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FOREWORD

I have the pleasure to preface the 2022 Rwanda Standards Treatment Guidelines and the Essential Medicines List (STGs/EML). This is the second edition after the 2013 STGs and 2015 EML.

The development of the STGs/EML is an essential part of the improvement of the quality of health care delivery especially at the primary healthcare level. Rwanda is committed to the attainment of the 2030 SDGs and especially goal 3 i.e. "good health and well-being" with one its target to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"

To attain the above-mentioned goals, special packaging of policies and strategies aligned to the Global Strategy for Women's, Children's and Adolescent's Health were developed through the MNCH strategic plan 2018- 2024 ensuring coordinated action to address cross-cutting health needs of our future. These guidelines have therefore integrated this plan accordingly

Equally important, this 2022 STGs/EML integrates Rwanda global commitment to the implementation of the One Health Policy that set-up policies, implementation strategies to prevent and control zoonotic diseases, plant diseases, food safety and specifically antimicrobial resistance. Rwanda has therefore set up a One Health Multi-sectoral Coordination Mechanism (OH-MCM) that will allow antimicrobial resistance surveillance, guide and monitor the use of antibiotics in Rwanda. This policy is in line with our commitment to the WHO Global Action Plan on Antimicrobial Resistance (2018).

We have therefore for the first time customized the WHO AWARE classification of antibiotics as well as the antibiotics prescription guidance. This will help not only reduce the current trend of antimicrobial resistance but importantly ensure better quality of healthcare of our population by reducing the negative impact of multi-drug resistance in Rwanda.

While the above global commitments inform our strategic choices, the STGs/EML are grounded first and foremost in our national diseases burden and specifically at the primary health care level. It is our hope that these guidelines will bring more evidence-based practice, more transparency in the care provision as well as access to efficient, affordable, and available medications in the country.

I would finally wish to acknowledge the strategic technical and financial contribution of the WHO that made this work possible despite the challenging environment due to Covid-19 pandemic.
This work would not have been possible without the active involvement of the professional medical/pharmacy societies/ associations, that reviewed the literature, held numerous online discussions, peer-reviewed several drafts and came up with the most suitable guidelines.
Several other partners provided support to this project in one way or another and I wish to thank all of them for their usual support

Dr. NGAMIJE M. Daniel
Minister of Health

Acknowledgement

The Ministry of Health wishes to acknowledge the support of various stakeholders in the making of the 2022 Standards Treatment Guidelines (STGs) and Essential Medicines List (EML). Without their contributions, it wouldn't have been possible to complete this work despite the restrictions made necessary by the Covid-19 Pandemics.

The World Health Organization availed the required financial and technical support throughout the project and was flexible to adjust to the challenges brought about by the stringent environment.

World AIDS Campaign International (WACI) Health made a significant financial input to allowing a smooth running of the project.

The Medicines, Technologies, and Pharmaceutical services program (USAID MTaPS) financial intervention especially in the shaping of the rational use of antibiotic guidelines has been a great input in the current work.

Clinton health access initiative (CHAI) have been instrumental and played a major role especially in developing the Clinical guidelines for hypoxemia screening and oxygen therapy administration in Neonates, children and adults.

The Ministry wishes to thank specifically all Rwanda Health professionals and Pharmacy Societies and Associations for their self-less spirit and gave their time to patiently review and update the previous 2013 STGs and 2015 EML spending very long hours online very often late in the night.

The Ministry of Health wishes to acknowledge and thank the consultants, Prof Emile Rwamasirabo, Dr. Raymond Muganga and Dr. Richard Butare who coordinated this 2022 STG/EML updates.

The Ministry also recognizes the important contribution of tertiary Hospitals including CHUK, CHUB and KFH that availed their microbiology data over 5 to 7 years that helped to profiling the antimicrobial resistance in Rwanda.

Special recognition goes also to the Experts Taskforce appointed by the MOH upon recommendation by the Medical and Pharmacy Societies and Associations. The team is composed as follows:

	Societies and Associations	**Coordinators**
1	The Rwanda Pediatric Association (RPA)	Prof. Musiime S.
2.	The Rwanda College of Physicians (RCP)	Dr. Muvunyi B.
2	The Rwanda Society of Obstetrics and Gynecology (RSOG)	Dr. Ruzigana G.
3	The Rwanda Surgical Society	Dr. Byiringiro F.
4	The Rwanda Psychiatric Society	Dr. Mudenge C.
5	The Rwanda Dental Surgeon Association (RDSA)	Dr. Bizimana A.
6	The Rwanda Ophthalmology Society (ROS)	Dr. Mutangana F.
7	The Rwanda Oncology Society (in formation)	Dr. Rubagumya F.
8	The Rwanda Otolaryngology and Neck Surgery Society (ROHNSS	Dr. Mukara Kaitesi
9	The Rwanda Dermatology Society (RDS)	Dr. Amani A.
10	The Rwanda Society of Anesthesiologists (RSA)	Dr. Rudakemwa A.
11	The National Pharmacy Council	Dr. Hitayezu F.

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List of Abbreviations and acronyms

ADHD	: Attention-Deficit Hyperactivity Disorder
AUDIT	: Alcohol Use Disorder Identification Test
CBT	: Cognitive Behaviour Therapy
CIWA-R	: Clinical Institute Withdrawal Assessment for Alcohol-Revised
CNS	: Central nervous System
CT	: Computer Tomography
DSM 5	: Diagnostic and Statistical Manual-5
DSM IV-TR	: Diagnostic and Statistical Manual –IV text Revised
DSM-IV	: Diagnostic and Statistical Manual
E.g	: Example
ECG	: Electrocardiogram
EEG	: Electroencephalogram
EFNS	: European Federation of Neurological Societies
FBC	: Full Blood Count
I.M	: Intramuscular
ID	: Intellectual disability
Mg	: Milligram
MRI	: Magnetic Resonance Imaging
OCD	: Obsessive compulsive disorder
OD	: Once a day
PO	: Per os
PTSD	: Post Traumatic Stress Disorder
PTSD	: Posttraumatic stress disorder
SSRI	: Selective serotonin re-uptake inhibitor
Tab	: Tablets
TID	: Three times a day

Psychotic Disorder

Psychosis is a condition of the mind broadly defined as a loss of contact with reality. It is estimated that 13 to 23 percent of people experience psychotic symptoms at some point in their lifetime and 1 to 4 percent will meet criteria for a psychotic disorder.

Brief Psychotic Disorder

Brief psychotic disorder is defined in DSM-5 as the presence of one or more psychotic symptoms with a sudden onset and full remission within one month.

Diagnosis

A.Presence of one or more of the following symptoms:

- 1. Delusions
- 2. Hallucinations
- 3. Disorganized speech
- 4.Grossly disorganized or catatonic behavior

B. Duration of an episode of the disturbance is at least a day but less than a month, with eventual full return to premorbid level of functioning.

C. Absence of symptoms comprising a bipolar or depressive disorder, or psychosis resulting from substance use/withdrawal or a general medical condition.

specify if there is a marked stressor – Symptoms are preceded by and apparently in response to a markedly stressful experience or a post-partum onset,

Treatment

The approach to individuals with brief psychotic disorder is the same as the general initial management of psychosis, regardless of the cause. This includes antipsychotic medications and adjunctive supportive therapy. Management of psychosis is briefly discussed here.

Essential information for patient and Family

Explanation to the family should include: that these signs and strange behaviour are symptoms of a mental illness. Acute episodes often have a good prognosis, but long-term course of the illness is difficult to predict from an acute episode. Continued treatment may be needed for several months after symptoms resolve. Educate the family further on medication including its side effects.

Adjunctive supportive therapy

Ensuring safety/determining site of care – The initial treatment decisions should be guided by the patient's ability to maintain safety.
This should be assessed by direct questioning about homicidal or suicidal ideation
Ensure the safety of the patient and those caring for him/her:

- Ensure that the patient's basic needs are met
- Take care not to harm the patient.
- Minimize stress and stimulation.
- Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
- Avoid confrontation or criticism unless it is necessary to prevent harmful or disruptive behavior.
- Agitation which is dangerous to the patient, the family or the community requires hospitalization or close observation in a secure place. If patients refuse treatment, legal measures may be needed
- Encourage resumption of normal activities after symptoms improve.

Medication

Pharmacological Treatment:
Acute phase:
I**n case of violent patients the first choice is:**
Typical Antipsychotic

- Chlorpromazine, IM, 100−300 mg/day in 3 or 4 divided doses
- Levomepromazine, IM, 100−200 mg/day in 3 or 4 divided doses
- Haloperidol, IM, 10 – 30 mg/day in3 or 4 divided doses

In case of non-violent patients the first choice is

Atypical Antipsychotic:

- Tabs Risperidone, tablets, 2 – 8 mg daily in divided doses.
- Quetiapine 50-750mg in divided doses.
- Olanzapine 5-20mg once a day.
- Aripiprazol 10-30mg once a day

Or

Typical antipsychotic:

- Tabs Haloperidol, tablets, 5 – 30 mg daily in divided doses
- Tabs Flupentixol, tablets, 1 – 6 mg daily in divided doses

- Tabs Chlorpromazine(Largactil), tablets, 25 – 1200 mg daily in divided doses
- Tabs Levomepromazine (Nozinan), tablets, 25 – 300 mg daily in divided doses

  NB: the doctor should consider the minimum effective dose.

The maintenance phase

Atypical Antipsychotic:

- Tabs Risperidone, tablets, 2 – 8 mg daily in divided doses.
- Quetiapine 50-750mg in divided doses.
- Olanzapine 5-20mg once a day.
- Aripiprazol 10-30mg once a day

Or

Typical antipsychotic:

- Tabs Haloperidol, tablets, 5 – 30 mg daily in divided doses
- Tabs Flupentixol, tablets, 1 – 6 mg daily in divided doses
- Tabs Chlorpromazine (Largactil), tablets, 25 – 1200 mg daily in divided doses
- Tabs Levomepromazine (Nozinan), tablets, 25 – 300 mg daily in divided doses

If no adherence and/or compliance, the patient should be put on the following medication:

- Flupentixol decanoate, 20 – 40 mg IM / 2 weeks
- Haloperidol decanoate, 50 – 200 mg/Month
- Tabs Pimozide, tablet, 4 – 8 mg / week orally

Non Pharmacological Treatment

- Individual psychotherapy
- Psycho-education
- Group psychotherapy
- Family therapy

Monitor for side effects of medication:

- Acute dystonia or spasms may be managed with injectable
  - *Im Diazepam 10mg* or antiparkinsonian drugs
- Akathisia (severe motor restlessness) may be managed with dosage

reduction or beta-blockers
  - *Tabs Propranolol 40-120mg per day in divided dose. OD.*
- Parkinsonian symptoms (tremor, akinesia) may be managed with oral antiparkinsonian.
  - *Tablets Biperiden 2 mg up to three times a day.*

In cases of severe side effects or the appearance of fever, rigidity, hypertension, stop antipsychotic medication and consider consultation by a specialist.

-- | Schizophrenia

Schizophrenia is a psychiatric disorder involving chronic or recurrent psychosis. It is commonly associated with impairments in social and occupational functioning. It is among the most disabling and economically catastrophic medical disorders, ranked by the World Health Organization as one of the top ten illnesses contributing to the global burden of disease

Diagnosis

DSM-5 diagnostic criteria for schizophrenia are described in more detail below

a. Two or more of the characteristic symptoms below are present for a significant portion of time during a one-month period (or less if successfully treated):

- Delusions
- Hallucinations
- Disorganized speech (eg, frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- Negative symptoms, ie, affective flattening, alogia, or avolition

b. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset. When the onset is in childhood or adolescence: failure to achieve expected level of interpersonal, academic, or occupational achievement.

c. Continuous signs of the disturbance persist for at least six months. The six-month period must include at least one month of symptoms (or less if successfully treated) that meet criterion.

Treatment

Psychoeducation for patient and families:

Explanation to the family and patients should include that:

These signs or strange behaviors are symptoms of a mental illness.

- Symptoms may come and go over time.
- Anticipate and prepare for relapses.
- Medication is a central component of treatment; it will both reduce current difficulties and prevent relapse.
- Family support is essential for compliance with treatment and effective rehabilitation.
- Community organizations can provide valuable support to patient and family.
- Discuss treatment plan with family members and obtain their support for it.
- Explain that drugs will prevent relapse and inform patient of side-effects.
- Encourage patient to function at the highest reasonable level in work and other daily activities.
- Encourage patient to respect community standards and expectations (dress, appearance, behavior).
- Minimize stress and stimulation:
- do not argue with psychotic thinking
- Avoid confrontation or criticism
- During periods when symptoms are more severe, rest and withdrawal from stress may be helpful.

Antipsychotic medication will reduce psychotic symptoms
Pharmacological Treatment
When Acute phase,
in case of violent patients the first choice is:

Typical Antipsychotic: one of the following medication

- Chlorpromazine, IM, 100−300 mg/day in 3 or 4 divided doses
- Levomepromazine, IM, 100−200 mg/day in 3 or 4 divided doses

Haloperidol, IM, 10 – 30 mg/day in3 or 4 divided doses
In case of non-violent patients the first choice is

Atypical Antipsychotic:one of the following medication

- Tabs Risperidone, tablets, 2 – 8 mg daily in divided doses.
- Quetiapine 50-750mg in divided doses.
- Olanzapine 5-20mg once a day.
- Aripiprazol 10-30mg once a day

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Typical antipsychotic:one of the following medication

- Tabs Haloperidol, tablets, 5 – 30 mg daily in divided doses
- Tabs Flupentixol, tablets, 1 – 6 mg daily in divided doses
- Tabs Chlorpromazine(Largactil), tablets, 25 – 1200 mg daily in divided doses
- Tabs Levomepromazine (Nozinan), tablets, 25 – 300 mg daily in divided doses
  NB: the doctor should consider the minimum effective dose.
- Tabs Pipamperon, tablets, 20 - 120 in divided doses
- Pipamperon Oral drop 40mg/ml, 20-120mg in divided doses
- Tabs Pimozide , tablets, 4 – 12 mg daily in divided doses

The maintenance phase

Atypical Antipsychotics: one of the following medications

- Tabs Risperidone, tablets, 2 – 8 mg daily in divided doses.
- Quetiapine 50-750mg in divided doses.
- Olanzapine 5-20mg once a day.
- Aripiprazol 10-30mg once a day

Or

Typical antipsychotic:one of the following medication

- Tabs Haloperidol, tablets, 5 – 30 mg daily in divided doses
- Tabs Flupentixol, tablets, 1 – 6 mg daily in divided doses
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If no adherence and/or compliance, the patient should be put on the following medication:

- Flupentixol decanoate, 20 – 40 mg IM / 2 weeks
- Haloperidol decanoate, 50 – 200 mg/Month
- Tabs Pimozide, tablet, 4 – 8 mg / week orally
-

Non Pharmacological Treatment

- Psycho-education
- Group psychotherapy
- Family therapy
- Individual psychotherapy

Monitor for side effects of medication

- Acute dystonias or spasms may be managed with injectable

IM Diazepam 10mg
Or
antiparkinsonian drugs Akathisia (severe motor restlessness) may be managed with dosage reduction or beta-blockers
1. Tabs Propranolol 40mg-120 mg- Parkinsonian symptoms (tremor, akinesia) may be managed with oral antiparkinsonian
2.Tablets Biperiden 2 mg up to three times a day.
In cases of severe side effects or the appearance of fever, rigidity, hypertension, stop antipsychotic medication and consider consultation.

Mood Disorders

-- | Bipolar Disorder

Bipolar disorder frequently disrupts mood, energy, activity, sleep, cognition, and behavior and patients thus struggle to maintain employment and interpersonal relationships

Manic episode

Diagnosis

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and increased goal-directed activity or energy, lasting at least 1 week and present most of the day.
B. During the above period in A., three (or more) of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior:
1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep.
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility as reported or observed.
6. Increase in goal-directed activity or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful

Consequences

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The episode is not attributable to the physiological effects of a substance or to another medical condition.
Note: A full manic episode that emerges during antidepressant treatment (e.g., medication) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Treatment

Psycho-education for patient and family

- Unexplained changes in mood and behaviors are symptoms of an illness.

- Effective treatments are available. Long-term treatment can prevent future episodes.
- Avoid confrontation unless necessary to prevent harmful or dangerous acts
- Advise caution about impulsive or dangerous behavior
- Close observation by family members is often needed
- If agitation or disruptive behavior is severe, consider hospitalization.

If patient displays agitation, extreme or disruptive behavior, antipsychotic medication may be needed initially. In case the patient is left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, legal problems, financial problems or high-risk sexual behavior.

Pharmacological Treatment

Severe manic episode:

Mood stabilizers: one of the following medication:

1. Valproic Acid (depakine): 500-2000mg/day in two divided doses
2. Carbamazepine (Tegretol): 400-1600mg/day in two divided doses.

In addition to one of the following antipsychotic medication:

1. Chlorpromazine, IM or PO, 50-300 mg/day in divided doses
1. Levomepromazine, IM or PO 50 – 300mg/day in divided dose

Adjunctive Non Pharmacological Treatment

- Psychoeducation
- Psychotherapy
- Family therapy
- Individual psychotherapy

-- | Major Depressive Disorder

Diagnosis

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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

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

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode

Treatment

Psycho-education for patient and family

- Depression is a common illness and effective treatments are available.
- Depression is not weakness or laziness, patients are trying hard to cope.
- Close supervision by family or friends, or hospitalization, may be needed. Ask about risk of harm to others.
- Plan short-term activities that give the patient enjoyment or build confidence.
- Encourage the patient to resist pessimism and self-criticism, not to act on pessimistic ideas (e. g., ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.

- Identify current life problems or social stresses. Focus on small, specific steps patients might take towards reducing or better managing these problems.
- Avoid major decisions or life changes.

- If physical symptoms are present, discuss the link between physical symptoms and mood
- After improvement, plan with patient the action to be taken if signs of relapse occur.
- Consider antidepressant drugs if sad mood or loss of interest are prominent for at least two weeks and four or more of these symptoms are present:
- Fatigue or loss of interest, disturbed sleep, guilt or self-reproach, poor concentration, thoughts of death or suicide, disturbed appetite, agitation or slowing of movement and speech.
- In severe cases, consider medication at the first visit. In moderate cases, consider medication at a follow-up visit if counseling is not sufficiently helpful.

Ask about risk of suicide: Has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past. Can the patient be sure not to act on suicidal ideas?

Non-Pharmacological Treatment

Psychotherapy such as cognitive behavioural therapy, Problem Management Plus (PM+)

Medications

Adults:

- Initially Clomipramine, Amitriptyline or Imipramine 25–50 mg, oral taken early evening – once a day. Increase by 25 mg every 3–5 days up to a maximum dose of 150 mg respectively for clomipramine and amitriptyline and up to a maximum of 300mg for imipramine orally at night. The patient's tolerance will determine the rate of increase of the dose.
- If the patient refuses oral antidepressants, use Clomipramine, injection. Start by 25mg in IV fluids. Increase gradually up to 150 mg daily
- Note: the patient should get the minimum effective dose.

Children: 6–12 years; 5–15 mg, oral, 12 hourly

Alternative treatment:

Adults and Children above 8 years

1. Tabs Fluoxetine, oral, 20–60 mg daily as a single dose in the morning
2. Tabs Citalopram 20-40mg per day
3. Tabs Setraline ,oral 50-200mg daily as single dose (especially for pregnant women)

Note :

-If anxiety symptoms and insomnia are coexisting with depression, one of the following anxiolytics treatment may be required for a short period (not more than 10 to 15 days):

Diazepam 10 mg nocte or Zolpidem nocte 10 mg orally or *Lorazepam oral 2.5 mg, as needed, maximum 10 mg daily divided into two to three doses*

-For the first single episode of depression, antidepressants should be continued for at least 6 months after remission of symptoms, as there is a high risk of relapse.

-Stop antidepressants immediately if manic swing occurs.

-Admit patients with suicidal tendencies and keep under close observation.

Anxiety Disorders

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. *Fear* is the emotional response to real or perceived imminent threat, whereas *anxiety* is anticipation of future threat. Many of the anxiety disorders develop in childhood and tend to persist if not treated

Generalized Anxiety Disorder (Gad)

Diagnosis

GAD is characterized by excessive worry and or fear that is difficult to control, cause significant distress and impairment, and occur on more days than not for at least six months.

GAD is a relatively common disorder, most often with onset during adulthood and a chronic course. GAD can lead to significant impairments in role functioning, diminished quality of life, and high healthcare costs.

Treatment

Psycho-education for patient and family

- Fear and worry have both physical and mental effects.
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.
- Encourage the patient to practice daily relaxation methods to reduce physical symptoms of tension.
- Encourage the patient to engage in pleasurable activities and exercise, and to resume activities that have been helpful in the past.
- Identifying and challenging exaggerated worries can reduce anxiety symptoms.
- Identify exaggerated worries or pessimistic thoughts (e. g., when daughter is five minutes late from school, patient worries that she may have had an accident).

Non Pharmacological Treatment

- Cognitive behavioral therapy
- Reassurance
- Teach relaxation methods

- Regular exercise

Encourage healthy social activities

Medications:

One of the following medications can be used. The antidepressant stays the treatment of choice

1. Tabs Fluoxetine, 20 mg-60mg, oral, as a single morning dose
2. Tabs Imipramine or Amitryptiline can be used in doses of 25–300 mg as an oral single and evening dose.
3. Tabs Diazepam, oral, 5-10 mg; 2 to 3 times daily for 2 weeks. Do NOT give for more than 15 days continuously.

-- | Phobia

Diagnosis

Phobia is a type of anxiety disorder that causes an individual to experience extreme, irrational fear about a situation, living creature, place or object.

Treatment

Psycho-education for patient and family

- Phobias can be treated.
- Avoiding feared situations allows the fear to grow stronger.
- The patient should avoid using alcohol or benzodiazepine drugs to cope with feared situations.

Non Pharmacological Treatment

- Cognitive behavioural therapy

Medications:

One of the following medication can be used. The antidepressant stays the treatment of choice

1. Tabs Fluoxetine, 20 mg-60mg, oral, as a single morning dose
2. Tabs Imipramine or Amitryptiline can be used in doses of 25–300 mg as an oral single dose.
3. Tabs Diazepam, oral, 5-10 mg 2 to 3 times daily. Do NOT give for more than 15 days continuously

-- | Panic Disorder

Panic disorder is a chronic illness characterized by recurrent panic attacks, at least some of which are unexpected, accompanied either by anxiety about having future attacks or about the implications of attacks, or by a change in behavior due to attacks.

Diagnosis

Panic attacks classically present with spontaneous, discrete episodes of intense fear that begin abruptly and last for several minutes to an hour. In panic disorder, patients experience recurrent panic attacks, at least some of which are not triggered or expected, and one month or more of either worry about future attacks/consequences, or a significant maladaptive change in behavior related to the attacks, such as avoidance of the precipitating circumstances.

Treatment

Psycho-education for patient and family

- Panic is common and can be treated.
- Anxiety often produces frightening physical sensations. Chest pain, dizziness or shortness of breath is not necessarily signs of a physical illness: they will pass when anxiety is controlled.
- Panic anxiety also causes frightening thoughts (fear of dying, a feeling that one is going mad or will lose control). These also pass when anxiety is controlled.
- Mental and physical anxiety reinforces each other. Concentrating on physical symptoms will increase fear.
- A person who withdraws from or avoids situations where attacks have occurred will only strengthen his/her anxiety.

Non Pharmacological Treatment

- Cognitive behavioral therapy

Medications:

One of the following medication can be used. The antidepressant stays the treatment of choice

1. Tabs Fluoxetine, 20 mg-60mg, oral, as a single morning dose
2. Tabs Imipramine or Amitryptiline can be used in doses of 25–300 mg

as a single, oral dose.

3. Tabs Diazepam, oral, 5 -10mg 2 to 3 times daily. Do NOT give for more than 15 days continuously.

Obsessive-Compulsive Disorder

Diagnosis

Obsessive-compulsive disorder (OCD) is characterized by recurrent, intrusive, and distressing thoughts, images, or impulses (ie, obsessions), and repetitive mental or behavioral acts that the individual feels driven to perform (ie, compulsions) to prevent or reduce distress.

Treatment

Medications

1. Tabs Fluoxetine, 20 mg-60mg, oral, as a single morning dose
2. Among tricyclics, Tabs clomipramine is effective and can be used in doses of 25–250 mg as a single, oral morning dose.

Note: For complicated cases, an augmentation to the antidepressant of a small dose of antipsychotic like Olanzapine 2.5 to 5 mg or Risperidone 1 to 2 mg can be effective.

Non Pharmacological Treatment

- Cognitive behavioral therapy

Trauma- And Stressor-Related Disorders

Trauma- and stressor-related disorders include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders.

-- | Adjustment Disorders

Diagnosis

- The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
  -Marked distress that is out of proportion to the severity or intensity of the stressor,
  -Significant impairment in social, occupational, or other important areas of functioning.
- The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder
- The symptoms do not represent normal bereavement.
- Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Treatment

Psycho-education for patient and family

- Stressful events often have mental and physical effects.
- Stress-related symptoms usually last few days or weeks

Non pharmacological approach:

Cognitivo-behavioral Therapy (CBT) like psychotherapy:

- Encourage the patient to acknowledge the personal significance of the stressful event.
- Review and reinforce positive steps the patient has taken to deal with the stress.
- Identify steps the patient can take to modify the situation that produced the stress. If the situation cannot be changed, discuss problem-solving strategies.
- Identify relatives, friends and community resources able to offer support.
- Short-term rest and relief from stress may help the patient.

Encourage a return to usual activities within a few weeks.

Medication:

Most acute stress reactions will resolve without use of medication. However, if severe anxiety symptoms occur, use anti anxiety drugs for up to three days (e.g., benzodiazepines such as;
1.Tabs lorazepam 0.5-1.0 mg up to three times a day.
If the patient has severe insomnia, use hypnotic drugs for up to three days (e.g. trazodone 50-100mg per night or zolpidem 10mg per night,).

-- | Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) has been described as **the complex somatic, cognitive, affective, and behavioral effects of psychological trauma.**

Diagnosis

A. Exposure to actual or threatened death, serious injury, or sexual violence.
B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)..
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred.
D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance

F. Duration of the disturbance is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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

Treatment

Pharmacological Treatment: one of the following can be used:

1. SSRI and SNRIs such as Tabs fluoxetine 20-60mg , oral, daily f
2. Tabs Imipramine or Amitryptiline can be used in doses of 25–250 mg as a single, oral dose.
3. Tabs Fluoxetine, 20 mg, oral, as a single morning dose

Note: In complicated cases with psychotic features, antipsychotics such as risperidone 0,5 to 4mg daily or quetiapine 25-400mg. In case of nightmares and other sleep disturbances, Prazosin 3-15mg at bed time will be more indicated.

Non Pharmacological Treatment

- Cognitive behavioral therapy especially the trauma focused psychotherapy is the treatment of choice.

Somatic Symptom And Related Disorders

These disorders includes the diagnoses of somatic symptom disorder, illness anxiety disorder (hypochondiasis), conversion disorder (functional neurological symptom disorder), psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder.

Diagnosis

All of the disorders in this chapter share a common feature: the prominence of somatic symptoms associated with significant distress and impairment. Individuals with disorders with prominent somatic symptoms are commonly encountered in primary care and other medical settings but are less commonly encountered in psychiatric and other mental health settings. Their history and physical examination do not indicate the presence of a medical condition. Medical test results are either normal or do not explain the person's symptoms. Patients are convinced that their symptoms result from some type of undetected and untreated bodily derangement.
These complaints are real given that the patients do actually experience these symptoms. They result from mind – body interactions in which the brain sends various signals that impinge on the patient's awareness, indicating a severe problem in the body.

Treatment

Specific non pharmacological treatments:
Cognitive-behavioral therapy and other therapy that includes general advice, lifestyle change, relaxation.

Medications:

1.Tabs Amitriptyline or Imipramine 25−250 mg, oral taken early evening
2.Tabs Fluoxetine 20-60mg in the morning
3.Tab Diazepam 10 mg at night for 10 day

Substance-Related And Addictive Disorders

These disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants : tobacco; and other (or unknown) substances. These 10 classes are not fully distinct. The substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. The following conditions may be classified as substance- induced: intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders).

-- | Alcohol Use Disorders

The World Health Organization estimated that more than 283 million people (5 percent of adults) had a current (past 12-month) alcohol use disorder worldwide.

Diagnosis

Harmful alcohol use

- Heavy alcohol use (quantity defined by local standards, e. g., over 21 Units of alcohol per week for men, over 14 units of alcohol per week in women)
- Overuse of alcohol has caused physical harm (e. g., liver disease, gastrointestinal bleeding), psychological harm (e. g., depression or anxiety due to alcohol) or has led to harmful social consequences (e. g., loss of job).

Standard questionnaires (e.g., AUDIT) may help identify harmful use.

Alcohol dependence

- Continued alcohol use despite harm
- Difficulty controlling alcohol use
- Strong desire to use alcohol
- Tolerance (drinks large amounts of alcohol without appearing intoxicated)
- Withdrawal (anxiety, tremors, sweating after stopping drinking).

Treatment

Psycho-education for patient and family

- Alcohol dependence is an illness with serious consequences.
- Stopping or reducing alcohol use will bring mental and physical benefits.
- Drinking during pregnancy can harm the baby.

In some cases of harmful alcohol use without dependence, controlled or reduced drinking' is a reasonable goal.
For patients with alcohol dependence, abstinence from alcohol is the goal.
Because abrupt abstinence can cause withdrawal symptoms, medical supervision is necessary. Relapse is common. Controlling or stopping drinking often requires several attempts.

Motivation interview

For patients willing to stop now

- Set a definite day to quit.
- Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events.
- Make specific plans to avoid drinking (e. g., ways to face stressful events without alcohol, ways to respond to friends who still drink).
- Help patients to identify family members or friends who will support stopping alcohol use.
- Discus symptoms and management of alcohol withdrawal.

If reducing drinking is a reasonable goal (or if patient is unwilling to quit)
-Negotiate for a clear goal for decreased use
-Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events).
-Self-help organizations (e. g., Alcoholics Anonymous) are often helpful.

Non Pharmacological Treatment
-Group therapy
-Adequate nutrition

Pharmacological Treatment
Uncomplicated alcohol dependence (First week)
Admit for one week. Stop all alcohol use.
Then *Give Thiamine inj 100 mg (IV/IM)2 to 3 time a day for 3 to 7 days*
AND
Give Diazepam, oral, as follows:

- Day 1 Diazepam 10 – 20 mg twice daily
- Day 2 Diazepam 10 – 20 mg twice daily
- Day 3 Diazepam 5 – 10 mg twice daily
- Day 4 Diazepam 5 – 10 mg twice daily
- Day 5 Diazepam 10 mg at night
- Day 6 Diazepam 10 mg at night
- Day 7 Diazepam 5 mg at night

Uncomplicated alcohol dependence (second week)

- Tab Diazepam 5 mg once daily for 2–7 days then STOP.
- Give thiamine oral 50-100 mg daily and indefinitely as long as the patient still taking alcohol.
- Give folic acid oral 5 mg daily
- Give multivitamin and mineral preparations daily for about one month

***Note*:** If there is a history of concomitant diazepam abuse, this may not be effective therefore consult a specialist.

Maintenance treatment

1. Antabuse, tab 100-500mg once a day for at least 3 to 6 months.
2. Tabs-Acamprosate oral 666 mg Three times a day least for 6 months
3. Naltrexone oral 50-100mg daily for 3 to 6 months (Patient must be opioid free for at least 7 to 10 days).

-- | Cannabis Use Disorders

Diagnosis

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

1. Cannabis is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
4. Craving, or a strong desire or urge to use cannabis.

5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
10. Tolerance,
11. Withdrawal

Treatment

Psycho-education for patient and family

- Abstinence is the goal; the patient and family should concentrate on this.
- Stopping or reducing drug use will bring mental and physical benefits.
- Using drugs during pregnancy will harm the baby.
- Relapse is common. Controlling or stopping drug use often requires several attempts.

Movational Interview:

For patients willing to stop now

- Set a definite day to quit.
- Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events).
- Make specific plans to avoid drug use (e.g., how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug use.

If reducing drug use is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than one marijuana cigarette per day with two drug-free days per week).
- Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events).
- Introduce self-monitoring procedures and safer drug-use behaviors (e. g., time restrictions, slowing down rate of use).

- For patients not willing to stop or reduce use now
- Do not reject or blame.
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to reassess health and discuss drug use.
- For patients who do not succeed or relapse
- Identify and give credit for any success.
- Discuss situations that led to relapse.
- Return to earlier steps above.
- Self-help organizations (e. g., Cannabis Anonymous) are often helpful.

Non-pharmacological

- Psychotherapy
- Supportive Group

Medication:

For Craving: Bupropion: 150-300mg OD.
Note: Cannabis users may develop psychosis, anxiety, mood disorders, and a withdrawal state. Therefore we treat the presenting symptoms accordingly.

-- | Opioid Use Disorder

Diagnostic Criteria

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

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance,
11. Withdrawal symptoms such as Dysphoric mood, Nausea or vomiting., Muscle aches, Lacrimation or rhinorrhea, Pupillary dilation, piloerection, or sweating, Diarrhea, Yawning, Fever, Insomnia.

Treatment

Psycho-education for patient and family

- Abstinence is the goal; the patient and family should concentrate on this.
- Stopping or reducing drug use will bring mental and physical benefits.
- Using drugs during pregnancy will harm the baby.
- For intravenous drug users, there is a risk of getting or giving HIV infection, hepatitis or other blood borne infections. Discuss appropriate precautions (use condoms, do not re-use needles).
- Relapse is common. Controlling or stopping drug use often requires several attempts.

Movational Interview:

For patients willing to stop now

- Set a definite day to quit.
- Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events).
- Make specific plans to avoid drug use (e.g., how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug use.

If reducing drug use is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than one marijuana cigarette per day with two drug-free days per week).
- Discuss strategies to avoid or cope with high-risk situations (e. g., social situations, stressful events).
- Introduce self-monitoring procedures and safer drug-use behaviors (e. g., time restrictions, slowing down rate of use).

- For patients not willing to stop or reduce use now
- Do not reject or blame.
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to reassess health and discuss drug use.
- For patients who do not succeed or relapse
- Identify and give credit for any success.
- Discuss situations that led to relapse.
- Return to earlier steps above.
- Self-help organizations (e. g., Narcotics Anonymous) are often helpful.

Non-pharmacological

- Psychotherapy
- Supportive Group

Medication:

One of the following medications can be used:

1. Methadone syrup, 20mg-120mg/day in divided dose and prescribed in a specialized mental health facility.
2. Clonidine tabs 0.1 mg -1.2mg/day in 3 or 4 divided doses.
3. Buprenorphine sublingual tabs, 4mg to 24mg/day once a day

Note: the prescriber should use the minimum effective dose.

Neurocognitive Disorders

These disorders includes "Dementia, Delirium, Amnestic, and Other Cognitive Disorders". They encompass the group of disorders in which the primary clinical deficit is in cognitive function, and that are acquired rather than developmental. Although cognitive deficits are present in many if not all mental disorders (e.g., schizophrenia, bipolar disorders), only disorders whose core features are cognitive are included in the NCD category.

-- | Delirium

- Families may request help because patient is confused or agitated.
- Delirium may occur in hospitalized patients for physical conditions.
- Patients may appear uncooperative or fearful.

Diagnosis

Acute onset of:

- Confusion (patient appears confused, struggles to understand surroundings)
- Clouded thinking **or** awareness.
- Often accompanied by:
    - Poor memory
    - Emotional upset
    - Wandering attention
    - Withdrawal from others
    - Suspiciousness
    - Agitation
    - Loss of orientation
    - Hearing voices
    - Visions or illusions
    - Disturbed sleep (reversal of sleep pattern)

Symptoms often develop rapidly and may change from hour to hour.
May occur in patients with previously normal mental function or in those with dementia.

Milder stresses (medication, mild infections) may cause delirium in older patients or in those with dementia.

Treatment

Psycho-eduction for patient and family

- Strange behavior or speech is symptoms of an illness.
- Take measures to prevent the patient from harming him/herself or others (e. g., remove unsafe objects, restrain if necessary).
- Supportive contact with familiar people can reduce confusion.
- Provide frequent reminders of time and place to reduce confusion.
- Hospitalization may be required because of agitation or because of physical illness which is causing delirium.

Medication

- Avoid use of sedative or hypnotic medications (e. g., benzodiazepines) except for the treatment of alcohol or sedative withdrawal.
- Antipsychotic medication in low doses (*Tablets Haloperidol 2-l0 mg once or twice a day,* may be needed to control agitation, psychotic symptoms or aggression).

Be aware of drug side-effects (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Psychiatric Emergencies

Suicide

The word suicide means "self-murder." If successful, it is a fatal act that fulfils the person's wish to die. various terms used to describe para-suicidal thoughts or behaviours that is, suicidality , ideation should be used with clear meaning and purpose.Nearly 45,000 people in the United States and more than 800,000 worldwide die by suicide each year. In Rwanda from 2019 to 2020, 576 peoples died by suicide as reported by the Rwanda Investigation Bureau in September 2021.

Primary care providers may be in a unique position to prevent suicide due to their frequent interactions with suicidal patients.

Risk factors

- Gender. Men commit suicide three times more often than women. Women attempt suicide four times more often than men.

- Method. Men' s higher rate of successful suicide is related to the methods they use (e.g., firearms, hanging), while women more commonly take an overdose of psychoactive substances or a poison.
- Age. Rates increase with age
- Marital status. Rate is twice as high in single persons
- Mental illness, Depression, schizophrenia, alcohol and drug abuse
- Chronic physical condition

Treatment

- Do not leave a suicidal patient alone; remove any potentially dangerous objects from the room.
- Assess whether the attempt was planned or impulsive. Determine the lethality of the method, the chances of discovery (whether the patient was alone or notified someone), and the reaction to being saved (whether the patient is disappointed or relieved). Also, determine whether the factors that led to the attempt have changed.
- Patients with severe depression may be treated on an outpatient basis if their families can supervise them closely and if treatment can be initiated rapidly. Otherwise, hospitalization is necessary. The suicidal ideation of alcoholic patients generally remits with abstinence in a few days. If depression persists after the physiologic signs of alcohol withdrawal have resolved, a high suspicion of major depression is warranted. All suicidal patients who are intoxicated by alcohol or drugs must be reassessed when they are sober.

-- | Agitation/Aggression

Diagnosis

Agitation is an acute state of anxiety, heightened emotional arousal, and increased motor activity. Although not specific to psychosis, untreated psychosis is associated with an increased risk for agitation and aggressive behaviors. These can sometimes lead to intentional or unintentional bodily harm to self or others. Clinicians should observe the patient's behaviors, including body language and voice intonation, and use appropriate safety measures for the evaluation.

Treatment

Non- Pharmacological

- Maintain safety
- Verbal de-escalation/distraction
- Physical restraint (manual and/or mechanical)
- Calling for security or police assistance

Medications:

Intramuscular

1. 1.Diazepam 10mg IM
   or
2. Lorazepam 2 – 4 mg Im (Max 6mg/24hrs) Sedation in 30 – 45 minutes; peaks in 1 – 3 hours, lasts 4 – 6 hours
   + / -
3. Haldol 5mg IM (Max 18mg / 24hrs) Sedation in 10 minutes; peaks in 20 minutes or Chlorpromazine 100- 400mg/day IM, in divided doses
   Note: Chlorpromazine IV is contra indicated.

EPILEPSY

Epilepsy is a disorder of the brain characterized by recurrent seizures, which are brief episodes of involuntary movement that involve a part of the body or entire body and are sometimes accompanied by loss of consciousness and control of bowel or bladder function. Seizures are a result of excessive electrical discharges in a group of brain cells.

Treatment

Non Pharmacological Treatment

Psycho-education of the patient and family

Ensure safety of the patient including to remove false teeth if present
Immediate emergency measures:
If patient is seen convulsing:
Ensure that the patient does not harm himself and that the airway is clear
Clothing about the neck should be loosened
After convulsions cease, turn the patient into semi–prone position, ensure the airway is clear

Medications

Anti–convulsing medicine therapy:

Type of Seizure Drug Dose

Table 1. Treatment of 1st and 2 nd generation

Product	Daily dose	Mg/day (adult)	Mg/ day (child)	Indication	Side effects	Teratogenicity
Phenobabital	1	1,5-3mg/kg	3-4mg/kg	Generalized-tonic-clonic and partial seizure	Irritability and cognitive hints	Yes
Phenytoin	2	2-6mg/kg	4-8mg/kg	Generalized-tonic-clonic and partial seizure	Hypertrophic Gingivitis, Hirsutism, Hypofolique / vitD	Yes
Carbamazine	2	10-15mg/kg	5-20mg/kg	Generalized-tonic-clonic and partial seizure	Nausea, Digestive, Drunkenness, Diplopia	Yes
Valproic acid	2	15-20mg/kg	2030mg/kg	Generalized-tonic-clonic and partial seizure	Weight gain, Hair loss, Hematologic, Hepatotoxicity, Pancreas	Yes
Diazepam (valium)	2-3	0,1-0,2mg/kg	0,1-0,2mg/kg	Status Epilepticus	Dependence Paradoxical Effect, Sedation	Unknown
Clonazepam	1-3	0.05-0.1mg/kg		Status Epilepticus	Sedative, Dependence	Unknown

Management of Status Epilepticus

Non pharmacological Treatment

Remove false teeth if present
Insert a Brook's airway (oropharyngeal tube) to maintain airway
Give oxygen
Give Diazepam IV , 10–20 mg, not faster than 2 mg/minute
Or
Clonazepam, IV, 1 mg , May be repeated after 5 minutes. Maximum dose: 4 mg. Or
Lorazepam, IV/IM, 4 mg

If there is no venous access:
Diazepam, rectal, 10 mg using the contents of an ampoule
Or
Clonazepam, IM, 1 mg
If seizures continue:
Set up IV infusion of Diazepam in Sodium Chloride 0.9% 40−80 mg per litre to be infused over six hours. Give at 5 mg/min until seizures stop
If seizures still uncontrolled 60 minutes after it began:
Deepen sedation and ventilate for safe Transfer to a facility where the patient can be appropriately manage.

Recommendations

Take adequate history to define the type of epilepsy.
Treatment can be stopped only after 2-5years free of seizures, a normal EEG and full discussion with patient.
If hypoglycaemia is suspected, treat as appropriate for adult or child.

The Neurodevelopmental Disorders

These disorders are a group of conditions with onset in the developmental period.
They typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning.

The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. These include disorders such the intellectual development disorders, autism spectrum disorders or attention-deficit/ hyperactivity disorder (ADHD).

-- | Intellectual Disability (Intellectual Developmental Disorders)

Intellectual disability (ID) is a neurodevelopmental disorder with multiple etiologies. It is characterized by deficits in intellectual and adaptive functioning of varying severity, presenting before 18 years of age.

Diagnosis:

The following three criteria must be met:

- Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience.
- Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility.
- Onset of intellectual and adaptive deficits during the developmental period.

Treatment

Psychoeducation for patient and family

- Early training can help a mentally retarded person towards independence and self-care.
- Retarded children are capable of loving relationships.
- Reward effort. Allow retarded children and adults to function at the highest level of their ability in school, work and family.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child.
- Offer empathy and reassurance.
- Advise families that training will be helpful but that miracle cures do not exist.

Medication

Except in the case of certain physical or psychiatric disorders, medical treatment cannot improve mental function.
Retardation may occur with other disorders that require medical treatment (e. g., Epilepsy, spasticity psychiatric illness such as depression).

-- | Attention Deficit Hyperactivity Disorder (Adhd)

This is a disorder that manifests in childhood with symptoms of hyperactivity, impulsivity, and/or inattention. The symptoms affect cognitive, academic, behavioral, emotional, and social functioning
Diagnostic criteria for ADHD include symptoms of hyperactivity, impulsivity, and/or inattention that occur in more than one setting and affect function (eg, academic, social, emotional, etc.).

Diagnosis

Usually there is:

- Severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- Abnormal physical restlessness (most evident in classroom or at mealtimes)
- Impulsiveness (the patient cannot wait his or her turn, or acts without thinking).
- Sometimes there may be discipline problems, underachievement in school, proneness to accidents.
- This pattern occurs in all situations (home, school, play).

Treatment

Psycho-education for patient and family

- Hyperkinetic behavior is not the child's fault
- The outcome is better if parents can be calm and accepting.
- Hyperactive children need extra help to remain calm and attentive at home and school
- Some hyperactive children continue to have difficulties into adulthood, but most make a satisfactory adjustment.
- Encourage parents to give positive feedback or recognition when the child is able to pay attention.

- Avoid punishment.
- Advise parents to discuss the problem with the child's school teacher (to explain that learning will be in short bursts, immediate rewards will encourage attention, and periods of individual attention in class may be beneficial).
- Stress the need to minimize distractions (e.g., have child sit at front of class).
- Sport or other physical activity may help release excess energy.
- Encourage parents to meet with the school psychologist or counsellor (if available).

Medication

For more severe cases, stimulant medication may improve attention and reduce overactivity (e.g.,Tabs methylphenidate 10-60 mg a day)

-- | Autism Spectrum Disorders

DIAGNOSIS

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
    - Deficits in social-emotional reciprocity,
    - Deficits in nonverbal communicative behaviors
    - Deficits in developing, maintaining, and understanding relationships
- Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history :
    - Stereotyped or repetitive motor movements, use of objects, or speech
    - Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
    - Highly restricted, fixated interests that are abnormal in intensity or focus
    - Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment
- Symptoms must be present in the early developmental period
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

Psycho-education to the family:
Explain:

- what ASD is
- When to take the child to the doctor.

Treatment

- The right treatment for autism spectrum disorder depends on the age of the child, How severe the disorders is and whether the child has any other medical problem. ASD can not be cured.
- The treatment of ASD focuses on Behavioral and educational interventions that target the core symptoms of ASD.
- The psychopharmacologic interventions such as Risperidone, Citalopram, aripriprazol, methylphenidates or other stimulants, do not treat the underlying ASD but they improve the child's functioning and ability to participate in the behavioral interventions.

Disruptive, Impulse-Control, and Conduct Disorders

Disruptive, impulse-control, and conduct disorders include conditions involving problems in the self-control of emotions and behaviors.

Diagnosis

A consistent pattern of abnormally aggressive or defiant behavior such as:

- Fighting, bullying, truancy, cruelty, stealing, lying, vandalism.
- Conduct must be judged by what is normal for age and culture.
- Conduct disorder may be associated with stress at home or school

Treatment

Psycho-education for patient and family

- Effective discipline should be clear and consistent, but not harsh.
- Avoid punishment. It is more helpful to reward positive behavior.
- Ask about the reasons for disruptive behavior, Alter the child's circumstances accordingly, as far as is possible.
- Encourage parents to give positive feedback or recognition for good behavior.
- Parents should make discipline consistent.

- Advise parents to discuss this approach to discipline with teachers.
- Relatives, friends or community resources can support parents in providing consistent discipline. No appropriate treatment has been established

Elimination Disorders

Elimination disorders all involve the inappropriate elimination of urine or feces and are usually first diagnosed in childhood or adolescence.

-- | Enuresis

Diagnosis

- Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
- The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- Chronological age is at least 5 years.
- The behavior is not attributable to the physiological effects of a substance

Treatment

Psycho-education for patient and family

- Enuresis is usually part of a specific delay in development. It is often hereditary.
- The outlook is good. Treatment is usually effective.
- Enuresis is not within a child's voluntary control.
- Punishment and scolding are unlikely to help and may increase emotional distress.
- Make the child a part of his/her own treatment.
- Have the child keep a record of dry nights on a calendar.
- Give praise and encouragement for success.
- Offer reassurance if the child is anxious about using toilets (e. g., at night, away from home).
- If available, simple alarm systems will warn the child of night-time wetting and can improve bladder control. Ensure that the child wakes and urinates in the toilet when the alarm sounds. Up to 12 weeks of use may be needed.

- Exercises to increase bladder control while awake may be helpful (resisting urge to urinate for longer and longer periods! stopping urination in mid-stream).

Medication

Regular use of medication is usually not though it can help when children have a special need to be dry. Effective medications include:

1. Tabs imipramine (25-50mg two hours before bedtime),
2. Desmopressin 0.1-0.2 mg at bed time.
3. Oxybutynin5mg at bedtime.

-- | Encopresis

Diagnosis

- Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
- At least one such event occurs each month for at least 3 months.
- Chronological age is at least 4 years (or equivalent developmental level).
- The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.

Treatment

- The earlier that treatment begins for encopresis, the better.
- The first step involves clearing the colon of retained, impacted stool.
- The treatment focuses on encouraging healthy bowel movements.
- Psychotherapy may be a helpful addition to treatment.

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The list of contributors

Ministry of Health and Stakeholders

	Names	Institution
1	Dr Corneille NTIHABOSE	MOH
2	Dr Parfait UWALIRAYE	MOH
3	Dr Nathalie UMUTONI	MOH
4	Dr MUVUNYI Zuberi	MOH
5	Theobald HABIYAREMYE	MOH
6	Eliezer NSENGIYUMVA	MOH
7	Dr Felix SAYINZOGA	RBC
8	Dr Francois UWINKINDI	RBC
9	Dr Evariste NTAGANDA	RBC
10	Dr Jean Louis MANGARA	RBC
11	Marc HAGENIMANA	RBC
12	Frederic MUHOZA	RFDA
13	Dr Lysette UMUTESI	RSSB
14	Alexis RULISA	RSSB
15	Esperance MUKARUSINE	RSSB
16	Dr Emmanuel SABAYESU	MMI
17	Diane MUTONI	RMS
18	Jean Bernard MUNYANGANZO	RMS
19	Julie KIMONYO	NCNM
20	Prof. Annette UWINEZA	RMDC
21	Jean Damascene GASHEREBUKA	RAHP
22	Prof. Emile RWAMASIRABO	Consultant
22	Dr Raymond MUGANGA	Consultant
23	Dr Richard BUTARE	Consultant
24	Prof. Charlotte M. BAVUMA	RCP
25	Stella Matutina TUYISENGE	WHO

26	Dr William NIRINGIYIMANA	RHIA
27	Patrick RUGAMBYA	MPC
28	Eugene R. Abinene	USAID
29	Theogene NDAYAMBAJE	RFDA
30	Jean D'Amour URAMUTSE	NUDOR
31	Ines MUSABYEMARIYA	FHI
32	Dr Georges RUZIGANA	RSOG

Mental Health

No	Names	Specialty
1	Dr. Musoni Emmanuel	Psychiatry
2	Dr. Yubahwe Janvier	Psychiatry
3	Dr. Mudenge Charles	Psychiatry
4	Dr. Rutakayire Bizoza	Psychiatry
5	Dr. Butare Richard	Consultant
6	Dr. Muganga Raymond	Consultant
7	Prof. Bizoza Rutakayire	Psychiatry
8	Prof. Emile Rwamasirabo	Consultant