undertaken at the PHC-HWC. Once the individual is diagnosed with a condition, or referred to higher care services records regarding treatment regimen will be maintained by you at PHC-HWC to facilitate follow up.

7. LOGISTICS MANAGEMENT

You shall ensure that continuous supply of medicines is maintained at PHC-HWC for individuals diagnosed with mental health disorder. These will be dispensed at SHC-HWC, as per MO's prescription.

CHAPTER 11

LEGAL FRAMEWORK FOR MENTAL HEALTH AND NATIONAL MENTAL HEALTH PROGRAM

Law refers to the rules formed by authority for regulating the behaviour of the members of community or country. Each state has their own law which regulates the care and treatment of the people who suffer from psychiatric illness. The law attempts to balance between protection of the mentally ill person's rights and the safety of the community. You should be aware of legal aspects related to caring for person with mental illness, to ensure their rights.

THE MENTAL HEALTH CARE ACT, 2017 (MHCA)

The Mental Health Care Act, 2017 was passed on 7 April 2017 and came into force from July 7, 2018. The law was described in its opening paragraph as "An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto".

This Act superseded the previously existing the Mental Health Act, 1987 that was passed on 22 May 1987.

SALIENT FEATURES OF THE ACT

1. Protects the right of persons with mental illness
2. In case of future care, individual can make advance directive
3. Prescribes the minimum standards for establishing, registering and controlling mental health establishments for mentally ill persons
4. Regulate the procedure of admission and discharge of mentally ill persons to mental health establishments either on voluntary basis or involuntary
5. The Mental Health Care Act, 2017 enable individuals in such section by decriminalize the suicide attempt and clearly states that person who attempt suicide should be referred for evaluation and treatment. Now, the State governments have a duty to provide care, treatment and rehabilitation to the person
6. Provides every person right to access to mental healthcare and treatment services by the Government

7. Enable mentally ill persons by providing free legal aid services
8. Restrict non-professionals to discharge function with punishment for not binding to the Act
9. Establish duties and responsibility for police in respect of persons with mental illness
10. Provides provisions for the use of ambulance services and extent the quality as provided to persons with physical illness
11. Prohibits certain procedures such as:
 - i. Sterilization of men or women, when meant as a treatment for mental illness
 - ii. Chaining a person in any manner or form whatsoever
 - iii. Seclusion of persons with mental illness
 - iv. Electro-convulsion therapy without anaesthesia

The Mental Health Care Act, 2017 decriminalizes attempt to suicide and clearly states that person who attempts suicide should be referred for evaluation and treatment and the State government holds the responsibility to provide care to them.

The National Mental Health Program, 2017 (NMHP) was launched with the stated objectives:

1. To ensure the availability and accessibility of mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population
2. Encourage the application of mental health knowledge in general health care and social development
3. Promote community participation in mental health services development and stimulate efforts towards self-help in community

To address the huge burden of mental disorders and shortage of qualified professionals in the field of mental health, Government of India has been implementing National Mental Health Program (NMHP) since 1982. The District Mental Health Program was added to the Program in 1996. The Manpower development schemes (Scheme-A & B) became part of the Program in 2009.

MANPOWER DEVELOPMENT SCHEMES

The Scheme-A is for establishment of Centres of Excellence and Scheme-B is for strengthening/ establishment of Post Graduate departments in mental health specialties.

CENTRE OF EXCELLENCE (SCHEME-A)

Scheme-A includes financial support towards construction, technical and non-technical equipment, library and faculty salary to the existing Central and State Mental Health Institutions. The Scheme was initiated in the year 2009 and continued during the 12th Five Year Plan period and beyond. Till date 25 institutions have been supported for establishment as Centres of Excellence in the field of Mental Health.

STRENGTHENING/ESTABLISHMENT OF PG DEPARTMENTS IN MENTAL HEALTH SPECIALTIES (SCHEME-B)

Scheme-B includes financial support for strengthening/establishment of Post-Graduate Departments in mental health specialties viz. Psychiatry, Clinical Psychology, Psychiatric Social Work and Psychiatric Nurse. Till date support has been provided for strengthening/establishment of 47 PG Departments in Mental Health specialities.

Integration of mental health with primary health care through the NMHP was one of the major strategies for enabling care for mental disorders at the level of primary care. However, the program came with certain limitations in terms of giving more emphasis on curative components rather than promotive and preventive aspects. To overcome this challenge, an initiative was taken where the district was considered to be the administrative and implementation unit of this program

The District Mental Health Program (DMHP) has been in existence since 2003, and provides basic mental health care services for a range of facility and community-based interventions. To assess the feasibility of DMHP, National Institute of Mental Health and Neurosciences (NIMHANS) undertook a pilot project (1985-1990) at the Bellary District of Karnataka. Till now, DMHP have been implemented in 692 districts in India.

OBJECTIVES OF DMHP

1. To provide sustainable basic mental health services in community and integration of these with other services
2. Early detection and treatment in community itself to ensure ease of care givers
3. To take pressure off mental hospitals
4. To reduce stigma, to rehabilitate patients within the community
5. To detect as well as manage and refer cases of epilepsy

SERVICES PROVIDED UNDER DMHP

- ▶ DMHP has been supported in 692 districts across the country to basic mental health services to the community and to integrate these with general health services.

- ▶ It envisages a community based approach to the problem, which includes recruitment of a mental health team at the district level which includes a clinical psychologist, psychiatrist, psychiatric social worker & psychiatric nurse. Provide service for early detection & treatment of mental illness in the community (OPD/ Indoor & follow up).
- ▶ Generation of community awareness is a continued activity under the program. Awareness is generated in the community regarding the mental disorders and the availability of mental health services by adopting various mass media and interpersonal communication methods.

THE RIGHTS OF PERSONS WITH DISABILITIES ACT, 2016

The Rights of Persons with Disability Act defines 'person with disability' as a person with long term intellectual or sensory impairment which hinders his full and effective participation in society equally with others. The Bill will replace the existing PwD Act, 1995, which was enacted 21 years back.

Some of the salient features of the Act are as follows:

1. The types of disabilities have been increased from existing 7 to 21 and the Central Government will have the power to add more types of disabilities and includes disabilities due to mental illness, chronic neurological conditions, etc.
2. Speech and Language Disability and Specific Learning Disability have been added for the first time. Acid Attack Victims have been included. Dwarfism, muscular dystrophy have has been indicated as separate class of specified disability. The new categories of disabilities also included three blood disorders, Thalassemia, Hemophilia and Sickle Cell disease.
3. Additional benefits such as reservation in higher education, government jobs, reservation in allocation of land, poverty alleviation schemes etc. have been provided for persons with benchmark disabilities and those with high support needs.
4. Every child with benchmark disability between the age group of 6 and 18 years shall have the right to free education.
5. Government funded educational institutions as well as the government recognized institutions will have to provide inclusive education to the children with disabilities.
6. The Bill provides for penalties for offences committed against persons with disabilities and also violation of the provisions of the new law. Special Courts will be designated in each district to handle cases concerning violation of rights of PwDs.

The specific disabilities under the Act are:

- ▶ Physical disability- e.g. locomotor disability, visual disability, hearing impairment
- ▶ Intellectual disability- e.g. specific learning disabilities, Autism spectrum disorder
- ▶ Disability due to long standing neurological problems such as multiple sclerosis and blood disorders such as hemophilia
- ▶ Multiple disabilities
- ▶ Any other disability which may be notified by Government

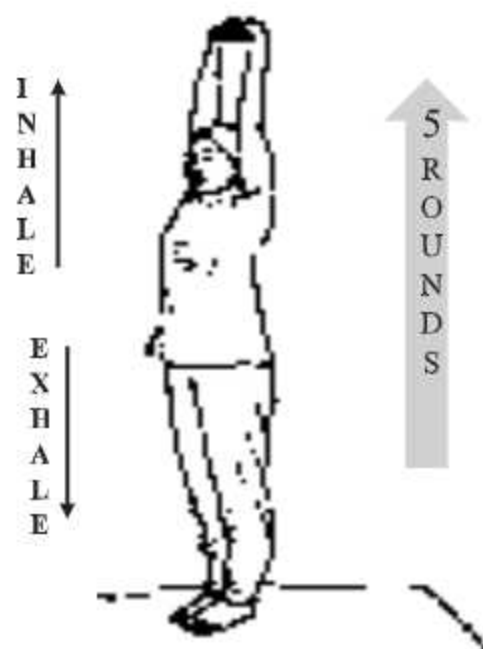
The application for assessment of disability shall be accompanied by: (a) proof of residence (b) two recent passport size photographs and (c) Aadhaar number. The disability legislation prescribes punishment for fraudulently availing any benefit.

ANNEXURES

Annexure 1: Twenty-minute Yoga Module

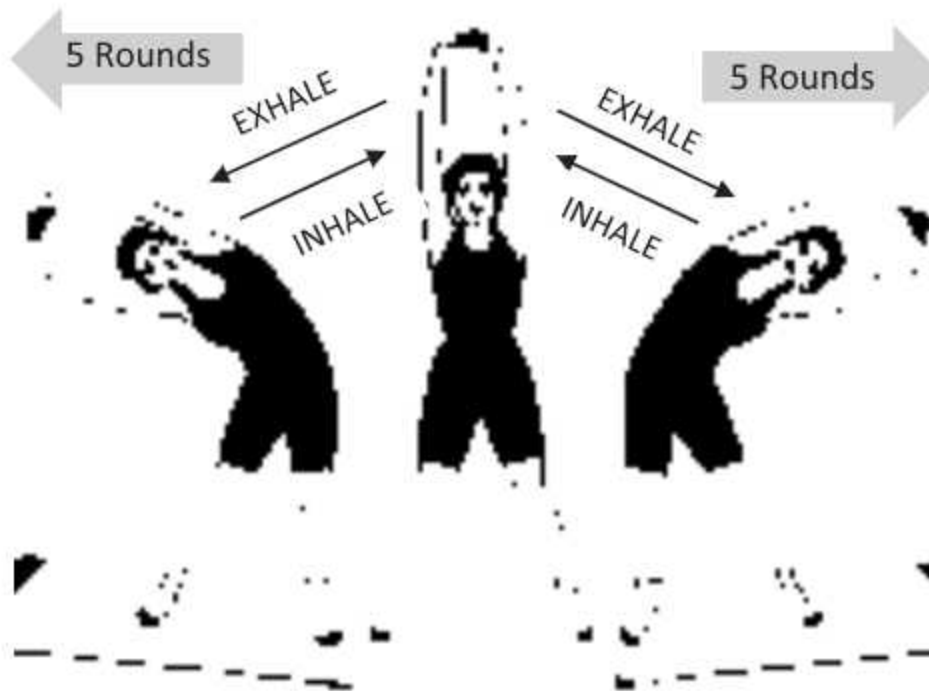
Twenty-minute Yoga Module to Promote Mental Well-being and Overall Health

S.No.	Description of Yoga Practice	Time (Total 20 minutes)
1	<p>Tadasana stretch and side-bending:</p> <ul style="list-style-type: none">• Stand with feet together.• Interlock your fingers and keep them on your chest.• Breath in, stretch the hands up above your head with keeping the fingers interlocked, stretch the whole body up at the peak of inhalation,• Breath-out and come back. Perform 5 rounds.	2 Minutes



Now, bend sideways with hands stretched up.

- Breath out bend towards right, breath in back to centre.
- Repeat same on left side. Perform 5 rounds each side



Precautions:

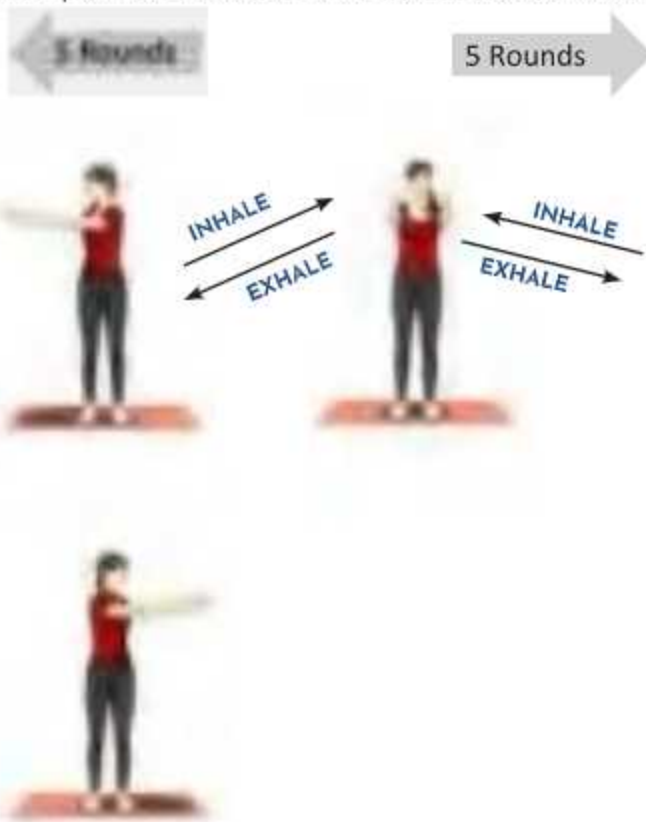
- People with heart ailments should do it cautiously and avoid raising your hands over the head (people with heart disease can keep hands on the waist).

2.

Katichakrasana Spinal Twisting:

2 minutes

- Stand with your legs 2-feet apart.
- Breathe in, stretch your arms in front at the shoulder level, parallel to each other, palms facing each other.
- Breathe out, twist along your spine and look towards your right
- Breathe in as you come to centre
- Breathe out, twist along your spine and look towards your left
- Practice this for 5 rounds on each side.
- Maintain the final pose for 5 counts on both sides in the last round.

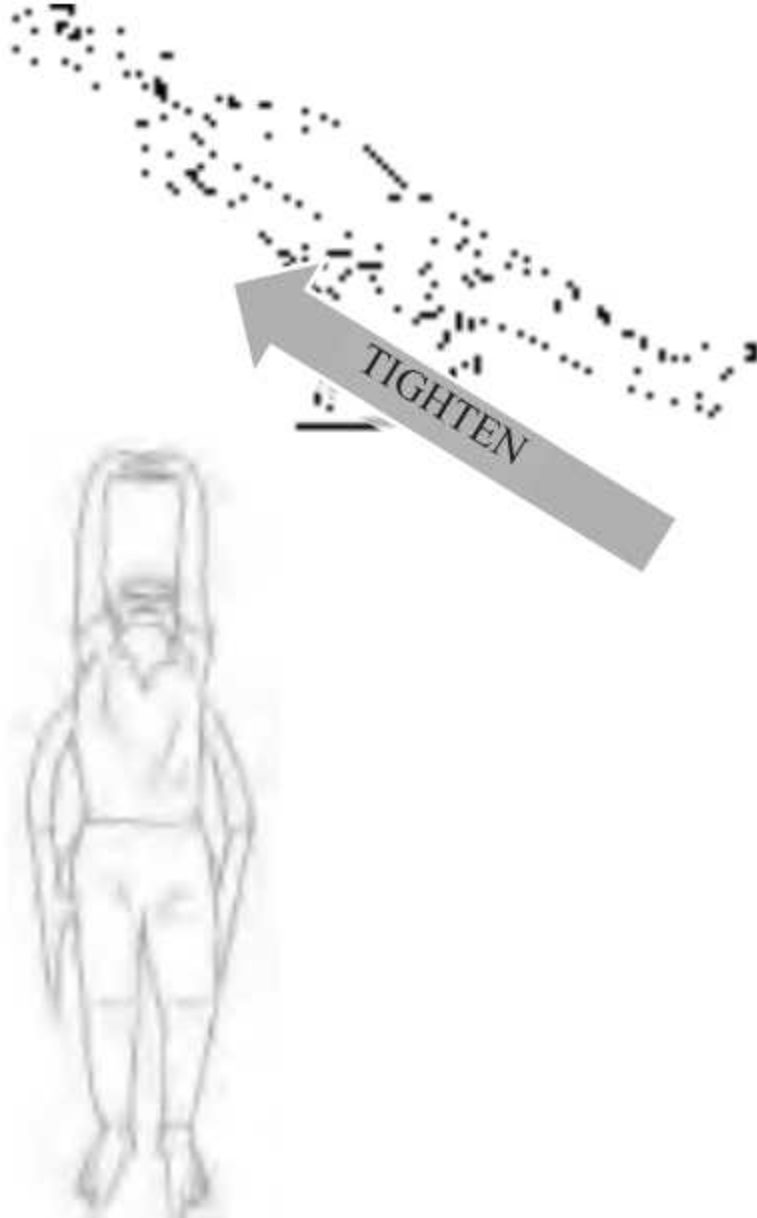


3

Instant Relaxation Technique:

1 minute

- Sit on the chair with your legs stretched in front.
- Interlock your fingers, stretch your arms up over your head,
- Squeeze and tighten all your muscles from your toes to your head.
- Squeeze your eyes, clench your teeth, tighten your face.
- Tighten the whole body!
- Tighten! Tighten!! Tighten!!! (for 5-10 seconds)
- Release and relax the entire body.

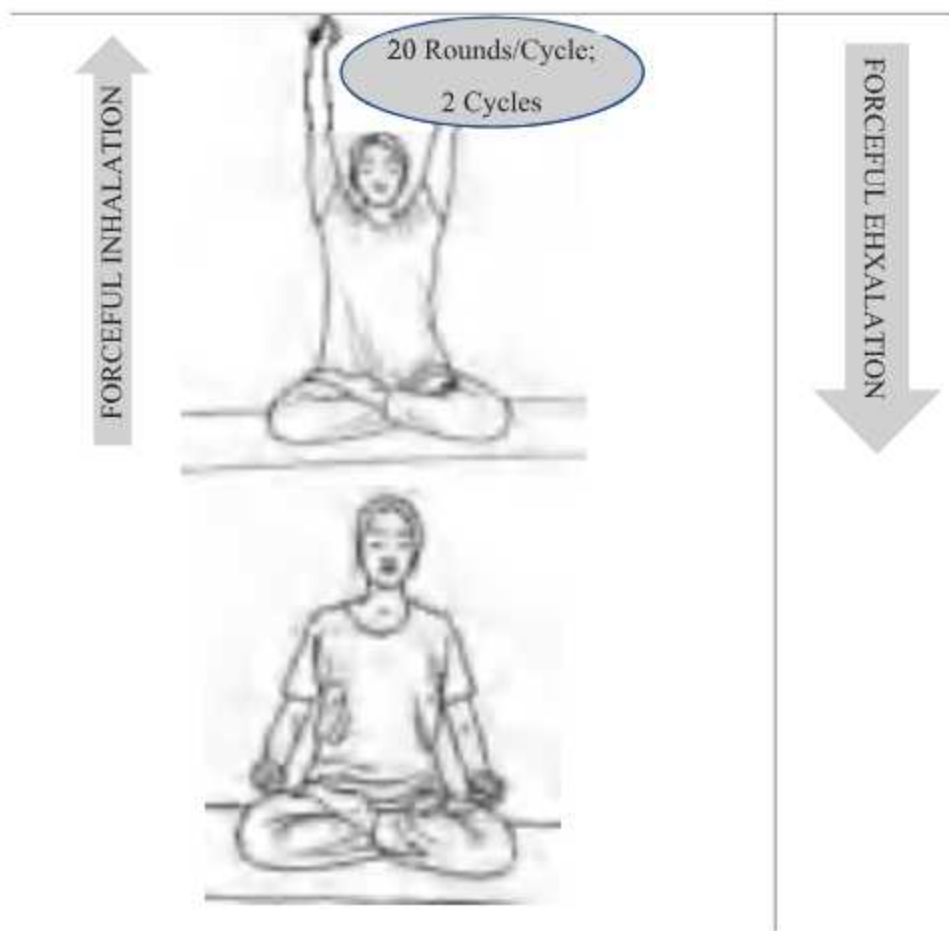


4.

Bhastrika Pranayama:

5 minutes

- Sit with your back and neck straight.
- Make a fist of your hands, place it in front of your shoulders
- Inhale forcefully while throwing your hands up and opening your fists.
- Exhale forcefully while drawing your hands down and closing your fists
- Perform 20 rounds/cycle for 2 cycles
- After the practice, close your eyes and observe your breath



Precautions:

- People with neck pain, back pain and any heart ailment, avoid using hands. Instead use your chest to breathe in and out.
- People suffering from epilepsy/fits or have had any recent surgery (within 6 months) should completely avoid the practice.

5.

Nadishuddhi Pranayama:

5 minutes

- Sit with your back and neck straight.
- Adopt *Nasika mudra* in right hand, i.e bend your index and middle fingers down
- Breathe-in slowly from left nostril, breathe-out from right; then breathe-in from right and breathe-out from left. This completes 1 cycle
- Perform 5 more rounds
- Note: Slow and gentle breathing; be aware of the sensation of air in the nostrils during



6.

Bhramari Pranayama:

5 minutes

- Sit with back and neck straight.
- Gently cover your eyes with your fingers and close your ears with thumbs.
- Touch the tip of your tongue to the upper palate.
- Take a deep breath in and produce the humming sound (mmmmm) as you breath out
- Perform 6 cycles.
- Sit in silence and observe the vibrations in the head and facial region.



Precautions:

- People with headache/migraine should avoid chanting loud. They should perform gentle chants and feel the soothing vibrations in the head region.

Recommendations:

- This module can be practiced every day or twice a day according to the need of the individual.
 - This brief module can be practiced on chair or yoga mat.
 - Practice yoga in a well-ventilated place.
 - Practice this module 3 hours after a meal or 2 hours after a snack.
 - Avoid intake of tea or coffee for at least 1 hour before practice.
 - Wear loose and comfortable cotton clothes to practice yoga.
-

Annexure 2: Self-care Strategies

Advice for sleeping problems

- ▶ The mind needs the sleep to recover from the stresses of daily life
- ▶ Keep to regular hours for going to bed and waking up
- ▶ Avoid daytime naps
- ▶ Avoid tea or coffee after 5 pm
- ▶ It may help you to take a bath before you go to sleep or drink a glass of milk
- ▶ Avoid taking sleeping pills or alcohol for sleeping problem
- ▶ Don't stay in bed if you can't fall asleep, try to do a relaxing activity (such as reading a book, listening to pleasant music, do breathing exercises or yoga)
- ▶ A good night sleep is essential to be mentally healthy!

Advice for a healthy diet

- ▶ Eat meals at regular intervals
- ▶ If you have no appetite try to eat small portions
- ▶ If available, eat fruits and green vegetables daily
- ▶ If available, eat healthy meats such as fish and chicken
- ▶ If possible, your diet should have fibre (eat whole grains, chapattis, cereals)
- ▶ Eggs may provide you with some important vitamins if you don't eat meat
- ▶ What we eat has an effect on our body as well as on our mind!

Encourage regular exercise and enjoyable activities

- ▶ Choose any enjoyable activity (e.g., going for a walk every morning)
- ▶ Start with small and simple activities
- ▶ Increase the activities gradually (e.g., 30 min instead of 15 min)
- ▶ Try to spend time with friends and relatives
- ▶ If you are religious, try to be regular with your prayers and visits to places of worship
- ▶ Think of hobbies you had when you were still feeling better or when you were younger, you might pick them up again or even start something you always wanted to do
- ▶ Being active will make you feel less tired and more energetic, this will make you feel better about yourself

Encourage regular relaxation

- ▶ Choose any form of relaxation you may prefer

- ▶ Practice the breathing exercise in the morning and before you go to bed and whenever needed
- ▶ If you know to practice yoga it is very advisable to do it daily. You can also attend Yoga sessions at nearest HWC.
- ▶ Take time for any relaxing activity you may enjoy (e.g., reading a book, praying, listening to music, go for walks.)
- ▶ Relaxing will relieve aches, muscular tension and improve the concentration

Advise to avoid alcohol, tobacco and sleeping pills- Don't consume alcohol, tobacco or sleeping pills, because:

- ▶ Alcohol, tobacco and sleeping pills are highly addictive (this means you cannot be without it any more)
- ▶ Drinking too much can cause damage to the brain and many other organs
- ▶ When people get drunk, they do things which they usually wouldn't (people can become aggressive or have accidents because of poor judgement)
- ▶ Being under the influence of alcohol can increase the risk of suicide
- ▶ Too much consumption of alcohol can cause financial problems and arguments with the family and at work
- ▶ Regular use of these substances will make your problems increase

Encourage to seek support from family and friends

- ▶ Talk about your feelings
- ▶ Activate your social networks
- ▶ Seek support from others
- ▶ Contact somebody who has similar problems
- ▶ Sharing feelings and problems with others is a big relief and may provide the opportunity to get help

Annexure 3

Self-Reporting Questionnaire 20 - English version [30-day recall period]

1. Do you often have headaches? Yes/No
2. Is your appetite poor? Yes/No
3. Do you sleep badly? Yes/No
4. Are you easily frightened? Yes/No
5. Do your hands shake? Yes/No
6. Do you feel nervous, tense or worried? Yes/No
7. Is your digestion poor? Yes/No
8. Do you have trouble thinking clearly? Yes/No
9. Do you feel unhappy? Yes/No
10. Do you cry more than usual? Yes/No
11. Do you find it difficult to enjoy your daily activities? Yes/No
12. Do you find it difficult to make decisions? Yes/No
13. Is your daily work suffering? Yes/No
14. Are you unable to play a useful part in life? Yes/No
15. Have you lost interest in things? Yes/No
16. Do you feel that you are a worthless person? Yes/No
17. Has the thought of ending your life been on your mind? Yes/No
18. Do you feel tired all the time? Yes/No
19. Do you have uncomfortable feelings in your stomach? Yes/No
20. Are you easily tired? Yes/No

Annexure 4: Patient Health Questionnaire-9

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Feeling down, depressed, or hopeless.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Trouble falling/stay in gas leep, sleeping too much.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Feeling tired or having little energy.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Poor appetite or overeating.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i. Thoughts that you would be better off dead or of hurting yourself in someway.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. If you checked off any problem on this questionnaires of ar, how difficult have these problems made it for you today our work, take care of things at home, or get along with other people?

Not Difficult at all

Somewhat difficult

Very difficult

Extremely difficult

TOTAL SCORE -----

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Score	Recommended actions
0-4	Normal range or full remission. The score suggests the patient may not need depression treatment.
5-9	Minimal depressive symptoms. Support, educate, call if worse, return in 1 month.
10-14	Major depression, mild severity. Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment. Treat with antidepressant or psychotherapy.
15-19	Major depression, moderate severity. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 or higher	Major depression, severe severity. Warrants treatment with antidepressant and psychotherapy, especially if not improved on immunotherapy; follow frequently.

Annexure 5: Mini Mental Status Examination

Mini-Mental State Examination (MMSE)

Patient's Name: _____

Instructions: Ask the question in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? Country? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient the name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write and sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)
		
30		TOTAL

If value < 24 refer the individual to PHC-MO, if the individual has studied above 8th Class

If value < 21 refer the individual to PHC-MO, if the individual has studied above 8th Class

Annexure 6: Everyday Abilities Scale of India

Everyday Abilities Scale for India

1. Does he/she ever forget that he/she has just come out and he forgets about he/she has just come out?
 2. Does he/she calculate in an appropriate place?
 3. Do he/she clothes ever get dirty from water or dirt?
- Ask the following about his clothes:
4. Is he/she shirt buttoned properly?
 5. Is he/she shirt buttoned and properly?
 6. Is he/she able to work as a member of a household in a group activity and he/she does different roles from people with him/her but able to participate?
 7. Does he/she respect his/her spouse, an important family member, his marriage?
 8. Is he/she a member of household/ family activities in celebration or important task and he/she takes it through to completion?
 9. Is he/she able to remember important activities and he/she follow?
 10. Is he/she is able to follow a sequence of activities and he/she follow to do it?
 11. Does he/she manage his personal events such as marriage, divorce, public appearance?
 12. Does he/she ever lose his/her way in the village?
 13. Are they able to handle calculations and money?
 14. Is there a change in his/her personality or personality?
 15. Is there any recent change?

All questions are to be asked to the person. He is given 3 good scores and one for the additional factor.

Points to keep in mind:

- All these should be a new symptom or appearance not present in the individual few months or years before.
- History to be taken from a close caregiver, staying with person for longer than duration of appearance of symptoms.

Annexure 7: Alcohol Use Disorders Identification Test

Audit Questions: Please tick the response that best fits your drinking.

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
1. How often do you have a drink containing alcohol?	<input type="checkbox"/> Go to Qs 9 & 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many standard drinks do you have on a typical day when you are drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more standard drinks on one occasion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No	Yes, but not in the last year	Yes, during the last year		
9. Have you or someone else been injured because of your drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Supplementary Questions	No	Probably Not	Unsure	Possibly	Definitely
i. Do you think you presently have a problem with drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very easy	Fairly easy	Neither difficult nor easy	Fairly difficult	Very Difficult
ii. In the next 3 months, how difficult would you find it to cut down or stop drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Responses to questions 1 to 8 are scored 0, 1, 2, 3 or 4. Questions 9 and 10 have possible responses of 0, 2 and 4. The range of possible scores is from 0 to 40, which is interpreted as follows:

- ▶ 0: abstinent and never had any problems from alcohol use
- ▶ 1 to 7: Low-risk alcohol use
- ▶ 8 to 14: Harmful alcohol use
- ▶ 15 or more: Alcohol dependence

Annexure 8: Community Based Assessment Checklist

Community Based Assessment Checklist (CBAC)

revised draft 6th October 2020 V.5

General Information				
Name of ASHA:	Village/Ward:			
Name of MPW/ANM:	Sub Centre:			
	PHC/UPHC:			
Personal Details				
Name:	Any Identifier (Aadhar Card/ any other UID-Voter ID etc.):			
Age:	State Health Insurance Schemes: Yes/No			
If yes, specify:				
Sex:	Telephone No. (self/ family member/ other-specify details):			
Address:				
Does this person have any of the following: visible defect /known disability/Bed ridden/ require support for Activities of Daily Living	If yes, Please specify			
Part A: Risk Assessment				
Question	Range	Circle Any	Write Score	
1. What is your age	0-29 years 30-39 years 40-49 years 50-59 years ≥ 60 years			
		1		
		2		
		3		
		4		
2. Do you smoke or consume smokeless products such as gutka or khaini?	Never Used to consume in the past/ Sometimes now Daily			
		0		
		1		
		2		
3. Do you consume alcohol daily	No Yes			
		0		
		1		
4. Measurement of waist (in cm)	Female 80 cm or less 81-90 cm More than 90 cm	Male 90 cm or less 91-100 cm More than 100 cm		
			0	
			1	
			2	
5. Do you undertake any physical activities for minimum of 150 minutes in a week? (Daily minimum 30 minutes per day – Five days a week)	At least 150 minutes in a week Less than 150 minutes in a week			
			0	
			1	
6. Do you have a family history (any one of your parents or siblings) of high blood pressure, diabetes and heart disease?	No Yes			
			0	
			2	
Total Score				
Every individual needs to be screened irrespective of their scores.				
A score above 4 indicates that the person may be at higher risk of NCDs and needs to be prioritized for attending the weekly screening day				

Annexure 8 (Contd.)...

Training Manual on Mental, Neurological and Substance Use (MNS) Disorders Care for Staff Nurses at Ayushman Bharat – Health and Wellness Centres

...Annexure 8 (Contd.)

Part B: Early Detection: Ask if Patient has any of these Symptoms				
B1: Women and Men		Y/N	Y/N	
Shortness of breath (difficulty in breathing)	<input type="checkbox"/>	History of fits	<input type="checkbox"/>	
Coughing more than 2 weeks*	<input type="checkbox"/>	Difficulty in opening mouth	<input type="checkbox"/>	
Blood in sputum*	<input type="checkbox"/>	Any ulcers in mouth that has not healed in two weeks	<input type="checkbox"/>	
Fever for > 2 weeks*	<input type="checkbox"/>	Any growth in mouth that has not healed in two weeks	<input type="checkbox"/>	
Loss of weight*	<input type="checkbox"/>	Any white or red patch in mouth that has not healed in two weeks	<input type="checkbox"/>	
Night Sweats*	<input type="checkbox"/>	Pain while chewing	<input type="checkbox"/>	
Are you currently taking anti-TB drugs**	<input type="checkbox"/>	Any change in the tone of your voice	<input type="checkbox"/>	
Anyone in family currently suffering from TB**	<input type="checkbox"/>	Any hypopigmented patch(es) or discolored lesion(s) with loss of sensation	<input type="checkbox"/>	
History of TB *	<input type="checkbox"/>	Any thickened skin	<input type="checkbox"/>	
Recurrent ulceration on palm or sole	<input type="checkbox"/>	Any nodules on skin	<input type="checkbox"/>	
Recurrent tingling on palm(s) or sole(s)	<input type="checkbox"/>	Recurrent numbness on palm(s) or sole(s)	<input type="checkbox"/>	
Cloudy or blurred vision	<input type="checkbox"/>	Clawing of fingers in hands and/or feet	<input type="checkbox"/>	
Difficulty in reading	<input type="checkbox"/>	Tingling and numbness in hands and/or feet	<input type="checkbox"/>	
Pain in eyes lasting for more than a week	<input type="checkbox"/>	Inability to close eyelid	<input type="checkbox"/>	
Redness in eyes lasting for more than a week	<input type="checkbox"/>	Difficulty in holding objects with hands/ fingers	<input type="checkbox"/>	
Difficulty in hearing	<input type="checkbox"/>	Weakness in feet that causes difficulty in walking	<input type="checkbox"/>	
B2: Women only		Y/N	Y/N	
Lump in the breast	<input type="checkbox"/>	Bleeding after menopause	<input type="checkbox"/>	
Blood stained discharge from the nipple	<input type="checkbox"/>	Bleeding after intercourse	<input type="checkbox"/>	
Change in shape and size of breast	<input type="checkbox"/>	Foul smelling vaginal discharge	<input type="checkbox"/>	
Bleeding between periods	<input type="checkbox"/>		<input type="checkbox"/>	
B3: Elderly Specific (60 years and above)		Y/N	Y/N	
Feeling unsteady while standing or walking	<input type="checkbox"/>	Needing help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet	<input type="checkbox"/>	
Suffering from any physical disability that restricts movement	<input type="checkbox"/>	Forgetting names of your near ones or your own home address	<input type="checkbox"/>	
In case of individual answers Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available				
*If the response is Yes- action suggested: Sputum sample collection and transport to nearest TB testing center				
** If the answer is yes, tracing of all family members to be done by ANM/MPW				
Part C: Risk factors for COPD				
Circle all that Apply				
Type of Fuel used for cooking – Firewood / Crop Residue / Cow dung cake / Coal / Kerosene / LPG				
Occupational exposure – Crop residue burning/burning of garbage – leaves/working in industries with smoke, gas and dust exposure such as brick kilns and glass factories etc.				
Part D: PHQ 2				
Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	+1	+2	+3
2. Feeling down, depressed or hopeless?	0	+1	+2	+3
Total Score				
Anyone with total score greater than 3 should be referred to CHO/ MO (PHC/UPHC)				

Annexure 9: Community Informant Decision Tool

Community Informant Decision Tool (Sample screening and diagnostic tools for adoption/adaptation by states)

Name

Location

DEPRESSION

Since the last Dashain festival Ram Bahadur looks really down and sad. It seemed to have started when his wife died. Nowadays, along with the loss of interest in his work he doesn't feel like doing anything, not even taking care of his baby son. These days, as he cannot fall asleep at night and has difficulty sleeping, he feels weak and fatigue. He has stalled to get angry and irritated with his family and friends even about trivial matters. As he feels easily tired and weak, he has started thinking that he cannot do anything in his life. Since past few days, he has started feeling that his future is dark because of which he does not want to live or feels that his life is useless. For 5 months he has hardly worked on the field anymore, he just sits at home all day.

Referred by (Name): _____

☐ Teacher☐ Mother's Group☐ Traditional Healer☐ FCHV

OBSERVATION



QUESTION

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply)
- Moderate match (person has significant features of this descriptions)
- Good match (description apply Well)
- Very good match (person exemplifies description, prototypical case)

1 } Finished

2 }

3 }

4 }

Go to A2/A3



A2 Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2



A3 Does this person want support in dealing with these problems?

- No 1
- No 2

PSYCHOSIS

Since a few months, some changes can be seen in Prakash's behavior. He thinks of himself as a very powerful and superior being. He tells everyone that he can do things that others cannot do. He keeps talking weird things and monotonously and during such times, even if his family members or neighbors ask him to stop, he doesn't stop. He says that while he is sitting alone or when there is no one around him, he hears voices that are talking or calling to him. He has slowly stopped showing interest in the household and community activities that he is supposed to do. Due to such behavior, he had to stop the work he was doing. Often he just wanders around the town, not washed and looking very dirty. Prakash seems like a different person now.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION



QUESTION

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) 1 } Finished
- Moderate match (person has significant features of this descriptions) 2
- Good match (description apply Well) 3 } Go to A2/A3
- Very good match (person exemplifies description, prototypical case) 4



A2 Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2



A3 Does this person want support in dealing with these problems?

- No 1
- No 2

EPILEPSY

One day when Rita was helping her mother in the kitchen, she suddenly got fits and fell off on the floor. Her whole body started to tremble. Since then this happens once in a while. In the same way, her body limbs starts making jerky movements and her mouth gets frothy and sometimes small blood drops starts coming out from her mouth. In few minutes, everything stops and she opens her eyes and feels tired so she sleeps for a very long time. After she wakes up, her mother asks her what had happened to her but in reply she says that she is completely unaware of what happened. She had this same problem three times last year. Once when she had fits, she urinated in her clothes. Because of her problem Rita finds it very difficult to go outside of her home.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV
OBSERVATION**QUESTION**

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ALCOHOL USE DISORDER

Rajan drinks alcohol all the time, due to which, whenever someone goes near him, one can smell the strong stench of alcohol emanating from him. Because he always drinks alcohol, his speech is slurred and others find it very difficult to understand him. As he craves for alcohol everyday, he keeps consuming alcohol. After drinking alcohol, he speaks or does whatever he likes. Once he starts drinking alcohol, he cannot control himself and he always ends up drinking a lot. Due to heavy drinking, he has trembling limbs, sweats profusely, feels restless, and has increased palpitation. These days he no longer finds pleasure in activities he used to enjoy earlier, instead he has started to become engrossed in drinking alcohol. Due to such behavior, he is not able to complete his daily activities.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION



QUESTION

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1 } Finished

2

3

4

Go to A2/A3



A2 Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2



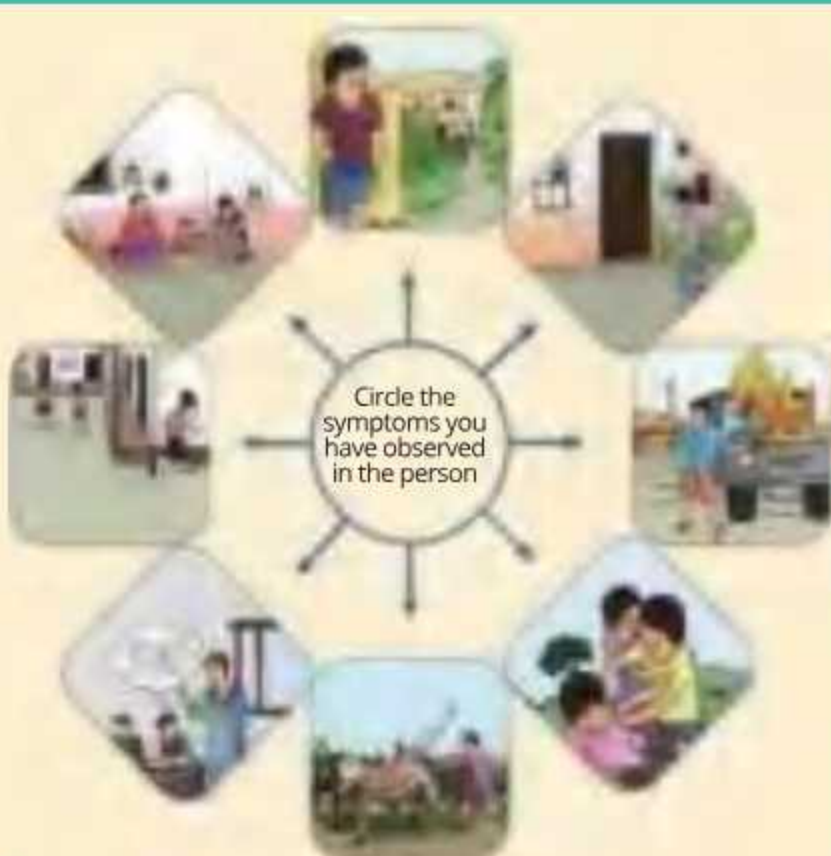
A3 Does this person want support in dealing with these problems?

- No 1
- No 2

BEHAVIORAL PROBLEM

Hari, an eleven year old boy currently studying in class five, is obstinate and does not obey his parents. He has always been a difficult boy. Not only does he vandalize his family's and neighbor's possessions, he also steals things and set fire to a barn before. He gets angry with his friends without any apparent reason, and is involved in physical fights with his peers. Often when he sees cattle, he chases them and beats them. He cannot concentrate on his studies and while going to school, he runs away and goes elsewhere. He often lies to his family and strolls around the village. At times he runs away and doesn't even return home at night or for a very long time. As a result of this, Hari is doing very badly in school and has no friends.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV
OBSERVATION**QUESTION**

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Annexure 10: FAQs

Q. Can I suggest medications if necessary, especially common ones?

A. NO. You can only dispense medications which are already prescribed by the MO, encourage compliance, and monitor for side effects and toxicity at follow-up.

Q. How will I know when to make a referral?

A. This manual provides some red flags for referral at the end of each chapter on mental health conditions.

Q. What is psycho education?

A. Psycho education helps to make the patients and their family members understand the illness and support their capability to deal with the illness.

Q. How will I counsel a patient and family member during my first contact?

A. Initial counselling with patient and care givers would focus on mainly understanding the nature of the illness, identify the triggering factor, give more time for listening non judgmentally and encourage the family members to get appropriate professional help.

Q. Does the patient need rehabilitation when on regular medication?

A. Medication will help to take care of the symptoms but rehabilitation along with regular medication will help to function to the best of your abilities.

Q. Is it possible that people with CMDs are just lazy/weak/ lying/ pretending?

A. CMDs are NOT due to laziness/weakness. The symptoms are very real and distressing to the person.

Q. If people with CMDs are ignored then they will 'come around'?

A. CMDs need to be treated, like any other medical illness.

Q. Can people with depression sometimes seek attention by saying they feel like dying?

A. Any expression of death wishes should be taken seriously. As a routine, when there is depression, the family should be advised to keep the person under strict supervision.

Q. What is the common age when schizophrenia can occur?

A. Schizophrenia affects both genders equally. Symptoms such as hallucinations and delusions usually begin between age from 16 to 30 yrs.

Q. Is there any cure for schizophrenia?

A. There is no cure for schizophrenia, but it is a condition managed with medication and psychosocial treatment.

Q. How common is schizophrenia?

A. The condition occurs for about 1 in 100 people, and affects people at all socioeconomic status.

Q. If a person is diagnosed with bipolar disorder, will he or she be on medication for the rest of the life?

A. Not necessarily. However, persons are encouraged to take on medication regularly.

Q. How can lifestyle influence bipolar disorder?

A. Lack of a regular routine and disturbed sleep pattern can stimulate a mood episode. Choosing proper work and leisure activities with proper sleep and rest is very essential for to healthy life.

Q. Are Children with conduct disorder, just bad children?

A. Actually, children with CD have "difficulty in following rules and behaving in a socially acceptable manner" behavioural modification training improve their social skills.

Q. How can the parents of children with mental disorders cope up with their life?

A. They can attend Parent education program about treatment opportunities, to Improve confidence, correcting misperceptions, to change negative attitudes about behaviour, training on problem solving, communication and conflict resolutions, to establish support groups, to increase social support networks, to Improve coping skills, parent -child interaction program and disciplinary methods.

Q. What are the potential problems children with CD may face in their future life?

A. They may face:

- ▶ Anger, aggression, anxiety Emotional disturbance and other mental illness.
- ▶ Risk for dropping out of school
- ▶ Risk of abusing Alcohol and another illegal Drug
- ▶ Risk of developing with serious illness like sexual transmitted diseases and HIV-AIDS.

Q. Does ADHD occur only in boys?

A. Girls are also affected with ADHD.

Q. Do children with ADHD ultimately outgrow their condition?

A. Most of the child hood ADHD will continue in adolescence and adult life, yet they are vulnerable to get mood disorders, anxiety disorder and alcohol dependence.

Q. When is Intellectual Disability detected?

A. Generally Intellectual Disability is detected in childhood. Many genetic abnormalities can be identified before birth and immediately after birth. Sometimes it may be incidentally screened during some other assessments.

Q. Can a child with Intellectual Disability be cured?

A. Intellectual Disability cannot be cured but proper rehabilitation and continuous support can help them to function to their maximum abilities.

Q. Can Intellectual Disability be treated with medicine?

A. There is no medication to treat Intellectual Disability. Some specific conditions can be treated with medication. Psychosocial management along with rehabilitation help them to function better.

Q. Can epilepsy spread from one person to another?

A. No, it is not a infectious disease. Sometimes, more than one family member can be affected due to genetic cause.

Q. Should a patient who is having seizures be given food or water?

A. A patient should NEVER be given anything by mouth during the seizure episode. It can block the breathing passage and lead to pneumonia or death due to blockage of breathing passage.

Q. Can a child with epilepsy go to school or play sports?

A. Yes, all children with epilepsy can go to school and play sports under supervision but should avoid activities like swimming, cycling and high-risk sports.

Q. Can a person with epilepsy exercise?

A. A person with epilepsy can exercise. However, they should avoid lifting heavy weights.

Q. Can treatment of epilepsy be stopped after 2-3 years?

A. No, the treatment duration depends on the epilepsy type and have to be individualized. Some types of epilepsies may require lifelong treatment. However, in some cases the drugs may be tapered and stopped if the patient remains seizure free for 2-3 years. But this has to be done only after consultation with the treating physician.

Q. Can a person with epilepsy marry and have children?

A. People with epilepsy can lead a normal life and can work, marry and have children like others. However, seizures in a female with epilepsy should be well controlled before conceiving. Some drugs may require to be changed in before conceiving to prevent harmful effect on the baby.

Q. Is dementia a normal part of ageing?

A. Although the risk of developing dementia increases with age, dementia is not a normal part of ageing and is due to some disease process affecting the brain.

Q. Does dementia affect older people only?

A. Although dementia usually occurs in individuals above the age of 65 years, it can also affect younger people. This is called early-onset dementia and can affect people in their 40s and 50s. The most common types affecting younger people are Alzheimer's disease and frontotemporal dementia.

Q. What is the difference between dementia and Alzheimer's disease?

A. Dementia is a broad term to describe progressive cognitive dysfunction. Alzheimer's disease is a type of dementia in which patients may experience progressive decline in memory, word finding, visuospatial function.

Q. Is there a cure for dementia?

A. There is no cure for dementia although several pharmacological and non-pharmacological treatment options are available.

Q. Can dementia be prevented?

A. There is increasing evidence that maintaining a healthy lifestyle helps to maintain good brain health. Optimum control of hypertension and diabetes can also help in this. Smoking cessation is also very important. Finally, engagement in mental activities and social engagement also play a role.

Q. Does alcohol/tobacco damage health only when used in large amounts?

A. No, there is no safe limit to alcohol/tobacco use.

Q. Does alcohol/tobacco make a person look attractive/improve sexual performance?

A. No, alcohol/tobacco causes rapid aging, and also leads to infertility.

Q. Does alcohol/tobacco make a person to work better?

A. No. Because of dependence, the person finds that his hand shakes, or he may not be able to concentrate if he does not use alcohol/tobacco. The person needs to stop using, and with treatment, handshakes and other problems will reduce. Continued use damages brain and the person will not be able to work at all.

Q. Does alcohol help a person to sleep better?

A. No. Alcohol just disturbs the natural sleep process. So, although a person may sleep for several hours, when he wakes up, he still feels tired and drowsy.

Q. Is chewing tobacco safer than smoking?

A. No. Tobacco, in ANY form, is deadly and dangerous for health.

Q. Is it true that people who talk about suicide will not commit suicide?

A. No. Most of the people who commit suicide would have given definite warning signs.

Q. Once a person is suicidal, is he/she always suicidal?

A. Suicidal thoughts may return but they are not permanent and in some, it may never return.

Q. If a person attempts suicide but fails, is he/she punishable by law?

A. No. Suicide is not a crime. But the person who attempted suicide should be referred to a doctor for evaluation and treatment.

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Namaste!

You are a valuable member of the Ayushman Bharat–Health and Wellness Centre (AB-HWC) team committed to delivering quality comprehensive primary healthcare services to the people of the country.

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National Health Systems Resource Centre