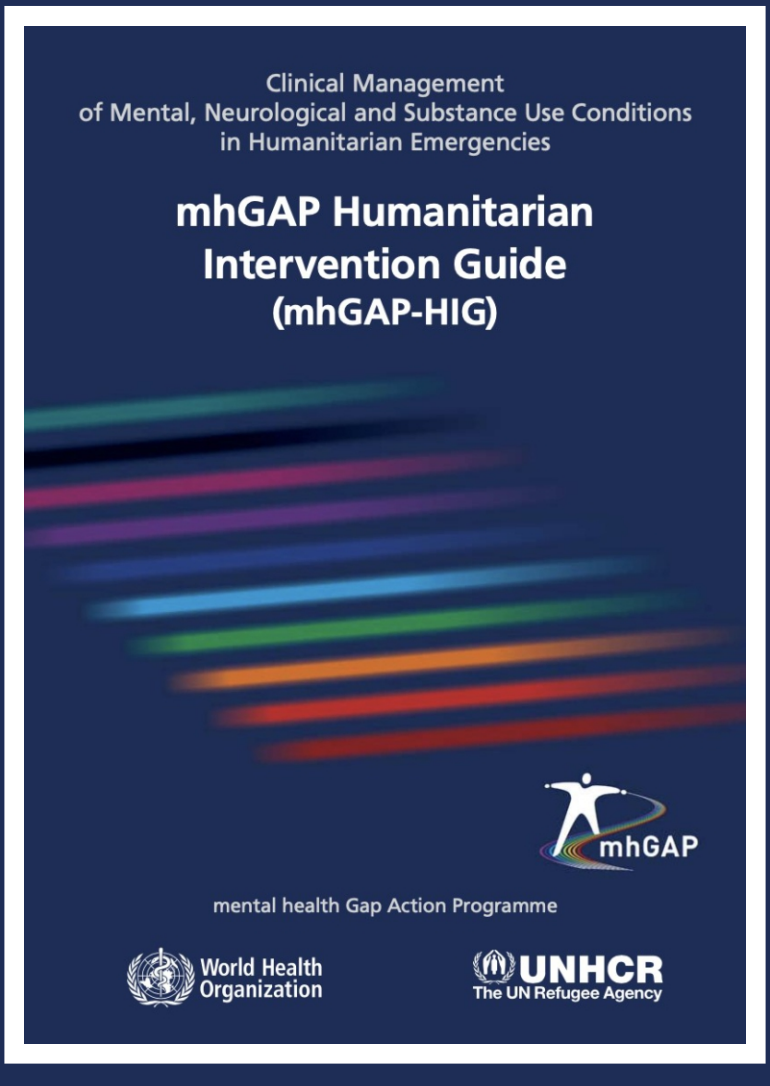
MHPSS
MENTAL HEALTH & PSYCHOSOCIAL SUPPORT
THE mhGAP-HIG FOR PAKISTAN

mhGAP-HIG-PK

The mhGAP-Humanitarian Intervention Guide

(Adapted for Pakistan)



Ministry of Planning, Development & Special Initiatives
Government of Pakistan

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The mhGAP-HIG-PK guide has been adapted from the mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. World Health Organization and United Nations High Commissioner for Refugees (WHO, 2015). The clinical protocols have been supplemented by evidence-based clinical tools including key questions and examination techniques, derived from Implementing the mental health Gap Action Programme intervention guide: a job aid for non-specialist health professionals (EMRO WHO, 2021). The World Health Organization is not responsible for the content or accuracy of this adaptation.

This guide has also been developed into a mobile application – mhGAP-HIG-PK (for Android and iOS), as an integrated component of a comprehensive digital model for providing multi-layered mental health and psychosocial support (MHPSS) services in Pakistan.

The digital copy is available at: https://pc.gov.pk/uploads/downloads/mhGAP-HIG-PK.pdf

The first draft of the guide was prepared in 2020, with the support of International Medical Corps, Pakistan. The final draft was prepared in 2021, as part of the Mental Health and Psychosocial Support initiative by the Ministry of Planning, Development and Special Initiatives during the emergency response to COVID-19 and was funded by UNICEF Pakistan.

The guide was formally launched by the Ministry of Planning, Development and Special Initiatives on the World Mental Health Day, 10th October 2022 with the support of the World Health Organization, Pakistan.

First 500 copies were printed in 2023 and additional 500 copies were reprinted in 2025, with the support of International Medical Corps, Pakistan.

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Foreword

Pakistan has been increasingly facing multiple humanitarian crises over years. These include natural disasters (e.g., earthquake), climate related disasters (e.g., floods), conflict related challenges (e.g., terrorism, internally displaced populations, refugees), public health challenges, political instability and socio-economic crisis.

The burden of mental health conditions during a humanitarian crisis is huge. Approximately 1 in 5 people (including children) might need mental healthcare. People with mental disorders are vulnerable to stigma and human rights abuse. Some of the mental disorders are leading causes of illness and disability, and are responsible for immense suffering, premature death and suicides.

In view of a severe dearth of specialist resources in the country, it is estimated that 75 percent of people with mental disorders do not receive any treatment. To address this serious gap in mental healthcare, the Ministry of Planning, Development and Special Initiatives has developed an innovative digital model for an evidence-driven, multi-layered mental healthcare that is both rights-based and scalable, while taking into account local needs and resources.

The mhGAP Humanitarian Intervention Guide (mhGAP-HIG) has been developed by the World Health Organization and UNHCR to help people suffering from a diverse range of mental, substance use, and neurological problems during a humanitarian crisis. It is a widely-used evidence-based manual for the management of these conditions in non-specialized health settings.

The present guide has been adapted from mhGAP-HIG for our cultural and healthcare context. It is a simple, practical tool that aims to train non-specialists to assess and manage acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual disability, harmful substance use and risk of suicide. The guide will help them conduct standardized clinical interviews and examination to identify and manage mental health conditions using both pharmacological and psychosocial interventions.

The protocols in the mhGAP-HIG highlight the areas to be examined but do not direct how to do so. For example, based on a diagnostic criterion for a disorder, a list of symptoms is provided in the mhGAP-HIG. There is likely to be a wide variation between how non-specialists will apply these protocols after their training. In Pakistan, the predominant model of healthcare is bio-medical and the pre-service training in recognizing mental health conditions is limited. As a result, there is little emphasis on interview skills and basic psychosocial interventions. Therefore, detailed clinical tools including interview questions and examination techniques have been added, both in English and Urdu.

Another objective of this document is to help the healthcare providers remain person-centered and protect the rights of the people. Issues like privacy of the patient and need for confidentiality have been emphasized. Clear guidelines have been added for clinical scenarios where the healthcare provider might need to share vital information with others and tips on how to do that.

Contextualization of the guide

The contextualization of the mhGAP-HIG followed a rigorous, evidence-informed, and participatory process, guided by World Health Organizations' recommended methodology for contextualization. At the initial stage, four implementation gaps were identified through a situational analysis, focused group discussions, and key informant interviews. These included gaps in knowledge, skills and attitude, the gap between knowledge and clinical practice; limitations in training resources and the absence of structured supervision and referral mechanisms. These gaps were addressed through a multiphase process. This included a multi-stakeholder adaptation workshop and a Delphi consensus approach to systematically revise the content of mhGAP-HIG.

To overcome training and supervision barriers, the adapted guide was digitized into a mobile application integrated with the MHPSS service model. The digital application provides integrated features for real-time remote supervision and acts as a clinical reference tool for non-specialists after training.

In 2023, in collaboration with Department of Health, Khyber Pakhtunkhwa, and International Medical Corps Pakistan, field testing of the adapted guide was conducted to strengthen mental healthcare services in nine districts of KP (Chitral, Haripur, Kohat, Lower Dir, Mansehra, Mardan, Nowshera, Peshawar, and Swabi). A training needs assessment was conducted through a desk review and focus group discussions, to understand challenges for implementing the guidelines. The pilot testing involved training of trainers, and the capacity building of 105 primary healthcare workers, including 74 primary care physicians and 31 clinical psychologists. For implementing the mhGAP-HIG-PK, six training workshops were conducted, each lasted for five days.

All trainings were evaluated using a pre-post design and demonstrated significant improvements in knowledge and skills, particularly in assessment and management of mental health conditions. Participants advocated for the broadening the scope of mhGAP trainings, ensuring refresher courses and integrating the guide into the pre-service training of medical doctors and clinical psychologists.

Following the training phase, the trained primary healthcare workers were offered remote supervision for three months. During this period, 413 cases were submitted through mhGAP-HIG mobile application. Case-based supervision was provided through individual and group discussions using district-based WhatsApp groups. The supervision data offered valuable insights about clinical trends and compliance with mhGAP protocols. Supervision was particularly helpful to guide assessment process, plan management (including both pharmacological and psychosocial interventions), and making decisions about referral, in accordance with mhGAP protocols. The supervision phase was followed by three refresher training workshops, each lasting for three days.

The pilot testing revealed that the adapted mhGAP-HIG guide, supported by digital tools, is both feasible and effective in implementation and strengthening mental health service delivery in low-resource primary care settings.

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[1] Humayun, A., Muneeb, N., Najmussaqib, A., Haq, I., & Asif, M. (2025). Bridging the gaps: Contextualizing the mhGAP Humanitarian Intervention Guide to implement in Pakistan. Medrvix. https://doi.org/10.1101/2025.05.21.

[2] Humayun, A., & Najmussaqib, M. (2025). Implementing the mhGAP-HIG: The process and evaluation of training primary health care workers in Khyber Pakhtunkhwa, Pakistan. Manuscript submitted for publication.

[3] Humayun, A., Najmussaqib, A., & Muneeb, N. (2025). Supervision-based evaluation of primary healthcare workers' performance after mhGAP HIG training in Pakistan. SSM - Mental Health, 100451. https://doi.org/10.1016/j.ssmmh.2025.100451

Table of Contents

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

GPC

This module outlines the general principles of care for people with Mental, Neurological and Substance Use (MNS) conditions in humanitarian setting.

The model consists of following principle:

1. **Principle of communication**
2. **Principle of assessment**
3. **Principle management**
4. **Principle of reducing stress and strengthening social support**
5. **Principle of protection of human rights**
6 **Principle of attention to overall well-being**

1. PRINCIPLES OF COMMUNICATION

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

Create an environment that facilitates open communication

1. How to introduce yourself

After greeting the patient & introducing yourself, explain that:

1. You would be making brief notes during the consultation so that you don't miss something important.
2. You would refer to your (mhGAP) guide (on your table/phone) to check important points.
3. You would like to see the patient first for an assessment (with a chaperone, where needed) and would then invite the carers for further discussion. If the person wants others to stay, respect this.
4. How much time would you spend on this consultation and examination.
5. Then close the door to ensure privacy and reassure the patient that the consultation is confidential. Let the person know that information discussed will not be shared without their permission, except when you perceive a risk to the person or to others.

سب سے پہلے مریض سے سلام دعا کر کے، اپنا تعارف کروائیں۔ مریض کو واضح کریں کہ :

۲۔ مشورے کے دوران آپ اہم نکات نوٹ کریں گے۔

۳۔ اس دوران آپ اپنی کتاب یا فون میں سے ضروری نکات بھی چیک کریں گے۔

۴۔ مریض کو سمجھائیں کے پہلے آپ اس کا معائنہ کریں گے اور پھر اس کے گھر والوں سے مزید معلومات لیں گے۔

۵۔ یہ بھی واضح کریں کے آپ کو معائنہ کرنے میں تقریباً کتنا وقت لگے گا۔

۶۔ مریض کی اجازت سے کمرے کا دروازہ بند کر لیں تا کہ بات چیت تسلی سے ہو اور مریض کو یقین دلائیں کہ آپ مکمل رازداری رکھیں گے۔

2. How to start the interview

Start the interview with an open-ended question inviting the patient to describe the problem or main reasons for seeking help. It is best not to interrupt (for at least a minute) and carefully note down all complaints.

Can you tell me what brings you to see me?
Have you had any recent health (physical or mental) problems?
Could you describe what are your symptoms/problems? When did it/these first start?
Please share what has been troubling you?

شروع میں ایسے سوال کریں جس سے مریض اپنی تکلیف کو تفصیل سے بیان کر سکے۔

کوشش کریں کے کم از کم ایک منٹ کے لیے ان کی بات کو کاٹا نہ جائے۔

کیا آپ بتا سکتے ہیں کہ مجھ سے ملنے کی وجہ کیا ہے؟

کیا آپ کو حال ہی میں ذہنی یا جسمانی صحت کا مسئلہ پیش آیا ہے؟

کیاآپ اپنے مسائل یاعلامات بیان کر سکتے ہیں؟ یہ شروع کب ہوئیں؟
برائے مہربانی اپنی تکلیف کی وجہ مجھ سے شئیر کریں۔

3. What questions to ask

A list of questions has been provided for each area of examination to help the healthcare providers, but not all questions need to be asked from each patient.

معائنے کے ہر حصے کیلیے سوالات کی ایک فہرست مہیا کی گئی ہے مگر ہر مریض سے سارے سوالات پوچھنے کی ضرورت نہیں۔

4. How to plan treatment

For planning treatment, all efforts should be made to involve patients in treatment decisions instead of imposing any advice.

For psychosocial interventions, patients should also be actively engaged by attentively listening to them.

The healthcare providers should explore what the patients already know about their options, how much would they like to know, identify gaps in their knowledge, share relevant facts about treatment and allow them to ask as many questions as needed.

ہر ممکن کوشش کرنی چاہیے کہ علاج کی منصوبہ سازی میں مریض کو شامل کریں بجائے کہ مشورے مسلط کیے جائیں۔
نفسیاتی علاج کے لیے مریض کی شمولیت یقینی بنائیں اور انکی بات دھیان سے سنیں۔ پہلے سے اندازہ کریں کہ مریض پہلے سے علاج کے بارے میں کتنا جانتے ہیں اور کتنا جاننا چاہتے ہیں؟ ان کی معلومات میں کیا کمی ہے؟ ان کے ساتھ متعلقہ حقائق شئیر کریں اور ان کو اجازت دیں کہ وہ جتنے سوال پوچھنا چاہیں پوچھ لیں۔

Involve the person with the MNS condition as much as possible

1. Even if the person's functioning is impaired, always try to involve them in the discussion. This is also true for children, Youth and elderly people with MNS conditions. Do not ignore them by talking with their carers only.

2. Always try to explain to the person what you are doing (e.g., during physical examination) and what are you planning to do.
   Some example questions that can be used throughout the assessment to actively engage the person, rather than giving a lecture:
   What do you already know about your condition?
   What problems are affecting you the most?
   Would you like to explore possible solutions for your problems?

آپ اپنی کیفیت کے بارے میں کیا جانتے ہیں؟
کون سے مسئلے سے آپ سب سے زیادہ پریشان ہیں؟
کیاآپ اپنے مسائل کا حل تلاش کرنا سیکھنا چاہتے ہیں؟

1. Start by listening

– Allow the person with an MNS condition to speak without interruption. Distressed people may not always give a clear history. When this happens, be patient and ask for clarification. Try not to rush them.

– Do not press the person to discuss or describe potentially traumatic events if they do not wish to open up. Simply let them know that you are there to listen.

– If they discuss the traumatic experience, be empathic and convey that you understand the person's feelings.
That sounds like a very challenging experience.
I understand how painful this has been for you.
I can see why you are so sad/frightened etc.

آپ کے حالات سن کر آپ کی دشواری کا اندازہ ہوتا ہے۔ میں سمجھ سکتا ہوں کہ یہ آپ کے لئے کتنا تکلیف دہ رہا ہے اور آپ اتنے پریشان کیوں ہیں۔

– Children may need more time to feel comfortable. Use language that they can understand. Establishing a relationship with children may require talking about their interests (toys, friends, school, etc.).

2. Be clear and concise

– Use language that the person is familiar with. Avoid using technical terms.
– Stress can impair people's ability to process information. Provide one point at a time to help the person understand what is being said before moving on to the next point.
– Summarize and repeat key points. It can be helpful to ask the person or carers to write down important points. Alternatively, provide a written summary of the key points for the person.
– Use effective questioning skills

Open questions

These questions are inviting to start a discussion and lets patients tell their experience in their own words. The one noticeable aspect of open questions is that they are short and suggest no anticipated reply.
How are you feeling?
Tell me about yourself?
Can you describe your problems?

آپ اپنی کیفیت کے بارے میں کیسا محسوس کر رہے ہیں؟ مجھے اپنے مسئلے کے بارے میں تفصیل بتائیں۔

Closed questions

Once the person had an opportunity to describe their problems, a list of closed ended questions can help check a list of symptoms. The closed questions have 'Yes' or 'No' answers which may not describe fully what the patient wants to say.

Are you feeling sad?
Do you enjoy your work?
Do you sleep well?

کیا آپ اداس اور پریشان ہیں؟
کیا آپ کو اپنے کام میں پہلے کی طرح مزہ آتا ہے؟
کیا آپ کی نیند اچھی ہے؟

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

– Let the person know that you will respect the confidentiality of the information.
– Never belittle the person's feelings, preach or be judgmental.
– Acknowledge that it may have been difficult for the person to share.
– If referral to other services is necessary, explain clearly what the next steps will be. Seek the consent of the person to share information with other providers who may be able to help.

You have told me that your neighbour has done something very bad to you. I will not share this with anyone else but I can think of some people who may be able to help you. Is it OK if I discuss your experience with my colleague from agency X?

آپ نے مجھ پر بھروسہ کر کہ بتایا ہے کہ آپ کے پڑوسی نے آپ کے ساتھ بہت برا کیا ہے۔
میں اسکا ذکر کسی کے ساتھ نہیں کروں گا مگر اس سلسلے میں میرے کچھ ساتھی آپ کی مدد کر سکتے ہیں۔
اگر آپ کی اجازت ہو تو کیا میں ان کو آپ کے مسئلے کے بارے میں بتا سکتا ہوں؟

4. Do not judge people by their behaviours

– People with severe MNS conditions may demonstrate unusual behaviours. Understand that this may be because of their illness. Stay calm and patient. Never laugh at the person.

– If the person behaves inappropriately (e.g., agitated, aggressive, threatening), look for the source of the problem and suggest solutions. Involve their carers or other staff members in creating a calm, quiet space. If they are extremely distressed or agitated, you may need to prioritize their consultation and bring them into your consulting space at once.

5. If needed, use appropriate interpreters

– If needed, try to work with trained interpreters, preferably of the same gender as the person with the MNS condition. If a trained interpreter is not available, other health-care staff or carers may interpret, with the consent of the person.

– In situations where the carer interprets, be aware that the person with the MNS condition may not fully disclose. In addition, conflict of interest between the person and the carer may influence communication. If this becomes an issue, arrange for an appropriate interpreter for future visits.

– Instruct the interpreter to maintain confidentiality and translate literally, without adding their own thoughts and interpretations.

2. PRINCIPLES OF ASSESSMENT

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

The assessment of a person with an MNS condition includes observing and noting the overall appearance, mood, facial expression, body language and speech.

1. Explore the presenting complaints
Presenting complaints are the main problems that the person is presenting with, and these are the primary reasons for the visit. These are best understood in the person's own words.

Start with open ended questions and focus in depth on relevant areas with more specific closed ended questions as necessary.

Can you describe your problem?
When and how did the problem start?
What do you think is the cause?
How does this problem affect your work or daily life?
Have you sought any help? Did you try any medication (e.g., prescribed, non-prescribed, herbal)? Did that help?

آپ اپنی تکلیف کے بارے میں تفصیل بتائیں۔
یہ تکلیف کب اور کیسے شروع ہوئی؟ آپ کے خیال میں اس کی وجہ کیا ہے؟
اس تکلیف کی وجہ سے آپ کا کام یا روزمرہ کی زندگی کیسے متاثر ہو رہی ہے؟
کیا آپ نے اس تکلیف کے لیے پہلے کوئی مشورہ یا علاج کیا ہے؟ کیا اس سے کوئی فائدہ ہوا؟

2. Explore possible family history of MNS conditions
Do you know of anyone in your family who has had a similar problem?
کیا آپ کے خاندان میں کسی اور رشتے دار کو ایسا مسئلہ یا بیماری کبھی ہوئی ہے؟

3. Explore the person's general health history
Ask about any previous physical health problem:

Have you had any serious health problem in the past?
Do you have any health problem for which you are currently receiving care?

Ask if the person is taking any medication:
Are you taking any prescribed medication right now?
What is the name of that medication? Did you bring it with you? How often do you take it?

اس سے پہلے کیا آپ کو کوئی اور بیماری ہوئی ہے؟
کیا آپ کسی اور بیماری کا علاج کروا رہے ہیں؟
کیا آپ کسی بیماری کے لیے کوئی دوائی استعمال کر رہے ہیں؟ اس دوائی کا نام کیا ہے اور آپ اسے کیسے استعمال کر رہے ہیں؟

Ask if the person has ever had an allergic reaction to a medication.

4. Explore stressors, coping strategies and social support

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

اس حادثے (حالات) کی وجہ سے آپ کی زندگی کیسے متاثر ہوئی ہے؟
کیا آپ کے خاندان میں کوئی جانی نقصان ہوا ہے؟
اس وقت آپ کے سب سے بڑے مسائل کیا ہیں؟
آپ ان مسائل کو حل کرنے کی کوشش کیسے کر رہے ہیں؟
آپ کو کس طرح کی مدد مہیا ہے؟
کیا آپ کے رشتے دار یا دوست مدد کر رہے ہیں؟

5. Explore possible alcohol and drug use

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

I need to ask you a few routine questions as part of the assessment. Do you take alcohol (or any other substance known to be a problem in the area)? [If yes] How much per day/week?

Do you take any tablets when you feel stressed, upset or afraid? Is there anything you use when you have pain? Do you take sleeping tablets? [If yes] How much/many do you take per day/week? Since when?

میں نے معائنہ مکمل کرنے کے لیے آپ سے نشے کے متعلق کچھ سوال پوچھنے ہیں۔
کیا آپ شراب یا کوئی اور نشہ آور چیز استعمال کرتے ہیں؟
اگر ہاں، ایک ہفتے یا دن میں کتنی مقدار استعمال کرتے ہیں؟

کیا آپ اپنی پریشانی یا ذہنی دباؤ کے لیے کوئی دوائی استعمال کرتے ہیں؟ یا درد کے لیے گولیاں کھاتے ہیں؟ یا کبھی نیند کی گولیاں استعمال کرتے ہیں؟ ہفتے میں کتنے دن ایسی دوائی استعمال کرتے ہیں؟ کب سے کر رہے ہیں؟

6. Explore possible suicidal thoughts and suicide attempts
Questions regarding suicide may also be perceived as offensive, but they are also essential questions in an MNS assessment.
Try to ask questions in a culturally sensitive and non-judgmental way.
What are your hopes for the future?

If the person expresses hopelessness, ask further questions, such as:
Do you feel that life is worth living?
Do you think about hurting yourself?
H*ave you made any plans to end your life?*

آپ کو اپنا مستقبل کیسا لگتا ہے؟
کیا آپ کو کبھی ایسا لگتا ہے کہ زندگی جینے کے قابل نہیں رہی؟
کیا آپ نے کبھی اپنے آپ کو نقصان پہنچانے کے بارے میں سوچا ہے؟
کیا آپ نے کبھی زندگی کو ختم کرنے کے طریقے کے بارے میں سوچا ہے

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

8. Rule out MNS conditions
If an MNS condition is suspected, go to the relevant module for assessment.

If a person presents with features relevant to more than one MNS condition, then all relevant modules need to be considered.

3. PRINCIPLES OF MANAGEMENT

Many MNS conditions are chronic, requiring long-term monitoring and follow-up. In humanitarian settings, however, continuity of care may be difficult because mental health care is not consistently available or people have been or are about to be displaced.

Therefore, it is important to recognize the carers of people with MNS conditions as a valuable resource. They may be able to provide consistent care, support and monitoring throughout the crisis.

Carers include anyone who shares responsibility for the well-being of the person with an MNS condition, including family, friends or other trusted people. Increasing the person's and the carer's understanding of the MNS condition, management plan and follow-up plan will enhance adherence.

1. Manage both mental and physical conditions in people with MNS conditions
Always provide information about the condition and discuss achievable goals to agree on a management plan with the person.
If the person agrees, involve the carer in this discussion.

For the management plan, provide information on:

- Expected benefits of treatment
- Duration of treatment
- Importance of adhering to treatment, including practicing any relevant psychological interventions (e.g., relaxation training) at home and how carers could help
- Potential side-effects of any medication being prescribed
- Potential involvement of social workers, case managers, community health workers or other trusted members in the community
- Financial aspects of the management plan, if relevant.

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

1. Confirm that the person and the carer understand and agree on the management plan (e.g., you may ask both to repeat the essentials of the plan).

2. Encourage self-monitoring of the symptoms and educate the person and carer on when to seek urgent care.

3. Arrange a follow-up visit:

- Create a follow-up plan, taking into consideration the current humanitarian situation (e.g., fleeing/ moving population and disruptions in services).
- If the person is unlikely to be able to access the same clinic, provide a brief written management plan and encourage the person to visit another clinic.
- Provide contact information for other healthcare facilities nearby.
- Initial follow-up visits should be more frequent until the symptoms begin to respond to treatment.
- Explain that the person can return to the clinic at any time in between follow-up visits if needed (e.g., when experiencing side-effects of medications).

3. Follow up visits

Once the symptoms start improving, less frequent but regular appointments are recommended.

At each follow-up meeting, assess:

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

During the entire follow-up period:

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

If a person is pregnant or breastfeeding:

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

4. PRINCIPLES OF REDUCING STRESS AND STRENGTHENING SOCIAL SUPPORT

Reducing stress and strengthening social support are an integral part of MNS treatment in humanitarian settings, where people often experience extremely high levels of stress. This includes not only the stress felt by people with MNS conditions but also the stress felt by their carers and dependents. Stress often contributes to or worsens existing MNS conditions. Social support can diminish many of the adverse effects of stress; therefore, attention to social support is essential.

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

آجکل آپ کی سب سے بڑی پریشانی کیا ہے؟
آپ اس پریشانی سے کیسے نمٹ رہے ہیں؟
کونسے ایسے کام ہیں جو آپ کو ذہنی سکون اور حوصلہ دیتے ہیں؟
آپ کس شخص کو اپنے مسئلے آسانی سے بتا سکتے ہیں؟ جب آپ پریشان ہوتے ہیں تو آپ کس سے مشورے کرتے ہیں؟
آپ کے اپنے گھر والوں سے تعلقات کیسے ہیں؟ ان کی وجہ سے آپ کو کب حوصلہ ملتا ہے اور کب پریشانی ہوتی ہے؟

2. Be aware of signs of abuse or neglect
1. Be attentive to potential signs of sexual or physical abuse (including domestic violence) in women, children and older people (e.g., unexplained bruises or injuries, excessive fear, reluctance to discuss matters when a family member is present).
2. Be attentive to potential signs of neglect, particularly in children, people living with disability and older people (e.g., malnourishment in a family with access to sufficient food, a child who is overly withdrawn).
3. When signs of abuse or neglect are present, interview the person in a private space to ask if anything painful is going on.
4. If you suspect abuse or neglect:

- Talk immediately with your supervisor to discuss the plan of action.
- With the person's consent, identify community resources (e.g., trusted legal services and protection networks) for protection.

3. Problem-solving technique
Use problem-solving techniques to help the person address major stressors.
When stressors cannot be solved or reduced, problem-solving techniques may be used to identify ways to cope with the stressor.
In general, do not give direct advice. Try to encourage the person to develop their own solutions.
When working with children and adolescents, it is essential to assess and address the carer's sources of stress as well.

Box 1: Steps in Problem Solving		
	Step	Description
1	**Enlist**	List problems as solvable (can be influenced or changed) and unsolvable (cannot be influenced or changed)
	Example	*1. Not being able to travel because of the pandemic (unsolvable)* *2. Husband got fired (unsolvable)* *3. Fighting with husband (solvable)* *4. Increased loadshedding in late hours. (unsolvable)* *5. Putting on weight due to lack of exercise (solvable)*
2	Choose a problem	Choose an easier (solvable) problem to start with
	Example	*Fighting with husband*
3	**Define**	1. Choose the elements of the problem that are practical in nature and can be controlled or influenced to some extent 2. Keep the explanation of the problem as specific and as brief as possible 3. Try not to include more than one problem 4. If a problem has many parts, break it down and deal with each part separately
	Example	*Fighting with husband each day since he lost his job*
4	**Brainstorm**	1. First, think of as many solutions to the problem as possible. Do not worry if the solutions are good or bad at this stage 2. Think of what you can do by yourself and also think of people who can help you manage parts of the problem 3. Consider existing personal strengths, resources or support 4. You can ask yourself what you would say to a friend if you have trouble thinking of solutions
	Example	*1. Do nothing – wait for him to find a job and see if the situation improves.* *2. Tell him he needs to talk to a community elder for help.* *3. Tell him to try harder to find a job.* *4. I could look for a way to make money.* *5. Talk with my friends about the problems – ask for their advice.* *6. Ask my mother for advice.* *7. Tell my husband that I am distressed.*
5	**Decide and choose helpful strategies**	1. From the list of potential solutions, choose those that are most helpful to influencing the problem 2. Helpful strategies are those that have very few disadvantages for you or others 3. Helpful strategies are those that can be carried out (e.g., you have the financial means, other resources or ability to carry out the solution) 4. You can choose more than one solution
	Example	*1. Talk with my trusted friend(s) about the problem. One friend has had a similar problem with her husband and is more likely to understand the situation.* *2. Ask my mother for advice. Mention the problem and ask what she would do.* *3. Tell my husband that I am not happy.*

6	**Plan action**	− Develop a detailed plan of how and when you will carry out the solutions − Pick the day and time when you will do this − Choose which solutions you will try first if there are more than one − Discuss what resources (e.g. money, transport, another person and so on) you might need to carry out the plan − Think of aids to remind yourself to carry out the plan (notes, calendar, plan activities to coincide with meals or other routine events)
	Example	*Tuesday: Talk to trusted friend at 10:00 am. Talk with friend about fighting with my husband and get advice.* *Thursday: When talking to my mother, mention to her that I have been having some problems with my husband. Ask her what she would do in my situation.* *Saturday morning: Husband will be home. Tell him that I have been feeling very unhappy because we have been fighting a lot. Wait for his response.*
7	**Review**	− Think about what you did and what effect this had on the original problem − Think about any difficulties you had in acting on the plan − Think about and plan what you can do next to continue to influence and manage the problem, given what you completed in the last week
	Example	*Trusted friend was very supportive. Although she did not have any new advice, speaking to her helped. I felt better afterward, and my mood improved a little. We also talked about other things that gave me a break from feeling sad.* *My mother said that I need to speak with my husband but be understanding of his frustration and not blame him for losing his job. She helped me practice how I would talk to him, so I felt more confident.* *I spoke to my husband the same evening because I felt confident about approaching him. He agreed with me, but we are still not sure what to do about it but will keep discussing it till we do. I feel better after discussing it.*

مسائل کا حل تلاش کرنے کی مشق

پریشانی کی کیفیت میں اکثر ذہن مسائل میں الجھ جاتا ہے اور اُن کا حل ڈھونڈنے میں مشکل پیش آتی ہے۔ اس مشق کے ذریعے آپ ان الجھنوں سے نمٹ کر، اپنے مسائل کا حل تلاش کر سکتے ہیں

	مرحلہ	تفصیل
۱	**تمام مسائل کی لسٹ**	۔جو مسئلے حل ہو سکتے ہیں، ان کو ایک طرف ترتیب میں لکھیں۔ اور جو مسئلے حل نہیں ہو سکتے (یا جن پر آپ کا زور نہیں ہے)، ان کو دوسری طرف لکھ لیں۔
	مثال	۱۔ وبا کی وجہ سے باہر نہ جا پانا (کوئی حل نہیں) ۲۔ خاوند کی نوکری کا چھوٹ جانا (کوئی حل نہیں) ۳۔ خاوند سے لڑائی ہونا (حل ہے) ۴۔ بجلی کا بار بار چلا جانا (کوئی حل نہیں) ۵۔ ورزش نہ کرنے کی وجہ سے وزن کا بڑھنا (حل ہے)
۲	**ایک مسئلہ کا انتخاب**	۔اب اس لسٹ میں ایک ایسے مسئلہ کا انتخاب کریں جس کا حل نسبتاً آسان لگتا ہو۔
	مثال	خاوند سے لڑائی
۳	**ممکنہ حل**	۔اس مسئلہ کے ان عملی پہلوؤں پر غور کریں جو کہ نسبتاً آپ کے بس میں ہیں اور انہیں تبدیل کیا جا سکتا ہے۔ ۔کوشش کریں کے مسئلے کی وضاحت مخصوص اور مختصر ہو۔ ۔کوشش کریں کے ایک سے زیادہ مسئلہ شامل نہ ہو۔ ۔اگر مسئلہ پیچیدہ ہے تو اس کو چھوٹے حصّوں میں تقسیم کریں اور ہر حصّے کا علیحدہ علیحدہ تجزیہ کریں۔
	مثال	خاوند کی نوکری چھُوٹنے کے بعد سے روز لڑائی ہونا۔
۴	**مسئلے کے عملی پہلو**	۔مسئلے کے تمام ممکنہ حل سوچیں۔ اس بات کی پرواہ نہ کریں کے وہ صحیح ہیں یا غلط۔ ۔غور کریں کہ حل کے کون سے پہلو آپ اکیلے کر سکتے ہیں اور کون سے پہلوؤں کیلئے آپ کو کن لوگوں کی مدد درکار ہو گی۔ ۔موجودہ صلاحیات، وسائل، اور مدد کے ذریعوں پر غور کریں۔ ۔اگر آپ کو حل سوچنے میں مشکل ہو رہی ہے تو آپ اپنے آپ سے پُوچھیں کے اگر یہی مسئلہ آپ کے دوست کو ہوتا، تو آپ اسے کیا مشورہ دیتے؟
	مثال	۱۔ صبر کروں، نئی نوکری ملنے کا انتظار کروں کہ شاید سب ٹھیک ہو جائے۔ ۲۔ خاوند سے کہوں کے انہیں کسی بڑے سے بات کرنی چاہیئے۔ ۳۔ خاوند سے کہوں کی نوکری تلاش کرنے کیلئے زیادہ کوشش کریں۔ ۴۔ میں خُود کمانے کیلئے کوئی طریقہ سوچوں۔ ۵۔ میں اپنے عزیزوں سے مشورہ کروں۔ ۶۔ میں اپنی والدہ سے مشورہ کروں۔ ۷۔ اپنے خاوند کو بتاوں کہ میں پریشان ہوں۔

۵	**موثر حل کا انتخاب**	۔ممکنہ حل کی فہرست سے سب سے موثر حل کا انتخاب کریں۔ ۔موثر حل وہ ہو گا جس کے نُقصانات سب سے کم ہوں گے اور جن پر عمل کرنے کیلئے آپ کے پاس پیسے، وسائل، اور صلاحیت موجود ہے۔ ۔آپ ایک سے زیادہ حل کا انتخاب کر سکتے ہیں۔
	مثال	ا۔اپنی عزیز سہیلی سے اس مسئلے پہ بات کروں گی۔اس کے ساتھ بھی ملتا جلتا مسئلہ ہوا تھا۔اس لیئے وہ میرا مسئلہ بہتر طریقے سے سمجھے گی۔ ۲۔اپنی والدہ سے مشورہ کرُوں گی کہ میری جگہ وہ کیا کرتیں۔ ۳۔خاوند کو بتاوں گی کہ میں پریشان ہوں۔
۶	**حکمتِ عملی**	۔اب آپ اس حل پر عمل کرنے کے لیے تفصیلی پلین بنائیں۔ ۔اسکو کرنے کا دن اور وقت مقرر کریں۔ ۔اگر آپ نے ایک سے زیادہ حل کا انتخاب کیا ہے تو فیصلہ کریں کے پہلے کون سے حل کو آزمائیں گے۔ ۔اندازہ لگائیں کے آپ کو کن وسائل کی ضرورت ہو گی (مثلاً پیسے، گاڑی، کوئی اور شخص، وغیرہ) ۔ ۔اپنی یاد دہانی کیلئے ہر معاملے کو نوٹ کر لیں (پیغام، کیلینڈر پر نشان، روزمرہ کی سرگرمی کے ساتھ جوڑنا جیسے دوپہر کا کھانا وغیرہ) ۔
	مثال	منگل: سہیلی سے صبح دس بجے بات کروں گی کہ میری خاوند سے آجکل بہت لڑائی ہو رہی ہے۔مجھے کیا کرنا چاہیئے؟ جمعرات: اپنی والدہ سے بات چیت کے دوران اُنھیں خاوند کے ساتھ مسئلے کے بارے میں بتاؤں گی۔اُن سے پوچھوں گی کہ وہ میری جگہ ہوتیں تو کیا کرتیں؟ ہفتہ کی صُبح: خاوند گھر پہ ہوں گے تب میں اُنھیں بتاؤں گی کہ میں جھگڑوں کی وجہ سے پریشان ہوں، اُن کا ردِ عمل دیکھوں گی۔
۷	**جائزہ**	۔آپ نے جو حل آزمایا اور اسکے نتیجے کے بارے میں سوچیں۔ ۔اپنے پلین پر عمل کرتے ہوئے جو مسائل ہوئے، ان کے بارے میں سوچیں۔ ۔اگلی بار کی حکمتِ عملی کے بارے میں سوچیں۔اس میں آپ کیا تبدیلی لانا چاہیں گے تاکہ مسئلہ زیادہ بہتر طریقے سے حل ہو۔
	مثال	میری سہیلی نے مجھے بہت حوصلہ دیا۔حالانکہ اس کے پاس میرے مسئلے کا کوئی حل نہیں تھا مگر اس سے بات کر کے مجھے تسلّی ہوئی ہے اور میرا دل ہلکا ہوا ہے۔اس سے میں بہتر محسوس کر رہی ہوں۔ہم نے اور چیزوں کے بارے میں بھی باتیں کیں جس کی وجہ سے وقتی طور پر میرا دھیان اپنی پریشانی سے ہٹ گیا تھا۔ میری والدہ نے مجھے سمجھایا کہ مجھے خاوند سے نرمی کے ساتھ بات کرنی چاہیئے، ان کو قصوروار ہونے کا احساس دلائے بغیر۔انھوں نے میرے ساتھ بات کرنے کی پریکٹس کی جس سے مجھ میں اعتماد بڑھا۔ حوصلہ بڑھنے کی وجہ سے میں نے خاوند سے اسی شام بات کی۔انھوں نے بھی اعتراف کیا ہم بہت لڑنے لگے ہیں مگر ابھی ہم دونوں کو سمجھ نہیں آرہا کے اس کا حل کیا ہے۔ان سے بات کرنے کی وجہ سے میرے ذہن سے بہت حد تک بوجھ کم ہو گیا ہے۔

4. Strengthen social support
Start by inquiring:

What comforts you when you are upset?
Do you talk to anyone about your problems and what you are going through?
Is there any person who you feel can give you support?

پریشانی میں آپ کو سکون کیسے ملتا ہے؟
کس شخص سے بات کرنے سے آپ کی پریشانی کم ہوتی ہے؟
مشکل وقت میں کون آپ کو سب سے زیادہ سہارا دیتا ہے؟

Then follow the guidelines:
1. Help the person to identify supportive and trusted family members, friends and community members and to think through how each one can be involved in helping.

2. With the person's consent, refer them to other community resources for social support:
- Social or protection services
- Shelter, food and non-food items
- Community centres, self-help and support groups
- Income-generating and other vocational activities
- Formal/informal education
- Child-friendly spaces

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

5. Stress management
Start by inquiring:
What are your sources of stress?
What can you do about these?

آپ کو کن معاملات سے ذہنی دباؤ محسوس ہوتا ہے؟
آپ کے خیال میں ان کا حل کیا ہے؟

- Teach the person and the carers specific stress management techniques (e.g., slow breathing technique)
- In some settings, you can refer to a health worker (e.g., nurse or psychosocial worker) who can teach these techniques.

Box 2: Relaxation exercise - Slow breathing technique

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

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

1. Before we start, we will relax the body. Gently shake and loosen your arms and legs. Let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.
2. Now place one hand on your belly and the other hand on your upper chest. Imagine you have a balloon in your stomach and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Now I am going to exhale through my mouth to get all the air out of my stomach.
   [Demonstrate breathing from the stomach – try and exaggerate the pushing out and in of your stomach]
3. Now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out; then breathe in. If you can, try and breathe in through your nose and out through your mouth.
4. Now slow the rate of your breathing down. So we are going to take three seconds to breathe in, then two seconds to hold your breath, and three seconds to breathe out. I will count with you. You may close your eyes or keep them open.
   So breathe in, 1, 2, 3. Hold, 1, 2. And breathe out, 1, 2, 3. Do you notice how slowly I count?
5. Repeat this breathing exercise for approximately one minute.

Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down when you are stressed.
OK, now try on your own for one minute.

سانس لینے کی مشق

میں آپ کو سانس لینے کی مشق سکھاؤں گا جس سے آپ ذہنی ٹینشن پر قابو پا سکتے ہیں۔
یہ طریقہ اس اصول پر کام کرتا ہے کہ ذہنی دباؤ میں ہمارا سانس تیز ہو جاتا ہے اور گہرا نہیں رہتا، جو مزید تناؤ پیدا کر دیتا ہے۔ اس مشق کے ذریعے آپ پریشانی میں اپنی سانس کو بے قابو ہونے سے بچا سکتے ہیں۔

۱۔ سب سے پہلے اپنے آپ کو آرام دہ کریں۔ اپنے بازوؤں اور ٹانگوں کو ہلائیں اور بلکل ڈھیلا چھوڑ دیں۔ اپنے کندھوں کو پیچھے کی طرف گھمائیں اور اپنے سر کو دائیں سے بائیں ہلائیں۔

۲۔ اب ایک ہاتھ اپنے پیٹ پر رکھیں اور دوسرا اپنی چھاتی پر۔ آپ ایسا سوچیں کہ آپ کے پیٹ میں ایک غبارہ ہے۔ جب آپ سانس اندر کھینچیں گے تو یہ غبارہ پھول جائے گا اس سے آپ کا پیٹ باہر کی طرف آئے گا۔ جب آپ سانس باہر نکالیں گے تو پیٹ اندر کی طرف چلا جائے گا۔ پہلے مجھے دیکھیں کہ میں کیسے اپنے سانس کے ذریعے پیٹ سے ہوا اندر اور باہر کرتا ہوں۔

۳۔ اب آپ میری طرح اپنے پیٹ سے سانس لینے کی کوشش کریں۔ یاد رکھیں پہلے ہم سانس پیٹ سے باہر نکالیں گے تاکہ ساری ہوا نکل جائے۔ پھر سانس اندر لیں گے۔ کوشش کریں کہ ناک کے ذریعے سانس پیٹ میں لے جائیں اور منہ سے باہر نکالیں۔

۴۔ اب آپ نے اپنی سانس کی رفتار کو کم کرنا ہے۔ ہم تین سیکنڈ کیلئے سانس اندر کھینچیں گے۔ پھر دو سیکنڈ کیلئے سانس روکیں گے اور پھر تین سیکنڈ کیلئے سانس باہر نکالیں گے۔ میں آپ کے ساتھ گنوں گا۔
آپ اپنی آنکھیں کھلی یا بند رکھ سکتے ہیں۔
اب سانس اندر لیں: ایک، دو، تین۔
روکیں: ایک، دو۔
اور اب باہر نکالیں: ایک، دو، تین۔
آپ نے دیکھا کہ میں کتنے آہستہ آہستہ گن رہا تھا؟

۵۔ تقریباً ایک منٹ تک مشق جاری رکھیں۔

شروع میں آپ مشق کریں تو وقت گننے کی فکر نہ کریں۔ پریشانی یا دباؤ میں اپنی سانس کی رفتار کو آہستہ کرنے کی بہترین کوشش کریں۔

6. Address stress of the carers

Acknowledge that it is stressful to care for people with MNS conditions, but tell the carer that it is important that they continue to do so.

Even when this is difficult, carers need to respect the dignity of the people they care for and involve them in making decisions about their own lives as much as possible.

Ask the carer(s) about:

1. Worries and anxiety around caring for the person with MNS conditions in the current emergency situation
2. Practical challenges (e.g., burden on the carers' time, freedom, money)
3. Ability to carry out other daily activities, such as work or participation in community events
4. Physical fatigue
5. Social support available to the carers
6. Psychological well-being. If carers seem distressed or unstable, assess them for MNS conditions

Address the carers' needs and concerns:

1. Giving information
2. Linking the carer with relevant community services and supports
3. Discussing respite care. Another family member or a suitable person can take over the care of the person temporarily while the main carer takes a rest or carries out other important activities
4. Performing problem-solving counselling and teaching stress management;
5. Managing any MNS conditions identified in the carer.

5. PRINCIPLES OF PROTECTION OF HUMAN RIGHTS

1. People with severe MNS conditions need protection since they are at higher risk of human rights violations. They often experience difficulties in taking care of themselves and their families in addition to facing discrimination in many areas of life, including work, housing and family life.

2. They may have poor access to humanitarian aid. They may experience abuse or neglect in their own families and are often denied opportunities to fully participate in the community. Some people with severe MNS conditions may not be aware that they have a problem that requires care and support.

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

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

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

Key actions to address the protection of people with MNS conditions living in communities in humanitarian settings:

1. Engage the key stakeholders

1. Identify key stakeholders who should be made aware of the protection issues surrounding people with MNS conditions.

These key stakeholders include:

- people with MNS conditions and their carers
- community leaders (e.g., elected community representatives, community elders, teachers, religious leaders, traditional and spiritual healers)
- managers of various services (e.g., protection/ security, health, shelter, water and sanitation, nutrition, education, livelihood programmes)
- managers of disability services (many disability services inadvertently overlook disability due to MNS conditions)
- representatives of community groups (youth or women's groups) and human rights organizations; police and legal authorities.

2. Organize awareness-raising activities for the key stakeholders ?

- Consider offering orientation workshops on MNS conditions.
- Consult people with MNS conditions, their carers and the disability and social service sectors in the design and implementation of awareness-raising activities.
- During the awareness raising activities:
    Educate and dispel misconceptions about people with MNS conditions.

Educate on the rights of people with MNS conditions, including equal access to humanitarian aid and protection.
Dispel discrimination against people with MNS conditions.
Advocate for support for the carers of people with MNS conditions.

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

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

3. Promote the integration of people with severe MNS conditions in the community

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

6. PRINCIPLES OF ATTENTION TO OVERALL WELL-BEING

In addition to clinical care, people with MNS conditions need a range of other supports for their overall well-being. This is especially true in humanitarian settings where basic services, social structures, family life and security are often disrupted. People with MNS conditions face extra challenges to their daily routines and basic self-care.

1. Support people with MNS conditions to safely access services necessary for survival and for a dignified way of living
For example: water, sanitation, food aid, shelter, livelihoods support
This may involve:
1. advising about the availability and location of such services;
2. actively referring and working with the social sector to connect people to social services
3. advising about security issues when the person is not sufficiently aware of threats to security.

2. Arrange priority access to relevant activities for people with MNS conditions
For example, helping children with such conditions to access child-friendly spaces.

3. Support the general physical health of people with MNS conditions

- Arrange regular health assessments and vaccinations.
- Advise about basic self-care e.g., nutrition, physical activity, safe sex, family planning.

Your role of health-care provider extends beyond clinical care to advocacy for the overall well-being of people with MNS conditions across multiple sectors, as shown in the IASC Guidelines pyramid.

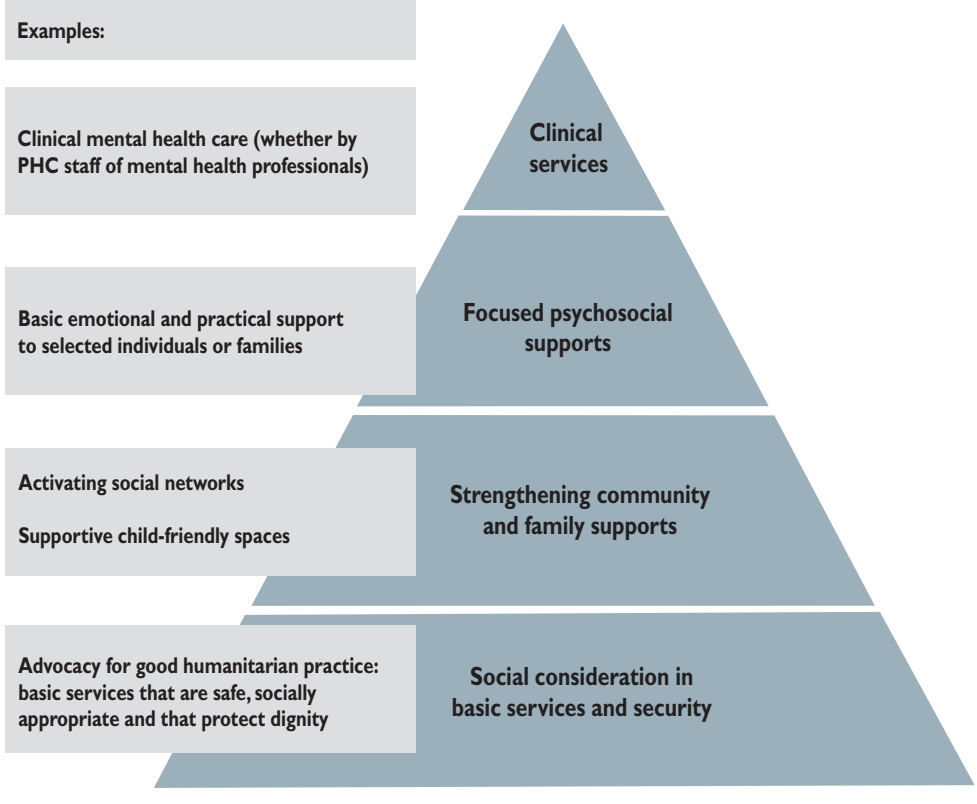


Figure GPC 1. The IASC intervention pyramid for mental health and psychosocial support in emergencies (adapted with permission)

Acute Stress

ACU

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

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

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

Significant symptoms of acute stress

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

The present module covers assessment and management of significant symptoms of acute stress.

ASSESSMENT

ASSESSMENT QUESTION 1: HAS THE PERSON RECENTLY EXPERIENCED A POTENTIALLY TRAUMATIC EVENT?

1. Ask if the person has experienced a potentially traumatic event
A potentially traumatic event is any threatening or horrific event such as a calamity, physical or sexual violence, witnessing of atrocity, or major accidents or injuries.

What major stress have you experienced? Have you experienced something that was very frightening or horrific or has made you feel very bad? Has your life been in danger?

آپ کس قسم کی آزمائش یا حادثے سے گزرے ہیں؟ کیا اس دوران آپ کو کوئی شدید پریشانی یا خوف لاحق ہوا ہے؟
اس دوران آپ نے اپنی زندگی کو کوئی خطرہ محسوس کیا ہو؟

2. Ask how much time has passed since the event(s)
Has the traumatic event occurred within a month or still occurring?

کیا حادثہ پچھلے ایک ماہ میں ہوا ہے یا اب بھی جاری ہے؟

3. If a major loss (e.g., the death of a loved one) has occurred, also assess for GRI.

4. If a potentially traumatic event has occurred more than 1 month ago, then consider other conditions including DEP, PTSD, PSY, SUB.

ASSESSMENT QUESTION 2: IF A POTENTIALLY TRAUMATIC EVENT HAS OCCURRED WITHIN THE LAST MONTH, DOES THE PERSON HAVE SIGNIFICANT SYMPTOMS OF STRESS?

1. Anxiety about threats related to the traumatic event(s)
How are you feeling about the event/ situation? If you are anxious, please describe it.
What worries or apprehensions are you experiencing?
Do you feel like you're in danger or threatened in some way?

آپ اس حادثے کے بارے میں کیسا محسوس کر رہے ہیں؟ اگر آپ پریشان ہیں تو مجھے اس کے بارے میں بتائیں۔
آپ اس واقعے کے بارے میں کیا پریشانی یا خدشہ محسوس کرتے ہیں؟ کیا آپ اب بھی خطرہ محسوس کرتے ہیں؟

2. Sleep problems
Have you noticed any changes in your sleep? For example, is your sleep disturbed? Do you have any trouble going off to sleep? Do you wake up early in the morning? Are you sleeping more than usual?

کیا آپ نے اپنی نیند میں کوئی تبدیلی محسوس کی ہے؟ مثلاً نیند کے آنے میں دیر لگتی ہے، بار بار آنکھ کھل جاتی ہے یا پہلے سے زیادہ نیند آ رہی ہے؟

3. Concentration problems
What has your concentration been like recently? For example, can you read an article in the paper or watch a TV program right through? When you are talking to another person can you concentrate on what they are saying to you?
آج کل آپ کی توجہ دینے کی صلاحیت کیسی ہے؟ مثال کے طور پر، اخبار پڑھنے میں یا ٹی وی دیکھنے میں یا لوگوں سے ملنے اور بات چیت کرنے میں ذہن بھٹک تو نہیں جاتا؟

4. Recurring frightening dreams, flashbacks or intrusive memories of the events, accompanied by intense fear or horror

Have you experienced unpleasant dreams or nightmares related to the trauma? How often does that happen? Can you deal with it?

کیا آپ کو ان حالات کی وجہ سے کوئی برے یا ڈراؤنے خواب آتے ہیں؟ ایسا کتنی دفعہ ہو رہا ہے؟
کیا یہ آپ کے لئے قابل برداشت ہے؟

5. Deliberate avoidance of thoughts, memories, activities or situations that remind the person of the events

For example, avoiding talking about issues that are reminders, or avoiding going back to places where the events happened.

Are you trying to avoid thoughts or discussions about the event? Does it cause you distress?

کیا آپ ان حالات (اس حادثے) کے بارے میں سوچنے یا بات کرنے سے گریز کرتے ہیں؟ کیا اس سے آپکی پریشانی میں اضافہ ہوتا ہے؟

6. Being 'jumpy' or 'on edge'

For example, excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements

Are you feeling agitated or nervous?
Do you get easily startled these days? or on edge all the time?

کیا آج کل آپ پریشانی اور گھبراہٹ محسوس کر رہے ہیں؟
کیا آپ آسانی سے چونک جاتے ہیں؟ کیا آپ کو ہر وقت ایسا لگتا ہے کہ ابھی کچھ بُرا ہو جائے گا

7. Feeling shocked, dazed or numb, or inability to feel anything

Are you feeling numb?
Are you feeling distant or cut off from people?
Do you have any difficulty in experiencing feelings like other people do?

کیا آپ کو ایسا محسوس ہوتا ہے جیسے آپ سُن ہو گئے ہوں؟
کیا اپنے آپ کو لوگوں سے دور اور علیحدہ محسوس کرتے ہیں؟
کیا آپ اور لوگوں کی طرح اپنے جذبات محسوس کرتے ہیں؟

8. Changes of behaviour

For example, aggression, social isolation and withdrawal, risk-taking behaviour in adolescents, regressive behaviour such as bed wetting, clinginess or tearfulness in children

For adults:

Have you noticed any change in your behaviour?
For example, are you getting more irritable or aggressive?
Or are you withdrawing from other people?

کیا اپ نے اپنے رویّے میں کوئی تبدیلی محسوس کی ہے؟
مثلاً آپ زیادہ غصہ کرنے لگے ہوں یا چڑچڑاپن محسوس کرتے ہوں؟
یا آپ اور لوگوں سے الگ تھلگ رہتے ہوں؟

For adolescents:
Have you noticed that you are any developing harmful tendencies?
For example, have you started to smoke, or take drugs?
Are you spending too much time on your phone, computer or TV?
Are you driving recklessly?

کیا آپ میں کوئی نقصان دہ رجحانات پیدا ہو رہے ہیں؟
مثلاً آپ نے سگریٹ نوشی یا کسی نشے کا استعمال شروع کر دیا ہو؟
یا آپ فون، ٹی وی یا کمپیوٹر کو بہت زیادہ وقت کے لئے استعمال کر رہے ہوں؟
کیا آپ لاپرواہی سے گاڑی چلا رہے ہیں؟

For children:
Have you noticed any change in the child's behaviour?
For example, does the child appear more tearful?
Has the child started wetting bed at night?
How does the child behave when separated from parents?

کیا آپ نے اپنے بچے کے رویّے میں کوئی تبدیلی محسوس کی ہے؟
مثال کے طور پر کیا بچہ پہلے سے زیادہ روتا ہے؟
کیا بچہ رات کو سوتے میں پیشاب کرنے لگا ہے؟
اگر ماں باپ دور ہوں تو بچے کے رویّے میں کیا تبدیلی آتی ہے؟

9. Hyperventilation
For example, rapid breathing, shortness of breath.
Have you noticed any changes in your breathing?
Are there times when you feel short of breath or start breathing too rapidly?

آپ نے سانس لینے میں کوئی تبدیلی محسوس کی ہے؟
آپ کو کبھی گھٹن محسوس ہوتی ہو یا سانس زیادہ تیز ہو جاتی ہو؟

10. Medically unexplained physical complaints
For example, palpitations, dizziness, headaches, generalized aches and pains.
Have you been experiencing any physical complaints (e.g., palpitations, dizziness, headaches, generalized aches and pains) without any evidence of a physical illness?

کیا آپ جسمانی طور پر کوئی علامات محسوس کرتے ہیں مثلاً دل کی دھڑکن تیز ہونا، چکر آنا، سر یا جسم میں درد ہونا وغیرہ جبکہ کسی جسمانی بیماری کا ثبوت بھی نہ ہو؟

11. Dissociative symptoms relating to the body
For example, medically unexplained paralysis, inability to speak or see, pseudoseizures.
Did any unusual symptoms start without an underlying cause? For example, inability to walk, inability to speak? Experiencing any 'fits'?

کیا کوئی انہونی علامات اچانک سے شروع ہوئی ہیں؟
جن کی وجہ معلوم نہ ہو سکے؟
مثلاً چلنے یا بولنے کی صلاحیت کھو دینا، جھٹکے لگنا یا بے ہوشی کے دورے پڑنا؟

Differences between an epileptic and dissociative fit			
	Check	Epileptic seizure	Dissociative 'fit'
1	Consciousness	Impaired	Not impaired
2	Awareness of surrounding	Lost	Usually altered and not lost
3	Pattern	Regular	Irregular
4	Occurrence	Any time, even during sleep	Usually in the company of people
5	Duration	Few seconds or few minutes	Longer, many minutes to hours
6	Tongue bite	May be present	Absent
7	Urinary incontinence	May be present	Absent
8	Movements of the body	Consistent with tonic clonic fit	Not consistent with tonic clonic fit
9	Injury	May injure him/herself	Injury rare

ASSESSMENT QUESTION 3: IS THERE A CONCURRENT CONDITION?

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

Check for any other mental, neurological and substance use (MNS) condition including DEP that may explain the symptoms and manage accordingly if found.

BASIC MANAGEMENT PLAN

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

PSYCHOSOCIAL INTERVENTIONS

1. Provide basic psychosocial support

- Allow the person to speak without interruption. Distressed people may not always give a clear history. When this happens, be patient and ask for clarification. Try not to rush them.
- Do not press the person to discuss or describe potentially traumatic events if they do not wish to open up. Simply let them know that you are there to listen.
- If they discuss the traumatic experience, be empathic and convey that you understand the person's feelings.

  That sounds like a very challenging experience.
  I understand how painful this has been for you.
  I can see why you are so sad/frightened etc.

آپ کے حالات سن کر آپ کی دشواری کا اندازہ ہوتا ہے۔
میں سمجھ سکتا ہوں کہ یہ آپ کے لئے کتنا تکلیف دہ رہا ہے اور آپ اتنے پریشان کیوں ہیں۔

- Ask the person about his/her needs and concerns.
- Help the person to address basic needs, access services and connect with family and other social support.
- Protect the person from (further) harm.
- Educate the person about normal reactions to acute stress

People often have these reactions after such events. In most cases, reactions will reduce over time.

ایسے حالات میں یہ کیفیات عام ہیں اور یہ وقت گزرنے کے ساتھ ساتھ بہتر ہو جاتی ہیں۔

2. Offer additional psychosocial support

1. Address current psychosocial stressors
2. Strengthen social support.
3. Teach stress management.

Go to Principles of Reducing Stress and Strengthening Social Support in GPC.

3. In case of sleep problems

Advise on sleep hygiene:

People commonly develop sleep problems (insomnia) after experiencing extreme stress.
Some causes in the environment can cause problems in sleep e.g., noise.
Some physical causes can cause problems in sleep e.g., physical pain.
Maintain regular sleep routine e.g., regular times for going to bed and waking up.
Avoid coffee, nicotine and alcohol late in the day or before going to bed.
Use of alcohol can cause sleep problems.

پریشانی کے حالات میں نیند کے مسائل عام ہوتے ہیں۔
ارد گرد کے ماحول کے مسائل کی وجہ سے بھی نیند خراب ہو سکتی ہے مثلاً شور کی وجہ سے۔
کسی جسمانی تکلیف (درد وغیرہ) کی وجہ سے بھی نیند کے مسائل آسکتے ہیں۔
سونے جاگنے کے اوقات میں باقاعدگی رکھیں۔
سونے کے وقت کافی، سگریٹ، شراب وغیرہ سے پرہیز کریں۔
شراب کا استعمال نیند میں مسائل پیدا کر سکتا ہے۔

4. In the case of bedwetting in children

Obtain the history of bedwetting to confirm that it started after experiencing a stressful event. Rule out and manage other possible causes e.g., urinary tract infection.

Educate the carers:

- Bedwetting is a common, harmless reaction in children who experience stress.
- Children should not be punished for bedwetting because punishment adds to the child's stress and may make the problem worse.
- The carer should avoid embarrassing the child by mentioning bedwetting in public.
- Carers should remain calm and emotionally supportive.

مشکل حالات یا کسی حادثے کے بعد بچوں میں رات کو سوتے میں پیشاب کرنا ایک عام مسئلہ ہے۔

- سب سے پہلے مکمل تحقیق کر لیں کہ مسئلہ کسی پریشانی کے بعد شروع ہوا ہے اور بچے کو کوئی اور بیماری نہیں ہے۔
- یہ کوئی مضر بیماری نہیں ہے۔ گھر والے خود پر سکون اور حوصلے میں رہیں۔
- بچوں کو اس مسئلے کی وجہ سے سزا نہ دیں۔ سزا کی وجہ سے بچے زیادہ ذہنی دباؤ کا شکار ہو جاتے ہیں جس سے مسئلہ خراب ہو سکتا ہے۔
- اور لوگوں کے سامنے اس مسئلے کو بیان کر کے بچوں کو شرمندہ نہ کریں۔
- گھر والے خود پریشان نہ ہوں اور پر سکون رہیں۔

Train the carers to use simple behavioural interventions:

- Avoid excessive fluid intake before sleep
- Reward toileting before sleep
- Reward dry nights
- The reward can be anything the child likes, such as appreciation, extra playtime, or stars on a chart.

گھر والوں کو سکھائیں کہ بچے کو سونے سے پہلے زیادہ پانی نہ دیں۔
اس کی حوصلہ افزائی کریں کہ وہ سونے سے پہلے باتھ روم جانے کی عادت بنائے۔
اگر وہ ہدایات پر عمل کرے تو اسے انعام دیں۔
اگر وہ بستر پر پیشاب نہ کرے تو اسے انعام دیں۔
انعام میں شاباش دینا یا کھیل کود کیلئے زیادہ وقت دینا یا چارٹ پر سٹار دینا شامل ہیں۔

If the problem persists after one month, re-assess for any concurrent mental disorder.

If there is no concurrent mental disorder or if there is no response to treatment, refer to a specialist.

5. In the case of hyperventilation (breathing extremely fast and uncontrollably)

Follow the guidelines:

- Rule out and manage other possible causes, even if hyperventilation started immediately after a stressful event, always conduct necessary medical investigations to identify possible physical causes such as lung disease.
- If no physical cause is identified, reassure the person that hyperventilation sometimes occurs after experiencing extreme stress and that it is unlikely to be a serious medical problem.
- Be calm and remove potential sources of anxiety if possible.
- Help the person regain normal breathing by practicing slow breathing in GPC.
- Do not recommend breathing into a paper bag.

سب سے پہلے مکمل تحقیق کر لیں کہ سانس کا مسئلہ کسی اور بیماری کی وجہ سے نہیں ہے۔ چاہے یہ مسئلہ حادثے کے بعد ہی شروع ہوا ہو۔ پھیپھڑوں کی بیماری کے لیے ضروری ٹیسٹ کروائیں۔

اس کے بعد اس شخص کو حوصلہ دیں کہ شدید پریشانی کے عالم میں سانس لینے میں دشواری ہو سکتی ہے۔ اسکا یہ مطلب نہیں کہ آپ کو کوئی خطرناک بیماری ہے۔

آپ خود پر سکون رہیں اور پریشانی کی وجوہات سے دور رہیں۔

سانس لینے کی مشق کے ذریعے سانس کو قابو کرنے کی کوشش کریں۔

البتہ لفافے میں سانس لینے کی تجویز نہ کریں۔

6. In the case of a dissociative symptom relating to the body

Dissociative symptoms may present as symptom of acute stress. These include medically unexplained paralysis, inability to speak or see, “pseudo-seizures” etc.

- Always rule out and manage other possible causes, even if the symptoms started immediately after a stressful event.
- Always conduct necessary medical investigations to identify possible physical causes.
- See EPI for guidance on medical investigations relevant to seizures/convulsions.
- Important DO NOTs:
  Do not blame or make fun of the patient
  Do not administer Ammonia or any other coercive method.

Then follow the guidelines:

- Acknowledge the person’s suffering and maintain a respectful attitude.
- Identify and avoid reinforcing any gain that the person may get from the symptoms.
- Ask for the person’s own explanation of the symptoms and apply the general guidance on the management of medically unexplained somatic symptoms in **OTH**.
- Reassure the person that these symptoms sometimes develop after experiencing extreme stress and that it is unlikely to be a serious medical problem.
- Consider the use of culturally specific interventions that do no harm.

سب سے پہلے مکمل تحقیق کر لیں کہ سانس کا مسئلہ کسی اور بیماری کی وجہ سے نہیں ہے۔ چاہے یہ مسئلہ حادثے کے بعد ہی شروع ہوا ہو۔ کسی قسم کی ممکنہ بیماری کے لیے ضروری ٹیسٹ کروائیں۔

ہمدردی اور احترام سے مریض کی علامات کو سمجھیں۔

ایسے عمل یا رویّے جو ان علامات کو بڑھا رہے ہوں، انکو دور کرنے کی کوشش کریں۔

یہ ضرور پوچھیں کہ مریض کی اپنی نظر میں ان علامات کی کیا وجہ ہے۔

مریض کو تسلی دیں کہ شدید پریشانی میں اس قسم کی علامات آسکتی ہیں۔ اس کا یہ مطلب نہیں کہ انہیں کوئی خطرناک مسئلہ ہے۔

7. Manage concurrent conditions

PHARMACOLOGICAL INTERVENTION

Before prescribing Benzodiazepines (sleeping tablets), ensure:

- Consider prescribing medicines only in exceptionally severe cases where psychological interventions (e.g., relaxation techniques) are not feasible or not effective.
- Always explain that this is only a temporary solution for an extremely severe sleep problem and that these medicines cause dependence (usually within 4-6 weeks).

نیند کی ادویات صرف اس صورت میں تجویز کریں جب مسئلہ شدید ہو یا صرف مشورے یا ذہنی دباؤ کی مشق سے فائدہ نہ ہو سکے۔

ادویات شروع کرنے سے پہلے ہمیشہ بتائیں کہ یہ دوائیں نیند کے شدید مسائل کا وقتی حل ہیں اور چار سے چھ ہفتے میں ان ادویات کی عادت ہو جاتی ہے۔

Benzodiazepines	
Indication	In severe cases where insomnia causes considerable difficulty with daily functioning
Duration of use	Short-term treatment (3–7 days) with benzodiazepines may be considered
Commonly used Benzodiazepines	Diazepam, Alprazolam, Bromazepam, Clonazepam
Dose	For adults, Diazepam 2–5 mg at bedtime For older people, Diazepam 1–2.5 mg at bedtime or For adults, Bromazepam 3mg at bedtime For older people, Bromazepam 1.5mg at bedtime
Common side-effects	Drowsiness and muscle weakness These medicines may slow down breathing. Regular monitoring may be necessary. Avoid this medication in women who are pregnant or breastfeeding. Monitor for side-effects frequently when used in older people.

Benzodiazepines should not be used for:

- insomnia caused by bereavement in adults or children.
- Any other symptoms of acute stress or PTSD.

FOLLOW-UP

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

Grief

GRI

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

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

Significant symptoms of grief

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

The present module covers assessment and management of significant symptoms of grief.

Prolonged grief disorder

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

ASSESSMENT

ASSESSMENT QUESTION 1: DOES THE PERSON HAVE SIGNIFICANT SYMPTOMS OF GRIEF?

A. Has the person experienced a major loss in the last 6 months?

How has the disaster/conflict affected you?
Have you suffered any losses? a family member or a friend? your house or valuables? your job or livelihood? your community?
How has the loss affected you?
Are any family members or friends missing?

How long has it been since the disaster/conflict?

اس سانحے (تنازعہ یا حالات) سے آپ کیسے متاثر ہوئے ہیں؟
کیا آپ کو کوئی نقصان پہنچا ہے؟ جیسے کہ خاندان میں کوئی جانی نقصان ہوا ہو؟
آپ کے گھر یا قیمتی اشیاء کو نقصان پہنچا ہو؟ آپ کی کمائی کا ذریعہ متاثر ہوا ہو؟
اس نقصان کا آپ پہ کیا اثر ہوا ہے؟
کیا کوئی گھر والا یا دوست گم شدہ ہے؟
اس حادثے کو پیش آئے کتنا عرصہ گزر چکا ہے؟

If a major loss has occurred more than 6 months ago or if a potentially traumatic event has occurred more than 1 month ago

Consider other conditions DEP, PTSD, PSY, SUB or Prolonged Grief Disorder.

B. If a major loss has occurred within last 6 months, does the person have any of the significant symptoms of grief?

1. Sadness, anxiety, anger, despair

What has your mood been like lately? or how would you describe your mood?
Do you feel angry about your loss?
Do you feel that life is empty or meaningless without the deceased?
How do you see the future? Do you, sometimes, end up losing hope?

آپ اپنے دل میں کیسا محسوس کرتے ہے؟ آپ اپنے مزاج کو کس طرح بیان کریں گے؟ ان دنوں آپ کا مزاج کیسا ہے؟
کیا آپ اپنے نقصان پہ خفگی یا غصّہ محسوس کرتے ہیں؟
کیا آپ کو اپنے عزیز کے بغیر زندگی بے معنی اور نامکمل لگتی ہے؟
آپکو اپنا مستقبل کیسا لگتا ہے؟ کیا آپ کبھی ناامیدی محسوس کرتے ہیں؟

2. Yearning and preoccupation with loss

Have you felt yourself longing and yearning for the deceased? How often?

آپ کو فوت ہوئے شخص کی یاد اور تڑپ کتنی شدّت سے محسوس ہوتی ہے؟

3. Intrusive memories, images and thoughts of the deceased

How often or how much do you have images or thoughts of the deceased?
Do you feel you can't avoid thinking about the deceased?

آپ فوت ہوئے شخص کے بارے میں کتنا سوچتے ہیں؟
کتنی دفعہ ایسا ہوا ہے کہ ان کا خیال آئے یا چہرہ دکھائی دے؟
کیا آپ کو ایسا محسوس ہوا ہے کہ آپ ان کے بارے میں سوچنے پر مجبور ہیں؟

4. Loss of appetite

Have you noticed any changes in your appetite?
Do you have less or more appetite than usual these days?

آج کل آپ کی بھوک کیسی ہے؟ کیا اس میں کوئی کمی یا زیادتی ہوئی ہے؟

5. Loss of energy

How is your energy level? Do you easily get tired during the day also when you have not done anything especially hard?

آج کل آپ کے جسم میں طاقت کیسی ہے؟ کیا آپ تھکاتھکا محسوس کرتے ہیں یا آسانی سے تھک جاتے ہیں؟

6. Sleep problems

Have you noticed any changes in your sleep?
For example, have you had any trouble Going to sleep during the past month? Do you wake up early in the morning? Are you sleeping more than usual? Do you wake up unrefreshed?

کیا آپ نے پچھلے ایک ماہ میں اپنی نیند میں کوئی تبدیلی محسوس کی ہے؟ مثلاً نیند کے آنے میں دیر لگتی ہو؟ کیا آپ صبح بہت جلدی اٹھ جاتے ہیں؟ پہلے سے زیادہ نیند آ رہی ہو؟
کیا آپ سونے کے بعد صبح تازہ دم نہیں اٹھتے ہیں؟

7. Concentration problems

What has your concentration been like recently? Can you read an article in the paper or watch a TV program right through? When you are talking to another person can you concentrate on what they are saying to you?

آج کل آپکی توجہ دینے کی صلاحیت کیسی ہے؟ مثلاً اخبار پڑھنے میں یا ٹی وی دیکھنے میں یا لوگوں سے بات چیت کرنے میں ذہن بھٹک تو نہیں جاتا؟

8. Social isolation and withdrawal

Do you prefer to be on your own or do you feel better when others are around?
Do you try to avoid company of other people?

آپ اکیلا رہنا چاہتے ہیں یا لوگوں کے درمیان بہتر محسوس کرتے ہیں؟
کیا آپ لوگوں سے ملنے سے پرہیز کرتے ہیں؟

9. Medically unexplained physical complaints
For example: palpitations, headaches, generalized aches and pains.

Have you been experiencing any physical complaints (e.g., palpitations, dizziness, headaches, generalized aches and pains) without any evidence of a physical illness?

کیا آپ کو کوئی جسمانی علامات ہیں (مثلاً دل کی دھڑکن کا تیز ہونا، چکر آنا، سر درد ہونا یا جسم میں درد ہونا وغیرہ) جب کہ کسی متعلقہ بیماری کی تشخیص نہ ہوئی ہو؟

10. Culturally specific grief reactions

For example: hearing the voice of the deceased person, being visited by the deceased person in dreams.

Do you frequently hear the voice of the deceased person?
Does the deceased frequently visit you in dreams?

کیا آپ کو فوت شدہ شخص کی آواز اکثر سنائی دیتی ہے؟
کیا آپ ان کو اکثر خواب میں دیکھتے ہیں؟

C. Does the person have considerable difficulty with daily functioning because of the symptoms (beyond what is culturally expected) or seeking help for the symptoms.

This question needs to be adapted depending on the role & responsibilities of the patient.

Do you have any difficulty performing your duties at work?
Do you have any difficulty performing your household responsibilities/looking after your children?
Do you have any difficulty in your routine work/studies?

کیا آپ کو اپنا کام کرنے میں کوئی مشکل پیش آتی ہے؟
کیا آپ کو گھر کے کام میں یا بچوں کی دیکھ بھال میں کوئی مشکل پیش آتی ہے؟
کیا آپ کو اپنی پڑھائی کرنے میں کوئی مشکل پیش آتی ہے؟

Significant symptoms of grief are likely if the person meets all the criteria in A, B and C.

ASSESSMENT QUESTION 2: IS THERE A CONCURRENT CONDITION?

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

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTION

1. Provide basic psychosocial support

- Listen carefully. DO NOT pressure the person to talk.
  Children may need more time to feel comfortable. Use language that they can understand. Establishing a relationship with children may require talking about their interests (toys, friends, school, etc.).
- Be empathic by conveying that you understand the person's feelings.

  Following are some examples:
  That sounds like a very challenging experience.
  I understand how painful this has been for you.
  I can see why you are so sad/frightened etc.

  آپ کے حالات سن کر آپ کی دشواری کا اندازہ ہوتا ہے۔ میں سمجھ سکتا ہوں کہ یہ آپ کے لئے کتنا تکلیف دہ رہا ہے اور آپ اتنے پریشان کیوں ہیں۔

- Ask the person about his/her needs and concerns.
- Help the person to address basic needs, access services and connect with family and other social supports.
- Protect the person from (further) harm.

2. Discuss and support culturally appropriate adjustment/mourning processes

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

3. Address current psychosocial stressors and strengthen social support.

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

آجکل آپ کی سب سے بڑی پریشانی کیا ہے؟
آپ اس پریشانی سے کیسے نمٹ رہے ہیں؟
کونسے ایسے کام ہیں جو آپ کو ذہنی سکون اور حوصلہ دیتے ہیں؟
آپ کس شخص کو اپنے مسئلے بتانے میں آسانی محسوس کرتے ہیں؟ جب آپ پریشان ہوتے ہیں تو آپ کس سے مشورے کرتے ہیں؟
آپ کے اپنے گھر والوں سے تعلقات کیسے ہیں؟ ان کی وجہ سے آپ کو کب حوصلہ ملتا ہے اور کب پریشانی ہوتی ہے؟

Then follow the guidelines:

- Strengthen social supports and try to reactivate the person's social networks.
  Identify prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychosocial support (e.g., family gatherings, visiting neighbours, community activities, religious activities, etc.).
- Identify and discuss relevant psychosocial issues that place stress on the person and/or impact their life including, but not limited to, family and relationship problems, employment/ occupation/livelihood issues, housing, finances, access to basic security and services, stigma, discrimination, etc.
- Assist the person to manage stress by discussing methods such as problem-solving techniques.
- Assess and manage any situation of maltreatment, abuse (e.g., domestic violence) & neglect of children or the elderly.
- Discuss with the person possible referrals to a trusted protection agency or informal protection network. Contact legal and community resources, as appropriate.
- Identify supportive family members and involve them as much as possible and appropriate.

4. Educate the person about common reactions to losses

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

اتنے بڑے سانحے کے بعد لوگ مختلف کیفیات سے گزرتے ہیں۔ کچھ لوگوں کے جذبات میں شدّت ہوتی ہے اور کچھ ایسا نہیں کرتے۔

رونا کمزوری کی علامت نہیں ہے۔

جو لوگ نہیں روتے ان کی تکلیف بھی اتنی ہی شدید ہوتی ہے مگر وہ اس کا اظہار مختلف طریقوں سے کرتے ہیں۔

آپ کو ایسا لگ سکتا ہے کہ یہ تکلیف اور اداسی کبھی ختم نہیں ہو گی، مگر زیادہ تر لوگوں میں وقت کے ساتھ ساتھ پریشانی میں کمی آجاتی ہے۔

کبھی آپ ٹھیک محسوس کرتے ہیں پھر کوئی چیز آپ کو صدمے کی یاد دلا دیتی ہے۔ ایسا سب کے ساتھ ہوتا ہے اور وقت کے ساتھ ان جذبات میں کمی آجاتی ہے۔

غم سے نمٹنے کا کوئی صحیح یا غلط طریقہ نہیں ہے، کبھی شدید اداسی ہوتی ہے اور کسی وقت آپ بہتر محسوس کرتے ہیں، کسی بھی موقع پہ اپنی کیفیت کی وجہ سے اپنے آپ کو الزام نہ دیں۔

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

6. For children and adolescents

- Answer the child's questions by providing clear and honest explanations that are appropriate to the child's level of development. Do not lie when asked about a loss (e.g., Where is my mother?). This will create confusion and may damage the person's trust in the health provider.

- Check for and correct “magical thinking” common in young children (e.g., children may think that they are responsible for the loss; for example, they may think that their loved one died because they were naughty or because they were upset with them).
- For children, adolescents and other vulnerable persons who have lost parents or other carers, address the need for protection and ensure consistent, supportive caregiving, including socio-emotional support. If needed, connect the person to trusted protection agencies/networks.

7. Teach stress management

Go to GPC

8. Specific management of sleep problems, bedwetting, hyperventilation and dissociative symptoms after recent loss

For specific management of sleep problems, bedwetting, hyperventilation and dissociative symptoms after recent loss, Go to ACU.

9. Manage concurrent conditions.

FOLLOW UP

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

Monitor improvement:

How have you been?
Have you noticed any improvement?
What problems (symptoms) are resolving/getting better?
What problems (symptoms) are not improving?
Have you been able to do the things you were doing before this loss?

اب آپ کی طبیعت کیسی ہے؟

کیا آپ نے کوئی بہتری محسوس کی؟

آپ کے کونسے مسائل (علامات) بہتر ہو رہے ہیں؟

آپ کے کونسے مسائل (علامات) بہتر نہیں ہو رہے ہیں؟

کیا آپ اپنا کام اسی طرح کر پاتے ہیں جیسے آپ اس صدمے سے پہلے کرتے تھے؟

When to refer?

If prolonged grief is suspected, consult a specialist.

What is Prolonged Grief Disorder?

1. The symptoms of bereavement include severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain.
2. Considerable difficulty with daily functioning for at least 6 months.
3. This period may be longer than six months in cultures where the expected duration for mourning/bereavement is longer than 6 months.

Moderate-severe Depressive Disorder

DEP

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

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

Typical presenting complaints of moderate-severe depressive disorder:

- Low energy, fatigue, sleep problems
- Multiple persistent physical symptoms with no clear cause (e.g. aches and pains)
- Persistent sadness or depressed mood, anxiety
- Little interest in or pleasure from activities.

ASSESSMENT

ASSESSMENT QUESTION 1: DOES THE PERSON HAVE MODERATE-SEVERE DEPRESSIVE DISORDER?

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

1. Persistent depressed mood

You should be familiar with local terms and expressions to describe depressed mood (sadness) and use these terms as well.
Note your observations and inquire:
What has your mood been like lately?
How would you describe your mood?

آپ اپنے دل میں کیسا محسوس کرتے ہے؟
آپ اپنے مزاج کو کس طرح بیان کریں گے؟
ان دنوں آپ کا مزاج کیسا ہے؟

2. Markedly diminished interest in or pleasure from activities

How has your interest been?
If reduced, how long has that been so?
How is your interest in your work, family, hobbies, personal care, environment etc.?
Are you able to enjoy things you used to like e.g., taking a walk, working at your hobbies, reading, meeting people etc.?

آج کل آپ کی دلچسپی کیسی ہے؟
کتنے عرصے سے آپ اپنی دلچسپی میں کمی محسوس کر رہے ہیں؟
اپنے کام میں، میل جول میں، مشغلوں میں، اپنی دیکھ بھال میں اور ارد گرد کے ماحول میں آپ کی دلچسپی کیسی ہے؟
کیا آپ جن چیزوں سے پہلے محظوظ ہوتے تھے ان میں اب بھی مزا آتا ہے مثلاً سیر کرنا، مشاغل پر کام کرنا، کتابیں پڑھنا، لوگوں سے ملنا وغیرہ؟

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

1. Disturbed sleep or sleeping too much

Have you noticed any changes in your sleep?
For example, have you had any trouble Going to sleep during the past month?
Do you wake up early in the morning?
Are you sleeping more than usual?
Do you wake up unrefreshed?

کیا آپ نے پچھلے ایک ماہ میں اپنی نیند میں کوئی تبدیلی محسوس کی ہے؟
مثلاً نیند کے آنے میں دیر لگتی ہو؟
کیا آپ صبح بہت جلدی اُٹھ جاتے ہیں؟
پہلے سے زیادہ نیند آرہی ہو؟
کیا آپ سونے کے بعد صبح تازہ دم اٹھتے ہیں؟

2. Significant change in appetite or weight (decrease or increase)

Have you noticed any changes in your appetite?
Have you lost or gained any weight during the past three months?

آج کل آپ کی بھوک کیسی ہے؟
کیا اس میں کوئی کمی یا زیادتی ہوئی ہے؟
کیا آپ نے پچھلے تین ماہ میں اپنے وزن میں کوئی تبدیلی محسوس کی ہے؟

3. Beliefs of worthlessness or excessive guilt

Have you experienced any negative thought?
For example, do you feel like a failure?
Do you feel disappointed in yourself?
Do you feel worthless?

کیا آپ کو آج کل کوئی منفی سوچ پریشان کرتی ہے؟
مثلاً اپنا آپ بے کار لگتا ہو؟
اپنے آپ کو ناکام سمجھتے ہوں؟
اپنے آپ سے مایوس ہوں؟

4. Fatigue or loss of energy

How is your energy level?
Do you easily get tired during the day also when you have not done anything especially hard?

آج کل آپ کے جسم میں طاقت کیسی ہے؟
کیا آپ تھکا تھکا محسوس کرتے ہیں یا آسانی سے تھک جاتے ہیں؟

5. Reduced ability to concentrate

What has your concentration been like recently?
Can you read an article in the paper or watch a TV program right through?
When you are talking to another person can you concentrate on what they are saying to you?

To test concentration, do the following tests:
Name the days of the week in backward order like Sunday, Saturday, Friday and further?
Count backwards from 20 like 20, 19, 18, and further?

آج کل آپ کی توجہ دینے کی صلاحیت کیسی ہے؟
مثلاً اخبار پڑھنے میں یا ٹی وی دیکھنے میں میں ذہن بھٹک تو نہیں جاتا؟
کسی سے بات کرتے وقت کیا آپ انکی بات پر توجہ دے سکتے ہیں؟

دھیان دینے کی صلاحیت کو چیک کرنے کیلئے، نیچے دیے گئے ٹیسٹ کروائیں:
ہفتے کے دنوں کے نام الٹی ترتیب میں بتائیں جیسے اتوار، ہفتہ، جمعہ وغیرہ
بیس سے الٹی گنتی گنیں جیسے بیس، انیس، اٹھارہ وغیرہ؟

6. Indecisiveness

How is your ability to make decisions? Are you finding it difficult to make decisions?

آج کل آپ کی فیصلے کرنے کی صلاحیت کیسی ہے؟ کیا آپ کو فیصلے کرنے میں کوئی مشکل پیش آ رہی ہے؟

7. Observable agitation or physical restlessness

Note this during examination, or ask the carers.

8. Talking or moving more slowly than normal

Note this during examination, or ask the carers.

9. Hopelessness about the future

This may be a difficult question and needs to be asked sensitively.

When people experience stressful events, most will usually experience a range of different emotions, like extreme sadness and excessive hopelessness. Now I am going to check for these thoughts.

How do you see the future? Do you, sometimes, end up losing hope?

کچھ لوگ پریشان حالات سے گزرتے ہیں تو بے حد اداسی یا شدید ناامیدی محسوس کرتے ہیں۔
میں اب ایسے خیالات کے بارے میں سوال کروں گا/گی۔

آپ کو اپنا مستقبل کیسا لگتا ہے؟ کیا آپ کبھی ناامیدی محسوس کرتے ہیں؟

10. Suicidal thoughts or acts

This may be a difficult question and needs to be asked sensitively.

Sometimes when people feel very sad and lose hope, they may think about dying or, ending their own life. These thoughts are not uncommon and it is important that I check for these. Is that okay with you? Can we continue with the interview?

کچھ لوگ اداسی اور ناامیدی کی صورت میں موت کے بارے میں یا اپنی زندگی ختم کرنے کے بارے میں بھی سوچتے ہیں۔ ڈپریشن میں یہ سوچیں عام ہوتی ہیں اور ان کے بارے میں پوچھنا ضروری ہے۔ آپ کو اس سے کوئی اعتراض تو نہیں؟ کیا ہم اپنی بات جاری رکھیں؟

Have you ever felt that life isn't worth living? Have you ever felt like ending it all?
Have you ever made a suicide plan? Have you ever tried to harm yourself?

کیا آپ کو کبھی ایسا لگتا ہے کہ زندگی جینے کے قابل نہیں رہی؟ کیا آپ نے کبھی زندگی کو ختم کرنے کے بارے میں سوچا ہے؟ کیا آپ کو کبھی خودکشی کا خیال آیا ہے؟ کیا آپ نے کبھی اپنے آپ کو نقصان پہنچانے کی کوشش کی ہے؟

If there is risk of self-harm or suicide, inform the patient that you might have to discuss your concerns with his/her family.

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

This question needs to be adapted depending on the role & responsibilities of the patient.

Do you have any difficulty performing your duties at work? Do you have any difficulty performing your household responsibilities/looking after your children? Do you have any difficulty in your routine work/studies?

کیا آپ کو اپنا کام کرنے میں کوئی مشکل پیش آتی ہے؟ کیا آپ کو گھر کے کام میں یا بچوں کی دیکھ بھال میں کوئی مشکل پیش آتی ہے؟ کیا آپ کو اپنی پڑھائی کرنے میں کوئی مشکل پیش آتی ہے؟

If A, B and C all 3 are present for at least 2 weeks, then moderate-severe depressive disorder is likely. Delusions or hallucinations may be present. Check for these. If present, treatment for depressive disorder needs to be adapted. Consult a specialist.

If delusions or hallucinations are present, consult a specialist.

If the person's symptoms do not meet the criteria for moderate-severe depressive disorder, go to OTH module for assessment and management of the presenting complaint.

ASSESSMENT QUESTION 2: ARE THERE OTHER POSSIBLE EXPLANATIONS FOR THE SYMPTOMS (OTHER THAN MODERATE-SEVERE DEPRESSIVE DISORDER)?

1. **Rule out concurrent physical conditions that can resemble depressive disorder.**

Note your observations, ask screening questions AND conduct a physical examination.

Is this a physical condition that can resemble or exacerbate depression?
For example, anaemia, malnutrition, hypothyroidism, mood changes from substance use and medication side-effects (e.g., mood changes from steroids)?

Look for signs of a physical illness, for example:

- Pallor
- Weight loss
- Goiter (enlarged thyroid gland)
- Dry, rough skin
- Coarse hair or hair loss
- Eye and face swelling.

2. **Rule out Bipolar Affective Disorder**
   Check history of Mania in the past.

What is Mania or a manic episode?

When many of the following symptoms were present for more than 1 week & these symptoms cause significant difficulty with daily functioning or were a danger to the person or to others.

1. Decreased need for sleep
2. Euphoric, expansive or irritable mood
3. Racing thoughts; being easily distracted
4. Increased activity, feeling of increased energy or rapid speech
5. Impulsive or reckless behaviors such as excessive gambling or spending, making important decisions without adequate planning
6. Unrealistically inflated self-esteem.

If a manic episode has ever occurred, then the depression is likely to be part of another disorder called Bipolar Affective Disorder and requires different management.

- Impaired functioning is part of a normal response after bereavement (within cultural norms)
- None of the following symptoms are present:
  - beliefs of worthlessness
  - suicidal ideation
  - psychotic symptoms (delusions or hallucinations)
- There is no previous history of depressive disorder or manic episode

What is Prolonged Grief Disorder?

At least 6 months (or for a period that is much longer than what is expected in that person's culture), after the death of a close family member/friend, if a person continues to experience:

1. Considerable difficulty with daily functioning and
2. Symptoms including *severe preoccupation* with or *intense longing* for the deceased person accompanied by *intense emotional pain*

Consult a specialist if this disorder is suspected.

ASSESSMENT QUESTION 3: IS THERE A CONCURRENT MENTAL, NEUROLOGICAL AND SUBSTANCE USE (MNS) CONDITION REQUIRING MANAGEMENT?

For example:
Substance abuse
Risk of self-harm / suicide

Please go to the relevant module for questions to exclude common mental disorders.

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

Start by inquiring:

What do you think is happening to you?
Do you know about Depression?

آپ کے خیال میں آپ کی موجودہ کیفیت کی وجہ کیا ہے؟
کیا آپ ڈپریشن کے بارے میں جانتے ہیں؟

Then follow the guidelines:

- Depression is a very common condition that can happen to anybody.
- The occurrence of depression does not mean that the person is weak or lazy.
- The negative attitudes of others (e.g., "You should be stronger", "Pull yourself together") may relate to the fact that depression is not a visible condition (unlike a fracture or a wound) and the false idea that people can easily control their depression by sheer force of will.
- People with depression tend to have unrealistically negative opinions about themselves, their life and their future. Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression improves.

ڈپریشن ایک بہت عام بیماری ہے جو کسی کو بھی لاحق ہوسکتی ہے۔
ڈپریشن ہونے کا یہ مطلب نہیں کہ وہ شخص کمزور یا سُست ہے۔
لوگوں کے منفی رویے (مثلاً ان کی رائے کہ آپ کو زیادہ مضبوط ہونا چاہیے یا اپنے آپ کو سنبھالنا چاہیئے) کی عام وجہ یہ ہے کہ ڈپریشن کی بیماری نظر نہیں آتی۔ (جیسے کہ ٹوٹی ہوئی ہڈی یا چوٹ نظر آتی ہے) اور خیال کیا جاتا ہے کے لوگ خود اپنی قوت ارادی سے ڈپریشن پر قابو پا سکتے ہیں۔
ڈپریشن میں مریض اپنی زندگی اور مستقبل کے بارے میں منفی سوچ رکھتے ہیں، یہاں تک کہ ناامید ہو جاتے ہیں یا بے کار محسوس کرتے ہیں۔ یہ تمام خیالات ڈپریشن کے علاج سے بہتر ہو جاتے ہیں۔

2. Promote functioning in daily activities

Start by inquiring:
When you were feeling better, what is one task, at home or at work that you were doing regularly that you are no longer doing or that you do less?

بیماری سے پہلے کونسے کام، گھر پہ یا باہر، آپ باقاعدگی سے کرتے تھے جو اب نہیں کر رہے یا کم کر رہے ہیں؟

Then follow the guidelines:
Start again (or continue) activities that were previously pleasurable.
Maintain regular sleeping and waking times.
To be as physically active as possible.
Eat regularly despite changes in appetite.
Spend time with trusted friends and family.
Participate in community and other social activities as much as possible.

وہ کام دوبارہ شروع کریں جن سے پہلے محظوظ ہوتے تھے۔
سونے اور جاگنے کے اوقات کی پابندی کریں۔

جسمانی ورزش باقاعدگی سے کریں۔
بھوک میں کمی کے باوجود اپنی خوراک کا خیال رکھیں۔
اپنے عزیز و اقارب کے ساتھ وقت گزارنے کی کوشش کریں۔
کوشش کریں کہ سماجی سرگرمیوں میں حصہ لیں۔

3. Offer psycho-social support

Start by inquiring:
What comforts you when you are upset? Is there any person who you feel can give you support?

پریشانی کے وقت آپ کو تسلّی کیسے ملتی ہے؟ کس شخص کی موجودگی سے آپ کو سہارا ملتا ہے؟

Then follow the guidelines:

- Offer the person an opportunity to talk, preferably in a private space.
- Explore patient's understanding of the causes of his or her symptoms.
- Explore current psychosocial stressors and address social issues or relationship difficulties.
- Assess any situation of maltreatment, abuse (e.g., domestic violence) and neglect (e.g., of children or older people).

4. If trained and supervised therapists are available, refer the patient for:

- Problem-solving counselling
- Cognitive behavioural therapy
- Interpersonal therapy
- Behavioural activation

PHARMACOLOGICAL INTERVENTIONS

To select an antidepressant, consider the symptom pattern (sedating or non-sedating), the side-effect profile of the medication, and the efficacy of previous antidepressant treatments, presence of comorbid physical illness etc.

Always discuss:

Antidepressants are not addictive.
There is a delay in onset of action.
There are potential side effects of medication, which are usually self-limiting.
The possibility of discontinuation/ withdrawal symptoms on missing doses, and that these symptoms are usually mild and self-limiting.
Antidepressant medication usually needs to be continued for at least 9–12 months after the person feels well.
Medications should not be stopped just because the person has experienced some improvement (it is not like a painkiller for headaches).

ڈپریشن کی دوائیاں نشہ آور یا عادی بنانے والی نہیں ہوتیں۔
دوائی شروع کرنے کے کچھ ہفتے بعد بہتری آتی ہے۔
ان کے مضر اثرات عموماً وقت کے ساتھ کم ہو جاتے ہیں۔
دوائی میں ناغہ کرنے سے وقتی طور پر بے چینی ہو سکتی ہے۔
ڈپریشن کی دوا بہتر ہونے کے بعد نو سے بارہ ماہ تک جاری رکھنا ضروری ہوتا ہے۔
دوا بہتر محسوس کرتے ہی بند کر دینے سے علاج نامکمل رہتا ہے۔

Table DEP 1: Antidepressants

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

[a]Available in the Interagency Emergency Health Kit (WHO, 2011)
[b]TCA indicates tricyclic antidepressant
[c]SSRI indicates selective serotonin reuptake inhibitor
[d]Minimum effective dose in adults: 75 mg (sedation may be seen at lower doses).

Box Dep 1: Precautions for antidepressant medication in special groups		
1	People at risk of self-harm or suicide	– Fluoxetine is the first choice. – Monitor frequently (e.g. once a week). – To avoid overdoses in risk of self-harm/ suicide, ensure a limited supply of antidepressants (e.g. dispense for one week at a time)
2	Adolescents (12-18 years old)	– Consider fluoxetine (but no other selective serotonin reuptake inhibitors (SSRI) or tricyclic antidepressants (TCAs) only if symptoms persist or worsen despite psychosocial interventions
3	Older people	– Avoid amitriptyline if possible. – Consider increased risk of drug interactions, and give greater time for response (a minimum of 6 – 12 weeks before considering that medication is ineffective, and 12 weeks if there is a partial response within this period).
4	People with cardiovascular disease	– Do not prescribe amitriptyline.
5	Pregnant or breastfeeding women	– Avoid antidepressants if possible. Consider antidepressants at the lowest effective dose if there is no response to psychosocial interventions. – If the woman is breastfeeding, avoid fluoxetine. – Consult a specialist, if available.

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

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

If the person has a history of manic episode, consult a specialist.

If a specialist is not immediately available, prescribe an antidepressant in combination with a mood stabilizer such as carbamazepine or valproate (Table DEP 2).

- Start the medicine at a low dose. Increase slowly over the following weeks.
- If possible, avoid carbamazepine and valproate in women who are pregnant or who are planning pregnancy, because of potential harm to the fetus from the medication.The decision to start mood stabilizers for a pregnant woman should be made after discussing with the woman.
- The severity and frequency of manic and depressive episodes should be taken into consideration.
- Consult a specialist for ongoing treatment of bipolar disorder.

Tell the person and the carers to stop the antidepressant immediately and return for help if symptoms of manic episode develop.

Table DEP 2: Mood stabilizers in bipolar disorder

	Carbamazepine	Valproate
Starting dose	200 mg/day	400 mg/day
Typical effective dose	400-600 mg/day (max. dose 1400 mg/day)	1000-2000 mg/day (max. dose 2500 mg/day)
Dosing schedule	Twice daily, oral	Twice daily, oral
Rare but serious side-effects	◆ Severe skin rash (Stevens-Johnson syndrome*, toxic epidermal necrolysis*) ◆ Bone marrow depression*	◆ Drowsiness ◆ Confusion
Common side-effects	◆ Drowsiness ◆ Troubling walking ◆ Nausea	◆ Lethargy ◆ Sedation ◆ Tremor ◆ Nausea, diarrhoea ◆ Weight gain ◆ Transient hair loss (re-growth normally begins within 6 months) ◆ Impaired hepatic function

FOLLOW UP

Monitor response to treatment

- If symptoms do not improve after 4 – 6 weeks, review diagnosis, check compliance and consider increasing the dose.
- Identify and try to address reasons for poor adherence (e.g., side-effects, costs, person's beliefs about the disorder and treatment).
- If symptoms of mania emerge during treatment, immediately stop antidepressants and assess for and manage mania.
- If symptoms persist after 6 weeks at maximum dose, then consider switching to another treatment or, refer the patient to a specialist.

Terminating antidepressant treatment

Consider stopping antidepressant medication when:

- No or minimal depressive symptoms for 9 – 12 months.
- Been able to carry out routine activities for that time period.
- Reduce doses gradually over at least a 4-week period.
- Remind the person about the possibility of discontinuation/withdrawal symptoms on stopping or reducing the dose, and that these symptoms are usually mild and self-limiting.
- Advise about early symptoms of relapse (e.g., alteration in sleep or appetite for more than 3 days) and when to come for routine follow-up.
- Monitor and reassure for mild withdrawal symptoms (common: dizziness, tingling, anxiety, irritability, fatigue, headache, nausea, sleep problems).

WHEN TO REFER?

- Risk of suicide or has attempted suicide recently.
- Severe depression.
- History of acute or chronic physical illness or recent head injury.
- History of drug abuse.
- Past history of epilepsy or psychosis.
- Gross memory impairment and disorientation.
- No improvement after 6 weeks of treatment.
- Pregnancy or breastfeeding.

Post-traumatic Stress Disorder PTSD

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

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

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

Typical presenting complaints of PTSD

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

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

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

ASSESSMENT

ASSESSMENT QUESTION 1: HAS THE PERSON EXPERIENCED A POTENTIALLY TRAUMATIC EVENT MORE THAN 1 MONTH AGO?

1. Ask if the person has experienced a potentially traumatic event

A potentially traumatic event is any threatening or horrific event such as physical or sexual violence (including domestic violence), witnessing of atrocity, destruction of the person's house, or major accidents or injuries.

How have you been affected by the event or situation (threat/disaster/conflict)?
Has your life been in danger?
Have you experienced something that was very frightening or horrific?

آپ اس حادثے یا آزمائش سے کیسے متاثر ہوئے ہیں؟

اس دوران آپ کی اپنی زندگی کو خطرہ محسوس ہوا ہے؟

کیا اس دوران آپ کو شدید پریشانی یا خوف لاحق ہوا ہے؟

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

When did the potentially traumatic event occur?

یہ حادثہ کب ہوا؟

ASSESSMENT QUESTION 2: IF A POTENTIALLY TRAUMATIC EVENT OCCURRED MORE THAN 1 MONTH AGO, DOES THE PERSON HAVE PTSD?

1. Re-experiencing symptoms
These are repeated and unwanted recollections of the event **as though it is occurring in the here and now** (e.g., frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).

In children this may involve replaying or drawing the events repeatedly. Younger children may have frightening dreams without a clear content.
Have you had any unpleasant dreams about the event?
Have there been times when you suddenly felt as if the event was actually happening again?
How often does that happen? Can you deal with it?

کیا آپ کو اس حادثے کی وجہ سے کوئی برے یا ڈراؤنے خواب آتے ہیں؟

کیا آپ کو کبھی ایسا محسوس ہوا کہ وہ حادثہ دوبارہ ہو رہا ہے؟

ایسا کتنی دفعہ محسوس ہوا ہے؟ آپ اس کیفیت کا مقابلہ کیسے کرتے ہیں؟

2. Avoidance symptoms
These involve deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event e.g., avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened.

Are you trying to avoid thoughts or discussions about the event? Does it cause you distress? Have you tried to avoid things that remind you of the event like certain people, or places?

کیا آپ اس حادثے کے بارے میں سوچنے یا بات کرنے سے گریز کرتے ہیں؟ کیا اس سے آپ کی پریشانی میں اضافہ ہوتا ہے؟

کیا آپ ان لوگوں اور جگہوں سے دور رہنے کی کوشش کرتے ہیں جو آپ کو اس حادثے کی یاد دلاتے ہیں؟

3. Hyperarousal symptoms

These symptoms involve excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements e.g., being jumpy or on edge.

Are you feeling agitated or nervous? Do you get easily startled these days? Or on edge all the time? Have you been especially alert even when there was no specific threat or danger?

کیا آج کل آپ پریشانی اور گھبراہٹ محسوس کر رہے ہیں؟ کیا آپ آسانی سے چونک جاتے ہیں؟

کیا آپ کو لگتا ہے کہ ابھی کچھ بُرا ہو جائے گا؟

کیا آپ کو کسی خطرے کے بغیر بھی خوف رہتا ہے؟

4. Considerable difficulty with daily functioning

Do you have any difficulty performing your duties at work? Do you have any difficulty performing your household responsibilities/looking after your children?
Do you have any difficulty in your routine work/studies?

کیا آپ کو اپنا کام کرنے میں کوئی مشکل پیش آتی ہے؟

کیا آپ کو گھر کے کام میں یا بچوں کی دیکھ بھال میں کوئی مشکل پیش آتی ہے؟

کیا آپ کو اپنی پڑھائی کرنے میں کوئی مشکل پیش آتی ہے؟

If all of the above are present approximately 1 month after the event, then PTSD is likely

ASSESSMENT QUESTION 3: IS THERE A CONCURRENT CONDITION?

1. Assess and manage any concurrent physical conditions that may explain the symptoms

Note your observations, ask screening questions AND conduct a physical examination.

Are there signs and symptoms suggesting anaemia, hypothyroidism, mood changes from substance use and medication side-effects?

Do you have any medical illness?
Are you taking any other medications?

کیا آپ کو کوئی جسمانی بیماری ہے؟

کیا آپ کوئی دوائیاں باقائدگی سے لے رہے ہیں؟

2. Assess for and manage all other MNS conditions that are covered in this guide.

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

1. Psychoeducation

Start with inquiring:
What do you think is happening to you?
Do you know about PTSD?

آپ کے خیال میں آپ کی موجودہ کیفیت کی کیا وجہ ہے؟

کیا آپ پی ٹی ایس ڈی کے بارے میں کچھ جانتے ہیں؟

Then follow the guidelines:

- Many people recover from PTSD over time without treatment while others need treatment.
- People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they experienced when the event was actually happening. They may also have frightening dreams.
- People with PTSD often feel that they are still in danger and may feel very tense. They are easily startled (jumpy) or constantly on the watch for danger.
- People with PTSD try to avoid any reminders of the event. Such avoidance may cause problems in their lives.
- People with PTSD may sometimes have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

وقت گزرنے کے ساتھ ساتھ بیشتر لوگ اس کیفیت سے بہتر ہو جاتے ہیں جب کہ کچھ لوگوں کو علاج کی ضرورت پڑ سکتی ہے۔

پی ٹی ایس ڈی میں لوگوں کو بار بار حادثے کے خیال آتے ہیں۔ ایسی صورت میں ان کو وہی جذبات دوبارہ محسوس ہوتے ہیں جو حادثے کے دوران ہوئے تھے جیسا کہ ڈر اور شدید خوف۔ ان کو ڈراؤنے خواب بھی آ سکتے ہیں۔

پی ٹی ایس ڈی میں لوگ شدید خطرہ اور پریشانی محسوس کر سکتے ہیں۔ وہ آسانی سے چونک جاتے ہیں اور ہر وقت خطرہ محسوس کرتے ہیں۔

پی ٹی ایس ڈی میں لوگ حادثے کی نشانیوں سے بھی گریز کرتے ہیں۔ اس سے ان کی زندگی میں مسائل پیدا ہو سکتے ہیں۔

پی ٹی ایس ڈی میں لوگوں کو دیگر جسمانی اور نفسیاتی مسائل بھی ہو سکتے ہیں جیسا کہ جسم میں درد ہونا، طاقت کی کمی، تھکاوٹ، چڑچڑاپن اور اداسی یا خفگی وغیرہ۔

Advise the person to:

- Continue their normal daily routine as much as possible.
- Talk to trusted people about what happened and how they feel, but only when they are ready to do so.
- Engage in relaxing activities to reduce anxiety and tension.
- Avoid using alcohol or drugs to cope with PTSD symptoms.
-

روزمرہ کی روٹین کو جتنا ہو سکے جاری رکھیں۔

جب آپ ذہنی طور پر تیار ہوں تو قابل اعتماد لوگوں سے اس وقت کے بارے میں بات کریں اور اپنے جذبات بتائیں۔

ایسے کاموں میں مصروف ہوں جن سے آپ کی گھبراہٹ اور پریشانی کم ہو۔

پی ٹی ایس ڈی سے مقابلے کے لئے نشے کا استعمال نہ کریں۔

2. Offer psychosocial support

1. Address current psychosocial stressors.
2. Strengthen social supports.
3. Teach stress management.

Go to the Principles of Reducing Stress and Strengthening Social Support in GPC

If the above interventions do not help, refer the person to a specialist for cognitive behavioural therapy, EMDR or stress management.

PHARMACOLOGICAL INTERVENTIONS

– If psychological interventions do not work or are unavailable, consider antidepressants (selective serotonin reuptake inhibitors or tricyclic antidepressants).
– Go to DEP for detailed guidance on prescribing antidepressants.
– DO NOT prescribe antidepressants in children and adolescents.

FOLLOW-UP

– Schedule and conduct regular follow-up sessions according to the Principles of Management in GPC.
– Schedule the second appointment within 2–4 weeks and subsequent appointments depending on the course of the disorder.

Psychosis

PSY

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

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

Typical presenting complaints of psychosis

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

Strange beliefs

Hearing voices or seeing things that are not there
Extreme suspicion

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

ASSESSMENT

ASSESSMENT QUESTION 1: DOES THE PERSON HAVE PSYCHOSIS?

- People with psychosis may have abnormal thoughts/beliefs but this does not mean that everything they say is wrong or imaginary.

- Careful listening and observation are the key to an assessment.

- More than one visit may be necessary for full assessment.

- Carers are often a source of helpful information.

What is Psychosis?

It is likely if some of the following symptoms are present:

1. **Abnormal behavior** such as odd, eccentric, aimless and agitated activity or maintaining an abnormal body posture or not moving at all.
2. **Disorganized thoughts and speech** that switch between topics without logical connection; speech that is difficult to follow.
3. **Delusions** which are fixed false beliefs or suspicions that are firmly held (even when there is no evidence)
4. **Hallucinations** mean hearing, seeing or feeling things that are not there
5. **Unusual experiences** such as believing that others place thoughts in one's mind, that others withdraw thoughts from one's mind or that one's thoughts are being broadcast to others.
6. **Chronic symptoms** that involve a loss of normal functioning, including:
   - lack of energy or motivation to do daily chores and work
   - apathy and social withdrawal
   - poor personal care or neglect
   - lack of emotional experience and expressiveness

Imminent risk of suicide and harm to and from others should always be excluded.

Note your observations, as well as ask questions:

1. Abnormal appearance & behaviour?

Note:
Appearance
- Odd or inappropriate appearance; wearing odd clothes, ornaments; odd posture/gestures/gait etc.
- Signs of self-neglect

Behaviour
- Aggressive e.g., agitated, abusive, threatening
- Violent e.g., breaking things, hitting others
- Looks paranoid
- Constantly fiddling, changing position, standing or sitting down

- Fearful of surroundings, suspicious of people around
- Self-muttering, self-talking

2. Disorganized thoughts and speech

Note incoherent/irrelevant speech

3. Delusions

Look for hints that the person might have unusual experiences, ask the person and check from carers.

Have you wanted to stay away from other people? If yes, why?
Have you been suspicious of their intentions? Or that they might actually harm you?
Do they seem to laugh at you? Talk about you? Spy on you?

کیا آپ دوسرے لوگوں سے الگ تھلک رہتے ہیں؟ اس کی کیا وجہ ہے؟
کیا آپ کو ان کے ارادوں پہ کوئی شک ہوتا ہے؟ کیا آپ کو لگا کہ وہ آپ کو کوئی نقصان پہنچا سکتے ہیں؟
کیا ایسا لگتا ہے کہ وہ آپ کا مذاق اڑاتے ہیں؟ آپ کے بارے میں باتیں کرتے ہیں؟ آپ پر چھپ کے نظر رکھتے ہیں؟

Probe further by asking what the person means, and listen carefully.

4. Hallucinations

Look for hints that the person might have unusual experiences, ask the person and check from carers.

Do you ever seem to hear voices when there is no one around?
Have you ever had visions, or seen things other people couldn't see?

کیا آپ کو آوازیں سنائی دیتیں ہیں جب کہ ارد گرد کوئی موجود نہ ہو؟ یا آپ کو کبھی کوئی مناظر یا نقشے دکھائی دیتے ہوں یا آپ نے کوئی چیزیں دیکھی ہیں جو اور لوگوں کو نہ دکھائی دیں؟

5. Unusual experiences

Look for hints that the person might have unusual experiences, ask the person and check from carers.

Do you receive messages in the newspapers or on TV or radio?
Or those things were arranged so as to have a special meaning for you, or even that harm might come to you. Can you describe that?

کیا آپ کو اخباروں، ٹی وی یا ریڈیو کے ذریعے سے کوئی پیغامات ملتے ہیں؟
یا چیزیں اس طرح ترتیب کی ہوں جیسے وہ آپ کو کوئی خاص پیغام دے رہے ہوں، یا آپ کو کوئی نقصان پہنچا سکیں؟ کیا آپ مزید تفصیل بتا سکتے ہیں؟

6. Chronic symptoms that involve a loss of normal functioning

Note your observations and check from carers.

- lack of energy or motivation
- apathy and social withdrawal
- poor personal care or neglect
- lack of emotional experience and expressiveness

Always assess for risk of suicide and harm to/from others.

ASSESSMENT QUESTION 2: ARE THERE ACUTE PHYSICAL CAUSES OF PSYCHOTIC SYMPTOMS THAT CAN BE MANAGED?

1. **Rule out delirium from acute physical causes?**

Box 1: What is Delirium?

It is a transient fluctuating mental state characterized by disturbed attention that develops over a short period of time and tends to fluctuate during the course of a day.

Common causes:
Head injury, infections (e.g., cerebral malaria, sepsis or urosepsis), dehydration and metabolic abnormalities (e.g., hypoglycaemia, hyponatraemia).

Note your observations, ask screening questions, conduct a physical examination and consider laboratory investigations.

Observe
- Confusion
- Disoriented in time, place and person
- Talking irrelevantly and incoherently
- Not paying attention to instructions, not engaging
- Agitation and restlessness

Examine the patient
- *What time of the day is it?*
- *What is this place where we are sitting?*
- *What is the name of the person who has come along with you?*
- *Name the days of the week in backward order like Sunday, Saturday, Friday and further?*
- *Count backwards from 20 like 19, 18, 17 and further?*

ابھی دن کا کونسا وقت ہے؟

یہ جگہ کونسی ہے جہاں ہم بیٹھے ہیں؟

آپ کے ساتھ آنے والے شخص کا کیا نام ہے؟

ہفتے کے دنوں کے نام الٹی ترتیب میں بتائیں۔ جیسا کہ اتوار، ہفتہ، جمعہ وغیرہ۔

بیس سے الٹی گنتی گنیے۔ جیسا کہ انیس، اٹھارہ، سترہ وغیرہ۔

Physical examination and investigations
- Conduct a thorough physical examination (or as much as possible)
- Review laboratory tests (rule out infections, dehydration, metabolic abnormalities)
- Review recent medications (such as anti-malarial medication, steroids)

Ask the carers
- *How long has the patient not been well?*
- *What are the changes in his/her behavior?*
- *Has the patient been overly agitated and aggressive or has been quiet and withdrawn?*
- *Has the patient been forgetful or disoriented (about time, place)?*
- *Has the patient been suffering from fever, vomiting, diarrhea, cough, rigidity?*

مریض کتنے عرصے سے بیمار ہے؟

ان کے رویے یا طور طریقے میں کیا تبدیلیاں آئیں ہیں؟

کیا مریض بہت غصّے میں اور بیتاب رہتا ہے یا خاموش اور لوگوں سے دور رہتا ہے؟

کیا مریض چیزیں بھولنے لگا ہے یا ماحول سے لاتعلق ظاہر ہوتا ہے؟

کیا مریض کو بخار، الٹیاں، اسہال، کھانسی یا جسم کی اکڑاہٹ جیسی کوئی علامات ہیں؟

2. Rule out medication side-effects

- Certain antimalaria medications
- Psychoactive prescription medicines e.g., anti-psychotic medication, benzodiazepines (sleeping tablets)

3. Rule out alcohol or drug intoxication/withdrawal?

Look for signs of alcohol or drug use as well.

- *Do you use tobacco, alcohol, or psychoactive prescription medicines?*
- *If yes, how long have you been using these? How did you start?*
- *Have you ever tried to stop? If yes, which factors were helpful? Which factors led to a relapse?*
- *Is there anyone else in your family or social circle that uses tobacco, alcohol or psychoactive prescription medicines*?

کیا آپ تمباکو، شراب یا نشے کی کوئی ادویات کا استعمال کرتے ہیں؟

اگر ہاں، تو کتنے عرصے سے استعمال کر رہے ہیں؟ یہ شروع کیسے ہوا تھا؟

کیا آپ نے کبھی نشے کو چھوڑنے کی کوشش کی؟ کونسے عناصر مددگار تھے؟ کن عناصر کی وجہ سے آپ دوبارہ مجبور ہو گئے تھے؟

کیا آپ کے خاندان یا عزیزوں میں کوئی شخص تمباکو، شراب یا ذہن پر اثر ڈالنے والی ادویات کا استعمال کرتا ہے؟

ASSESSMENT QUESTION 3: IS THIS A MANIC EPISODE?

Box 2: What is mania / a manic episode?

When many of the following symptoms were present for more than 1 week & these symptoms cause significant difficulty with daily functioning or were a danger to the person or to others.

1. Decreased need for sleep
2. Euphoric, expansive or irritable mood
3. Racing thoughts; being easily distracted
4. Increased activity, feeling of increased energy or rapid speech
5. Impulsive or reckless behaviors such as excessive gambling or spending, making important decisions without adequate planning
6. Unrealistically inflated self-esteem

1. Note your observations

- Overactive e.g., not sitting in one place, moving back and forth in chair
- Overconfident e.g., shaking hands and moving around as if the place belongs to him/her
- Disinhibited e.g., singing songs, overfamiliar behaviour, making inappropriate comments

- Elated in mood e.g., joyous, cheerful
- Having flight of ideas e.g., moving rapidly from one idea to another
- Having pressure of speech e.g., talking excessively, difficult to interrupt
- Easily distractible e.g., loses focus by stimuli in the surroundings

2. Decreased need for sleep

How has your sleep been?
Do you need less sleep than usual?

آج کل آپ کی نیند کیسی رہی؟
کیا آج کل آپ کو نیند کی ضرورت کم محسوس ہو رہی ہے؟

3. Euphoric, expansive or irritable mood

How has your mood been?
Have you sometimes felt particularly cheerful and on top of the world, without any reason?

آج کل آپ کا مزاج کیسا رہا؟
کیا آج کل آپ بغیر وجہ کے بہت خوش اور پر اعتماد محسوس کرتے ہیں؟

4. Racing thoughts; being easily distracted

How has your attention/focus been?
Do you get distracted easily?

آج کل آپ کی توجہ دینے کی صلاحیت کیسی رہی؟
کیا آپ کا دھیان آسانی سے ہٹ جاتا ہے؟

5. Increased activity, feeling of increased energy or rapid speech

Do you feel particularly full of energy lately, or full of exciting ideas?
Do you find yourself extremely active but not getting tired?
Have you been talking more than usual?

کیا آپ خود کو زیادہ پر جوش یا اپنے میں بھرپور جوشیلے خیالات محسوس کرتے ہیں؟
کیا آپ اپنے اندر غیر معمولی طاقت محسوس کرتے ہیں جس کی وجہ سے تھکان ہوتی ہی نہ ہو؟
کیا آج کل آپ ضرورت سے زیادہ باتیں کرنے لگے ہیں؟

6. Impulsive or reckless behaviors such as excessive gambling or spending, making important decisions without adequate planning

Have you been shopping excessively?
Have you made any unusual decisions recently?

کیا آج کل آپ ضرورت سے زیادہ خریداری کرنے لگے ہیں؟
حال ہی میں کیا آپ نے کوئی غیر معمولی فیصلے کیے ہیں؟

7. Unrealistically inflated self-esteem

Do you believe that you have special powers and you are on a special mission on earth?
Do you believe that you are a prophet or a president who has been assigned special duties?

کیا آپ کو لگتا ہے کہ آپ کے پاس کوئی مخصوص طاقت یا صلاحیت ہے اور آپ کوئی خاص مقصد کیلیے اس دنیا میں آئے ہیں؟
کیا آپ کو لگتا ہے آپ کو خاص ذمہ داریاں دی گئی ہیں مثلاً کوئی پیغمبر ہوں یا ملک کے صدر ہوں؟

BASIC MANAGEMENT PLAN

PHARMACOLOGICAL INTERVENTIONS

Involve the patient and the carers (as much as possible).

If the patient is too unwell initially, try to involve him/her as soon as the condition improves.

Start by inquiring:

How do you feel about taking a medicine that can treat your condition?
Do you know anything about anti-psychotic medication?
Do you know about the dose of the medication?
Do you know about the possible side effects of medication?
Do you have any concerns regarding medication?
Do you have any questions?

آپ کا دوائی لینے کے بارے میں کیا خیال ہے جس سے آپ کی کیفیت بہتر ہو سکتی ہے؟
آپ اینٹی سائکوٹیک ادویات کے بارے میں کچھ جانتے ہیں؟
کیا آپ ادویات کی خوراک کے بارے میں جانتے ہیں؟
کیا آپ ادویات کے کچھ ممکنہ ضمنی اثرات کے بارے میں جانتے ہیں؟
کیا آپ کے دوائی کے متعلق کوئی خدشات ہیں؟
کیا آپ کے ذہن میں کوئی اور سوال ہیں؟

Always discuss:
- The importance of taking the medication as prescribed.
- The dose, duration of treatment and potential side-effects of medications.

1. For psychosis *without* acute physical causes

Initiate an oral antipsychotic medication. Consider intramuscular (I.M.) treatment only if oral treatment is not feasible. Check if the person has used an antipsychotic medication in the past that helped control the symptoms. If yes, resume the medication at the same dose. If the medication is not available, start a new medication. The involvement of a carer or health worker in keeping and giving out the medication will be essential at the start of treatment to ensure safe compliance.

- Prescribe only one antipsychotic at a time.
- "Start low, go up slow": start with the lowest therapeutic dose and increase slowly to achieve the desired effect at the lowest effective dose.
- Try the medication for an adequate amount of time at a typical effective dose before considering it ineffective (i.e. for at least 4–6 weeks).
- Use the lowest effective oral dose in women who are planning pregnancy, are pregnant or are breastfeeding.
- If agitation cannot be adequately managed by an antipsychotic alone, give a dose of benzodiazepine (e.g. diazepam, maximum 5 mg orally) and consult a specialist immediately.

2. For psychotic symptoms from acute physical causes

Manage the acute cause.

Only prescribe antipsychotic medication at a moment when there is a need to control agitation, psychotic symptoms or aggression. Stop the medication as soon as these symptoms resolve. Consider intramuscular treatment only if oral treatment is not feasible.
Prescribe an oral antipsychotic medication e.g., Haloperidol, initially 0.5 mg per day, increase up to 2.5–5 mg 3 times a day if needed.

3. For manic episode

- Initiate an oral antipsychotic medication
- When the person is extremely agitated despite antipsychotic treatment, consider adding a dose of benzodiazepine (e.g., diazepam, maximum 5 mg orally) and consult a specialist immediately.
- A manic episode is part of bipolar disorder (see box 2). Once the acute mania is managed, the person needs assessment and treatment for bipolar disorder with a mood stabilizer such as valproate or carbamazepine.
- Consult a specialist for management.

Table PSY 1: Antipsychotic medications

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

[a] Available in the Interagency Emergency Health Kit (WHO, 2011)
[b] Up to 1 g may be necessary in severe cases.
[c] Stop antipsychotic medicine immediately if this syndrome is suspected and keep the person cold and provide sufficient fluid.

Table PSY 2: Anticholinergic medications

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

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

Anti-cholinergic medications

Manage side-effects

- In case of significant acute extrapyramidal side-effects such as Parkinsonism (combination of tremors, muscular rigidity and decreased body movements) or akathisia (inability to sit still/feeling restless):

  Reduce the dose of antipsychotic medication.
  If extrapyramidal side effects persist despite reducing the dose, consider short-term use of anticholinergics (e.g., biperiden for 4-8 weeks).
- In case of acute dystonia (acute spasm of muscles, typically of neck, tongue and jaw):
  Stop antipsychotic medication temporarily and provide anticholinergics.
  If these are not available, diazepam may be given to induce muscle relaxation.
- If possible, consult a specialist about the duration of treatment and when to discontinue antipsychotic medications.
- In general, continue the antipsychotic medication for at least 12 months after the symptoms resolve.
- Taper down slowly when discontinuing the medication over several months.
- Never stop the medication abruptly.

PSYCHOSOCIAL INTERVENTIONS

1. Offer psychoeducation

Start by inquiring:
- What do the person and the carer already know about psychosis?
- What are the gaps and misconceptions in their knowledge about psychosis?
- What questions do they have about psychosis?

آپ سائکوسس کے بارے میں کیا جانتے ہیں؟
آپ کو کیا معلوم نہیں ہے یا آپ مزید کیا جاننا چاہتے ہیں؟

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

سائکوسس کی بیماری قابل علاج ہے اور مریض ٹھیک ہوسکتا ہے۔
ذہنی دباؤ یا پریشانی سے بیماری میں شدّت آسکتی ہے۔
ہنگامی حالات میں بھی کوشش کریں کہ سماجی، تعلیمی اور پیشہ ورانہ مشاغل کو جاری رکھیں۔
شراب، چرس یا غیر تجویز کردہ ادویات کا استعمال ہرگز نہ کریں کیونکہ یہ سائکوٹیک علامات کو مزید خراب کرسکتی ہیں۔
سائکوسس کے شکار مریضوں کے لیے ضروری ہے کہ وہ تجویز کردہ ادویات باقاعدگی سے استعمال کریں اور ڈاکٹر کو چیک کرواتے رہیں۔
سائکوٹیک علامات کے دوبارہ شروع ہونے یا مزید بگڑنے کی صورت میں فوراً ڈاکٹر کو چیک کرائیں کیونکہ دوائی کو تبدیل کرنے کی ضرورت ہوسکتی ہے۔

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

مریض کے ساتھ بحث نہ کریں کہ اسکے خیالات یا تجربات حقیقت میں درست نہیں ہیں۔
مریض جب غیر معمولی رویہ یا غصّہ دکھائے تو جذباتی نہ ہوں اور مریض سے جھگڑا نہ کریں۔
مریض کے ساتھ بحث کرنے یا مخالفت کرنے سے گریز کریں۔
جس قدر ممکن ہو مریض کو گھومنے پھرنے کی آزادی دیں۔ مگر کسی صورت میں ان کو یا ان کی وجہ سے دوسروں کو، کسی خطرے میں نہ ڈالیں۔

سائکوسس جادو یا سائے کی وجہ سے نہیں ہوتا۔
بیمار ہونے کا الزام مریض یا خاندان کے کسی فرد پر لگانے سے گریز کریں۔
اگر مریض خاتون ہے اور ان کا حال ہی میں بچہ پیدا ہوا ہے، تو بچے کی حفاظت کیلیے اسے مریض کے ساتھ اکیلا ہر گز نہ چھوڑیں

2. Facilitate rehabilitation back into the community

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

3. Support the carers

Start by inquiring:

- Who are the main carers?
- Who else provides care?
- What care do they provide?
- What is difficult to manage?
- What are the options available to provide support for the carers?
- How do they usually cope with stress?
- Is there any support available for the carers?

مریض کا زیادہ تر خیال کون رکھتا ہے؟
اس کے علاوہ اور کون ان کا خیال رکھتا ہے؟ وہ کس قسم کی مدد کرتے ہیں؟
مریض کی دیکھ بھال میں کن معمولات کو حل کرنا مشکل ہے؟
خیال رکھنے والوں کی مدد کیسے کی جا سکتی ہے؟
خیال رکھنے والے خود اپنی پریشانی یا ذہنی دباؤ سے کیسے نمٹتے ہیں؟
کیا خیال رکھنے والوں کی کوئی مدد کرتا ہے؟

For the guidelines on ‘Reducing Stress and Strengthening Social Support’, Go to GPC

FOLLOW-UP

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

Epilepsy/Seizures

EPI

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

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

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

Typical presenting complaints of convulsive epilepsy

› A history of convulsive movements or seizures.

ASSESSMENT

ASSESSMENT QUESTION 1: DOES THE PERSON MEET THE CRITERIA FOR CONVULSIVE SEIZURE?

1. **Ask the person and carer, if the person has had any of the following symptoms:**

– Convulsive movements lasting longer than 1–2 minutes

What was the duration of the seizure? How long did the seizure last, was it longer than 1-2 mins?

دورہ کتنے دیر تک رہا؟ کیا دورے کا دورانیہ ایک یا دو منٹ سے زیادہ تھا؟

– Loss of or impaired consciousness
Was the patient not able to relate to the environment during the seizure?
Does the patient have recollection of the seizure? Is the patient able to talk during the seizure?

کیا مریض دورے کے دوران ارد گرد کے ماحول سے لاتعلق تھا؟ کیا مریض کو دورے کے واقعات یاد ہیں؟

کیا مریض دورے کے دوران بات کر سکتا تھا، جواب دے رہا تھا؟

– Stiffness or rigidity of the body or limbs lasting longer than 1–2 minutes

Did the eyes, face, head, arms, or legs move abnormally?

کیا جسم کے کسی حصّے میں جیسا آنکھیں، چہرہ، سر، بازو، یا ٹانگوں میں تناؤ یا جھٹکے لگے تھے؟

– Bitten or bruised tongue or bodily injury

Does the person bite his tongue during the seizures?
Has the person sustained any injury during the seizures?

کیا کبھی دورے کے دوران مریض کی زبان کٹی ہے؟ کیا دورے کی وجہ سے مریض کو کبھی چوٹ لگی ہے؟

– Loss of bladder or bowel control during the episode

Does the person lose bladder control during the seizure?

کیا کبھی دورے کے دوران مریض کا پیشاب نکلا ہے؟

– After the abnormal movements, the person may demonstrate confusion, drowsiness, sleepiness or abnormal behaviour. The person may also complain of fatigue, headache, or muscle ache.

How did the person feel after the seizure? Was the person confused or tired? Could the person speak normally? Did the person have a headache?

دورے کے بعد مریض کیسا محسوس کر رہا تھا؟ کیا دورے کے بعد مریض کو تھکاوٹ یا بوکھلاہٹ ہوئی؟

کیا مریض صحیح طرح سے بات کر رہا تھا؟ کیا مریض کے سر میں درد ہوا تھا؟

2. **The person meets the criteria for a convulsive seizure if there are convulsive movements and at least 2 other symptoms from the above list.**

3. **Suspect non-convulsive seizures or other medical conditions if only 1 or 2 of the above criteria are present.**

   See ACU for guidance on medical investigations relevant to pseudo-seizures/convulsions

- Consult a specialist (mental health professional) if the person has had more than one non-convulsive seizure.
- Manage accordingly if other medical conditions are suspected.
- Follow up after 3 months to re-assess.

ASSESSMENT QUESTION 2: IN THE CASE OF CONVULSIVE SEIZURE, IS THERE AN ACUTE CAUSE?

1. Check signs and symptoms of neuro-infection
- Fever
- Headache
- Meningeal irritation e.g., stiff neck.

2. **Check for other possible causes of convulsions**
- head injury
- metabolic abnormality e.g., hypoglycaemia, hyponatraemia, alcohol or drug intoxication or withdrawal

3. **If there is an identifiable acute cause of convulsive seizure, treat the cause**
- Maintenance treatment with antiepileptic medications is not required in these cases.

4. Refer to a hospital immediately if neuro-infection, head injury or metabolic abnormality is suspected
- Suspect neuro-infection in a child (aged 6 months to 6 years) with a fever if any of the following criteria for complex febrile seizures is present:
  - focal seizure – seizure starts in one part of the body
  - prolonged seizure – seizure lasts more than 15 minutes
  - repetitive seizure – more than 1 seizure during the current illness.
- If none of the above 3 criteria are present in a febrile child, suspect simple febrile seizure. Manage the fever and look for its cause according to local IMCI guidelines. Observe the child for 24 hours.

5. Follow up in 3 months to re-assess

ASSESSMENT QUESTION 3: IN CASE OF CONVULSIVE SEIZURE WITHOUT AN IDENTIFIED ACUTE CAUSE, IS THIS EPILEPSY?

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

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

1. Educate the person and carers about epilepsy

Start by inquiring:

What do you think about your condition? Do you know about Epilepsy?

آپ کے خیال میں آپ کی موجودہ کیفیت کی وجہ کیا ہے؟ آپ مرگی کے بارے میں کیا جانتے ہیں؟

Then follow these guidelines:

1. What is epilepsy and what causes it?

- Epilepsy is a chronic condition, but with medication three out of every four people can be seizure-free.
- Epilepsy involves recurrent seizures.
- A seizure is a problem related to abnormal electrical activity in the brain.
- Epilepsy is not caused by witchcraft or spirits.
- Epilepsy is not contagious.

مرگی کے بیماری طویل عرصے تک چل سکتی ہے۔ مگر دوائیوں کے باقاعدہ استعمال سے زیادہ تر (چار میں سے تین) لوگوں کو دوبارہ دورے نہیں پڑتے۔

مرگی کی بیماری میں دورے بار بار آسکتے ہیں۔

مرگی کا دورہ دماغ کے برقی نظام میں خلل کے نتیجے میں پڑتا ہے۔

یہ تکلیف کالے جادو اور جن بھوت کی وجہ سے نہیں ہوتی۔

مرگی چھوت کی بیماری نہیں ہے۔

2. What are the relevant lifestyle issues?

- People with epilepsy can lead normal lives.
- They can marry and have healthy children.
- They can work productively and safely at most jobs.
- Children with epilepsy can go to school.

مرگی کی بیماری کے ساتھ معمول کی زندگی گزارنا ممکن ہے۔

مرگی کے مریض شادی بھی کر سکتے ہیں اور ان کی اولاد بھی صحت مند ہوتی ہے۔

یہ لوگ اپنا کام بخوبی اور ذمہ داری کے ساتھ کر سکتے ہیں۔

مرگی سے متاثرہ بچے اسکول جاسکتے ہیں۔

3. What should people with epilepsy avoid?

- jobs that require working near heavy machinery or fire.
- swimming.
- alcohol and recreational drugs.
- looking at flashing lights.
- changing sleep patterns (e.g., sleeping much less than usual).

- مرگی سے متاثرہ لوگوں کو مندرجہ ذیل سے پرہیز کرنا چاہئیے:
- ایسے کام جس میں بھاری مشینری یا آگ کا استعمال ہو۔
- تیرنے سے۔
- نشہ آور چیزوں کے استعمال سے۔
- تیز روشنی سے۔
- معمول سے کم سونے سے۔

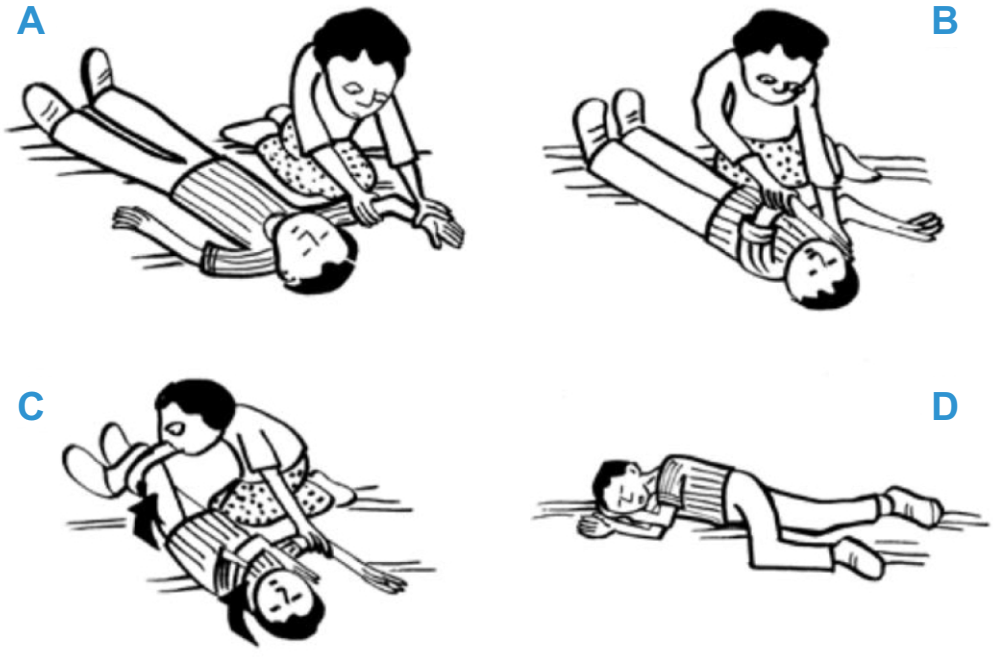
4. What to do at home when seizures occur?

1. If a seizure starts while the person is standing or sitting, help to prevent a fall injury by gently assisting them to sit or lie on the ground.
2. Make sure that the person is breathing properly.
3. Loosen the clothes around the neck.
4. Place the person in the **recovery position** (see Figures A–D below).
5. Do not try to restrain or hold the person to the floor.
6. Do not put anything in the person's mouth.
7. Move any hard or sharp objects away from the person to prevent injury.
8. Stay with the person until the seizure stops and the person regains consciousness.

- دورے کے وقت چوٹ سے بچانے کے لیے مریض کو بیٹھنے یا لیٹنے میں مدد کریں۔
- ہر ممکن احتیاط کریں کہ مریض کو سانس لینے میں دشواری نہ ہو۔
- گردن کے ارد گرد کپڑوں کو ڈھیلا کر دیں۔
- مریض کو دورے سے بحال ہونی والی حالت میں رکھیں۔ (see Figures A–D below)
- مریض کو زبردستی جکڑنے یا پکڑنے کے کوشش نہ کریں۔
- مریض کے منہ میں کوئی چیز نہ ڈالیں۔
- مریض کے ارد گرد سے نوکدار یا تیز چیزیں ہٹادیں۔
- مریض کے ہوش میں آنے تک اس کے ساتھ رہیں۔

5. What is the Recovery Position?

Figures A–D: The recovery position



Step A

Kneel on the floor on one side of the person. Place the arm closest to you at a right angle to their body with the person's hand upwards towards the head (see Figure A above).

مریض کے ساتھ زمین پر بیٹھیں۔مریض کا جو بازو آپ سے قریب ہے اس کو ۹۰ درجے کے زاویے پر اس طرح موڑیں کہ ہاتھ کا رخ مریض کے سر کی طرف ہو۔

Step B

Place the other hand on the side of the person's face, so that the back of the hand is touching the cheek (see Figure B above).

مریض کا دوسرا ہاتھ اس کے منہ کے سات رکھیں تا کہ ہاتھ کا پچھلا حصّہ اس کے گلے سے جڑا ہو۔

Step C

Bend the knee furthest from you to a right angle. Roll the person carefully onto his or her side by pulling on the bent knee (see Figure C above).

مریض کو جو گھٹنا آپ سے دور ہے اس کو اپنی طرف ۹۰ درجے پہ موڑیں۔ پھر مریض کو اپنی طرف کروٹ پر لٹا دیں۔

Step D

The person's top arm should be supporting the head and the bottom arm will stop the person from rolling too far (see Figure D above).

Open the person's airway by gently tilting his or her head back and lifting the chin, and check that nothing is blocking the airway.

This manoeuvre moves the tongue out of the airway and helps the person breathe better and prevents choking from secretions and vomit.

مریض کااوپر والا بازوانکے سر کو سہارادے گااور نیچے والا بازوانکے جسم کو بہت زیادہ گھومنے سے بچائے گا۔

مریض کے سر کواحتیاط سے پیچھے کے طرف کریں۔

اس بات کے تسلی کرلیں کے گلے میں کچھ پھنساہواتو نہیں ہے۔

سر کو پیچھے کرنے سے زبان سانس کے نالی سے ہٹ جاتی ہے۔

اب وہ آسانی سے سانس لے سکتاہےاور سانس رکنے کاخطرہ نہیں رہتا۔

Ask the person and the carers to keep a simple seizure diary

Figure EPI1: Example seizure diary

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

PHARMACOLOGICAL INTERVENTIONS

1. Check if the person has ever used an antiepileptic medication that controlled the seizures.
If yes, then resume the medication at the same dose.

2. If the medication is not available, start a new medication.

3. Choose only one antiepileptic drug (see Table 1).
– Consider potential side-effects, drug-disease interactions or drug-drug interactions. Consult the National or WHO Formulary, as necessary.

– Start with the lowest dose and increase gradually until complete seizure control is obtained.

4. Explain to the person and carers:
– Medication dosing schedule (see Table 1).
– Potential side-effects (see Table 1).
– Most side-effects are mild and will resolve over time.
– If severe side-effects occur, the person should immediately stop the medication and seek medical help.
– Importance of medication adherence as missed doses or abrupt discontinuation can cause seizures to recur.
– The medications should be taken at the same time each day.
– It takes time for the medication to start working, usually takes a few weeks before the effect becomes clear.
– Continue the medication until the person has not had a seizure for at least 2 years.
– Importance of regular follow-up.

Table EPI 1: Antiepileptic medications

	Phenobarbital[a]	Carbamazepine	Phenytoin	Valproate
Starting dose in children	2–3 mg/kg/day	5 mg/kg/day	3–4 mg/kg/day	15–20 mg/kg/day
Typical effective dose in children	2–6 mg/kg/day	10–30 mg/kg/day	3–8 mg/kg/day (max. dose 300 mg/day)	15–30 mg/kg/day
Starting dose in adults	60 mg/day	200–400 mg/day	150–200 mg/day	400 mg/day
Typical effective dose in adults	60–180 mg/day	400–1400 mg/day	200–400 mg/day	400–2000 mg/day
Dosing schedule	Once daily at bedtime	Twice daily	In children, give twice daily; in adults, it can be given once daily	Usually 2 or 3 times daily
Rare but serious side-effects	• Severe skin rash (Stevens-Johnson syndrome*) • Bone marrow depression* • Liver failure	• Severe skin rash (Stevens-Johnson syndrome*, toxic epidermal necrolysis*) • Bone marrow depression*	• Anaemia and other haematological abnormalities • Hypersensitivity reactions including severe skin rash (Stevens-Johnson syndrome*) • Hepatitis	• Drowsiness • Confusion
Common side-effects	• Drowsiness • Hyperactivity in children	• Drowsiness • Trouble walking • Nausea	• Nausea, vomiting, constipation • Tremor • Drowsiness • Ataxia and slurred speech • Motor twitching • Mental confusion	• Lethargy • Sedation • Tremor • Nausea, diarrhoea • Weight gain • Transient hair loss (regrowth normally begins within 6 months) • Impaired hepatic function
Precautions	• Avoid phenobarbital in children with intellectual disability or behavioural problems			• Avoid valproate in pregnant women

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

Special management considerations for women with epilepsy

Box EPI 1: Special management considerations for women with epilepsy

» If the woman is of **childbearing age:**
- Give folate 5 mg/day to prevent possible birth defects if she becomes pregnant.

» If she is **pregnant**:
- Consult with a specialist for management.
- Advise more frequent antenatal visits and delivery in a hospital.
- At delivery, give 1 mg **vitamin K** intramuscularly (i.m.) to the newborn.

» The decision to start an antiepileptic medication in a pregnant woman should be made together with the woman. The severity and frequency of the seizures as well as the potential harm to the fetus from either the seizures or the medication should be considered. If the decision is made to start medication, then either **phenobarbital** or **carbamazepine** can be used. Valproate and polytherapy* should be avoided.

» Carbamazepine can be used by women who are **breastfeeding.**

Assessment and management of a person who is convulsing or is unconscious following a seizure

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

Assessment and management of acute seizures should proceed simultaneously.

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

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

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

» **Management of seizures**
- Put the person on their side in the **recovery position** ***(see Basic management plan and Figures A–D above)***.
- If the seizure does not spontaneously stop after 1–2 minutes, insert an intravenous (i.v.) line as quickly as possible and give **glucose** and **benzodiazepines** slowly (30 drops/minute).
  - If an i.v. line is difficult to establish, give the benzodiazepines through the rectum.
  - Caution: **benzodiazepines can slow down breathing.** Give oxygen if available and monitor the person's respiratory status frequently.
  - **Child glucose dose**: 2–5 ml/kg of 10% glucose
  - **Child benzodiazepines dose**:
    - diazepam rectally 0.2–0.5 mg/kg or
    - diazepam i.v. 0.1–0.3 mg/kg or
    - lorazepam i.v. 0.1 mg/kg.
  - **Adult glucose dose**: 25-50 ml of 50% glucose
  - **Adult benzodiazepines dose**:
    - diazepam rectally 10–20 mg or
    - diazepam i.v. 10–20 mg slowly or
    - lorazepam i.v. 4 mg.
  - **Do not give benzodiazepines intramuscularly (i.m.).**
- Give the **second dose** of benzodiazepines if the seizure continues for 5–10 minutes after the first dose.
- Use the same dose as the first dose.
- **Do not give more than 2 doses of benzodiazepines. If the person needs more than 2 doses, they should be sent to a hospital.**
- Suspect **status epilepticus** if:
  - Seizures occur frequently and the person does not recover in between episodes, or
  - Seizures are not responsive to 2 doses of benzodiazepines, or
  - Seizures last for more than 5 minutes.

» **Refer urgently to a hospital:**
- If status epilepticus is suspected (see above)
- If the person does not respond to the first 2 doses of benzodiazepines
- If the person is having breathing problems after receiving benzodiazepines.

FOLLOW UP

1. Ensure regular follow-up

- For the first 3 months or until seizures are controlled, schedule follow-up appointments at least once a month.
- Meet every 3 months if seizures are controlled.
- Refer to Principles of Management in GPC for more detailed advice on follow-up.

2. At each follow-up:

Monitor for seizure control

Refer to the seizure diary to see how well seizures are controlled.

Review antiepileptic medication

Maintain or adjust the antiepileptic medication according to how well the seizures are controlled:

1. If seizures are still not controlled at the maximum therapeutic dose of one medication or the side effects have become intolerable, change to another medication. Gradually increase the dose until seizures are controlled.
2. If seizures are very infrequent and a further increase in the dose may produce severe side effects, then the current dose may be acceptable.
3. Consult a specialist if 2 medications were tried one after another and neither achieved adequate seizure control. Avoid treatment with more than one antiepileptic medication at a time.
4. Consider stopping the antiepileptic medication if no seizure has occurred in the last 2 years.
5. When stopping the medication, the dose should be tapered down slowly over several months to avoid seizures from medication withdrawal.
6. Involve carers in monitoring for seizure control.
7. Review lifestyle issues and provide further psychoeducation/support to the person and the carers.

Intellectual Disability

ID

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

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

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

Typical presenting complaints

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

ASSESSMENT

ASSESSMENT QUESTION 1: DOES THE PERSON HAVE INTELLECTUAL DISABILITY?

1. Review the person's skills and functioning

a. For young children and toddlers

Assess whether the child has fully reached age-appropriate milestones across all developmental areas.
Box 1: Developmental milestones: Warning signs to watch for.

Start by inquiring:
Is your child behaving like others of the same age?
What kinds of things can your child do alone (sitting, walking, eating, dressing or toileting)?
How does your child communicate with you?
Does the child smile at you?
Does the child react to his/her name?
Is the child able to ask for what he/she wants?
How does your child play?
Is your child able to play well with other children of the same age?

کیا آپ کے بچے کا طور طریقہ اپنے ہم عمر بچوں جیسا ہے؟
آپ کا بچہ کون کون سا کام خود کر سکتا ہے (بیٹھنا، چلنا، کھانا، کپڑے پہننا یا پیشاب کی ضرورت بتانا)؟
آپ کا بچہ کس طرح سے اپنی بات آپ کو سمجھاتا ہے؟
کیا آپ کا بچہ آپ کو دیکھ کر مسکراتا ہے؟ کیا وہ اپنا نام پہچانتا ہے؟
کیا آپ کا بچہ اپنی ضرورت بتا سکتا ہے؟
آپ کا بچہ کھیلتا کیسے ہے؟
کیا وہ اپنے ہم عمر بچوں کے ساتھ کھیل سکتا ہے؟

b. For older children and adolescents

Check whether they go to school and, if so, how they are managing schoolwork (learning, reading and writing) and everyday household activities.

Check how much help the person is currently receiving to do daily activities (e.g., at home, school, work).
Are you going to school? How are you doing in school?
Are you able to finish your schoolwork?
Do you often have difficulties in school because you cannot understand or follow instructions?

کیا آپ سکول جاتے ہیں؟
سکول میں آپ کا کام کیسا جا رہا ہے؟
کیا آپ سکول کا کام ختم کر پاتے ہیں؟
کیا سکول کا سبق سمجھنے میں کوئی مشکل ہوتی ہے؟

c. For adults
Check how much help the person is currently receiving to do daily activities (e.g., at home or at work).

Ask whether they work and, if so, how they are managing their work and other daily activities.
Do you work? What kind of work do you do?
Do you often get into trouble at work because you cannot understand or follow instructions?

آپ کیا کیا کام کر لیتے ہیں؟
کیا آپ کو کام میں ہدایات سمجھنے میں کوئی مشکل ہوتی ہے؟

2. Rule out treatable or reversible conditions

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

a. Rule out visual impairment
For a child >6 months, ask the carer if the child can do the following, while directly observing the child yourself:

– If the child can follow a moving object with their eyes
– If the child can recognize familiar people
– If the child can grab an object with their hands.

If any of the answers is **No**, inform the carer that the child may have impaired vision and consult a specialist, if available.

b. Rule out hearing impairment
For a child >6 months, ask the carer if the child can do the following, while directly observing the child yourself:
– If the child turns his/her head to see who is speaking from behind
– If the child reacts to loud noises
– If the child makes various vocal sounds (tata, dada, baba).

If any of the answers is **No**, inform the carer that the child may have impaired hearing and consult a specialist, if available.

c. Rule out problems in the environment

1. DEP in the mother or main carer

Note down your observations as well as ask questions.
What has your mood been like lately? or how would you describe your mood?
Are you able to enjoy things you used to like e.g., taking a walk, working at your hobbies, reading, meeting people etc.?
How has your interest been? If reduced, how long has that been so?
Have you noticed any changes in your sleep in the last one month?

What has your concentration been like recently? Can you read an article in the paper or watch a TV program right through? When you are talking to another person can you concentrate on what they are saying to you?

آپ اپنے دل میں کیسا محسوس کرتے ہے؟ آپ اپنے مزاج کو کس طرح بیان کریں گے؟ ان دنوں آپ کا مزاج کیسا ہے؟
کیا آپ جن چیزوں سے پہلے محظوظ ہوتے تھے ان میں اب بھی مزہ آتا ہے مثلاً سیر کرنا، مشاغل پر کام کرنا، کتابیں پڑھنا اور لوگوں سے ملنا وغیرہ؟
آج کل آپ کی دلچسپی کیسی ہے؟ کتنے عرصے سے آپ اپنی دلچسپی میں کمی محسوس کر رہے ہیں؟
کیا آپ نے پچھلے ایک ماہ میں اپنی نیند میں کوئی تبدیلی محسوس کی ہے؟
آج کل آپکی توجہ دینے کی صلاحیت کیسی ہے؟ مثلاً اخبار پڑھنے میں یا ٹی وی دیکھنے میں یا لوگوں سے بات چیت کرنے میں ذہن بھٹک تو نہیں جاتا؟

2. Lack of stimulation

Stimulation is essential for brain development in young children.

Who regularly interacts and plays with the child?
How do you/they play with your child? How often?
How do you/they communicate with your child? How often?

بچے کے ساتھ سب سے زیادہ کون کھیلتا ہے یا زیادہ وقت گزارتا ہے؟
آپ بچے کے ساتھ کتنا وقت گزارتے ہیں اور کس طرح کھیلتے ہیں؟
آپ بچے کے ساتھ کیسے بات چیت کرتے ہیں؟ کتنی بار کرتے ہیں؟

3. Rule out malnutrition

Rule out nutritional or hormonal deficiencies including iodine deficiency and hypothyroidism.

Note the signs that indicate malnutrition.

- Mouth ulcers
- Brittle nails
- Dry skin
- Pitting oedema (after applying pressure on dorsum of foot for a few seconds, a pit remains after the finger is removed)
- Lethargy
- Weight loss, visible severe wasting and absence of fat
- Swelling in the neck
- Hair changes like thin hair
- Fever
- Ear discharge
- Painful swelling behind the ear
- Enlarged lymph nodes

  Ref: Management of the child with a serious infection or severe malnutrition. Guidelines for care at the first-referral level in developing countries. World Health Organization. Geneva, WHO, 2000

4. Rule out EPI

Epilepsy can mimic or occur together with intellectual disability.

Did the person have convulsive movements lasting longer than 1-2 minutes?
Did the person sustain loss of consciousness or impaired consciousness during seizures?
Did the person bite his tongue during the seizures?
Did the person lose bladder control during the seizure?
Did the person experience confusion or fatigue after the seizure?

کیا کبھی مریض کو ایک دو منٹ سے زیادہ دیر تک جھٹکے لگے ہیں؟
کیا مریض کبھی دورے کے دوران بیہوش یا نیم بیہوش ہوا ہے؟
کیا دورے کے دوران کبھی مریض کی زبان کٹی ہے؟
کیا دورے کے دوران کبھی مریض کا پیشاب نکلا ہے؟
کیا مریض کو دورے کے بعد تھکاوٹ یا بوکھلاہٹ ہوئی ہے؟

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

1. For confirmed cases of hearing and visual impairments, provide or advocate for necessary aids (glasses, hearing aid).
2. Manage depressive disorder in the carer, if applicable.
3. Teach the carer how to provide a more stimulating environment for young children.
4. Refer the person to Early Childhood Development (ECD) programmes, if appropriate.
5. Intellectual disability is likely if there is a significant delay in reaching expected developmental milestones and difficulty meeting demands of daily life treatable or reversible conditions have been ruled out or addressed.

ASSESSMENT QUESTION 2: ARE THERE ASSOCIATED BEHAVIOURAL PROBLEMS?

1. Does not listen to carers

Does the child actively defy or refuse to go along with adults' requests or rules?

کیا بچہ بڑوں کی بات ماننے سے انکار کرتا ہے یا ان کی ہدایات یا اصولوں پہ عمل نہ کرتا ہو؟

2. Temper tantrums e.g., aggressive and self-harming behaviour when upset

Does the child frequently lose temper?
Does the child show severe tantrums which result in self injury or physical aggression?

کیا بچہ اکثر غصّہ یا بدتمیزی کرتا ہے؟
کیا بچہ کبھی آپے سے باہر ہو جاتا ہے، یہاں تک کہ اپنے آپ کو یا دوسروں کو نقصان پہنچائے؟

3. Eating non-organic materials

4. Reckless sexual or other problematic behaviour

Does the child bully, threaten, or intimidate others?
Has the child stolen things that have value?

کیا بچہ دوسرے بچوں کو ڈراتا یا دھمکاتا ہے؟ کیا بچے نے کبھی چوری کی ہے؟

BASIC MANAGEMENT PLAN

1. Offer Psychoeducation

Start by inquiring:
What do the carers already know about the problem?
What are the efforts that the carers are making?
What are the challenges they face?
What are their expectations?
Do they know of anyone else facing similar challenges?

بچے کے گھر والے اس مسئلے کے بارے میں کیا جانتے ہیں؟
وہ اس مسئلے کو حل کرنے کے لیے کیا کوشش کر رہے ہیں؟
ان کو کن مسائل کا سامنا ہے؟
ان کی کیا توقعات ہیں؟
کیا وہ کسی اور کو جانتے ہیں جن کو ایسے ہی مسائل کا سامنا ہو؟

Then follow the guidelines:
- People with intellectual disability should not be blamed for the disability.
- The person will learn and develop but will remain behind his/her age mates, efforts to teach new skills and behaviors should be made.
- The aim is for the carers to have realistic expectations and to be kind and supportive.
- Educate the carers that the person is more vulnerable to physical and sexual abuse in general, requiring extra attention and protection.
- Educate carers to avoid institutionalization.

ذہنی طور پہ کمزور یا معزور بچوں اور لوگوں کو الزام نہ دیں۔
وہ سیکھنے کی صلاحیت رکھتے ہیں مگر وہ اپنے ہم عُمر لوگوں سے پیچھے رہیں گے، نئے کام اور ہنر سکھانے کی کوشش کرنا ضروری ہے۔
گھر والوں کی مدد کریں کہ وہ مناسب توقعات رکھیں، نرم دلی اور حوصلہ مندی سے اس آزمائش کا مقابلہ کریں.
دیکھ بھال کرنے والوں کو بتائیں کہ ان بچوں کو جسمانی اور جنسی زیادتی کا خطرہ ہوتا ہے۔ اس لیے انہیں زیادہ تحفظ اور توجہ کی ضرورت ہے۔
دیکھ بھال کرنے والوں کو سمجھائیں کہ ان بچوں کو کسی ادارے میں داخل کروانے سے گریز کریں۔

2. Provide parenting skills training

a. Assess the problem

1. What stresses the person and what makes them happy;
2. What causes behavior problems and what prevents them;
3. What the person's strengths and weaknesses are; and
4. How the person learns best.

کونسی باتوں سے یہ شخص پریشان ہوتا ہے اور کونسی بات سے خوش ہوتا ہے؟

کونسی باتوں سے اس کے رویے میں مسائل پیدا ہوتے ہیں اور کونسی باتوں سے مسائل بہتر ہوتے ہیں؟
اس شخص کی منفی اور مثبت عادات یا خصوصیات کیا ہیں؟
اس شخص کو نئی بات سیکھنا کیسے ممکن ہوتا ہے؟

b. Educate the carers

1. The aim should be to improve positive interactions between parent/carer and child.
2. Carers should be able to learn the skills that can help reduce behaviour problems.
3. Train the person to perform self-care and hygiene according to the person's level of functioning (e.g, toilet training, brushing teeth, bathing, wearing clothes, and so on).
4. Regulate the person's daily activities (such as eating, playing, learning, working and sleeping).

گھر والوں کی مدد کریں کہ وہ بچے کے ساتھ ایک مثبت اور صحت مند رویہ رکھیں۔
گھر والوں کی مدد کریں کہ وہ بچے کی بہتر تربیت یا صحیح عادات کیسے سکھائیں۔
اس شخص کو ذاتی صفائی اور اپنا خیال رکھنا سکھائیں، جو کام ابھی نہیں آتا، اس سے شروع کریں (مثلاً باتھ روم کا استعمال، دانتوں کی صفائی، نہانا، کپڑے پہننا، وغیرہ)۔
اس شخص کی روزمرہ کے معمولات میں باقاعدگی رکھیں (جیسا کہ کھانا کھانا، کھیلانا، پڑھائی، کام کرنا، سونا)۔

c. Modify behaviour

1. Reward the person when the behavior is good (reinforcement) and withhold rewards when the behaviour is problematic.
2. Use clear, simple and short instructions on what the person should do rather than what the person should not do.
3. Break complex activities into smaller steps so that the person can learn and be rewarded one step at a time (e.g., learning to put trousers on before buttoning them up).
4. Offer reward for positive behaviour. Reward could be a compliment, a clap or a hug.
5. Ignore problematic behavior. Attention can reinforce behavior problems.
6. NOT use threats or physical punishments when the behaviour is problematic

اچھی کارکردگی پر اس شخص کو انعام دیں۔ اور کام مکمل نہ ہونے کی صورت میں انعام نہ دیں۔
آسان اور واضح ہدایت دیں۔ صاف لفظوں میں بتائیں کہ اسے کیا اور کیسے کرنا ہے۔
ایک مشکل کام کو سکھانے کے لئے چھوٹے چھوٹے کاموں میں تقسیم کریں (مثلاً پتلون اوپر چڑھانے کے بعد بٹن بند کرنا) کارکردگی کی بہتری پہ انعام دیں۔
اچھی کارکردگی پر انعام دیں۔ انعام کچھ بھی ہوسکتا ہے مثلاً شاباش دینا، تالی بجانا یا پیار کرنا وغیرہ۔ بچے کی بنیادی ضروریات جیسا کہ خوراک، آرام، پیار، یا توجہ انعام نہیں ہیں۔
غلط رویّوں کو نظرانداز کریں۔ توجہ دینے سے یا بار بار منع کرنے سے غلط رویہ مزید بڑھتا ہے۔
غلط کام کی صورت میں مارنے یا ڈانٹنے یا ڈرانے کا کوئی فائدہ نہیں ہوتا۔

3. Promote community-based protection

Explore available resources for community-based protection (e.g., informal groups, local NGOs, governmental agencies or international agencies) and ask for relevant support for the person.

4. Advocate for inclusion in community activities

a) If the person is a child, keep them in normal schools as much as possible.
Liaise with the child's school to explore possibilities of adapting the learning environment to the child.
Simple tips are available in *Inclusive Education of Children at Risk* (INEE)

b) Encourage participation in enjoyable social activities in the community.
c) Explore available resources for community-based rehabilitation programmes and advocate for inclusion of the person with disability in such a programme.

5. Support the carers

Start by inquiring:
What impact does the child's condition have on the carer?
How are they coping? Personally? Socially? Emotionally?
What sources of support do the carers have?

بچے کے مسئلے کی وجہ سے اس کی دیکھ بھال کرنے والوں پر کیا اثر ہو رہا ہے؟
وہ اس مسئلے کا مقابلہ کیسے کر رہے ہیں؟
دیکھ بھال کرنے والوں کو خود کتنی مدد مل رہی ہے؟

Then follow the guidelines:
1. Assess the psychosocial impact of the child/adolescent's disorders on the carers, and offer support for their personal, social, and mental health needs.
2. Promote necessary support and resources for their family life, employment, social activities, and health.
3. Arrange for respite care (trustworthy carers taking over care on a short-term basis) to give primary carers a break.
4. Support family to handle social and familial problems and help to problem solve.

Go to the Principles of Reducing Stress and Strengthening Social Support in GPC

5. If possible, refer to a specialist

1. All children with developmental delay should be seen for further assessment, at least once, by a specialist (pediatrician, mental health specialist, neurologist).
2. If visual or hearing impairment is suspected.
3. If there is no improvement or further deterioration in development or behavior.
4. If you suspect danger to the child or others.
5. If physical health is affected (such as nutrition problems).
6. Limit financial burden on families seeking multiple opinions and further investigation.

FOLLOW-UP

Schedule and conduct follow-up sessions according to the Principles of Management in GPC
Monitor improvement by asking:
How has the person been?
Have you noticed any improvement?
What problems (symptoms) are resolving/getting better?
What problems (symptoms) are not improving?

اب ان کی طبیعت کیسی ہے؟
کیا آپ نے کوئی بہتری محسوس کی؟
آپ کے خیال میں کون سے مسائل (علامات) بہتر ہو رہے ہیں؟
آپ کے خیال میں کون سے مسائل (علامات) بہتر نہیں ہو رہے ہیں؟

Box ID 1: Developmental milestones: warning signs to watch for (Page 88)

By the age of 1 MONTH	• Poor suckling at the breast or refusing to suckle • Little movement of arms and legs • Little or no reaction to loud sounds or bright light • Crying for long periods for no apparent reason • Vomiting and diarrhoea, which can lead to dehydration
By the age of 6 MONTHS	• Stiffness or difficulty moving limbs • Constant moving of the head (this might indicate an ear infection, which could lead to deafness if not treated) • Little or no response to sound, familiar faces or the breast • Refusing the breast or other foods
By the age of 12 MONTHS	• Does not make sound in response to others • Does not look at objects that move • Listlessness and lack of response to the caregiver • Lack of appetite or refusal of food
By the age of 2 YEARS	• Lack of response to others • Difficulty keeping balance while walking • Injuries and unexplained changes in behaviour (especially if the child has been cared for by others) • Lack of appetite
By the age of 3 YEARS	• Loss of interest in playing • Frequent falling • Difficulty manipulating small objects • Failure to understand simple messages • Inability to speak using several words • Little or no interest in food
By the age of 5 YEARS	• Fear, anger or violence when playing with other children, which could be signs of emotional problems or abuse
By the age of 8 YEARS	• Difficulties making and keeping friends and participating in group activities • Avoiding a task or challenge without trying, or showing signs of helplessness • Trouble communicating needs. thoughts and emotions • Trouble focusing on tasks, understanding and completing schoolwork • Excessive aggression or shyness with friends and family

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

Harmful Use of Alcohol and Drugs

SUB

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

Typical presenting complaints

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

ASSESSMENT

ASSESSMENT QUESTION 1: IS THERE HARM TO PHYSICAL OR MENTAL HEALTH AND/OR GENERAL WELLBEING FROM ALCOHOL OR DRUG USE?

A. ASSESS

Explore the use of alcohol or drugs, without sounding judgmental

1. **Amount and pattern of use**

Do you use any substance of dependence? What kind?
How do you take them – by mouth, injection, snorting?
How much/how often per day/week?
Do you drink alcohol? If so, in what form? How many drinks per day/week?
Do you use prescribed sleeping tablets/anxiety pills/painkillers? What kind? How many per day/ week?

کیا آپ منشیات کا استعمال کرتے ہیں؟ کیا استعمال کرتے ہیں؟
کس طریقے سے استعمال کرتے ہیں؟ مثلاً کھاتے ہیں، ٹیکہ لگاتے ہیں یا ناک کے ذریعے؟
دن یا ہفتے میں کتنی مقدار یا کتنی مرتبہ استعمال کرتے ہیں؟
کیا آپ شراب کا استعمال کرتے ہیں؟
دن یا ہفتے میں کتنی مقدار یا کتنی مرتبہ استعمال کرتے ہیں؟
کیا آپ نیند کی یا درد کی دوائی استعمال کرتے ہیں؟ دوا کا نام کیا ہے؟ دن یا ہفتے میں کتنی دفعہ استعمال کرتے ہیں؟

2. **Triggers to alcohol or drug use**

What makes you want to take alcohol or drugs?

نشہ کرنے کی کیا وجوہات ہیں؟

3. **Harm to self or others**

- **Medical problems or injuries as a result of alcohol or drug use**

Have you experienced health problems since you started drinking alcohol or using drugs?
Have you ever been injured while you were under the influence of alcohol or drugs?

کیا آپ کو نشے کی وجہ سے صحت کا کوئی مسئلہ ہوا ہے؟
کیا نشے کی حالت میں کبھی کوئی چوٹ لگی ہو؟

- **Continued use of alcohol or drugs despite advice to stop**

Have you continued to use alcohol or drugs despite medical advice to stop?
For example, in case of pregnancy or breastfeeding, stomach or liver problems because of drinking or drug use, or during use of medications that have harmful interactions with alcohol or drugs (such as sedatives, analgesics or tuberculosis medications)

کیا آپ کو کبھی نشے کے استعمال سے منع کیا گیا ہے مگر آپ منع نہ ہوئے ہوں؟
جیسا کہ حمل یا بچے کو دودھ پلاتے وقت، معدے یا جگر کے مسائل کی وجہ سے، یا ایسی دوائیوں کے استعمال کے دوران جو نشے کی وجہ سے زیادہ نقصان دہ ہوسکتی ہیں۔

- **Social problems as a result of alcohol or drug use**

Financial or legal problems
Occupational problems
Difficulty caring for children or other dependents
Violence towards others
Relationship/marital problems

Have you ever been in trouble with money or broken the law because of alcohol or drug use?
Have you ever lost a job or done badly at work because of your alcohol or drug use?
Have you ever found it hard to take care of your child/family because of alcohol or drug use?
Have you ever hurt someone while taking alcohol or drugs?
Has your alcohol or drug use ever caused a problem with your partner?

کیا آپ کو کبھی نشہ کی وجہ سے پیسوں کا نقصان ہوا یا قانون کے ساتھ کوئی مسئلہ بنا ہے؟
کیا نشے کی وجہ سے کام میں کوئی حرج یا نوکری میں مسائل آئے یا نوکری ختم ہوئی ہو؟
کیا نشے کی وجہ سے بچوں یا گھر والوں کی ذمہ داری میں کوئی کوتاہی ہوئی ہے؟
کیا نشے کی حالت میں کبھی آپ نے کسی کو نقصان پہنچایا ہے؟
کیا نشے کی وجہ سے آپ کی ازدواجی زندگی میں کوئی مشکلات آئی ہیں؟

B. EXAMINE

Perform a quick general physical examination to look for signs of chronic alcohol or drug use

1. Malnutrition, Anemia, severe weight loss
2. Drug use side effects (e.g., constipation, hallucinations), overdose, and withdrawal
3. Gastrointestinal bleeding
4. Abdominal pain, blood in vomit, blood in stool or black stool
5. Liver disease (severe)
6. Jaundice, ascites, enlarged and hardened liver and spleen, hepatic encephalopathy
7. Malnutrition, severe weight loss
8. Evidence of infections associated with drug use e.g., HIV, hepatitis B or C, injection site skin infections or tuberculosis

NOTE: Assess for both harmful alcohol and drug use in the same person as they often occur together.

C. BASIC INVESTIGATIONS

1. Haematological investigations
2. Haemoglobin, ESR, Blood counts
3. Renal function tests
4. Liver function tests
5. Hepatitis B
6. Hepatitis C
7. Tests for HIV antibody
8. Chest X Ray
9. ECG
10. Urine test for drug screen

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

1. Manage the harmful effects of alcohol or drug use

1. Provide necessary medical care for physical consequences of harmful alcohol or drug use.
2. Manage any concurrent mental conditions, such as DEP, PTSD, PSY.
3. Address urgent social consequences e.g., liaise with protection services in case of abuse, such as gender-based violence.

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

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

آپ کے خیال میں کیا آپ کو نشے کا مسئلہ ہے؟
کیا آپ نے کبھی نشہ کم کرنے یا چھوڑنے کے بارے میں سوچا ہے؟
کیا آپ نے ماضی میں نشہ کو کم کرنے یا چھوڑنے کی کوشش کی ہے؟

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

Initiate a brief motivational conversation about harmful use. Do not be judgmental, but try to understand what motivates the person to use alcohol or drugs.

Ask about the perceived benefits and harms of alcohol or drug use.

What kind of pleasure do you get when taking alcohol or drugs?
Do you see any negative aspects of taking alcohol or drugs?
Did you ever regret using alcohol or drugs?

آپ کو نشے کے استعمال سے کسی قسم کی تسکین ملتی ہے؟
آپ کے خیال میں نشہ کرنے سے آپ کو کوئی نقصان ہے؟
کیا آپ کو نشہ کرنے کا کوئی افسوس ہوتا ہے؟

Challenge any exaggerated sense of benefit from alcohol or drug use.
For example, if the person uses alcohol or drugs to try to forget life problems.
Is forgetting the problem really a good thing?
Does that make the problem go away?

کیا اپنے مسئلے کو بھلا دینے سے وہ مسائل حل ہو جاتے ہیں؟
کیا نشہ کرنے سے مسئلہ حل ہو جاتا ہے؟

Highlight some of the negative aspects of alcohol and drug use that may have been underestimated by the person.
How much money do you spend buying alcohol or drugs? Per week? Per month? Per year?
What else could you be doing with that money?

آپ نشے پر کتنا پیسہ خرچ کرتے ہیں؟ ہفتے میں کتنا، مہینے اور سال میں کتنا؟
اگر آپ نشہ نہ کرتے تو ان پیسوں کا اور کیا استعمال کر سکتے ہیں؟

Provide additional information on the harmful effects of alcohol and drugs, both short-term and long term.
Alcohol or drugs may result in serious medical and mental health problems, including injuries and addiction.

Acknowledge that stopping alcohol or drug use is difficult.
1. Let the person know you are willing to support them.
2. Encourage people to decide for themselves if it is a good idea to stop alcohol or drugs.
3. If the person is not ready to stop or reduce alcohol or drugs, respect the decision.
4. Ask the person to come back another time to talk further.

Repeat the brief motivational conversations described above over several sessions.

4. Discuss various ways to reduce or stop harmful use

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

5. Offer psychosocial support

1. Address current psychosocial stressors.
2. Strengthen social support.
3. Teach stress management.

Go to the Principles of Reducing Stress and Strengthening Social Support in GPC

PHARMACOLOGICAL INTERVENTIONS

Management of withdrawal symptoms

Withdrawal from opiates

1. Symptomatic treatment for withdrawal.
2. Provide support and information.
3. Encourage oral fluids; an intravenous infusion should be used only in dehydrated states where the patient is unable to drink.
4. Ensure fluid and electrolyte balance.
5. Monitor vital signs regularly.
6. Treat any infection immediately.
7. Treat symptoms, as required (see table below).

Treatment of withdrawal symptoms		
Symptoms	**Drug**	**Dose**
Agitation	Haloperidol (Serenace)	Up to 15 mg/d
Diarrhoea	Loperamide hydrochloride (Imodium)	Up to 6 - 8 mg/d
Nausea, vomiting	Metoclopramide hydrochloride (Maxolon)	As required, up to three times/d
Stomach cramps	Hyoscinebutylbromide (Buscopan)	As required, up to three times/d
Muscular pains	Non-steroidal anti-inflammatory drugs	As required

Withdrawal from Benzodiazepines

1. Reduce dose gradually.
2. If withdrawal symptoms occur consider maintaining the patient on the same dose and adopt a slower pace of reduction.
3. Reduce the dose further in smaller fortnightly steps, preferably to reduce more slowly than too quickly.
4. Stop completely: this may vary from 4 weeks to a year or more, after initiating the reduction, again depending on individuals.
5. Always assess for underlying mental illness, if untreated.

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

Typical presenting complaints of person with life-threatening alcohol withdrawal

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

Assessment of life-threatening alcohol withdrawal

Assessment question 1: Is this alcohol withdrawal?

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

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

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

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

Emergency management plan for life-threatening alcohol withdrawal

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

- The dose of diazepam treatment depends on the person's tolerance* for diazepam, the severity of the withdrawal symptoms and the presence of concurrent physical disorders.
  - Adjust the dose to the observed effect. The right dose is the one that gives slight sedation.
    - Too high a dose can cause over-sedation and depress respiration. Monitor the person's respiratory rate and level of sedation (e.g. sleepiness) frequently.
    - Too low a dose risks seizures/delirium.
- Monitor the withdrawal symptoms frequently (every 3–4 hours). Continue to use diazepam until symptoms resolve (typically 3–4 days but no longer than 7 days).
- In the case of a withdrawal seizure, DO NOT use antiepileptic drugs. Continue using diazepam.
- Symptoms of **delirium** such as confusion, agitation or hallucinations can persist for several weeks after other alcohol withdrawal symptoms have resolved. In this case, consider using **antipsychotics** such as **haloperidol** 2.5–5 mg orally up to 3 times daily until confusion, agitation or hallucinations improve. In some cases it may take several weeks for hallucinations and confusion to resolve. Do not oversedate.
- If possible, provide a quiet, non-stimulating and well-lit environment. Try to provide some light even at night to prevent falls if the person decides to get up in the middle of the night. Consider putting the person on a mattress on the floor to prevent injury. If possible, ask a carer to stay with the person and monitor. Avoid restraints if at all possible.

2. Address malnutrition

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

3. Maintain hydration

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

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

Table SUB 1: Diazepam for life-threatening alcohol withdrawal

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

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

FOLLOW-UP

1. Continue to offer support, discuss and work together with the person and the carers about reducing or stopping alcohol or drug use.

2. Schedule and conduct regular follow-up sessions, as in GPC

3. At every visit, assess motivation and check:
   - Is the person improving?
   - What substances is the person still using? And what amount?
   - Is the person completely abstinent from substance use?
   - What are the factors which are protecting him from substance use?
   - Has the person noticed any improvement?
   - Are there any signs of MNS disorders e.g., DEP, PSY?

When to refer?

1. Mental illness is suspected but could not be diagnosed.
2. In case of severe mental illness.
3. In case of severe withdrawal where detoxification is preferred under specialist supervision.
4. In case of severe physical complications (e.g., aspiration pneumonia, respiratory depression).
5. When there is risk of harm to self or others.
6. In case opinions are needed for the purposes of assisting the court.

Suicide

SUI

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

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

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

- Feeling extremely upset or distressed
- Profound hopelessness or sadness
- Past attempts of self-harm (e.g. acute pesticide intoxication, medication overdose, self-inflicted wounds).

ASSESSMENT

ASSESSMENT QUESTION 1: HAS THE PERSON RECENTLY ATTEMPTED SUICIDE OR SELF-HARM?

1. Poisoning or medication overdose

You should be familiar with signs of common types of poisoning in your healthcare context.

If the patient has presented with overdose or poisoning, monitor the vital signs
Blood pressure, temperature, respiratory rate and heart rate.

You should know the signs of organophosphate poisoning (rat pills), which is common in Pakistan.

Bradycardia, hypotension.
Difficulty breathing, wheezing, cough, running nose.
Increased salivation, nausea and vomiting, abdominal pain, diarrhea, fecal incontinence.
Blurred vision, pupil size.
Increased lacrimation, increased sweating.
[Ref: Jokanović M. Neurotoxic effects of organophosphorus pesticides and possible association with neurodegenerative diseases in man: A review. Toxicology. 2018 Dec 01; 410: 125-131]

2. Self-inflicted wound

You should:
1. Remain non judgmental
2. Calm the person and carer and let him or her know that you can help
3. Assess the severity of the wound

Cuts that do not involve fat or muscle tissue (superficial), are not bleeding heavily, are less than 1/2 inch long and do not involve the face can be managed without stitches.
[Ref: Ubbink DT, Brölmann FE, Go PM, Vermeulen H. Evidence-Based Care of Acute Wounds: A Perspective. Adv Wound Care (New Rochelle). 2015;4 (5):286–294]

You should do a detailed assessment of the suicide risk in all patients presenting with self-cutting.

3. Loss of consciousness

Initially observe the patient for spontaneous eye-opening.
Try to engage the patient in conversation and assess if they are orientated.

If the patient doesn't look fully alert, check level of consciousness.
Can you hear me?
Can you tell me your name?
Do you know where you are at the moment?
Do you know what the date is today?
Can you move your fingers?
Ask the patient to perform a two-part request (e.g. "Lift your right arm off the bed and make a fist")
[Ref: Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. Lancet. 1974 Jul 13;2(7872):81-4]

کیا آپ میری آواز سن سکتے ہیں؟

کیا آپ اپنا نام بتا سکتے ہیں؟

کیا آپ جانتے ہیں آپ ابھی کہاں ہیں؟

کیا آپ جانتے ہیں کہ آج کیا تاریخ ہے؟

کیا آپ اپنی انگلیاں ہلا سکتے ہیں؟

مریض کو ایسی حرکت کرنے کو کہیں جو دو حصوں میں ہو (اپنا بازو بستر سے اٹھایئے اور مٹھی بند کریں)

ASSESSMENT QUESTION 2: IS THERE AN IMMINENT RISK OF SUICIDE OR SELF-HARM?

This is a highly sensitive assessment which needs unhurried and careful examination.

Box 1: How to assess for risk of suicide or self-harm	
1 Create a safe and private atmosphere for the person to share thoughts.	Do not judge the person for being suicidal. Offer to talk with the person alone or with other people of their choice.
2 Observe	Severe emotional distress or hopelessness. Violent behavior or extreme agitation. Withdrawal or unwillingness to communicate.
3 Use a series of questions where any answer naturally leads to another question to assess thoughts or plans of suicide. Start with the present	*How do you feel?* *Some people feel very sad and lose hope during difficult times, I am now going to ask about these feelings.* *How do you see your future?* *Do you ever feel hopeless about your future?* *When feeling sad and hopeless, some people have thoughts about death or suicide. These thoughts are common during depression and it is important that I ask about them.* *Is that ok with you? Should we continue the interview?* *Have you ever felt that life is not worth living anymore?* *Have you ever thought about hurting yourself?* *Have you ever thought about ending your life?* *If so, how are you planning to do it?* *Have you considered when to do it?* آپ کیسا محسوس کر رہے ہیں؟ کچھ لوگ پریشان حالات سے گزرتے ہیں تو بے حد اداسی یا شدید ناامیدی محسوس کرتے ہیں۔ میں اب ایسے خیالات کے بارے میں سوال کروں گا۔

		آپکو اپنا مستقبل کیسا لگتا ہے؟ کیا آپ کبھی ناامیدی محسوس کرتے ہیں؟ کچھ لوگ اداسی اور ناامیدی کی صورت میں موت کے بارے میں یا اپنی زندگی ختم کرنے کے بارے بھی میں سوچتے ہیں۔ ڈپریشن میں یہ سوچیں عام ہوتی ہیں اور ان کے بارے میں پوچھنا ضروری ہے۔ آپ کو اس سے کوئی اعتراض تو نہیں؟ کیا ہم اپنی بات جاری رکھیں؟ کیا آپ کو کبھی ایسا لگتا ہے کہ زندگی جینے کے قابل نہیں رہی؟ کیا آپ نے کبھی اپنے آپ کو نقصان پہنچانے کی کوشش کی ہے؟ کیا آپ کو کبھی خودکشی کا خیال آیا ہے؟ اگر ہاں، تو آپ نے اسکا کوئی طریقہ سوچا ہے؟ کیا آپ نے سوچا ہے کہ آپ کب کریں گے؟
4	Check if the person has access to means of suicide (e.g., pesticides, rope, weapons, knives, prescribed medications and drugs)	Do you have the means to end your life? For example, check if the patient has been saving tablets for an overdose or knows where a gun is kept in the house etc. کیا آپ نے سوچا ہے کہ اپنے آپ کو کیسے نقصان پہنچائیں گے؟ کیا آپ کے پاس وہ شے یا ذریعہ موجود ہے جس سے آپ ایسا کر سکتے ہیں؟
5	If the person has expressed suicidal ideas	Maintain a calm and supportive attitude Do not make false promises
6	Also check for acts of self-harm in the past year	*Have you ever acted upon these thoughts in the past?* *If you have not acted upon them, how close do you feel you came to acting?* *What stopped you from acting on them?* *Were there other times during the last year when you tried to harm yourself?* *How did you feel after your attempt? Did you feel relief or regret at being alive?* کیا آپ نے اس قسم کے خیالات پہ پہلے کبھی عمل کیا ہے؟ اس کے بارے میں بتائیں۔ اگر نہیں کیا تو آپ کو کیا لگتا ہے کہ آپ عمل کرنے کے کتنے قریب آئے تھے؟ آپ کو ایسا عمل کرنے سے کس چیز نے روکا تھا؟ کیا پچھلے سال میں کوئی ایسے مواقع تھے جن میں آپ نے خود کو نقصان پہنچانے کی کوشش کی تھی؟ اس کوشش کے بعد آپ نے کیسا محسوس کیا تھا؟ شکر کیا یا پچھتائے؟

ASSESSMENT QUESTION 3: ARE THERE CONCURRENT CONDITIONS ASSOCIATED WITH SUICIDE OR SELF-HARM?

1. Chronic pain or disability

Chronic pain is an emotional experience and is defined as pain lasting greater than six months.
[Ref: Raffaeli W, Arnaudo E. Pain as a disease: an overview. J Pain Res. 2017; 10:2003–2008]

In your view what could be the cause of the pain?
How long have you experienced this pain? (in weeks)
Where do you feel the pain?
What does the pain feel like?
Does anything that you do reduce your pain?
Does anything that you do make your pain worse? How is this pain affecting the person?
Has the person received any treatment for the pain?

آپ کی نظر میں تکلیف کی وجہ کیا ہوسکتی ہے؟

آپ کتنے عرصے سے یہ تکلیف محسوس کر رہے ہیں؟(ہفتوں میں)

آپ تکلیف کہاں محسوس کر رہے ہیں؟اس کے بارے میں تفصیل بتائیں۔

یہ تکلیف کیسی محسوس ہوتی ہے؟

اس تکلیف میں کمی کیسے آتی ہے؟اور کب یہ تکلیف بڑھتی ہے؟

یہ تکلیف آپ کو کیسے اثرانداز کر رہی ہے؟

کیا آپ نے اس تکلیف کا کوئی علاج کروایا ہے؟

2. Moderate-severe depressive disorder

What has your mood been like lately? or how would you describe your mood?
Were you able to enjoy things before the act?
Have you lost interest in things you enjoyed?
How is your energy level? Do you easily get tired during the day also when you have not done anything especially hard?
Have you noticed any changes in your sleep in the last one month? What has your concentration been like recently? Can you read an article in the paper or watch a TV program right through? When you are talking to another person can you concentrate on what they are saying to you?

آپ اپنے دل میں کیسا محسوس کرتے ہیں ؟آپ اپنے مزاج کو کس طرح بیان کریں گے ؟ ان دنوں آپ کا مزاج کیسا ہے ؟

کیا آپ جن چیزوں سے پہلے محظوظ ہوتے تھے ان میں اب بھی مزا آتا ہے مثلاً سیر کرنا، مشاغل پر کام کرنا، کتابیں پڑھنا اور لوگوں سے ملنا وغیرہ؟

آج کل آپ کی دلچسپی کیسی ہے ؟کتنے عرصے سے آپ اپنی دلچسپی میں کمی محسوس کر رہے ہیں؟

آج کل آپ کے جسم میں طاقت کیسی ہے؟ کیا آپ تھکا تھکا محسوس کرتے ہیں یا آسانی سے تھک جاتے ہیں؟

کیا آپ نے پچھلے ایک ماہ میں اپنی نیند میں کوئی تبدیلی محسوس کی ہے ؟

آج کل آپکی توجہ دینے کی صلاحیت کیسی ہے ؟ مثلاً اخبار پڑھنے میں یا ٹی وی دیکھنے میں یا لوگوں سے بات چیت کرنے میں ذہن بھٹک تو نہیں جاتا ؟

3. Psychosis

Do you ever seem to hear voices when there is no one around?
Have there been times when the voices told you to hurt or kill yourself?

کیا آپ کو کبھی آوازیں سنائی دیتیں ہیں جب کہ ارد گرد کوئی نہ ہو؟

کیا کبھی ایسا ہوا ہے کہ آوازوں نے آپ کو خود کو نقصان پہچانے کیلئے کہا ہو؟

4. Harmful alcohol or drug use

Do you take alcohol? If yes, how much? How often? (If the use is excessive, check for signs of dependence)

Do you use any substances or drugs? If yes, how much? How often? (If the use is excessive, check for signs of dependence)

کیا آپ کوئی نشہ یا شراب نوشی کرتے ہیں؟ اس کے بارے میں تفصیل بتائیں۔

5. Post-traumatic stress disorder

6. Acute emotional distress

See ACU, GRI, OTH

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

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

1. Treat those who have inflicted self-harm with the same care, respect and privacy given to others.
2. Do not punish them.
3. Treat the injury or poisoning.

For acute pesticide intoxication
[Ref: Clinical Management of Acute Pesticide Intoxication WHO, 2008]
In the case of a prescribed medication overdose (e.g., an anti-depressant) where medication is still required:

- Choose the least harmful alternative medication.
- If possible, prescribe the new medication for short periods of time only (few days - 1 week at a time) to prevent another overdose.
- Ask the carers to supervise medication.

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

A Monitor the person

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

B Offer psychosocial support

1. DO NOT start by offering potential solutions to the person's problems. Instead, try to instill hope.

Many people who have been in similar situations – feeling hopeless, wishing they were dead – have then discovered that there is hope, and their feelings have improved with time.

بہت سے لوگ جو آپ جیسے حالات سے گزر رہے ہوتے ہیں، مایوسی محسوس کرتے ہیں، خواہش کرتے ہیں کہ زندہ نہ ہوتے، اور پھر ان کو امید کی کرن مل جاتی ہے اور ان کے جذبات وقت کے ساتھ بہتر ہو جاتے ہیں۔

2. Focus on the person's strengths by encouraging them to talk about how earlier problems have been resolved.

Have you ever found it as difficult, or close to this, in the past?
What happened back then?
What has helped you in the past?
Who has been your main support at difficult times before?

کیا آپ کو پہلے کبھی اتنی مشکل پیش آئی تھی، یا اس سے قریب ترین؟

تب کیا ہوا تھا؟

اس وقت آپ کی کس نے مدد کی تھی؟

آپ کو اس مشکل وقت میں کس نے سہارا دیا تھا؟

3. Help the person to identify reasons to stay alive.

Always start by acknowledging the severity of distress. This is best done after listening and understanding patient's experience as well as possible.

I understand how difficult this has been for you.
Then gently ask something like:
Who are the people that care for you the most?
Who are the people that you care about the most?
What do you care about the most?
Is there anything/anyone that gives you a reason for you to live?

میں سمجھ سکتا ہوں کہ آپ کے لیے کتنا مشکل تھا؟

آپ کی سب سے زیادہ پرواہ کون کرتا ہے؟

آپ سب سے زیادہ پرواہ کس کی کرتے ہیں یا کس شخص کی کرتے ہیں۔

کیا وجہ یا کونسا شخص آپ کو زندگی کی امید دلاتا ہے؟

4. Search together for solutions to the problems.

– Ask the patient to enlist all the problems they are currently facing.
– Then discuss which problems might have a solution.
– Highlight the solutions where the patient has some control or influence over the problem.
– Check if there is someone else who might be able to provide some help.

5. Mobilize carers, friends, other trusted individuals and community resources to monitor and support the person if they are at imminent risk of suicide.

How is your relationship with your family? In what way do your family and friends support you and in what way do you feel stressed by them?
Who do you feel most comfortable sharing your problems with? When you are not feeling well, who do you turn to for help or advice?
When was the last time you spoke to them? Do they know about your problems?
Would you like some help in contacting your friends/family?
Would you like me to help you connect with anyone else/any service?

آپ کے اپنے گھر والوں سے تعلقات کیسے ہیں؟ ان کی وجہ سے آپ کو کب حوصلہ ملتا ہے اور کب پریشانی ہوتی ہے؟

آپ آسانی سے کس سے اپنے مسئلے پر بات کر سکتے ہیں؟ جب آپ اچھا محسوس نہ کر رہے ہوں، آپ کس سے مشورہ یا مدد مانگتے ہیں؟

آپ نے آخری دفعہ کب ان سے بات کی تھی؟ کیا وہ آپ کے مسائل کے بارے میں جانتے ہیں؟

کیا آپ اپنے گھر والوں یا دوستوں سے رابطہ کرنے میں مدد چاہتے ہیں؟

کیا آپ کسی اور سے رابطہ کرنے میں یا کسی سروس سے رابطے میں میری مدد چاہتے ہیں؟

– Advise the person and carers to restrict access to means of self-harm/suicide (e.g., pesticides/toxic substances, prescription medications, firearms, etc.) when the person has thoughts or plans of self-harm/suicide.

– Explain to them about the need for 24-hour-per-day monitoring. Ensure that they come up with a concrete and feasible plan (e.g., who is monitoring the person at what time of the day).

6. Offer additional psychosocial support
Go to Principles of Reducing Stress and Strengthening Social Support in GPC

C Consult a mental health specialist if available.

3. Support the carers

Go to Principles of Reducing Stress and Strengthening Social Support in GPC

FOLLOW-UP

1. Make sure there is a concrete plan for follow-up sessions and that the carers take responsibility for ensuring follow-up.
   Go to Principles of Management in GPC

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

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

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

Other Significant Mental Health Complaints

OTH

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

Other mental health complaints include

- Various physical symptoms that do not have phsyical causes and
- Mood and behaviour changes that cause concern but do not fully meet the criteria of the conditions covered in other modules of this guide.

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

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

ASSESSMENT

ASSESSMENT QUESTION 1: IS THERE A PHYSICAL CAUSE THAT FULLY EXPLAINS THE PRESENTING SYMPTOMS?

1. **Conduct a general physical examination followed by appropriate medical investigations.**

   Rule out physical conditions and underlying causes of MNS presentations by history, physical examination and basic laboratory tests as needed and available.

   - Has the person been thoroughly investigated for these symptoms?
   - What were the outcomes of the physical investigation?
   - Did the investigations suggest an underlying physical cause?

2. **Manage any physical cause identified and recheck if the symptoms persist.**

ASSESSMENT QUESTION 2: IS THIS AN MNS CONDITION DISCUSSED IN ANOTHER MODULE OF THIS GUIDE?

It usually takes more than one meeting to complete the assessment.

1. **Significant symptoms acute stress (ACU)**

Core features:
– potentially traumatic event within the last month
– symptoms started after the event
– Help-seeking to relieve symptoms or has considerable difficulty with daily functioning because of the symptoms.

Have you experienced a traumatic event or a major stress the last one month?
Did your problem start after this event or stress?
How are you able to function in your daily routine?
Have you sought medical help for these problems?

کیا پچھلے ایک ماہ میں، آپ کسی حادثے یا آزمائش سے گزرے ہیں؟
کیا آپ کی علامات اس حادثے کے بعد شروع ہوئی تھیں؟
کیا آپ کو اپنا کام کرنے میں یا روزمرہ کے معمولات میں کوئی مشکل پیش آتی ہے؟
کیا آپ نے ان علامات کیلئے کسی ڈاکٹر سے مشورہ کیا ہے؟

2. Significant symptoms grief (GRI)

Core features:
– symptoms started after a major loss
– Help-seeking to relieve symptoms or has considerable difficulty with daily functioning because of the symptoms.
Have you suffered any losses? a family member or a friend?
Did your problem start after this loss?
Do you have any difficulty performing your daily routine?
Have you sought medical help for these problems?

کیا آپ کو کوئی جانی یا مالی نقصان ہوا ہے؟
کیا آپ کی علامات اس نقصان کے بعد شروع ہوئی تھیں؟

کیا آپ کو اپنا کام کرنے میں یا روزمرہ کے معمولات میں کوئی مشکل پیش آتی ہے؟
کیا آپ نے ان علامات کیلئے کسی ڈاکٹر سے مشورہ کیا ہے؟

3. Moderate-severe depressive disorder (DEP)

Core features (for at least 2 weeks):
- persistent depressed mood
- markedly diminished interest or pleasure in activities, especially those that were previously enjoyable
- Considerable difficulty with daily functioning because of the symptoms.

What has your mood been like lately? or how would you describe your mood?
Are you able to enjoy things you used to like e.g., taking a walk, working at your hobbies, reading, meeting people etc.?
How has your interest been? If reduced, how long has that been so?
Do you have any difficulty performing your daily routine?

آپ اپنے دل میں کیسا محسوس کرتے ہے؟ ان دنوں آپ کا مزاج کیسا ہے؟
کیا آپ جن چیزوں سے پہلے محظوظ ہوتے تھے ان میں اب بھی مزا آتا ہے مثلاً سیر کرنا، مشاغل پر کام کرنا، کتابیں پڑھنا اور لوگوں سے ملنا وغیرہ؟
آج کل آپ کی دلچسپی کیسی ہے؟ کتنے عرصے سے آپ اپنی دلچسپی میں کمی محسوس کر رہے ہیں؟
کیا آپ کو اپنا کام کرنے میں یا روزمرہ کے معمولات میں کوئی مشکل پیش آتی ہے؟

4. Post-traumatic stress disorder (PTSD)

Core features:
- potentially traumatic event that happened more than a month ago
- recurring frightening dreams, flashbacks* or intrusive memories* of the events accompanied by intense fear or horror
- deliberate avoidance of reminders of the event
- heightened sense of current threat (excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements)
- Considerable difficulty with daily functioning because of the symptoms.

Have you experienced a highly traumatic event? How long ago was that?
Have you had any frightening dreams or memories related to this event? How do you feel when this happens?
Do you avoid thinking or discussing this event? Does it cause you distress?
Do you feel extremely threatened all the time?
Do you have any difficulty performing your daily routine?

کیا آپ کسی شدید حادثے یا آزمائش سے گزرے ہیں؟ اس حادثے کو کتنا وقت گزر چکا ہے؟
کیا آپ کو اس حادثے سے متعلقہ ڈراؤنے خواب یا خوفزدہ خیالات آتے ہیں؟ ان کا آپ پر کیا اثر ہوتا ہے؟
کیا آپ اس حادثے کے بارے میں سوچنے یا بات کرنے سے گریز کرتے ہیں؟ کیا اس سے آپکی پریشانی میں اضافہ ہوتا ہے؟
کیا آپ کو ہر وقت شدید پریشانی یا خوف لاحق ہوتا ہے؟
کیا آپ کو اپنا کام کرنے میں یا روزمرہ کے معمولات میں کوئی مشکل پیش آتی ہے؟

5. Harmful alcohol or drug use (SUB)

Core feature:
– Use of alcohol or drugs that is causing harm to self-and/or others.

Do you use illegal drugs or alcohol?
Has this use of drug or alcohol caused you any harm?
Has your drug or alcohol use caused harm to others?

کیا آپ منشیات یا شراب کا استعمال کرتے ہیں؟
کیا اس نشے کی وجہ سے آپ کو کوئی نقصان ہو رہا ہے؟
کیا اس نشے کی وجہ سے کسی اور کو کوئی نقصان ہو رہا ہے؟

6. Suicide/self-harm (SUI)

Core features:
– Current acts of self-harm; current thoughts and plans of suicide, or
– Recent thoughts, plans and acts of self-harm in a person who is severely distressed, agitated, unwilling to communicate or withdrawn.

How do you see your future? What are your hopes for the future?
Have you ever felt that life isn't worth living? Have you ever felt like ending it all?
Have you ever thought about harming yourself? Ending your life?
Have you ever tried to harm yourself? Or made a plan to do so?

آپ کو اپنا مستقبل کیسا لگتا ہے؟ کیا آپ کبھی ناامیدی محسوس کرتے ہیں؟
کیا آپ کو کبھی ایسا لگتا ہے کے زندگی جینے کے قابل نہیں رہی؟ کبھی سب کچھ ختم کرنے کا خیال آیا ہے؟
۔کیا آپ نے کبھی اپنے آپ کو نقصان پہنچانے کی کوشش کی ہے؟ کیا آپ کو کبھی خودکشی کا خیال آیا ہے؟
کیا آپ نے کبھی زندگی کو ختم کرنے کے بارے میں سوچا ہے؟ کبھی ایسا کرنے کا کوئی طریقہ سوچا ہے؟

If any of the above conditions are suspected, then go to the appropriate module for assessment and management.

The person has another significant mental health complaint when:
1. Physical causes are excluded
2. The above MNS conditions are excluded
3. The person is seeking help to relieve symptoms or has considerable difficulty with daily functioning because of their symptoms

ASSESSMENT QUESTION 3: IF THE PERSON IS AN ADOLESCENT, IS THERE A BEHAVIORAL PROBLEM?

1. Interview both the adolescent and the carers to assess for persistent or concerning Behavioral problems.

Examples include:

- Initiating violence
- Drug use
- Bullying or being cruel to peers
- Vandalism
- Risky sexual behavior

2. If the adolescent has a behaviour problem, ask further questions about:

- Extreme stressors in the adolescent's past or current life (e.g., sexual abuse)
- Parenting (inconsistent or harsh discipline, limited emotional support, limited monitoring, mental condition in the carer)

- How the adolescent spends most of his or her time.
  How do you spend your time after work/school?
  Are there any regular activities that you do?
  Are you often bored?
  What do you do when you are bored?

آپ سکول یا کام کے بعد کیا کرتے ہیں؟
کوئی مشاغل ہیں جو باقائدگی سے کرتے ہوں؟
کیا آپ اکثر بوریت کا شکار رہتے ہیں؟
جب آپ بور ہوتے ہیں تو کیا کرتے ہیں؟

BASIC MANAGEMENT PLAN

PSYCHOSOCIAL INTERVENTIONS

DO NOT prescribe medicines for OTH (unless advised by a specialist).

DO NOT give vitamin injections or other ineffective treatments.

1. In all cases (whether the person presents with emotional, physical or behavioral problems), provide basic psychosocial support

1. Address current psychosocial stressors.
2. Strengthen social support.
3. Teach stress management.

Go to Principles of Reducing Stress and Strengthening Social Support in GPC

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

1. DO NOT order more laboratory or other investigations unless there is a clear medical indication (e.g., abnormal vital signs).

   – Ordering unnecessary clinical investigations may reinforce the person's belief that there is a physical problem.
   – Clinical investigations can have adverse side-effects.
   – It might not be cost-effective

2. Inform the person that no serious disease has been identified. Communicate the normal clinical and test findings.

   I have examined your test results carefully. These do not show any abnormality.

   میں نے آپ کی تمام رپورٹیں غور سے چیک کی ہیں۔ان میں کوئی مسئلہ نہیں ہے۔

3. If the person insists on further investigations, explain:

   Performing unnecessary investigations can be harmful because they can cause unnecessary worry and side-effects. I do not see a need for further investigations at this point.

   مزید ٹسٹ کروانے سے آپ کو کوئی فائدہ نہیں ہوگا۔البتہ خوامخواہ میں پریشانی بڑھنے کا خدشہ ہے۔

4. Acknowledge that the symptoms are not imaginary and that it is still important to address symptoms that cause significant distress.

   I understand how difficult this condition is for you. Lack of evidence in laboratory reports does not mean that you do not have a problem but that we need to find another way to address your symptoms.

   مجھے آپ کی تکلیف کا اندازہ ہے۔تمام ٹیسٹ ٹھیک ہونے کا مطلب یہ نہیں ہے کہ آپ کو علاج کی ضرورت نہیں ہے۔بلکہ ہمیں بڑی توجہ سے علاج کرنا چاہیئے۔

5. Ask for the person's own explanation for the cause of the symptoms. This may give clues as to the cause, help build a trusting relationship with the person and increase the person's adherence to management.

What do you think has caused these symptoms?
When did this start or when do these worsen?

آپ کے خیال میں ان علامات کے شروع ہونے کی وجہ کیا تھی؟ یا یہ کن معمولات کی وجہ سے زیادہ خراب ہو جاتی ہیں؟

6. Explain that emotional suffering/stress often involves the experience of bodily sensations (stomach ache, muscle tension, etc.). Ask for and discuss potential links between the person's emotions/stress and symptoms.

There is a direct link between our emotional distress and emergence of bodily symptoms.
In your case:
What are the triggers for the symptoms?
How does the person find relief from the symptoms?
(Using the cues discussed above), Is it possible that the condition is worsening because of present stressors?

ذہنی پریشانی اور جسمانی علامات کا گہرا تعلق ہوتا ہے۔
غور کریں کہ آپ کی علامات کن وجہ سے یا کن معمولات کی وجہ سے زیادہ خراب ہوتی ہیں؟
ان علامات میں بہتری کیسے آتی ہے؟
کیا یہ ممکن ہے کہ (اب مریض کے حالات کی مثال دیں) اس پریشانی سے یہ علامات بگڑ رہی ہوں؟

7. Encourage continuation of (or gradual return to) daily activities.

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

1. Take time to listen to the adolescent's own perception of the problem.
Preferably do this without the presence of the carers.

2. Provide psychoeducation to the adolescents and their carers.

- Adolescents sometimes develop problematic behaviours when they are angry, bored, anxious or sad. They need continuous care and support despite their behaviour.
- Carers should make every effort to communicate with the adolescent, even that it is difficult.

3. Educate the carers.
- Try to identify positive, enjoyable activities that you can do together.
- Be consistent with respect to what the adolescent is allowed to do and not allowed to do.
- Praise or reward the adolescent for good behaviours and correct only the most problematic behaviours.
- Never use physical punishment. Use praise for good behaviour more than punishment for bad.
- Do not confront the adolescent when you are very upset. Wait until you are calm.

4. Educate the adolescent about healthy coping mechanisms.

- There are healthy ways to deal with boredom, stress or anger (e.g., doing activities that are relaxing, being physically active, engaging in community activities).
- It can be helpful to talk to trusted people about feeling angry, bored, anxious or sad.
- Alcohol and other substance use can worsen feelings of anger and depression and should be avoided.

5. Promote participation in educational & other activities.

- Formal and informal education
- Concrete, purposeful, common interest activities (e.g., constructing shelters)
- Structured sports programmes.

6. Remember also to apply the Principles of Reducing Stress and Strengthening Social Support in GPC to this group of adolescents and their carers.

FOLLOW-UP

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

1. Epilepsy/ seizures

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

2. Alcohol or other substance use disorder

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

3. Intellectual disability

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

4. Psychotic disorder (including mania)

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

5. Moderate-severe emotional disorder/depression

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

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

6. Other psychological complaint

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

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

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

7. Medically unexplained somatic complaint

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

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

Annex 2: Glossary[10] [11]

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

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

Drug-disease interaction	**Situation where a drug prescribed to treat one health condition affects another health condition in the same person.**
Drug-drug interaction	**Situation where two drugs taken by the same person interact with each other, altering the effect of either or both drugs. Interactions can include lessening the effect of a drug, enhancing or speeding up an effect, or having a toxic effect.**
Extrapyramidal side-effects	**Abnormalities in muscle movement, mostly caused by antipsychotic Medication. These include muscle tremors, stiffness, spasms and/or akathisia.**
Eye movement desensitisation and reprocessing (EMDR)	**Psychological treatment based on the idea that negative thoughts, feeling and behaviours result from unprocessed memories of traumatic events. The treatment involves standardized procedures that include focusing simultaneously on (a) association of traumatic images, thoughts, emotions and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements.**
Flashback	**An episode where the person believes and acts for a moment as though they are back at the time of the event, living through it again. People with flashbacks briefly lose touch with reality, usually for a few seconds or minutes.**
Hallucination	**False perception of reality: seeing, hearing, feeling, smelling or tasting things that are not real.**
Hepatic encephalopathy	**Abnormal mental state including drowsiness, confusion or coma caused by liver dysfunction.**
Hyperthyroidism	**Condition in which the thyroid gland produces and secretes excessive amounts of thyroid hormones. Some of the symptoms of this condition such as delirium, tremors. high blood pressure and increased heart rate may be confused with alcohol withdrawal.**
Hyperventilation	**Breathing abnormally fast, resulting in hypocapnia (too little CO_2 in the blood). This can produce characteristic symptoms of tingling or having a sensation of pins and needles in the fingers and around the mouth, chest pain and dizziness.**
Hypoglycaemia	**Abnormally low concentration of glucose (sugar) in the blood.**
Hyponatraemia	**Abnormally low concentration of sodium (salt) in the blood.**
Hypothyroidism	**Abnormally low activity of the thyroid gland. In adults, it can cause a range of symptoms such as fatigue, lethargy, weight gain and low mood that can be confused with depression if present at birth and untreated, it may lead to intellectual disability and failure to grow.**
Interpersonal therapy (IPT)	**Psychological treatment that focuses on the link between depressive symptoms and interpersonal problems, especially those involving loss, conflict, isolation and major life changes.**
Intrusive memories	**Recurrent, unwanted, distressing memories of a traumatic event.**
Iodine deficiency	**Condition where the body lacks iodine required for normal production of thyroid hormone, affecting growth and development.**
Khat	**Leaves of the shrub Catha edulis, containing a stimulant substance. It is both a recreational drug and a drug of abuse and can create dependence.**
Log-roll	**Method of turning a person from one side to another without bending their neck or back, in order to prevent spinal cord damage.**
Medically unexplained paralysis	**Partial or total loss of strength in any part of the body without any identifiable organic cause.**
Meningeal irritation	**Irritation of the layers of tissue that cover the brain and spinal cord, usually caused by an infection.**
Metabolic abnormality	**Abnormality in the body's hormones, minerals, electrolytes or vitamins.**
Mourning	**The processes through which a bereaved person pays attention, bids farewell and memorialises the dead, both in private and in public. Mourning usually involves rituals such as funerals and customary behaviours such as changing clothing, remaining at home and fasting.**
Neuroinfection	**Infection involving the brain and/or spinal cord.**
Neuroleptic malignant syndrome	**A rare but life-threatening condition caused by antipsychotic medications, which is characterised by fever, delirium, muscular rigidity and high blood pressure.**
Non-steroidal anti-inflammatory drugs (NSAIDs)	**Group of drugs used to suppress inflammation. They are often used for pain relief (for example, ibuprofen is an NSAID).**
Opiate	**Narcotic drug derived from the opium poppy. Opiates are very effective painkillers but can be addictive and create dependence. Heroin is an opiate.**
Orthostatic hypotension	**Sudden drop of blood pressure that can occur when one changes position form lying to sitting or standing up, usually leading to feelings of light-headedness or dizziness. It is not life-threatening.**

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

Annex 3: Symptom Index

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

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

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