MENTAL HEALTH

COMPLETE LOSKEWA NOTES

Definition of Mental Health

Mental health is defined by the **World Health Organization (WHO)** as **"a state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community."**

This definition emphasizes:

- **Well-being**: Encompassing emotional, psychological, and social aspects, not merely the absence of mental disorders.
- **Functionality**: The ability to manage daily challenges, maintain relationships, and achieve personal goals.
- **Community Contribution**: Active participation in social and cultural activities, reflecting mental health's role in societal harmony.
- **Dynamic Nature**: Mental health is not static; it fluctuates based on life circumstances, stressors, and support systems.

In the context of Nepal, mental health also involves cultural and spiritual dimensions, where balance in mind, body, and community relationships is valued. Stigma and limited resources often challenge the recognition of mental health as a priority, making it critical for ANMs to promote awareness and holistic care.

Management of Clients with Mental Disorders

The management of clients with mental disorders requires a multidisciplinary, client-centered approach to address acute symptoms, promote recovery, and prevent relapse. ANMs play a pivotal role in providing initial care, facilitating referrals, and supporting families, particularly in resource-limited settings like Nepal. Below is an expanded explanation with practical strategies, cultural considerations, and case-based applications.

1. Comprehensive Assessment

- **Detailed History-Taking**:
  - Collect data on psychiatric history (previous episodes, hospitalizations), medical history (e.g., epilepsy, head injury), substance use (e.g., alcohol, cannabis), and family history of mental illness.
  - Assess social determinants like poverty, domestic violence, or migration, which are prevalent in Nepal and contribute to mental health issues.
- **Mental Status Examination (MSE)**:
  - **Appearance**: Note hygiene, grooming, or unusual attire (e.g., disheveled in depression, bizarre clothing in mania).
  - **Behavior**: Observe agitation, withdrawal, or repetitive actions.
  - **Mood and Affect**: Identify sadness, euphoria, or inappropriate emotions.
  - **Thought Processes**: Detect delusions (e.g., persecution in schizophrenia) or obsessions (e.g., contamination fears in OCD).
  - **Cognition**: Test memory, orientation, and concentration.
  - **Insight and Judgment**: Evaluate the client's awareness of their condition and decision-making ability.
- **Risk Assessment**:

- Screen for suicidal or homicidal ideation using direct questions (e.g., "Have you thought about harming yourself or others?").
- Identify risk factors like recent loss, substance abuse, or access to lethal means (e.g., pesticides, common in rural Nepal).

- **Cultural Considerations**:
  - In Nepal, clients may describe symptoms through cultural idioms (e.g., "jhum-jhum" for dissociation or numbness).
  - Be aware of stigma; families may attribute mental illness to supernatural causes (e.g., possession by spirits) and seek traditional healers first.

2. Therapeutic Interventions

- **Pharmacological Management**:
  - **Common Medications**:
    - **Antipsychotics**: Typical (e.g., Haloperidol for acute psychosis) and atypical (e.g., Olanzapine for schizophrenia with fewer side effects).
    - **Antidepressants**: SSRIs (e.g., Fluoxetine) for depression; monitor for side effects like nausea or sexual dysfunction.
    - **Mood Stabilizers**: Lithium for bipolar disorder; requires regular blood level monitoring to prevent toxicity.
    - **Anxiolytics**: Short-term use of Benzodiazepines (e.g., Diazepam) for acute anxiety; caution against dependence.
  - **Nursing Responsibilities**:
    - Administer medications as prescribed, ensuring correct dosage and timing.
    - Educate clients about side effects (e.g., weight gain with antipsychotics, drowsiness with anxiolytics).
    - Monitor for adverse effects like **extrapyramidal symptoms** (EPS) (tremors, rigidity) or **neuroleptic malignant syndrome** (fever, muscle rigidity).
    - Ensure adherence, as non-compliance is common due to stigma or lack of awareness.
- **Psychotherapy**:
  - **Cognitive Behavioral Therapy (CBT)**: Effective for depression, anxiety, and PTSD. ANMs can refer clients to psychologists or trained counselors.
  - **Interpersonal Therapy (IPT)**: Focuses on improving relationships, useful for depression linked to social stressors (e.g., domestic violence).
  - **Group Therapy**: Encourages peer support, particularly for substance abuse or postpartum depression.
  - **Challenges in Nepal**: Limited availability of trained therapists; ANMs may provide basic counseling or psychoeducation.
- **Electroconvulsive Therapy (ECT)**:
  - Indicated for severe depression, catatonia, or acute mania unresponsive to medications.
  - Performed in tertiary centers (e.g., Tribhuvan University Teaching Hospital). ANMs prepare clients by explaining the procedure and monitoring post-ECT recovery (e.g., confusion, headache).

3. Nursing Interventions

- **Therapeutic Communication**:
  - Use open-ended questions (e.g., "Can you tell me how you've been feeling?") to encourage expression.

- Avoid confrontation with delusional clients; instead, acknowledge their feelings (e.g., “It sounds distressing to feel that way”).

- **Safety Measures**:
  - Remove sharp objects, medications, or ropes from the environment to prevent self-harm.
  - Use de-escalation techniques for agitated clients: maintain a calm tone, avoid sudden movements, and offer space.
  - Implement restraints only as a last resort, following Nepal Nursing Council ethical guidelines and documenting the rationale.
- **Crisis Management**:
  - For suicidal clients, stay with them, remove means of harm, and refer urgently to a psychiatrist.
  - For aggressive clients, ensure staff safety and use PRN medications if prescribed.
- **Support for ADLs**:
  - Assist with hygiene, nutrition, and sleep, as clients with severe depression or psychosis may neglect self-care.
  - Example: Encourage small, achievable goals (e.g., “Let’s brush your teeth together today”).
- **Family Involvement**:
  - Educate families to reduce stigma and promote support (e.g., “Mental illness is treatable, like diabetes”).
  - Address myths (e.g., mental illness as a curse) with culturally sensitive explanations.

4. Psychosocial Support and Rehabilitation

- **Psychoeducation**:
  - Teach clients and families about the disorder, treatment benefits, and relapse prevention.
  - Example: Explain that antidepressants may take 2–4 weeks to show effects.
- **Support Groups**:
  - Connect clients to community-based groups, such as those for alcohol dependence or postpartum depression.
  - In Nepal, NGOs like **KOSHISH** or **CMC-Nepal** offer such services.
- **Vocational Rehabilitation**:
  - Facilitate skill training (e.g., tailoring, farming) to promote financial independence.
  - Coordinate with local NGOs or government programs for job placement.
- **Social Reintegration**:
  - Help clients rebuild social connections through community activities (e.g., festivals, women’s groups).
  - Address stigma by engaging community leaders (e.g., FCHVs, religious figures).

5. Community-Based Care in Nepal

- **Role of Health Posts**: ANMs at health posts screen for mental health issues, provide basic counseling, and refer to district hospitals.
- **Collaboration with FCHVs**: Female Community Health Volunteers identify cases (e.g., postpartum depression) and link them to ANMs.
- **Mental Health Programs**: Nepal’s **Community Mental Health Program** (supported by WHO and MoHP) trains ANMs to deliver basic mental health services.
- **HMIS Integration**: Document cases in the Health Management Information System to track prevalence and treatment outcomes.

6. Legal and Ethical Considerations

- **Client Rights**: Uphold rights to dignity, privacy, and informed consent as per Nepal’s **Constitution 2072 BS** (Article 28: Right to Health).

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- **Involuntary Treatment**: Follow legal protocols for admitting clients who pose a risk to themselves or others, ensuring oversight by a psychiatrist.
- **Confidentiality**: Protect client information, sharing only with authorized personnel.
- **Ethical Practice**: Adhere to Nepal Nursing Council standards, avoiding coercion or discrimination.

7. Case Example

- **Scenario**: A 30-year-old woman in Koshi Province presents with sadness, insomnia, and suicidal thoughts after losing her job. She believes her condition is due to a curse.
- **Management**:
  - Assess using MSE; confirm depression with suicidal ideation.
  - Ensure safety by removing harmful objects and involving family.
  - Refer to a psychiatrist for antidepressants (e.g., Sertraline) and counseling.
  - Educate the family about depression as a medical condition, addressing cultural beliefs.
  - Follow up through FCHVs to ensure medication adherence and social support.

8.2 Characteristics of Mentally Ill Patients (Elaborated)

The characteristics of mentally ill patients vary widely but are critical for accurate assessment and intervention. These characteristics reflect disruptions in mood, thought, behavior, cognition, and physical functioning. Below is an expanded discussion with specific examples, cultural nuances, and implications for ANM practice in Nepal.

1. Mood and Affect Alterations

- **Depression**: Persistent low mood, crying spells, or feelings of worthlessness. Example: A postpartum mother refusing to care for her newborn.
- **Mania**: Euphoria, talkativeness, or irritability. Example: A bipolar client spending excessively during a manic episode.
- **Anxiety**: Restlessness, trembling, or fearfulness. Example: A client with GAD worrying excessively about family safety.
- **Labile Affect**: Rapid mood swings, seen in bipolar disorder or borderline personality disorder.
- **Cultural Note**: In Nepal, depression may be expressed as physical complaints (e.g., “body pain”) due to stigma around emotional expression.

2. Thought Process Disturbances

- **Delusions**: Fixed false beliefs, e.g., a schizophrenic client believing they are being poisoned by neighbors.
- **Hallucinations**: Auditory (hearing voices) or visual (seeing figures), common in psychosis. Example: A client with schizophrenia responding to unseen voices.
- **Obsessions**: Intrusive thoughts, e.g., fear of contamination in OCD leading to repeated handwashing.
- **Thought Blocking**: Sudden interruption in speech, seen in schizophrenia.
- **Implication**: ANMs must differentiate delusions from cultural beliefs (e.g., spiritual visions) through careful history-taking.

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3. Behavioral Changes

- **Agitation**: Pacing, shouting, or aggression, often in acute psychosis or mania. Example: A client with mania disrupting a health post.
- **Withdrawal**: Social isolation, e.g., a depressed client avoiding family gatherings.
- **Compulsions**: Repetitive behaviors, e.g., checking locks in OCD.
- **Self-Harm**: Cutting, burning, or suicide attempts, requiring immediate intervention.
- **Cultural Note**: In Nepal, self-harm may be underreported due to shame; ANMs should screen discreetly.

4. Cognitive Impairments

- **Memory Loss**: Forgetting recent events, seen in dementia or severe depression (pseudo-dementia).
- **Poor Concentration**: Inability to focus, e.g., an anxious client unable to follow instructions.
- **Disorientation**: Confusion about time/place, common in delirium or psychosis.
- **Implication**: ANMs should use simple language and repeat instructions for clients with cognitive deficits.

5. Physical Symptoms

- **Sleep Disturbances**: Insomnia (anxiety, depression) or hypersomnia (atypical depression). Example: A client with PTSD unable to sleep due to nightmares.
- **Appetite Changes**: Anorexia in depression or overeating in stress-related disorders.
- **Fatigue**: Common in depression or medication side effects (e.g., antipsychotics).
- **Psychosomatic Symptoms**: Headaches or chest pain without organic cause, frequent in Nepal due to somatic expression of distress.

6. Social and Functional Impairment

- **Relationship Strain**: Arguments or withdrawal from family, e.g., a schizophrenic client mistrusting relatives.
- **Occupational Dysfunction**: Inability to work, e.g., a depressed farmer neglecting crops.
- **Stigma**: Social exclusion, especially in rural Nepal, where mental illness may lead to ostracism.
- **Implication**: ANMs should involve community leaders to reduce stigma and promote acceptance.

7. Risk Behaviors

- **Suicidal Ideation**: Verbalizing plans (e.g., "I want to end it all") or hoarding pesticides.
- **Substance Abuse**: Alcohol or cannabis use to cope, common in Nepal's rural areas.
- **Homicidal Tendencies**: Rare but possible in paranoid schizophrenia or severe mania.
- **Implication**: ANMs must prioritize safety, using tools like the **Columbia-Suicide Severity Rating Scale** (if trained) and referring high-risk cases.

8. Case Example

- **Scenario**: A 25-year-old man in Koshi Province is withdrawn, hears voices, and believes his neighbors are plotting against him.
- **Characteristics**:
  - Hallucinations (auditory), delusions (paranoid), social withdrawal, poor hygiene.

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- Likely diagnosis: Schizophrenia.
- **ANM Action**:
  - Conduct MSE, noting thought disturbances and behavior.
  - Ensure safety by involving family to monitor him.
  - Refer to a psychiatrist for antipsychotic medication.
  - Educate family to reduce stigma and encourage treatment adherence.

8.3 Classification of Mental Disorders (Elaborated)

The classification of mental disorders provides a framework for diagnosis, treatment planning, and research. In Nepal, the **ICD-10** (WHO) is the standard system used in health facilities, integrated into the **HMIS**. Below is an expanded classification with detailed examples, clinical features, and relevance to ANM practice.

1. Organic Mental Disorders

- **Definition**: Disorders due to brain dysfunction from medical conditions, trauma, or substances.
- **Examples**:
  - **Delirium**: Acute onset, fluctuating consciousness, disorientation (e.g., elderly patient with UTI).
  - **Dementia**: Progressive memory loss, impaired judgment (e.g., Alzheimer's, vascular dementia).
  - **Substance-Induced Disorders**: Psychosis or mood changes from alcohol, cannabis, or drugs.
- **ANM Role**: Identify delirium in hospitalized patients, monitor for worsening, and refer for medical evaluation.

2. Substance-Related and Addictive Disorders

- **Definition**: Disorders from substance use or behavioral addictions causing dependence or withdrawal.
- **Examples**:
  - **Alcohol Use Disorder**: Tolerance, withdrawal symptoms (tremors, seizures).
  - **Cannabis Use Disorder**: Common in Nepal, leading to psychosis or amotivational syndrome.
  - **Gambling Disorder**: Compulsive gambling causing financial ruin.
- **ANM Role**: Screen for substance use in clients with erratic behavior, refer to de-addiction programs, and involve FCHVs for community follow-up.

3. Schizophrenia Spectrum and Psychotic Disorders

- **Definition**: Characterized by psychosis (delusions, hallucinations, disorganized thinking).
- **Examples**:
  - **Schizophrenia**: Chronic symptoms (>6 months), negative symptoms (apathy, social withdrawal).
  - **Schizoaffective Disorder**: Psychosis with mood episodes (depression or mania).
  - **Delusional Disorder**: Persistent delusions without other psychotic symptoms.
- **ANM Role**: Recognize early signs (e.g., social withdrawal, odd behavior), refer to psychiatrists, and monitor medication adherence.

4. Mood Disorders

- **Definition**: Disorders of mood, ranging from depression to mania.
- **Examples**:
    - **Major Depressive Disorder**: Low mood, anhedonia, suicidal thoughts (common in postpartum women).
    - **Bipolar I Disorder**: Manic episodes with or without depression.
    - **Cyclothymic Disorder**: Chronic, milder mood swings.
- **ANM Role**: Screen postpartum mothers for depression, provide supportive counseling, and refer severe cases.

5. Anxiety Disorders

- **Definition**: Excessive fear or anxiety impairing functioning.
- **Examples**:
    - **Generalized Anxiety Disorder**: Chronic worry about multiple issues.
    - **Panic Disorder**: Sudden panic attacks with palpitations, sweating.
    - **Social Anxiety Disorder**: Fear of social situations.
    - **OCD**: Obsessions and compulsions (e.g., excessive cleaning).
- **ANM Role**: Teach relaxation techniques (e.g., deep breathing), refer for CBT, and educate families about anxiety.

6. Personality Disorders

- **Definition**: Enduring maladaptive patterns of behavior and cognition.
- **Examples**:
    - **Borderline Personality Disorder**: Emotional instability, self-harm.
    - **Antisocial Personality Disorder**: Disregard for laws, lack of empathy.
    - **Avoidant Personality Disorder**: Extreme shyness, fear of rejection.
- **ANM Role**: Manage challenging behaviors with patience, refer to psychologists for therapy.

7. Neurodevelopmental Disorders

- **Definition**: Disorders affecting development, typically diagnosed in childhood.
- **Examples**:
    - **Autism Spectrum Disorder**: Impaired social interaction, repetitive behaviors.
    - **ADHD**: Inattention, hyperactivity, impulsivity.
    - **Intellectual Disability**: Below-average intellectual functioning.
- **ANM Role**: Identify developmental delays during child health visits, refer to pediatricians or special education services.

8. Other Disorders

- **PTSD**: Flashbacks, avoidance after trauma (e.g., earthquake survivors in Nepal).
- **Somatic Symptom Disorder**: Excessive focus on physical symptoms.
- **Eating Disorders**: Rare in Nepal but emerging (e.g., anorexia in urban areas).
- **ANM Role**: Screen for trauma in disaster-prone areas, provide basic counseling, and refer complex cases.

Nepal-Specific Considerations:

- **Prevalence**: Depression (20–30% in community studies), anxiety, and substance abuse are common; schizophrenia and bipolar disorder are less prevalent but severe.

- **Challenges**: Limited psychiatric facilities (e.g., only 1–2 psychiatrists per district in Koshi Province), reliance on primary care, and stigma.
- **ICD-10 Use**: ANMs document diagnoses like **F32 (Depressive Episode)** or **F20 (Schizophrenia)** in HMIS for tracking.

8.4 Community Mental Health and Role of ANMs in Nepal (New Topic)

Community mental health focuses on delivering accessible, culturally appropriate mental health services at the grassroots level. In Nepal, where mental health resources are scarce (e.g., <0.5 psychiatrists per 100,000 population), ANMs are critical in bridging the gap between communities and specialized care. This section outlines the community mental health framework and ANMs' roles, with a focus on Koshi Province.

1. Community Mental Health Framework in Nepal

- **National Mental Health Strategy (2020)**:
  - Aims to integrate mental health into primary health care, train frontline workers (e.g., ANMs, FCHVs), and reduce stigma.
  - Prioritizes common disorders (depression, anxiety, epilepsy) and high-risk groups (postpartum women, adolescents).
- **Community Mental Health Program**:
  - Supported by WHO and Nepal's Ministry of Health and Population (MoHP).
  - Trains ANMs to screen, provide basic interventions, and refer cases.
  - Operates through health posts, primary health centers, and district hospitals.
- **HMIS Integration**:
  - Mental health indicators (e.g., number of depression cases, referrals) are recorded in the Health Management Information System.
  - Ensures data-driven planning and resource allocation.

2. Role of ANMs in Community Mental Health

- **Screening and Identification**:
  - Use simple tools (e.g., **PHQ-9** for depression, **GAD-7** for anxiety) to screen clients during routine visits (e.g., ANC, PNC, immunization).
  - Identify high-risk groups: postpartum women, adolescents, disaster survivors, or those with chronic illnesses.
  - Example: Screen a postpartum mother for depression if she reports persistent sadness or neglects her baby.
- **Basic Interventions**:
  - Provide psychoeducation on mental health, stress management, and coping strategies.
  - Teach relaxation techniques (e.g., deep breathing, mindfulness) for anxiety.
  - Administer prescribed medications (e.g., Fluoxetine) under medical supervision.
- **Referral and Follow-Up**:
  - Refer severe cases (e.g., psychosis, suicidal ideation) to district hospitals or psychiatric centers (e.g., Biratnagar for Koshi Province).
  - Coordinate with FCHVs for home visits to monitor treatment adherence.
  - Example: Refer a client with schizophrenia to a psychiatrist and follow up to ensure they attend appointments.
- **Community Education**:
  - Conduct awareness campaigns to reduce stigma, using local languages (e.g., Nepali, Maithili).

- Address myths (e.g., mental illness as possession) through community meetings or women's groups.
- Example: Organize a health talk with FCHVs to explain that depression is treatable with medication and counseling.

- **Collaboration**:
  - Work with FCHVs, MCHWs, and traditional birth attendants (TBAs) to identify cases early.
  - Partner with NGOs (e.g., KOSHISH, TPO Nepal) for training, counseling, or rehabilitation services.
- **Documentation**:
  - Record mental health cases in HMIS, including diagnosis, treatment, and referrals.
  - Example: Document a case of postpartum depression as **F53 (Mental disorders associated with puerperium)** in HMIS.

3. Challenges in Community Mental Health

- **Stigma**: Families may hide mental illness due to fear of social exclusion.
- **Resource Constraints**: Limited psychiatrists, medications, or counseling services in rural Koshi Province.
- **Cultural Barriers**: Preference for traditional healers delays medical care.
- **Workload**: ANMs juggle multiple roles (e.g., maternal care, immunization), limiting time for mental health.

4. Strategies to Overcome Challenges

- **Training**: Regular mental health training for ANMs through MoHP or NGOs (e.g., **mhGAP** program by WHO).
- **Community Engagement**: Involve religious leaders, teachers, and VDC chairpersons to promote mental health acceptance.
- **Task-Sharing**: Delegate screening and follow-up to FCHVs to reduce ANM workload.
- **Telemedicine**: Use mobile apps or teleconsultation for psychiatric support in remote areas.

5. Case Example

- **Scenario**: A 40-year-old farmer in Koshi Province is drinking heavily, isolating himself, and neglecting his family after a crop failure.
- **ANM Role**:
  - Screen for depression and alcohol use disorder using PHQ-9 and AUDIT tools.
  - Provide counseling on stress management and refer to a de-addiction program.
  - Educate the family about alcohol dependence as a treatable condition.
  - Collaborate with FCHVs to monitor his progress and ensure follow-up visits.
  - Document the case in HMIS for district-level reporting.

6. Relevance to ANM Exam

- Questions may test ANMs' ability to identify mental health roles (e.g., "What is the primary role of ANMs in community mental health?" Answer: Screening and referral).
- Knowledge of HMIS documentation or FCHV collaboration may be assessed, aligning with the administrative focus in the ANM SET 1 document.

Integration with ANM SET 1 Document

The provided document emphasizes service-related knowledge, including community health and

administrative frameworks. Mental health aligns with:

- **Service Delivery**: Questions on managing clients (e.g., safety for suicidal patients) or community roles (e.g., FCHV collaboration).
- **Cultural Context**: Addressing stigma and cultural beliefs, as seen in Nepal-specific questions (e.g., constitutional rights, Koshi Province regulations).
- **HMIS**: Documentation of mental health cases, similar to maternity care records mentioned in the document.

Key Takeaways for ANM Students

- **Management**: Combine assessment, medication, counseling, and safety measures, with cultural sensitivity for Nepal's context.
- **Characteristics**: Recognize mood, thought, and behavioral changes to guide diagnosis and intervention.
- **Classification**: Use ICD-10 to categorize disorders, focusing on common conditions like depression and anxiety.
- **Community Role**: ANMs are frontline mental health workers, screening, referring, and educating communities to reduce stigma.

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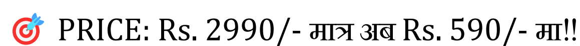
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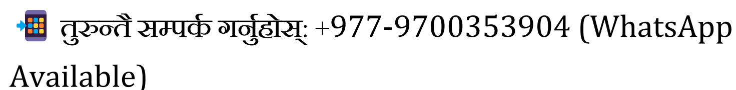
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