GUIDELINES

For

GENERAL PRACTITIONERS

2024

Press record

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FOREWORD

It is a great honor for me to write a foreword to Guidelines for General Practitioners by General Practitioners' society, Myanmar Medical Association (Central).

General practitioners are the primary health providers in the community looking after the majority of the people of our country. They are being trusted and depend upon by every families in the surrounding area where they practice. The first and foremost care by the General Practitioners are the most important for all the people.

Guidelines based on a critical appraisal of scientific evidence (evidence-based guidelines) clarify which interventions are of proved benefit and document the quality of the supporting data. They alert clinicians to interventions unsupported by good science, reinforce the importance and methods of critical appraisal, and call attention to ineffective, dangerous, and wasteful practices.

Clinical guidelines can improve the quality of clinical decisions. They offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve the consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies.

The Myanmar Medical Association together with the GP society has been helping out with the CME and CPD program for the Member doctors both inhouse sessions and online courses. This guideline is one of the essential parts of this CPD for the GPs.

I would like to congratulate the GP society for their effort for producing this guideline and also, I would like to encourage them to review and updated regularly.

Professor Aye Aung
President
Myanmar Medical Association

April, 2024

PREFACE

We are writing this letter to express our sincerest gratitude and appreciation for the successful completion of the **second edition** of the **General Practitioners' Guidelines**. This accomplishment is the result of an exceptional collaborative effort, and we would like to extend our thanks to all those involved.

The General Practitioners' Guidelines has been an invaluable resource since its inception with the launch of the first edition in November 2017. As per the initial plan, the guidelines were intended to be updated every three years to ensure the most up-to-date information reaches Myanmar General Practitioners, enhancing their knowledge in primary healthcare and family health.

However, the unforeseen outbreak of the Covid-19 pandemic disrupted our plans and posed numerous challenges for the team. In-person meetings became impossible due to safety concerns, making it necessary for us to find alternative means of communication and collaboration. Despite the adversity faced, the team members demonstrated remarkable resilience and adaptability by utilizing online platforms and technology to continue the update process.

We would like to extend our deepest gratitude to the dedicated team members who persevered and worked tirelessly during these trying times. Their commitment, professionalism, and unwavering dedication to the project enabled us to overcome the obstacles posed by the pandemic and successfully complete the second edition of the guideline.

Furthermore, we would like to express our sincere appreciation to the specialist societies that actively contributed to the development of the guidelines. Their expertise and invaluable insights have ensured that the content remains current, accurate, and relevant, enabling our General Practitioners to provide the highest quality of care to their patients.

We would also like to extend our heartfelt thanks to the esteemed President of the Myanmar Medical Association, for their continuous support and guidance throughout this endeavor. Their leadership and unwavering commitment to advancing medical knowledge in Myanmar have been instrumental in the success of this Guidelines.

Moreover, the decision to distribute the guideline as electronic copies reflects our commitment to ensuring easy access for all Myanmar General Practitioners. By making it available in this format, we aim to facilitate the dissemination of updated knowledge, thus empowering our healthcare professionals to deliver the best possible care to the community.

In conclusion, we would like to express our deepest gratitude to all those who contributed to the development and distribution of the General Practitioners' Guidelines Second Edition. The unwavering supports and collective efforts have made a significant impact on enhancing primary healthcare and family health care in Myanmar.

Once again, thank you for your outstanding dedication, resilience, and invaluable contributions. We look forward to our continued collaboration in advancing medical knowledge and improving healthcare outcomes for all.

Dr Khine Soe Win and Dr Win Zaw April, 2024
General Practitioners' Society (Central)
Myanmar Medical Association

EDITORIAL

It is my privilege to inform you that our updated and revised edition of "**Guidelines for General Practitioners**" will be published very soon and it is my great pleasure to be the editor-in-chief of this guideline book. There are various reasons for revising and updating the previous edition.

This is the fact that some important topics, for example, malaria and family violence are missing in the first edition and some clinical practice guidelines like Diabetes Management have been changed during the interim period. Of course, this opportunity arises due to the emergence of COVID-19 in the world. As all you know, Medicine is an ever-changing science; we need to consider updating our guidelines at least five- yearly. Hence the time is up now!

Education is achieved by assimilating information from many resources and readers of this book can enhance their learning experience in terms of reflecting in their daily Family/General Practice. We all take immerse pride in contributing good educational resource dedicated to Myanmar General Practitioners. The editors and authors anticipate that the readers will both enjoy and profit from their work in preparing this volume.

Happy studying and learning,

Dr Win Lwin Thein
Editor-in chief
Vice President (GP Society)
April, 2024

ACKNOWLEDGEMENT

We would like to thank all our talented and hard-working colleagues who have contributed to the ongoing development of the **Guidelines for General Practitioners**.

Especially, we would like to highlight the significance of the second edition which appears when the family medicine development process in Myanmar is being idle. Many factors are impeding the developing process lately, which has been accelerated previously by the commitment of the MOHS, the medical universities, and the General Practitioners' Society before the COVID-19 pandemic started.

No one can deny that the Myanmar health care system is lacking a strong and effective primary care task force. The best solution to mend this defect is retraining the thousands of general practitioners who are working individually across the country. Here comes the role of family medicine to train these GPs and primary care doctors to be able to use its principles effectively and, in turn, strengthen primary care.

Many GPs are using some family medicine principles consciously or unconsciously in varying degree of competency. Person-centered care, continuity of care, and family-oriented care became the culture of most practices for a long time. But only a few GPs can enjoy the most effective coordinated care and seamless continuity of care with secondary and tertiary care providers. The reasons behind this would be the absence of standardization in general practitioners' service quality and unawareness of the value of family medicine practitioners by other specialties and the public.

To resolve this ambiguity, primary care doctors should be involved in the retraining programs and thereafter CME/CPD and other life-long-learning programs which prescribe family medicine curricula.

We also acknowledge the effort of the contributors to make this new edition more family medicine-oriented, in addition to the Family Medicine chapter at the beginning of the book. We genuinely believe that the new edition will be a better reference for the GP/FP who wants to practice quality primary care and for future family medicine programs in Myanmar.

Finally, we would like to thank all academic writers who contributed to the General Practice Guidelines-first edition. Without their kind support, this second edition could never have happened.

Regards,

Dr. Tin Aye and Dr. Kyaw Thu

General Practitioners' Society (Central), MMA **April, 2024**

LIST OF CONTRIBUTORS

1. *Aung Cho Myint, Prof*
2. *Aung Maw, Dr*
3. *Aye Aung, Prof*
4. *Aye Aye Than, Dr*
5. *Aye Aye Thein, Dr*
6. *Chit Soe, Prof*
7. *Hla Myat Nwe, Prof*
8. *Hla Myint Tun, Dr*
9. *Hlaing Mya Win, Prof*
10. *Hlaing Myint, Dr*
11. *Htay Win, Dr*
12. *Htin Aung Saw, Prof*
13. *Htun Lwin Nyein, Prof*
14. *Khin Hla Hla, Prof*
15. *Khin Hta Yi, Prof*
16. *Khin Mi Mi, Dr*
17. *Khin Ohnmar Khine, Prof*
18. *Khin Saw Than, Prof*
19. *Khine Khine Zaw, Prof*
20. *Khine Soe Win, Dr*
21. *Ko Ko, Prof*
22. *Kyaw Myint Naing, Prof*
23. *Kyaw Thu, Dr*
24. *Kyaw Zin Wai, Prof*
25. *Kyi Kyi Nyunt, Prof*
26. *Kyi Kyi Thinn, Prof*
27. *Kyin Htwe, Dr*
28. *Lin Htet, Dr*
29. *Lwin May Oo, Dr*
30. *Mar Mar Kyi, Prof*
31. *Maung Maung Sein, Prof*
32. *May Thandar Oo, Dr*
33. *Min Han, Prof*
34. *Min Yazar, Dr*
35. *Min Zaw Oo, Prof*
36. *Moe Naing, Dr*
37. *Moe Wint Aung, Prof*
38. *Mya Thae Han, Dr*
39. *Mya Win Hnit, Dr*
40. *Myint Thaung, Prof*
41. *Myo Khine, Dr*
42. *Myo Lwin Nyein, Prof*
43. *Myo Nyunt Aung, Dr*
44. *Myo Oo, Prof*
45. *Naing Oo, Prof*
46. *Nang Phyu Phyu Aung, Prof*
47. *Nwe Mar Tun, Prof*
48. *Nwe Nwe Aung, Dr*
49. *Nyein Moe Thaw, Dr*
50. *Phyu Phyu Khaing, Dr*
51. *Rai Mra, Prof*
52. *Samuel Kyaw Hla, Prof*
53. *Saw Win, Prof*
54. *Sein Way Lwin, Dr*
55. *Than Htike, Dr*
56. *Than Than Aung, A Prof*
57. *Than Than Aye, Prof*
58. *Thar Thar Oo, Dr*
59. *Thein Aung, Prof*
60. *Thein Myint, Prof*
61. *Thet Naing Maung, Dr*
62. *Thin Thin Nwe, Dr*
63. *Tin Aye, Dr*
64. *Tin Nyunt, Dr*
65. *Tin Tin Aye, Dr*
66. *Tin Tin Hla, Dr*
67. *Tint Tint Kyi, Prof*
68. *Vijay Kumar, Dr*
69. *Win Lwin Thein, Dr*
70. *Win Zaw, Dr*
71. *Yin Yin Soe, Prof*
72. *Yin Yin Zaw, Prof*
73. *Yu Yu Lwin, Dr*
74. *Zaw Lynn Aung, Prof*

SYMBOLS AND ABBREVIATIONS

AAA abdominal aortic aneurysm
ABC airway, breathing, circulation
ABCD airway, breathing, circulation, dextrose
ABO A, B and O blood groups
ACE angiotensin-converting enzyme
ACEI angiotensin-converting enzyme inhibitor
ACTH adrenocorticotrophic hormone
ADHD attention deficit hyperactivity disorder
ADT adult diphtheria vaccine
AFP alpha-fetoprotein
AI aortic incompetence
AIDS acquired immunodeficiency syndrome
AIIRA angiotensin II (2) reuptake antagonist
AKF acute kidney failure
ALE average life expectancy
ALL acute lymphocytic leukaemia
ALP alkaline phosphatase
ALT alanine aminotransferase
AMI acute myocardial infarction
AML acute myeloid leukaemia
ANA antinuclear antibody
ANF antinuclear factor
AP anterior–posterior
APH ante-partum haemorrhage
ASD atrial septal defect
ASIS anterior superior iliac spine
ASOT antistreptolysin O titre
AST aspartate aminotransferase
AV atrioventricular
AZT azidothymidine
BCC basal cell carcinoma
BCG bacille Calmette-Guérin
BMD bone mass density
BMI body mass index
BP blood pressure
BPH benign prostatic hyperplasia
Ca carcinoma
CABG coronary artery bypass grafting
CAD coronary artery disease
CAP community acquired pneumonia
CBT cognitive behaviour therapy
CCF congestive cardiac failure
CCU coronary care unit
CD4 T helper cell
CD8 T suppressor cell
CDT combined diphtheria/tetanus vaccine
CEA carcinoembryonic antigen
CFS chronic fatigue syndrome
CHD coronary heart disease
CHF chronic heart failure
CIN cervical intraepithelial neoplasia
CK creatinine kinase
CKD chronic kidney disease
CKF chronic kidney failure
CML chronic myeloid leukaemia
CMV cytomegalovirus
CNS central nervous system
COAD chronic obstructive airways disease
COC combined oral contraceptive
COCP combined oral contraceptive pill
COPD chronic obstructive pulmonary disease
COX cyclooxygenase
CPA cardiopulmonary arrest
CPAP continuous positive airways pressure
CPK creatine phosphokinase
CPR cardiopulmonary resuscitation
CR controlled release
CREST calcinosis cutis; Raynaud's phenomenon; oesophageal involvement; sclerodactyly; telangiectasia
CRF chronic renal failure
CR(K)F chronic renal (kidney) failure
CRP C-reactive protein
CSF cerebrospinal fluid
CT computerised tomography
CTS carpal tunnel syndrome
CVA cerebrovascular accident
CVS cardiovascular system
CXR chest X-ray
DBP diastolic blood pressure
DC direct current
DHA docosahexaenoic acid
DI diabetes insipidus
DIC disseminated intravascular coagulation
dL decilitre
DMARDs disease modifying antirheumatic drugs
DNA deoxyribose-nucleic acid
DRABC defibrillation, resuscitation, airway, breathing, circulation
drug dosage bd—twice daily, tid/tds -three times daily, qid/qds -four times daily
ds double strand
DS double strength
DSM diagnostic and statistical manual (of mental disorders)
DU duodenal ulcer
DUB dysfunctional uterine bleeding
DVT deep venous thrombosis
EBM Epstein-Barr mononucleosis (glandular fever)
EBV Epstein-Barr virus
ECG electrocardiogram
ECT electroconvulsive therapy
EDD expected due date
EEG electroencephalogram
ELISA enzyme linked immunosorbent assay
ESRF end-stage renal failure
ESR(K)F end stage renal (kidney) failure
ERCP endoscopic retrograde cholangiopancreatography
esp. especially
ESR erythrocyte sedimentation rate
FB foreign body
FBE full blood count

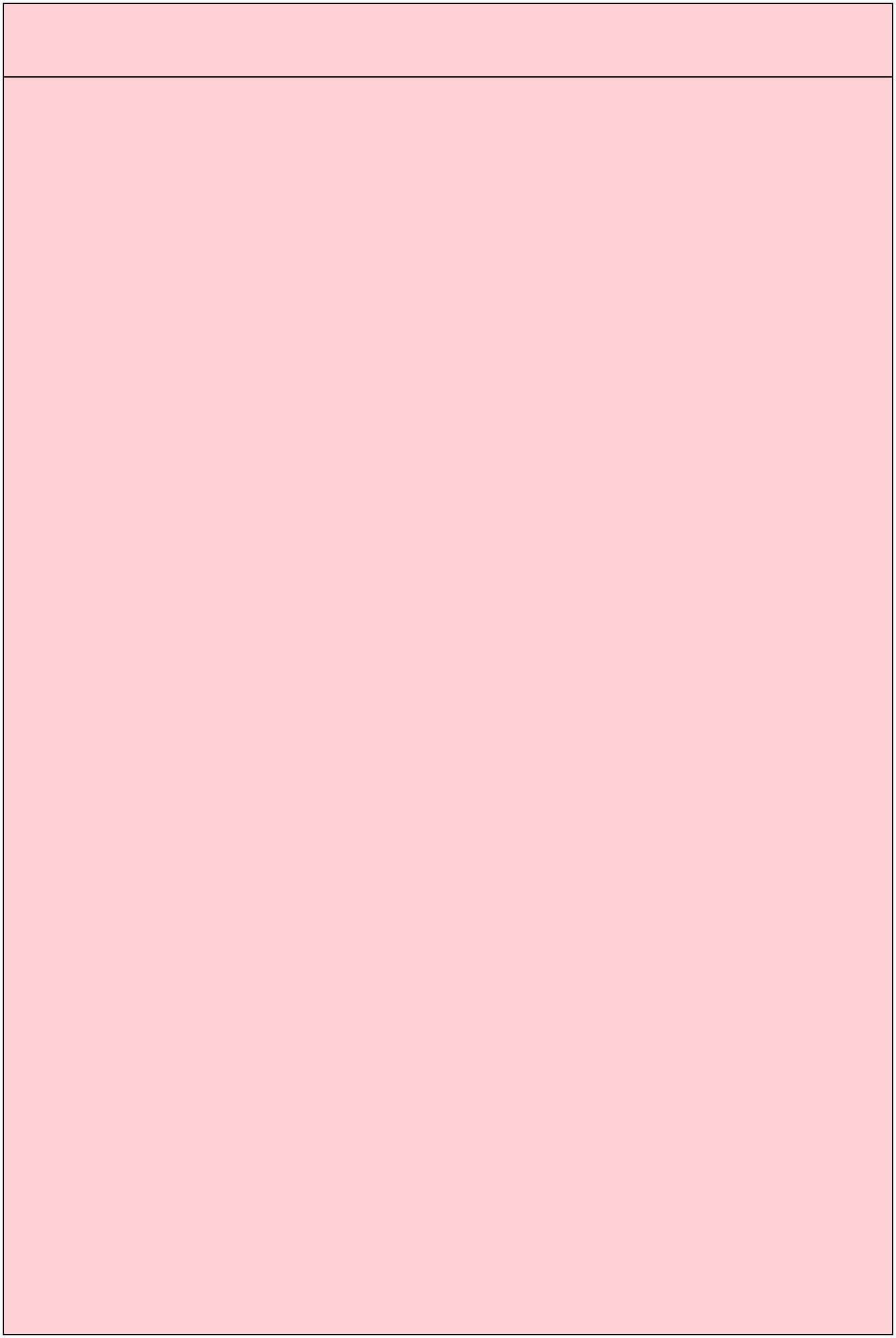
FEV1 forced expiratory volume in 1 second
fL femtolitre = (1e–15) litre
FSH follicle stimulating hormone
FUO fever of undetermined origin
FVC forced vital capacity
g gram
GA general anaesthetic
GABHS group A beta-haemolytic streptococcus
GBS Guillain-Barré syndrome
GFR glomerular filtration rate
GI glycaemic index
GIT gastrointestinal tract
GLP glucagon-like peptide
GnRH gonadotrophin-releasing hormone
GO gastro-oesophageal
GORD gastro-oesophageal refl ux
GP general practitioner
G-6-PD glucose-6-phosphate
GU gastric ulcer
HAV hepatitis A virus
anti-HAV hepatitis A antibody
Hb haemoglobin
HbA haemoglobin A
anti-HBc hepatitis B core antibody
HBeAg hepatitis B e antigen
anti-HBs hepatitis B surface antibody
HBsAg hepatitis B surface antigen
HBV hepatitis B virus
HCG human chorionic gonadotropin
HCV hepatitis C virus
anti-HCV hepatitis C virus antibody
HDL high-density lipoprotein
HEV hepatitis E virus
HFM hand, foot and mouth
HFV hepatitis F virus
HGV hepatitis G virus
HIV human immunodeficiency virus
HNPCC hereditary nonpolyposis colorectal cancer
HPV human papilloma virus
HRT hormone replacement therapy
HSV herpes simplex viral infection
IBS irritable bowel syndrome
ICE ice, compression, elevation
ICS inhaled corticosteroid
ICS intercondylar separation
ICT immunochromatographic test
IDDM insulin dependent diabetes mellitus
IDU injecting drug user
IgE immunoglobulin E
IgG immunoglobulin G
IgM immunoglobulin M
IHD ischaemic heart disease
IM, IMI intramuscular injection
inc. including
IPPV intermittent positive pressure variation
IR internal rotation
ITP idiopathic (or immune) thrombocytopenia purpura
IUCD intrauterine contraceptive device
IUGR intrauterine growth retardation
IV intravenous
IVI intravenous injection
IVP intravenous pyelogram
IVU intravenous urogram
JCA juvenile chronic arthritis
JVP jugular venous pulse
KA keratoacanthoma
kg kilogram
KOH potassium hydroxide
LA local anaesthetic
LABA long acting beta agonist
LBBB left branch bundle block
LBO large bowel obstruction
LBP low back pain
LDH/LH lactic dehydrogenase
LDL low-density lipoprotein
LFTs liver function tests
LH luteinising hormone
LHRH luteinising hormone releasing hormone
LIF left iliac fossa
LMN lower motor neurone
LNG levonorgestrel
LRTI lower respiratory tract infection
LSD lysergic acid
LUQ left upper quadrant
LUTS lower urinary tract symptoms
LV left ventricular
LVH left ventricular hypertrophy
mane in morning
MAOI monoamine oxidase inhibitor
mcg microgram (also µg)
MCV mean corpuscular volume
MDI metered dose inhaler
MDR multi-drug resistant TB
MI myocardial infarction
MRCP magnetic resonance cholangiography
MRI magnetic resonance imaging
MS multiple sclerosis
MSM men who have sex with men
MSU midstream urine
N normal
NAD no abnormality detected
NGU non-gonococcal urethritis
NHL non-Hodgkin's lymphoma
NIDDM non-insulin dependent diabetes mellitus
nocte at night
NSAIDs non-steroidal anti-inflammatory drugs
NSU non-specific urethritis
(o) taken orally
OA osteoarthritis
OCP oral contraceptive pill
OGTT oral glucose tolerance test
OSA obstructive sleep apnoea
OTC over the counter
PA posterior–anterior
PAN polyarteritis nodosa
Pap Papanicolaou
pc after meals
PCA percutaneous continuous analgesia
PCB post coital bleeding

PCL posterior cruciate ligament
PCOS polycystic ovarian syndrome
PCP pneumocystis carinii pneumonia
PCR polymerase chain reaction
PCV packed cell volume
PDA patent ductus arteriosus
PEF peak expiratory flow
PEFR peak expiratory flow rate
PET pre-eclamptic toxaemia
PFT pulmonary function test
PH past history
PID pelvic inflammatory disease
PLISSIT permission: limited information: specific suggestion: intensive therapy
PMS premenstrual syndrome
PMT premenstrual tension
POP plaster of Paris
POP progestogen-only pill
PPI proton-pump inhibitor
PPROM preterm premature rupture of membranes
PR per rectum
prn as and when needed
PROM premature rupture of membranes
PSA prostate specific antigen
PSIS posterior superior iliac spine
PSVT paroxysmal supraventricular tachycardia
PT prothrombin time
PTC percutaneous transhepatic cholangiography
PU peptic ulcer
PUO pyrexia of undetermined origin
pv per vagina
qds, qid four times daily
RA rheumatoid arthritis
RBBB right branch bundle block
RBC red blood cell
RCT randomised controlled trial
RF rheumatic fever
Rh rhesus
RIB rest in bed
RICE rest, ice, compression, elevation
RIF right iliac fossa
RPR rapid plasma reagin
RR relative risk
RSV respiratory syncytial virus
RT reverse transcriptase
rtPA recombinant tissue plasminogen activator
SAH subarachnoid haemorrhage
SARS severe acute respiratory distress syndrome
SBE subacute bacterial endocarditis
SBO small bowel obstruction
SBP systolic blood pressure
SC/SCI subcutaneous/subcutaneous injection
SCC squamous cell carcinoma
SCG sodium cromoglycate
SIADH syndrome of secretion of inappropriate antidiuretic hormone
SIDS sudden infant death syndrome
SIJ sacroiliac joint
SL sublingual
SLE systemic lupus erythematosus
SLR straight leg raising
SND sensorineural deafness
SNHL sensorineural hearing loss
SNRI serotonin noradrenaline reuptake inhibitor
SOB shortness of breath
sp species
SR sustained release
SSRI selective serotonin reuptake inhibitor
SSS sick sinus syndrome
stat at once
STI sexually transmitted infection
SVC superior vena cava
SVT supraventricular tachycardia
T3 tri-iodothyronine
T4 thyroxine
TB tuberculosis
tds, tid three times daily
TENS transcutaneous electrical nerve stimulation
TFTs thyroid function tests
TG triglyceride
TIA transient ischaemic attack
TIBC total iron binding capacity
TM tympanic membrane
TMJ temporomandibular joint
TNF tissue necrosis factor
TOF tracheo-oesophageal fistula
TORCH toxoplasmosis, rubella, cytomegalovirus, herpes virus
TPHA Treponema pallidum haemoglutination test
TSE testicular self-examination
TSH thyroid-stimulating hormone
TT thrombin time
TV tidal volume
U units
UC ulcerative colitis
U & E urea and electrolytes
µg microgram
UMN upper motor neurone
URTI upper respiratory tract infection
US ultrasound
UTI urinary tract infection
U ultraviolet
VC vital capacity
VDRL Venereal Disease Reference Laboratory
VF ventricular fibrillation
VMA vanillyl mandelic acid
VSD ventricular septal defect
VT ventricular tachycardia
VUR vesico-ureteric reflux
VWD von Willebrand's disease
WBC white blood cells
WCC white cell count
WHO World Health Organization
WPW Wolff-Parkinson-White
XL sex linked

CHAPTER (11) MENTAL HEALTH

Chapter (11)
Mental Health

1. Mental Health
    a. Psychiatric emergency
    b. Schizophrenia
    c. Mood disorders
    d. Depressive disorders
    e. Anxiety and related disorders
    f. Obsessive Compulsive and related disorders
    g. Trauma and stressor related disorders
    h. Somatic Symptom and related disorders
2. Substance Misuse
    a. Alcohol use disorder
    b. Tobacco use disorder
    c. Substance use disorders



PSYCHIATRIC EMERGENCY

Introduction

- Psychiatric emergency is a condition wherein the patient has acute disturbances of thought, affect and psychomotor activity which if untreated leading to a threat to his existence (suicide), or threat to the people in the environment (homicide).

Objectives of Psychiatric Emergency Intervention

- To safeguard the life of patient
- To reduce the anxiety of the family members
- To provide the emotional security to others in the environment
- To educate the client and family members

Factors precipitating psychiatric emergencies

- Certain condition or stressor predisposes the client family members to seek immediate intervention as they feel discomfort.
- Disharmony between client and his environment
- Sudden unexpected disorganization in person
- Unable to cope with the stressful situation or family in handling the stressors

Features Indicating a Possibility of Medical Illness

- Acute Onset
- Old Age
- First Episode
- Non-auditory hallucinations
- Disorientation/Confusion
- Memory impairment
- Catatonic state
- Neurological symptoms like unconsciousness, seizures, and visual problems.
- Head injury

Initial approaches during psychiatric emergency

- The initial approach to the patient should be warm, direct and concerned.
- A quick evaluation to identify the nature of the condition and to institute care on the basis of seriousness is essential.
- The emergency staff should have been trained for handling psychiatric emergencies.
- The security must be adequate to control violent and dangerous patients.
- Medicolegal cases need to be registered separately and informed to the concerned officer. History and clinical findings should be recorded clearly in the emergency file.
- Patient's conditions and plans of management should be explained in simple language to the patient and family members.

Evaluation of Psychiatric Emergencies

- The nature and availability of support system and capacity of the patient to use it.
- Dangerousness: suicidal or homicidal ideation, substance intoxication
- Psychiatric history and current psychiatric status, including patient's ways of coping with similar stressors previously.

- Ability to care for oneself.
- Motivation and capacity to participate in the treatment process.
- The request(s) of patient and family.
- Co-morbid medical conditions

EMERGENCY PSYCHIATRIC MANAGEMENT

SUICIDE ATTEMPTS AND SUICIDAL IDEATION

- Suicidal attempt is one of the commonest psychiatric emergencies. Suicide is a type of deliberate self-harm and is defined as an intentional human act of killing oneself.

Aetiology

1.Psychiatric Disorders

Major depression:

- The commonest conditions associated with a high risk of suicide. It is due to pervasive and persistent sadness, delusions of guilt, helplessness, hopelessness and worthlessness. The risk of suicide is more when the acute phase has passed and the patient has more energy to carry out his suicidal plans.

Schizophrenia:

- The major risk factors among schizophrenics include the presence of associated depression, young age and high levels of premorbid functioning (especially during college education). People in this risk group are more likely to see suicide as a reasonable alternative.

Mania:

- Manic patients may occasionally commit suicide as the result of grandiose ideation. They may carry out some dangerous activity that can cost them their life.

Drug or alcohol abuse:

- Due to depression in the withdrawal phase. Also, the loss of friends and family, self-respect, status, and a general realization of the havoc alcohol has created in his life.

Dementia, delirium:

- Organic conditions such as delirium and dementia due to changes of mood like anxiety and depression may also induce suicidal tendency.

Personality disorder:

- Individuals with histrionic and borderline traits may occasionally attempt suicide.

2. Physical Disorders:

- Patients with incurable or painful physical disorders like, cancer and AIDS.

3.Psychosocial Factors:

- Failure in board exam
- Marital problems
- Loss of loved object
- Isolation and alienation from social groups
- Financial and occupational difficulties

Risk factors for suicide

- Age:
  - Males above 40 years of age

- Females above 55 years of age

- Sex:
  - Men have greater risk of completed suicide
  - Women have higher rate of attempted suicide.
- Being unmarried, divorced widowed, or separated
- Having a definite suicidal plan
- History of previous suicidal attempts
- Recent losses

Assessment of Suicidality

Table 1

SBQ-R Suicide Behaviours Questionnaire-Revised

Patient Name _____Date of visit_____

Instructions: Please check the number beside the statement or phrase that best applies to you

1. Have you ever thought about or attempted to kill yourself? (check one only)

☐ 1. Never
☐ 2. It was just a brief passing thought
☐ 3a. I have had a plan at least once to kill myself bout did not try to do it
☐ 3b. I have had a plan at lease once to kill myself and really wanted to die
☐ 4a. I have attempted to ill myself, but did not want to die
☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

☐ 1. Never
☐ 2. Rarely (1 time)
☐ 3. Sometimes (2 times)
☐ 4. Often (3-4 times)
☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might to do it? (check one only)

☐ 1. No
☐ 2a. Yes, at one time, but did not really want to die
☐ 2b. Yes, at one time, and really wanted to die
☐ 3a. Yes, more than once, but did not want to do it
☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

☐ 0. Never
☐ 1. No chance at all
☐ 2. Rather unlikely
☐ 3. Unlikely
☐ 4. Likely
☐ 5. Rather likely
☐ 6. Very likely

Table 2

SBQ-R-Scoring

Item 1: taps into lifetime suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 point	
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	Total point ( )
Item 2: assesses the frequency of suicidal ideation over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	
	Very Often (5 more times)	5 points	Total points ( )
Item 3: taps into the threat of suicide attempts			
Selected response 1		1 point	
Selected response 2		2 points	
Selected response 3a or 3b		3 points	
Item 4: evaluates self-reported likelihood of suicidal behaviour in the future			
Selected Response:	Never	0 point	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather likely	5 points	
	Very Likely	6 points	Total points ( )
Sum all the scores circled/checked by the respondents. The total score should range from 3-18			Total Score ( )

Psychometric Properties			
	Cutoff score	**Sensitivity**	**Specificity**
Adult General Population	≥7	93%	95%
Adult Psychatric Inpatients	≥8	80%	91%

Management

- All psychiatric patients need to be asked about suicidal ideation as a part of routine assessment. Asking about suicidal attempt does not provoke the patient to commit suicide or instil the idea to do so.
- Clinicians should consider screening patients with possible suicidal ideation for depression, anxiety, and alcohol use to help determine symptom severity. (SOR B)
- Direct inquiry about suicidal ideation in patients with risk factors is associated with more effective treatment and management. (SOR B)
- Be aware of certain signs which may indicate that the individual may commit suicide, such as:
    - Suicidal threat
    - Writing farewell letters
    - Giving away treasured articles
    - Making a will
    - Closing bank accounts
    - Appearing peaceful and happy after a period of depression
    - Refusing to eat or drink, maintain personal hygiene.
- Patients who have expressed suicidal ideation but deny current suicidal intent, have no plan or means in place, and have good social support may be treated as an outpatient therapy
- Patients with specific plans for suicide who have the means to complete their plan should be offered inpatient admission.

Monitoring the patient's safety needs and further management:

- Take all suicidal threats or attempts seriously and notify psychiatrist.
- Search for toxic agents such as drugs / alcohol.
- Do not leave the drug tray within reach of the patient, make sure that the daily medication is swallowed.
- Remove sharp instruments such as razor, blades, knives, glass bottles from his environment.
- Remove straps and clothing such as belts, neckties.
- Do not allow the patient to bolt his/her door on the inside, make sure that somebody accompanies to the bathroom.
- Patient should be kept in constant observation and should never be left alone.
- Have good vigilance especially during morning hours.
- Spend time with him, talk to him, and allow him to ventilate his feelings.
- Encourage him to talk about his suicidal plans/methods.
- If suicidal tendencies are very severe, sedation should be given as prescribed. In schizophrenia, atypical antipsychotics such as clozapine are effective.
- Encourage verbal communication of suicidal ideas as well as his/ her fear and depressive thoughts.
- Enhance self-esteem of the patient by focusing on his strengths rather than weaknesses. His positive qualities should be emphasized with realistic praise and appreciation. This fosters a sense of self-worth and enables him to take control of his life situation.
- Antidepressants are often the first-line treatment for mood disorders, but warning has been issued because of increased risk of suicidality among adolescents and young adults in the early months after starting selective serotonin reuptake inhibitor therapy
- After initial stabilization and improvement of suicidal ideation, patients will need follow-up care with mental health clinicians or community mental health care programs.

Management of Attempted Suicide

- Assess for vital signs, check airway, if necessary clear airway.

- If pulse is weak, start IV fluids.
- Tum patient's head and neck to one side to prevent regurgitation and swallowing of vomitus.
- Emergency measures to be instituted in case of self-inflicted injuries.
- Management of shock.
- Transfer the patient to medical centre immediately.

Management of completed suicide

- If there is no evidence of life, leave the body in the same position/room in which it was found Inform authorities, record the incident accurately
- Once the patient is transferred to mortuary or police custody clean the place with disinfectant solution
- A completed suicide causes stress for the patient's loved ones and physician. Bereavement reaction of survivors after suicide is more likely to feel shame and to blame themselves for the loss. The physician should be prepared to empathetically support the family members through this difficult transition without assigning blame.

VIOLENT OR AGGRESSIVE BEHAVIOR OR EXCITEMENT

- This is a severe form of aggressiveness. During this stage, patient will be irrational, uncooperative, delusional and assaultive.
- The risk of violence is especially high in those societies where there is easier access to firearms and prevalence of alcohol/drug misuse.

Aetiology

- Organic psychiatric disorders like, delirium, dementia, Wernicke-Korsakoff syndrome or psychosis.
- Other psychiatric disorders like schizophrenia, mania, agitated depression, withdrawal from alcohol and drugs, epilepsy, acute stress reaction, panic disorder and personality disorders.
- The use of alcohol also predisposes to violence.

Signs of Impending Assault

- Anger, excitement, loud voice,
- Demanding immediate attention
- Staring eyes, flared nose, flushed face, hands clenched or gripped
- Pacing about in the room, pushing furniture, slamming objects
- Possessing weapons

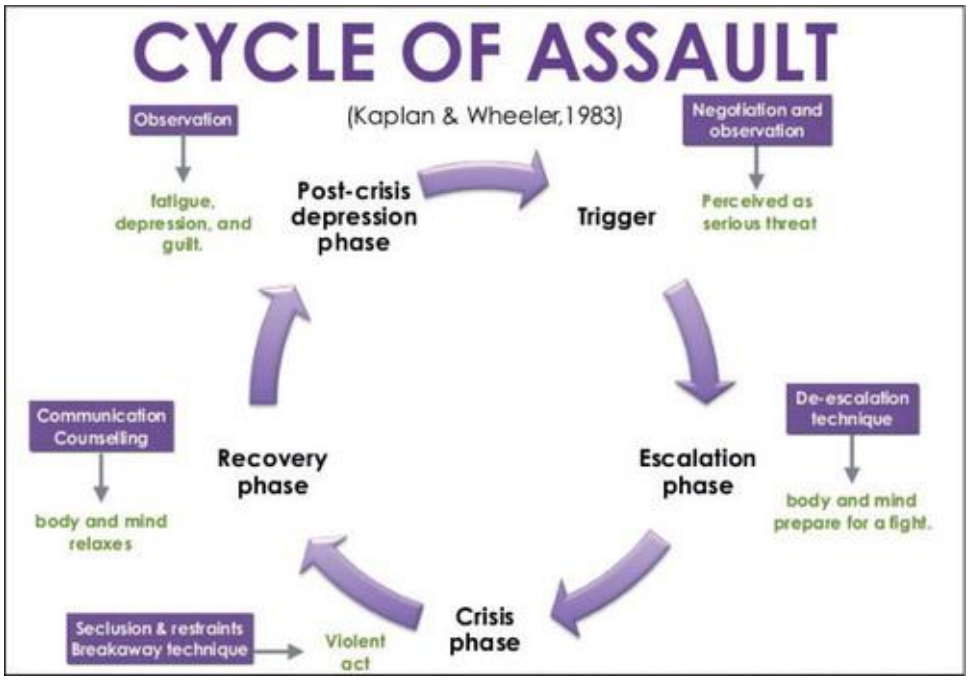
The assault cycle

- One recognized method of identifying behaviors that can lead to violence is the assault cycle. Learning and understanding the phases of the assault cycle will help healthcare workers to identify the patterns of escalating behavior and assist them to respond appropriately.
- The Assault Cycle is divided into five separate, distinct and observable phases.
- **Phase I: The Triggering Event** - This phase includes any event that an individual perceives as a serious threat to well-being. The event may be observable (name calling by another person, a disturbing phone call, loss of a privilege) or not observable (a flashback or memory, a delusion or hallucination, a reaction to medication).
- **Phase II: Escalation** - The person's mind and body prepare to do battle with the cause of the triggering event. The person's muscles become increasingly tense and active; his/her ritual behaviours of combat occupy more and more space in the overall behavioural pattern. (See above -Signs of Impending

Assault)

- **Phase III: Crisis** - The behavioural pattern explodes into one or more physical assaults on the perceived source of the threat. The individual will threaten injury, hit, kick, throw objects at people, etc. An individual cannot sustain this level of energy forever.
- **Phase IV: Recovery** - With the battle over, the muscles become progressively more relaxed and ritual combat behaviours become less frequent. It is important to note, however, that the individual is not yet at baseline and is vulnerable to reescalation.
- **Phase V: Post-Crisis Depression** - The physical and emotional symptoms of fatigue and/or depression dominate the behavioural pattern. Observable behaviours frequently include crying, hiding, sleeping, curling up in a fetal position or self-blame.

Fig. 1. **Assault Cycle showing the escalating behaviours and appropriate interventions**



Managing Violence and Aggressions

Staff Training

- Health and social care provider organizations should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting.

Anticipating and reducing the risk of violence and aggression

- To recognize the early signs of agitation, irritation, anger and aggression (See above)
- To understand the likely causes of aggression or violence.
- Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.
- To use skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)

De-escalation

- The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. There are three components in de-escalation.
- ***Self-control:***
    - Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, appear calm, voice low and monotonous, safe and open body posture (relax, arms at the side, hands outward) and avoiding prolonged eye contact when carrying out de-escalation.
- ***Stance (Self-protection):***
    - To recognise the importance of personal space: stand between the door and the patient two-arm length away, at the same eye level. Never see a potentially violent person alone. If a patient is carrying a weapon, ask them to place it in a neutral location rather than handing it over.
    - If a patient who is at risk of becoming violent or aggressive is in a room or area where there are objects that could be used as weapons, remove the objects or relocate the patient.
- ***De-escalation process:***
    - Use techniques for distraction and calming, and ways to encourage relaxation. Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations without provoking aggression.
    - Communicate with respect and empathy with the patient at all stages of De-escalation. Listen intently to the patient and offer choices and optimism.
    - P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation.

Using p.r.n. (pro re nata) Medication (Chemical Restraints)

- The use of medication as part of a strategy to de-escalate or prevent from violence or aggression. It does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression.
- If the patient is willing to take medication;
    - Olanzapine 5mg sublingual not more than 20mg/day (or)
    - Clonazepam 0.5 mg PO, not more than 4 mg/day (or)
    - Risperidone 0.5 mg PO not more than 3 mg/day (or)
    - Lorazepam 2mg PO, not more than 10 mg/day can be given.
- If parenteral route is preferred and patient does not have the evidence of cardiovascular disease;
    - intramuscular haloperidol 5 mg hourly prn, not to exceed 18 mg/day.
- If the patient has the evidence of cardiovascular disease;
    - intramuscular lorazepam 2mg hourly prn can be used with the limit of 20mg/day (or)
    - intramuscular diazepam 10 mg 6-12 hourly, not more than 30 mg/8 hours.
- Ensure that the maximum daily dose is specified and all p.r.n medications does not inadvertently exceed the maximum daily dose.

Breakaway techniques

- A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

Restrictive interventions

- Interventions that include observation, seclusion, manual restraint, mechanical restraint and rapid tranquillization.
- If the patient is not calmed down by de-escalation and refuses p.r.n medication, restraints may become necessary. That may infringe a person's human rights and freedom of movement.

1.Observation

- A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a patient to ensure the patient's safety and the safety of others.

2. Seclusion

- The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

3. Manual restraint

- A skilled, hands-on method of physical restraint **used by trained healthcare professionals** to prevent patients from harming themselves, endangering others or compromising the therapeutic environment.
- *Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police. (NICE guideline Published: 28 May 2015)*

4. Mechanical restraint

- A method of physical intervention involving the use of **authorized equipment,** for example handcuffs or restraining belts, applied in a skilled manner by **designated healthcare professionals**.
- Use mechanical restraint only as a last resort and its purpose is to safely immobilize or restrict movement of part(s) of the body of the patient to prevent from an extreme violence directed at other people or limiting self-injurious behaviour.

5. Rapid tranquillization

- Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.
- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead. (NICE guidelines 2015)

Patient-centered care

- Once the patient is sedated, arrange the patient for referral.
- If the referral is not feasible, following measures should be taken:
- In particular check for history of convulsions, fever, recent intake of alcohol, fluctuations of consciousness.
- Carry out complete physical examination.
- Look for evidence of **dehydration and malnutrition.** If there is severe dehydration, IV drip may be started.
- Following application of restraints, observe patient every 15 minutes to ensure that nutritional and elimination needs are met. Also observe for any numbness, tingling or cyanosis in the extremities. It is important to choose the least restrictive alternative as far as possible for these patients.

Reference:

Violence and aggression: short-term management in mental health, health and community settings NICE guideline Published: 28 May 2015 www.nice.org.uk/guidance/ng10

PANIC ATTACKS (SEE ALSO PANIC DISORDER)

- Episodes of intense fear characterized by a constellation of symptoms including palpitations, sweating, tremors, feelings of choking, trembling or shaking, sense of shortness of breath or smothering, chest pain, nausea, abdominal distress, fear of losing control or going crazy, feeling dizzy, unsteady, light-headed, or faint, fear of dying, paraesthesia, chills or hot flashes.
- These symptoms develop rapidly, reach a peak of intensity in about 10min, and generally do not last longer than 20–30min (rarely over 1hr).
- Attacks may be either **spontaneous/unexpected** ('out of the blue') or **situational/expected** (usually **where** attacks have occurred previously).

Emergency Management of an ACUTE PANIC ATTACK

- Talking down#: Explain the nature of symptoms to the patient and why they come.
- Maintain a reassuring and calm attitude (most panic attacks resolve spontaneously within 30min). (See Panic First Aid below)
- If symptoms are severe and distressing consider prompt use of benzodiazepines* (immediate relief of anxiety may help reassure the patient, provide confidence that treatment is possible, and reduce subsequent 'emergency' presentations).
- If first presentation, exclude medical causes (may require admission to hospital for specific tests).
- If panic attacks are recurrent, consider differential diagnosis for panic disorder and address underlying disorder (may require psychiatric referral).
- **Benzodiazepines (e.g. alprazolam or clonazepam) are not recommended by NICE. They should be used with caution (due to potential for abuse or dependence and cognitive impairment), but may be effective for severe, frequent, incapacitating symptoms. Use for 1–2wks in combination with an antidepressant may offer symptomatic relief until the antidepressant becomes effective.*
- #"Talking down"
  - Explain the nature of the symptoms to the patient
  - Racing of the heart is due to adrenalin produced by the panic.
  - Paresthesia/feelings of dizziness are secondary to over breathing due to panic
  - Breathing exercises - Count breaths in and out gently slowing breathing rate
  - Propranolol 10 -20 mg stat may be helpful (Contraindicated in Asthma/heart failure, verapamil or diltiazem can be tried)

Move to stop PANIC: PANIC FIRST AID

- **Be still: resist escaping.**
  - ***I will still be safe if I don't run.***
- **Go with your body's reaction: don't fit it.**
  - ***All the sensations I am feeling now will pass. I can allow this to wash over me***
- **Stay in the present: don't futurize. Keep your attention only on what's happening now, rather than what could happen in the future**
- **Deflate the danger: tell yourself the facts.**
  - ***All the sensations of panic are harmless, no matter how intense -the response is protective in nature.***
- **Dampen down the reaction:**
  - ***Breathe slowly into your belly***
  - ***Relax your muscles***
  - ***Stabilize your energy***
- **Be consistent: don't resort to bad habits.**

When Panic Attacks by Dr Aine Tubridy
http ://wellbeingfoundation.com/jirs taid-pa nic.html

Differential Diagnosis of ACUTE PANIC ATTACK

- Dysthymia (persistent mild depression),
- Asthma
- Anaphylaxis
- Thyrotoxicosis
- Hypoglycemia
- Temporal lobe epilepsy

CATATONIC STUPOR

- **Stupor** is a clinical syndrome of akinesis and mutism but with relative preservation of conscious awareness. The patient is conscious but there is non-responsiveness to the surroundings.
- Catatonic stupor is a subtype of stupor presenting with signs and symptoms including immobility, mutism, negativism, ambitendency, catalepsy and waxy flexibility, echolalia, echopraxia, automatic obedience, posturing, mannerisms, stenotypes, etc.,

Causes

- The most important causes include:
  - **Psychiatric (Functional)**
    - Schizophrenia
    - Mood disorders (bipolar disorders, major depressive disorder)
    - Antipsychotic drugs
  - **Organic**
    - Encephalitis
    - Carbon monoxide poisoning
    - Serum potassium imbalance (periodic paralysis)

Management

- Ensure patent airway
- Administer IV fluids
- Collect history and perform physical examination
- Draw blood for investigations before starting any treatment
- Withhold antipsychotic medication if the patient was taking
- Trial of lorazepam 1-2 mg every 4-12 hours PO up to 6 days and gradual reduction.
- *Zolpidem challenge test* after treatment with BZD had failed. 7.5 -40 mg PO/day
- Other care is same as that for an unconscious patient.

GRIEF AND BEREAVEMENT

- Grief is areaction of an individual to a significant loss including person, things, experiences such as relationship and job.
- Bereavement is a period of mourning or a state of intense grief following the death of a loved one.

Factors affecting GRIEF reaction:

- Abruptness of loss.
- Extent of loss.
- Preparation of loss.
- Significance of the lost person /object to the individual.

- Past experience of grief
- Cultural background.
- Personality traits.

UNCOMPLICATED GRIEF

- The clinical features of uncomplicated grief are sadness, yearning for the deceased, crying, anger, insomnia, poor appetite, loss of interest, guilt, social withdrawal. and death wish.
- Stages:
  - ***Hours to days***: Shock and disbelief.
  - ***Weeks to months***: Anger, resentment, depression
  - ***Six months to a year***: Acceptance of reality

Management

- Evaluation to find out any primary psychiatric disorder. Those without underlying mental disorders do not usually require any specific treatment, such as medication or grief counseling.
- Early intervention is *not* recommended because it may interfere with the grieving process. Patients with extended grief or grief complicated by depression may receive greater benefit from counseling.

Crisis intervention

- Most reviews recommend tailoring the intervention to the cues and perceived needs of the bereaved. Patient is encouraged to talk about his feeling concerning the deceased in privacy.
- Responding to patients' cues can provide appropriate support after a loss. Kind, compassionate words spoken with empathy and a short phone call a couple days after the visit to check in or a personal note can be of tremendous comfort.
- Patients can be reassured that their emotions, feelings, and pain are normal and that everyone experiences grief and loss a little differently.
- The patient can be assured that the intensity of these emotions will subside significantly by six months and diminish by one year.
- The family physician should encourage the patient to get enough exercise and sleep, to eat well, avoid excessive alcohol intake and lower the risk of associated morbidity, including myocardial infarction.
- Maintaining social interactions can be helpful for patients and should be also encouraged.

Ref: Helping Patients Cope with Grief: Am Fam Physician. 2019;100(1):54-56

Pharmacotherapy

- Avoid drug treatment, as far as possible. Prescribe nighttime sedatives on as-needed (SOS) basis.
- Refer to psychiatric services for primary psychiatric condition, if necessary.

COMPLICATED GRIEF (UNRESOLVED GRIEF)

Prevalence

- 10% to 20% after the loss of a romantic partner and even higher after the loss of a child
- During the first few months after a loss, many signs and symptoms of normal grief are the same as those of complicated grief.
- Complicated grief is like being in an ongoing, heightened state of mourning that keeps the patients from healing. It can be diagnosed when grieving continues to be intense, persistent and debilitating beyond **12 months**.

Signs and symptoms of complicated grief

may include:

- Intense sorrow, pain and rumination over the loss of the loved one
- Extreme focus on reminders of the loved one or excessive avoidance of reminders
- Problems accepting the death

- Numbness or detachment
- Inability to enjoy life or think back on positive experiences with the loved one
- Having trouble carrying out normal routines
- Isolation from others and withdrawal from social activities
- Depression, deep sadness, guilt or self-blame
- Believing that he/she did something wrong or could have prevented the death
- Feeling life isn't worth living and suicidality.

Management

- Referral for complicated grief psychotherapy.
- If psychotherapy is not feasible, the family doctor should try to:
    - explain about complicated grief including grief reactions, grief symptoms and how to overcome
    - help the patient to adjust to the loss and redefining the life goals
    - encourage the patient to hold imagined conversations with the loved one and retell the circumstances of the death to help him/her become less distressed by images and thoughts of the loved one
    - teach how to explore the thought patterns, identify dysfunctional thoughts (catastrophic thinking) and reframe the thoughts into more positive ones to change subsequent emotions and behaviours.
    - help to improve coping skills
    - reduce feelings of blame and guilt
- Medications:
    - antidepressants may be helpful in people who have clinical depression as well as complicated grief.
- Hospitalization for the patients with physical illnesses and suicidality.

HYSTERICAL ATTACKS

- Hysteria or conversion disorder is a disorder whereby a person expresses emotional turmoil by converting it into a bodily symptom. **The term "hysteria" is no longer used.**
- Conversion disorder may present as an affliction of organs of special senses i.e. as hysterical deafness, hysterical blindness. It may also affect the voluntary nervous system and patients may present with hyperventilation, convulsions, paraesthesias, hysterical paraplegia, ataxia etc.
- The symptoms and signs of conversion hysteria are **not consciously simulated** as opposed to malingering.
- Neurological examination of the affected part of the body reveals an intact neuromuscular apparatus with normal reflexes.

Management

- All presentations are marked by a dramatic quality and sadness of mood.
- Hysterical fit must be distinguished from genuine fits (epileptic seizures).
- As hysterical symptoms can cause panic among relatives. The family physician should explain to the relatives the psychological nature of symptoms and reassure that no harm would come to the patient.
- Help the patient realize the meaning of symptoms, and help him find alternative ways of coping with stress such as:
    - Concentrate on the present instead of focusing on yesterday or tomorrow
    - Engage in breathing exercises
    - Write in a journal
    - Get physically active

    - Develop a consistent sleep schedule
- Secondary hysteria due to anxiety and depression- anxiolytics and antidepressants may help

TRANSIENT SITUATIONAL DISTURBANCE (DSM II) (RENAMED AS ADJUSTMENT DISORDER- SINCE DSM III)

- A state of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (WHO, 1992)
- Onset of symptoms is usually **within one month** of the onset of the stressful event according to ICD-10 (WHO, 1992) or within three months and **do not last longer than 6 months** according to DSM-5. (More than 6 months= persistent/ chronic adjustment disorder)
- Symptoms can vary from mild to severe, depending on the intensity of the triggering situation and the personal significance for the patient.

Common Physical and Emotional Symptoms

- Insomnia
- Headaches, body aches and soreness
- Palpitations.
- Sweating hands.
- Symptoms of anxiety and depression including being anxious or agitated, feeling trapped, hopeless, poor concentration, lacking energy, loss of self-esteem, loss of interest.
- Abusing alcohol or drugs.
- Having suicidal thoughts or behaviors.

Management

- Reassurance as many people with adjustment disorders find treatment helpful, and they often need only brief treatment.
- Allowing the patient to ventilate his/her feelings to a trusted person.
- Counselling by a professional or referral for psychotherapy
- Medications such as antidepressants (SSRI/SNRI) and anxiolytics (short term BZD) may be added to help with symptoms of depression and anxiety.

DELIRIUM TREMENS (SEE ALSO IN ALCOHOL USE DISORDER)

- Delirium tremens (DTs) is the most severe form of ethanol withdrawal, manifested by altered mental status (global confusion) and sympathetic overdrive (autonomic hyperactivity), which can progress to cardiovascular collapse.
- Minor alcohol withdrawal is characterized by tremor, anxiety, nausea, vomiting, and insomnia.
- Major alcohol withdrawal signs and symptoms include visual hallucinations and auditory hallucinations, whole body tremor, vomiting, diaphoresis, hypertension and seizures.
- *https://emedicine.medscape.com/article/166032-overview*

Management

- Keep the patient in a calm, quiet, safe and well-lit environment.
- Sedation is usually given with diazepam 10mg or lorazepam 4mg IV, followed by oral administration.
- Ongoing reassessment and maintain fluid and electrolyte balance.
- Thiamine: to prevent from Wernicke encephalopathy and Korsakoff syndrome.
- Reassure patient and family.

EPILEPTIC FUROR

- Following epileptic attack, patient may have a sudden outburst of rage or excitement during which an irrational act of violence may be committed.

Management

- Sedation: Inj. Diazepam 10 mg IV [or] Inj. Phenobarbital (Luminal) 10 mg IV followed by oral anticonvulsants
- Haloperidol 10 mg IV helps to reduce psychotic behavior.

ACUTE DRUG-INDUCED EXTRAPYRAMIDAL SYMPTOMS

- Extrapyramidal Side effects (EPS), commonly referred to as drug-induced movement disorders are among the most common adverse drug effects patients experience from dopamine-receptor blocking agents.

Highest incidence:

- Haloperidol and phenothiazine (61.6%) (Centrally acting dopamine-receptor blocking agents, the first-generation antipsychotics).

Less frequently:

- Atypical antipsychotics
- Antiemetics (metoclopramide 4-25%, droperidol, and prochlorperazine 25-57%)
- Lithium
- Serotonin reuptake inhibitors (SSRIs)
- Stimulants
- Tricyclic antidepressants (TCAs).

Symptoms and Signs

- On physical exam, dystonia manifests with involuntary muscle contractions resulting in abnormal posturing or repetitive movements,
- The back and extremities- opisthotonus
- Neck – torticollis
- Jaw – trismus
- Eyes - oculogyric crisis
- Abdominal wall and pelvic muscles - tortipelvic crisis
- Facial and tongue muscles - buccolingual crisis
- The clinician must evaluate these patients for pain and particularly difficulty in breathing, swallowing, and speech.
- Neuroleptic malignant syndrome is rare but most serious of these symptoms and occurs in a small minority of patients taking neuroleptics, especially high-potency compounds.

Management

- Dystonic reactions are rarely life-threatening, and the clinician should discontinue the offending agent and manage pain if present.
- Emergency airway intervention if laryngeal and pharyngeal dystonic reactions may increase the risk of imminent respiratory arrest.
- Treatment is symptomatic and includes cooling the patient, maintaining fluid and electrolyte balance.
- If the causative medication is a typical first-generation antipsychotic, switching to an atypical antipsychotic may be trialed.

- Administration of an antimuscarinic agent (benztropine, trihexyphenidyl) or diphenhydramine may relieve dystonia within minutes.
- In cases of tardive dystonia, administration of benzodiazepine, trial of muscle relaxant (e.g., baclofen).

DRUG TOXICITY

- Drug toxicity generally occurs over time, while drug overdose happens when too much of a substance is consumed at once.
- Drug toxicity is typically accidental, while drug overdose can be either accidental or intentional.
- In either case all attempts must be made to find out the drug consumed. A detailed history should be collected and symptomatic treatment instituted.
- A very common drug is lithium.
- The symptoms include drowsiness, vomiting, abdominal pain, confusion, blurred vision, acute circulatory failure, stupor and coma, generalized convulsions, oliguria and death.

Diagnosis of Drug Toxicity

- Acute drug toxicity is more easily diagnosed as the symptoms follow the taking of the medication just one time. Blood tests can also screen for levels of the medication in the bloodstream.
- Chronic drug toxicity is harder to identify. Stopping the medication, then "re-challenging" it later is one method of testing whether the symptoms are caused by the medicine.

Management

- Administer Oxygen
- Start i/v line
- Assess for cardiac arrhythmias
- Acute overdose: gastric lavage, activated charcoal, consider antidote
- Refer for haemodialysis
- Administer anticonvulsants as appropriate

VICTIMS OF DISASTER

- Victims of disaster are people, who have survived a sudden, unexpected, overwhelming stress. This is beyond what is normally expected in life, like in an earthquake, flood, riots and terrorism.
- Anger, frustration, guilt, numbness and confusion are common features in these people.

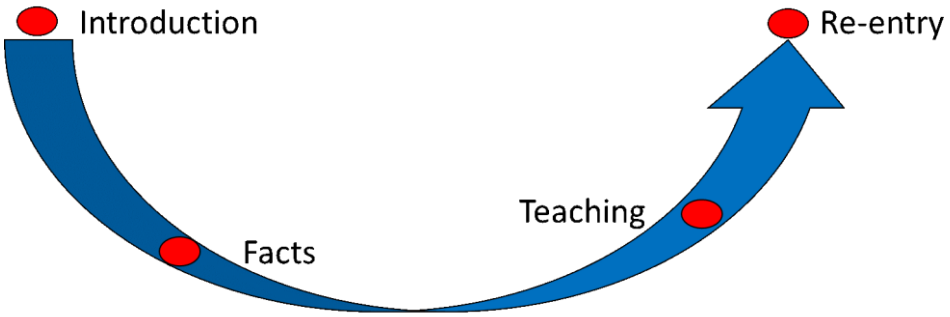
Management

- Treatment for life threatening physical problems

Crisis Management Briefing (CMB)

- An efficient and effective way for the people to get clear, concise, and regular communication during a critical incident. It is designed to provide information about the incident, control rumors, educate about symptoms of distress, inform about basic stress management, and identify resources available for continued support. The communication is mostly one-sided.
- It can be delivered to a small or large group that include all kinds of participants, from survivors to spectators.
- CMBs can, and frequently should, be done in the course of a critical incident.
- CMB can be given by someone who has taken a level of responsibility for the incident such as leadership within an organization or response managers.
- A CMB can lose some of its effectiveness if the speakers are overly emotionally invested in the events.
- A CMB moves quickly through 4 phases of communication; Introduction, Fact, Teaching, and Re-Entry (Mitchell 2006). Most CMBs will take less than an hour.

Fig.2 Crisis Management Briefing



Introduction Phase

- The introduction is the part of the briefing where audience members are introduced to the people involved in giving the briefing and the reason for the briefing.

Fact Phase

- This phase is about getting everyone on the same page as to what has happened and where the situation stands at the moment. It is beneficial to put the known facts in chronological order.
- Facts should be delivered in a business tone, with little emotional reaction from the speaker.

Teaching Phase

- It is often the longest portion of the briefing, where the voice of communication will change from **what has happened to what will happen**. It should address physical, emotional, mental, and spiritual expectations and resources.

Re-Entry Phase

- This phase concludes the CMB. Start this phase by normalizing and validating the struggle that the events have caused,
- CBM may be especially useful in response to community violence / terrorism and can be tailed to smaller group applications.
- By doing CBM, the need for CISD can be assessed.

Critical Incident Stress Debriefing (CISD)

- CISD is a special technique to help normal people deal with abnormal situations. It is a structured group discussion concerning the critical incident which follows a structure of 7 phases. Debriefing allows those involved with the incident to process the event and reflect on its impact.
- Only trained individuals should initiate a CISD. Untrained individuals can cause more harm than good if they do not understand the reasons behind and steps involved in a Debriefing.
- CISD should be done **after the first 24 hours** of the incident to 10 days.
- **CISD includes seven phases:** Introduction, Fact, Thought, Reaction, Symptom, Teaching and Re-entry.
- In selected cases benzodiazepines for short term are prescribed to reduce anxiety and induce sleep.
- Referral to mental health service, if required

RAPE VICTIM (SEE MORE DETAILS IN SEXUAL VIOLENCE, CHAPTER 17)

- Rape is a perpetuation of an act of sexual intercourse with a female against her will and consent.

Signs and Symptoms

- Acute disorganization characterized by self-blame, fear of being killed, feeling of being killed, feelings of degradation and loss of self-esteem, feelings of depersonalization, unable to remember important parts of the event (dissociative amnesia) and serialization of recurrent intrusive thoughts are commonly seen.
- Long term psychological effects like post-traumatic stress disorders (PTSD), anxiety and depression can occur in some cases.

Management

- Be supportive, reassuring and non-judgmental
- Physical examination for any injuries
- Give morning after pill to prevent possible pregnancy. Send sample for STD and HIV infection.
- Explain to the patient the possibility of PTSD, sexual problems like vaginismus (vaginism) and anorgasmia may appear later.

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

Schizophrenia Spectrum and Other Psychotic Disorders includes the following.

A. Schizophrenia
B. Other psychotic disorders, and
C. Schizotypal (personality) disorder.

They are defined by abnormalities in one or more of the following five domains:

- Delusion
- Hallucinations
- disorganized thinking (speech)
- grossly disorganized or abnormal motor behavior (including catatonia), and
- negative symptoms. {a lack of normal function and include diminished emotional expression, alogia (diminished speech output), avolition (i.e., reduced goal-directed activity due to decreased motivation), asociality (apparent lack of interest in social interactions), and anhedonia (decreased ability to experience pleasure from positive stimuli)}

Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition.

SCHIZOPHRENIA

Schizophrenia is the most common psychotic mental disorder. According to a 2019 data, schizophrenia is the third leading diagnosis among mental health problems in Myanmar.[1]

The age of highest tendency to have a syndromic phase

- Men - between 18 and 25 years of age.
- Women - two peaks; the first between 25 and mid-30s, and the second after 40 years of age.
- Initial presentation before 15 years of age is possible but rare.

Etiology

It is a multifactorial process involving the interaction of genetic predisposition and environmental factors (the polygenic threshold model).

Environmental factors that increase the risk of schizophrenia

1. During fetal development and early life infections (e.g., rubella, influenza, Toxoplasma gondii, herpes simplex virus type 2)
2. Nutritional deficiencies (e.g., folic acid, iron, vitamin D)
3. Pregnancy and birth complications, neonatal hypoxic events
4. Childhood trauma
5. Substance use disorder especially cannabis use
6. Socioeconomic status.

Clinical Presentation

It is important to identify schizophrenia early in the course of disease because those who are treated early have better long-term outcomes. Primary care physicians must be vigilant in identifying people with psychotic symptoms, using current diagnostic criteria (e.g. DSM-5) or specialty care referral to aid in diagnosis.

Schizophrenia is characterized by two sets of categorical symptoms, with at least **one positive symptom** (delusion, hallucinations, disorganized thinking) and either **one negative symptom** (see

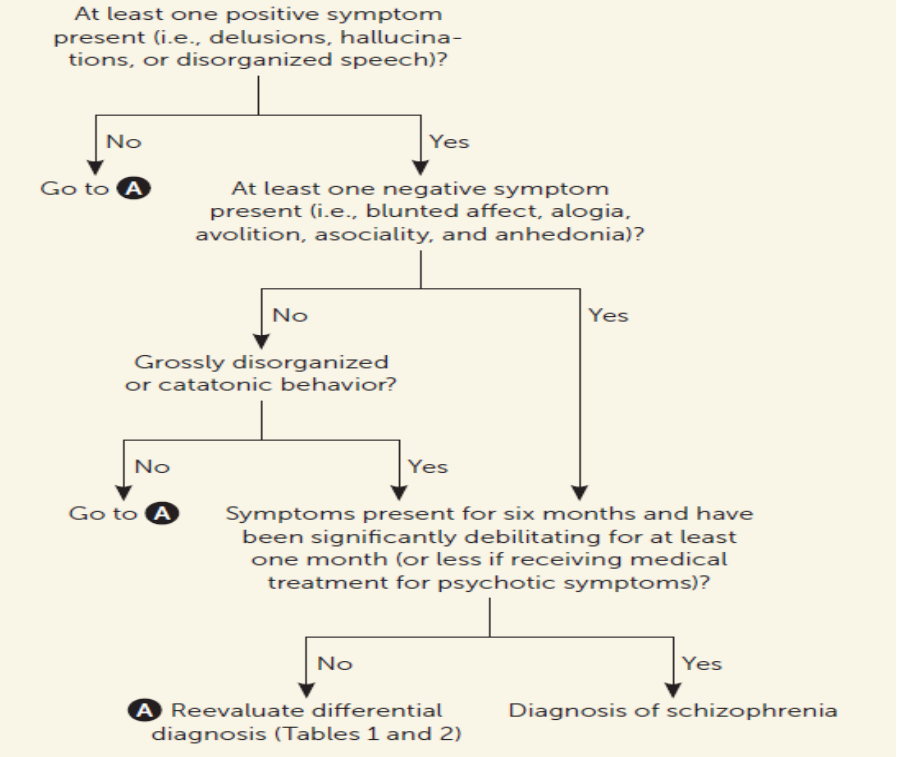
above) or **grossly disorganized** or **catatonic behavio**r present for at least six months.
Symptoms must be present for at least six months and be significantly debilitating for at least one month (or less if receiving clinical treatment).
Other psychiatric disorders and medical conditions that mimic schizophrenia should be ruled out when patients present with symptoms are reviewed.

Psychiatric Conditions That Can Mimic Schizophrenia

Conditions	Distinguishing features
Bipolar disorder with psychotic features	Psychotic symptoms during manic or depressive episodes
Brief psychotic disorder	Delusions, hallucinations, and other psychotic symptoms lastir more than one day but less than one month
Delusional disorder	Fixation on false beliefs or nonbizarre delusions without other psychotic symptoms
Major depressive disorder with psychotic features	Psychotic symptoms with mood disturbances qualifying for concomitant major depressive disorder diagnosis
Obsessive-compulsive disorder	Significant obsessions, compulsions, and preoccupations
Posttraumatic stress disorder	Symptoms related to reliving inciting traumatic event
Schizoaffective disorder	Mania or depression occurring concomitantly with psychotic symptoms; psychotic symptoms without mood disturbance
Schizophreniform disorder	Psychotic symptoms lasting at least one month, but less than six months
Schizotypal personality disorder	No hallucinations or delusions with personality Features

Medical Conditions That Can Present with Psychosis

1. Cushion syndrome
2. Delirium
3. Dementia
4. Intracranial tumor
5. Paraneoplastic and non-paraneoplastic autoimmune syndromes with psychosis
6. Porphyria
7. Substance abuse
8. Systemic lupus erythematosus
9. Thyroid disorders
10. Vitamin B12 deficiency
11. Wilson disease



Algorithm for the Diagnosis of Schizophrenia

Am Fam Physician.October 2022 ◆ Volume 106, Number 4

Treatment

The primary goal for initial treatment of schizophrenia should be to reduce acute positive symptoms by using first or second-generation antipsychotics allowing the patient to return to a baseline level of function and prevent long-term disability. (Recommendation A)

Treatment for schizophrenia should continue for life. Primary care physicians who are comfortable prescribing antipsychotics can play a vital role in treating patients in resource-constrained environments.

Patients with a first episode of psychosis who receive a formal diagnosis of schizophrenia should be treated in a coordinated specialty care program (Recommendation B)

Person centered medication

The factors a family physician should consider in selection of medication include:

- individual preference
- prior treatment response
- adherence history
- relevant medical history and risk factors
- adverse effects, and
- long-term treatment planning, including cost and access to medication.

Antipsychotics

First generation antipsychotics

- Dopamine receptor antagonists.
- More incidence of extrapyramidal symptoms
- Chlorpromazine, fluphenazine, perphenazine and haloperidol are available.

Second-generation antipsychotics

- Serotonin receptor antagonists
- Generally preferred as first-line agents

- Associated with the development of metabolic syndrome
- Aripiprazole, olanzapine, quetiapine and risperidone are available.

Antipsychotic Medications and Adjunctive Treatments for Schizophrenia

Medication	Initial dosage (mg/day)	Typical dosage range (mg/day)	Common adverse effects
First-generation antipsychotics			
Chlorpromazine	25 to 100	200 to 800	Dry mouth, elevated prolactin levels, extrapyramidal symptoms, glucose intolerance, postural hypotension, somnolence, weight gain
Fluphenazine	2.5 to 10	6 to 20	Akathisia, parkinsonism, dystonia, hyperproteinemia
Haloperidol	1 to 15	5 to 20	Dry mouth, extrapyramidal symptoms, galactorrhea, hyperprolactinemia, hypotension, somnolence, tachycardia
Perphenazine	8 to 16	8 to 32	Dry mouth, extrapyramidal symptoms, galactorrhea, hyperprolactinemia, hypotension, somnolence, tachycardia
Second-generation antipsychotics			
Aripiprazole	10 to 15	10 to 15	Anxiety, constipation, dizziness, headache, insomnia
Clozapine	12.5 to 25	300 to 450	Hyperlipidemia, diabetes mellitus, orthostasis, seizures
Olanzapine	5 to 10	10 to 20	Weight gain, hyperlipidemia, diabetes, akathisia, hyperprolactinemia, postural hypotension
Quetiapine	Immediate release: 50 Extended release: 300	400 to 800	Hyperlipidemia, agitation, dizziness, dry mouth, hypotension, somnolence, weight gain
Risperidone	2	2 to 8	Anxiety, hyperprolactinemia, hypotension, insomnia, metabolic changes, nausea, weight gain

Maintenance Therapy

Patients with schizophrenia should continue maintenance therapy while being monitored for treatment effectiveness and adverse effects. The goal of maintenance therapy is to prevent relapse into active phase schizophrenia and maximize social function and quality of life.

Primary care physicians should be aware that patients with schizophrenia have an increased risk of cardiovascular disease as well as overall mortality.

Treatment-resistant Schizophrenia

Treatment-resistant schizophrenia is the persistence of significant symptoms despite adequate pharmacologic treatment.

Schizophrenia refractory to first- and second-generation antipsychotics should be treated with clozapine. (Recommendation B)

Clozapine has an FDA boxed warning in the US, highlighting the risk of severe neutropenia (e.g., agranulocytosis), myocarditis, cardiomyopathy, seizures, and profound hypotension. Oral and long-acting injectable clozapine require additional training for the physician.

Adjunctive treatments

The psychosocial therapies should be offered as adjunctive treatments, such as:

- cognitive behavior therapy for psychosis
- psychoeducation

- supported employment services
- assertive community care, and
- family interventions

(Recommendation B).

However, electroconvulsive therapy (ECT) was associated with memory impairment (NNH = 4) and headache (NNH = 8) even though ECT adjunctive treatment with clozapine is superior to clozapine monotherapy for treatment-resistant schizophrenia (NNT = 3).

Relapse was reduced with family interventions, psychoeducation, illness self-management, and early interventions following the first episode of psychosis.

Prognosis

The clinical course and prognosis of people with schizophrenia are marked with heterogeneity and the unpredictable disease course.

People with schizophrenia have mortality rates two to four times greater than the general population. Most deaths are related to an increased rate of cardiovascular disease with concomitant renal disease, respiratory diseases, stroke, cancer, and thromboembolic events.

People with schizophrenia should be screened by a primary care physician for cardiovascular disease and receive at least annual metabolic screening and counseling with interventions to prevent weight gain and attempt to mitigate other factors, such as smoking. A large cohort study found that maintenance therapy with antipsychotic medications reduces rates of suicide and overall mortality.

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1. Our World in Data: Burden of disease from each Category of mental illness, Myanmar, 2019. https://ourworldindata.org/grapher/burden-disease-from-each-mental-illness?country=~MMR
2. Diagnostic and Statistical Manual of Mental Disorders; Fifth Edition (DSM-5), American Psychiatric Association.
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MOOD DISORDERS

- Bipolar and related disorders
- Dysthymic disorder
- Depressive disorders

BIPOLAR AND RELATED DISORDERS

- Bipolar disorders are common, recurrent mental health conditions of variable severity.
- Bipolar disorders are difficult to diagnose.
- Affected individuals have higher rates of other mental health disorders, substance use disorders, and comorbid chronic medical illnesses.
- Physicians should consider bipolar disorder in any patient presenting with depression.

Categories and Types of Bipolar Disorders

Bipolar I disorder: Manic or mixed feature episode with or without psychosis and/or major depression

Bipolar II disorder: Hypomanic episode with major depression; no history of mania, but can have a history of hypomania

Cyclothymia: Hypomanic and depressive symptoms that do not meet bipolar II disorder criteria, no major depressive episodes, occurring over two years, with no more than two months free of symptoms

Bipolar disorder, not otherwise specified: Does not meet criteria for major depression, bipolar I disorder, bipolar II disorder, or cyclothymia (e.g., less than one week of manic symptoms, without psychosis or hospitalization)

Substance-induced mania (include name of substance: e.g. steroids, alcohol, cocaine, or prescription antidepressants).

Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased **goal-directed** activity or energy, **lasting at least 1 week** and present most of the day, nearly every day (or any duration if hospitalization is necessary). (Presence of psychotic symptoms like delusion of grandeur, auditory hallucinations)

Hypomanic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
- **Mood:** predominately elevated, irritable
- **Speech &thought:** pressured, flight of ideas, poor attention
- **Behaviour:** Insomnia, loss of inhibitions: sexual promiscuity, overspending, risk-taking, compulsive gambling, increased appetite.

Major Depressive Episode (See in Depressive Disorders)

Assessment of Acute Manic Episode

- Lookfor
  - Several days of:
    - marked elevated or irritable mood

        - Excessive energy and activity
        - Excessive talking
        - Recklessness
- Past history:
    - Depressed mood
    - Decreased energy and activity
- People who suffer only manic episodes (without depression) are also classified as having bipolar disorder.
- Complete recovery between episodes is common in bipolar disorder.

Differential diagnosis

- Hypoglycemia
- Alcohol or drug abuse
- Steroid side effects
- Temporal lobe epilepsy
- Frontal lobe dysfunction (d/t tumor or stroke)
- Thyrotoxicosis

Look for concurrent conditions

- Alcohol use or drug use disorders
- Suicide/ self-harm
- Dementia
- Concurrent medical illness e.g. stroke, diabetes, hypertension, HIV/AIDS, cerebral malaria, or steroid use

Management of Bipolar Disorders

- Patients with acute mania require hospitalization because of risk of harm to self or others. If acute mania is suspected, exclude other physical causes and refer promptly for specialist assessment, diagnosis and management.
- Alcohol/drug misuse is common co-morbidity.
- Sedation whilst awaiting admission may be required - try oral medication first, Olanzapine 10mg po (5-20mg/d).
- Only if oral treatment is not feasible, consider i/m haloperidol 1.5 - 3mg (typically effective dose 3-20 mg)
- The first-line treatment for bipolar disorders should be pharmacotherapy including mood stabilizers, such as lithium, anticonvulsants(valproate), and antipsychotics such as quetiapine, olanzapine, risperidone which should be continued indefinitely because of the risk of patient relapse.
- Monotherapy with antidepressants is **contraindicated** during episodes with mixed features, manic episodes, and in bipolar I disorder.
- Ongoing management involves monitoring for suicidal ideation, substance use disorders, treatment adherence, and recognizing medical complications of pharmacotherapy.
- Psychotherapy is a useful adjunct to pharmacotherapy.
- Patients and their families should be educated about the chronic nature of this illness, possible relapse, suicidality, environmental triggers (e.g., seasonal light changes, shift work, other circadian disruption), and the effectiveness of early intervention to reduce complications.

DEPRESSIVE DISORDERS

- Serious medical illness that negatively affects how you feel, how you think, and how you act.
- These disorders are common and 30-50% cases are not detected although most are mild cases and more likely to resolve spontaneously.

Types of Depressive Disorders

- **Disruptive mood dysregulation disorder**
- **Major depressive disorder (including major depressive episode)**
- **Persistent depressive disorder (dysthymia)**
- **Premenstrual dysphoric disorder**
- **Substance/medication-induced depressive disorder**
- **Depressive disorder due to another medical condition**
- **Other specified depressive disorder, and unspecified depressive disorder.**

MAJOR DEPRESSIVE DISORDERS

Diagnostic criteria (DSM-5)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1) Depressed mood most of the day (e.g., feels sad, empty, hopeless, appears tearful, in children and adolescents- can be irritable mood.)
2) Markedly diminished interest or pleasure.
3) Significant weight loss when not dieting, or weight gain (e.g. more than 5% of body weight)
4) Insomnia or hypersomnia nearly every day.
5) Psychomotor agitation or retardation nearly every day
6) Fatigue or loss of energy nearly every day.
7) Feelings of worthlessness or excessive or inappropriate guilt.
8) Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Screening questions for Depression

The Patient Health Questionnaire-2 (PHQ -2)

1. During the past 2 weeks, have you often been bothered by **feeling down, depressed, or hopeless?**
2. During the past 2 weeks, have you often bothered by having **little interest or pleasure in doing things?**

If positive response to either question, investigate further, e.g., with PHQ9 to confirm diagnosis and assess severity.

Severity Assessment of Depression

Table. 3

THE PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name:_____Date of Visit:_____

Over the past 2 weeks, how often have you been bothered by any of 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
3. Trouble falling asleep, saying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? □Not difficult at all □Somewhat difficult □Very difficult □Extremely difficult				

- *Sub threshold depressive symptoms (<5)*
- *Mild (5-9)*
- *Moderate (10-14)*
- *Moderately severe (15-19)*
- *Severe (symptoms markedly interfere with functioning+/- psychotic symptoms) (≥20)*

Biopsychosocial assessment

- Important to exclude differential diagnosis and treatment options
- Current symptoms (nature, onset, duration, severity)
- Past history of depression and or mood elevation (? Bipolar disorder)
- Family history of mental illness
- Quality of relationships
- Living conditions- social support
- Employment/financial worries
- Alcohol/substance misuse
- Suicidal ideation
- Treatment options
- Past experience of response to treatment
- Co- morbid mental/ physical health problems
- Awareness of sources of help
- The patient's views about the cause of his /her symptoms
- Need for follow-up

Management of Depression

- Assess suicide risk with Suicide Behaviors Questionnaire-Revised (See above in Assessment of Suicidality)
- **If high risk,**
  - refer as emergency to mental health specialist center or hospital.
- **If low risk**
  - Remove means of self-harm
  - Create secure and supportive environment, if possible, offer separate, quiet room while waiting.
  - Do not leave the person alone
  - Supervise and assign a family member to ensure safety.
  - Attend mental state, and emotional distress.
  - Maintain regular contact and follow-up for as long as the suicidal risk persists.

Pharmacological Treatment

- Medication is required for moderate/severe depression (or) mild/sub-threshold depression not responded to non--pharmacological treatment.
- SSRI (fluoxetine 10- 20mg od /sertraline 50-150mg od/ escitalopram 10-20mg od)
- SNRI (venlafaxine 75 – 225 mg od/ duloxetine20-60mg od)
- Start low dose, go slow to titrate.
- Time to response- 4-6wks

Side-effects:

- Dyspepsia, GI Bleeding especially co-administering with NSAIDS
- Increased anxiety/agitation within 2wk of treatment
- Hyponatremia in elderly people those taking SSRI or SNRI (Highest risk in the first 2-4 weeks and seems to diminish over time) (Lower risk with mirtazapine)

Patient- centered Approach for depression

- Discuss choice of drug and non-pharmacological therapy.
- Cognitive therapy is equally effective as antidepressant in mild/ moderate depression.
- Combined therapy is more effective than either treatment alone.
- Discuss side effects, not all side effects undesirable (SSRI may help premature ejaculation). Warn that there may be an initial worsening of symptoms in the first few weeks before therapeutic effects are seen.
- Assess after 4-6 wks.
- If effective, continue for at least 4-6 months after recovery, if stopped too soon 50% relapse.
- If no effect seen, increase dose and review in 2weeks.
- If still no response, increase dose unless poorly tolerated. Review in 2weeks. If no response or poor tolerability, switch to an alternative class of antidepressant.
- **Recurrent depression:** of those who have one episode of major depression 50-85% will have further episodes. Continuing antidepressants lowers the odds of relapse by 65% which is about half the absolute risk.

Psycho-Education Points

- Depression is a very common problem that can happen to anybody.
- Depressed people tend to have unrealistic negative options about themselves, their life and their future.
- Effective treatment is possible. It tends to take at least a few weeks before treatment reduces the symptoms of depression. Adherence to any prescribed treatment is important.
- The following need to be emphasized:

- Continue activities that used to be interesting or give pleasure
- Maintain a regular sleep cycle, (establish regular sleep/wake times, avoid excess eating, smoking, or alcohol before sleep, create a proper environment for sleep, take regular physical activity)
- Regular social activity (participation in communal social activities
- Structured physical activity program (exercises)
- Recognizing thoughts of self-harm or suicide and coming back for help when these occur

- In older people, to seek help for physical health problems.
- Offer the person an opportunity to talk, preferably in a private space. Explore idea of symptoms, their concerns and their expectations.
- Ask about current psychosocial stressors and address to the extent.

Referral to Mental Health Specialists

- URGENT
  - High suicide risk
  - Severe self-neglect
  - Depression complicated by psychotic symptoms
- ROUTINE or SOON
  - Depression complicated by psychotic co-morbidity or psychosocial factors
  - Inadequate response to multiple treatments.

SSRI Discontinuation reactions

- Occur once a drug has been used ≥ 8wk.
- Usually become apparent <5days after stopping the drug.
- Reduced risk by tapering dose (4 - 6wks).
- Symptoms: GI disturbances, headache, Nausea, paraesthesia, dizziness, anxiety, tinnitus, sleep disturbances, flu like symptoms. (FINISH-See below)
- Follow-up: if patient do not attend appointments. Give patient and or Family/carers clear advice on what to do if patient's mood deteriorates and how to access urgent support, both in and out of hours.

Table. 4

FINISH: A mnemonic for discontinuation Symptoms
F – Flu-like symptoms
I – Insomnia
N – Nausea
I – Imbalance
S – Sensory disturbance
H – Hyperarousal

PERSISTENT DEPRESSIVE DISORDERS (DYSTHYMIA)

- Dysthymia is a milder, but long-lasting form of depression.
- People with this condition may also have bouts of major depression at times.
- The people with this condition may be described as having a gloomy personality, constantly complaining or incapable of having fun.
- Though persistent depressive disorder is not as severe as major depression, because of the chronic nature of persistent depressive disorder, coping with depression symptoms can be challenging,

Diagnostic criteria (DSM-5)

A. Depressed mood for most of the days, as indicated by either subjective account or observation by others, for **at least 2 years.**
(In children and adolescents, mood can be irritable and duration must be at least 1 year).
B. Presence, while depressed, of ***two (or more) of the following***:

1. **Poor appetite or overeating.**
2. **Insomnia or hypersomnia.**
3. **Low energy or fatigue.**
4. **Low self-esteem.**
5. **Poor concentration or difficulty making decisions.**
6. **Feelings of hopelessness.**

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

*Note: Criteria for a major depressive episode include four symptoms that are **absent** from the symptom list for persistent depressive disorder (dysthymia).*

Management

For adults: a combination of psychotherapy and medication can be effective.
For children and adolescents; psychotherapy may be the first line recommendation, but sometimes antidepressants are also needed.

Medications

Following antidepressants are used.

- Selective serotonin reuptake inhibitors (SSRIs)
- Tricyclic antidepressants (TCAs)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)

ANXIETY AND RELATED DISORDERS

Anxiety disorders include disorders that share features of excessive fear and, anxiety and related behavioral disturbances. *Fear* is the emotional response to real or perceived imminent threat, whereas *anxiety* is anticipation of future threat.

Classification of Anxiety Disorders (DSM-5)

- Generalized anxiety disorder
- Panic disorder
- Phobia e.g. Agoraphobia
- Social anxiety disorder
- Separation anxiety disorder
- Selective mutism

GENERALIZED ANXIETY DISORDERS

Diagnostic criteria (DSM-5)

A. Excessive anxiety and worry occurring more days than not for **at least 6 months**, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (Only one item is required in children.)
    i. Restlessness or feeling keyed up or on edge.
    ii. Being easily fatigued.
    iii. Difficulty concentrating or mind going blank.
    iv. Irritability.
    v. Muscle tension.
    vi. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (drugs, caffeine, medications) or another medical condition (e.g., hyperthyroidism, temporal lobe epilepsy) or another mental disorder (e.g., panic disorder, social anxiety disorder)

(Anxiety +3 somatic symptoms and present for 6mth)

Clinical symptoms

Can present in various ways:

- Insomnia
- poor concentration
- goose flesh
- butterflies in the stomach
- Hyperventilation
- Headache
- sweating
- palpitation
- poor appetite
- nausea
- lump in throat unrelated to swallowing
- difficulty in getting to sleep
- excessive concern about self and bodily functions
- repetitive thoughts and activities

Children's symptoms

- Thumb-sucking; nail biting, bed wetting, food fads

Associations

- Anxiety is often accompanied by ***depression, dysthymia*** and other anxiety disorders including simple phobias, social phobia and panic disorder. Also may be a feature of ***early schizophrenia.***

Assessment

- Check Thyroid Functions.
- Use GAD- 2 screening tool.
- The first two items (core anxiety symptoms) of GAD-7 screening tool (See below). 86% in sensitivity and 83% in specificity for cut-off of 3.
- **GAD-2**

  Ask:
  - Over the last 2 weeks, how often have you been bothered by the following problems?
  - Feeling nervous, anxious, or on edge
    - (0) Not At all, (1) Several Days, (2) More than half the days, (3) Nearly every day
  - Not being able to stop or control worrying
    - (0) Not At all, (1) Several Days, (2) More than half the days, (3) Nearly everyday Interpretation: 0 – 2 = Negative, 3 – 6 = GAD
  - (< 3 and still suspicious 7 Ask *"Do you find yourself avoiding places or activities and does this cause you problems?" If the answer is* **yes, Consider anxiety disorder.)**

GAD-7 Scale

- The GAD-seven scale works by measuring the severity of anxiety symptoms.
- It is administered at the beginning of treatment to get a baseline measure of anxiety symptoms.
- It can then be given periodically throughout treatment to track changes in anxiety levels.

Table. . Generalized Anxiety Disorder-7

Generalized Anxiety Disorder-7 Scale				
Over the last 2 weeks, how often have you been bothered by the following problems? (Use – to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful mght happen	0	1	2	3
For office coding: Total Score	( )	( )	( )	( )

Scoring instructions

Scores of 5, 10 and 15 are taken as the cutoff points for mild, moderate and severe anxiety respectively.

0-4: Minimal anxiety 5-9: Mild anxiety

10-14: Moderate anxiety 15-21: Severe anxiety

Management of GAD

- Avoid caffeine, excess alcohol, and illicit drugs
- Use a stepped treatment approach

Stepped Treatment Approach

Step 1. Identification and assessment, education and active monitoring Symptom control:

- Listening is a good way to reduce anxiety.
- Explain that headache is not from tumor, and that palpitations are harmless. Anything done to enrich patient's relationship with others may well help.
- Regular exercise
- CBT and relaxation appear to be the best specific measures with 50-60% recovering over 6 months.

Step 2. Offer low intensity psychological interventions

- Individual non-facilitated self-help (self-administered intervention intended to treat GAD involved a self-help resource, e.g. book or workbook), individual guided, Self – help, psycho educational groups

Step 3. Offer high intensity psychological intervention

- (e.g. CBT, Applied relaxation and/or drug treatment)

Step 4. Offer referral for specialist treatment

Step 1 and 2 = ***Normally primary care***
Step 3 = ***Normally primary care with review every 2-4 weeks in the first 3 months then every 3 months thereafter.***
Step 4 = ***Normally in specialist service, secondary care will initiate treatment and primary care will continue.***

Drug Treatment

SSRI and SNRI are recommended as first-line treatment for GAD (Strength of Recommendation A)

- SSRI (sertraline 50 to 150mg od, escitalopram 5-20 mg od)
- SNRI (venlafaxine 37.5 to 225mg od /day)
- caution: <30yr-increased suicidal thought in 1wk
- Follow up <**1**wk, weekly for 1 month
- If drug treatment is effective, continue for 6 to 12 months after achieving treatment response to reduce the rate of relapse. (SOR B)
- If no benefit, consider alternative SSRI/ SNRI or add a psychological therapy
- Pregabalin is an option if unable to tolerate.
- Do not offer antipsychotic medication.
- Avoid benzodiazepines to use as first-line therapy (SOR B) except for acute crises; restrict use to <4wk due to potential for dependence.
- Psychotherapy is as effective as medication for GAD (SOR A)
- Physical activity reduces symptoms of anxiety (SOR B)

Referral

- If severe anxiety with marked functional impairment and
- Risk of self-harm/suicide
- Significant co-morbidity (e.g. Substance misuse, personality disorder or complex physical health problems)
- Self-neglect
- Inadequate response to drug treatment

PANIC DISORDERS

DSM-5 Criteria for PANIC DISORDER

- Experiencing of **recurrent panic attacks**, with 1 or more attacks, followed by at least 1 month of fear of another panic attack or significant maladaptive behavior related to the attacks which often includes avoiding situations that might induce an attack.
- A **panic attack** is an abrupt period of intense fear or discomfort accompanied by 4 or more of the following 13 systemic symptoms:
    - Palpitations, pounding heart, or accelerated heart rate
    - Sweating
    - Trembling or shaking
    - Shortness of breath or feeling of smothering
    - Feelings of choking
    - Chest pain or discomfort
    - Nausea or abdominal distress
    - Feeling dizzy, unsteady, lightheaded, or faint
    - Chills or heat sensations
    - Paresthesias (ie, numbness or tingling sensations)
    - Derealization (ie, feeling of unreality) or depersonalization (ie, being detached from oneself)
    - Fear of losing control or going crazy
    - Fear of dying

Association

- Depression (56%), GAD, agoraphobia, substance misuse, suicide

Differential Diagnosis of PANIC DISORDER

- Social phobia or another specific (simple) phobia, OCD, PTSD or separation anxiety disorder.
- Alcohol withdrawal,
- drug misuse/withdrawal,
- other psychiatric disorders (e.g. psychosis),
- hyperthyroidism,
- temporal lobe epilepsy,
- cardiac arrhythmia,
- labyrinthitis,
- hypoglycaemia,
- hyperparathyroidism,
- pheochromocytoma.

Management of Acute Panic Attack (See above in Psychiatric Emergency)

Management of Panic Disorder

Psychotherapy

- Psychotherapy can be as effective as medication for panic disorder. Cognitive behavior has the best level of evidence (SOR A)
- The aim is to **help** the patient **understand panic attacks and panic disorder and learn how to cope with them**.

Medication

- Selective serotonin reuptake inhibitors are considered first-line therapy for panic disorder (SOR B)
- To avoid relapse, medication should be **continued for 12 months** after symptoms improve before tapering. (SOR C)
- Physical activity is a cost-effective treatment for panic disorder. (SOR B)
- Benzodiazepines can be used as augmentation, but only for short term because they are associated with tolerance. (SOR B)

OBSESSIVE COMPULSIVE AND RELATED DISORDERS

- Obsessive Compulsive Disorder
- Body Dysmorphic Disorder
- Trichotillomania
- Excoriation Disorder
- Hoarding Disorder

OBSESSIVE-COMPULSIVE DISORDERS

- Obsessive-compulsive disorder (OCD) is a chronic illness that can cause marked distress and disability.
- It is a complex disorder with a variety of manifestations and symptom dimensions, some of which are under recognized.
- Early recognition and treatment with OCD-specific therapies may improve outcomes, but there is often a delay in diagnosis. (The average time it takes to receive treatment after meeting diagnostic criteria is 11 years)

Table 6. Common Symptoms in Patients with OCD

Obsession	Examples	Associated compulsive behaviour
Aggressive	Fear of harming others, recurrent violent images	Monitoring the news for reports of violent crimes, asking for reassurance about being a good person
Contamination	Fear of being contaminated or contaminating others: • fear of being contaminated by germs, infections, or environmental factors, • fear of being contaminated by bad or immoral persons	Washing or cleaning rituals
Pathologic doubt, completeness	Recurrent worries about doing things incorrectly or incompletely, thereby negatively affecting the patient or others	Checking excessively, performing actions in a particular order
Religious	Thoughts about being immoral and eternal damnation	Asking forgiveness, praying, reassurance seeking
Self-control	Fear of making inappropriate comments in public	Avoiding being around others
Sexual	Recurrent thoughts about being a pedophile or sexually deviant, recurrent thoughts about acting sexually inappropriate toward others	Avoiding situations that trigger the thoughts, performing mental rituals to counteract the thoughts
Superstition	Fears of certain “bad” numbers or colours	Counting excessively
Symmetry and exactness	Recurrent thoughts of needing to do things in a balanced or exact fashion	Ordering and arranging

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Diagnosis

- Physicians should consider the possibility of OCD in patients with general complaints of anxiety or depression with additional clues such as alluding to intrusive thoughts or repetitive behaviors,

avoidance of particular locations or objects, excessive concerns about illness or injury, and repetitive reassurance-seeking behavior.

- If OCD is suspected, the use of simple initial screening questions (see below) can be helpful for primary care physicians.

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you would like to get rid of but cannot?
- Do your daily activities take a long time to finish"
- Are you concerned about putting things in a special order, or are you very upset by mess?
- Do these problems trouble you?
- *Note: If a person answers "yes" to any of these questions and the symptom causes distress, a diagnostic interview or patient symptom inventory should be administered*

Table 7. OCD Initial Screening Questions

Am Fam Physician. 2015;92(10):896-903

- The diagnosis of OCD should be confirmed with DSM-5 criteria or through psychiatric referral.

Comorbidities

The most common psychiatric comorbidities of OCD are:

- **Anxiety disorders** (75.8%), including panic disorder, social phobia, other specific phobias and PTSD
- **Mood disorders** (63.3%) including major depressive disorder (40.7%), impulse control disorders (55.9%) and substance use disorders (38.6%).

Management

- Patients with OCD should be monitored for psychiatric comorbidities and suicide risk. (Strength of Recommendation C).
- Cognitive behavior therapy, specifically exposure and response prevention, is the most effective psychotherapy method for treating OCD. (SOR A)
- SSRIs are recommended as first-line pharmacologic therapy for OCD. (SOR A)
- Fluoxetine, fluvoxamine, paroxetine, and sertraline have been approved for the treatment of OCD. There are dose limitations for citalopram because of concerns about QT prolongation.
- A trial of SSRI therapy should continue for 8 to 12 weeks, with at least 4 to 6 weeks at the maximal tolerable dosage. (SOR C)
- Patients with OCD require a higher dosage of an SSRI compared with other indications.
- Indefinite SSRI therapy should be considered to prevent OCD relapse. At a minimum, SSRIs should be continued for 1 to 2 years before attempting to discontinue. (SOR C)
- Augmenting SSRI therapy with an atypical antipsychotic is effective in some patients with OCD who have inadequate response to SSRI therapy. (SOR B)

(Table 8) Obsessive-Compulsive–Related Disorders

Disorder	Diagnostic criteria	Clinical features	Preferred treatment
Body dysmorphic disorder	Preoccupation with perceived defects or flaws in physical appearance that leads to repetitive behaviors or mental acts in response to the apparent concerns	Poor insight Seeks care from dermatologists and cosmetic surgeons to address perceived defects Symptom onset during adolescence Waxing and waning course	Cognitive behavior therapy (exposure and response prevention) Some SOR for SSRIs

Excoriation (skin-picking) disorder	Recurrent skin picking resulting in skin lesions Repeated attempts to decrease or stop skin picking	More common in females Symptom onset at the beginning of puberty	Habit reversal therapy Limited studies evaluating response to pharmacotherapy
Hoarding disorder	Persistent difficulty discarding or parting with possessions because of strong urges to save items and/or distress with discarding items Accumulation of possessions to a degree that the space where possessions accumulate cannot be used as intended	75% of patients with hoarding disorder have comorbid mood or anxiety disorders The hoarding causes significant distress or impairment in function Symptom onset between 11 and 15 years of age, equally in men & women Symptoms or hoarding behaviors progressively worsen	Behavior therapy targeted toward removal of hoarded items and reduction in accumulation of new items No data to support pharmacotherapy
Trichotillomania (hair-pulling disorder)	Recurrent pulling of hair from any part of the body resulting in hair loss Repeated attempts to decrease or stop hair pulling	More common in females Symptom onset at the beginning of puberty	Habit reversal therapy Mixed to poor response to SSRIs

TRAUMA AND STRESSOR RELATED DISORDERS

- Acute Stress Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Adjustment Disorder
- Reactive attachment disorder
- Disinhibited social engagement disorder

ACUTE STRESS DISORDER

Diagnostic criteria (dsm5)

- **A.** The significant symptoms of acute stress begin after RECENT (within approximately one month) exposure to actual or threatened death, serious injury, or sexual violation in one (or more) by directly experiencing or witnessing the events or learning from a close family member or a close friend.
- **B.** Presence of nine (or more) of the following symptoms from any of the five categories.
    - *Intrusion symptoms* – recurrent distressing memories or dreams, dissociative reactions (e.g. flash backs).
    - *Negative mood* –inability to experience to positive emotions
    - *Dissociative symptoms* - seeing oneself from another's perspective, dissociative amnesia
    - *Avoidance symptoms*- efforts to avoid distressing memories or thoughts or external reminders.
    - *Arousal symptoms*- sleep disturbance, irritable behavior and angry outbursts, hypervigilance, problems with concentration
- **C.** Symptoms typically begin immediately after the trauma, but persistence for at least **3 days and up to a month.**

Management

- Psychological first aid.
- Listen, DO NOT pressure the person to talk
- Assess needs and concerns
- Help the person to address immediate basic physical needs (e.g. shelter)
- Help people connect to services, family, social supports, and accurate information
- As far as possible, help protect the person from further harm
- Assess for current stressors and/or ongoing abuse
- Consider stress management; Breathing exercises, Progressive muscle relaxation
- Help people to identify and strengthen positive coping methods and social support
- Do not prescribe benzodiazepines or antidepressants for acute stress symptoms
- Ask the person to return if the symptoms become more severe or no improvement by one month after the event. (To assess for PTSD)

Ref: mhGAP Intervention Guide Module

POST-TRAUMATIC STRESS DISORDER (PTSD)

- May occur in 25-30% of those who have experienced/witnessed an actual or threatened death, serious injury, or sexual violence **at least a month ago** e.g. major accident, fire, assault, military combat, natural disasters (e.g. cyclone, earthquake), rape.

Symptoms

- **Re-experiencing (Intrusion) symptoms**; repeated and unwanted recollections of the event as though occurring in the here and now (e.g. frightening dreams, flashbacks or intrusive

memories accompanied by intense fear or horror)

- **Avoidance symptoms;** deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event
- **Hyperarousal symptoms-** related to a sense of heightened current threat; hypervigilance or exaggerated startle responses

Associations

- Depression
- Anxiety
- Drug/alcohol abuse and dependence

Diagnosis

A person is likely to have **PTSD** if she/he meets **all of the** following criteria:

- Has experienced a potentially traumatic event at least a month ago
- Has at least one re-experiencing symptom
  and
  One avoidance symptom
  and
  One hyper-arousal symptom
- Has difficulties in day-to-day functioning

Management

- Assess for and if possible, address current stressors and/or ongoing abuse
- Offer psychoeducation
- Explain the course of symptoms – beginning of some stress-related reactions in the first few days to weeks, symptoms of PTSD after one month and many people recover from PTSD over time without treatment. However, treatment may speed up the recovery process.
- Explain the nature of PTSD – easily startled(jumpy) and constantly on the watch for danger; unwanted recollections of the event (re-experiencing symptoms); trying to avoid any reminders of the event and which can cause problems in their lives (e.g. going to work); trying to avoid thinking about something usually results in thinking about it more; may sometimes have concurrent problems like aches and pains, low energy, irritability and depressed mood.
- Explain that the effective treatment is available – but likely to take several weeks to reduce the symptoms
- If trained therapists are available, consider referral for cognitive behavioral therapy with a trauma focus (CBT-T), or Eye Movement Desensitization and Reprocessing (EMDR)
- Consider stress management (see 10-tips for chronic stress relief below)
- Help people to identify and strengthen positive coping methods (ask them what is going well. How do they keep going? How have they previously coped with hardship?) and social support (identify people who give emotional support- Hand technique)
- Encourage resumption of social activities and normal routine
- In adults, consider antidepressants when stress management, CBT-T and EMDR prove ineffective or are unavailable.
- To recognize the thoughts of suicide and come back for help when these occur

Refer

- If severe acute stress symptoms <4wk or ongoing intrusive symptoms >4wk after trauma which require advanced psychological interventions such as CBT-T or EMDR

Self-help Stress Management Strategies

10 tips for chronic stress relief

1. Ensure you get enough sleep and rest–avoid using sleeping tablets to achieve this
2. Look after yourself and your own health, e.g. don't skip meals, sit down to eat, take time out to spend time with family and friends, make time for hobbies and relaxation, do not ignore health worries.
3. Avoid using nicotine, alcohol, or caffeine as a means of stress relief
4. Work off stress with physical exercise -reduce levels of adrenaline release and increase release of natural endorphins which increase a sense of well-being and enhanced sleep
5. Try relaxation techniques; breathing exercises, progressive muscle relaxation
6. Avoid interpersonal conflicts - try to agree more and be more tolerant
7. Learn to accept what you can't change
8. Learn to say 'no'
9. Manage your time better -prioritize and delegate; create time buffers to deal with unexpected overruns and emergencies
10. Try to sort out the cause of the stress, e.g. talk to line manager at work, arrange marriage or debt counseling, arrange more childcare

Time management made easy;

- This technique aims to transform and overwhelming volume of work into a series of manageable tasks.
- Make a list of all the things you need to do
- List them in order of genuine importance
- Note whether you really need to do the tasks, what you need to do personally, and what can be delegated to others
- Note a timescale in which each task needs to be done, e.g. immediately, within a day, within a week, within a month, etc.

SOMATIC SYMPTOM AND RELATED DISORDERS

Classification (DSM-5)

- Somatic symptom disorder
- Conversion disorder (functional neurological symptom disorder)
- Psychological factors affecting other medical conditions
- Factitious disorder
- Other specified somatic symptom and related disorder
- Unspecified somatic symptom and related disorder.
- All of the disorders in this category share a common feature: **the prominence of somatic symptoms associated with significant distress and impairment.**

Individuals with disorders with prominent somatic symptoms are commonly encountered in primary care and other medical settings but are less commonly encountered in psychiatric and other mental health settings.

- These disorders should be considered early in the evaluation of patients with unexplained symptoms to prevent unnecessary interventions and testing.
- Treatment success can be enhanced by:
    - discussing the possibility of a somatic symptom and related disorder with the patient early in the evaluation process
    - limiting unnecessary diagnostic and medical treatments
    - focusing on the management of the disorder rather than its cure
    - using appropriate medications and psychotherapy for comorbidities
    - maintaining a psycho-educational and collaborative relationship with patients and
    - referring patients to mental health professionals when appropriate.
- The unexplained symptoms of somatic symptom disorders often lead to general health anxiety; more frequent office visits, unnecessary laboratory or imaging tests, or costly and potentially dangerous invasive procedures.
- The main feature of these disorders is a concern with physical symptoms that are attributed to a nonpsychiatric disease. This concern can manifest as one or more somatic symptoms that result in excessive thoughts, feelings, or behaviors related to those symptoms and that are distressing or result in significant disruption of daily life.

Table 9. SORT: Key Recommendation for practice

Clinical Recommendation	*SOR Rating*	*Comments*
Fostering a strong physician-patient relationship is integral to managing somatic symptom and related disorders.	C	Recommendations from clinical practice settings
Cognitive behavior therapy is effective in treating patients with somatic symptom related disorders.	B	Consistent findings from randomized controlled trials
Psychiatric consultation helps improve the effects of somatic symptom related disorders.	B	Consistent findings from randomized controlled trials

Diagnosis

- The challenge in working with somatic symptom disorders in the primary care setting is to simultaneously exclude medical causes for physical symptoms while considering a mental health diagnosis.
- There are no specific physical examination findings or laboratory data that are helpful in confirming these disorders; it often is the lack of any physical or laboratory findings to explain the patient's excessive preoccupation with somatic symptoms that initially prompts the physician to consider the diagnosis.

Diagnostic Criteria

- One of the following criteria must be present:
  - Significant thoughts about the seriousness of the symptoms;
  - A high level of anxiety about the symptoms; or
  - Excessive energy spent regarding symptomatic concern.
- Although somatic symptoms need not be continuously present, they must be persistent (present for **more than six months**).
- Two specifiers of this condition in the DSM-5 are “with predominant pain” and “persistent.”
- Somatic symptom disorders can be mild, moderate, or severe.
- ***Note: Malingering** must be excluded before diagnosing a somatic symptom disorder.*
  - **Malingering:** the purposeful feigning of physical symptoms for external gain (e.g., financial or legal benefit, avoidance of undesired situations).
- **In somatic symptom disorders,** there are **no obvious gains or incentives** for the patient, and the physical symptoms are not willfully adopted or feigned; rather, anxiety and fear facilitate the initiation, exacerbation, and maintenance of these disorders.
- One screening tool is used in primary care settings, the Patient Health Questionnaire (PHQ 15), to screen somatic symptom disorders.

Table 10

The Patient Health Questionnaire - 15			
During the past four weeks, how much have you been bothered by the following symptoms?			
Symptoms	**Not at all**	**A little**	**A lot**
Back pain	0	1	2
Chest pain	0	1	2
Constipation, loose bowels, or diarrhoea	0	1	2
Dizziness	0	1	2
Fainting	0	1	2
Feeling tired or having low energy	0	1	2
Feeling your heart pound or race	0	1	2
Headache	0	1	2
Menstrual cramps or other problems with your periods (women only)	0	1	2
Nausea, gas, ir indigestion	0	1	2
Pain in your arms, legs, or joints	0	1	2
Pain or problems during sexual intercourse	0	1	2
Shortness of breath	0	1	2
Stomach pain	0	1	2
Trouble sleeping	0	1	2

The more recently developed Somatic Symptom Scale-8 (*Table 11*) shows promise in measuring somatic symptom burden. A study determines it is a reliable and valid self-report measure of somatic symptom burden.

Table 11: The Somatic Symptom Scale-8

Somatic Symptom Scale - 8					
During the past four weeks, how much have you been bothered by the following symptoms?					
Symptoms	**Not at all**	**A little bit**	**Some what**	**Quite a bit**	**Very much**
Back pain	0	1	2	3	4
Chest pain	0	1	2	3	4
Dizziness	0	1	2	3	4
Feeling tired or low energy	0	1	2	3	4
Headache	0	1	2	3	4
Pain in your arms, legs, or joints	0	1	2	3	4
Stomach and Bowel problems	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Score = ( )					
Scoring: Non to minimal (0-3), low (4-7), medium (8-11), high (12-15), very high (16-32)					

SOMATIC SYMPTOM RELATED DISORDERS

Table 12. Subsets of Somatic Symptom Disorder

Subset	Description
Conversion disorder	One or more symptoms of altered voluntary motor or sensory function inconsistent with a known condition. The symptoms typically do not conform to known anatomic pathways or physiologic mechanisms (Pseudo-neurologic).
Factitious disorder	Falsification of physical or psychological symptoms, or induced injury or disease; can be with regard to self or imposed on others, although not for personal gain (as with malingering)
Illness anxiety disorder	Preoccupation with getting or having a serious medical disorder; the two types include care-seeking and care-avoidant; previously included in **hypochondriasis.**
Psychological factors affecting other medical conditions	A medical condition must exist, and psychological factors must negatively affect the condition
Other specified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but do not meet full criteria for any of the above disorders (e.g. Pseudocyesis)
Unspecified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but do not meet criteria for any of the above disorders; should be used only when there is insufficient information to make a more specific diagnosis. (e.g. chronic fatigue which cannot be fully explained by a known medical condition)

Pain disorder, which was previously included in DSM-IV TR is removed in DSM-5. Which should be diagnosed as ‘somatic symptom disorder with predominant pain’ or ‘psychological factors affecting other medical condition' or an ‘adjustment disorder’ appropriately.

Differentia diagnosis

- Depression,
- Panic disorder
- Generalized anxiety disorder,

- Substance use disorder,
- Syndromes of unclear etiology (e.g. Nonmalignant pain syndrome, chronic fatigue syndrome), and
- Non-psychiatric medical conditions.

Management

- The management of somatic symptom disorders requires a multifaceted approach tailored to the individual patient.
- The primary care clinicians should keep in mind psychological, social, and cultural factors that influence somatic symptoms to choose the correct treatment plan.
- General treatment tenets for the primary care clinician include:
    - scheduling regular, short-interval visits to avoid the need for symptoms to get an appointment
    - establishing a collaborative, therapeutic alliance with the patient
    - acknowledging and legitimizing symptoms once the patient has been evaluated for other medical and psychiatric diseases
    - limiting diagnostic testing and reassuring the patient that serious medical diseases have been ruled out
    - educating patients about coping with physical symptoms
    - setting a treatment goal of functional improvement rather than cure
    - appropriately referring patients to subspecialists and mental health professionals.
- CARE MD treatment approach was developed to help primary care clinicians work more effectively with patients who have somatic symptom disorder. (See below)

Table 13: CARE MD Approach to Somatic Symptom Disorder

Component	Description
Consultation (psychiatry or cognitive behaviour therapy	Consult and collaborate with mental health professionals
Assessment	Evaluate for other medical and psychiatric diseases
Regular visits	Schedule short-interval follow-up to stop overuse of medical care (e.g., inappropriate emergency department visit, excessive calls) and avoid the need for symptoms to get an appointment; stress coping rather than cure
Empathy	Spend most of the time listening to the patient and acknowledge that what he or she is feeling is real
Medical-psychiatric interface	Emphasize the mind-body connection; avoid comments such as “there is nothing medically wrong with you”
Do no harm	Limit diagnostic testing and referrals to subspecialist; reassure the patient that serious medical diseases have been ruled out

Cognitive Behavioral Therapy

- *SOR: multicenter RCT, reviews of controlled clinical show;*
    - Effective for treatment of somatic symptom disorder and medically unexplained symptoms.
    - “Health anxious” patients had sustained symptomatic benefit over two years, with no significant effect on total costs.
    - Reduced physical symptoms, psychological distress, and disability.

Mindfulness-Based Therapy

- *SOR: Meta-analysis of RCTs show;*
    - May be effective in treating some aspects of somatic symptom disorder
    - Significant and sustained improvements in clinical outcomes (overall symptom severity, depression, and anxiety) compared with control groups

Pharmacotherapy

- *SOR: Systematic reviews of controlled trials show;*
  - Amitriptyline shows benefit for one or more of the following outcomes: fatigue, functional symptoms, global improvement, morning stiffness, pain, sleep, and tender points.
  - Fluoxetine (Prozac) shows benefit for functional status, global well-being, morning stiffness, pain, sleep, and tender points
  - Monoamine oxidase inhibitors, bupropion (Wellbutrin), antiepileptics, and antipsychotics showed no benefit and should not be used.

St. John's Wort

- *SOR: Randomized, double-blind, placebo-controlled trials (lower-quality studies) show;*
  - More effective than placebo for improvement in self-reported somatic symptoms;
  - Well-tolerated and safe

A strong, positive relationship between the physician and the patient is essential and should be coupled with frequent, supportive visits, while avoiding the temptation to medicate or test when these interventions are not clearly indicated.

Considering referral

- Collaboration with a psychiatrist or other mental health professional may help with the subtleties between these disorders and their psychiatric comorbidities, the severity of disorders, and improvements in symptom severity, social functioning, and health care use when multiple interventions are employed.
- Avoiding confrontation
- Avoid unnecessary medical tests and specialty referrals, and be cautious when pursuing new symptoms with new tests and referrals
- Focus treatment on function, not symptom, and on management of the disorder, not cure
- Address lifestyle modifications and stress reduction, and include the patient's family if appropriate and possible
- Treat comorbid psychiatric disorders with appropriate interventions
- Use medications sparingly and always for an identified cause
- Schedule regular, brief follow-up office visits with the patient (five minutes each month may be sufficient) to provide attention and reassurance while limiting frequent telephone calls and "urgent" visits
- Collaborate with mental health professionals as necessary to assist with the initial diagnosis or to provide treatment

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ALCOHOL USE DISORDER

- Alcohol misuse is **a major public health and social concern for Myanmar**.
- The readily available cheap alcohol has created a national problem for Myanmar's underfunded public health system.
- Per capita consumption (liters of pure alcohol per person ages 15+ per year) is increasing, from 2.9L in 2010 to 4.8L in 2016.
- Excessive drinkers with noticeable social, physical and psychological problems are supposed to require medical treatment.

Spectrum of Alcohol Use Disorder

- Acute intoxication/ Binge drinking
- Risky drinking or hazardous alcohol use
- Alcohol dependence
- Chronic dependence

Diagnostic Criteria for Alcohol Use Disorder (DSM-5)

■ A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for alcohol.
  - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

ALCOHOL ACUTE INTOXICATION

- The degree of intoxication is determined by the amount of alcohol ingested, the duration of the ingestion, and the patient's tolerance.
- Usually after consuming **4 or more drinks** (female), or **5 or more drinks** (male) **in about 2 hours.**

Table. 14. Blood alcohol level and clinical symptoms

At the level of:	Clinical Symptoms
20 mg/dL	mild euphoria, mild impairment of coordination, and mood alterations
20 - 80 mg/dL	generally accepted as an unsafe level for motor vehicle operation
80 - 100 mg/dL	delayed reaction times and slurred speech
100 - 200 mg/dL	ataxia, grossly slurred speech, and incoordination occur
>400 mg/dL	coma, respiratory depression, hypothermia, and death

Diagnostic Criteria of ALCOHOL INTOXICATION (DSM-5)

A. Recent ingestion of alcohol.

B. Clinically significant problematic behavioral or psychological changes (e.g. inappropriate sexual or aggressive behavior, mood lability, impaired judgement) that developed during, or shortly after, alcohol ingestion.

C. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use:

1. Slurred speech.
2. Incoordination.
3. Unsteady gait.
4. Nystagmus.
5. Impairment in attention or memory.
6. Stupor or coma.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Management

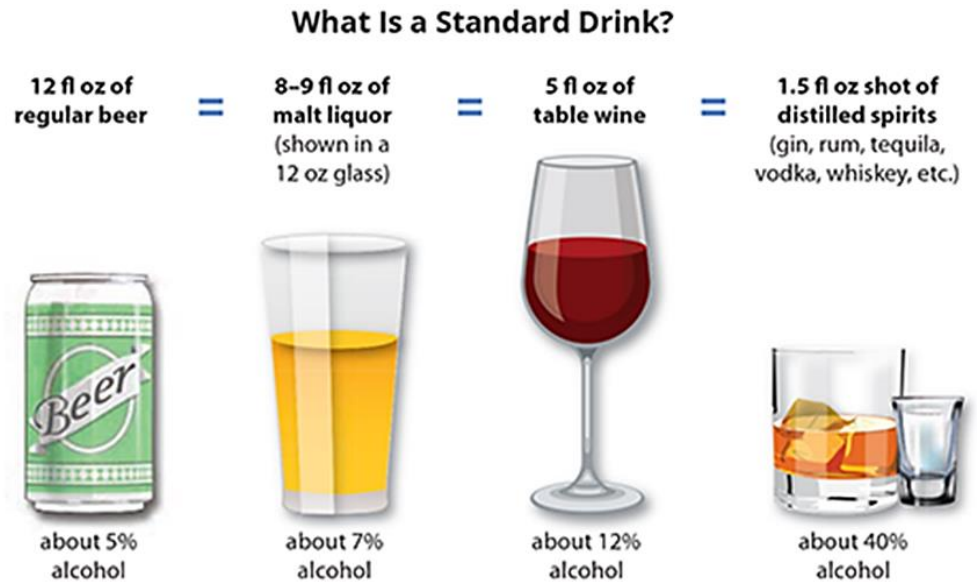
- Protecting the airway, keep in left lateral position
- Careful monitoring of vital signs.
- Performing basic resuscitation, if necessary.
- The patient should be placed in a warm protective environment.
- Thiamine and glucose should always be administered. (Chronic alcoholism is associated with hypoglycemia and thiamine deficient states)
- Refer to hospital if necessary.
- If methanol poisoning is suspected, refer to hospital for emergency management.
- Should look for additional drug use (consider urine toxicology screen)

RISKY ALCOHOL USE (AT-RISK USE)

- Exceeding the recommended limits of:
  - ***For all women and men 65 years or older: No more than 3 drinks per day and no more than 7 drinks per week***
  - ***For men (21 to 64 years): No more than 4 drinks per day and no more than 14 drinks per week***

(NIAA = National Institute on Alcohol Abuse and Alcoholism)

Fig. 3. Standard Drink



1 Unit = one small glass of wine = one half pint of beer = 25ml of 40% alcohol Myanmar unit one peg (တပတ်) = 62.5 ml = 2.5 Unit

HAZARDOUS USE

A pattern of substance use that increases the risk of harmful consequences; in contrast to harmful use, hazardous use refers to patterns of use that are of **public health significance**, despite the absence of a current alcohol use disorder in the individual user. (WHO)

HARMFUL USE

A pattern of drinking that is already causing damage to health; the damage may be either physical (e.g., liver damage from chronic drinking) or mental (e.g., depressive episodes secondary to drinking) (WHO)

UNHEALTHY USE

Either hazardous use or harmful use. {American Society of Addiction Medicine (ASAM)}
Any alcohol use is considered unhealthy in pregnant women and adolescents.

SCREENING FOR UNHEALTHY ALCOHOL USE

- The USPSTF recommends screening for **unhealthy alcohol use in primary care settings** in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with **brief behavioral counseling interventions** to reduce unhealthy alcohol use. (SOR B)
- Of the available screening tools, the USPSTF determined that 1-item to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults 18 years or older.

Single alcohol screening question (sasq)

The SASQ is a 1-item screening instrument. It has adequate sensitivity and specificity across the unhealthy alcohol use spectrum and requires less than 1 minute to administer.

Single Alcohol Screening Question

How many times in the past year have you had five (for men<65) or four (for women and all adults older than 65 years) or more drinks in a day?

An answer of one or more is considered a positive screen
Sn= 73-88%, Sp=74-100%

Table 15. Alcohol Use Disorder Identification Test-Consumption (AUDIT-C)

Questions	0	1	2	3	4	Score
1. *How often do you have a drink containing alcohol:*	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. *How many drinks containing alcohol do you have on a typical day when you are drinking?*	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. *How often do you have six or more drinks on one occasion?*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

- *0-3 Low-risk drinking (advise no use)*
- *4-5 Moderate-risk drinking (advise no use and provide brief counseling intervention or consider referral to a specialist addiction service)*
- *≥6 High-risk drinking (definite referral to a specialist addiction service)*
- *Sn=74%, Sp=83%*

CAGE Questionnaire

1. *Ever felt ought to **C**ut down on your drinking?*
2. *Have people **a**nnoyed you by criticizing your drinking?*
3. *Ever felt bad or **g**uilty about your drinking?*
4. *Ever had an **e**ye-opener to steady nerves in the morning?*

- **2** or more "**yes**" means Dependency.
- Although the **CAGE** questionnaire is easy and widely used screening tool for alcohol dependency in primary care, its accuracy varies in ambulatory setting. It detects **only alcohol dependence** rather than the full spectrum of unhealthy alcohol use.
- (Sensitivity 91%, Specificity 87.8% for alcohol dependence and 87.5% and 80.9% for alcohol misuse)

Interventions

- Primary care settings often used the **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (**SBIRT**) approach.
- Brief (five- to 10-minute) multi-contact counseling interventions seem to have the best SOR of effectiveness.
- A recent meta-analysis found that brief interventions reduced unhealthy alcohol use with a decrease of 1.6 drinks per week.
- Counseling interventions include personalized **normative feedback**.
  - Discussing the patient's alcohol use compared with national norms.
  - patient-specific adverse alcohol effects, and
  - mutual agreements to specific drinking amounts
- Personalized normative feedback was often combined with motivational interviewing or more extensive cognitive behavioral counseling.
- **Other cognitive behavioral strategies** frequently used:
  - Drinking diaries

- Action plans
- Alcohol use “prescriptions”
- Stress management
- Problem-solving

ALCOHOL DEPENDENCE (AD)

- DSM5 combines alcohol abuse and dependence into a single Alcohol Use Disorder; mild, moderate and severe.
- AD is at the moderate to severe spectrum of alcohol use disorder.

Screening alcohol dependence:

- AUDIT-C score ≥6
- CAGE score ≥2

Treatment of AD

- Alcohol dependent patients are appropriate to refer to the treatment center to provide:
- Detoxification
- Medical treatment (See below)
- Professional rehab or counseling
- Self-help group support

Counseling and Rehabilitation

- State clearly the results of the assessment and explain both the short-term risks of continuing use at the current level.
- Have a short discussion about the person's motivations for their alcohol use (not having alcohol at home, not going to pubs)
- Motivate complete cessation of alcohol.
- Advise daily consumption of thiamine 100mg.
- **If the person is willing to stop using alcohol,**
  - facilitate alcohol cessation.
  - Determine the appropriate setting to cease alcohol.
  - Set a definite day to quit
  - Plan the cessation of alcohol.
  - Discuss correct way to avoid or cope with high risk situation for relapse drinking
  - Make specific plans to avoid drinking. eg how to respond invitation for drinking
  - Discuss with family members for support, encouragement and understanding of patient's behavior during detoxification
  - Arrange detoxification if necessary
- **For those not willing to stop now,**
  - do not reject or blame
  - Try to motivate the patient to take treatment
- **For those who brought by relatives to stop drinking,**
  - Discuss about problems related to alcohol consumption
  - Try to motivate the patient to take treatment
  - If the patient agrees to take treatment, follow the line for those willing to stop now

ALCOHOL WITHDRAWAL SYNDROME (AWS)

- The patients who have alcohol dependence are at risk of developing alcohol withdrawal syndrome if they abruptly abstain from alcohol use.
- Alcohol withdrawal syndrome begins six to 24 hours after the last intake of alcohol or even 6 days after.

- Alcohol withdrawal also occurs following cessation of heavy alcohol consumption for >2 weeks.
- Alcohol withdrawal affects the central nervous system, autonomic nervous system, and cognitive function.
- If AWS is not treated or is undertreated, delirium tremens can occur. This condition is a severe hyperadrenergic state and life threatening.

Table. 16. Stages of Alcohol Withdrawal Syndrome

Stage	Symptoms
1.Mild	Anxiety, tremor, insomnia, headache, palpitations, gastrointestinal disturbances
2. Moderate	Mild symptoms + diaphoresis, increased systolic blood pressure, tachypnea, tachycardia, confusion, mild hyperthermia
3.Delirium tremens	Moderate symptoms + disorientation, impaired attention, visual and/or auditory hallucinations, seizures

LOOK FOR

- Tremor in hands
- Sweating
- Vomiting
- Increased pulse and blood pressure
- Agitation

ASK ABOUT

- Headache
- Profound insomnia
- Transient illusion and hallucination, e.g. insects crawling under the skin
- Nausea
- Anxiety
- Seizures and confusion may occur in severe cases.
- Past episodes of severe alcohol withdrawal including delirium and seizures. Other medical or psychiatric problems or benzodiazepine dependence.

Treatment of AWS

Treatment Goals:

- To reduce withdrawal symptoms
- To prevent seizures, delirium tremens, and death
- To prepare the patient for long-term abstinence from alcohol use.

Treat where?

- Outpatient treatment is appropriate in patients with mild or moderate AWS, if there are no contraindications (SOR C)
- Patients who have not had alcohol in at least five days may also receive outpatient treatment.
- The self-completed,10-item SAWS (Short Alcohol Withdrawal Scale) has been validated in the outpatient setting to assess the severity and decide where to treat.

Table.17

Short Alcohol Withdrawal Scale (SAWS)				
Item	None (0 point)	Mild (1 point)	Moderate (2 points)	Severe (3 points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

Patients indicate how they have felt in the past 24 hours.
Mild AWS <12 points; Moderate to severe AWS ≥12 points. (Consider hospital treatment if >12)

Contraindications to Outpatient Treatment (HOME DETOX) of AWS

- Abnormal laboratory results
- Absence of a support network (Physician's expertise, family)
- Acute illness
- High risk of delirium tremens
- History of a withdrawal seizure
- Long-term intake of large amounts of alcohol
- Poorly controlled chronic medical conditions (e.g., diabetes mellitus, COPD, CHF)
- Serious psychiatric conditions (e.g., suicidal ideation, psychosis)
- Severe alcohol withdrawal symptoms (SAWS >12)
- Urine drug screen positive for other substances

General Management of AWS & Detoxication

- Nursing care
- Frequent monitoring of vital signs, mostly daily
- Correct fluid and electrolytes requirements. (typically K+, Mg++)
- Treat immediately with diazepam (Benzodiazepines)
- Take precaution in liver failure and older patients

Medications

- Thiamine (100- 300mg daily) and folic acid (1 mg daily)
- (Thiamine supplementation lowers the risk of Wernicke encephalopathy)
- Long-acting benzodiazepines (diazepam, chlordiazepoxide) should be administered early to reduce psychomotor agitation.
- Intermediate-acting BD (lorazepam, oxazepam) are safer for patients with hepatic dysfunction and older patients.

Table. 18: Benzodiazepine Regimen for Alcohol Detoxication (Moderate Dependence)

Day	Morning	Noon	Evening	Night	Total Dose
1	2 tabs	2 tabs	2 tabs	2 tabs	C80/D40
2	2 tabs	0 tab	2 tabs	2 tabs	C60/D30
3	2 tabs	0 tab	0 tab	2 tabs	C40/D20
4	0 tab	0 tab	0 tab	2 tabs	C20/D10
5	0 tab	0 tab	0 tab	2 tabs	C20/D10

C = Chlordiazepoxide 10 mg, D = Diazepam 5 mg

Benzodiazepines can be administered using a fixed-dose or symptom-triggered schedule.
A front-loading, or loading-dose, schedule is not recommended.

Points for HOME DETOX (community detoxication)

- Helping a patient through home alcohol detoxification has high patient satisfaction rates and is hugely rewarding for the family doctors.
- New SORs show that the majority of dependent drinkers can detox safely and successfully at home and do not require hospital admission.
- Home detox has better outcome, more acceptability and cheaper cost.
- A non-judgemental approach and the use of motivational interviewing techniques are essential
- Daily review by a family doctor or nurse is important for at least the first four days.
- Ongoing psychosocial support is essential for recovery.
- {Home detox – supporting patients to overcome alcohol addiction (Chris Davis Australian Prescriber, 3 December 2018)}
  https://www.nps.org.au/australian-prescriber/articles/home-detox-supporting-patients-to-overcome-alcohol-addiction

ACUTE CONFUSION OR CLOUDING OF CONSCIOUSNESS WITH RECENT HISTORY OF HEAVY ALCOHOL CONSUMPTION

Look for

- Wernicke's encephalopathy (**NOA**=nystagmus, ophthalmoplegia, ataxia) (Oculomotor dysfunction, abnormal mentation, ataxia)
- Head injury (bleeding from head or lacerations)
- Alcohol withdrawal delirium (Delirium Tremens),
- (**CAT** – *confusion and* disorientation, *autonomic hyperactivity:* tachycardia, hypertension, *Tremors* or body shakes)

ACUTE WERNICKE'S ENCEPHALOPATHY

- Treat all suspected cases with i/v. or i/m. thiamine 100 mg stat and refer.
- *Head injury should be excluded*
- Monitor GCS and stabilize patient, and refer

ALCOHOL WITHDRAWAL DELIRIUM

- i/v. or i/m. thiamine 100mg, refer

Medications for maintaining abstinence in AUD

Table.19

Drugs	Dosage
Acamprosate (Campral)	Two 333-mg enteric-coated tablets three times per day
Disulfiram (Antabuse)	250 mg once per day; if not effective, increase to 500 mg once per day
Fluoxetine (Prozac)	Begin with 20 mg per day; may increase to 60 to 80 mg per day
Gabapentin (Neurontin)	300 mg twice per day or once-daily dosages up to 1,800 mg at bedtime
Naltrexone (Revia [oral], Vivitrol [injectable])	Oral: 50 to 100 mg per day
Ondansetron (Zofran)	Not more than 8mg twice per day
Sertraline (Zoloft)	Begin with 50 mg per day; may increase to 200 mg per day
Topiramate (Topamax)	Begin with 25-mg dose; increase to a total of 300 mg given twice per day

Detox and Counseling

- Detox without counseling or motivational interviewing has poor drinking outcome.
- Counseling for alcohol addiction can change perceptions, feelings and behaviors to help individuals identify drinking problems.
- People can also learn to take the steps needed to combat triggers and cravings that can lead to relapse.

(Alcohol Addiction Counseling | Types of Therapy for Alcoholism)
https://www.drugrehab.com/addiction/alcohol/counseling/

Prevention

- Health education
- The pricing of alcohol beverages
- Control on sale

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3. *Myanmar: Rising Mental Health Issues Linked to Alcohol Posted on August 11, 2019, Movendi International.*
4. *WHO Global Alcohol Status Report 2018*
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6. *Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: Recommendation Statement by USPSTF:American Family Physician, June 15, 2019*
7. *Identification of and Treatment for Unhealthy Alcohol Use in Primary Care Settings: Elizabeth Salisbury-Afshar, Michael Fleming: American Family Physician June 15, 2019*
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9. *Medications for Alcohol Use Disorder: American Family Physician, March 15, 2016*

TOBACCO USE DISORDER

- Tobacco use disorder is common among individuals who use cigarettes and smokeless tobacco daily and is uncommon among individuals who do not use tobacco daily or who use nicotine medications.

Diagnostic criteria (DSM-5)

- A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring **within a 12-month period**:
  1. Tobacco is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control tobacco use.
  3. A great deal of time is spent in activities necessary to obtain or use tobacco.
  4. Craving, or a strong desire or urge to use tobacco.
  5. Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., interference with work).
  6. Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., arguments with others about tobacco use).
  7. Important social, occupational, or recreational activities are given up or reduced because of tobacco use.
  8. Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).
  9. Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco.
  10. Tolerance, as defined by either of the following:
      - A need for markedly increased amounts of tobacco to achieve the desired effect.
      - A markedly diminished effect with continued use of the same amount of tobacco.
  11. Withdrawal, as manifested by either of the following:
      - The characteristic withdrawal syndrome for tobacco (Irritability, frustration, or anger, anxiety, difficulty concentrating, increased appetite. etc., with clinically significant distress)
      - Tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms.

SMOKING

- Smoking is the **greatest single cause of illness** and premature death. Half of all regular smokers will die as a result of smoking.
- Worldwide, more than 7 million people die annually of tobacco-related illnesses, including cancer, cardiovascular disease, and chronic obstructive pulmonary disease.
- Primary care physicians have an opportunity to offer office-based smoking cessation interventions to the smokers who visits their offices.
  - **Light smoker:** <half pack/day,
  - **Heavy smoker:** >1 pack/day (1 pack = 20 cigarettes)
- Smoking is associated with increased risk of
  - Cancers: lung, lip, mouth, stomach, colon, bladder
  - Cardiovascular disease: CHD, CVD, peripheral vascular disease
  - Chronic lung disease: COPD, recurrent chest infection, exacerbation of asthma Problems in pregnancy: (PET, IUGR, preterm delivery, neonatal and late foetal death)
  - Diabetes mellitus
  - Thrombosis
  - Osteoporosis
  - Dyspepsia and/or gastric ulcer

- Passive smoking is associated with
  - increased risk of coronary heart disease and lung cancer (increased by 25%)
  - increased risk of cot death, bronchitis, and otitis media in children

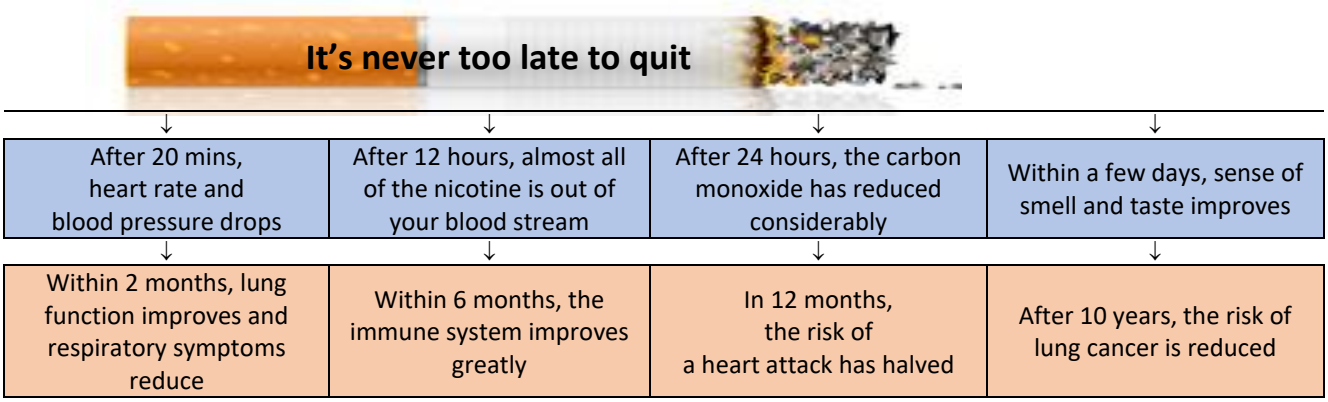

Table 21. SORT: Key Recommendations for Practice

Clinical Recommendation	SOR rating
All adults should be screened routinely for tobacco use.	**A**
All smokers should be encouraged to quit at every clinical contact.	**A**
Motivational interventions should be used with patients who are not yet ready to quit smoking.	**A**
Physicians should encourage appropriate patients to use effective medications for treatment of tobacco dependence to improve quit rates.	**A**
Heavy smokers should be encouraged to use higher dosages of a nicotine replacement therapy, or more than one form ("patch plus" regimen).	**B**
Pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit.	**B**
Sustained-release bupropion (Zyban) or a nicotine replacement therapy (particularly gum and lozenges) may be more appropriate for smokers who are concerned about weight gain after quitting.	**C**

Management plan for Smoking Cessation

5A's framework

- **Ask**
  - about tobacco use at every visit.
  - *Include questions about tobacco use when assessing the patient's vital signs.*
  - *Placing tobacco-use status stickers on patient charts, noting tobacco use in electronic medical records.*
- **Advise**
  - to quit through clear personalized messages.
  - *Advice to patients should be clear (direct expression of the need for smoking cessation), strong (highlighting the importance of cessation), and personalized (linking the patient's health goals to cessation)*
- **Assess**
  - willingness to quit.
  - *Willingness to quit and barriers to quitting should be assessed, as well as smoking history and current level of nicotine dependence;*

- *Patients should be asked about their timeline for quitting and about previous attempts.*
- *"Have you ever tried to cut back on or quit smoking?"*
- *"Are you willing to quit smoking now? What keeps you from quitting?"*
- *"How soon after getting up in the morning do you smoke?" (<30 minutes?)*
- *"Do you ever smoke in prohibited area?"*

- **Assist**
  - effort to quit or refer
  - Offer support and additional resources if available (e.g., referral to counseling);
  - Help patients to anticipate difficulties and encourage them to prepare their social support systems and their environment for the impending change
  - Help to set a quit date. Remove cigarettes, matches. Explain friends and family. Reward for accomplishment.
  - *"Are you worried about anything in particular when it comes to quitting? Do you worry about cravings or irritability? Or weight gain?"*
  - *"I would like to help you quit. Can I tell you about some of the things we know can increase your odds of success?"*
  - Explain - Nicotine withdrawal symptoms:
    - *urges to smoke (70%),*
    - *increased appetite (70% mean 3-4kg increased),*
    - *depression (60%),*
    - *restlessness (60%),*
    - *poor concentration (60%),*
    - *irritability /aggression (50%),*
    - *nighttime awakenings (25%),*
    - *light headedness (usually first few days after quitting- I 0%)*
- **Arrange** follow-up and support
  - Follow-up plans should be set;
    - For patients who have recently quit, it is important to elicit the benefits of quitting and ask patients to anticipate and problem solve about situations that might lead to relapse;
    - Follow-up contacts should also readjust the dosages of therapeutic agents that may be altered by smoking cessation (e.g., beta blockers, antipsychotics, insulin, benzodiazepines)
  - Abstinence by the quit date is highly predictive of long-term success.
  - *"I would like to see you in the office (or talk to you by phone) on your quit date."*
  - *"What problems have you had? Are there situations you worry about confronting without cigarettes?"*

Aids to Smoking Cessation

Nicotine Replacement Therapy (NRT)

- (**Adhesive patch, chewing gum, lozenges*, nose spray and inhaler)**
  - Increase the chance of quitting successfully by50-70%. All preparations are equally effective. Skin patches deliver nicotine to the brain slower than smoking cigarettes, and other forms deliver faster. (Lozenges available in Myanmar)
  - Start with higher doses for patients who are highly dependent. Continue treatment for 3months, tailing off dose gradually over 2weeks before stopping (except gum which can be stopped abruptly).
  - Contraindication: immediately post-MI, stroke, or TIA, and for patients with arrhythmia.
- **Bupropion**
  - (>18 years) 1-2weeks before-quite date
  - 150 mg cm x 3d

- 150mg bd 12 weeks to 6 months -maintenance dose depend on patient
- *Contraindicated in epilepsy*

- **Varenicline**
  - (Chantix- selective alpha$_4$-beta$_2$ nicotine receptor partial agonist) (>18yr) lwk before quite date
  - 0.5 mg po for 3d
  - 0.5 mg po bd for 4d
  - 1mg bd for 11wk - 12wk for reduced chance of relapse.
  - Increases the chance of a successful quit two to three folds.
  - *Contraindicated in psychiatric illness*
  - *AE- neuropsychiatric symptom? increased risk of coronary events*
- **Behavioural Interventionist**
  - A variety of behavioral interventions are effective for smoking cessation. However, most of them are not yet initiated in Myanmar. The behavioral interventions may include following;
    - Providing individual counseling
    - Group counseling
    - Guaranteed financial incentives
    - Text message–based counseling
    - Telephone counseling
    - Printed self-help materials
    - Internet-based intervention
- All of the interventions provide additional benefit even when smoking cessation pharmaco-therapy is prescribed. There are no apparent harms of behavioral interventions. (SOR: A)
- Greater frequency and duration of contact are more effective.

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SUBSTANCE USE DISORDERS

- The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. (DSM5)
- An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.

Diagnostic Criteria in general for all Substance Use Disorders (DSM-5)

- **Criterion A**
- **Impaired control**
  - The individual may take the substance in larger amounts or over a longer period than was originally intended.
  - The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.
  - The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects
  - Craving is manifested by an intense desire or urge for the drug.
- **Social impairment**
  - Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home.
  - The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
  - Important social, occupational, or recreational activities may be given up or reduced because of substance use.
- **Risky use**
  - Recurrent substance use in situations in which it is physically hazardous.
  - The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- **Pharmacological criteria**
  - Tolerance is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.
  - Withdrawal is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance.
- **Severity and Specifiers**
  - Substance use disorders occur in a broad range of severity; mild, moderate and severe,
  - As a general estimate of severity, a mild substance use disorder is suggested by the presence of two to three symptoms, moderate by four to five symptoms, and severe by six or more symptoms.

Causes

- Alcohol
- Caffeine
- Cannabis
- Hallucinogen (phencyclidine and others)
- Inhalant
- Opioid
- Sedative, hypnotic, or anxiolytic
- Stimulant or
- Tobacco categories

SUBSTANCE-INDUCED DISORDERS

- ACUTE INTOXICATION
- WITHDRAWAL

Opioid Overdose or other Sedative Overdose or Mixed Drug with or without Alcohol Overdose

- Unresponsive or minimally response
- Slow respiratory rate
- Pinpoint pupils (opioid overdose)

Treatment

- Before urgent referral, take care airway, breathing, and circulation
- Inj: naloxone 0.4 - 2 mg IM/IV/SC, repeat every 2-3 minutes PRN, not to exceed 10 mg.

Managing Acute Methamphetamine or other Stimulant Intoxication or Overdose

- **Step one: observe clinical signs of toxicity**
  - During this stage observing signs of toxicity have higher priority than trying to determine the methamphetamine dose consumed. (Some individuals may experience toxicity symptoms after relatively low doses)
  - Symptoms which may alert clinicians to potential toxicity and overdose include:
    - Chest pain
    - Rapid increase in body temperature
    - Psychotic features (such as hallucinations, paranoia or delusions)
    - Behavioural disturbances which may put the individual or others at risk
    - Seizures
    - Uncontrolled hypertension
    - Dilated pupils.
- **Step two: monitor vital signs.**
  - Check pulse, blood pressure and temperature
- **Step three: attempt verbal calming of the situation if required**
  - Talk quietly and calmly to the patient
  - Do not raise voice or become agitated
  - Take the person to a quiet place where there are no distractions or potential weapons
  - If acute behavioural disturbance is a feature of toxicity, using a physical restraint is not recommended as it may worsen the situation.
- **Step four: sedation if necessary**
  - A titrated dose of a short acting benzodiazepine is recommended until acute behavioural disturbance is controlled.
  - Patient should not be sedated to the point where they are unconscious.
- **Step five: regular hydration and observation**
  - For significantly elevated vital signs, more intensive intervention may be required, including intravenous hydration line and cardiac monitoring.
  - For mild cases of serotonin toxicity, supportive care, regular observation and consideration of sedation with a benzodiazepine or antipsychotic may be required.
  - For more serious serotonin toxicity, supportive care in an emergency department setting with an emergency medicine specialist is advised.
- **Managing aggressive or agitated behaviour and delirium**
  - Clinicians and service providers must be aware and informed about the safety procedures and appropriate response to manage patients who present in an agitated or aggressive

condition.

- **Suggested sedatives to manage difficult behavior**
  - Administer 10-20 mg of diazepam (oral if possible) every 30 minutes until the patient is lightly sedated.
  - Do not provide more than 120mg of diazepam in a 24-hour period without the capacity for continuous monitoring.
  - Intravenous (IV) use of benzodiazepines should be reserved for epileptic seizures. (Resuscitation equipment should be available)
- **Managing methamphetamine/amphetamine-induced acute psychotic symptoms**
  - If there is evidence that the person has recently taken amphetamine-type stimulants (ATS) and is *still experiencing the stimulant effects of ATS* (such as raised pulse and blood pressure, sweating, agitation and rapid movements), ***then the first line of treatment should be benzodiazepines.***
  - If there is *no recent history of ATS*, ***antipsychotics*** should be used.
  - ***Olanzapine***
    - Initial dose: 10 or 15 mg orally once a day
    - Maintenance dose: 5 to 20 mg orally once a day
  - ***Haloperidol***
    - Oral: initial dose: 0.5 to 5 mg orally 2 to 3 times a day. Maintenance dose: 1 to 30 mg/day in 2 to 3 divided doses.
    - Parenteral: 2 to 5 mg IM or IV for prompt control. May repeat every 4 to 8 hours

ACUTE OPIOID WITHDRAWAL

- History of opioid dependence, recent heavy use ceasing in the last days
- Muscle aches and pain, abdominal cramps, headaches
- Nausea, vomiting, diarrhea
- Dilated pupils
- Raised pulse and blood pressure
- Yawning, running eyes and nose, pilo-erection(gooseflesh)
- anxiety, restlessness

Treatment

- Opioid Substitution Therapy (OST) e.g. buprenorphine.
- Methadone maintenance treatment (MMT) (See below)

MANAGING METHAMPHETAMINE OR OTHER STIMULANTS WITHDRAWAL

Table 22. Time course of methamphetamine and ATS withdrawal

Phase	Time since last stimulant use	Common signs and symptoms
Crash	Typically commences 12-24 hours after last amphetamine use and subsides by 2-4 days	• Exhaustion, fatigue, agitation and irritability, depression, muscle ache • Sleep disturbances (typically increased sleep, although insomnia or restless sleep may occur)
Withdrawal	Typically commences 2-4 days after last use, peaks in severity over 7-10 days and then subsides over 2-4 weeks	• Strong craving • Fluctuating mood and energy level, alternating between irritability, restlessness, anxiety and agitation • Fatigue, lack of energy
Extinction	Weeks to months	• Gradual resumption of normal mood with

Phase	Time since last stimulant use	Common signs and symptoms
		episodic fluctuation in mood and energy level, alternating between irritability, restlessness, anxiety, agitation, fatigue, lack of energy • Episodic craving • Disturbed sleep

Protracted phase

- One to three months, sometimes longer sleep patterns improve, energy levels get better, mood settles, slowly resolving anhedonia, (Being unable to feel pleasure)
- Managing withdrawal from methamphetamine consists
  - primarily of psychosocial interventions, which may be supplemented with:
  - medications, such as benzodiazepines (for example diazepam), to reduce symptoms of insomnia and anxiety during the first few days.
- The use of medications should be determined on an individual basis according to what symptoms are prominent.
- Methamphetamine withdrawal is relatively safe and most commonly can occur as an outpatient or home detoxification. However, treatment completion rates as an outpatient or during home detoxification remain poor and rates of relapse immediately after withdrawal are high.
- For a person with evidence of significant polydrug use, psychotic symptoms, severe depression, or potential medical complications, an in-patient setting may be more appropriate,

HARM REDUCTION FOR PATIENT WITH SUBSTANCE USE DISORDER

- Patients engaged in high-risk activities are often ambivalent about changing their behavior.
- Harm reduction is an approach that focuses on limiting harm and improving quality of life for patients who persist with high-risk behaviors.
- The foundations of harm reduction are pragmatism and compassion.
- Acknowledging the complexity of high-risk behavior and using a supportive, practical approach to address the situation can decrease friction between the patient and physician and build trusting therapeutic relationships.
- The leading harm reduction interventions target **prevention of overdose** and **infection**, and also **reproductive issues**.
- Harm Reduction measures can decrease criminal activities to finance drug habit.

Overdose education and naloxone distribution (including usage of naloxone kits)

- Medications for opioid use disorder to reduce opioid overdose and acute care use.
- (Methadone, buprenorphine, extended-release naltrexone)
- *{Methadone available in Methadone Maintenance Treatment (MMT) Programs in Drug Treatment Centers (DTC)*}*

Prevention of Infections

- Testing for hepatitis B, C, HIV and STIs
- Diagnosis of tuberculosis
- Needle and syringe program to prevent hepatitis B, C and HIV infection.

Reproductive health

- Long-acting reversible contraception for women of reproductive age to decrease unintended pregnancy.
- Use of condom, use of lubricants

The combination of motivational interviewing and harm reduction can decrease risk, improve the therapeutic relationship and prevent physicians from feeling helpless.

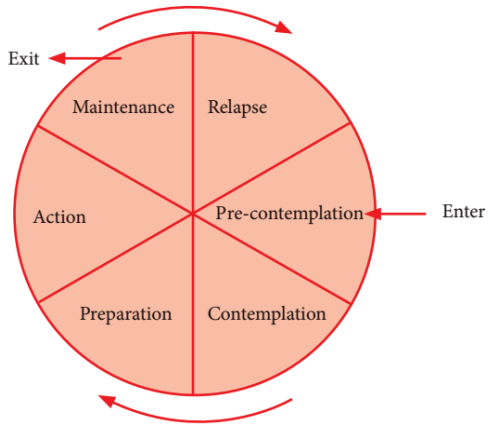
Warning Signs and Symptoms suggesting Drug Misuse

- Inappropriate behaviour
- Lack of self-care
- Unexplained nasal discharge
- evidence of injecting (e.g., marked veins)
- Hepatitis or HIV infection
- Unusually constricted/dilated pupils
- Social factors: Family disruption, criminal history

The Role of Primary Health Care Team

- Primary health Care team has a vital role in identifying drug misuse.
- Assess health and willingness to modify drug abuse (see motivational model of Change for Addiction)
- Appropriate referral for specialist assessment and treatment. *It is imperative that people who use opioids be enrolled in opioid substitution treatment programs to cut the vicious cycle of addiction and halt the spread of infectious diseases such as HIV.*

Motivational model of change



Other education for HARM REDUCTION

- Safer route of drug administration e.g. Smoking/rectal administration for heroin abusers.
- Discourage IM/Subcutaneous administration.
- Specific risks of drugs (e.g. psychosis with amphetamines; local risks; such as contaminated street drugs
- Safe injecting advice and overdose prevention
- Safe sexual practice/condom use
- Driving and drug misuse
- **Safe injecting advice**
    - Never inject alone
    - Always inject with the blood flow and rotate sites - avoid neck, groin, penis, axilla, foot and hand veins, and any infected areas/swollen limbs - even if veins are distended.
    - Use sterile, new injecting equipment with the smallest bore needle possible and dispose of all equipment safely after use
    - Avoid unsuitable preparations e.g. crushed tablets and/or injecting cocktails of drugs (injection of heroin and cocaine together is known as 'speed balling' or 'snowballing')
    - Learn basic principles of first aid and CPR (provide information on courses available). Encourage calling for an ambulance. Educating about usage of naloxone if feasible

- **Preventing overdose, be aware of risk factors:**
    - Injecting heroin
    - Longer injecting career
    - High levels of alcohol use
    - Lowered tolerance after detoxification/imprisonment
    - Depression, suicidal thoughts
    - Multiple drug use - particularly CNS depressants
    - Sharing equipment/other high risk injecting behavior - indicate low concern about personal risk
    - Not being on a treatment programme or premature exit from a methadone maintenance treatment programme
    - Recent non-fatal overdose
    - High levels of use/intoxication

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3. *Guidelines for the Management of Methamphetamine Use Disorders in Myanmar: Department of Medical Services, Ministry of Health and Sports, The Republic of the Union of Myanmar October 2017*
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5. **Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar: Department of Health, Ministry of Health, The Republic of the Union of Myanmar 2012.*