

MALAWI QUICK GUIDE TO MENTAL HEALTH



COLLEGE OF MEDICINE
Excellence yesterday, today and tomorrow



'Mental illness is Everyone's Business STOP the Stigma'



Malawi Quick Guide to Mental Health

Contributors and Acknowledgments

Organisations supporting this publication:

- Scotland-Malawi Mental Health Education Project (SMMHEP)
- Government of Malawi, Ministry of Health
- University of Malawi (College of Medicine, Kamuzu College of Nursing, Chancellor College)
- St John of God Hospitaller Health Services, Malawi
- Mental Health Users and Carers Association (MeHUCA)

Funding

This guide was made possible through funding from the Scottish Government International Development Fund.

Acknowledgements

We acknowledge the following publications from which material has been adapted for this guide

- mhGAP Intervention Guide Version 2.0 – World Health Organisation (2016)
- Where There is No Psychiatrist – Vikram Patel and Charlotte Hanlon (2018)
- Malawi Standard Treatment Guidelines (MSTG) (2015)
- Essential Skills for Mental Health Care – Jim Crabb and Emma Razi (2007)
- Malawi Mental Health Handbook – M. Wilkinson (1992)
- Malawi HSA Mental Health Training Guide – J Wright, S. Common, F Kauye, C Chiwandira (2015)
- Psychiatry PRN: Principles, Reality, Next Steps – Sarah Stringer, Laurence Church et al. (2009)
- Psychiatry at a Glance – Cornelius Katona, Claudia Cooper et al. (2015)
- Crash Course Psychiatry – Katie Marwick, Steven Birrell et al. (2013)
- Patient information leaflets from Royal College of Psychiatrists, UK; MIND, UK; and the National Centre for Mental Health, UK

Lead Editors

Donncha S Mullin and Robert C Stewart

Contributors

Thank you to the following for their contributions: Jen Ahrens, Ben Baig, Chiwoza Bandawe, Peter Bennie, Evelyn Chilemba, Jim Crabb, Anita Ganai, Heather Gardiner, Selena Gleadow Ware, Saulos Gondwe, Jude Halford, Felix Kauye, Harry Kawiya, Demoubly Kokota, Kazione Kulisewa, Sarah Leslie, Olive Liwimbi, Chitsanzo Mafuta, Charles Masulani, Thandiwe Mkandawire, Atupele Milanzi, Lindsay Mizen, Naloli Mukiwa, Jennifer Mutch, Owen Mwale, Mwawi Ng'oma, Maddy Osborn, Emma Razi, Carol Robertson, Limbika Sengani, Devlin Silungwe, Roger Smyth, Mira Thomas, Michael Udedi, Elaine Wallace (book cover), Jerome Wright, other SMMHEP trustees and volunteers. Apologies to anyone who has been missed.

Illustrations by Haswell Kunyenje.

1st Edition, May 2020

Copyright © 2020 Scotland-Malawi Mental Health Education Project (SMMHEP)

Permission granted to reproduce for personal and educational use only. Commercial copying, hiring, lending is prohibited.

Introduction to the Guide

Who is it for?

The **Malawi Quick Guide to Mental Health** was produced to provide practical information for the assessment and management of mental disorders in Malawi. The Guide is for the busy primary care healthcare provider working at first- and second-level healthcare facilities in Malawi. Brought together in May 2020 during the global COVID-19 pandemic, it particularly aims to support non-specialist healthcare workers who find themselves caring for people with mental disorders for the first time. In Malawi, there are three Consultant Psychiatrists for a population of approximately 20 million people. It is clear that we cannot rely solely on specialists to provide mental health care.

What does it contain?

The Malawi Quick Guide to Mental Health opens with advice for managing mental health during a time of crisis, such as the current global COVID-19 pandemic (Part 1).

There is detail on how to perform mental health first aid and quick reference sheets for managing **Mental Health Emergencies** (Part 2).

Principles of Assessment and Management (Part 3) provides an overview of good clinical practice and describes how to perform a mental health assessment.

The guide prioritises disorders based on their level of burden in terms of mortality, morbidity and disability. These priority disorders include delirium, depression, anxiety disorders, psychoses, self-harm/suicide, drug and alcohol use disorders, epilepsy, and dementia. In **Assessment and Management of Psychiatric Disorders and Epilepsy** (Part 4) the guide focuses on management approaches identified based both on evidence about their effectiveness and their feasibility in Malawi.

Important considerations in the assessment and care are described for **Special Patient Groups** (Part 5) including older adults, mothers, and children.

There are **Information Leaflets for Patients and Carers** (Part 6) in English and Chichewa that have

been in part adapted with permission from material available on the websites of the Royal College of Psychiatrists, Mind and the National Centre for Mental Health. These leaflets can be photocopied and handed to patients and their carers as appropriate.

Other Resources (Part 7) include advice on how to ask assessment questions in Chichewa and a temporary treatment order for photocopying.

What it is not

This quick guide is not a comprehensive textbook and there will be many cases that cannot be managed by following the guidance contained in it. Recognising your limits and those of your service is important for the safety of patients. There is information on when to refer to specialists in the section titled Key Principles of Managing Mental Health in Part 3.

Further Reference

The **Malawi Quick Guide to Mental Health** should be used alongside more comprehensive sources such as the mhGAP Intervention Guide (2016) and mhGAP phone app, Where There is No Psychiatrist (2018) and the Malawi Standard Treatment Guidelines (MSTG) (2015).

The following are available free online. The links below were functioning at the time of publication but if you encounter any problems just search their title online and look for free pdf version:

- mhGAP Intervention Guide Version 2.0 (2016)
- mhGAP-IG App (e-mhGAP) available in both Apple and Android stores
- Where There is No Psychiatrist (2018)
- Malawi Standard Treatment Guidelines (MSTG) (2015)
- Problem Management Plus (PM+) (2018)

Table of Contents

CONTRIBUTORS AND ACKNOWLEDGMENTS	2
INTRODUCTION TO THE GUIDE.....	3
PART 1 - MENTAL HEALTH DURING THE COVID-19 PANDEMIC (AND OTHER CRISES)	
MENTAL WELLBEING OF PATIENTS DURING A PANDEMIC	8
FRONTLINE WORKERS’ MENTAL WELLBEING DURING A PANDEMIC	9
SUPPORTING YOUR TEAM DURING A PANDEMIC	10
PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID.....	12
PART 2 - MENTAL HEALTH EMERGENCIES	
AGGRESSIVE OR AGITATED PATIENT (INCLUDING RAPID TRANQUILISATION).....	13
ALCOHOL WITHDRAWAL (DELIRIUM TREMENS).....	14
STATUS EPILEPTICUS.....	15
SUICIDE RISK ASSESSMENT	16
SUICIDE RISK MANAGEMENT	17
PART 3 - PRINCIPLES OF ASSESSMENT AND MANAGEMENT	
OVERVIEW OF MENTAL HEALTH AND MENTAL ILLNESS	20
STIGMA AND DISCRIMINATION	22
COMMUNICATION SKILLS	23
MENTAL HEALTH ASSESSMENT (1).....	24
MENTAL HEALTH ASSESSMENT (2).....	25
RISK ASSESSMENT.....	26
MASTER CHART.....	27
KEY PRINCIPLES OF MANAGING MENTAL ILLNESS.....	28
PSYCHOSOCIAL TREATMENTS	29
PHARMACOLOGICAL TREATMENTS AND PRINCIPLES OF PRESCRIBING.....	30
MENTAL HEALTH LAW IN MALAWI	31
PART 4 - ASSESSMENT AND MANAGEMENT OF PSYCHIATRIC DISORDERS (AND EPILEPSY)	
DELIRIUM ASSESSMENT.....	34
DELIRIUM MANAGEMENT.....	35
PSYCHOSIS ASSESSMENT	36
PSYCHOSIS MANAGEMENT	37
DEPRESSION ASSESSMENT.....	38
DEPRESSION MANAGEMENT	39
BIPOLAR DISORDER ASSESSMENT.....	40
BIPOLAR DISORDER MANAGEMENT	41
ANXIETY DISORDERS.....	42
STRESS REACTIONS	43
DEMENTIA ASSESSMENT.....	44

DEMENTIA MANAGEMENT	45
DRUG AND ALCOHOL DEPENDENCE ASSESSMENT	46
DRUG AND ALCOHOL DEPENDENCE MANAGEMENT	47
EPILEPSY ASSESSMENT	48
EPILEPSY MANAGEMENT	49
PART 5 - SPECIAL PATIENT POPULATIONS	
OLDER ADULTS	52
WOMEN WHO ARE PREGNANT OR HAVE RECENTLY GIVEN BIRTH.....	54
CHILDREN AND ADOLESCENTS.....	56
PART 6 - INFORMATION LEAFLETS FOR PATIENTS AND CARERS	
INFORMATION ON ALCOHOL DEPENDENCE	60
INFORMATION ON ANXIETY AND PHOBIAS	62
INFORMATION ON BIPOLAR DISORDER	64
INFORMATION ON DELIRIUM	66
INFORMATION ON DEMENTIA.....	68
INFORMATION ON DEPRESSION	70
INFORMATION ON EPILEPSY	72
INFORMATION ON PSYCHOSIS.....	74
INFORMATION ON POST-TRAUMATIC STRESS DISORDER	76
INFORMATION ON SELF-HARM.....	77
MENTAL WELLBEING DURING A PANDEMIC	80
PART 7 - OTHER RESOURCES	
TIPS FOR ASKING ABOUT SYMPTOMS IN CHICHEWA	84
A NOTE ABOUT CULTURAL BELIEFS	87
HEALTH PASSPORT SUMMARY FORMAT.....	89
TEMPORARY TREATMENT ORDER (TTO)	90

PART 1

Mental Health during the COVID-19 Pandemic (and other crises)

Mental wellbeing of patients during a pandemic

Frontline workers' mental wellbeing during a pandemic

Supporting your team during a pandemic

Mental wellbeing of patients during a pandemic

Adapted with permission from Royal College of Psychiatrists, MIND and National Centre for Mental Health leaflets

What is a pandemic?

A pandemic is an outbreak of disease that spreads quickly and affects many individuals at the same time. The disease COVID-19 is one such example. The following information can be adapted and given to patients with mental illnesses during this current crisis. It is also available in the patient information leaflet section for photocopying.

Practical advice for staying at home

- Eat well and drink plenty of water
- Keep taking your medication – ask for a supply
- Continue accessing treatment and support if possible – ask teams to phone you
- Keep your home as clean and tidy as you can
- Find ways to work or study at home, if possible

Taking care of your mental health

Anxiety associated with Covid-19

- Don't keep re-reading the same advice if this is unhelpful for you.
- Let other people know you're struggling
- Breathing exercises can help you cope and feel more in control.

Anxiety associated with obsessive hand-washing

- Set limits, like washing your hands for the recommended 20 seconds.
- Plan something to do after washing your hands. This could help distract you and change your focus.

Connect with people

- Try the MeHUCA support group – details below
- Phone people you would normally see in person

Decide on your routine

- Plan how you'll spend your time. It might help to write this down on paper and put it on the wall.
- Try to follow your ordinary routine as much as possible. Get up at the same time as normal, follow your usual morning routines, and go to bed at your usual time.

Try to keep active by

- cleaning your home and doing chores
- dancing to music
- sitting less or doing seated exercises if you can't stand

Get as much sunlight, fresh air and nature as you can, while sticking to Government guidelines on social distancing

- If you have to self-isolate indoors, spend time with the windows open to let in fresh air.
- Arrange a comfortable space to sit, for example by a window

Find ways to spend your time

- Text or call a loved one if you cannot meet in person
- Sort through your possessions
- Gardening or attending to vegetables or flowers

Find ways to relax and be creative

- Arts and crafts
- DIY
- Playing musical instruments

Take care with news and information

- If news stories or social media make you feel anxious or confused, think about switching off or limiting what you look at for a while

Advice for MeHUCA group members

From an April 2019 mental health leaflet (with permission):

In the event of regular meetings for peer support groups being suspended, group members can:

- Check in on group members via phone to provide peer support and maintain contact
- Maintain contact with service providers at district hospitals or Health centre working directly with the support group to access credible information on the virus, medication, and psychosocial support.
- If you feel overwhelmed, talk to a health worker or counsellor.
- Do not use stigmatizing and discriminatory language and actions in the event a support group member is diagnosed with COVID-19

Frontline workers' mental wellbeing during a pandemic

Adapted from the Interagency Standing Committee (IASC) Interim Briefing Note on COVID-19 Outbreak Readiness and Response Operations available from: <http://interagencystandingcommittee.org>

It is not possible to properly look after someone else if you have not been looking after yourself. It is really important to check in with yourself at this time and talk to someone if you have any worries that you are starting to struggle. Feel free to use the strategies in this book to help yourself, particularly those on relaxing, but do not be tempted to self-medicate and always seek the opinion of a professional if you have any concerns about your wellbeing.

Stress

It is very normal to be feeling stressed in the current situation. You may feel that you are not doing a good enough job or that there is a high demand for your skills.

Feeling stress does not mean that you cannot do your job or that you are weak.

Stress can be useful ('eustress' rather than 'distress') in the short term as feeling stress currently may be keeping you going at your job and providing a sense of purpose.

Chronic stress can affect your mental wellbeing and your work and can affect you even after the situation improves. If the stress becomes overwhelming, please approach your lead or the appropriate person to ensure you are provided with the right support.

Managing your stress and psychosocial wellbeing during this time is as important as managing your physical health.

Recognising signs of stress

Remember, if your stress worsens and you feel overwhelmed, you are not to blame. Everyone experiences stress and copes with it differently. Ongoing and old pressures from your personal life can affect your mental wellbeing in your day-to-day job.

You may notice:

- changes in how you are working

- your mood may change such as increased irritability, feeling low or more anxious
- you may feel chronically exhausted or it may feel harder to relax during respite periods
- or you may have unexplained physical complaints such as body pain or stomach aches.

Coping strategies

- Different people find different things helpful but good general tips are to:
- Ensure rest and breaks during work and adequate sleep between shifts
- Eat sufficient and healthy food
- Exercise
- Stay in contact with family and friends
- **Avoid using tobacco, alcohol or other drugs as a means of coping.** In the long term, these can worsen your mental and physical wellbeing.

Stigma

Some workers may unfortunately be excluded by their family or community due to stigma. This can make an already challenging situation far more difficult. If possible, staying connected with your loved ones through digital methods is one way to maintain contact. Turn to your colleagues, your manager or other trusted persons for social support and remember, your colleagues may be having similar experiences to you.

Be confident in your abilities

This is likely a unique and unprecedented scenario for many workers, particularly if you have not been involved in similar responses. Even so, using the strategies that you have used in the past to manage times of stress can benefit you now. The strategies to improve and lessen the feelings of stress are the same, even if the scenario is different.

For information about the rights of workers during the COVID-19 outbreak, refer to:

WHO. Coronavirus disease (COVID-19) outbreak: Rights, roles and responsibilities of health workers, including key considerations for occupational safety and health. WHO: Geneva, 2020.

Supporting your team during a pandemic

Team management and leadership

If you are leading or managing a team:

- ensure good quality communication and accurate information updates are provided to all staff – consider a WhatsApp group among your colleagues if that suits your needs
- rotate workers from high-stress to lower-stress functions routinely rather than based on a staff member identifying their need to be rotated
- partner inexperienced workers with their more experienced colleagues. A 'buddy' system may help to provide support, monitor stress and reinforce safety procedures
- initiate, encourage and monitor work breaks
- implement flexible schedules for workers who are directly impacted or have a family member impacted by a stressful event
- actively monitor team members and remain vigilant for signs of stress; adopt a 'nip it in the bud' approach rather than waiting for people to become unwell or experience a crisis
- managers and team leads are also facing similar stressors as their staff, and often additional pressure in the level of responsibility of their role. It is important that the above provisions and strategies are in place for both workers and managers, and that managers are able to role-model self-care strategies to mitigate stress.

Establish new ways of working

Organisations will be required to reorganise tasks to ensure clinical time is released to focus on delivering direct patient care. This may mean that staff vulnerable to COVID-19, or non-clinical staff are asked to fulfil non-direct patient contact tasks to free up direct clinical capacity.

If working remotely, you will need to consider how you will deliver work as a team - what collaborative working platforms will be used, how you will communicate and how you support each other through challenges. Some of it might be trial and error so it is also important to think about how you will reflect on what's working and what isn't.

Staffing models

As part of business continuity planning, all teams should consider what service it can deliver with reduced staff numbers and how it will cope with various scenarios. In particular:

Clear lines of delegation

Consultants and team leaders/managers need to have clear lines of delegation in case they are incapacitated.

Safe communication

During this period, safe communication of complex clinical information will continue to be critical within teams.

Maintain good communication with colleagues/trainees even when isolated or working from home (e.g. daily brief medical wellbeing hubs (catch ups) in units/team via skype/telephone).

Local solutions should be found for doing this in the most appropriate way to enable social distancing e.g. several staff members coming together in a small office should be avoided and alternative methods of meeting together introduced. This will also have implications for ward rounds and meetings in in-patient settings, and alternatives to group gatherings must be sought.

Difficult decision-making and incidents

If in doubt, please ask your peers/colleagues and provide support and supervision when colleagues come to you. This is the time to break artificial barriers and work together to keep both staff and patients safe.

Getting additional staff

Discuss with your local voluntary organisation including willing members of public (university students, volunteers, retired staff) who can provide support if resources are depleted. However, be mindful of precautionary steps.

Look to get staff from other industries (i.e. those that have recently lost jobs (travel, hospitality etc)) and encourage them to work in your healthcare organisation.

Staff redeployment

At times of crisis, local mental health services may be asked to assist general health services.

This may be done after ensuring that patients with mental illness continue to receive the care and support that they need.

PART 2

Mental Health Emergencies

Psychological and Mental Health First Aid

Aggressive or Agitated Patient (including Rapid Tranquilisation)

Alcohol Withdrawal (Delirium Tremens)

Status Epilepticus

Suicide Risk Assessment and Management

Psychological and Mental Health First Aid

Psychological First Aid (PFA)

According to the World Health Organization, PFA “involves humane, supportive and practical help to fellow human beings who have suffered a serious crisis event”.

PFA involves looking, listening and linking when helping someone who has suffered a crisis event. It involves helping people responsibly - respecting their safety, dignity and rights - whilst also looking after your own health and wellbeing. It emphasizes listening rather than putting pressure on the affected person to speak. The steps include:

Psychological First Aid

- LOOK
- LISTEN
- LINK

Look

- Check for safety
- Check for people with obvious urgent basic needs
- Check for people with serious distress reactions

Listen

- Approach people who may need support
- Ask about people’s needs and concerns
- Listen to people, and help them to feel calm

Link

- Help people address basic needs and access services
- Help people cope with problems
- Give information
- Connect people with loved ones and social support

Some people may require special attention in a crisis e.g. children and adolescents, people with health conditions and disabilities, older people and people at risk of discrimination and/or violence.

Though a specific health or social care background is not required to offer PFA, it is recommended that any work done in crisis settings is done with the support of an organisation or community group.

For further information, refer to the WHO publication *Psychological first aid: Guide for field workers* (2011), free to download from the WHO website.

Mental Health First Aid (MHFA)

MHFA is similar to PFA in that it offers basic skills for helping a person experiencing a mental health crisis. However, in addition, MHFA offers tools to support someone with long-term mental health issues, or who is experiencing the first signs of a mental disorder. The Mental Health First Aid Action Plan provides the following five steps when helping someone experiencing a mental health crisis:

Mental Health First Aid (ALGEE)

1. **ASSESS** for risk of suicide or harm
2. **LISTEN** non-judgmentally
3. **GIVE** reassurance and information
4. **ENCOURAGE** appropriate professional help
5. **ENCOURAGE** self-help and other supports

Approach, assess and assist with any crisis

- If you are worried about someone, carefully consider the time and place that you will APPROACH them about it
- ASSESS for signs of crisis or risk of self-harm/suicide, and ASSIST the person if they are in crisis

Listen non-judgementally

- A person experiencing a mental health problem needs to be able to talk without feeling judged
- LISTEN non-judgementally and show the person that you care

Give Support and Information

- GIVE the person whatever SUPPORT you are able to, whether emotional or practical
- GIVE the person INFORMATION that can help them understand what they are experiencing. Use information leaflets from this guide and recommended websites.

Encourage appropriate professional help

- ENCOURAGE the person to engage with your professional help or any service you refer to

Encourage other supports

- ENCOURAGE the person to use self-help strategies and to avoid using alcohol or other drugs to cope
- ENCOURAGE the person to seek the support of family, friends and others.

For further information on MHFA refer to mhfaengland.org/mhfa-centre/resources

Aggressive or Agitated Patient (including Rapid Tranquilisation)

The vast majority of people with psychiatric disorders are never aggressive or violent. However, if someone presents in this way, it is important to be able to manage the situation safely.

The aim of management is to alleviate suffering and to prevent harm / injury to the patient and the health care staff. It is also to allow investigation and management of the underlying cause of the aggression e.g. delirium, drug intoxication, psychosis, mania, dementia etc.

First step: De-escalation

- Treat in a quiet place and remove dangerous objects
- Ensure your own safety – avoid being trapped in a corner, have other staff or guardians with you
- Give clear, brief, assertive instructions
- Explain your purpose or intention
- Negotiate options and try to understand the reason for their distress
- Avoid verbal and non-verbal threats
- Allow greater body space than normal
- If patient comes while tied do not immediately remove physical restraints until safe to do so
- Identify any signs of a general medical condition
- Identify symptoms of delirium, drug intoxication, psychosis, mania, dementia etc.

Second step: Oral Medication

If trying to calm the person is unsuccessful, offer oral medicine first. You may need to give an antipsychotic and a benzodiazepine if the patient is severely agitated:

Oral Antipsychotic options:

- Haloperidol 2.5 mg OR
- Chlorpromazine 100 mg OR
- Olanzapine 10 mg OR
- Risperidone 2 mg

Oral Benzodiazepine options:

- Diazepam 10 mg OR
- Lorazepam 1–2 mg

Monitor pulse, BP, breathing rate and temperature every 30 minutes. Repeat oral medication up to two more times at 30-minute intervals if still agitated.

Third step: Intramuscular Medication (IM)

If the person refuses oral medicine, only treat against their will if there is an immediate risk of harm to them or to others. Have at least four additional people to handle the patient if **rapid tranquilization** is needed. Restrain the person in a safe way – one person for each limb avoiding head, neck and chest. You are likely to need an antipsychotic plus one of the other medications listed below:

IM Antipsychotic options:

- Haloperidol 5 mg OR
- Chlorpromazine 25 to 100 mg OR

Other IM option:

- Promethazine 50 mg

IM Benzodiazepine options:

- Lorazepam 1–2 mg, if available

Monitor pulse, BP, breathing rate and temperature every 30 minutes.

Wait for 30 mins. If disturbed behaviour persists, repeat the dose.

Fourth Step: Intravenous Medication

Use a large vein – **Diazepam** 10mg slow push over at least 5 minutes. Repeat after 5-10 min if insufficient effect (up to three times).

Monitor pulse, BP, breathing rate and temperature every 30 minutes.

Note: if giving IV **Diazepam**, monitor breathing rate VERY closely as it can cause the patient to stop breathing.

Refer patient to hospital urgently if still no response after following the above steps.

Caution

- Do not use medication to treat behavioural disturbance in a child
- Avoid benzodiazepines for dementia and in delirium if possible
- Use lower doses in elderly and people with medical conditions

Alcohol Withdrawal (Delirium Tremens)

Definition

Acute confusion that occurs within hours to days of stopping or reducing alcohol intake after prolonged (weeks to months) or prolonged heavy consumption. Usually occurs at 24-48 hours after last drink and it can last for 7-10 days if untreated.

Signs and symptoms

- malaise, nausea/vomiting
- tremors, sweating, shaking
- increased heart rate and blood pressure
- agitation, confusion, labile mood
- insomnia

Severe withdrawal, or '**delirium tremens**' ('shaking delirium'), occurs in 5% of withdrawals and has a mortality of up to 15%, partly as a result of other medical complications. Symptoms as above plus some of:

- confusion
- marked agitation
- aggression
- hallucinations (usually visual)
- delusions
- seizures.

Delirium Tremens is a medical emergency. Urgent management as an inpatient by the medical team is required.

If not treated appropriately, it can lead to long-term brain damage (Wernicke's encephalitis and Korsakoff's syndrome). It is particularly important to always give **thiamine** to prevent this.

Assessment

Person has recently stopped drinking alcohol and is now showing any of the above symptoms.

Investigations

- Full physical examination including vital signs (to exclude other causes of delirium)
- Consider FBC / LFT
- Blood or urinary glucose

Management of withdrawal

Aim is to reduce the symptoms associated with alcohol withdrawal which can result in seizures and potentially be fatal.

A short course of **Diazepam** should be given, initially at least four times a day, reducing in dose over a week, titrated according to symptom resolution, e.g.:

- Diazepam 20mg oral qid on day 1
- Diazepam 15mg oral qid on day 2
- Diazepam 10mg oral qid on day 3
- Diazepam 5mg oral qid on day 4
- Diazepam 5mg oral bd on day 5
- Diazepam 5mg oral nocte on day 6

Caution: Diazepam can cause slowed breathing (respiratory depression) particularly if taken with alcohol. If possible, arrange for a family member to administer the medication.

Note: The dose of Diazepam should be reduced in the physically frail or those with liver impairment.

Always give **Thiamine** supplementation also:

- Thiamine 100mg orally tds for 1 month
- Thiamine 100mg orally od indefinitely

More severe cases

If markedly agitated and unable to comply with oral medication:

- Diazepam 5-10mg IM or slow IV injection (max 5mg/minute) up to 4 times per day until able to comply with oral treatment
- Thiamine 100mg IV/IM
- IV fluids may be required if evidence of dehydration (low BP, tachycardic). Caution: don't give glucose/dextrose unless you have already given IM/IV thiamine

Follow-up

- If agitation is severe, review patient every few hours
- As an outpatient, review at least every 24-48 hours until stable
- If admitted, review every 8 hours until stable
- Once detoxification is complete, offer advice regarding safe levels of alcohol and counselling support if planning to stop drinking

Red Flags

Admit as medical emergency:

- anybody with delirium tremens
- people with high risk of seizures (previous seizures, known epilepsy, prolonged heavy alcohol use)
- people with co-morbid physical illnesses (HIV, jaundice)

Status Epilepticus

Note: this is a medical emergency, not a mental health emergency, but often in Malawi it is brought to mental health services. While basic seizure management can be done in mental health settings, the goal should be to stabilize the patient and refer to medical colleagues.

Mental health practitioners should NOT be managing children with seizures – refer to Paediatrics as an emergency.

Definition

Continuous seizure activity or seizures without recovery of consciousness for > 30 minutes. However, treatment should be given for any seizure lasting longer than 5 minutes.

Always an emergency, mortality is high. Best managed in a hospital.

Treatment

Clear airway, insert IV-line (if available), position patient in the recovery position (see below).

Do **not** insert any object between the teeth.

Unavailable drug? - just move down to next stage.

Stage 1

Convulsion >5 mins

Check blood sugar. Give **glucose**, if suspicious of hypoglycaemia. Give Thiamine 100mg IV or IM once daily before giving glucose if patient suffers from alcoholism. Continue for 3 days.

No IV access, give:

- **Diazepam** rectally 10mg
OR
- **Midazolam** buccally/intranasally 10mg adult, if available

IV access, give:

- **Diazepam** 10mg IV
OR
- **Lorazepam** 4mg IV, if available

Stage 2

Convulsions continue after 10 mins

Give second dose of medication in Stage 1

Stage 3

Convulsions continuing

Refer urgently to medical setting

Recheck Airway Breathing Circulation (ABC), monitor need for intubation/ventilation if available

If patient improves, start anti-epileptic treatment and continue until cause of status epilepticus is treated.

Monitor continuously for respiratory depression when administering **Diazepam**, especially if IV.



Recovery position

Suicide Risk Assessment

When assessing someone who has attempted suicide, or who is presenting with suicidal ideation:

- Manage any physical effect of the attempt and keep the person safe (see management).
- Assess the current risk of suicide – low, medium, or high – and assess whether the patient has depression or another mental illness.
- Always treat the person with respect as you would any other patient. Although suicide is illegal in Malawi, reassure the patient that you will respect their right to confidentiality and that you would only disclose information to anyone outside of the medical team if there was a serious risk to the patient or someone else.

History of presenting complaint

Take a careful history of events leading up to the assessment. If the person has already made a suicide attempt assess for indicators that this was a high-risk attempt (see box that follows the suicide risk management section).

Does the patient have symptoms of depression?

Ask about the key symptoms:

- Depressed mood (most of the day, almost every day)
- Loss of interest or pleasure in activities that are normally pleasurable
- Decreased energy or easily fatigued

If these are present, ask about additional symptoms, including guilty or pessimistic thoughts, disturbed sleep or diminished appetite.

The depressed patient may show self-neglect, slow speech and movement, and poor eye contact on mental state examination.

In psychotic depression there may be false (delusional) beliefs that the person is a bad person, physically ill, or in financial ruin.

Does the patient have symptoms of psychosis or other mental illness?

Other mental illnesses, such as schizophrenia, have a risk of suicide.

Check for key symptoms:

- delusional beliefs
- hallucinations
- difficult-to-follow or disorganised thinking

Check for command hallucinations such as voices instructing the person to harm himself.

Other risk factors include:

- Chronic painful illnesses.
- Alcohol dependence
- Availability of means: e.g. poisons, paracetamol,
- Family history of suicide.
- Lack of social support or recent adverse life events (loss of job, bereavement, or loss of relationship).
- Being separated or divorced
- Being male and older
- Unemployment

Making a decision about the risk

Assessment of risk takes many factors into account.

Indicators of **high risk** include:

- Committing a dangerous act of self-harm/attempted suicide:
 - evidence of pre-planning
 - taking steps to avoid being found
 - lack of regret
 - continuing wish to die or suicidal plans
- Symptoms of depression, psychosis or alcohol dependence
- Drinking alcohol heavily
- Social isolation or continuing extreme social adversity.
- Being an older, male or unemployed
- Having a chronic physical illness
- Being divorced or separated

Suicide Risk Management

If you are assessing someone who has attempted suicide (e.g. hanging, ingested poisons such as organophosphate pesticide (tamec), overdose of medication) first ensure medical stabilisation (AIRWAY, BREATHING, CIRCULATION).

Make an URGENT referral to medical team if needed

How best to manage a patient who has made an attempt on their life, depends on what their level of risk is of making a further attempt.

It is impossible to predict the future but by following the advice in the risk assessment section and asking the questions in the box at the end of this suicide section, you will be better able to make an informed decision on the patient's risk level.

High risk patients - with mental illness

The key to reducing the likelihood of future suicide is to treat the mental illness.

Hospital admission is usually needed (or very close family support and frequent outpatient appointments).

If risk is very high, patient may need special supervision to prevent suicide attempt even in hospital. DO NOT leave the person alone; assign a named staff or family member to ensure person's safety at all times.

Take practical steps to keep the patient safe: remove poisons, weapons, and dangerous items from the patient's immediate environment, including ligature points, if possible.

High risk patients – no mental illness

Such patients include those with lots of psychosocial stress and maybe alcohol/substance misuse but without a diagnosable mental illness.

Hospital admission may not be appropriate (but admit if you are uncertain and it is sometimes useful to manage short-term crisis). Out-patient follow-up is needed.

Encourage patient and guardian to cooperate with steps to stay safe: remove poisons, weapons, and dangerous items from the environment.

Encourage the patient to avoid alcohol and other drugs. Offer treatment for drug and alcohol problems if possible.

Offer problem-solving support where this is available – see psychosocial interventions section.

Ensure patient has contact details for local mental health services and 'crisis plan' for emergencies.

Moderate risk patients

Treat any mental illness and offer further psychiatric treatment where appropriate.

Agree on a plan to keep the patient safe and a 'crisis plan' including contact details for future crises.

Low risk patients

Remember that patients who have self-harmed, even if they seem at low risk of suicide, are still more likely to die by suicide than the rest of the population.

Offer details of support services in case of future crisis.

Offer advice about alcohol and drug use, where this is present.

Supportive discussion about current stressful issues may be helpful but psychiatric follow-up is not usually required.

For all patients

- Attend to mental state and emotional distress.
- Educate the person about the relationship between mental health, stress and the risk of suicide
- Educate the guardian likewise
- Identify any available psychosocial support.
- Offer carers support

Questions to ask following a suicide attempt to determine level of risk	
Situation	What were the circumstances of the suicide attempt? <ul style="list-style-type: none"> - What was the immediate precipitant? - Any recent stressors such as debt, relationship breakdown, domestic violence? - Where was the person at the time? - Was the person alone? Were there people nearby?
Substances	<ul style="list-style-type: none"> - Was the person intoxicated by alcohol or another substance? - Did they first think of suicide or self-harm before they became intoxicated or after?
Planning	<ul style="list-style-type: none"> - Was the act planned in advance, or impulsive? - If the act was planned, how far in advance was a plan made? - How detailed was the plan?
Precautions	Had the person made any precautions to prevent being found? <ul style="list-style-type: none"> - For example, cancelling expected visitors or appointments, going to an unfamiliar or distant place, locking doors. - Or, was it likely that a family member, visitor, or passer-by would find them?
Last acts	Did the person carry out any final acts, expecting to die? <ul style="list-style-type: none"> - Letters to family - A recently made will - Funeral arrangements - Financial or family arrangements for after the person's death
The act itself	How dangerous was the act, and how likely to cause death? <ul style="list-style-type: none"> - Very dangerous – hanging, firearms, jumping from height, drowning attempt - Moderately dangerous – pesticide ingestion, large overdose of dangerous medication, deep cuts with a blade - Less dangerous – smaller overdose of less-dangerous medication, superficial cuts or burns.
Intent	What was the intended outcome? <ul style="list-style-type: none"> - Did the person want to die and believe that they would die? - Did the person want to die at the time but soon regret it? - Was this an act of self-harm not intended to be fatal but to demonstrate how distressed the person was? - Was the self-harm a habitual comforting response to distress, for example by superficial self-cutting?
Help-seeking	Did the person seek help after the suicide attempt? <ul style="list-style-type: none"> - Did they tell somebody or seek help? - Or were they only found by chance? For example, by an unexpected visitor or someone returning from work early. - Did they go willingly and accept medical treatment? - Or did they refuse or resist treatment?
Current attitude to the act	<ul style="list-style-type: none"> - Does the person regret their actions? - Or is the person upset because they are still alive?
Future plans	<ul style="list-style-type: none"> - Does the person have future plans of suicide? Ask for full details about thoughts of suicide. - Or does the person have other positive plans for the future such as returning to work, addressing financial problems, or trying treatment for mental illness.

Part 3

Principles of Assessment and Management

Overview of mental health and mental illness

Stigma and discrimination

Mental Health Assessment

Psychiatric History

Mental state examination

Risk Assessment

Master Chart

Key Principles of Managing Mental Illness

Psychosocial Treatments

Pharmacological Treatments and Principles of Prescribing

Mental Health Law in Malawi

Overview of mental health and mental illness

What are mental health and mental illness?

In Malawi, if you ask somebody “What is mental illness?”, they are likely to answer “misala”. And if you ask them to describe someone with misala they will say that the person is likely to be talkative, not talking sense, wandering aimlessly, taking off his clothes, and even harming others or property.

The person they are describing is likely to be someone with an acute severe mental illness such as mania or acute psychosis. In this quick reference guide you will learn that:

1. Most people with “misala” do not harm others, can recover with the correct care and treatment, and can live fulfilling lives in the community.
2. Mental health problems are more varied than just “misala”. Instead they include all the problems described in this guide, and many more not covered here.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organisation)

There can be no health without mental health.

People with good **mental health** have a positive sense of wellbeing, can enjoy relationships with others, and feel spiritually at ease.

Just as the physical body can become ill, so can the mind. A **mental illness** is any illness that:

- affects an individual's thoughts, emotions or behaviour

AND

- causes a negative effect on the person's life, including family life, work and physical health.

Sometimes people have experiences that appear similar to mental illness but that are normal emotional reactions (e.g. bereavement), or are culturally understandable (e.g. some strong religious experiences). We must be careful not to mistakenly diagnose this as mental illness.

Mental illness affects an individual's thoughts, emotions or behaviour and causes a negative effect on the person's life.

Types of mental illness include:

- organic mental disorders - injury or disease affecting brain tissues or caused by chemical or hormonal abnormalities in the body
- substance misuse
- psychotic disorders
- mood and anxiety disorders
- developmental disorders
- behavioural disorders affecting children.

Mental illness is **common**. It will affect 1 in 5 people at some point in life.

As health workers we need to take time to look after our own mental health, recognise colleagues who are struggling, and provide support to each other.

The bio-psycho-social approach

The causes of mental health problems can be **biological, psychological, and social**. There may also be spiritual and cultural factors. Usually multiple factors interact to cause a person to have a particular mental health problem at a particular time.

- **Biological** (physical) factors include alcohol and drugs, diseases directly affecting the brain, malnutrition, and family history of mental illness (genetic influences).
- **Psychological** factors are those that arise from the typical way that a person thinks or feels e.g. a tendency to think that the worst things are going to happen, difficulty in trusting others, unhelpful ways of coping with problems.
- **Social** factors include early childhood difficulties including abuse, current relationship stresses, and challenging socio-economic conditions such as poverty, unemployment, community violence, and war.

We have to consider all these areas - biological, psychological and social - when looking to understand the causes of mental illness, and in planning its treatment. This is called the **bio-psycho-social approach**.

The stress-vulnerability model

Some factors can make someone **vulnerable** to mental illness whilst others act as **stressors or triggers** for an episode of mental illness.

It is also very important to think about the positive factors in a person's life that make them less likely to have mental health problems or make it more likely that they will recover from an episode of mental illness. These are called **protective factors**.

Vulnerability – The factors that make an individual more vulnerable to mental illness include:

Psycho-social

- any kind of trauma as a child (including bullying, abuse, neglect, physical illness)
- living in a community that is not their place of origin

Biological

- family history of mental illness (a “genetic” vulnerability)
- poor childhood nutrition

Stressors and triggers – some stress can be a positive motivating factor to enable people to achieve their goals, such as studying for an exam.

However, stress can also contribute to mental health problems, particularly if there are many stressors or if the stress goes on for a long time. Stressors and other triggers of mental illness include:

Psycho-social

- relationship, money, family, school, work or housing problems
- bereavement or any other type of loss
- being a victim of crime, assault, abuse or bullying
- belief that one is under the power of witches

Biological

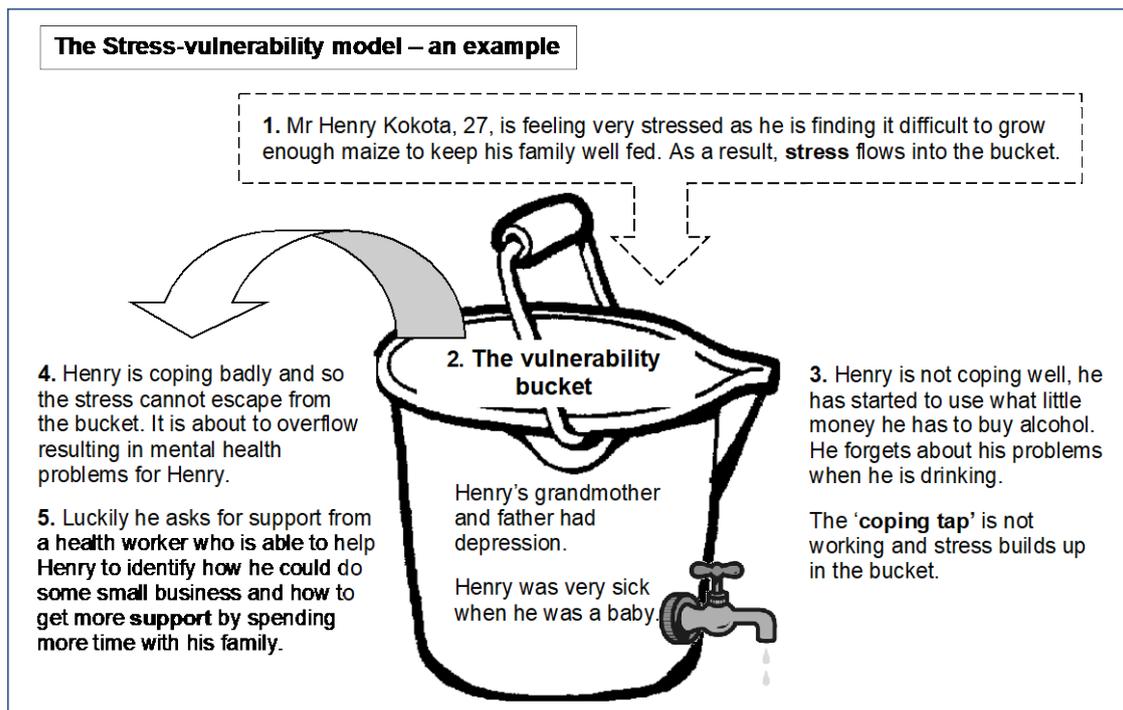
- physical illness e.g. HIV/AIDS, malaria
- use of drugs or alcohol

Coping skills – Different people ‘cope’ with stress in different ways. Helpful coping mechanisms include talking to family or friends about the stressful situation. Unhelpful coping mechanisms can perpetuate mental illness. Drinking alcohol, taking illicit drugs and social isolation are all unhelpful coping mechanisms.

Support and security - Being able to confide in others, feeling safe in your home, having financial security, fulfilling a meaningful role within the family or community are all protective factors that can prevent the onset of mental illness and promote recovery from an episode of mental illness.

The **Stress-vulnerability Model** explains how vulnerability, stressors, coping and support interact to lead to mental health problems:

Vulnerability + stressors (+/- coping +/- support) = risk of mental health problem



Stigma and discrimination

Common **myths and misconceptions** about mental illness include:

- People with mental illness cannot be treated
- People with mental illness are dangerous and cannot be trusted
- People with mental illness do not recover
- Mental illness only happens to other people
- A mental illness is not a real illness
- It is the fault of the individual with mental illness as they are being punished by a higher being (God, ancestors) for doing wrong
- Mental illness is caused by witchcraft
- Mental illness is *only* caused by use of drugs and alcohol

All of these beliefs are **false**.



Misconceptions like these leads to **stigma**. Stigma against people with mental illness is the belief that they are inferior or dangerous. **Discrimination** refers to the actions of individuals and organisations that arise from stigma.

Discrimination against people with mental illness can take many forms:

- People with mental illness may be mistreated by family, community and even by health workers.
- People with mental illness may not be given equal opportunities in work and education and in access to health care.
- Decision makers do not prioritise mental illness. This can lead to underfunding of mental health services and increases the likelihood that people with mental illness will experience human rights abuses.

Stigma and discrimination can make people with mental illness feel isolated, lonely and misunderstood. This can exacerbate existing mental health problems and prevent the individual from interacting with their community and accessing the support they need.

Health workers must work towards dispelling the myths around mental illness in the community and within the hospital or clinic setting. This will help to reduce the stigma of mental illness and help people to recover.

The best way to reduce stigma about mental illness is for individuals and communities to meet with people with mental health problems. They will see that people with mental health problems are “just the same as them” in that they have families, friends and jobs. They will learn that, with correct treatment, people can recover from mental illness and lead happy and productive lives.

Mental Health Users and Carers Association (MEHUCA)

It is very important that the voices of people living with mental illness and their carers are heard. To ensure that this happens, the Mental Health Users and Carers Association (MEHUCA) was set up in Malawi in 2011.

The mission of the association is to enhance the welfare of all persons living with mental illness, intellectual disability and other mental health problems, and to enable them to assume their rightful role in society.

The objectives of MEHUCA include:

- To promote the human rights of persons with mental health problems in Malawi, and to work for equality of rights and opportunities for persons with mental health problems.
- To carry out awareness campaigns on the nature of mental health problems and availability of treatment, with the purpose of reducing stigmatising attitudes toward those living with mental health problems, and improving access to mental health care.
- To facilitate the full participation of people with mental health problems (users), and carers of people with mental health problems, in the design, formulation, implementation and evaluation of policies, programmes, and services for their needs, and to monitor, evaluate and review such services.

Communication Skills

Create a good relationship

Creating a good therapeutic relationship means communicating positively to ensure the patient is comfortable talking to you about their problems.

Positive attitudes

Positive attitudes and good communication skills are essential in order to assess and help a patient with a mental illness. Follow these tips:

- Be caring and friendly (listen carefully, be interested and understanding)
- Be respectful and accepting of the patient's feelings and experiences
- Be genuine and sincere
- Be empathic (try to put yourself in the place of the person; ask yourself "How would I feel if I had these experiences?")
- Be sensitive to the patient's age, gender and culture
- Be self-aware (be aware of the way that the patient makes you feel). This is important for looking after your own wellbeing and can be a guide to how the patient is feeling

Negative attitudes

Unfortunately, many people, including some health workers, have negative feelings towards people with mental illness, for example:

- fear that the individual may attack them
- disapproval at the individual's lack of hygiene
- frustration that the interview may take longer
- amusement at the odd behaviour shown
- anger towards the individual who they believe is wasting their time with 'no real illness'

These feelings can make it difficult for some people to help those with mental illness. The patient is also likely to be less comfortable and less likely to share information if he or she suspects their health worker has any negative feelings towards them. If you recognise these attitudes in yourself, remind yourself about how unhelpful they are and do your best to overcome them.

A person with a mental illness should be treated with the same respect and compassion as anyone else. **Ask yourself: if one of your family members became mentally ill, how would you hope for them to be treated?**

Communication skills

Although difficult in a busy clinic, try to find a quiet and private area in the clinic if possible, so the patient

feels comfortable talking about things of a sensitive nature.



Body Language

Show positive body language (SOLER):

- Sit facing the patient
- Open posture
- Lean forwards and towards the patient
- Establish eye contact
- Relax

Tips for good communication

- Greet the person (and any guardians) and introduce yourself.
- Ask if the patient would prefer to be interviewed alone so that they can feel free to say exactly what is happening without worrying what their guardian knows
- Use simple and clear language.
- Speak to the patient first. Ask the guardian later.
- Initially ask open questions ("how do you feel about him", rather than "why did you hit him") that allow the patient to explain his or her problems in their own words.
- You can then use closed questions to clarify specific information.
- Allow moments of silence if needed so the patient can have time to think or feel upset.
- Clarify your understanding by summarising what you have heard e.g. "So you started to feel low about a month after your baby was born, is that right?"
- Show empathy e.g. "It must have been very frightening when you heard those voices".
- Explain why you are taking notes during the interview. If you are talking about very sensitive topics it may be better to stop making notes for a period so that the person knows that you are giving your full attention.
- Ask about the guardian's experience of how the patient has been.

Mental Health Assessment (1)

The components of a mental health assessment include:

- History
- Mental state examination
- Physical examination
- Informant history
- Review of previous notes
- Investigations
- Risk assessment

History

Record key information

Personal information (name, date of birth etc), name and contact details of guardians, source of referral, who else was present. See Other Resources (Part 7) for an example of a good (brief) health passport entry.

Presenting problem

Ask an open question and record what the person says in his or her own words.

History of presenting problem

This is usually the **MOST IMPORTANT** part of the assessment.

- What symptoms (thoughts / feelings / behaviour) did the person experience?
- When exactly did this start?
- Was there a triggering event?
- Was there a physical illness?
- Was it linked to alcohol or drug use?
- What happened next?
- Have the symptoms changed or worsened?
- How are the person's daily activities / work / family life affected?
- Are there other associated symptoms e.g. changes in sleep, appetite etc?
- What does the person think is the cause of the problem?
- Did the person seek treatment previously e.g. medical, traditional healing, prayers? Did it work?

Past psychiatric history

Past mental illnesses, triggers, symptoms, diagnoses, treatments. Any history of aggression to others or harm to self. Any mental hospital admissions (voluntary/involuntary). Was there full recovery between each episode?

Past medical/surgical history

Any serious medical illnesses or surgical operations (and dates if recent).

Social history

Describe current accommodation, occupation, financial situation and family. Who does the patient live with? Is there any current experience of violence or other abuse?

Drug history and allergies

All current medications, then record all previous psychotropic medications, their dosage and duration and their effectiveness.

Family history

Family psychiatric illness history ('breakdowns'), suicides, hospitalisations, drug and/or alcohol abuse.

Personal history

Find out if there are unusual features of the patient's early life, development, education, occupational history and relationships.

Substance use

Alcohol, drug and tobacco use

Forensic history

Any arrests, any convictions, any violence? Any imprisonments?

Premorbid personality

How would the patient's friends/family describe him or her? How does the patient usually cope at times of stress?

Recognise and rule out delirium

When you are taking the history, you might observe:

- the person is drowsy, disorientated and unable to concentrate
- there was rapid onset of symptoms
- there is a history of recent physical illness or ingestion of alcohol/drugs
- the person is malnourished or dehydrated

If so, check for these features:

- Is the patient's level of consciousness reduced? Is he or she less alert and aware of what's going on than you would expect?
- Does the patient not know where they are or what day it is?

If these features are present, delirium is likely, so go directly to a physical examination. **Delirium is a medical emergency.** See Delirium chapter in Part 4.

Mental Health Assessment (2)

Mental state examination (MSE)

This is the process of observing the person during the assessment and identifying any abnormal behaviours, thoughts and emotions. You should start to do this as soon as you meet the person, and continue throughout the assessment, noting down anything important. Mental state examination (MSE) can be divided into the following sections:

Appearance and behaviour - what do you notice about the person appearance? What does the person do during the interview? Is the person fully awake or drowsy?

- Note: general health, hygiene, dress, rapport, eye contact, motor activity (agitation or retardation), abnormal movements (any side-effects from antipsychotics?)

Speech - is there anything unusual about the way that the person speaks?

- Note: tone, speed, volume. Any made up words?

Mood and affect - what emotions does the person appear to be experiencing?

- Note: **mood** is the underlying emotion. Report patient's own words (subjective) and what you perceive (objective) i.e. low / normal / elated'.
- Note: **affect** is the observed (transient) manifestation of the emotion e.g. blunted (lacking normal responses), labile (excessively changeable), irritable (may occur in mania).

Thought content and form - are you able to understand what the person is saying? What are the main things that the person is concerned about? Do they have any unusual beliefs?

- Note: **thought content** includes any delusions (fixed, false beliefs, not keeping with patient's culture), depressed cognitions (e.g. guilt, hopelessness), ruminations (persistent disabling worries), obsessions, phobias. Always ask about suicidal or homicidal thoughts.
- Note: normal **thought form** is when statements are connected by their meanings. If it's very difficult to follow a patient's thought flow, it's likely abnormal.

Perception - is the person reporting that they are hearing or seeing anything strange?

- Note: **Illusions** are misinterpretations of normal perceptions e.g. thinking a bit of dirt is a small insect – these can happen normally and when tired or physically ill. **Hallucinations** are perceptions in the absence of an external stimulus e.g. hearing voices (auditory hallucinations).

Cognition - Does the person know where they are (orientation)? Do they have any difficulties remembering things?

Insight - What does the person think explains what is happening? Does the person think that they are ill?

How do I ask questions?

You may be unsure as to how exactly to ask the questions to take the history and, in particular, to ask about specific symptoms such as low mood, suicidal thoughts, and psychotic symptoms. Don't worry! At the back of this guide you will find examples of questions you can use in both English and Chichewa. You might decide to ask things slightly differently and you should not just go through the questions in a list. However, you will find them helpful to refer to as you learn to conduct psychiatric interviews.

Physical examination

An appropriate physical examination is an **ESSENTIAL** part of a psychiatric assessment to rule out physical illness as the cause of a person's mental health problem, to identify any comorbid conditions, and to assess for effects of self-neglect.

At a minimum you should check vital signs (Heart Rate, Respiratory Rate, Temperature, Blood Pressure) and act on any abnormal findings.

Informant history

Taking a history from people who know the person with the presenting problem is often very helpful. You need to have the permission of the patient to speak to other people unless the person's judgement and ability to understand the situation is impaired, and/or it is a high risk situation.

Review of previous notes

These can provide a lot of very useful information but always make decisions based on your current assessment (as past notes may not always be accurate)

Investigations

Further physical investigations, if available, can help identify underlying medical/surgical causes of delirium and assess the physical state of a person who has not been eating/drinking.

Risk Assessment

See next page.

Risk Assessment

Keeping safe when conducting a psychiatric assessment

Only a small number of people with mental illness are violent or dangerous. However, when assessing a person with mental illness think of your safety before a situation arises:

- Find out if a patient has a history of violence or police involvement. Past behaviour is a predictor of future behaviour.
- Sit in the seat nearest to the door so it is possible to leave the room quickly.
- Situations that are particularly risky might be in those with alcohol/drug intoxication or withdrawal, psychosis, mania, or dementia/delirium.
- Read the warning signs that someone is becoming aggressive such as facial expression, agitation, and hostility. Act accordingly.
- Trust your instincts!
- If you feel unsafe, you could suggest taking a break so that you can decide what to do and call for help.
- Follow the advice in the chapter on Managing an Aggressive or Agitated Patient.

If you are seeing somebody in their own home, let people know **where** you are going and **what time** you will be back.

Assessing risk to the patient

Risk can be grouped into four main categories:

1. **Suicide/Self-harm**
2. **Self-neglect**
3. **Harm to others**
4. **Harm or exploitation by others**

It is very important to find out what the immediate risk is to a patient in order to take action and ensure safety. The following risk screening questions are a critical part of the assessment:

Have you had thoughts about hurting yourself or ending your life?

This is a difficult thing to ask but it always needs to be done. It may stop someone from committing suicide. Asking this question saves lives. If the person answers yes, you need to ask for further detail. See Suicide risk assessment and also Part 7 of this book for tips on asking about this.

How much have you been eating and drinking over the last few days?

People with a serious mental illness may not be eating or drinking enough, or their carers may not be giving them enough food or water.

Have you had any thoughts of hurting someone else?

This is another difficult thing to ask but it also needs to be done particularly if the person is aggressive or is experiencing psychotic symptoms. If the person answers yes, you need to ask for further detail such as if the person has thoughts of harming a specific person, a plan, access to a weapon etc.

Is anyone hurting you?

People with mental illness are vulnerable to harm from others. Ask if anyone is hurting them and look for signs that would mean this was true for example: frightened behaviour, cuts, bruises or weight loss.

Deciding on level of risk

Consider the four types of risk:

1. Suicide/Self-harm
2. Self-neglect
3. Harm to others (deliberate harm or neglect e.g. of children)
4. Harm or exploitation by others

Take into account the following:

- The answers to the risk screening questions that you have asked
- Current mental state
- Any previous high-risk behaviours
- Evidence of self-neglect
- Evidence of alcohol or drug misuse
- Access to dangerous items
- Any children (or other dependents) who could be at risk
- What support that the person has at home

Classify each of the 4 types of risk as HIGH / MEDIUM / LOW / MORE INFORMATION NEEDED.

If you think a risk is high, note down why and/or what the specific risk is. Make sure that your assessment “fits the facts” e.g. if you recorded that the person had beaten his mother yesterday, then it would not make sense if you recorded the risk to others as low; it is clearly high!

Note down any **other risks** e.g. risk of absconding, or noncompliance with medication.

Refer to separate section for management of those actively suicidal, for those self-harming, or for managing the agitated or aggressive patient.

For high risk patients, consider if admission to a mental hospital is necessary and, if so, whether using the Mental Health Act (see section) is necessary.

Master Chart

This is a rough guide to where to go to in the guide based on the main symptom.

Main symptoms	Likely condition	Go to:
Confusion	Delirium	Delirium Assessment and Management (Part 4, Pages 36 to 37)
Aggression with confusion	Delirium	Delirium Assessment and Management (Part 4, Pages 36 to 37) If needed: Agitated or Aggressive Patient (Part 2, Page 14)
Aggression without confusion	Psychotic disorder Alcohol and drug misuse	Psychosis Assessment and Management (Part 4, Page 38 to 39) If needed: Agitated or Aggressive Patient (Part 2, Page 14)
Strange thoughts, experiences and behaviour	Psychotic disorder	Psychosis Assessment and Management (Part 4, Page 38 to 39)
Sadness, worry and social withdrawal	Depression Psychosocial distress	Depression Assessment and Management (Part 4, Pages 40 to 41)
Suicidal thoughts/actions	Depression Psychotic disorder Alcohol and drug misuse	Suicidal Patient Assessment and Management (Part 2, Pages 17 to 18)
Seizures	Acute general medical condition Epilepsy	Epilepsy Assessment and Management (Part 4, Pages 50 to 51) If needed: Status Epilepticus (Part 2, Page 16)
Alcohol and drug dependence	Alcohol and drug dependence	Drug and alcohol dependence Assessment and Management (Part 4, Pages 48 to 49)
Gradual onset forgetfulness/unusual behaviour in an elderly person	Dementia Depression Delirium	Dementia Assessment and Management (Part 4, Pages 46 to 47)
Unusual behaviour in a new mother	Postpartum psychosis Depression	Women who are pregnant or have recently given birth (Part 5, Pages 56 to 57)
Unusual behaviour in a child		Children and Adolescents (Part 5, Pages 58 to 60)

Note: Remember that the condition might not always be what you first expect. Be prepared to consider differential diagnoses, particularly that the presentation might be result of an underlying general medical condition.

Key Principles of Managing Mental Illness

Principles of helping someone manage mental illness

There are many things to consider when supporting somebody with a mental health problem. Some of these include:

1. Work with the patient

- Create the management plan in collaboration with the patient.
- Explore how important is treatment to the patient and are they ready to participate in their care.
- Encourage the patient to monitor their symptoms and explain when they should seek help.

2. Inform the patient

- the expected duration of treatment
- potential side-effects of any medication
- alternative treatment options
- the importance of adhering to the treatment plan
- their likely prognosis – be honest and realistic

3. Involve family and community

- Encourage the patient's family to become involved in their care.
- Try to link the patient to community support (self-help groups, church, school).
- Use the local community's resources to contact people who have not returned for regular follow-up appointments.

4. Provide appropriate and effective follow-up

- Continually monitor for treatment outcomes, drug interactions (including with alcohol, over-the-counter medication and traditional medicines) and treatment side-effects.
- During a follow-up appointment, reassess the patient's expectations of the treatment, their clinical status, their understanding of the treatment and their adherence to the treatment and correct any misconceptions.
- Provide more frequent follow-up visits for who may be vulnerable and isolated (e.g. older people).

5. Seek help if required and available: facilitate referral to specialists (see box).

6. Ensure that people are treated in a holistic manner

- Meet the mental health needs of people with physical illnesses, as well as the physical health needs of people with mental illnesses.

7. Take extra care when treating childbearing women

- Request more frequent follow-up visits for pregnant women or women who are planning a pregnancy.
- Assess the potential risk of medication on the foetus or baby when providing care to a pregnant or breastfeeding woman.
- Ensure babies of women on medication who are breastfeeding are monitored for adverse effects.

Referrals

Refer the following people to hospital and/or specialist services:

- People with mental illness and evidence of a physical illness such as head injury or high fever.
- People who are so disturbed that they can no longer be managed at home.
- People who are taking large amounts of alcohol or drugs, as stopping suddenly may lead to a severe withdrawal reaction.
- People whose illness is continuing to have a serious effect on their personal life or work, despite your efforts to provide treatment.
- People who have made a serious suicide attempt e.g. attempted hanging, poisoning. They must be referred for urgent medical review. Once this is done they must be assessed for ongoing suicide risk, ideally by mental health specialist.
- People presenting with seizures should (if available) be managed by paediatrics or medicine. Ideally, they should be assessed by a specialist doctor (a physician or neurologist) before they start to take regular anticonvulsant medication.

Remember that when you refer someone always write a **referral note** explaining the background to the problem and what treatments you have already tried.

Psychosocial Treatments

Psychosocial treatments are non-pharmacologic interventions that are designed to decrease the severity of symptoms, avoid hospitalisation, improve psychosocial functioning (e.g. work and social relationships) and improve overall mental wellbeing.

Psychosocial treatments are the preferred first-line treatment for mild-to-moderate mental disorders. **For mental disorders that require treatment with medication, it is important to also deliver psychosocial treatment.**

There are many different types of psychosocial treatment. Some treatments are brief and can be delivered at all levels of health service including primary care. A few of these are outlined here.

For more detail refer to the freely available mhGAP Intervention Guide or phone app, and the excellent book, *Where There is No Psychiatrist* (2018). The WHO guide titled *Problem Management Plus (PM+)* (2018) has much more detail. Download details for these are in the introduction to this guide.

Psychoeducation

This should be done with every patient. Use the information leaflets in this book to help you explain the mental disorder to an individual and family. Discuss the following:

- the condition and what the expected course and outcome are
- what treatments are available
- duration of treatment
- importance of sticking with treatment
- potential side-effects of treatment and what to do if these are experienced
- involvement of other members of the health team or community services

Relaxation Techniques

There are many types of relaxation exercises and all are good for people who are stressed. This breathing technique is just one:

- Lie down in a room that is quiet and where you will not be disturbed.
- Close your eyes. Concentrate your mind on your breathing rhythm.
- Now, concentrate on breathing slow, regular, steady breaths through the nose, taking a deep breath in.
- Then let go of the breath slowly.
- Try to spend at least 10 min a day doing this exercise.

Counselling & Problem-solving

Counselling is usually fairly short and aims to help people to be clearer about their problems – and by being clearer, to come up with their own answers. It is often used to help people cope with recent events they have found difficult. It is beneficial for mild anxiety and depression amongst others. Counselling involves providing a non-judgemental listening ear to help the person to identify and solve problems. A specific type of counselling is Problem Solving therapy (see box below)

1. **Explain the problem solving approach** e.g. "People with difficulties like yours can be helped by looking at the way in which they handle stress and deal with problems. I would like to discuss some of your problems and think of ways in which you can try and deal with them"
2. **Identify the problems that cause the person distress** e.g. relationship, employment, financial, physical health, sexual problems; bereavement.
3. **Prioritize the problems** i.e. List them in order
4. **Select the problem to be addressed.** Target a problem which has a potential solution in the short-term. Remember that the aim of the treatment is to teach the person problem-solving skills, not to try and solve all their problems
5. **Think about all possible solutions to the problem.** If many options are available, focus on those which are most practical given the person's social situation
6. **Select the most appropriate solution.** Plan on how to carry out the solution. Set specific targets which are achievable.
7. **Implement the solution**
8. **Review sessions (if feasible).** Evaluate how well the person managed in completing tasks. If progress has not been made, identify barriers, discuss ways to address these, and set new goals

Identify supportive family members and involve them as much as possible and appropriate

Cognitive-Behavioural Therapy (CBT)

CBT is a very popular and evidence-based therapy for many different problems. The aim is to change the way people think, feel and behave.

Interpersonal Therapy (IPT)

IPT is a form of psychotherapy that focuses on the person's relationships with other people, and major changes in their life e.g. marriage, illness etc.

Pharmacological Treatments and Principles of Prescribing

The main groups of medicines used to treat mental illness are:

Antipsychotics

These reduce hallucinations, delusions and agitation in conditions with psychotic symptoms. Examples: chlorpromazine, haloperidol, risperidone

Antidepressants

Used to treat depression and anxiety disorders. Examples: fluoxetine, amitriptyline.

Anxiolytics

Used to manage anxiety-related conditions. These medicines are addictive and should not be used for more than two weeks. Also used to manage alcohol withdrawal and control seizures. Examples: diazepam and lorazepam.

Mood stabilizers

Used in the treatment of bipolar disorder. Examples: carbamazepine, sodium valproate, lithium.

Other medications include antiepileptic drugs, anticholinergics (to manage side effects of antipsychotics), and medications used to treat alcohol problems.

Principles of Prescribing

Following these principles will help ensure the safe administration of medications for mental illness. These medications are generally safe but they are powerful and can have serious consequences for the patient if not safely prescribed or monitored correctly. It is therefore vital that they are used correctly.

Before prescribing medication

- Make a correct diagnosis or diagnoses.
- Consider psychosocial interventions.
- Assess the risks and benefits of any medicine.
- Review the success of previous medicines and other interventions.
- Get to know the medicine you prescribe. Never prescribe a medicine you know little about.
- Is the patient taking any drug which could affect metabolism or pharmacological action of the psychiatric medicine? E.g. Carbamazepine, Sodium Valproate, some HIV regimens.
- Advise the patient to avoid illicit drugs or alcohol.
- There is some evidence that a patient whose family members have responded to certain agents are likely to do the same. It's worth a try.

- Check that the medicine prescribed is available in the patient's community.
- Advise that the medicine is taken with water and food if possible.
- Always check about allergies.
- Medicine should not be used simply because the patient expects it.

Starting medication

- Start with the lowest possible dose and increase the dose slowly.
- Try to avoid using more than one medicine (polypharmacy).
- Target symptoms, for example use a more sedating agent if insomnia is a problem.
- Inform and involve the patient and their family in all decisions.
- Be aware when prescribing in these circumstances:
 - Pregnancy and breastfeeding (some medicine should not be taken)
 - Elderly (use lower doses – see section)
 - Children (use lower doses – see section)
 - HIV, renal or hepatic impairment (use lower doses or avoid some medicines)

Continuing medication

- Review the need for medicine at each appointment and make a plan to reduce and stop once the required length of treatment is complete, while monitoring for return of any symptoms.
- Ensure the patient takes the medicine at the appropriate time and for the duration of the course.
- If a patient does not improve after a course of medicine, it is important to check that the patient has been taking the right dose for the right length of time. It is also important to check if the patient is using alcohol or drugs as this can stop medicine from working properly. It is useful to check the diagnosis and ensure that the person does not have a physical illness that presents in a way similar to a mental illness.

Stopping medication

- Avoid suddenly stopping medicine if possible; decrease the dose slowly. The longer the patient has been on the medicine; the more gradual the decrease.

Mental Health Law in Malawi

In order to protect the **human rights** of people with mental illness we should:

- Allow people with mental illness to control their own life and live within the community if it is possible.
- Treat people with mental disorder in a dignified manner, show respect and do not discriminate.
- Whenever possible, allow people to make their own decisions about treatment.

However, when acutely unwell, some people with mental disorders may be unable to make decisions, may be at risk to themselves or others, and would benefit from treatment.

The **Malawi Mental Health Treatment Act 1948** allows medical professionals and the courts to force someone to be admitted to hospital for treatment. Taking away a person's liberty is very serious even if it is being done to protect the person or others.

Admission to hospital can be frightening and cause long-term stigma by the community. Therefore, it is very important to consider whether treatment could be given without admission to hospital e.g. with family support, regular follow up visits. If this is safe and feasible then this should be tried.

Temporary Treatment Order (TTO)

The part of the law that you are most likely to use is the Temporary Treatment Order (TTO). This allows you to admit someone with mental illness even if they do not agree. This is what you need to do to complete a TTO:

A. The TTO requires a written application by a relative (e.g. a short letter or note requesting the admission). If this is not available, you must explain in the referral letter why you were not able to obtain it (e.g. there were no relatives present or contactable at the time)

B. The application must be accompanied by your signed recommendation as a medical practitioner. This is the **TTO form** (see Part 7). You **MUST** examine the person and specify the date you did this. You need to decide whether all 3 of the following criteria are met:

1. The person is “**suffering from mental disorder or mental defect**”.

Either you have made a diagnosis, or you are clear that the person has a mental illness even if you are not certain of the exact diagnosis.

AND

2. The person is “**likely to benefit by temporary treatment in a mental hospital**”

In other words, the person's health and safety will be improved by admission to hospital for the treatment that can be provided there (e.g. medication, specialist nursing care). This benefit is likely if the person currently poses a risk of self-neglect, or harm to self or to other persons. E.g.

- Has attacked someone
- Has immediate plans of suicide
- Is not eating/drinking
- Is not taking care of himself/herself in the way that they would do normally when well.

AND

3. The person is “for the time being incapable of expressing himself/herself as willing or unwilling to receive such treatment”

This requires you to assess the person's “**capacity**” to make their own decision about receiving treatment. You should assess the following 4 questions. If the answer to one or more of these questions is no, then the person likely lacks capacity.

1) Do they understand the information about their condition, and the treatment being suggested?
e.g. someone with acute psychosis may not believe mental illness exists nor accept that their actions carry risk.

2) Can they retain this information? (i.e. remember it for long enough to make a decision)
e.g. Someone with delirium may be too distracted or drowsy.

3) Can they weigh up the information?
e.g. someone with psychotic depression may understand the treatment but refuse because he thinks he is wicked and deserves to die. Someone may be too distracted by hearing voices to weigh up the information.

4) Can they communicate their decision?
If someone has communication difficulties (e.g. deafness, intellectual impairment) you must do all you can to help him/her understand and to communicate their decision e.g. writing it down, putting it in simple language.

C. Once you have signed the TTO form, the person must be admitted within 14 days, or another assessment will need to take place.

In the hospital, the TTO lasts up to 12 months but must be discharged by the clinician as soon as the person no longer meets the criteria for detention.

Other important parts of the Malawi Mental Health Treatment Act

If someone is arrested by the police for a crime and it is suspected that the person may have a mental disorder, the magistrate can order that the person be admitted to psychiatric hospital on a **30-Day Order** (for further medical examination) or a long-term **Reception Order** for assessment and treatment.

Sometimes a person may commit a serious offence (e.g. murder) when acutely unwell but when taking regular medication, the risk of them doing so again is assessed to be low, and they are discharged from hospital.

In this situation the hospital should discharge the patient back to the police/court and should also advise the district mental health team to provide close follow up.

The district mental health team should keep a record of all those people who require this close follow up.

They should ensure that each person is attending for treatment and make contact with them if they default treatment. They should seek advice from the specialist hospital and alert the police if needed.



Zomba Mental Hospital

Part 4

Assessment and Management of Psychiatric Disorders (and Epilepsy)

Delirium

Psychosis

Depression

Bipolar Disorder

Anxiety

Stress Reactions

Dementia

Drug and Alcohol Dependence

Epilepsy

Delirium Assessment

Definition and causes

Delirium is:

- a sudden onset (hours to days) of confusion
- usually accompanied by drowsiness or agitation
- caused by a general medical or surgical condition (an underlying organic cause)
- usually reversible
- a medical emergency that should not be treated by mental health practitioners alone

There may be a history that hints at the underlying medical/surgical cause e.g. the symptoms may coincide with fever and headache (suggesting an infection) or follow a traffic accident (suggesting trauma).

Some groups are at particular risk of developing delirium:

- People in hospital
- People with chronic conditions such as HIV/AIDS, TB or systemic illness
- Older adults
- Children
- People who misuse alcohol or drugs
- People with unmanaged pain

IMPORTANT: Diagnosing delirium and referring appropriately is one of the most important skills you can develop from this quick guide.

Failure to recognise and treat delirium can lead to people dying unnecessarily from treatable physical illness. You should always suspect delirium in a patient who presents with sudden onset confusion or drowsiness. **Treat it as a medical emergency.**

Simplified Assessment

In addition to the general psychiatric assessment and mental state examination outlined earlier in the guide, the following information is crucial to obtain if you suspect delirium:

Does the person have any of the following?

1. From informant history:

- Recent onset of confusion and/or strange behaviour and/or aggression
- History of recent accident (especially head injury), physical illness, or ingestion of drugs/poison
- Symptoms vary over the day (maybe worse at night)

2. Is the person disorientated? Ask these questions:

- What is the time of day, day of the week, date, season?
- What is this place we are in? Where do you live?
- (If family member or friend present) Do you recognize this person?

3. Does the person have altered level of consciousness (drowsiness)? – this may fluctuate.

If yes, then DELIRIUM is likely.



Appearance + Behaviour	Slowed movements or sometimes agitation, sweating
Speech	Slurred and/or muddled
Mood	Often variable
Thought	Confused. May have persecutory delusions
Perception	Hallucinations – usually visual
Cognition	Drowsiness and disorientation
Insight	Impaired

It is important to remember that people who have a history of mental illness may present with delirium due to a comorbid general medical/surgical condition. If the person has symptoms of delirium you must investigate for an underlying cause. Never just say that someone is a "known psychiatric case" and miss a diagnosis of delirium!

Delirium is always a high risk condition. Additional risks include aggression, wandering, pulling out drips etc.

Delirium Management

Core management

- Provide immediate medical care (**A**irway, **B**reathing, **C**irculation).
- Safely manage any aggression (see section in Part 2 of this guide).
- Keep the person safe, encourage fluids.
- Urgently refer and transport to District Hospital emergency department.
- The mainstay of treatment is identifying and treating the underlying medical or surgical (organic) cause.
- If transfer is delayed, investigate and treat possible underlying general medical condition.
- Explain to the person and family what is happening (use the patient information leaflet in Part 6).

Refer to clinician in emergency department – ask medics for a delirium workup / confusion screen.

If after full investigation and treatment the person has persistent psychiatric symptoms, then carefully review the patient. Refer to tertiary care if needed.

The mental health team should not be in charge of the care of someone with suspected delirium but should liaise with the treating speciality (e.g. medicine, surgery, obstetrics) and offer advice on management of agitation or aggression if needed.

The role of psychiatric treatment is to control the behavioural disturbances in order to allow identification and management of the underlying cause (e.g. infections, alcohol withdrawal, hypoglycaemia etc.)

Psychosocial

Advice for managing a delirious patient:

- Keep in a quiet room away from loud noises or excitement.
- Reassure, as they may be feeling frightened.
- Remind them of who you are, where they are, what the time is and what has happened to them.
- Care for by one person (if possible). This will help them feel less confused. If a nurse is not able to do this, then a family member can do this job.

If the person is aggressive and agitated even after doing these things, you may have to prescribe some medication such as low-dose haloperidol.

Medication

For behavioural disturbances or aggression give short course of low dose of antipsychotic medication:

1st line: **Oral Haloperidol** 2.5mg bd for 7 days or until agitation / confusion resolves.

2nd line: If the patient is refusing oral medications, use **IM Haloperidol** 2.5 – 5mg bd until sufficiently improved to accept medications orally.

3rd line: If agitation is very severe despite the above measures, consider adding **Diazepam** 5 – 10mg PO or slow IV push for short time or until less agitated (3-5 days).

Reserve Diazepam use for cases where agitation is posing a very high risk, Diazepam can worsen the condition. Intravenous or high dose Diazepam can cause respiratory depression/ distress.

Review and Monitoring

- Monitoring of physical condition at least every 8 hours until stable.
- Mental Health review every 24-48 hours. If agitation is severe, review the patient more regularly.
- Once symptoms have resolved, reduce and stop the antipsychotics.

Follow-up

- After discharge. arrange follow up in 5-7 days' time to ensure patient remains stable.

Psychosis Assessment

Definition

For the purposes of this quick guide, psychotic disorders are conditions with at least two of the following symptoms:

- hallucinations (usually hearing voices)
- delusions (fixed, false beliefs, not shared by others in the person's culture)
- disorganised behaviour and/or speech (agitation, hyperactivity / inactivity, incoherent / irrelevant speech, signs of self-neglect)

Other symptoms include social withdrawal and lack of motivation. The person usually does not realise that they are mentally unwell (i.e. lacks insight).

Acute psychosis describes an episode of psychosis lasting less than a month. Many people who have a single episode of acute psychosis will have no recurrence.

Chronic psychosis refers to those who have further episodes of psychosis. Some will go on to develop persistent disabling symptoms. This group of disorders includes schizophrenia.

It is hard to tell the difference between acute psychosis and mania (part of Bipolar Disorder – see separate chapter). In acute mania, there are often psychotic symptoms but also:

- Elevated or irritable mood; inflated self-esteem
- Decreased need for sleep
- Increased activity and energy
- Impulsive or reckless behaviours such as excessive spending and sexual indiscretion

Causes

The cause of psychotic disorders is not fully understood but includes genetic factors, early childhood adversity and stressful environmental factors.

Risk

Up to 20% of people with chronic psychosis will commit suicide. If the person is aggressive or at risk of harm to self or others, see these sections.



IMPORTANT: It is crucial to consider the cause of psychotic symptoms before making a diagnosis.

Delirium, dementia, severe depression, mania and drug-induced psychosis are all common causes and the management is often quite different for these conditions. If you suspect these, see their sections for further assessment and management

Simplified Assessment

In addition to the general psychiatric assessment and mental state examination outlined earlier in the guide, the following information is crucial to obtain if you suspect psychosis:

Ask the patient and family whether this is the first episode of illness (acute psychosis), or whether there are previous episodes of illness (chronic psychosis).

- see Part 7 of this book for English and Chichewa translations of good questions to ask about psychosis.

- Any infections, accidents, changes to medications etc. (this could be delirium)?
- Assess for any of the symptoms of severe depression including nihilistic delusions or hallucinations that started with or after depressed mood (this could be psychotic depression).
- Any recent chamba (cannabis) use before symptoms (this could be drug-induced psychosis)?
- Any recent stressful event or emotional trauma (this could be acute stress reaction)?
- Any long-term cognitive impairment (this could be dementia or intellectual disability)?

Typical MSE

A + B	Often self-neglect, agitation, disordered, bizarre clothing, preoccupied
Speech	Loud/none, odd words
Mood	Often distressed / perplexed, elated if manic
Thought	Delusions, thought interference, difficult to follow
Perception	Hallucinations – usually voices. <i>Visual suggests DELIRIUM</i>
Cognition	Impaired concentration, <i>drowsiness suggests DELIRIUM</i>
Insight	Impaired, often none at all

Psychosis Management

Core management

- If delirium, dementia, depression, alcohol/drug related – see other sections
- Psychoeducate patient and guardians
- Stop any drugs likely to make it worse
- Start antipsychotic and titrate up to an effective dose
- Manage any side-effects

Red Flags

Refer or admit if necessary:

- If there is a high risk of self-neglect, vulnerability, harm to others or suicide.
- If insight is lacking and no guardian can ensure compliance with medication.
- If the person refuses to go to hospital you may need to detain them using the Mental Health Act. (see Part 3 of this guide).

Investigations

Look for physical cause for the symptoms:

- Try to rule out delirium, drug and alcohol use/withdrawal etc.
- Full physical exam
- FBC, VDRL, MRDT, HIV
- Urine drug screen if available

Psychosocial

- Supportive counselling about the illness
- Psychoeducation of guardians – photocopy information leaflet on psychosis
- Promote functioning in daily activities
- Reduce stress and strengthen social supports

Medication

Commence antipsychotic drug (the following are adult doses, use lower doses in over 65s – see chapter in Part 5).

Start at lower dose range if first episode.

Discuss importance of compliance - note it takes 1-2 weeks for medications to work. Increase gradually to usual treatment dose for 2 weeks before switching, unless side-effects intolerable.

- Start **Chlorpromazine** 100 – 300mg nocte
Or
- **Haloperidol** 2.5 – 5mg nocte

- If no improvement after 2 weeks at effective dose or experiencing lots of side-effects (see box) switch to **Risperidone** 1-2mg nocte

If psychosis could be due to a manic episode, stop any anti-depressant drugs as they will make it worse.

In drug-induced psychosis, if the person stops using the drug, the symptoms may resolve. A short course of oral **Diazepam** 10mg bd for one week may help withdrawal symptoms.

In cases of chronic psychosis and where compliance to oral meds is poor (despite counselling and attempts to manage side-effects) consider a long-acting depot such as:

- **Fluphenazine** 12.5mg im into a large muscle as a test dose followed by **Fluphenazine** 25 – 50mg im every 4 weeks. Dose can be increased by 12.5 – 25mg after at least 3 months.

Side effects

Chlorpromazine: sedation, postural hypotension (dizziness on standing), constipation, photosensitivity (rash in sunlight). **Haloperidol:** extra-pyramidal side effects (EPSE) (tremor, rigidity, slowed movements), salivation.

Acute dystonia (rapid onset of severe muscle stiffness e.g. neck turning to one side, eyes rolling upwards) is a very distressing EPSE. Stop antipsychotic, give **Trihexyphenidyl** (“Artane” / “Benzhexol”) 5mg orally, IM or IV max tds. Refer urgently.

If chronic EPSE, reduce dose of antipsychotic and/or add **Trihexyphenidyl** (“Artane” / “Benzhexol”) 5mg orally daily. Refer for review.

Referral

- Persisting/worsening symptoms despite 6-8 weeks of antipsychotic medication at effective dose.
- If side-effects are not manageable (see above)

Follow-up

- Review every 1-2 weeks initially and then every 1 month once more stable.
- Screen for ongoing symptoms and monitor for medication side-effects at each review.
- Continue medication for at least one year from complete symptom resolution if this is a first episode, or several years if multiple episodes.
- If psychosis is secondary to drug use, consider withdrawing medication six months after complete symptom resolution.

Depression Assessment

Definition

Depression is a mood disorder in which the person experiences persistent low mood and loss of interest/pleasure, as well as other symptoms such as loss of sleep and appetite, and suicidal ideas.

It is important that we do not diagnose normal brief periods of unhappiness as depression.

Therefore, you should make a diagnosis of depression only if (1) there are multiple symptoms, (2) these symptoms last at least 2 weeks, and (3) the person has difficulty carrying out their usual work, school, domestic or social activities.

IMPORTANT: It is very important to recognise and treat depression because:

- Depression is disabling and distressing for the person and their family.
- 15% of people with moderate/severe depression commit suicide.
- If depression is untreated it can become more severe or chronic.

Causes

People with a family history of depression and/or those who have experienced abuse in childhood are more vulnerable to depression.

Depression is often a reaction to ongoing stressors such as poverty or domestic violence.

Alcohol abuse and physical illnesses are other common causes.

Without treatment, an episode of depression usually lasts 4-6 months, though it can last longer especially if the person has ongoing social problems.

50% of people who have one episode of depression will go on to have further episodes. This is called **recurrent depression**.



Simplified Assessment

At least two weeks of:

- Persistent low mood and/or
- Loss of interest in or pleasure from activities

AND

Several of the following additional symptoms:

- Disturbed sleep or sleeping too much
- Change in appetite or weight (usually loss)
- Fatigue or loss of energy
- Reduced concentration
- Talking or moving more slowly than usual (or sometimes agitation and restlessness)
- Thoughts of guilt, worthlessness and hopelessness
- Suicidal thoughts or acts

AND

- the person has difficulty carrying out their usual work, school, domestic or social activities.

In **severe depression**, people can experience false ideas (delusions) or hear voices (hallucinations). These will have negative content that matches the person's low mood.

Typical MSE

A + B	Self-neglect, may look tearful, weight loss, slowed up movements, poor eye contact, looking downward
Speech	May say less and be quieter and slower than usual
Mood	Low, withdrawn, low energy, no enjoyment in life.
Thought	Slowed thinking, worthless, hopeless, pessimistic. May have thoughts of suicide. Only delusional in psychotic depression.
Perception	Hallucinations only in psychotic depression
Cognition	Poor concentration and sleep
Insight	Usually ok but may wish to die in and not accept treatment

Check for history of mania – treat for Bipolar Disorder if this exists (See Bipolar Disorder chapter)

Risk

- 10-15% of people with depression will commit suicide.
- Self-harm and self-neglect are common.

Depression Management

Core management

- Exclude general medical cause
- For mild/moderate use psychosocial treatments
- For moderate/severe consider addition of antidepressant medication
- Psychoeducate patient and guardians
- Manage any side-effects

Red Flags

- If there is a high risk of suicide or self-neglect (e.g. not drinking and eating enough) or there are psychotic features (delusions, hallucinations, stupor) admit to hospital. May need to be detained using the Mental Health Act.
- If the person is experiencing domestic violence, encourage to access local abuse support services and the police if needed.

Physical Exam and Investigations

- Always do a physical examination to look for reversible cause e.g. hypothyroidism, anaemia. Refer for treatment of any physical illnesses.
- Assess for signs of dehydration and/or malnutrition
- FBC, U&E, glucose + VDRL, consider TFTs, HIV test, urine drug screen if appropriate.

Treatment

The aim of treatment is to completely resolve symptoms so to relieve distress and allow the person to return to their previous activities.

Involving family in the management plan is important and usually helpful. However, be aware that relationship problems and abuse are common stressors that can cause depression.

Psychosocial

If mild-moderate depression (still managing to undertake most of daily activities):

- Supportive counselling and problem solving (listen to and try to understand their problems, help them to think about possible solutions, encourage enjoyable activities) See section on psychosocial interventions.
- Consider referral to local supportive groups (e.g. church, women's groups, MeHUCA)
- Manage any alcohol or drug use – see section
- If not improving, consider referral for specialist psychotherapy

Medication

For moderate to severe depression (or milder depression persisting despite counselling). Explain that antidepressants take 1-4 weeks before improvements are noticed.

1st line:

- Fluoxetine 20mg od
- If no/partial response, increase to 40mg after 3 - 4 weeks to max of 60mg (rarely needed)
- Monitor for side effects (agitation, initial increase in anxiety, GI upset, insomnia)

2nd line:

If not improved on **Fluoxetine** after 4-6 weeks or not tolerating:

- Switch to **Amitriptyline** 75mg nocte – start at 25mg and increase by 25mg every 3 days until dose is 75mg – helps with tolerability.
- Increase every 2 weeks by further 25mg if symptoms persist up to max. of 200mg nocte
- Monitor for side effects (sedation, hypotension, dry mouth, constipation, sexual dysfunction)

NOTE: If patient is suicidal, give **Amitriptyline** to the carer to keep safe – **Amitriptyline** can be fatal in overdose due to cardiac effects.

If patient is elderly or physically frail (e.g. HIV) reduce the starting dose to **Amitriptyline** 25mg nocte and increase the dose slowly.

If psychotic symptoms present, add an antipsychotic and consider referral/admission

Chlorpromazine 50-150mg nocte or **Haloperidol** 1.25-2.5mg nocte

Increase dose every 2 weeks until psychotic symptoms have resolved

Referral/Admission

- Ongoing or worsening symptoms
- Depression with psychotic symptoms
- Persistent or increasing suicidal ideation
- Evidence of dehydration or malnutrition

Follow-up

- Review the patient once a week until improving, thereafter every 2-4 weeks.
- Assess risk for committing suicide and side-effects at every review
- Continue medication for 6 months from complete resolution of symptoms (first episode) or 2 years (recurrent depression)
- Stop antidepressants gradually over 4-8 weeks, longer if necessary.

Bipolar Disorder Assessment

Definition

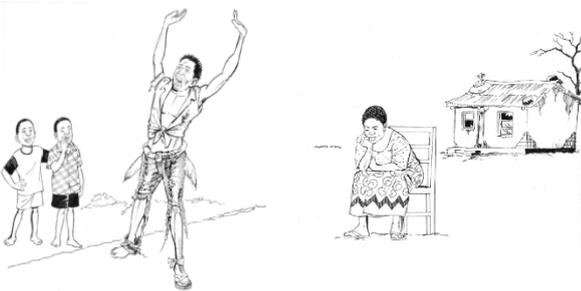
Bipolar disorder (previously called manic depression) is a condition in which a person has extreme changes in mood and activity levels - recurrent periods of being unusually happy or irritable (known as 'mania' or 'hypomania'), and (usually) also periods of being unusually sad ('depression').

IMPORTANT: The mood swings in Bipolar disorder are way beyond what would be considered normal for a particular individual, and are out of keeping with the person's personality.

Causes

Research suggests that bipolar disorder runs in families, and genes can influence whether someone develops the illness. We also know that the brain systems involved in controlling our moods work differently in people with bipolar disorder.

Factors such as life stress, lack of sleep and recreational drugs can trigger episodes of abnormal mood.



Simplified Assessment

Bipolar disorder is a complex illness which can vary a great deal in nature and severity between people.

In addition to the general psychiatric assessment and mental state examination outlined earlier in the guide, look for the following features if you suspect Bipolar disorder:

Mania and hypomania

In an acute manic or hypomanic episode, the person will experience several of the following symptoms, lasting for at least one week, and severely enough to interfere with their work or home life.

- Elevated or irritable mood
- Decreased need for sleep
- Increased activity and energy, increased or rapid speech
- Loss of normal social inhibitions such as sexual indiscretion
- Impulsive or reckless behaviours such as excessive spending, making important decisions without planning
- Being easily distracted
- Unrealistically inflated self-esteem

Mania is at the one extreme end. Some people with mania develop psychosis. These beliefs will match the mood of the person e.g. that they have superhuman powers. 'Hypomania' is a milder form of mania and there are no symptoms of psychosis.

Depression

Symptoms are the same as for depression (see section). See the separate section on depression assessment.

Typical MSE - Mania

A + B	Restless, disinhibited, bright or bizarre clothing, self-neglect
Speech	Loud, rapid, lots of ideas
Mood	Elated or Irritable
Thought	Grandiose ideas of wealth, importance, religious powers etc.
Perception	If severe may have hallucinations – usually voices. (<i>Visual suggests DELIRIUM</i>)
Cognition	Impaired concentration (<i>Confusion suggests DELIRIUM</i>)
Insight	Impaired, often none at all

Typical MSE – Depression

See depression section

Risk

In mania, risks include harm through reckless behaviour e.g. driving too fast, excessive alcohol, promiscuity. There is risk of harm by others in response to social disinhibition. In severe mania, self-neglect and exhaustion may occur. Mood can change quickly and suicide is a risk even during a manic episode. Depression carries risks as described in that section.

Bipolar Disorder Management

Core management

- Exclude general medical cause
- For acute mania, manage as per acute psychosis.
- Reduce risk of relapse with mood stabiliser or antipsychotic. Usually continued for at least 2 years.
- For depression in bipolar disorder only give antidepressant if also on mood stabiliser or antipsychotic
- Psychoeducate patient and guardians

Red Flags

Admission usually required if:

- Evidence of exhaustion, dehydration due to over-activity. IV fluid may be necessary
- Evidence that the patient is a high risk to themselves (self-harm/ neglect/ vulnerable to exploitation) or a risk to others (agitation/ aggression)
- No guardian available to monitor adherence to medication

Physical Exam and Investigations

- Full physical examination to exclude underlying physical causes (delirium)
- Vital signs: If severely unwell, dehydration/ exhaustion can be potentially fatal
- FBC and glucose
- If evidence of hyperthyroidism on examination (weight loss, tremor, exophthalmos, goitre) consider TFTs if available
- Consider HIV serotesting (HIV can present with secondary mania), U&E, VDRL, and urine drug screen if appropriate.

Psychosocial

- Psychoeducation – give a photocopy of the information leaflet on bipolar and any other appropriate leaflet
- Consider referral to local supportive groups (church, women's groups, MeHUCA)
- Reduce stress and strengthen social supports
- Promote functioning in daily living activities
- Support carers – give information leaflet

Medication

Initial treatment

Commence either a mood stabiliser or an anti-psychotic

- Give **Sodium Valproate** 400mg nocte. Increase weekly by 200mg until symptoms improved. Usual effective dose 600- 1000mg. Avoid in women of child-bearing age.
- or
- Give **Carbamazepine** 200mg nocte. Increase weekly by 200mg until on 400-600mg. Usual dose 400-600mg daily.
- Use a second-generation antipsychotic (e.g. **Risperidone** 1 – 2mg) in women of child-bearing age

If psychotic symptoms present also give an anti-psychotic medication such as:

- **Chlorpromazine** 100-200mg nocte or **Haloperidol** 2.5mg nocte.
- **Diazepam** 5mg TDS for a maximum of two weeks may help with reducing agitation and increase sleep in the acute management of mania

Medication tips

- If not improving, ensure that person has been on a typical effective dose of medication for a minimum of four to six weeks before considering switching
- If switching to another medication, begin that medication first and treat with both medications for 2 weeks before tapering off the first medication.
- If response is still poor, consult a specialist

Caution: Avoid Sodium Valproate in women of child-bearing age due to teratogenic effects. If no second-generation antipsychotic available, use Carbamazepine but ensure patient using adequate contraception.

Referral

- Ongoing or worsening symptoms despite adequate treatment for 2 – 4 weeks.

Follow-up

- For acute mania: Initial follow-up should be as frequent as possible, even daily, until acute symptoms respond to treatment. Once symptoms respond, monthly to quarterly follow-up is recommended.
- For persons not currently in manic or depressed states, follow-up at least every three months.

Anxiety Disorders

Definition

Everyone feels worried and anxious from time to time. This is normal particularly in response to major threats such as food insecurity. However, if these feelings result in physical and behavioural changes that interfere with daily life, they can become an 'anxiety disorder'.

The term anxiety disorder is a blanket term covering a number of different conditions. Panic attacks, phobias and generalized anxiety disorder share a number of key features and are therefore covered together in this brief section.

Signs and Symptoms

Psychological symptoms such as: feeling tense ('on edge') and worrying a lot about things. Feeling restless, irritable and impatient. Finding it hard to concentrate.

Physical symptoms such as: heart racing (palpitations), sweating, chest pains or difficulty breathing, feeling dizzy, lightheaded or faint. Nausea, diarrhoea, headache, muscle aches and tension are all common.



Types

- **Panic disorder:** when some of the above symptoms come on very quickly, are severe, and last about 10-30 minutes ('panic attacks') then stop.
- **Phobias:** An overwhelming fear of an object, place, situation etc. Examples include spiders, enclosed spaces and public transport.
- **Generalized anxiety disorder (GAD):** when some of the above symptoms are present most of the time regardless of the situation.

Assessment

- Ask about psychosocial stressors
- Ask about alcohol and drug use (including caffeine)
- physical examination (and investigations) to rule out other causes such as thyrotoxicosis, asthma, etc.

Treatment

- Psychoeducation: Explain anxiety to patient especially the link between physical and psychological symptoms. Give health advice such as reducing or stopping substance use, good diet, exercise etc.
- Relaxation methods such as breathing exercises are especially helpful in a panic attack.
- Consider using problem solving therapy to reduce stressors (see psychosocial treatments section).

If symptoms are severe:

Refer for Psychotherapy such as cognitive behavioural therapy (CBT) or interpersonal therapy (IPT), if available.

If not available or medication needed, prescribe:

1st line: Prescribe **Fluoxetine** 20mg once daily (morning) PO. Can gradually increase every few weeks to 60mg. Continue until symptoms resolve – usually at least 6 months.

2nd line: Prescribe **Amitriptyline** 50-150mg nocte PO. Can gradually increase every few weeks to 150mg. Continue until symptoms resolve – usually at least 6 months.

If palpitations are a major symptom, prescribe a beta blocker such as **Propranolol** 40mg OD. Increase if necessary to 40mg 3 times a day.

If anxiety symptoms worsen initially on starting Fluoxetine or Amitriptyline, a short dose of **Diazepam** 2 - 5mg up to max of four times daily PO for a maximum of 5-7 days is acceptable.

Red flags

For referral to if there is significant comorbid physical illness or the symptoms are interfering with activities of daily living.

Anxiety is often associated with depression and substance misuse. Consider admission if the patient is suicidal with no significant psychosocial support at home

Follow up

- Review patient once a week until symptoms resolve
- Once symptoms resolve, continue treatment for 6 months (except Diazepam which is only recommended for 5 to 7 days) and consider stopping thereafter
- Assess for substance use and other psychosocial stressors

Stress Reactions

Definition

Major stress involves threat or loss e.g.

- physical or sexual assault
- road traffic accidents
- natural disasters
- pandemics
- war
- bereavement



Reactions to these stressors involve:

- emotional responses (e.g. sadness, anger)
- physical symptoms (e.g. sweating, racing heart)
- psychological responses (e.g. denial, avoidance).

It is normal to experience some or all of these symptoms after a stressful event. It only becomes abnormal when reactions are amplified or prolonged, or the person develops maladaptive coping strategies.

Adjustment disorder

A range of abnormal responses to life stresses (e.g. separation, loss of job). Usually starts within weeks and lasts less than six months.

Symptoms usually include low mood and anxiousness (but not enough to diagnose depression or anxiety) with physical symptoms like dry mouth, racing heart, sweating.

Manage this with practical support (housing / job advice if necessary), use **problem-solving** approach (see section) and listen actively to allow space to work through feelings.

Acute Stress Reaction

Onset usually minutes to hours after an exceptional stress and lasts less than three days.

Mixed picture of symptoms such as dazed or perplexed, intensely anxious, racing heart / sweating.

Give practical support – keep person safe, re-orientate, engage family support. See **Psychological First Aid** in Part 2.

Post-traumatic Stress Disorder (PTSD)

Onset usually weeks to months after event and lasts for over one month (acute stress reaction if less than one month).

Symptoms include:
Intrusive thoughts, avoidance, increased arousal, numbness / detachment



Psychological first aid (see section) is the most helpful strategy for distress immediately after the event. (Do not *debrief* following the event as this can make it worse.) Counselling strategies are often of great help in recovery. Sleeping tablets (benzodiazepines) and antidepressants are very rarely useful in the immediate aftermath of trauma but antidepressants are helpful if other approaches have failed or if there are symptoms of depression. Refer for trauma-focused CBT, if available, or enquire about getting skills training in this area.

Normal Grief

Lasts less than two years. Usual stages: are shock and disbelief – anger – guilt and self-blame – sadness and despair – acceptance. The order is often not as straight-forward as this and people can jump forward and back through the stages during normal grief.

Support people grieving by encouraging them to describe their feelings. No specific treatment needed.

Abnormal Grief Reaction

Delayed onset, greater intensity and more prolonged than normal grief (at least six months). More likely if death was sudden, normal grieving was prevented by situation, there was a difficult relationship with the deceased.

Symptoms are intense and disabling and include: feeling numb, shocked or stunned by the loss and feeling angry or struggling to accept it. Feeling life is empty or confusion about one's purpose in life is common.

Abnormal grief responds well to encouraging a structured review of the relationship and allowing person to describe their feelings. May need referral for CBT. If person is clearly depressed, treat for depression.

Dementia Assessment

Definition

Dementia is an overall term for diseases and conditions that cause a decline in memory, language, problem-solving and other thinking skills that significantly affect a person's ability to perform everyday activities. Dementia is progressive i.e. the symptoms worsen over time. It usually affects older people – those over 65 years. However, younger people can also be affected, for example in HIV.

IMPORTANT: When considering dementia, first rule out any reversible cause of memory loss:

- Depression
- Medication side effects
- Excess use of alcohol
- Hypothyroidism
- Neurosyphilis
- Vitamin deficiency
- Normal pressure hydrocephalus
- If symptoms come on over days or weeks or if consciousness fluctuates, it is more likely DELIRIUM – see delirium chapter.

Causes

The most common causes of dementia in Malawi are diseases of the brain such as Alzheimer's disease, stroke and infection (HIV). Other causes include Parkinson's disease and alcohol-related brain damage.



Simplified Assessment

In addition to the general psychiatric assessment and mental state examination outlined earlier in the guide, the following information is crucial to obtain if you suspect dementia:

Does the person have any of the following?

1. From collateral history:
 - Six months or more of short-term memory loss and confusion
 - Difficulties recognising family members?
 - Losing things or getting lost themselves?
 - Disorientation – turning day into night?
 - Any progressive difficulties doing things for themselves, such as washing, dressing, cooking, eating, toileting?
 - Impaired memory for important life events like who they were married to or how many children/grandchildren they have?
2. Impaired cognition (orientation, memory etc)?

Ask these questions:

- What is the time of day, day of the week, date, year and season?
- What is your name, DOB, age?
- What is this place we are in? Where do you live?
- (If family member or friend present) Do you recognize this person? Do they think people who have died are still alive?

Typical MSE

A + B	Conscious and alert. Self-neglect (untidy appearance, weight loss), may look bewildered or indifferent. May look towards carer to speak for them
Speech	Clear but difficulty finding right words. Later may stop talking.
Mood	Often variable – sad/frightened if they are aware of their symptoms. They may remain happy in their own world. They may cling to relatives.
Thought	Confused. May easily misread situations. Persecutory delusions may occur.
Perception	Hallucinations later in illness
Cognition	Short-term memory poor, not recognising family/friends
Insight	Unaware of memory problems and changes that others see

Risk

People with dementia are very vulnerable and at a high risk of coming to harm accidentally, or getting lost. Engaging the family to help keep them safe is really important. Depression is common: assess for risk of suicide. If you have any concerns about abuse of the patient, engage with social work.

Dementia Management

Core management

- Exclude delirium and investigate for treatable causes.
- The aim of treatment is supportive as there is no cure for primary dementias (e.g. Alzheimer's Disease.)
- However, depression, psychosis etc affecting someone with dementia should be recognised and treated.
- Involving carers in the management plan is crucial as dementia is lifelong and will worsen progressively. Use information leaflet.

Red Flags

- If there is a sudden increase in confusion in known cases of dementia this may be due to acute infection, reaction to medication, acute psychosis, misuse of alcohol or drugs.
- Manage risks such as wandering, fires, exploitation by relatives.

Physical Exam and Investigations

- Always do a physical exam to rule out comorbid illnesses which can complicate dementia.
- Assess for depression which can cause confusion in the elderly.
- Look for possible causes – HIV, syphilis, TFTs, Cholesterol, high BP, poor diabetic control, alcohol use, vitamin deficiencies (B12 and folate).

Psychosocial

- Reassure, as they may be feeling frightened.
- Remind them of who they are, where they are, what the time is and what has happened to them repeatedly.
- Encourage good diet and exercise and teach family how to assist with personal hygiene.
- Encourage patient to use remaining abilities as much as possible to maintain independence.
- Use written or visual reminders to help memory
- Engage community and neighbours if person wanders and gets lost e.g. keep their address in their pocket
- If distressed, talk about fond memories from their past, with photos if available
- They may become angry with their family for restricting or stopping unsafe behaviour – this can be verbal or physical.

If the person becomes depressed or anxious, consider using an antidepressant. If the person is agitated with symptoms of psychosis (delusions or hallucinations) after doing these things, you may have to give them some medicine such as low-dose haloperidol to treat psychosis.

Medication

For **severe** behavioural disturbances or aggression consider short course of low dose of antipsychotic medications. Use of these medications in the elderly increases risk of falls etc. Therefore, always try psychosocial interventions first.

- 1st line: **Haloperidol** 1.25 PO od/bd for 7 days or until agitation resolves or
- 2nd line: **Risperidone** 0.5 – 1mg PO od/bd until agitation resolves.
- If the psychotic symptoms persist/return after stopping the above medication – refer for consideration of long-term antipsychotic use.
- If antipsychotics are unavailable, you can consider **Diazepam** 2mg PO od/bd, but be aware that it can worsen confusion.

Referral or admission

- If underlying condition and behavioural disturbance cannot be managed at home or health facility.
- If sudden deterioration, maybe need admission for investigation of cause (see box)

Follow-up

- If antipsychotics have been started, consider reviewing the patient once a week until stable.
- Once stable, review once every three to six months.
- Monitor for depression.
- Remember that new symptoms will emerge over time as the condition worsens.
- Always do a physical to rule out comorbid illnesses which can complicate dementia.
- Assess risk for committing suicide.
- Consider stopping antipsychotics if symptoms resolve.
- Consider continuing with low-dose antipsychotic if psychotic symptoms persist.
- Assess for carers stress and try to offer education about the illness.

Drug and Alcohol Dependence Assessment

The following summarises substance dependence. The emergency section of this guide contains information on alcohol withdrawal. See mhGAP Intervention Guide (2016) for detail on assessment and management of this and other substance-use disorders such as harmful use, acute intoxication, and overdose.

Definition

Dependence is when the use of a drug takes on a much higher priority for a person than other behaviours that once had greater value. It is characterized by a strong craving (urge) to use the substance and a loss of control over its use. It is often associated with high levels of substance use (tolerance) and withdrawal symptoms occur when the drug is stopped suddenly.

IMPORTANT:

People with substance-use disorders are ill rather than bad:

- some people have a vulnerability to substance-use disorder
- excessive drinking or drug use progresses through stages and at the advanced stage the person can no longer control their use
- excessive drinking or drug use can lead to physical and mental illness

People become dependent on many types of drugs e.g.: alcohol, cannabis/chamba, inhalants, opioids, sedatives, hypnotics and benzodiazepines.

Of note, **health-workers** are more likely to become dependent on pethidine and benzodiazepines, largely due to easy accessibility.

Simplified Assessment

Comorbid mental disorders are very common so assess carefully for signs or symptoms of these. In addition to the general psychiatric assessment and mental state examination outlined earlier in the guide, ask questions about the following features of dependence:

- High levels of frequent substance use
- A strong craving or sense of compulsion to use the substance
- Difficulty self-regulating the use of that substance despite the risks and harmful consequences
- Increasing levels of use and withdrawal



- symptoms on cessation

A 'unit' of alcohol (10 mL, 8 g) is roughly a 25ml single measure of spirits, a little less than a bottle of regular strength (4%) beer, or a small glass of wine.

Recent studies indicate that any amount of alcohol is potentially harmful but the conventional safe drinking limits are 14 units per week for men and women, with at least two drink-free days each week.

Drinking any amount of alcohol during pregnancy can seriously harm the unborn baby.

Risk

Depends on level of use and harm being caused. Often high risk of harm to person's home, work and social lives as well as person's mental and physical health.

High risk of suicide. Risk of accidental death due to acute intoxication, overdose and/or withdrawal.

Harm reduction strategies

- Do not drive while intoxicated
- Advise on safer sexual practices when intoxicated
- Have a low threshold for screening for infections like HIV/AIDS, TB and hepatitis
- Treat comorbidities

Drug and Alcohol Dependence Management

Core management

- Aim for substance reduction and risk management in those not ready to stop.
- Aim for cessation in those ready to stop but follow guidance below before stopping alcohol and benzodiazepines in heavy users.

Red Flags

- Comorbid depression: monitor for suicide risk.
- Alcohol withdrawal/ Delirium Tremens (see Emergency Management in Part 2)

Caution when stopping the following

Alcohol: Sudden alcohol cessation can lead to seizures and delirium; however, if the person is willing to stop using alcohol, facilitate this. (see section in Part 2). Prescribe **Thiamine** 100mg po or **Vitamin B Complex** daily as a minimum.

Benzodiazepines: Sudden cessation can lead to seizures and delirium. Consider gradually reducing the dose of benzodiazepine with supervised dispensing or refer for a more rapid reduction in an inpatient setting.

Opioids: Maintenance treatment (specialist prescription of replacement opioid medication) is generally more effective than detoxification.

Stopping other substances (e.g. Chamba)

- Advise stopping completely and ask them if they are ready to do this.
- Address food, housing and employment needs.
- Assess and treat any physical or mental health comorbidity – ideally after 2-3 weeks of abstinence, as some problems will resolve with abstinence.

Psychosocial treatment of dependence

Psychoeducation

- People can and do get better.
- If the patient is not ready now, encourage the them to come back to discuss the issue further.
- Success in reducing or stopping substance use is more likely if the decision is their own.
- Inform patient and carers about any locally available services to support them – use the patient and carer information leaflets.

Counselling

- Avoid causing shame - use a non-judgmental approach and try not to express surprise at any responses given.
- Counsel patient using a problem solving technique – see psychosocial intervention section for more.
- Explore brief interventions like motivational interviewing to help people reduce or quit – see mh GAP.

Strategies for reducing and stopping

- Identify triggers for use and ways to avoid them.
- Encourage the person not to keep substances at home.
- Peer support groups e.g. Alcoholics Anonymous where available, religious organizations etc.

Medication & Referral

Alcohol dependence

- Thiamine 100mg orally daily
- Determine the appropriate setting to cease alcohol use, and arrange inpatient detoxification, if necessary and possible.

Follow-up

- If person not yet ready to quit or reduce, agree with them when they want to be seen again.
- If ready to quit or reduce, review weekly.
- If newly abstinent, review every two weeks.
- Once abstinence established, review less frequently.

Epilepsy Assessment

Note, epilepsy is a medical (neurological) condition and should be managed by a medical team (ideally by a neurologist). Childhood epilepsy should be managed by paediatrics.

Traditionally, however, adult epilepsy has been managed by mental health in Malawi so the following section is included to support mental health staff during the period of transition to epilepsy being managed by medicine (neurology).

Definition

Epilepsy is a brain disorder. It is defined by recurring, unprovoked seizures also known as fits or convulsions. About one in every 100 people is affected by epilepsy. The severity of a seizure can vary greatly; from spells of absence (staring into space with no movement) to loss of consciousness and violent convulsions. The type of seizure a person has depends on the underlying cause of the seizure. Most start before age 30. Children may have febrile seizures if they have a fever, this is different to Epilepsy. There are two main types of epileptic seizure:

1. Convulsive seizures

This type of seizure affects the whole brain and the person having the seizure becomes **unconscious**. They may also:

- Fall to the floor
- Bite their tongue
- Become stiff and shake
- Their eyeballs may roll upwards
- Froth at the mouth
- Lose control of their bladder / bowels
- Their lips may turn blue
- Feel drowsy and confused after the event



2. Non-convulsive seizures

This type of seizure affects one part of the brain. The person may be awake but confused or lose touch with their surroundings and may experience the following:

- Jerky movements in one part of their body (e.g. their arm or leg)
- Their lips may smack together repeatedly
- They may stare into space and appear as if they are in a trance (absence seizure)

'Conversion' seizures

Before diagnosing someone with epilepsy, it is important to assess if these are conversion seizures, also known as psychogenic non-epileptic seizures (PNES). PNES are attacks that may look like epileptic seizures but are not caused by abnormal brain electrical discharges. Instead, they are an indicator of psychological distress. PNES is a real condition that happens in response to real stressors.

These seizures are not consciously produced and are not the patient's fault. During an attack, findings such as asynchronous or side-to-side movements, crying, and eye closure suggest PNES, whereas occurrence during sleep indicates epilepsy.

These seizures are more common in young women and are associated with psychological stress. See resources referenced in introduction for more information on management.

Causes

Any damage to the brain has the potential to cause seizures. Damage is commonly from head injuries (an accident, during childbirth) or infections (HIV, malaria). There is often a family history or genetic component. It is **not** caused by spirits or witchcraft!

IMPORTANT: Sometimes a seizure is related to a temporary condition, such as exposure to drugs, withdrawal from certain drugs and alcohol, a high fever or abnormal levels of sodium or glucose in the blood. If the seizure or seizures do not happen again once the underlying problem is corrected, the person does not have epilepsy.

Simplified Assessment

A detailed witness account is the most important aspect of assessment. Videos taken by relatives on smartphones can be really useful.

Risk

- People with epilepsy should not take baths or swim alone or cook over an open fire alone in case they harm themselves.
- People with epilepsy should not drive or operate heavy machinery in case they harm themselves and/or others.

Epilepsy Management

Note: Epilepsy is a medical (neurological) condition – see note on opposite page. **Only start treatment if no medical or paediatric service is available.**

- Look for treatable causes (infections, tumour, alcohol).
- If patient has more than two afebrile seizures on different days in a year, consider starting antiepileptic therapy.
- Always start with a small dose, increase gradually over weeks or months and use maximum dose of one drug before adding another
- Treatment should never be stopped suddenly due to risk of status epilepticus, taper over weeks or months
- If patient is a woman in the second half of pregnancy or recently given birth, suspect eclampsia and refer urgently.
- Any prolonged seizures or repeated seizures without recovery of consciousness in between (>30 minutes) is **Status Epilepticus** - a medical emergency and mortality is high. **For emergency management of a seizure – see separate management chart in Part 2**

Physical Exam and Investigations

- Always do a physical exam to look for reversible cause e.g. infection, alcohol
- FBC, U&E, glucose, VDRL + MRDT, consider HIV test, urine drug screen if appropriate.
- Assess for comorbid mental health conditions, higher rates of depression and suicide in those with epilepsy

Psychosocial

Epilepsy often has a considerable impact on the psychosocial wellbeing of patients

- Use information leaflets for patients and carers to reduce anxiety
- Adherence to medication is crucial
- Encourage a positive self-image
- Minimize time off school or work
- Maintaining a good diet, getting plenty of sleep and avoiding illegal drugs and alcohol decrease seizure frequency

Medication

Convulsive seizures in children

- **Sodium Valproate** 20-40mg/kg/day in 2 to 3 divided doses
Alternatively
- **Phenobarbitone** 5-8mg/kg nocte
Or
- **Carbamazepine** 2.5mg/kg bd and increase weekly by 5mg/kg until 20mg/kg is reached

Non-convulsive seizures in children

- **Carbamazepine** 2.5mg/kg/day bd
Alternatively
- **Sodium Valproate** 20-40mg/kg/day in 2 to 3 divided doses

Epilepsy treatment in Adults

- **Phenobarbitone** 60-180mg nocte
Alternatively
- **Carbamazepine** 200mg 1-2 times daily. Increase by 100-200mg weekly until dose is 800-1200mg per day
Or
- **Sodium Valproate** 600mg daily divided doses. Can be titrated up to 2000mg daily in two divided doses
Or
- **Phenytoin** 150-300mg daily in 1-2 doses.

Red Flags

- Avoid sodium valproate in women of childbearing age if at all possible.
- Avoid polytherapy in pregnant women.
- Carbamazepine preferred if breastfeeding.
- Sodium valproate is preferred in people with HIV due to fewer drug interactions; avoid phenytoin and carbamazepine in HIV where possible.

Referral

- Increasing frequency or duration of seizures despite medication

Admission

- Status Epilepticus; suspected eclampsia

Follow-up

- Reviewing the patient once a week until seizure management improving
- Assess risk for side effects, depression and suicide at every review
- Only consider stopping treatment if two years without seizures, reduce over month

Part 5

Special Patient Groups

Older Adults

Women who are pregnant or have recently given birth

Children and Adolescents

Older Adults

The assessment and management of mental health problems in older adults (>60 years) is largely the same as outlined in each of the relevant chapters, so refer directly to these chapters if treating an older adult with one of these presentations. However, there are some important considerations and a few key principles to keep in mind when working with older adults. These are described in this section.

Key considerations when working with older adults

For most older people, old age is a positive and rewarding period. However, as people age they are faced with new challenges that may affect their mental health such as:

Giving up work

Physical jobs become more and more difficult as we grow old. Jobs that require good memory or concentration also become more of a challenge. To many people (often men) work is central to life. When work has to stop, people can sometimes feel rejected, worthless and question their purpose. This can lead to low mood and anxiety. Loss of income can lead to financial or housing problems.

Bereavement

Older people frequently witness the death of their friends and older members of their family including their spouse and siblings. For some, repeated grief can be difficult to cope with. Older people can become lonely and isolated as a result.

Fear of death

As we age we become more aware of our own mortality. Many people fear death. They may fear the way in which they may die, specifically in pain, all alone or without dignity. They may worry about the welfare of those they will leave behind.

Sleep

Older people commonly have problems sleeping. If this problem is ongoing it can lead to tiredness, irritability and difficulty concentrating.

Physical health

As we age we begin to experience more physical health problems like arthritis, pain, falls, heart or lung disease.

Increase in mental health problems

The most common psychiatric disorders in older adults are depression and anxiety. Dementia, delirium and substance misuse are common too.

Key principles of care for older adults with mental health conditions

- Delirium is common in older adults so presume that any older adult with new onset confusion or odd behaviour has delirium until proven otherwise
- Screen older adults for depression especially if they attend a clinic regularly for other complaints
- Check for signs of dementia by asking patient and their family if they have noticed memory problems or trouble doing things for themselves
- Perform a physical health check on the elderly and manage or refer for treatment as necessary
- Address psychosocial stressors that are particularly relevant to the person, respecting their need for autonomy
- Manage sensory deficits (such as low vision or poor hearing) with appropriate devices (e.g. magnifying glass, hearing aids)
- Assess and manage risks:
 - Suicide
 - Neglect
 - Risk from others (e.g. abusive family)
 - Self-harm in an older adult should be considered to be with suicidal intent until proven otherwise
- Refer if needed. Review regularly

Differences to consider in assessment and management in older adults

Most conditions present similarly and are managed largely the same as in younger adults but be alert to the following:

Depression presentation in older adults

More likely to show:

- Cognitive impairment ("pseudodementia")
- Psychomotor agitation or retardation
- Poor appetite and weight loss
- Poor concentration
- Generalised anxiety
- Excessive concerns about physical health

When psychotic, older adults are particularly likely to have false, fixed ideas that they are physically unwell (in extreme cases believing they are dead), in financial ruin, or feel guilty.

Remember that older adults are at high risk for completed suicide.

Depression management in older adults

- Reducing social and sensory isolation is important (hearing aids and glasses)
- Remind the patient they are unwell and that their illness is treatable.
- Support carers
- Start medication (**Fluoxetine 20mg OD, usual max dose 40mg**) slowly and at a lower dose. Drugs take longer to work (6-8 weeks) so increase slowly.
- Try to avoid tricyclics (**Amitriptyline**) as they can cause anticholinergic side effects such as delirium, dizziness or confusion in older people.
- Electroconvulsive therapy (ECT) is very effective for severe depression, so consider referring to a specialist service any older person with severe depression with suicidal ideation, and those who have stopped eating or drinking or have failed to respond to medication.

Mania presentation in older adults

Less likely to be clearly elated in mood, although the patient generally has grandiose ideation. More likely to be irritable with a labile mood.

Antipsychotics are effective but **Haloperidol** (usual max dose 5mg daily) must be used with caution in elderly people with vascular risk factors because of increased risk of stroke. Use atypical/newer antipsychotics if available, such as: **Risperidone** (usual max dose 2mg).

Psychosis presentation in older adults

Older people with psychosis may have illnesses that have continued from their early life, such as schizophrenia. A first presentation of psychosis in older people is reasonably common in people who have dementia or may simply be a late onset psychotic illness.

As for mania above, use atypical/newer antipsychotics if available, such as **Risperidone**. Only use drugs in combination with a social intervention to reduce isolation.

Prescribing for older adults

- Use lower doses of medications (usually 50% of general adult dose)
- Increase doses very slowly (usually twice as slowly as in general adults)
- Anticipate increased risk of drug interactions as older people are often on more drugs – do not treat one side-effect with another drug
- Sedating drugs (**Diazepam**) may result in drowsiness, confusion, falls and delirium
- Tricyclic antidepressants (**Amitriptyline**) are more likely to cause confusion, anticholinergic side-effects (dry mouth/eyes/constipation) and low blood pressure with dizziness on standing
- Antipsychotics more likely to be associated with parkinsonism (stiffness, slowness and tremor) and increased risk of cerebrovascular accident (stroke)
- Keep therapy simple; that is, once daily administration whenever possible.



Women who are pregnant or have recently given birth

The *mental health* of women during pregnancy and the postpartum period is a critical part of maternal and child health (MCH).

Mental illness during this period can have long-term effects on the health of both the mother and her baby, if not appropriately managed.

Mental health conditions affecting women in pregnancy and postpartum include:

- Delirium (due to obstetric conditions (e.g. haemorrhage, infection) or another general medical illness).
- Postpartum psychosis (this affects 1:500 women after giving birth. Usual onset within 2 weeks of delivery. Symptoms (delusions, hallucinations, mania, severe depression) can come on quickly and vary from day-to-day. It is a psychiatric emergency).
- Relapse of a pre-existing illness (e.g. bipolar disorder).
- Reaction to traumas such as stillbirth and partner violence.
- Depression (10-15% of women)
- Anxiety (particularly in pregnancy)
- Alcohol misuse
- “Baby Blues” (this is a brief period of tearfulness, labile mood, anxiety etc that affects approx. 50% of mothers soon after delivery. No treatment is needed - just reassurance)

Key principles of care for maternal mental health conditions

- Be kind and empathic.
- Think about the (unborn) baby as well as the mother.
- Ensure nutrition and other physical needs are met.
- Assess and manage risks promptly:
 - Suicide
 - Neglect or harm to the baby
 - Risk from others (e.g. partner violence)
- Refer if needed. Review regularly.
- Consider the effect of medication on the (unborn) baby when prescribing in pregnancy and breastfeeding (see box)

Red Flag

NEVER prescribe sodium valproate in pregnancy (or to any woman of childbearing age).

Assessment and management of a pregnant or postpartum woman presenting with altered behaviour or unusual thoughts:

1. Is there immediate risk to herself or the baby e.g. neglecting the child, suicidal ideas.

- If YES, act quickly to keep mother and baby safe.
- Use the de-escalation/rapid tranquilisation section (BUT take particular care in pregnancy: make sure you have lots of assistance; give lowest effective doses of medication; minimise any restraint.)
- Assess and manage suicide risk.

2. Is she drowsy, confused (disorientated) and/or have physical signs/symptoms?

- If YES, then **DELIRIUM** is likely. It may be caused by an obstetric condition (e.g. haemorrhage, infection) or another general medical illness. This is an emergency. See the section on Delirium for management.

3. Does she have hallucinations and delusions? Or mania? Or severe depression?

- If YES, and she has recently delivered, the likely diagnosis is **POSTPARTUM PSYCHOSIS**. (If she is still pregnant, it may be relapse of a **pre-existing disorder** such as schizophrenia, bipolar disorder or recurrent depression.)
- Carry out a full physical exam to exclude **Delirium**. See the section on Delirium for management.
- Ensure safety (as above). Advise the family that the mother should not be left alone with the baby whilst she is unwell. A family member may need to look after the baby if the mother is very agitated and distressed. However, when she is more settled, she should be **closely** supervised to breastfeed and care for the baby.
- Refer to hospital for further assessment and management.

4. Is there a clear history of a traumatic event such as her husband beating her?

If YES, her behaviour could be a **REACTION TO TRAUMA**.

- Provide empathic care and reassurance
- Ensure her safety – if she is at risk of harm consider contacting ONE STOP centre and/or Police.
- Consider problem solving counselling.
- Low dose short term **chlorpromazine** (25mg) may be helpful to manage immediate distress.
- If not improving, reassess for other conditions and refer if needed.

5. Is she feeling persistently low in mood, or so worried that she is very distressed and/or not able to care for herself?

- If YES, this could be DEPRESSION AND ANXIETY.
- Assess and manage as per the Depression and Anxiety sections.
- Review more regularly than usual and always ask about thoughts of suicide or harm to the baby.
- Provide practical information in response to worries, and support in providing care and stimulation to the baby.
- Offer lots of praise!

Screening for mental health problems in maternity services

All women attending for antenatal care should be asked if they have a history of mental illness (e.g. postpartum psychosis, schizophrenia, bipolar disorder or recurrent depression). If YES, refer them to the mental health clinic. DON'T stop psychiatric medication without getting advice first.

Advise all women that they should not drink alcohol whilst pregnant.

It can also be helpful to ask women attending for antenatal care simple questions about mental wellbeing e.g.

1. During the last month, have you often been bothered by feeling down, depressed or hopeless? (YES/NO)
2. During the last month, have you often been bothered by little interest or pleasure in doing things? (YES/NO)

If YES, set aside some time to ask in more detail. Assess for (and manage) mental health conditions and offer basic counselling (see section on problem solving).

Prescribing in pregnancy and breastfeeding

- NEVER prescribe sodium valproate in pregnancy (or to any woman of childbearing age).
- Use psychosocial treatments (e.g. problem solving) for mild/moderate depression/anxiety.
- Do not leave a woman with severe mental illness untreated just because she is pregnant/breastfeeding.
- Most medications (except sodium valproate) can be prescribed with care.
- Keep to lowest effective dose. Avoid multiple medications.
- Avoid benzodiazapines (other than occasional doses)
- Don't start depot antipsychotic in pregnancy. But if the person is already prescribed depot and is stable, don't stop it.
- Monitor the breastfeeding baby for sedation or feeding difficulties.
- If it is not possible for the baby to breastfeed, make sure there is formula milk available.



Children and Adolescents

Overview

Children and adolescents can be affected by many types of mental health problems, just like adults.

We recommend referring to the mhGAP-Intervention Guide section on Child & Adolescent Mental & Behavioural Disorders for detailed guidance on how to assess for and manage common mental and behavioural disorders in young people. This is freely available online – see introduction section for more details.

Neurodevelopmental disorder is an umbrella term covering disorders that affect emotion, learning ability, self-control and memory and that unfold as the individual grows.

Examples include: intellectual disability, autism spectrum disorders, tic disorders and disorders of concentration and activity etc. These disorders have a childhood onset and the impairment or delay in functions is related to brain development. They have a steady course rather than the remissions and relapses that tend to characterize other mental disorders.

Behavioural disorder is an umbrella term used commonly to cover disorders such as conduct disorders.

Behavioural symptoms of varying levels of severity are very common in the general population (see box). Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioural disorders.

Emotional disorders are among the leading mental health-related causes of the global burden of disease in young people. Emotional disorders are characterized by increased levels of anxiety, depression, fear, and somatic symptoms. Diagnosis is similar to in adults but the management relies less on medication and more on psychosocial interventions.

The quality of home, school and social environments influence children's and adolescents' wellbeing and functioning. Exploring and addressing psychosocial stressors along with opportunities to activate supports are critical elements of the assessment and management plan. Genetics also play a part – be aware of biological, psychological and social factors in the origin of difficulties.

Key principles of care for children and adolescents

- Create a safe comfortable place when talking with the child, it does not have to be a clinical setting – a box of toys or crayons can help with younger children. Adolescents may be more comfortable in an informal setting.
- It is always necessary to consider the family/carer in the assessment and intervention
- You should speak to the young person alone, especially if you have concerns about abuse – see box below. Tell the guardian that it is routine to have time alone with the child in order to assess properly. Explain to the child that you will not share any information unless they give permission or there is an emergency situation.
- Ask the young person directly about any abuse, if developmentally appropriate and safe (e.g. not in the presence of carer who may have been abusive).
- You may also need to talk to the guardian alone, explain this to the young person.
- **DO NOT** consider starting medication – refer to a specialist if you think medication is necessary

At every visit:

- For all children, but especially those under 5 years, monitor child development.
- Assess for the presence of any new problem or symptom related to mood, behaviour or development/learning. For adolescents, assess for the presence of worsening mood (irritable, easily annoyed or frustrated, down or sad) or **suicidal thoughts or abnormal thought processes or experiences such as hallucinations or delusions**. Refer to risk assessment and suicide sections for more.
- Explore and address psychosocial stressors in the home, school or work environment, including exposure to violence or other forms of maltreatment.
- Assess opportunities for the young person to participate in family and social life.
- Assess carers' needs and support available to the family.
- Monitor attendance at school or workplace.
- Review management plan and monitor adherence to psychosocial interventions.
- If already on medication, review adherence, side-effects, and dosing.
- **DO NOT** consider starting medication – refer to a specialist if you think medication is necessary

Dealing with children whose behaviour is unacceptable

- All children will show challenging behaviours at some time or another, especially when they are young. This is normal – see box.
- When the disruptive behaviour is present for many months and is consistently associated with breaking family or school rules by lying, stealing, bullying, fighting or not attending school or workplace, then this is a mental health problem.
- Encourage families to regularly spend time on activities which both the child and parent enjoy.

The most common underlying cause of this problem is domestic abuse, which may or may not be directed at the child (they may witness it instead) and be a cause of inconsistent parental discipline. Hyperactivity (ADHD), intellectual disability and dyslexia are among other causes (see Where There is no Psychiatrist chapter 11).

Practising simple ways of encouraging positive behaviour and encouraging parent–child contracts on acceptable behaviours are the key methods of dealing with this problem.

Medication has no role except to treat underlying causes.

Age-appropriate disruptive behaviour

Toddlers and young children (18 months – 5 years)

- Refusing to do what they are told, breaking rules, arguing, whining, exaggerating, saying things that aren't true, denying they did anything wrong, being physically aggressive and blaming others for their misbehaviour.
- Brief tantrums (emotional outbursts with crying, screaming, hitting, etc.), usually lasting less than 5 minutes and not longer than 25 minutes, typically occur less than 3 times per week.

Middle Childhood (6 – 12 years)

- Avoidance of or delay in following instructions, complaining or arguing with adults or other children, occasionally losing their temper.

Adolescents (age 13-18 years)

- Testing rules and limits, saying that rules and limits are unfair or unnecessary, occasionally being rude, dismissive, argumentative or defiant with adults.

Psychosocial Interventions for Children and Adolescents

The following interventions have been largely adapted from the mhGAP Intervention Guide which is freely available online – see download information in introduction to this book.

Promoting well-being

Advice for carer

- Spend time with young person doing fun activities
- Listen to the young person and show them affection and respect
- Protect young person from any maltreatment
- Anticipate major life changes (puberty, starting school, birth of sibling) and provide support.

Advice for young person

- Lifestyle choices are crucial: get enough sleep, eat regularly, be physically active, spend time with trusted friends and family, avoid drugs and alcohol, participate in school and social activities.

Parenting Advice

Explain:

- the cause of the developmental delay or mental health difficulty to the carer and the young person in an understandable way
- to the carer that parenting someone with an emotional, behavioural or developmental delay or disorder can be rewarding but also very challenging.
- that people with mental disorders should not be blamed for having the disorder.

Help:

- carers and the young person to identify strengths and resources
- carers to be kind and supportive and show love and affection
- promote and protect human rights of the person and the family and be vigilant about maintaining human rights and dignity
- carers to have realistic expectations and encourage them to contact other carers of children/adolescents with similar conditions for mutual support – see MeHUCA contact details.

Praise the carer and the young person for their efforts.

For further guidance on psychosocial interventions for young people with developmental, behavioural and emotional problems, see the mhGAP Intervention Guide.



Child Abuse and Neglect

Definition: "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (WHO, 2016).

- Child abuse is much more common than is actually reported as most children are too scared or embarrassed, or feel they are to blame.
- The most common type of abuser is someone whom the child knows, male or female – often a parent, other relative, domestic help or family friend.
- Boys can be abused as well as girls.
- Abuse can be emotional, physical or sexual. All three types of abuse can damage the physical and mental health of children.
- Look for signs of abuse like unexplained injuries, age inappropriate sexual talk/play, sexually transmitted infections, being excessively dirty or wearing unsuitable clothing, withdrawn or fearful of parents, and carer using inappropriate threats (e.g. to abandon their child).
- It is important for you to inform the parents and relevant authorities immediately if you suspect abuse. It is essential to follow up on the action taken, especially when the abuser is in a position of authority, for instance, a teacher.
- Never doubt a child's claims that they are being abused. Take it seriously since it will not stop until someone intervenes and addresses the problem.

Part 6

Information Sheets for Patients and Carers

Alcohol Dependence

Anxiety and Phobias

Bipolar Affective Disorder

Delirium

Dementia

Depression

Epilepsy

Psychosis

Post-traumatic Stress Disorder

Self-harm

Staying well during a pandemic

Information on Alcohol Dependence

What is alcohol dependence?

In small amounts, alcohol can relax you for a few hours. With larger amounts, it can make you feel worse.

The desire to have this short-lived feeling then does not work, particularly if your body has developed tolerance to alcohol and you drink more to feel the same effects.

The problem is that it is easy to slip into drinking regularly, using it like a medicine. The benefits soon wear off and the drinking becomes part of a routine.

You also start to notice that:

- instead of choosing to have a drink, you feel the urge to have one
- you wake up with shaky hands and a feeling of nervousness
- you start to drink earlier and earlier in the day
- your work starts to suffer
- your drinking starts to affect your relationships
- you carry on drinking despite the problems it causes
- you start to 'binge drink' (see below) regularly
- you start to neglect other parts of your life

What problems does alcohol dependence cause?

If you use alcohol a lot, it can have a negative impact on your day-to-day life. For example, it could lead to problems with:

- money
- education and employment
- relationships
- housing
- low self-esteem
- finding it hard to maintain commitments, including appointments related to your alcohol use or mental health

Long-term effects

Alcohol can lead to:

- psychosis - hearing voices when there is nobody there
- memory problems either on their own (Korsakoff's Syndrome) or also affecting other areas of the brain (alcohol related dementia) - rather like but not the same as Alzheimer's dementia
- physical - damage organs, such as the liver or brain

How much is too much?

- A 'unit' of alcohol (10 mL, 8 g) is roughly a small glass of wine, a 25ml single measure of spirits or most of a bottle of regular strength (4%) beer.
- Recent studies show that any amount of alcohol is potentially harmful but the conventional safer drinking limits are 14 units per week for men and women, with at least two alcohol-free days each week. Drinking any amount of alcohol during pregnancy can seriously harm the unborn baby.

How can I get help for dependence?

Simple practical steps

- Use a drinks diary to record how much your drinking each day. This will help you identify when, where and with whom you are most likely to drink alcohol.
- Once you have identified these triggers, look for ways to avoid them
- Do not keep alcohol at home
- Use peer support groups e.g. Alcoholics Anonymous where available, religious organizations etc.
- Set yourself a target to reduce the amount of alcohol you drink
- Drink lower-strength, though full-taste, drinks, like 4% beers or 10% wines
- Involve your partner or a friend. They can help to agree a goal and keep track of your progress

Warning: if you are a heavy drinker, suddenly stopping all alcohol can lead to fits and confusion. Talk to your doctor first if planning to stop as you may need a medication called diazepam to replace the alcohol for the first few days.

Uthenga wokhudza matenda a kumwa mowa mwauchidakwa

Kodi kumwa mowa mwauchidakwa ndi chani?

Ngati munthu akumwa pang'ono, mowa ungate kukhazikitsa mtima pansi kwa maola angapo. Koma mowa wambiri ungate kubweretsa mavuto aakulu.

Pakadutsa nthawi munthu ukumwa mowa pang'ono, zikhumbokhumbo zokhazikitsa pansi mtima ndi mowa sizimathekanso makamaka ngati thupi lanu lafika pa mlingo wa uchidakwa ndipo munthu amamwa mowa wambiri kuti aledzere.

Vuto lalikulu ndilakuti ndikwapafupi kukhala chidakwa nkumamwa mowa ngati mankhwala. Zikatelo ubwino wa mowa onse umatha ndipo kulezera kumasanduka mbali ya moyo wanu.

Munthu amayamba kuona izi:

- Mmalo mosankha kukamwa chakumwa, munthu amakhala ndi chibaba chokamwa mowa
- Munthu amadzuka ndi manjenje mmanjama komanso osamva bwino m'thupi
- amayamba kuledzera kudakali m'mawa
- Ntchito imayamba kuvuta chifukwa cha mowa
- Mowa umayamba kukhudza maubale
- Amapitilizabe kuledzera angakhale mowawo ukumupatsa mavuto
- Amayamba kuledzera kwambiri nthawi zambiri
- Amasiya kulabadira mbali zina za moyo wake Kamba ka mowa

Kodi kudalira kuledzera mowa Kapena uchidakwa kumabweretsa mavuto anji kwa munthu?

Ngati ukuledzera kwambiri, mowa ungate kubweretsa mavuto pa moyo siku ndi tsiku. Mwachitsanzo, munthu angagwe mmavuto ndi zinthu izi:

- Ndalama
- Sukulu komanso ntchito
- Maubwenzi
- Nyumba
- Kukhala munthu osadzikhulupilira
- Kuvutika kukwanilitsa zoyenera kuchita monga kukalandira thandizo la uchidakwa komanso maganizo angwiro

Mavuto a m'gonagona a uchidakwa

Mowa ungapangitse:

- Misala-kumva mau palibepo munthu
- Vuto lokumbukira zinthu komanso mavuto a kuubongo
- Mavuto a thupi monga kuonongeka kwa ziwalo monga chiwinda komanso ubongo

Kodi tikamati mowa ochuluka timatanthauza chani?

- Gawo la mowa (10ml, 8g) ndi ka kapu ka galasi pamene ka 25ml ya toti kapena theka la payinti ya mowa (4%)
- Ndibwino kusamwa mowa. Ngati mukumwa, musapyole mlingo wa pa sabata imodzi omwe ndi kuchepela pa magawo 14 kwa amuna komanso akadzi komanso kukhala ndi masiku awiri pasabata osamwa mowa.

Ndingapeze bwanji thandizo la kumwa mowa mwauchidakwa?

Njira zapafupi ndi izi

- Lembani kuti pa tsiku mumamwa mowa ochuluka bwanji. Izi zingakuthandizeni kudziwa kuti kodi mowa mumamwa ndi ndani, mumamwera kuti, ndi ndani ndiponso nthawi zake ziti.
- Mukangodziwa zinthu zomwe zimakupangitsani kuledzera, pedzani njira zomwe mungadzitetedzere
- Osasunga mowa kunyumba
- Gwiritsani ntchito magulu aanzanu omwe ankamwa mowa ndipo anasiya, kapena mabungwe komanso mipingo kuti akuthandizeni
- Muzipatse nokha zoti mukwanilitse kuti muchepetse kumwa mowa
- Imwani mowa wamphamvu yochepa monga omwe uli ndi 4% kapena wine wochepela 10%
- Aloleni abwezi anu kapena wachikondi kutengapo gawo kuti musiyee mowa

Chenjezo: ngati mumaledzera mwauchidakwa, kungosiya mowa mwazizizi kungathe kubweretsa mavuto monga kukomoka, komanso kubaizika. Afotokozereni adokotala anu mukafuna kuyamba kusiya mowa. Mungathe kupasidwa mankhwala monga Valium kuti alowe mmalo mwa mowa makamaka matsiku oyambilira.

Information on Anxiety and phobias

What is anxiety?

It is normal to feel anxious or worried in situations that we see as threatening. In fact, a certain level of anxiety can be helpful in making us prepare for important events such as exams or job interviews, or by helping us escape from dangerous situations. Anxiety becomes a problem when it lasts a long time, becomes overwhelming, or affects the way we live our day to day lives.

What does anxiety feel like?

In the mind	In the body
Feeling worried Feeling tired Unable to concentrate Feeling irritable Sleeping badly Feeling depressed	Fast heartbeats Sweating Face goes pale Dry mouth Muscle tension + pains Trembling Numbness or tingling in fingers, toes or lips Breathing fast Dizziness Faintness Indigestion Passing water frequently Nausea, stomach pain Diarrhoea

Anxiety seems to take three main forms, but they overlap and most people will probably experience more than one type.

Generalised anxiety disorder (GAD)

You have the symptoms of anxiety most of the time.

Panic attacks

You get unpredictable, sudden and intense attacks of anxiety - often in a situation that is likely to make you anxious. The feelings come on suddenly and reach a peak in 10 minutes or less.

Phobia

You feel really frightened of something that is not actually dangerous and which most people do not find troublesome.

What causes these kinds of anxiety?

Usually it is a combination of or all of the following: our genes, our psychology, past trauma, drugs (even too much caffeine), and health problems.

How can I get help for anxiety?

Anxiety is very common and many of us overcome it or cope with it without professional help. However, trying the following tips can get you doing the things you want to do.

Lifestyle changes are usually the first thing to try. Getting more exercise, eating healthily and sleeping

well can help you feel much less anxious and better able to cope. Take some time out every day to do something relaxing, such as listening to music, gardening, or going for a walk

Talk about it

Try a friend or relative who you trust and respect, and who is a good listener.

Keep a diary

You may find it helpful to keep a diary to monitor how you feel and to identify possible triggers of anxiety and panic attacks.

Plan your day

Stick to your usual routines. Set yourself small daily goals and reward yourself for what you achieve.

Family and friends

It may be tempting to withdraw from social activities and stay at home. This will not help in the long run. It is important to stay engaged with other people and to try and keep doing the things you enjoy.

Medication

In moderate to severe cases, medication may be required. Many people find them effective, but they can have drawbacks. Some people experience unpleasant side effects, and they can take several weeks to work.

Avoid using alcohol or drugs to calm yourself down when you are feeling anxious. These can make symptoms worse and can interfere with any medication you may be taking.

A combination of lifestyle changes, talking therapies and medication is often the most effective way to treat anxiety.

Tips for families, partners and carers

One of the best ways to help a person with anxiety is to listen to their worries. Try to be patient and understanding.

- Avoid being judgmental or telling them to 'snap out of it'.
- Anxious people can sometimes be irritable or difficult to deal with. Try to be patient and not to take their reactions personally.
- Encourage the person having problems to stick to normal routines. Help them to establish small daily goals and recognise each success.
- If someone you care about is feeling very anxious, encourage them to get help rather than dealing with it by themselves. A good place to start is by discussing things with a healthcare worker.

Uthenga wokhudzana ndi matenda a nkhwana ndi mantha

Kodi matenda a nkhwana ndi chani?

Ndizabwinobwino munthu kukhala ndi nkhwana, mantha kapenso kudandaula pa zinthu zomwe zikubweretsa chiopsezo pa moyo wathu. Ndipo nkhwana yimatithandiza kuti tikonzekere zinthu zofunikira monga mayeso, kapena nthawi yoyankha mafunso pofunsira ntchito kapenanso kutithandiza kuzipulumutsa kuchokera ku zinthu zoopsa. Nkhawana ndi mantha zimakhala vuto pamene zikutenga nthawi yayitali kuti zithe, kapena zikupyola muyeso, kapenanso zikutipangitsa kusintha malingana ndi m'mene timakhalira m'moyo wathu wa tsiku ndi tsiku.

Kodi munthu amene ali ndi nkhwana amamva bwanji?

Mmaganizo	Mthupi
<ul style="list-style-type: none">Amakhala ndi malingaliro nthawi zonseAmamva kutopaKusakhazikikaAmataya mtima mwachanguAmavutika kugonaAmakhala okhumudwa	<ul style="list-style-type: none">Kuthamathanga mtimaKutuluka thukutaNkhope imatha kusinthaMilomo imaumaAmamva kukokeka ndi kupweteka m'minofuAmanjenjemeraAmamva kuzizilira makamaka dzala za mmanja, mapazi ndi milomoAmapuma mwansangangaAmamva chizungulire komanso chizumbazumbaKupotokola mmimbaKukodza pafupupafupiNseru, kutsegula komanso kupweteka m'mimba

Matenda a nkhwana amatenga mbali zitatatu makamaka, ngakhale nthawi zambiri mbalizi zimalowerelana.

Anthu ambiri amatha kudwala mitundu yoposera umodzi.

Kodi ndichani chomwe chimayambitsa mitundu ya nkhwana?

Nthawi zambiri zimakhala zinthu izi: chilengedwe chathupi lathu (majini), malingaliro kapena maganizo athu, zokhoma zomwe tinakumana nazo mmoyo wathu, mankhwala osokoneza ubongo (angakhale caffeni wambiri), komanso matenda ena amthupi.

Kodi Thandizo lamatenda a nkhwana ndingalipeze bwanji?

ambiri timatha kuthana nawo kapena kumakhala nawo osalandira thandizo kuchokera kuchipatala. Koma ngati nkhwana ndiyayikulu kapena takhala nayo kwa nthawi yayitali, nkhwana ingathe kubweretsa chiopsezo kumoyo wanthu wanthupi ndi kupangitsa munthu kusiya zinthu zimene ukufuna kupanga.

Makhalidwe a moyo wa tsiku ndi tsiku

Kusintha makhalidwe a moyo wa tsiku ndi tsiku ndi chi chinthu choyamba chomwe munthu ayenera kupanga. Kupanga masewero olimbitsa thupi, kudya zakudya zabwino zopatsa thanzi komanso kumagona bwino zingathe kuthandiza kuti munthu asamakhale ndi mantha komanso kukhala bwinobwino angkhale ali ndi nkhwana. Munthu ayenera kukhala ndi nthawi tsiku ndi tsiku kumapanga zinthu zomwe zimakhazikitsa mtima pansi monga kumvetsera nyimbo, kulima, kapena kuyenda ndawala.

Kulankhula poyera - mfotokozereni nzanu, kapena wachibale amene mumamukhulupilira komanso amatha kumvetsera mukamamuza zinthu.

Sungani mbiri ya tsiku ndi tsiku - Mutha kupeza zothandiza kusunga kabuku komwe muzigwiritsa ntchito kulembamo za mmene mukumvera komanso kuona zimene zikumayambitsa nkhwana yomwe muli nayo.

Konzani bwinobwino ndondomeko za tsiku lanu Onetsani kuti mukumapanga zinthu zomwe mumapanga nthawi zonse. Khazikitsani ndikupanga ntchito tsiku ndi tsiku ndipo muzithokoze nokha pa zomwe mwakwanilitsa.

Achibale ndi anansi Munthu yemwe ali ndi nkhwana angathe kuyetsedwa kudzipatula ndi kusiya zinthu zomwe amapanga ndi anthu ena. Zimenezi sidzothandiza. Nkufunika kumatanganidwa ndi anthu ena kuti tipilize kupanga zinthu zimene zimatisangalatsa.

Mankhwala Ngati vutoli lakula kwambiri, mankhwala ndiofunika. Anthu ambiri amapeza kuti mankhwala ndiothandiza kwambiri, koma angathenso kubweretsa mavuto.

Pewani kumwa mowa kapena kugwiritsa ntchito mankhwala ozunguza bongo ndicholinga choti mukhadzikitse mtima pansi ngati muli ndi nkhwana. Idzi zingathe kupangitsa kuti zizindikiro zipite patsogolo komanso zingathe kudzetsa mavuto ndi mankhwala amene mwalandira kuchipatala.

Makhalidwe a tsiku ndi tsiku, kulandira thandizo komanso mankhwala ndi zomwe zimathandiza kwambiri kuthana ndi mantha.

Malangizo kwa achibale, achikondi ndi anthu omuthangatira wodwalayo

Imodzi mwanjira zofunikira kwambiri zothandizira munthu amene ali ndi mantha ndi kumumvetsera nkhwana zake. Khalani odekha komanso omvetsetsa.

- Pewani kutenga mbali
- Anthu omwe ali ndi nkhwana nthawi zina amatha kukwiya mwapafupi kapena ovuta mukamawathandiza. Yetsetsani kudekha komanso osadzitengera zimene akukupangirani
- Mulimbikitseni munthu amane akuvutika kuti atsature zinthu zimene amapanga tsiku ndi tsiku. Athandizeni kuti azikhazikitsa mulingo wa ntchito zawo za tsiku ndi tsiku komanso muwayamikire akakwanilitsa zinthu zomwe amafuna kupanga

Information on Bipolar Disorder

What is bipolar disorder?

If you have bipolar disorder you will experience periods or 'episodes' of highs known as mania or hypomania and usually, periods of depression.

You may also have symptoms of psychosis, i.e. problems with thinking things that are not true (delusions) and seeing or hearing things that are not there (hallucinations).

What does bipolar disorder feel like?

Bipolar disorder is a complex illness which can vary a great deal in nature and severity between people.

In bipolar disorder, a person can have:

- manic or hypomanic periods (or 'episodes')
- depressive periods
- mixed periods

Mania is at the extreme end. Some people with mania develop something called psychosis. This is when someone has strong, bizarre beliefs e.g. that they have superhuman powers. 'Hypomania' is a milder form of mania. Equally, sometimes people with severe depression can develop psychosis.

What causes bipolar disorder?

Research suggests that bipolar disorder runs in families, and genes can influence whether someone develops the illness. We also know that the brain systems involved in controlling our moods work differently in people with bipolar disorder.

Factors such as life stress, lack of sleep and recreational drugs can trigger mood episodes

How can I get help for bipolar disorder?

Bipolar disorder can cause a great deal of distress, but there is a lot that can be done to stay as well as possible. This includes lifestyle changes, medication and talking treatments.

Lifestyle

Lifestyle changes are really important. Getting more exercise, eating healthily and sleeping well can help you avoid becoming unwell. Take some time out every day to do something relaxing, such as listening to music, gardening, or going for a walk. Avoid alcohol or other drugs.

Have a plan

Even if you are well now, you may have more episodes of low or high mood in the future. Try to have a plan in place in case you become unwell again.

Groups

Talk to other people who have bipolar disorder. Their knowledge and experience can be helpful. Organisations such as MeHUCA (<https://www.medcol.mw/mehuca/>) can help you to do this.

Medication

For many people with bipolar disorder medication is a key part of staying well.

Some medications work by preventing the extreme highs or lows caused by the condition; these are known as mood stabilisers, and often need to be taken daily for long periods. Other medications may then be used to treat episodes of high or low moods when they happen.

It is crucial to take medication regularly as prescribed because stopping and starting suddenly can make things worse.

There are many medications for bipolar and finding the one that works the best for you can take time – try to be patient.

If you have bipolar, are female, and planning a family, you should discuss it with your doctor. There are many important issues to consider around bipolar disorder and pregnancy.

Tips for families, partners and carers

- A loved one with bipolar disorder may need your help to stay well.
- Try to be open and understanding about their condition. Ask them about their concerns and how you can help.
- Talk to the mental health professionals who are looking after them. Don't be afraid to ask questions and for advice.
- Don't assume that every small mood change or disagreement is related to the illness.
- Have a plan for what to do if your relative becomes unwell in the future.
- Talk to others who care for people with bipolar disorder. They may have experienced similar situations and have useful tips. Organisations such as MeHUCA (<https://www.medcol.mw/mehuca/>) can help you to do this.

Uthenga okhudzana ndi matenda a Baipola

Kodi matenda a baipola ndichani?

Ngati munthu ali ndi matenda a Baipola amakhala ndi nthawi yosangalala monyanyira komanso kawirikawiri nthawi yokhumudwa.

Munthu angathenso kukhala ndi zizindikiro za misala monga mavuto ndi kuganiza zinthu zoti sizioona komanso kumaona kapena kumamva zinthu zoti palibe.

Kodi zizindikiro za Baipola ndi chani?

Matenda a baipola ndi ovuta chifukwa amatha kusiyana kwambiri malingana ndi munthu yemwe akudwala matendawa.

Munthu odwala matendawa amakhala ndi:

- Nthawi zosangalala monyanyira
- Nthawi zokhumudwa
- Nthawi yophatikizana yosangalala monyanyira ndiponso yokhumudwa.

Kusangala konyanyira kumakhala kumapeto kwenikweni. Anthu ena omwe ali ndi matenda osangalala monyanyira amathanso kukhala ndi misala. Akakhala ndi misala ndipamene munthu amakhala ndi maganizo achilendo mwachitsanzo, kuti iyeyo ali ndi mphamvu ngati Mulungu. Nthawi zina anthu omwe ndi okhumudwa amathanso kukhala ndi misala.

Kodi chimayambitsa matendawa ndi chani?

Kafukufuku akusonyeza kuti matenda a baipola amayenda m'magazi (ngati wachibale anadwalapo) ndipo majini amathandizira kuti munthu adwale kapena asadwale matendawa. Timadziwanso kuti ubongo omwe umatilamulira khalidwe (kusangala kapena kukhumudwa/kukwiya) umagwira ntchito mosiyana ndi anthu amene amadwala matenda a baipola.

Zinthu ngati mavuto kapena zokhoma za moyo, kusagona komanso mankhwala ozunguza bongo ndi mowa zingayambitse matenda a m'khalidwewa.

Kodi thandizo ndingalipeze bwanji lamatenda a baipola?

Matenda a baipola angathe kumvetsa chisoni kwa munthu yemwe akudwala, koma pali zinthu zambiri zomwe munthu angathe kupanga kuti akhale bwino bwino. Kusintha makhalidwe, mankhwala ndi thandizo lina zingathe kumuthandiza.

Makhalidwe - Kusintha makhalidwe nkofunikira kwambiri. Kupanga masewero olimbitsa thupi, kudya zakudya zopatsa thanzi komanso kugona kwambiri kungapangitse kupewa matendawa. Tsiku lina lilonse khalani ndi nthawi yopanga zinthu zomwe zingakukhazikeni mtima pansi monga ngati

kumvetsera nyimbo, kulima, kapena kukangoyenda. Pewani mowa komanso mankhwala ozunguza bongo.

Khalani ndi lingaliro

Ngati muli bwino panopa, mutha kudzakhala ndi nthawi yokhumudwa kapena kusangalala monyanyira mtsogolo. Khalani ndi lingaliro lopangiratu mutakhala kuti mwadzadwalanso matendewa.

Magulu - Lankhulani ndi anthu ena amene ali ndi matendewa. Nzeru ndi Kuzindikira kwawo zingathe kukuthandizani. Mabungwe monga ngati MeHUCA (<https://www.medcol.mw/mehuca/>) angathenso kuthandiza.

Mankhwala - Kwa anthu ambiri amene ali ndi matenda a baipola mankhwala ndi mbali yayikulu yopangitsa kuti akhale ndi moyo wangwirowo.

Mankhwala ena amathandiza kuti munthu usasangalale monyanyira kapenanso kukhumudwa zimene zimabwera Kamba ka matendawa. Munthu amayenera kumwa mankhwalawa tsiku ndi tsiku kwa nthawi yayitali. Mankhwala ena amathandiza pokhapokha munthu wasangalala monyanyira kapena wakhumudwa.

Nkofunikira kwambiri kumwa mankhwala mwandondomeko yake chikukwa kusiya mwazizi ndikuyambiranso zingapangitse matendawa kukula kwambiri.

Pali mankhwala ambiri a matenda a baipola ndipo kupeza okuyanjanani zingathe kutenga nthawi, kotero muyenera kukhala odekha

Ngati muli ndi baipola, ndipo ndinu wamkazi, ndipo mukufuna kulowa m'banja, onetsetsani kuti mwakambirana ndi adokotala. Pali zinthu zambiri zofunikira kudziwa zokhudzana ndi mimba ngati munthu ali ndi matenda a baipola.

Malangizo kwa achibale, wokonedwa ndi omwe akumusamaliran munthu yemwe ali ndi vutoli.

- Wokonedwa wanu yemwe ali ndi matenda a baipola afuna thandizo lanu
- Khalani omasuka komanso omvesetsa za matenda a m'bale wanu. Afunse zomwe zili kumtima kwawo ndipo kuti inuyo mungathandizepo bwanji.
- Lankhulani ndi adokotala othandiza maganizo angwirowo amene akusamalira wodwalayo. Osaopa kufusa mafunso komanso malangizo
- Osaganiza kuti chisangalalo chilichonse, kusakondwa kulikonse kapena kusagwirizana mzochitika kulikonse ndi Kamba ka matendawa.
- Khalani ndi lingaliro kuti mudzapanga chani m'bale wanu akadzadwalanso mtsogolo.

Information on Delirium

What is delirium?

Delirium is a state of mental confusion that starts suddenly and is caused by a physical condition of some sort. You don't know where you are, what time it is, or what's happening to you. It is also called an 'acute confusional state'.

What does delirium feel like?

It often starts suddenly and usually lifts when the condition causing it gets better. It can be frightening – not only for the person who is unwell, but also for those around him or her.

You may:

- not notice what is going on around you
- be unsure about where you are or what you are doing there
- be unable to follow a conversation or to speak clearly
- be very agitated or restless, unable to sit still and wander around
- be very slow or sleepy
- sleep during the day, but wake up at night
- have moods that change quickly – you can feel frightened, anxious, depressed or irritable
- have vivid dreams – these can be frightening and may carry on when you wake up
- worry that other people are trying to harm you
- hear noises or voices when there is nothing or no one to cause them.
- see people or things that aren't there.

What causes delirium?

Medical problems, surgery and medications can all cause delirium. Common causes include: a urine or chest infection, having a high temperature, malaria, dehydration, low salt levels, low haemoglobin (anaemia), suddenly stopping drugs or alcohol, major surgery, epilepsy, brain injury or infection, terminal illness, constipation, side-effects of medicine like pain killers and steroids, liver or kidney problems

How can I get help for delirium?

If someone becomes suddenly confused they need to see a doctor urgently. Once a physical cause has been identified, it needs to be treated. For example, a urine infection will be treated with antibiotics. Simple steps can be taken to help them feel safer and less agitated. These include:

- explaining to the person what has happened, and why they feel confused
- reassuring them that they are safe

- helping them to know what time it is and where they are - a large clock and a written message about where they are can be helpful
- having familiar items from home around the bedside
- having friends and family visit
- making sure that someone has their glasses and hearing aids – and that they are working!

Medication

Some people become so distressed that medication may be needed to calm them down. Sedative medications may do this but, unfortunately, they also make the delirium worse so they should only be prescribed if the person:

- becomes a danger to themselves or other people
- is very agitated or anxious
- believes others are trying to harm them
- is seeing or hearing things that are not there – low doses of anti-psychotic medication can help
- needs calming down so that they can have important investigations or treatment
- is someone who usually drinks a lot of alcohol and has stopped suddenly – to stop them having fits, they will need a regular dose of a sedative medication (a benzodiazepine), reduced over several days under close medical and nursing supervision.

Any sedative medication should be given at the lowest possible dose, for the shortest possible time.

Tips for families, partners and carers

You can help them to feel calmer, and more in control, if you:

- stay calm
- talk to them in short, simple sentences and check that they have understood you
- repeat things if necessary
- remind them of what is happening and how they are doing
- remind them of the time and date – make sure they can see a clock or a calendar
- listen to them and reassure them
- make sure they have their glasses and hearing aid
- help them to eat and drink
- try to make sure that someone they know well is with them – this is often most important during the evening, when confusion often gets worse
- if they are in hospital, bring in some familiar objects from home
- have a light on at night so that they can see where they are if they wake up

Uthenga okhudzana ndi matenda obaizika

Kodi deliriyamu ndi matenda anji?

Deliriyamu ndi matenda amene munthu amasokonekera maganizo komanso zochitika mwadzidzidzi kapena mosayembekezera. Deliriyamu imayamba kamba ka matenda omwe ali kale mthupi. Munthu sadzindikira komwe ali, nthawi, komanso zomwe zikumuchitikira.

Kodi zizindikiro za matendawa adeliriyamu ndi chani?

Matendawa amangoyamba mosayembekezeleka nthawi zambiri ndipo amatha ngati munthu wachira ku matenda omwe anayambitsa. Deliriyamu imabweretsa mantha osati kwa odwala yekha komanso achibale kapena anzake. Muthu amatha:

- Kusadzindikira zomwe zikuchitika
- Kusadziwa kumene ali kapena zomwe akupanga
- kusatsatira zomwe zikulankhulidwa kapena kusatha kulankhula bwino kumene
- Kusakhazikika, kuvutisa, komanso kumangoyendayenda.
- Kukhala ndi tulo tambiri makamaka masana
- Kugona masana koma kukhala maso usiku.
- Kukhala muma mudi osintha pafupipafupi. angathenso kukhala ndi mantha, kukhumudwa komaso kukwiya mwansanga.
- Kulota maloto oopsa omwe angampangitse kukhala ndi mantha aakulu.
- Kukhala ndi malingaliro oti anthu akufuna kumupanga chiwembu. Kumva phokoso kapena mau pamene palibe amene akuyankhula kapena kupanga phokosolo.
- Kuona anthu kapena zinthu zomwe palibepo.

Kodi chimayambitsa matenda obaizika ndi chani?

Matenda omwe ali kale mthupi, ma opaleshoni komanso mankhwala zingapangitse munthu Deliriyamu. Nthawi zambiri zomwe zimayambitsa ndi: matenda a muchikhodzodzo kapena mchifuwa, kutentha kwa thupi, Malungo, kuchepa kwa madzi mthupi, kuchepa kwa michele mthupi, kuchepa kwa magazi, kusiya mowa kapena mankhwala mosayembekezeleka, ma opaleshoni akuluakulu, khunyu, kuvulala kapena matenda amu ubongo, matenda a kayakaya, kusapita kuchimbudzi, mavuto odza ndi mankhwala monga ochepetsa ululu, vuto la impso komanso la chiwindi.

Kodi ndingapeze bwanji thandizo lokhudzana ndi matendawa?

Ngati munthu wabaizika ayenera kumutengera kuchipatala mwamsanga. Matenda omwe ayambitsa kubaizika akangopezekeka, ayenera kulandira thandizo la nthendayo. Mwachisanzo, matenda a mchikhodzodzo ayenera kupasidwa mankhwala ake (antibiotics).

Ndondomeko zophweka zoti tiitsatile pothandiza muthu yemwe wabaizika kuti asakhale pa chiopsezo komanso asakhale onthuthumira. Ndondomekozi ndi izi:

- Mlóngosoleleni munthuyo chomwe chachitika, komanso ndichifukwa chani wabaizika.
- Alimbikitseni kuti sali pa chiopsezo.

- Athandizeni kudziwa nthawi komanso malo omwe iwo ali.
- Ikani zinthu zomwe amaziona pafupipafupi kunyumba kwao pambali pawo
- Limbikitsani kuti abale ndi azinzawo adzizawaona
- Ngati amagwiritsa ntchito magalasi poona kapena zida zothanzira kumva, onenetsetsani ku zili ndi munthu wina pafupi komanso zikugwira bwino ntchito yake.

Mankhwala

Anthu ena amatha kusakhazikika ndi vutoli ndipo mankhwala angathe kuwathandiza kuwakhazikitsa mtima pansi. Mankhwala ogonetsa angathe kuthandiza angakhale angathenso kupititsa patsogolo vuto la Deliriyamu. Koteru ayenera kupasidwa kwa odwala ngati wodwalayo:

- wasanduka chiopsezo kwa moyo wake kapena kwa miyoyo ya anthu ena
- wavutika kwambiri moti sakukhazikika kapenanso akunthunthumira
- akuganiza kuti anthu ena akufuna kumupanga chiwembu
- akuona kapena kumva zinthu zimene palibepo-mankhwala othana ndi matenda a misala omwe ali a mlingo wochepelepo atha kuthandiza
- mpofunika kukhazikitsa mtima pansi ndi cholinga choti matenda omwe ayambitsa vutolo afufuzidwe komanso kuthandizidwa
- ngati ndi munthu woti amamwa mowa kwambiri ndiye wangosiya mwadzidzidzi-kuchepetsa kuti asagwe khunyu, ayenera kulandira mankhwala ogonetsa (benzodiazepine), namamuchepetsera mulingo wake pakamapita masiku angapo mbali inayi madokotala ndi anamwino akumuyang'anira bwino lomwe.

Mankhwala ali onse ogonetsa ayenera kupasidwa pa mlingo ochepetsetsa komanso kwa masiku ochepa

Malangizo kwa achibale, okonedwa komanso omuthangatila munthu odwalayo

Mutha kumuthandiza wodwalayo kuti mtima wake ukhale pansi komanso kupanga zinthu payekha ngati:

- inuyo mwakhazikitsa mtima wanu pansi
- mukulankhula naye mkanthawi kochepe, modekha komanso kuonetsetsa kuti akukumvetsetsani.
- Bwerenzani kuyankhula ngati nkofunikira
- Akumbutseni pa zomwe zikuchitika ndiponso mmene iwowo akupezerako
- Akumbutseni za nthawi ndi tsiku-ngati nkotheke aonetseteni wochi kapena kalendala
- Mvetserani kwa iwo ndipo apatseni chikhulupiliro
- Onetsetsani kuti magalasi awo komanso zomwe amagwiritsa ntchito pomvetsera mwapatsa ndipo zikugwira ntchito bwino lomwe
- Athandizeni kuti adye komanso amwe madzi
- Onetsetsani kuti munthu amene iwowo amamudziwa kwambiri ali pafupi nawo.
- Ngati ali kuchipatala, abweletsereni zinthu zimene amazionaona
- Onetsetsani kuti mwayatsa magetsi kapena nyali usiku onse ndicholinga choti akadzuka azindikire kumene ali.

Information on Dementia

What is Dementia?

Dementia is a general term used to describe a group of conditions which affect memory.

You find it harder to remember things and develop other problems with your thinking. These make it more difficult to cope with your day to day life.

These problems keep getting worse - or are 'progressive'. They are not a normal part of ageing.

What does dementia feel like?

There are many different types of dementia. They all involve loss of memory, but they also have other symptoms, which differ according to the cause. A dementia will often start off with memory problems, but a person with dementia can also find it hard to:

- plan and carry out day-to-day tasks
- communicate with others.

They may also have changes in their mood, ability to make decisions, or you may see changes in their personality.

As dementia is 'progressive', someone with dementia will become more dependent upon others to help them as time goes on.

What causes dementia?

Any of us can develop a dementia but it is not a natural or inevitable consequence of ageing. Some medical conditions that can make it more likely include:

- Parkinson's disease
- Strokes and heart disease
- High blood pressure and high cholesterol levels
- Type 2 diabetes mellitus.

It is important to try to treat and manage these risk factors, particularly high blood pressure and diabetes. It may also help, in the mid-life years, to manage any problems with hearing loss, obesity, social isolation and depression.

Genes also play a part in dementia but there is no test (yet) which can predict your personal risk. Lifestyle factors that can increase risk of various types of dementia include:

- smoking
- drinking more than the safe limit of alcohol - more than 14 units per week
- poor diet
- lack of physical activity
- being overweight
- repeated head injuries, eg in boxers.

As dementia is 'progressive', someone with dementia will become more dependent upon others to help them as time goes on.

How can I get help for dementia?

Simple practical steps

- Use a diary to help you remember appointments.
- Make lists of the things you have to do – and tick them off as you do them!
- Keep your mind active by reading or doing puzzles, learning new things and maintaining a sense of purpose in your life.
- Stay involved and connected – find your local bao group or other social activities which you enjoy.
- Eat a healthy diet and take physical exercise (it can help whatever your age).
- Get support if you are struggling with daily living or get advice if others feel you are finding things hard to manage. There are many ways in which family, friends and services can help you to live independently for as long as possible.

Medication

There are a group of drugs called acetylcholinesterase inhibitors that can slow down the progress of dementia a little, but they are not very effective and not available in Malawi yet.

Uthenga wokhudzana ndi matenda a Dimensha

Kodi matenda a dimensha ndi chani?

Dimensha ndi mawu omwe amagwiritsidwa ntchito pokamba za magulu a matenda okhudzana ndi kukumbukira zinthu.

Munthu odwala matendawa samatha kukumbukira zinthu bwinobwino ndiponso amakhala ndi mavuto mkaganizidwe. Kusakumbukira zinthu komanso mavuto ndi maganizidwewa amapangitsa kuti munthu asapilira ndi zinthu zimene amachita tsiku ndi tsiku.

Mavuto amenewa amanka nakula ndipo sikuti ndimbali yaukalamba.

Kodi zizindikiro za matenda a dimensha ndi chani?

Pali mitundu yambiri ya dimensha. Mitundu yonseyo imakhudzana ndi kakumbukilidwe/kuyiwala kwa zinthu, komanso ali ndi zizindikiro zina, zomwe zimasiyana malingana ndi chomwe chayambitsa matendawa. Dimensha nthawi zambiri imayamba ndi vuto lokumbukira zinthu, koma munthu amene ali ndi matendawa amavutikanso ku:

- Lingalira ndi kuchita zinthu zomwe amapanga tsiku ndi tsiku
- Kulumikizana ndi anthu ena.

Amathanso kusintha makhalidwe komanso kulephera kupanga zinthu payekha.

Chifukwa choti matenda a dimensha amanka nakula, munthu amene ali ndi vutoli amapitilira kudalira anthu ena kumuthandizira matsiku akamapita.

Chimayambitsa dimeshia ndichani?

Munthu wina aliyense angathe kudwala dimensha koma tiyenera kuzindikira kuti dimensha sinjira yomwe munthu aliyense amakalambirira. Matenda awa ndi amene nthawi zambiri amayambitsa dimensha:

- Matenda a manjenje (pakinisoni)
- Matenda ofa ziwalo komanso mavuto a mtima
- Matenda othamanga magazi (Bp) komanso okhala ndi Mafuta ambiri
- Matenda a shuga

Pachifukwachi, nkofunikira kwambiri kuthana ndi chiopsezo zimenezi makamaka kuthamanga kwa

magazi (BP) ndi matenda a shuga kuti tipewe dimensha. Zingathenso kuthandiza pamene munthu sunayambe kukalamba kuthana ndi mavuto monga akumva kunenepa kwambiri, kuzipatula komanso matenda okhumudwa.

Majini nawonso amathandizira kwambiri kudwala demesha angakhale nkosatheka kudziwilatu chiopsezo Kamba ka majini munthu ali nawo.

Makhalidwensho angathe kuika munthu pa chiopsezo chodwala matendewa. Makhalidwe amenewa ndi:

- Kusuta fodya
- Kumwa mowa mwauchidakwa
- Madyedwe osakhala bwino
- Kusapanga masewero olimbitsa thupi
- Kunenepa kwambiri
- Kuvulala kumutu kawirikawiri- osewera nk'honya

Chifukwa choti matenda a demesha amanka nakula, munthu amene ali ndi vutoli amapitilira kudalira anthu ena kumuthandizira masiku akamapita.

Ndingapeze bwanji thandizo la matendawa?

Njira za pafupi zoti mungathe kupanga

- Gwiritsani ntchito kabuku kuti kakuthandizeni kukumbukira zomwe mukufuna kupanga.
- Lembani mndandanda wa zinthu zomwe mutapange ndipo chongani zomwe mwapanga kale
- Onetsetsani kuti muli otanganidwa ndi zinthu monga kuwerenga kapena kupanga masewero olemba, kuphunzira zinthu za tsopano
- Lumikizani ndi anzanu ndipo muzitengapo gawo mzochitika
- Idyani chakudya chopatsa thanzi komanso pangani masewero olimbitsa thupi.
- Kalandileni thandizo ngati mukupeza mavuto osiyanasiyana ndi moyo wanu wa tsiku ndi tsiku komanso kalandileni uphungu ngati anthu ena akuona kuti mukulephera kukwanitsa kupanga zinthu. Pali njira zambiri zomwe abwenzi ndi achibale angathe kukuthandizani kuti mukhale moziyimila panokha

Mankwala

- Pali magulu a mankhwala otchedwa acetylcholinesterase inhibitors omwe amathandizira kuchepetsa kukula kwa matendawa koma sikuti amathandiza kwambiri komanso sapezeka kuno ku Malawi

Information on Depression

What is depression?

It is normal to feel sad or miserable sometimes. But if your mood stays low for weeks at a time, keeps returning, or interferes with your life, it could be a sign of depression.

Depression is not the same as being sad, and is not a sign of weakness or a character flaw. It is an illness, and can have a serious effect on a person's life and the lives of those around them. In severe cases it can make everyday life extremely difficult, and even lead to suicide.

What does depression feel like?

Depression affects everyone differently, but there are some common symptoms:

In the mind	In the body
Feeling sad or low for long periods of time Feeling hopeless or helpless Feelings of guilt Being anxious or worried a lot Feeling irritable Having no motivation or being unable to concentrate Losing interest in things that you normally enjoy Thoughts of suicide or hurting yourself In severe cases, a person with depression might experience symptoms of psychosis (e.g. hallucinations, such as hearing voices).	Feeling tired all the time / having no energy Losing interest in sex Changes in appetite - eating too much or too little Having trouble sleeping, or needing to sleep more than usual Moving or speaking more slowly than usual

What causes depression?

Research has found that changes in brain systems or the chemical balance of the brain may be at the root of depression. These changes can be triggered by stressful events in life, such as a bereavement, the breakdown of a relationship or losing your job. But for some people, the illness occurs for no apparent reason.

People with a family history of depression are more at risk of developing the illness, but not everyone in this situation will develop depression.

Some people are prone to suffering from depression at particular times in their lives. For example, some women may be particularly vulnerable to episodes of

depression in relation to childbirth. Depressive symptoms are also a part of bipolar disorder.

How can I get help for depression?

Lifestyle - Getting more exercise (even a 20- to 30-minute walk daily), eating healthily and sleeping well can all have a powerful effect on our moods. Avoid using alcohol or drugs to get through hard times. These can make symptoms worse and can interfere with any medication you may be taking.

Talk about it - Try a friend or relative who you trust and respect, and who is a good listener.

Self-help websites - Try *LivingLifeToTheFull* (littf.com) and *MoodGym* (moodgym.anu.edu.au) for more information.

Family and friends - It may be tempting to withdraw from social activities and stay at home. This will not help in the long run. It is important to stay engaged with other people and to try and keep doing the things you enjoy.

Medication - In moderate to severe cases, medication may be required. Many people find them effective, but they can have drawbacks. Some people experience unpleasant side effects, and they can take several weeks to work.

A combination of lifestyle changes, talking therapies and medication is often the most effective way to treat depression.

Tips for families, partners and carers

- One of the best ways to help a person with depression is to listen to their problems. This can help with tackling the root of their depression or just remind them that people do care about them.
- If someone you care about is depressed, encourage them to get help rather than dealing with it by themselves. Don't make them feel bad about taking medication or seeing a therapist.
- Telling someone with depression to 'snap out of it' or 'pull themselves together' is likely to make things worse. Remember that depression is not just being unhappy, it's an illness.
- Remember that people don't need to be depressed 'about' anything in particular. It can affect anyone, regardless of their situation.
- If someone you care about is depressed, it can help just to talk to them or spend time with them. It will make them feel cared about and help take their mind off their depression.
- People who are depressed can sometimes be irritable or difficult to deal with. Try to be patient with them.

Uthenga wa matenda okhumudwa

Kodi kukhumudwa ndichiyani?

Sichachilendo munthu kukhala ndi chisoni kapena kukwiya kumene, komanso kukumana ndi mavuto nthawi zina. Koma ngati mwakhumudwa kwa sabata, kapena mukukhumudwa pafupipafupi, kapena kukhumudwako kukukhudza moyo wanu wa tsiku ndi tsiku, zitha kutheka kuti muli ndi matenda okhumudwa.

Matenda okhumudwa sizitanthauza kuti munthu wakwiya komanso sikusonyeza kuti ndiwe munthu ofooka, kapena wakhalidwe loyipa. Kukhumudwa ndi matenda, komanso angathe kubweretsa mavuto aakulu kwa moyo wamunthu komanso omwe amuzungulira.

Kodi munthu amene wakhumudwa amamva bwanji?

Angakhale kuti matenda okhumudwa amakhuza anthu m'njira zosiyana siyana, koma pali zizindikiro zamatendawa zomwe zimapezeka kawirikawiri:

M'maganizo	M'thupi
kuzimva okwiya kapena odandaula kwa nthawi yayitali kusowa chiyembekezo kapena chikhulupiliro kuziona olakwa kunthunthumira komanso kudandaula kwambiri kusachedwa kupsa mtima kusowa chikhumbokhumbo chochita zinthu komanso kusakhazikika pochita zinthu kusowa chikhumbokhumbo chopanga zinthu zimene umakonda maganizo ofuna kuzipha kapena kuzivulaza kumene matendawa akakula kwambiri, munthu amatha kukhala ndi zizindikilo za matenda a misala monga kumva kapena kuona zinthu zomwe palibe.	Kumva kutopa nthawi zonse komanso kukhala opanda mphamvu Kusowa chidwi pa nkhani zogonana Kusintha mchilakolako cha madyedwe-kudya kwambiri kapena pang'ono Kusowa tulo, kapena kufuna kogona kwambiri mopyola muyeso Kuyenda kapena kulankhula pang'onpang'ono kusiyana ndimmene umachitira nthawi zonse.

Kodi chimayambitsa matenda okhumudwa ndichani?

Kafukufuku wapeza kuti kusintha kwa mmene ubongo umagwilira ntchito kapena kusokonekera kwa michele ya muubongo ndi zomwe zingathe kuyambitsa matenda okhumudwa. Kusintha kumeneku kungathe kuyamba chifukwa cha zikhomo za moyowu monga ngati, kuferedwa, kutha kwa mabanja, maubwenzi kapena ntchito. Koma kwa anthu ena matendawa amayamba popanda zifukwa zenizeni.

Anthu amene ku banja kwawo kuli anthu omwe anadwalapo matenda okhumudwa ali pachiopsezo chachikulu chodwala matendawa, komatu sikuti ndi aliyense amadwala.

Kwa anthu ena, nkwapafupi kudwala matenda okhumudwa m'nyengo zina za moyo wawo. Mwachitsanzo, azimayi ena amakhala pachiopsezo cha matenda nthawi uchembere. Zizindikiro za matenda a nkhwana ndimbali ina ya matenda a ma mkhalidwe kapena mamudi.

Kodi ndingapeze bwanji thandizo la matenda okhumudwa?

Makhalidwe - Kusintha m'makhalidwe ndi mbali imodzi ya thandizo yomwe munthu angathe kuyesa. Kupanga kwambiri masewero olimbitsa thupi (ngakhale kuyenda ndawala kwa mphindi 20 -30 tsiku lina lililonse), kudya zakudya zopatsa thanzi, komanso kugona bwino zingathe kupangitsa kuti munthu akhala bwino.

Kulankhula poyera - Yesani kumuza nzanu kapena wachibale amene mumamukhulupilira komanso kumpatsa ulemu ndipo amatha kumvetsera.

Masamba a intaneti odzithandizira wekha - Yesani *LivingLifeToTheFull (littf.com)* komanso *MoodGym (moodgym.anu.edu.au)* kuti mudziwe dzambiri

Achibale ndi Anansi - Munthu amayesedwa kudzipatula ndikukakhala kunyumba yekhayekha. Zimenezi sizingatithandize. Nkofunikira kwambiri kumatanganidwa ndi anthu ena kuti tipilize kupanga zinthu zimene umasangalala nazo.

Mankhwala - Matenda akakula kapena kukulitsitsa, mankhwala ndi ofunika. Anthu ambiri akamwa mankhwala amakhala bwino ngakhale nthawi zina mankhwala alonso ndizoofooka. Mankhwala angabweretse mavuto komanso angathe kutenga masabata angapo asanayambe kugwira ntchito.

Pewani kumwa mowa kapena kugwiritsa ntchito mankhwala ozunguza ubongo ndicholinga choti mukhadzikitse mtima pansu ngati muli ndi mantha. Izizi zingathe kupangitsa kuti zizindikiro zamatendawa zipite patsogolo komanso zingathe kudzetsa mavuto ndi mankhwala amene mwalandira kuchipatala.

Kusintha makhalidwe a tsiku ndi tsiku, kulandira thandizo komanso kumwa mankhwala ndi zomwe zimathandiza kwambiri kuthana ndi matenda okhumudwa.

Malangizo kwa achibale, okonedwa komanso anthu amene amathandizira anthu odwala matendawa.

- Imodzi mwanjira yabwino kwambiri yithandizira munthu yemwe ali ndi matenda okhumudwa ndi kumvetsera mavuto ake. Izizi zingathandize kuthana ndi chomwe chayambitsa matendawo komanso kuwakumbutsa kuti alipo anthu amene amalabadira za moyo wawo.
- Ngati munthu amene mumamulabadira ndiwokhumudwa, mulimbikitseni kuti akalandire thandizo kusiyana ndi kuti vutolo athane nalo yekha. Musampangitse kuti azizimvera chisoni chifukwa chomwa mankhwala kapena akamakumana ndi adokotala.
- Kumuuza munthu yemwe ali ndi matenda okhumudwa kuti angochokamoto mmavutowo zimakulitsa vutolo. Kumbukirani kuti kukhumudwa sikusasangalala kokha koma ndi matenda.
- Kumbukirani kuti anthu safunika kukhumudwa chifukwa cha china chake koma muthu wina aliyense angathe kukhumudwa angakhale palibe china chilichonse.

Information on Epilepsy

What is epilepsy?

A seizure or 'fit' is an episode of symptoms caused by a burst of abnormal electrical activity in the brain that usually lasts from a few seconds to a few minutes. Repeated seizures means that you have epilepsy.

What does epilepsy feel like?

The severity of a seizure can vary greatly; from spells of absence (staring into space with no movement) to loss of consciousness and violent convulsions. The type of seizure a person has depends on the underlying cause of the seizure.

In a **convulsive seizure** the whole brain is affected and the person having the seizure becomes unconscious. They may also:

- Fall to the floor
- Bite their tongue
- Become stiff and shake
- Their eyeballs may roll upwards
- Froth at the mouth
- Lose control of their bladder / bowels
- Their lips may turn blue

In a **non-convulsive seizure**, the person may be awake but confused or lose touch with their surroundings and may experience the following:

- Jerky movements in one part of their body (e.g. their arm or leg)
- Their lips may smack together repeatedly
- They may stare into space and appear as if they are in a trance (absence seizure)
- Many persons experience a warning or 'aura' that the seizure is about to start, such as hearing, seeing or smelling things which are unusual.

What causes epilepsy?

In many cases, no cause for the seizures can be found. The abnormal bursts of electrical activity in the brain occur for no known reason.

However, any damage to the brain has the potential to cause seizures. Damage is commonly from head injuries (an accident, during childbirth) or infections (HIV, malaria). There is often a family history or genetic component. It is **not** caused by spirits or witchcraft!

How can I get help for epilepsy?

Simple practical steps

- People with epilepsy should not take baths or swim alone or cook over an open fire alone in case they harm themselves.
- People with epilepsy should not drive or operate heavy machinery in case they harm themselves and others

Take steps to avoid your triggers for seizures. Triggers typically include:

- Stress and anxiety
- Lack of sleep
- Heavy alcohol intake or using street drugs
- Flickering lights such as from video games
- Irregular meals which may cause low blood sugar levels

Medication

Epilepsy cannot be cured with medication. However, with the right type and strength of medication, the majority of people with epilepsy do not have seizures.

You need to take medication **every day** to prevent seizures.

Treatment should never be stopped suddenly due to risk of prolonged seizure and maybe death. A trial without medication may be an option if you have not had any seizures over 2-3 years.

If a decision to stop treatment is made, a gradual reduction of the dose of medication is usually advised over several months. You should never stop taking medication without discussing it with a doctor.

Uthenga wokhudzana ndi matenda a Khunyu

Kodi matenda a khunyu ndi chani?

Kugwa chifufu ndi chizindikiro choti muubongomu katumizilidwe ka mauthenga sikakuyenda bwino. Zimenezi zimatenga kanthawi pang'ono (mphindi zochepe chabe). Ngati munthu akugwa chifufu pafupi pafupi, zimatanthauza kuti ali ndimatenda a khunyu.

Kodi matenda a khunyu amakhala bwanji?

Kukula kwa chifufu kungathe kusiyana kwambiri; wodwala ena simungawazindikire kuti akugwa chifufu pamene ena amatha kukomoka kumene kapenanso kumagwa ndi mphamvu. Koteru mtundu wa chifufu umene munthu ali nawo umatengera ndi chomwe chimayambitsa kugwa chifufu.

Munthu akamagwa chifufu ndi kukomoka, ubongo onse umakhala utakhudzidwa. Munthuyo angathenso:

- Kugwa pansi
- Kudziluma lilime
- Kuuma thupi komanso kumazigwededza kwambiri
- Kuyang'anitsa maso ake mmwamba
- Kutulukwa thovu kukamwa
- Kukodzedwa kapena kubibidwa kumene
- Milomo yawo kusintha mtundu.

Munthu yemwe amagwa mosazionetsera, amatha kukhala maso koma amangosokonekera zochitika komanso sadziwa kuti akuchita chani. Ndipo angathe kuonetsa zinthu izi:

- Kunjenjemera kwa mbali imodzi ya thupi lawo (monga mwendo kapena mkono)
- Milomo kumagundana mwapafupipafupi kwambiri
- Kuyang'anitsitsa malo amodzimidzi
- Ambiri amakhala ndi chenjezo loti agwa chifufu posachedwa (ngati kumva, kuona kapena kununkhidza zinthu zodabwitsa) choti chifufu chiyamba.

Kodi chimayambitsa matenda a khunyu ndi chani?

Chenicheni chomwe chimayambitsa matendawa nthawi zambiri sichimadziwika. Kusonekera kwa mauthenga mu ubongo kumatha kuchitika popanda chifukwa china chilichonse.

Komabe, kuvulala kwina kulikonse kwa muubongo kuli ndi kuthekera koyambitsa kugwa chifufu.

Kuvulala kumeneku nthawi zambiri kumapangika munthu akavulala kumutu (Ngozi, nthawi yobadwa) kapena matenda (HIV, Malungo). Komanso nthawi zambiri pamakhala mbiri kuchokera kwa makolo kapena achibale. Tiyenera kudzindikira kuti matenda a khunyu sayambitsidwa ndi mizimu komanso ufiti!

Thandizo ndingalipeze bwanji la matenda a khunyu?

Njira za pafupi ndi izi

- Anthu amene amadwala matenda a khunyu asamamasambe kapena kukasambira mumtsinje okha okha kapenanso kuphika pamoto kuopa kuti angadzipweteke okha.
- Anthu amene amadwala matenda a khunyu asamayendetse galimoto kapena kuyendetse makina kuopesa kuti angadzivulaze okha kapenso kuvulaza anthu ena.

Tenganipo gawo polpewa zinthu zomwe zimayambitsa kugwa chifufu. Zinthu ngati:

- Nkhawa komanso mantha
- Kusagona
- Kumwa mowa mwauchidakwa kapena kugwiritsa ntchito mankhwala ozunguza bongo
- Magetsi othwanima thwanima
- Kusakhala ndi nthawi yokhazikika yodyera chakudya zomwe zimapangitsa kuti shuga achepe mthupi

Mankhwala

Palibe mankhwala ochiza Matenda a khunyu. Komano ndi mlingo komanso mankhwala woyenera anthu ambiri amene amadwala matenda a khunyu sagwa chifufu. Mankhwala amateteza kuti munthu asamagwe chifufu.

Muyenera kumwa mankhwala tsiku ndi tsiku kuti mupewe kugwa chifufu.

Musasiye kapena kuchepesa mankhwala mwazizizi kuopetsa kugwa mowirikiza kapena kumwalira kumene.

Adokotala angathe kuyesa kukusiyitsa mankhwala ngati mwakhala wosagwa chifufu pakati pa dzaka ziwiri ndi zitatu.

Ngati chisankho chosiya mankhwala chapangidwa, mulingo wa mankhwala uyenera kumachepetsedwa pang'onopang'ono kwa miyezi ingapo. Musasiye kumwa mankhwala panokha popanda kuudzidwa ndi a dokotala.

Information on Psychosis

What is psychosis?

Psychosis (also called a 'psychotic experience' or 'psychotic episode') is when you perceive or interpret reality in a very different way from people around you. You might be said to 'lose touch' with reality.

Psychosis affects people in different ways. You might experience it once, have short episodes throughout your life, or live with it most of the time (e.g. schizophrenia).

Psychotic disorders are conditions with at least two of the following symptoms:

- hallucinations (usually hearing voices)
- delusions (strongly-held, false beliefs, not shared by others in the person's culture)
- disorganised behaviour and/or speech (agitation, hyperactivity / inactivity, incoherent / irrelevant speech, signs of self-neglect)

What does psychosis feel like?

Some people have positive experiences of psychosis. For example, if you see the faces of loved ones or hear their voices you may find this comforting. Some people say it helps them understand the world or makes them more creative.

However, for other people psychosis can be a very difficult or frightening experience. You may find that it:

- affects your behaviour or disrupts your life
- makes you feel very tired or overwhelmed
- makes you feel anxious, scared, threatened or confused
- leaves you finding it very difficult to trust some organisations or people.

It can also be upsetting if people around you dismiss your experiences as untrue when they seem very real to you. You may feel misunderstood and frustrated if other people don't understand. It might help to share our section for friends and family with them.

There are a lot of misunderstandings about what it means to experience psychosis. Lots of people wrongly think that the word 'psychotic' means 'dangerous'. The media often shows people with psychosis behaving like this even though very few people who experience psychosis ever hurt anyone else.

What causes psychosis?

The cause of long-lasting psychotic disorders like schizophrenia is not fully understood but includes genetic factors, early childhood adversity and stressful environmental factors.

Delirium, dementia, severe depression, and drug-induced psychosis are all common causes of psychosis and the treatment is different for all of these conditions.

How can I get help for psychosis?

Many people with schizophrenia now never have to go into hospital and are able to settle down, work and have lasting relationships.

How to Help Myself

It's important to keep taking your medication unless your doctor advises otherwise. This is true even if you feel well, as the medicine dampens down the symptoms. Stopping the medicine can lead to symptoms returning. Stopping suddenly can have other negative effects too, depending on your specific treatment.

If you have any worries about your medication or its side effects, speak to your doctor. There are usually ways of managing side effects, but if not then other tablets may be available.

Talk to other people with experience of schizophrenia. It can help to know you're not the only one, and they might be able to offer advice on managing the condition.

Try to stay as physically healthy as possible - eating healthily, exercising and getting enough sleep are also good for keeping mentally well. Some medications can cause weight gain as a side effect, so keep an eye on your weight after starting a new treatment - the team looking after you should do this too.

Symptoms vary a lot between different people. Learn to recognise what happens when you become unwell and be aware of the warning signs. This should be a part of your care plan and it can be useful to share these details with your family.

Uthenga wokhuzana ndi matenda a misala (psychosis)

Kodi misala (psychosis) ndi chani?

Misala (psychosis) ndi matenda omwe amapangitsa munthu kuganiza kapena kuona zinthu mosiyana kwambiri ndi anthu ena. Anthu amanena kuti munthu yemwe wadwala matenda a misala (psychosis) sakuganizanso ngati mmene umayenera kuganizira.

Matenda a misala (psychosis) amakhudza anthu m'njira zosiyanasiyana. Munthu angathe kudwala kamodzi, kapena kangapo ndithu mmoyo wake, kapena kukhala ndi matendawa moyo wake wonse (monga matenda a misala (psychosis) wotchedwa kuti schizophrenia) kumene.

Matenda a misala (psychosis) amakhala ndi zizindikiro zosachepelela ziwiri mwa izi:

- Kumva, kuona, kununkhiza zinthu zoti palibe (nthawi zambiri kumakhala kumva mau)
- Zikhulupililo zabodza anngkhale mchikhalidwe chamunthuyo
- Mkhaliidwe osokonekera ndinso kapena mayankhulidwe osokonekera

Kodi matenda a misala (psychosis) amamveka bwanji?

Kwa anthu ena, matenda a misala (psychosis) amawachitira ubwino. Mwachitsanzo ngati munthu akuona nkhope za anthu amene amawakonda kapenanso kumva mawu awo, zimatha kuwakhazika mtima pansu. Anthu ena amati zimawathandiza kumvetsetsa m'mene dziko lilili kapena kuwapangisa kuti akhale ndi danga lomapanga maluso osiyasiyana.

Kwa anthu ena, matenda a misala (psychosis) amabweretsa nyengo yovutitsitsa kapena yoopsa m'moyo mwawo. Matendawa:

- Amakhudza mkhalidwe komanso kusokoneza moyo wa munthu odwalayo kumene
- Amapangitsa munthu kutopa kwambiri
- Amabweretsa mantha, kunjenjemera komanso kusokonekera kumene
- Amapangisa munthu kusakhulupilira anthu kapena mabungwe.

Zingathenso kukhala zopweteka ngati achibale komanso abwenzi akumatsutsa zomwe zikukuchitikira kumaona ngati nkhamba kamwa pamene kwa iweyo ndizenizeni. Wodwala amatha kuona kuti anthu sakumakumvetsetsa ndipo atha kukhala okhudzidwa ngati anthu ena sakumumvetseta.

Pali kusamvetsetsana kwambiri pakati pa munthu yemwe akudwala matenda a misala (psychosis) ndi anthu ena. Anthu ambiri amakhulupilira kuti misala (psychosis) ndi chinthu choopsa kapena kuti nkhondo. Mauthenga kapena

masamba a pa intaneti amakonda kupereka chinthuzithunzi choti matenda a misala (psychosis) ndi nkhondo pamene ndi anthu ochepa chabe omwe amatha kuvulaza anzawo akadwala matenda amisala (psychosis).

Kodi chimayambitsa matenda amisala (psychosis) ndi chani?

Chimene chimayambitsa matenda a misala (psychosis) okhazikika monga a schizophrenia sichimamvetsetseka kwenikweni. Chilengedwe, zokhoma zomwe timakumana nazo kuubwana, komanso zipsinjo mmoyoyu ndi zina mwa zomwe zimatha kuyambitsa matendawa.

Matenda obaizika, matenda am'mutu obwera munthawi yaukalamba, matenda okhumudwa kwambiri, komanso mankhwala ozunguza ubongo ndi zinthu zomwe zimayambitsa misala (psychosis) nthawi zambiri. Thandizo la matenda a misala (psychosis) yoyambitsidwa ndi zinthu izi limakhalanso losiyana.

Kodi thandizo la matenda a misala (psychosis) ndingalipeze bwanji?

Anthu ambiri omwe amadwala matenda a misala (psychosis) ya mgonagona (schizophrenia) samafunikira kugonekedwa kuchipitala ndipo amakhala bwinobwino namagwiranso ntchito zawo ndiponso mmabanja awo.

Ndingadzithandize bwanji ngati ndili ndi matendawa

Nzofunikira kwambiri kupitiliza kumwa mankhwala omwe anakulembelani kuchipatala pokhapokha adokotala anu anena kuti simukuyenera kutero. Izizi n'zoona angakhale mukuziona kapena kudzimva kuti muli bwinobwino. Muli bwino Kamba ka mankhwala omwe azilizitsa matendawa. Kusiya mankhwala kungathe kupangitsa kuti zizindikiro za matendawa zibwerenso. Kungosiya mwazizizi kungabweretsenso mavuto ena malingana ndi mankhwala omwe mukumwa.

Ngati muli ndi madandaulo okhudzana ndi mankhwala anu, kapena mavuto omwe mankhwalawa akubweretsa, afotozozereni adokotala anu. Zilipo njira zothana ndi mavuto obwera Kamba ka mankhwala ndiponso adokotala angathe kusintha mankhwalawo. Chezani ndi anthu omwe anadwalapo matenda a misala (psychosis). Ndizothandiza kuzindira kuti sindinu nokha amene mwadwalapo matendawa ndipo anthu ena angathe kukupatsani malangizo a momwe mungazithandizire.

Zizindikiro zamatendawa zimasiyana malingana ndi munthu. Yesesani kuzindikira kapena kudziwa zomwe zimachitika ngati kuti mwadwala ndicholinga choti muziwe matendawa akamabwera. Izi ziyenera kukhala gawo la mmene mumadzitsamalira ndipo adziwitseni achibale.

Information on Post-Traumatic Stress Disorder

What is Post-traumatic Stress Disorder (PTSD)?

PTSD is the name given to a set of symptoms that some people develop after experiencing major traumatic events. The traumatic event can be a single incident or take place over many months or years.

Many people think of PTSD as something that affects people who have had traumatic experiences while serving in the military, but it can affect anyone who has experienced a traumatic situation.

What does PTSD feel like?

Many people feel grief-stricken, depressed, anxious, guilty and angry after a traumatic experience.

PTSD sufferers often experience repeated and intrusive distressing memories of the event. There may also be a feeling of reliving (or 're-experiencing') the event through 'flashbacks' or 'nightmares', which can be very distressing and disorientating. There can also be physical reactions such as shaking and sweating.

Because these memories can be very intense and upsetting, some PTSD sufferers may avoid people or situations that remind them of the trauma, or try to ignore the memories and avoid talking about what happened.

They may also feel anxious or irritable, and find it difficult to concentrate and sleep. Increased jumpiness and vigilance can also be present. For some people it can mean that doing ordinary things like going to work or school or going out with friends become very difficult.

What causes PTSD?

Any traumatic event such as serious traffic accidents, rape or sexual abuse, domestic violence, physical assault, traumatic childbirth, witnessing a violent death or virtually any other situation that is exceptionally threatening or catastrophic and likely to cause distress in almost anyone. The symptoms of PTSD can start immediately or after a delay of weeks or months, but usually within 6 months of the traumatic event. The symptoms last for over one month.

Tips for people with PTSD

Give yourself time and space to acknowledge what you have been through, and that you are having strong emotional reactions to it.

Avoid being self-critical about the problems that you are having. Many people experience similar problems, and it is not a sign of weakness.

You may be tempted to withdraw from social activities and your loved ones, but it's important to stay involved with the people who care about you. Support from other people is vital to your recovery from PTSD.

Avoid using alcohol and drugs to make you feel better. Although these may make you feel better in the short term, it can cause serious problems for you and your loved ones. They can also worsen symptoms and interfere with treatment.

Try to be healthy. Do what you can to eat a balanced diet and get some regular exercise – even if it's just going for a walk. Stick to normal routines as much as possible. If you have problems with sleep try to keep to a regular time when you wake and get up, and avoid caffeinated drinks after 4pm.

Set yourself small daily goals and challenges to confront the things that you avoid.

Remember the strengths that you have. It's important to remind yourself that you have strengths and coping skills that can get you through tough times.

Don't be afraid to seek help. Discuss your problems with someone that you can trust. Make an appointment to see a healthcare worker. There are a range of treatments that may be able to help you.

Tips for families, partners and carers

- Try to be patient and understanding with the person with PTSD.
- Avoid being critical of how the person is coping. Remember that they have been through some extremely distressing experiences.
- Try not to take symptoms like emotional numbness, anger, and withdrawal personally. If the person with PTSD seems distant, irritable, or closed off, remember that this may not have anything to do with you or your relationship.
- Don't put pressure on the person with PTSD to talk about their experience, but do allow them time and space to talk about it if they want to.
- People with PTSD sometimes feel hopeless or ashamed of how they are coping. Try to help the person to recognise their strengths and positive qualities.
- Try to encourage the sufferer to establish normal routines; this helps to restore a sense of order and control in their life. Help them to start with small daily goals and to recognise each success.
- If they haven't done so, try to encourage them to seek professional help. A good place to start is discussing things with your healthcare worker.

Uthenga okhudzana ndi matenda a nkhwawa yobwera Kamba ka chipsyinjo pa moyo

Kodi matenda a nkhwawa yobwera Kamba ka chipsyinjo pa moyo (Post-traumatic Stress Disorder) ndi chani?

Nkhawa yobwera Kamba ka chipsyinjo pa moyo ndi matenda omwe amonetsa zizindikro zingapo zomwe anthu ena amakhala nazo akakumana ndi zipsinjo zazikulu mmoyo wawo. Chipsinjo chachikulu chitha kubwera pakamodzi kapena kutenga miyezi kapenanso zaka zambiri zipsinjo zikuchitikabe.

Anthu ambiri amaganiza kuti matendawa amagwira anthu omwe anakumana ndi zipsinjo nthawi yankhondo basi, koma tiyenera kudzikira kuti matendawa angathe kugwira munthu wina aliyense amene anakumana ndi zipsinjo zazikulu mmoyo wake.

Kodi zizindikiro za matendawa ndichani?

Anthu ambiri amakhala ndi chisoni chachikulu, amakhumudwa, amakhala ndi nkhwawa, kudzionga ochimwa komanso nkwiyo akadutsa mchipsinjo chachikulu.

Anthu odwala matendawa nthawi zambiriri amakhala akukumbukira mwapafupipafupi zipsinjo za moyo zomwe zinawachitikira. Zipsinjo zimakhalanso ngati zikuwachitikiranso kudzera mukukumbukira kwaoko, komanso amakhala ndi maloto oopsa nthawi zambiri. Zinthu zimene zingathe kukhala zinthu zovuta kwambiri akamakhala tsiku ndi tsiku ndipo zotsatila zake thupinso limaonetsa zizindikiro monga kunjenjemera ndikutuluka thukuta chifukwa cha mantha.

Chifukwa choti munthu amakumbukira pafupipafupi komanso, anthu ena omwe amadwala matendawa safuna kuonana ndi anthu kapena zinthu zimene zimawakumbutsa zipsinjo anakumana nazo ndiponso amayesesa kusalabadira zomwe akukumbukirazo komanso kusalankhula zomwe zinachitikazo.

Anthuwa amathanso kukhala ndi mantha, kukwiya pafupipafupi, kusakhazikiza mmaganizo mwawo komanso kusagona. Nthawi zina amangolumphalumpha kulephera kukhazikika. Kwa anthu enanso, zimakhalanso zovuta kuchita zinthu zomwe amapanga tsiku ndi tsiku monga kupita ku sukulu, kutchito, kapenanso kucheza ndi anzinzawo kumene.

Kodi chimayambitsa matendawa ndichiyani?

Chipsinjo chili chonse monga Ngozi za pamsewu, kugwilidwa kapena kupangidwa chipongwe, nkhanza za m'banja, kumenyedwa, kubereka movutikira, kuonelera imfa yopweteka, kapena china chilichonse chomwe ndi choopsa choti munthu wina aliyense angathe kuopa.

Zizindikiro za matendawa zingathe kuyamba pompopompo kapena pakapita nthawi monga masabata kapena miyezi imene koma pasathe miyezi isanu ndi umodzi. Koma zizindikiro zimapyola mwezi watuthu.

Zothandiza kwa athu amene ali ndi matendawa

Munthu uyenera kudzipatsa mpata ndi nthawi kuvomereza zomwe unadutsamozo ndipo kuti ndiwe okhudzidwa kwambiri ndi zinthuzo. Nkofunika kupewa kumalingalira kwambiri pa zomwe ukudutsamo. Zindikirani kuti zinthu zimenezi zimachitikira anthu ambiri ndipo sizitanthauza kuti ndinu ofooka.

Mwina munayesapo kusiya kumasonkhana ndi kumapangira limodzi zinthu ndi anthu ena kapenanso okondedwa anu ndikumakhala panokha, koma zindikirani kuti nkofunika kwambiri kumakhalabe pamodzi ndikumachita zinthu limodzi ndi anthu amene amakulabadirani. Thandizo lochokera kwa anthu ena ndilofunika kwambiri kuti muthane ndi matendawa.

Pewani kumwa mowa kapena kugwiritsa ntchito mankhwala ozunguza ubongo ndicholinga choti mukhale bwino. Angakhale zinthuzi zingathe kukupangitsani kukhala ngati muli bwino, zingathenso kubweresa mavuto aakulu kwa inuyo komanso okondedwa anu. Mankhwala ozunguza ubongo ndi mowa zingathe kupangisa zizindikiro za matendawa kukula kwambiri komanso kulimbana ndi mankhwala amene mukumwa. Yesesani kukhala ndi thanzi labwino. Yesesani kudya zakudya zakasinthasintha komanso kupanga masewero olimbitsa thupi, angakhale kumakangoyenda.

limbikirani kupanga zinthu zimene mumapanga tsiku ndi tsiku. Ngati pali vuto ndi tulo yesesani kukhala ndi nthawi imodzi yodzikira komanso pewani kumwa khofi nthawi yikakwana folo koloko madzulo.

Pangani ndondomeko zoti mudzikwaniritsa tsiku ndi tsiku komanso limbikirani kusapanga zinthu zomwe simukufuna kupanga.

Kumbukirani mphamvu zopanga zabwino zomwe muli nazo. Nkofunikira kudzikumbutsa kuti muli ndikuthokera komanso kupilira zomwe zingakupangitseni kudutsamo mu nyengo zowawitsa.

Osaopa kukafuna thandizo. Kambalanani mavuto anu ndi munthu amene inuyo mumamukhulupilira. Pitani kuchipatala kuti mukaonane ndi a dokotala anu chifukwa lilipo thandizo loti mungathe kulandira.

Malangizo kwa achibale, okondedwa komanso anthu amene amathandizira anthu odwala matendawa.

- Yesetsani kukhala odekha komanso omuvetsetsa munthu amene akudwala matendawa
- Pewani kufufuza kwambiri kuti mudziwe kuti odwalayo akupilira bwanji ku mavuto ake.
- Yesesani kusatenga zizindikiro za matendawa ngati munthu akuchira dala, kuti ndi ukali, kapena kuti ali ndi mkhalidwe odzipatula. Ngati wodwalayo akukwiya pafupipafupi, akudipatula, kumbukirani kuti zimenezi sizikukhudzana ndi ubale opakati pa inu ndi odwalayo.
- Osamukakamiza wodwalayo kuti akuuzeni zomwe zikumuchitikira, koma lorani kuti akuuzeni kuchoka ku mtima kwawo komanso pa nthawi yawo.
- Nthawi zambiri anthu omwe ali ndi matendawa amakhala opanda chiyembekezo komanso amakhala ndi manyazi ndi mmene akupilira ku matendawa. Yesetsani kumuthandiza munthuyo kuzindikira upangili omwe ali nawo kuthana ndi vutolo.
- Alimbikitseni odwalawo kukwanilitsa kupanga zinthu zomwe amapanga tsiku ndi tsiku. Idzi zimathandizira kubwedzeretsa umoyo wawo wangwiro. Athandizireni kuyamba pang'onopang'ono ndiponso kuzindikira zonse zomwe iwowo akuchita bwino.
- Ngati sakutha kupanga bwino, alimbikitseni kuti apite kuchipatala kuti akakumane ndi adokotala

Information on Self-harm

What is self-harm?

Self-harm is when someone intentionally damages or injures their body.

There are many different ways people can intentionally harm themselves, such as cutting or burning their skin, punching or hitting themselves and poisoning themselves with tablets or toxic chemicals.

What does self-harm feel like?

Self-harm can help you to feel in control, and reduce uncomfortable feelings of tension and distress. If you feel guilty, it can be a way of punishing yourself and relieving your guilt. Either way, it can become a 'quick fix' for feeling bad.

What causes self-harm?

In most cases, people who self-harm do it to help them cope with overwhelming emotional issues, which may be caused by:

- Social problems - such as being bullied, having difficulties at work or school, coming to terms with their sexuality, debt or unemployment
- Trauma - such as physical or sexual abuse, the death of a close family member or friend, or having a miscarriage
- Psychological problems - such as low self-esteem, having repeated thoughts or voices telling them to self-harm, disassociating (losing touch with who they are and with their surroundings), or borderline personality disorder.

How can I get help for self-harm?

Identify triggers - Self-harm is often a way of dealing with emotional pain, so it is worth trying to identify what feelings make you want to hurt yourself. Once you are aware of your triggers you can take positive steps to reduce or stop the urge to self-harm.

Distract yourself - Distract from the urge to self-harm. Once you know your triggers, you can try and express your feelings in other ways. For example, hitting a pillow can help cope with anger, or having a cold shower can help you stop feeling numb.

Safety plan - Write a 'safety plan' for yourself. This could include details on what you can do for yourself, and who you can speak to if you need support. It can help to have something written down, and it is more likely to work because you choose the kind of support you feel most comfortable with.

Lifestyle - Look after your physical health as well as your mental health. Getting enough sleep, eating healthily and exercising regularly can help you feel more positive.

Talk - Ask for help and support. You don't have to cope with all of your problems alone. It is important to find support. If you're under 18 speak to adult you can talk to and trust.

Groups - Talk to other people who have had thoughts of self-harm. Their knowledge and experience can be helpful. Organisations such as MeHUCA (<https://www.medcol.mw/mehuca/>) can help you to do this.

Tips for families, partners and carers

People often try to keep self-harm secret because of shame or fear of discovery. It's often close family and friends who first notice when somebody is self-harming, and approaching the subject with care and understanding is very important.

If you think a friend or relative is self-harming, look out for any of the following signs:

- Unexplained cuts, bruises or burns, usually on their arms, wrists, thighs and chest.
- Keeping themselves fully covered at all times, even in hot weather.
- Signs of depression, like low mood, tearfulness or a lack of motivation or interest in anything.
- Self-loathing and expressing a wish to punish themselves.
- Not wanting to go on and wishing to end it all.
- Becoming very withdrawn and not speaking to others.
- Signs of low self-esteem, like blaming themselves for any problems or thinking they're not good enough for something.
- Signs they have been pulling out their hair.

They may also have problems with drugs or alcohol, or have issues with eating. People who self-harm can seriously hurt themselves, so it is important to try to encourage them to speak to a healthcare worker about the underlying issue.

Talk to others who care for people who self-harm. They may have experienced similar situations and have useful tips. Organisations such as MeHUCA (<https://www.medcol.mw/mehuca/>) can help you to do this.

Uthenga okhudzana ndi kudzivulaza

Kodi kudzivulaza ndichani?

Kudzivulaza ndipamene munthu mwadala akudzivulaza kapena kudzipweteka thupi lake.

Pali njira zambiri zimene anthu angathe kugwiritsa ntchito ndicholinga choti adzivulaze. Zina mwanjirazi ndi monga: kuzicheka kapena kuziotcha khungu, kuzibaya kapena kudzimenya komanso kumwa mankhwala oopsya (poizoni).

Kodi zizindikiro za matendawa ndichani?

Kuzivulaza kungapangitse munthu kuzikhulupilira, komanso kuchepetsa kusamva bwino mmaganizo makamaka munthu ngati ali ndi zipsyinjio. Ngati munthu akudzivera chisoni, kuzivulaza ndi njira imodzi yomwe anthu amagwiritsa ntchito pofuna kudzilanga komanso pofuna kuthetsa kuzimvera chisoniko. Munjira zonsezi, kuzivulaza kungathe kukhala ngati kukonza zinthu msangamsanga chifukwa chodzimvera chisoni.

Kodi chimapangitsa kudzivulaza mwadala ndichani?

Nthawi zambiri anthu amene amazivulaza mwadala amatero ndicholinga choti adzithandize kumva bwino akamadutsa munyengo zowawitsa m'maganizo monga:

- Mavuto okumana nawo munthu akamakhala ndi anthu ena- monga kunyozedwa, mavuto a kuntchito kapena kusukulu, ngongole, kukhala pa ulova komanso kusintha kwathupi mnyamata kapena mtsikana akamakula.
- Kuzunguzika kapena kuvulazidwa- mwachitsanzo kuvulazidwa thupi kapenanso kugwilidwa. Imfa ya abwenzi kapena wachibale angakhale mwan akapitilira (kutaya pakati).
- Mavuto a m'maganizo-monga kusadzikhulupilira, kumva mau a munthu oti palibe kapena kukhala ndi maganizo ozivulaza mwakawirikawiri, kudzipatula (ndi anthu ena omwe munthu amakhala nawo), komanso mkhalidwe wa munthu.

Kodi thandizo la vutoli ndingalipedze bwanji?

Kupedza zomwe zimayambitsa - Kudzivulaza mwadala nthawi zambiri ndi njira yodzithandizira munthu akamamva ululu wa m'maganizo. Pachifukwachi, nkofunikira kwambiri kupeza zinthu zomwe zimapangitsa kuti munthu akhale ndi maganizo odzivula mwadala. Munthu akangozindikira zomwe zimabweretsa magizowa, angathe kupanga ndondomeko zabwino zochepetsa kapena zothetsa kumene chilakolako chofuna kuzivulaza mwadala.

Zisokoneze wekha - Zitsokoneze wekha ku chilakolako chofuna kuzivula mwadala. Munthu atha kuyesera kupanga zinthu zina m'malo mozivulaza. Mwachitsanzo, kumenya pilo kungathe kuchepetsa ukali, kapena kusamba madzi ozizila kungathenso kukupangitsa kuti munthu akhale bwino.

Ndondomeko yabwino yozitetezela - Zilembereni nokha ndondomeko yabwino. Zina mwa zomwe zingalembedwe

mu ndondomekoyi ndi zinthu zoti ungazipangile wekha, ndiponso munthu amene ungate kumuuza ngati ukukumana ndi mavuto. Ndondomeko zolembedwa bwino zimathandiza komanso ndidzachidziwikire kuti zimakhala bwino chifukwa munthu amakhala atasankha yekha mtundu wa thandizo lomwe akufuna.

Makhalidwe - Ziyang'anileni moyo wanu wa thupi komanso wa m'magamizo. Kugona mokwanira, kudya chakudya chopatsa thanzi, ndiponso kupanga masewero olimbitsa thupi mwakawirikawiri zimathandiza munthu kukhala ndi moyo wabwino.

Lankhulani - Funani thandizo. Simuyenera kupilira mavuto anu onse panoka. Kupeza thandizo ndichinthu chofunika kwambiri. Ngati simunakwanitse zaka 18, lankhulani ndi munthu wamkulu amene mumamukhulupilira komanso kumumasukira.

Magulu - Afotokozereni anthu ena amene ali ndi mavuto ngati anuwo. Nzeru zawo komanso kuzindikira kwawo kungathe kukhala kothandiza. Magulu ngati la MeHUCA (<https://www.medcol.mw/mehuca/>) lingathe kukhala lothandiza.

Zomwe zingathandize kwa mabanja, achibale ndi omwe akuthandiza munthu yemwe ali ndi vutoli.

Nthawi zambiri anthu amasunga mwachinsinsi nkhani zozivulaza mwadala chifukwa cha manyazi komanso mantha. Nthawi zambiri amakhala munthu wachibale kapena abwenzi amene amazindikira kuti munthu wazivulaza mwadala. Pachifukwachi, kumufikira munthu wozivulazayo mwachikondi ndiponso mwachisamaliro nkofunika kwambiri. Ngati mukuganiza kuti mzanu kapena m'mbale wanu akuzivulaza mwadala, yang'anani zizindikiro izi:

- Kudzicheka kodabwitsa, kudzikhala pa khungu kapena kupsya kumene. makamaka m'mikono, manja, ntchafu ndi mchifuwa.
- Ngati munthuyo akuvala moziphimba nthawi zonse angakhale nthawi yotentha.
- Ngati munthuyo akuonetsa zizindikiro zokhumudwa monga kusasangalala, kulira pafupipafupi, ndiponso kusakhala ndi chilakolako kapena zikhumbokhumbo.
- Maganizo ofuna kudzilanga.
- Maganizo ofuna kudzipha.
- Kudzipatula komanso osalankhula ndi anthu.
- Zizindikiro zodzikayikila, kudzinamizira mafuvuto, komanso kuziona ngati osachita bwino pa chilichonse.
- Zizindikro zoti munthuyo akumakoka tsitsi lake.

Angathenso kumagwilitsa ntchito mankhwala ozunguza ubongo, kumwa mowa mwauchidakwa, komanso amavuta pa nkhani yodya chakudya. Anthu amene amazivulaza mwadala atha kuzipweteka modesa nkhuwa koteru nkofunikira kwambiri kuwalimbikitsa kulankhukla ndi adokotala awo pa mavuto omwe akukumana nawo. Lankhulani ndi anthu ena omwe amathandiza anthu amene amazivulaza mwadala. Angathe kukhala wozindikira pa nkhanizi ndikukhalanso ndi malangizo apadera. Mabungwe ngati MeHUCA (<https://www.medcol.mw/mehuca/>) angathe kuthandiza

Mental wellbeing during a pandemic

A pandemic is an outbreak of disease that spreads quickly and affects many individuals at the same time. The disease COVID-19 is one such example.

Practical advice for staying at home

- Eat well and drink plenty of water
- Keep taking your medication – ask for a supply
- Continue accessing treatment and support if possible – ask teams to phone you
- Keep your home as clean and tidy as you can
- Find ways to work or study at home, if possible

Taking care of your mental health

Hand washing and anxiety – tips if your feeling stressed or anxious

- Don't keep re-reading the same advice if this is unhelpful for you.
- Let other people know you're struggling e.g. you could ask them not to remind you to wash your hands.
- Breathing exercises can help you cope and feel more in control.
- Set limits, like washing your hands for the recommended 20 seconds.
- Plan something to do after washing your hands. This could help distract you and change your focus.

Connect with people

- Try the MeHUCA support group – details below
- Phone people you would normally see in person

Decide on your routine

- Plan how you'll spend your time. It might help to write this down on paper and put it on the wall.
- Try to follow your ordinary routine as much as possible. Get up at the same time as normal, follow your usual morning routines, and go to bed at your usual time.

Try to keep active

- cleaning your home
- dancing to music
- sitting less or doing seated exercises if you can't stand

Get as much sunlight, fresh air and nature as you can

- Spend time with the windows open to let in fresh air.
- Arrange a comfortable space to sit, for example by a window

Find ways to spend your time

- Maybe writing a letter to a loved one
- Sort through your possessions

Find ways to relax and be creative

- Arts and crafts
- DIY
- Playing musical instruments

Take care with news and information

- If news stories or social media make you feel anxious or confused, think about switching off or limiting what you look at for a while

Advice for MeHUCA group members

From an April 2019 mental health leaflet (with permission):

In the event of regular meetings for peer support groups being suspended, group members can:

- Check in on group members via phone to provide peer support and maintain contact
- Maintain contact with service providers at district hospitals or Health centre working directly with the support group to access credible information on the virus, medication, and psychosocial support.
- If you feel overwhelmed, talk to a health worker or counsellor.
- Do not use stigmatizing and discriminatory language and actions in the event a support group member is diagnosed with COVID-19

Maganizo angwirowi mthawi ya Mliri

Kodi mliri ndi chani?

Mliri ndi kuchulukitsa kwa matenda amene akufala mwamsanga kwambiri ndipo akukhudza anthu ambiri kwa nthawi imodzi. Nthenda ya COVID-19 ndi chitsanzo cha mliri.

Malangizo oti tingawakwanilitse pokhala kunyumba

- Idyani chakudya chopatsa thanzi ndiponso imwani madzi ambiri.
- Pitilizani kumwa mankhwala anu omwe mwapatsidwa kuchipatala mwandondomeko.
- Pitilizani kulandira thandizo- yimbani ma numbala omwe unduna wa zaumoyo unapeleka.
- Onetsetsani kuti pakhomu panu ndi paukhondo komanso posamalika nthawi ndi nthawi.
- Pezani njira zogwilira ntchito kapena zophunzilira muli kunyumba komweko.

Kusamalira maganizo anu kuti akhale angwirowi.

kusamba mmanja komanso nkhwawo-zoyenera kuchita ngati mukupezana ndi mavuto kapena muli ndi nkhwawo.

- Osamawerenga kawirikawiri malangizo omwe mukuona kuti sakukuthandizani.
- Adziwitseni anthu ena za mavuto anu- mwachitsanzo, mutha kuwakumbutsa kuti azikukumbutsani kusamba mmanja.
- Phunzirani mapumidwe abwino omwe agathe kukuthandidzani kupilira komanso kudzilamulira panokha
- Yikani milingo, monga kusamba mmanja pakatha ma sekondi makumi awiri.
- Lingalirani kupanga china chake mukatha kusamba m'manja. zimenezi zingathe kukuthandizani kukwanilitse zolinga zanu.

Lumikizanani ndi anthu

- Yesetsani kulumikizana ndi gulu la MeHUCA-Zambiri muzipeza pansipa.
- Yimbirani lanya anthu amene mumakumana nawo tsiku ndi tsiku.

Pangani ziganizo pa zomwe mumachita nthawi ndi nthawi

- Lingalirani m'mene mugwilitsire ntchito nthawi yanu. Zingathe kuthandiza kulemba papepala ndi kumata pakhoma.
- Yesetsani kutsatira mwandondomeko zinthu zomwe mumachita nthawi ndi nthawi. Dzukani mmene mumadzukira nthawi zonse, gwirani ntchito zonse zomwe mumagwira mwandondomeko, ndipo madzulo kukada,

kagoneni nthawi imene mumagona nthawi zonse.

Khalani otanganidwa

- Konzani pakhomu panu.
- Vinani nyimbo zomwe mumakonda.
- Onetsetsani kuti mukukhala pansu kwa kanthawi kochepe kapena pangani masewera olimbitsa thupi muli chikhalire ngati simungathe kuyimilira.

Landirani dzuwa lokwanira, kamphepo kabwino, komanso chilengedwe

- Onetsetsani kuti mazenera a nyumba yanu ndiotsegula bwino kuti mpweya wabwino udzilowa
- Onetsetsani kuti mukukhala pa malo abwino monga pafupi ndi zenera.

Pezani njira zotayitsira nthawi yanu

- Mwina kulemba kalata kwa okonedwa wanu.
- Longezani bwinobwino katundu wanu.

Pezani nthawi yoti mumasuke komanso kupuma

- Zojambulajambula zingathe kuthandiza.
- Kuyimba zida zosiyanasiananso kumathandiza kumasuka m'maganizo.

Samalirani ndi nkhwawo komanso mphekesera

- Ngati nkhwawo kapena mauthenga a mmatsamba a michezo akukupangisani kukhala ndi nkhwawo kapena kukusokonezani mutu, zimitsani kapena chepetsani kumawerenga kwa kanthawi ndithu.

Langizo kwa mamembala a gulu la MeHUCA

Kuchokera mkapepala ka maganizo angwirowi kosindikizidwa mu mumwezi wa epulo mchaka cha 2019 (atiloleza). Mu nthawi yoti kukumana kokhazikika kwa mmagulu kwayimitsidwa kapena kulesedwa, ma membala agululi atha:

- Kugwiritsa ntchito lanya polumikizana ndi cholinga chothandizana komanso kukumana.
- Kukumana ndi opeleka thandizo la maganizo angwirowi mu zipatala za m'maboma kapena zipatala zing'onong'ono zimene zimagwira ntchito ndi ma gulu othandizanawa ndi cholinga choti mamembala apeze uthenga woyenera okhudzana ndi matenda a corona, mankhwala komanso uphungu.
- Ngati mukuona kuti zinthu zakukuchulukirani, afotokozereni adokotala anu kapena opeleka uphungu.

Osapanga zinthu komanso kugwiritsa ntchito mawu obweretsa tsankho komanso kutsalana

Part 7

Other Resources

Tips for asking about symptoms in Chichewa

A note about cultural beliefs

Example of an entry in health passport

Temporary treatment order form

Tips for asking about symptoms in Chichewa

Difficulty asking questions

It is sometimes difficult to know how to ask about symptoms. Do not worry! See the following examples of ways of asking difficult questions. Practice what feels best for you.

Useful Screening Questions

Depressed mood

Have you been feeling unhappy or sad? Kodi mumakhala osasangalala kapena osakondwa?

Have you lost interest or pleasure in the things you usually enjoy? Kodi chinakuchokelani chilakolako chopanga zinthu zomwe zimakusangalatsani?

Suicidal thoughts

Have you ever thought about trying to end your life? Kodi munayamba mwaganizirapo zochotsa moyo wanu?

Anxiety

Do you feel nervous, tense or worried? kodi mumakhala ndi nkhawa, mantha kapena madandaulo?

Elated mood

Are you happier or more cheerful than usual? Kodi mukumakhala okondwa kapena osangalala kwambiri kuposa nthawi zones

Strange experiences, beliefs and behaviour:

Sometime when people are stressed they can have strange experiences. Has anything strange or unusual happened to you? Nthawi zina anthu akamasowa mtendere amatha kuona kapena kukumana ndi zinthu zodabwitsa. Kodi chilipo china chilichonse chodabwitsa chomwe chinakuchitikilani?

Did you ever hear things that other people couldn't such as noises or voices of people whispering or talking? Munayamba mwamvapo zinthu zomwe ena samamva monga phokoso, kapena anthu akunong'onezana kapena kuyakhula?

Asking about Depression

Depressed Mood

Now I'm going to ask you some more questions about your mood Tsopano ndikufunsani mafunso ena okhudzana ndi momwe mwakhala mukumvera mumtima mwanu monga kusangalala kapena kudandaula.

How have you been feeling recently? Kodi mwakhala mukumva bwanji masiku apitawa?

Have you been feeling low or sad? Kodi mwakhala osasangalala kapena kudandaula?

For how much of the time have you been feeling like that? Is it every day? For how long every day? Mwakhala mukumva kwa nthawi yayitali bwanji? Kodi ndi tsiku ndi tsiku kwa nthawi yayitali bwanji?

Does your mood change as the day goes on? When do you feel worst? Kodi zochitika zanu zimasinthika bwanji tsiku likamatha? Mumaipidwa nthawi yanji?

When did you start to feel this way? Did something happen that was upsetting or stressful? Mwayamba liti? Kodi munali ndi chiphinjo chilichonse?

How have these feelings affected your day-to-day life? Mamvedwe anu am'tima asokoneza bwanji zochitika zanu za tsiku ndi tsiku?

Have you been feeling tense and anxious? Mumakhala othunthumira?

Have you been irritable and short tempered? Mukumapsya mtima msanga ndi zinthu zazing'ono?

Anhedonia

Have you lost interest or pleasure in the things you usually enjoy? Kodi chinakuchokelani chilakolako chopanga zinthu zomwe zimakusangalatsani?

Have you stopped doing those things? Mwasiya kuchita zinthu zija?

Is there anything that you still enjoy? Kodi pali china chiri chonse chimene muma sangalatsidwa nacho?

Energy

How is your energy level? Mphamvu zanu zili bwanji muthupi mwanu?

Do you feel tired a lot of the time? Mumamva Kufooka?

Do you get tired easily? Kodi mukuma fooka msanga?

Sleep

How are you sleeping these days? Mbali ya tulo, mukumagona bwanji masiku ano?

Are you having trouble falling asleep or staying asleep? Kodi mumavutika kuti mupeze tulo kapena kukhala chigonele?

Are you waking up earlier than usual? Kodi mukumadzuka mwansanga kwambiri kusiyana ndimene mumadzukila nthawi zonse

How does that affect your energy levels? Kodi zimenezi zimasokoneza bwanji mphamvu kapena nyonga zanu?

Appetite

How has your appetite been recently? Kodi chilakolako chanu pa chakudya chili bwanji?

Are you eating less or more than is usual? Kodi mukumadya pang'ono kapena kwambiri?

Do you enjoy food as much as you usually do? Kodi mukumasangalala ndi chakudya?

Have you lost or gained any weight? Kodi mukuona ngati mukuwonda kapena mukunenepa?

Libido

When people feel low like this, they can lose their sex drive. Is this a problem for you? Anthu akakhala okhumudwa chonchi nthawi zina chilakolako chogonana chimawachokela. Limeneli ndi vuto kwa inu?

Concentration and memory

Do you have trouble thinking or concentrating? Kodi mumavutika poganiza kapena kukhala ndi chidwi popanga chinthu?

What kind of things did it interfere with? Nanga ndi zinthu zANJI zomwe zimasokonekera chifukwa cha vuto lakuganizali kapena lakusamvetsetsali

Is it hard to make decisions about everyday things? Kodi mumavutika kupanga chisankho kapena kumanga mfundo pa zinthu za tsiku ndi tsiku?

Worthlessness

Do you feel like you are worthless? Kodi mukuwona ngati ndinu munthu osafunikira?

Guilt

Have you been feeling guilty about things recently? What things? Kodi mukumamva chisoni ndi zinthu zochitika posachedwa? Ndi zinthu zotani?

Do you feel as though you have let people down? Kodi mukuwona ngati mwakhumudwitsa anthu ena?

Have you ever felt that you have committed a crime or done something terrible for which you should be punished? Kodi munavapo ngati mwapalamula kapena mwapanga china chake choipa kwambiri ndipo mukuyenera kulandira chilango?

Hopelessness

How have you been feeling about the future? Could things change for the better? Kodi zinthu zikhoza kusintha ndikukhalaso bwinobwino?

Asking about Suicidal thoughts

How do you see your future? Tsogolo lanu mumaliwona bwanji?

Do you ever feel hopeless about the future? Kodi mumaona ngati mulibe tsogolo?

Do you ever wish you were dead? Kodi munayamba mwafunapo kuti mutangofa? Have you ever thought about trying to end your life?

Kodi munayamba mwaganizirapo zochotsa moyo wanu?

Have you ever made plans or actually tried to kill yourself?

Kodi munayamba mwakonzapo ndondomeko yoziphela kapena kuyetsela kuzipha?

Do you have current plans to kill yourself?

Kodi panopa muli ndi ndondomeko iliyonse yofuna kuzipha?

Asking about Anxiety

Physical symptoms

How does your body feel when you are nervous? For example, choking feelings, breathing problems, palpitations, butterflies, shaking...

What do you think is happening when you get these feelings?

Thupi lanu limamva bwanji mukagwidwa ndi mantha? Mwachisazo, kusamwa, kubanika, Kuthamanga kwa mtima, kunjenjemera

Mumaganiza kuti chikuchitika ndi chiani mukamamva chonchi?

Psychological symptoms

What worries do you have? /what worries you the most?

Muli ndi nkhawa zANJI/Ndichani chimene chimakupasani nkhawa kwambiri?

Do you find it hard to concentrate?

Kodi mumavutika kukhala chidwi?

Can you relax and switch off?

Kodi mumatha kudekha ndi kusanganizila china chili chonse?

Have you felt as if you weren't real? (depersonalization)

Kodi munayamba mwazimva ngati si inu enieni?

Has the world around you felt unreal? (derealization)

Kodi dziko limaoneka ngati silenileni kwa inuyo?

Assessing if episodic or continuous

Do you feel anxious all the time or just some of the time?

Kodi mumamva nkhawa thawi zonse kapena mwa apo ndi apo?

Do you know what makes you anxious?

Kodi mumadziwa chimene chimakupangisani nkhawa?

What was happening or going through your mind when you last felt anxious?

Chimachitika ndi chani kapena mumaganiza chani pa nthawi yomaliza imene munali ndi nkhawa.

Asking about Hallucinations

General questions

(Can you hear/see things other people don't notice? Kodi mumamva kapena kuwona zinthu zomwe anthu ena samazimva kapena kudziwona?)

Have you seen or heard anything that's worried you recently? Kodi mwaona kapena kumva china chake chimene chikukudesani nkawa masiku ochepea apitawa?

If they are distracted (e.g. glancing about/mumbling) ask why... e.g. Is something making it hard for you to concentrate? Can you hear or see something? Chilipo chimene chikokusonezani kuti mukhale ndi chidwi? Kodi mukumva kapena kuona china chake?

Auditory

Did you ever hear things that other people couldn't such as noises or voices of people whispering or talking? Munayamba mwamvapo zinthu zomwe ena samamva monga phokoso, kapena anthu akunong'onezana kapena kuyakhula?

If yes, what did you hear? How often do you hear it? Ngati eya: Mumamva chani? Mumamzimva kangati patsiku?

Did they comment on what you were doing or thinking? Kodi mawuwo amanenelela zomwe mukupanga kapena mukuganiza?

Do they ever tell you what to do? Kodi amakuwuzani zinthu zoti muchite?

Do they ever say your thoughts aloud? Kodi amanena zimene mukuganiza mokweza?

How many voices did you hear? Were they talking to each other? Kodi mumamva mawu a anthu angati? Amayakhulitsana?

Visual

Did you have visions or see things that other people couldn't? (Were you awake at that time?) Kodi munali ndi maso mphenya kapena kuona zinthu zomwe ena samaona? (munali muli m'maso pa thawiya?)

Have you ever seen ghosts/sprits/visions? Kodi munaonako mizukwa (ziwanda)/mizimu/maso mphenya?

Somatic/Tactile

What about strange sensations in your body or on your skin? (e.g. like insects crawling?) Nanga mumamva zinthu zodabwitsa muthupi lanu kapena pa khungu lanu? (Ngati chinthu chikukuyendani?)

Gustatory/olfactory

Have you noticed any strange tastes or smells that have worried you? Kodi mumamva kukoma kodabwitsa kwa zakudya kapenanso fungo lodabwitsa lomwe limakudandaulitsani?

Asking about odd ideas/beliefs

Persecutory

Have other people been acting suspiciously? Is anyone going out of their way to give you a hard time, hurt you, or kill you? Kodi anthu ena akumapanga zinthu zokayikitsa? Alipo amene angofuna kukupatsani mpishupishu, Kukupwetekani kapena kukuphani?

Delusions of reference

Has it ever seemed like people were talking about or taking special notice of you? Kodi zimaoneka ngati anthu ena akumanena za inu kapena kukhala nanu chidwi?

What about receiving special messages from the TV, radio, or newspaper or from the way things were arranged around you? Nanga mumalandila uthenga okukhuzani kuchokela pa kanema, Wayilesi, kapena munyuzi. Kapenanso m'mene zinthu zimasanjidwila mokuzungulilani?

Passivity

Do you feel as if you are controlled by someone else, almost as if they have a remote control for you? Kodi mumamva ngati moyo wanu ukuyendesenda ndi munthu wina wake, ngati akukusogolerani ndi limoti?

Did you ever felt like someone or something outside yourself was controlling your thoughts or actions against your will? Kodi nthawi zina mumawona ngati munthu kapena chinthu china chake chimakupangitsani kuti muziganiza kapena kuchita zinthu zimene inu simukufuna?

Can anyone interfere with the thoughts in your head? Kodi munthu akhonza kuseweretsa kapena kosokoneza maganizo anu m'mutu mwanu?

Thought Insertion

Did you ever feel like certain thoughts that were not your own were put into your head? Kodi munayamba mwamvapo ngati maganizo ena ake omwe sali anu ayikidwa m'mutu mwanu?

Can anyone put their thoughts into your head without even talking to you? Kodi zontheke munthu koyika maganizo ake m'mutu mwanu ngakhale asanayakhule nanu?

Thought Withdrawal

Can anyone steal/take/pluck thoughts from your head? Kodi wina wake angabe/kutenga/kuchotsa maganizo m'mutu mwanu?

Thought Broadcasting

Did you ever feel as if your thoughts are being broadcast out loud so that other people could actually hear what you were thinking? Kodi munayamba mwamvapo ngati maganizo anu akuwulutsidwa mokweza kuti mpakana anthu ena kumamva zomwe mukuganiza?

Do you ever believe that someone could read your mind? Kodi mukukhulupilira kuti munthu akhonza kuziwa zomwe mukuganiza?

Religious delusions

Have you ever had any unusual religious experiences? Kodi muakomanapo ndi zinthu zodabwitsa zokhuzana ndi chipembezo?

Asking questions about Mania/Bipolar

Elated Mood

How have you been feeling recently? Kodi mukumamva bwanji masiku ano?

Are you happier or more cheerful than usual? Kodi mukumakhala okondwa kapena osangalala kwambiri kuposa nthawi zonse

When did you start feeling like this? What happened around then? Munayamba liti kumva chonchi? Chinachitika ndichani pa nthawiyo?

Increased energy

What are your energy levels like at the moment? Kodi mphamvu zanu zili bwanji panopa?

Have you always had this much energy? Kodi munali kale ndi mphavu zambiri chonchi?

How are you spending your new-found energy? Kodi mukugwilitsa ntchito bwanji mphamvu zatsopano zomwe mwazipezazi?

Were you much more talkative than usual? (did people have trouble stopping you or understanding you?) Kodi mumakonda kuyakhulayakhula kuposa nthawi zonse? (Kodi anthu amavutika kukuletsani kapena kukumvesetsani?)

Libido

Have you noticed a change in your sex drive, as well as your energy? Kodi mwaonako kusitha kulikonse pa chilakolako chanu chogonana kapena mphamvu zanu?

Sleep

How has your sleep been lately? Mbali ya tulo, mukumagona bwanji usiku?

Reckless behaviours

Have you been in any trouble recently? Kodi mwakhalapo mumavuto ena aliwose posachedwapa?

Have you been doing things you would not usually dare to do (Drugs/sex/gambling etc)? Kodi mwakhala mukupanga zinthu zoti simungapange muli bwino bwino (Mankhwala ozunguza bongo, Chiwerewere, juga)

Have you been spending a lot more than usual? Kodi mukuwononga ndalama zambiri kuposa nthawi zonse?

What happens when people irritate you? Chimachitika ndi chani anthu akakukwiwiyani?

Interest or enjoyment

You seem interested in so many different things- are these new interests? Mukuoneka kuti muli ndi chidwi chopanga zinthu zambiri zosiyanasiyana- Kodi chidwichi ndichatsopano?

You must have so much energy to do so much.... Mukuoneka kuti muli ndi mphavu zambiri kuti mupange zinthu zochulukira chonchi...

You're so busy...! When do you find time to sleep/eat/work? Ndinu otanganidwa kwambiri...Mumapeza bwanji nthawi yogona/kudya/kugwira ntchito?

Self-Worth

How do you think of yourself? Mumamva bwanji mukaziwona nokha?

Do you have more self-confidence than usual? Mumakhala ozikhulupilira kwambiri kuposa nthawi zonse?

How would you compare yourself with other people? Mungazisiyanitse bwanji ndi anthu ena?

You seem such a positive person...How do you see things turning out? Mukuoneka ngati ndinu munthu olingalila zinthu zabwino...mukuona ngati zinthu zikhoza kutha bwanji?

Grandiose ideas/delusions

Do you have any special talent or power? Muli ndi luso kapena mphamvu zapadeladela?

Does your life have a mission or special purpose? Muli ndi cholinga chapadeladela mu moyo wanu?

Delusions of reference

Have you seen or heard anything in the news that had a special meaning for you? Munaonako kapena kumva china chake mu nyuzi chomwe chinali ndi thandauzo la padeladela kwa inu?

Hallucinations

Has anyone important or famous spoken to you recently? Alipo wina wake ofunikira kapena otchuka amena wakuyakhulisa posachedwapa?

Do you pick up on things other people can't see or hear? Kodi mumatha kumva kapena kuona zinthu zomwe anthu ena saona kapena kumva?

Concentration/thought How has your concentration been? Kodi chidwi chanu pa zinthu chilli bwanji?

Are you easily distracted by things around you that you had trouble concentrating or staying on one track?

A note about cultural beliefs

Other Resources

Many people believe that mental illness is caused by supernatural powers or witchcraft. According to the traditional medicine system in Malawi, some of the causes of mental illness are:

- An Angry God punishes wrongdoers for violating taboos (*Chauta, Chiuta, Mulungu*).
- Ancestors and other spirits; who feel they have been forgotten, not recognised or not purified by sacrifice (*nsembe*).
- Witches working for individuals or village communities for personal benefit.
- Spirit possession (*mizimu, majini, vimbuza*) or intrusion of an object (living or inanimate) into the body.
- Loss of basic body equilibrium usually by the entry of excessive heat or cold (*mphepo ndi madzi oipa*).
- The 'evil eye' (*tsoka*) – aggression or punishment is directed against a person as a result of the will and power of another human being supernatural agent or being.

It is important that mental healthcare professionals are sensitive, respectful and empathic in their assessment and treatment of people with mental illness. It is important to understand the beliefs of the person and family, even if you don't agree with them.

It may help to network with other treatment providers (e.g. traditional healers) for consensus and compromise on some treatment areas.

However, it is also important that health workers protect patients from harmful aspects of traditional healing such as chaining, beatings or the use of traditional medicines that may make a patient more unwell.

You may hold strong religious beliefs or believe that witchcraft occurs in Malawi. That is ok. However, if somebody has a mental illness that could be helped using the approach described in this guide, you must help them to get the best treatment possible.



Health Passport Summary Format

It is vital to make a legible record in the patient health passport every time you review them. This will help you and any other practitioner the next time this patient is reviewed.

IMPORTANT: Ensure the patient identifying information on the health passport is recorded correctly (ie Name, DOB, Address, District, Contact number, Guardian's name and contact numbers)

Any review of a patient should record information under each of the following headings:

1. Age of Patient
2. Previous working diagnosis
3. List of Physical Comorbidities (if any)
4. Current medications and dose
5. Brief Summary of patient's complaints, symptoms or progress since the last review
6. Collateral information (if any)
7. Brief description of patient's current functionality (working, in school, social relationships etc)
8. Brief report on psychotropic drug side effects (if any)
9. Key Mental State Findings
10. Assessment i.e current diagnosis or working diagnosis
11. Plan of management
 - a. If medication prescribed – Dose, route of administration, frequency, duration of treatment clearly indicated
 - b. Next appointment date

Record the date, location and health worker's name and signature.

Temporary Treatment Order (TTO)

THE MENTAL TREATMENT ACT

(Cap. 34:02)

(Under section 22 Of the Act.)

Name of referring hospital.....

Cap. 34:02 Mental treatment

(subsidiary) mental treatment: (prescriber form) Rules

Form no.

In the matter of (Name of the patient)

In the district of.....

Ihereby to certify as follows

I on the day of

At thein the district of

I personally examined the said

Is of unsound mind and a proper person to be taken in charge and detailed under care.

2. I formed this conclusion on the following grounds

a) Facts and cating insanity observed by myself (here state observation).

b) Other facts, if any indicating insanity communicated to me by other (here information and from when).

Name of attending clinician and prescriber no.

Signed..... Qualification.....

(Here state whether the person giving the certification is a registered or licensed medical practitioner)

Malawi Quick Guide to Mental Health

The Malawi Quick Guide to Mental Health was produced to provide practical information for the assessment and management of mental disorders in Malawi. The Guide is for the busy primary care healthcare provider working at first- and second-level healthcare facilities in Malawi. Brought together in May 2020 during the global COVID-19 pandemic, it particularly aims to support non-specialist healthcare workers who find themselves caring for people with mental disorders for the first time. In Malawi, there are three Consultant Psychiatrists for a population of approximately 20 million people. It is clear that we cannot rely solely on specialists to provide mental health care.

What does it contain?

The Malawi Quick Guide to Mental Health opens with advice for managing mental health during a time of crisis, such as the current global COVID-19 pandemic (Part 1). There is detail on how to perform mental health first aid and quick reference sheets for managing Mental Health Emergencies (Part 2). Principles of Assessment and Management (Part 3) provides an overview of good clinical practice and describes how to perform a mental health assessment.

The guide then prioritises disorders based on their level of burden in terms of mortality, morbidity and disability. These priority disorders include delirium, depression, anxiety disorders, psychoses, self-harm/suicide, drug and alcohol use disorders, epilepsy, and dementia. In Assessment and Management of Psychiatric Disorders (Part 4) the guide focuses on management approaches identified based both on evidence about their effectiveness and their feasibility in Malawi.

Important considerations in the assessment and care are described for Special Patient Groups (Part 5) including older adults, mothers, and children. There are Information Leaflets for Patients and Carers (Part 6) in English and Chichewa that have been in part adapted with permission from material available on the websites of the Royal College of Psychiatrists, Mind and the National Centre for Mental Health. These leaflets can be photocopied and handed to patients and their carers as appropriate. Other Resources (Part 7) include advice on how to ask assessment questions in Chichewa.

This book was made possible by funding from the Scottish Government International Development Fund