

# mhGAP training manuals

for the mhGAP intervention guide for mental,  
neurological and substance use disorders in  
non-specialized health settings – version 2.0

(for field testing)



World Health  
Organization



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**WHO/MSD/MER/17.6**

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Printed in France.

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# Acronyms and abbreviations

AA-HA!	Global Accelerated Action for the Health of Adolescents (WHO)
ADHD	attention deficit hyperactivity disorder
AEDs	antiepileptic drugs
CBT	cognitive behavioural therapy
DALYs	disability-adjusted life years
ECP	essential care and practice
EPS	extrapyramidal symptoms
HIC	high-income countries
i.m.	intramuscular
IMCI	Management of Childhood Illness
IPT	group interpersonal therapy
i.v.	intravenous
LMIC	low- and middle-income countries
LIVES	Listen, Inquire, Validate, Enhance safety, Support (intervention)
MCQs	multiple choice questions
MDMA	3,4-methylenedioxymethamphetamine
MDT	multidisciplinary team
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
MNS	mental, neurological and substance use (disorders)
NGO	nongovernmental organization
OSCE	observed structural clinical examination
PM+	problem management plus
PTSD	post-traumatic stress disorder
SSRIs	selective serotonin reuptake inhibitors
TCAs	tricyclic antidepressants
THC	tetrahydrocannabinol
TNA	training needs assessment
ToHP	Training of Health-care Providers training manual
ToTS	Training of Trainers and Supervisors training manual

## mhGAP-IG Version 2.0 module abbreviations:

CMH	Child and adolescent mental and behavioural disorders
DEM	Dementia
DEP	Depression
ECP	Essential care and practice
EPI	Epilepsy
OTH	Other significant mental health complaints
PSY	Psychoses
SUB	Disorders due to substance use
SUI	Self-harm/suicide

# Acknowledgements

## Vision and conceptualization

The mhGAP training manuals for the mhGAP Intervention Guide for non-specialized health settings Version 2.0 have been developed under the overall guidance and conceptualization of Shekhar Saxena and Tarun Dua, WHO Department of Mental Health and Substance Abuse.

## Project coordination and editing

The team that coordinated the development of the mhGAP training manuals, including writing and editing, was Neerja Chowdhary, Georgina Grundy Campbell, Kenneth Carswell, Alexandra Fleischmann, Fahmy Hanna, Chiara Servili and Mark van Ommeren.

## Technical contribution and review

Valuable material, help and advice was received from technical staff at WHO headquarters, staff from WHO regional and country offices and many international experts and technical reviewers, including those who provided feedback on mhGAP version 1.0 training material. These contributions have been vital to the development of these mhGAP training manuals.

### WHO headquarters

At WHO headquarters, a team comprising staff members, consultants and interns provided technical guidance and support for the project. The team included: Nicolas Clark, Capucine de Fouchier, Nathalie Drew, Kathryn Laura Elliott, Michelle Karen Funk, Claudia Garcia, Moreno Esteva, Dzmitry Krupchanka, Sarah Frances Michael, Vladimir Poznyak, Dag Rekve, Katrin Seeher, Melissa Harper Shehadeh, Meredith Fendt-Newlin, Megin Reginders, Zsophia Szlamka and Edith van't Hof.

### WHO regional and country offices

Key collaborators from the WHO regional and country offices, who reviewed the manuals and provided valuable feedback included: Nazneen Anwar, Regional Office for South-East Asia; Tsogzolmaa Bayandorj, WHO Country Office, Vanuatu; Andrea Bruni, Regional Office for the Americas; Claudina Cayetano, Regional Office for the Americas; Daniel Chisholm, Regional Office for Europe; Manuel de Lara, WHO Turkey; Devora Kestel, Regional Office for the Americas; Sebastiana Da Gama Nkomo, Regional Office for Africa; Khalid Saeed, Regional Office for the Eastern Mediterranean; Yutaro Setoya, WHO Fiji; Martin Vandendyck, Regional Office for the Western Pacific.

### Expert reviewers

WHO gratefully acknowledges the contribution of the following people for their expert opinion and technical input in the development of the mhGAP training manuals: Nancy Baron, Psycho-Social Services and Training Institute in Cairo, Egypt; Alexander Blackie, Carter Center, Liberia; Boris Bodusan, Croatia; Janice Cooper, Carter Center, Liberia; Chris Dowrick, University of Liverpool, Liverpool, UK; Julian Eaton, CBM International, Togo and London School of Hygiene and Tropical Medicine, London, UK; Rabih El Chamay, Ministry of Health, Lebanon; Mohamed Elshazly, United Nations High Commissioner for Refugees, Iraq; Sandra Fortes, University of Rio de Janeiro State, Brazil; Usman Hamdani, Human Development Research Foundation, Islamabad, Pakistan; Sarah Harrison, International Committee of the Red Cross, Copenhagen, Denmark; Peter Hughes, Institute of Psychiatry, Psychology and Neuroscience, King's College, London, UK; Jerry Iaruel, Ministry of Health, Vanuatu; Stania Kamara, Institute of Psychiatry,

Psychology and Neuroscience, King's College, London, UK; Wissam Kheir, Ministry of Public Health, Beirut, Lebanon; Brandon Kohrt, Duke Global Health Institute, North Carolina, USA; Cindy Lam, The University of Hong Kong, China, Hong Kong SAR; Joanna Lee, United Nations Releif and Works Agency for Palestine Refugees in the Near East, Palestine; Christos Lionis, University of Crete, Crete; Leona C Mason, Carter Center, Liberia; Ashley Nemiro, International Rescue Committee, New York, USA; Jimmy Obed, Ministry of Health, Republic of Vanuatu; Laura Pacione, University of Toronto, Toronto, Canada; Karen Paul, International Medical Corps, USA; Pieter Ventevogel, United Nations High Commissioner for Refugees, Geneva, Switzerland; Inka Weissbecker, International Medical Corps, Washington, DC, USA; Lakshmi Vijayakumar, SNEHA Suicide Prevention Centre, Chennai, India; Anna Walder, Institute of Psychiatry, Psychology and Neuroscience, King's College, London, UK.

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of Montreal, Montreal, Canada; Emmanuel Streel, Public Mental Health and Substance Use Consultant, Belgium; Scott Stroup, Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute, New York, USA; Athula Sumathipala, Keele University, UK; Kiran Thakur, Johns Hopkins Hospital, Baltimore, USA; Rangaswamy Thara, Schizophrenia Research Foundation, India; Graham Thornicroft Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK; Mark Tomlinson, Stellenbosch University, South Africa; Nyan Tun, Yangon General Hospital, Myanmar; Carmen Valle, CBM, Freetown, Sierra Leone; Mohammad Taghi Yasamy, Geneva, Switzerland; Abe Wassie, Department of Psychiatry, Faculty of Medicine, Addis Ababa University and Amanuel Hospital, Ethiopia.

## Administrative support

We are grateful to Caroline Herment, Grazia Motturi and Cecilia Ophelia Riano for the support they provided in the development and publication of the mhGAP training manuals.

## Production team

We gratefully acknowledge the team responsible for the various elements leading towards the production of the mhGAP training manuals.

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**Graphic design and layout:** L'IV Com Sàrl, Villars-sous-Yens, Switzerland.

**Printing coordination:** Pascale Broisin, Frédérique Claudie Rodin, WHO, Geneva.

## Financial support

WHO would like to thank CBM and the National Institute of Mental Health, USA, for their financial support of the project.

# Read me first

## mhGAP training manuals for the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings – version 2.0 (for field testing)

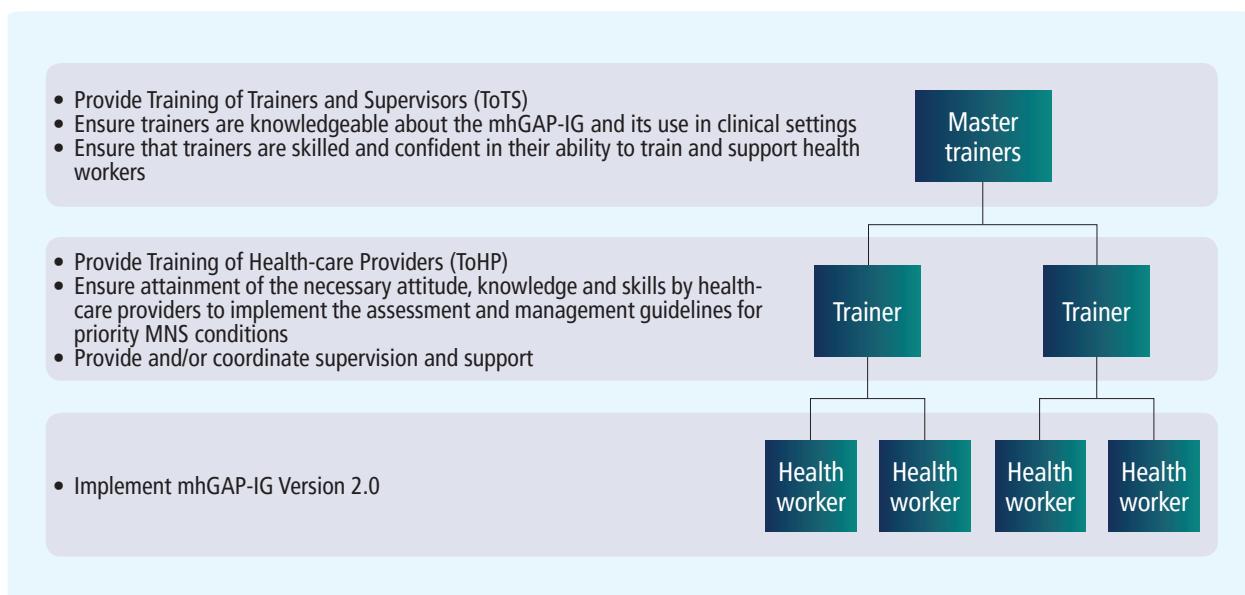
The WHO Mental Health Gap Action Programme (mhGAP) was launched by WHO in 2008 with the objective of scaling up care for mental, neurological and substance use (MNS) disorders. The mhGAP Intervention Guide (mhGAP-IG) was published in 2010 as a clinical decision-making tool for the assessment and management of priority MNS conditions using evidence-based guidance for non-specialist health-care providers.

The mhGAP-IG has been translated into more than 20 languages and, along with its supporting materials (e.g. training material), has had widespread application by a range of stakeholders in over 90 countries for integrated management of priority MNS disorders. Feedback and recommendations from international experts, as well as the latest evidence in the field, was collated to update the mhGAP-IG, leading to the release of mhGAP-IG Version 2.0 in 2016.

The mhGAP training manuals have been developed specifically for the mhGAP-IG Version 2.0, incorporating extensive review comments and feedback.

The mhGAP-IG training manuals follow the “cascade” model of training with two levels: master trainers who will train trainers/facilitators, who then in turn train non-specialist health-care providers (see Figure 1).

**Figure 1. Cascade model of training relating to the mhGAP training manuals**



The training of non-specialist health-care providers is competency-based and aims to ensure that participants develop the attitude, knowledge and skills required to use the mhGAP-IG. Attitude change is assessed by role plays and observations from supervision; knowledge is assessed by written tests (MCQs); and skills are assessed through practical sessions (peer- and facilitator-assessed role plays).

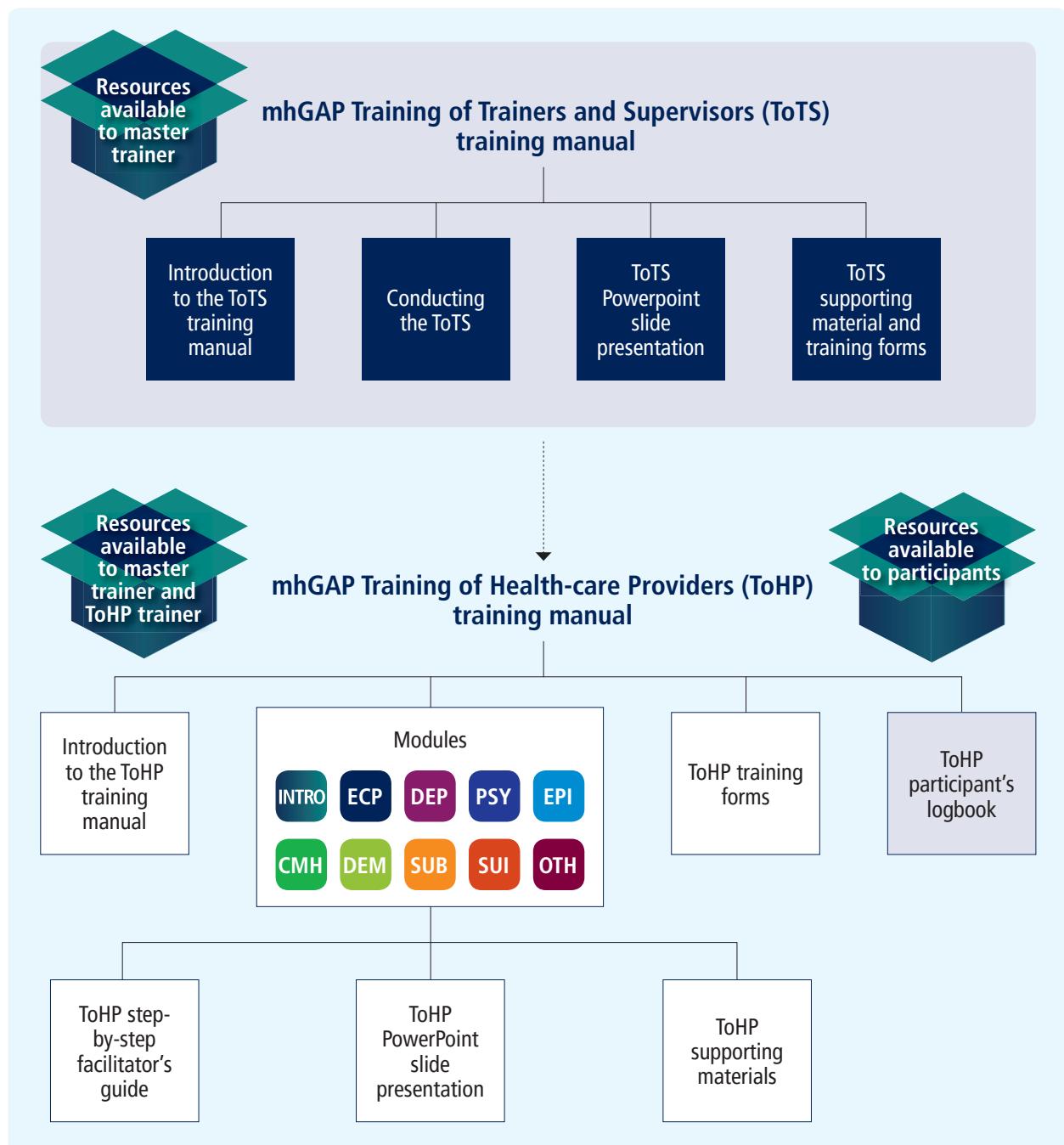
It is not expected that health-care providers will have gained mastery of every competency at the end of their training. Rather, competencies are seen as dynamic and contextual, where people are continuously improving and developing their competency in an area. For this reason, the overall assessment will not be purely "pass/fail", but focus on where people need to improve.

The mhGAP training manuals consist of:

- mhGAP Training of Trainers and Supervisors (ToTS) training manual
- mhGAP Training of Health-care Providers (ToHP) training manual

The contents of these training manuals are shown graphically in Figure 2.

**Figure 2. Graphical representation of the mhGAP training manuals**



## **mhGAP Training of Trainers and Supervisors (ToTS) training manual**

This training manual is written to assist master trainers to conduct training for future mhGAP trainers and supervisors, and is available as a hard copy and electronically. It is meant to be used along with the other components of the entire manual, i.e. the mhGAP Intervention Guide (mhGAP-IG) and the mhGAP Training of Health-care Providers (ToHP) training manual.

The ToTS training manual includes:

- An **introduction** to the Training of Trainers and Supervisors (ToTS) training manual.
- A section on **conducting a ToTS** with an accompanying PowerPoint slide presentation.
- **Supporting material and training forms**, i.e. training needs assessment, pre-and post-test, supervision role plays, evaluation forms.

## **mhGAP Training of Health-care Providers (ToHP) training manual**

This training manual is written to assist trainers/facilitators to conduct training for non-specialist health-care providers, who will be assessing and managing people with MNS conditions. It is available as a hard copy and electronically, and should be used alongside the mhGAP Intervention Guide (mhGAP-IG). The ToHP training manual includes:

- An **introduction** to the Training of Health-care Providers (ToHP) training manual.
- A **step-by-step facilitator's guide** for all mhGAP-IG modules, each with an accompanying PowerPoint slide presentation. In addition, supporting materials contain person stories, role plays and multiple choice questions (MCQs) for each module, to ensure the training is interactive and to provide assessment methods. A set of videos accompany the training manual – available online and in downloadable format.
- The **participant's logbook**, which holds additional learning material, details local services, plans for ongoing supervision and any assessments the participant has completed. The logbook is a living document, to which the health-care provider can add throughout the course and supervision, and where the health-care providers and facilitators/supervisors can identify strengths and weaknesses that they would like to work on during supervision.
- **ToHP training forms** include training needs assessment, pre- and post-test MCQs, core competency assessment forms and evaluation forms.

*The mhGAP training manuals are for field testing and for additional peer review. WHO is looking for your feedback. If you do use the materials, please give us feedback using the evaluation forms at [mhgap-info@who.int](mailto:mhgap-info@who.int).*

# **mhGAP Training of Trainers and Supervisors (ToTS) Training manual**

## ToTS



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# **Introduction to the Training of Trainers and Supervisors training manual**

**mhGAP Training of Trainers and Supervisors (ToTS)  
training manual**



# Introduction to the ToTS training manual

The mhGAP ToTS training manual has been designed to support implementation of the World Health Organization's (WHO) Mental Health Gap Action Programme (mhGAP) and to ensure that future trainers feel skilled and confident in their ability to train and supervise health-care providers to assess and manage priority mental, neurological and substance use (MNS) disorders. In particular, an emphasis has been placed on interactive and contemporary teaching and supervision skills.

The interactive teaching skills taught during the ToTS training are the same as those used in the mhGAP Training of Health-care Providers (ToHP) training manual. Thus, the ToTS participants can learn and practise using these teaching techniques whilst familiarizing themselves with the mhGAP ToHP training materials. Time has been built into the ToTS training to ensure that participants receive and can integrate feedback from their peers and the master trainer as they learn and develop their skills as trainers.

The ToTS training also includes a module on supervision, where the participants will identify the best method of supervision for their area, and start planning implementation.

## The ToTS training learning objectives

The ToTS training aims to ensure that future mhGAP trainers and supervisors:

1. Understand mhGAP-IG and its integration with general health care.
2. Understand teaching and competency principles as they relate to mhGAP-IG.
3. Understand implementation principles as they relate to mhGAP-IG.
4. Can prepare and evaluate a ToTS training course for mhGAP-IG.
5. Can utilize a variety of teaching methods and skills for mhGAP-IG with confidence.
6. Can perform assessment and feedback on mhGAP-IG ToTS training.
7. Can organize and perform supervision for mhGAP-IG use.
8. Promote mhGAP-IG use and training.

## Suggested training schedule

A suggested schedule for the ToTS training over the course of five days:

Day 1 topics covered: introduction to the mhGAP action programme; importance of integrating mental health into non-specialized health settings; implementation of mhGAP-IG and familiarization with mhGAP-IG Version 2.0; Essential care and practice (ECP).

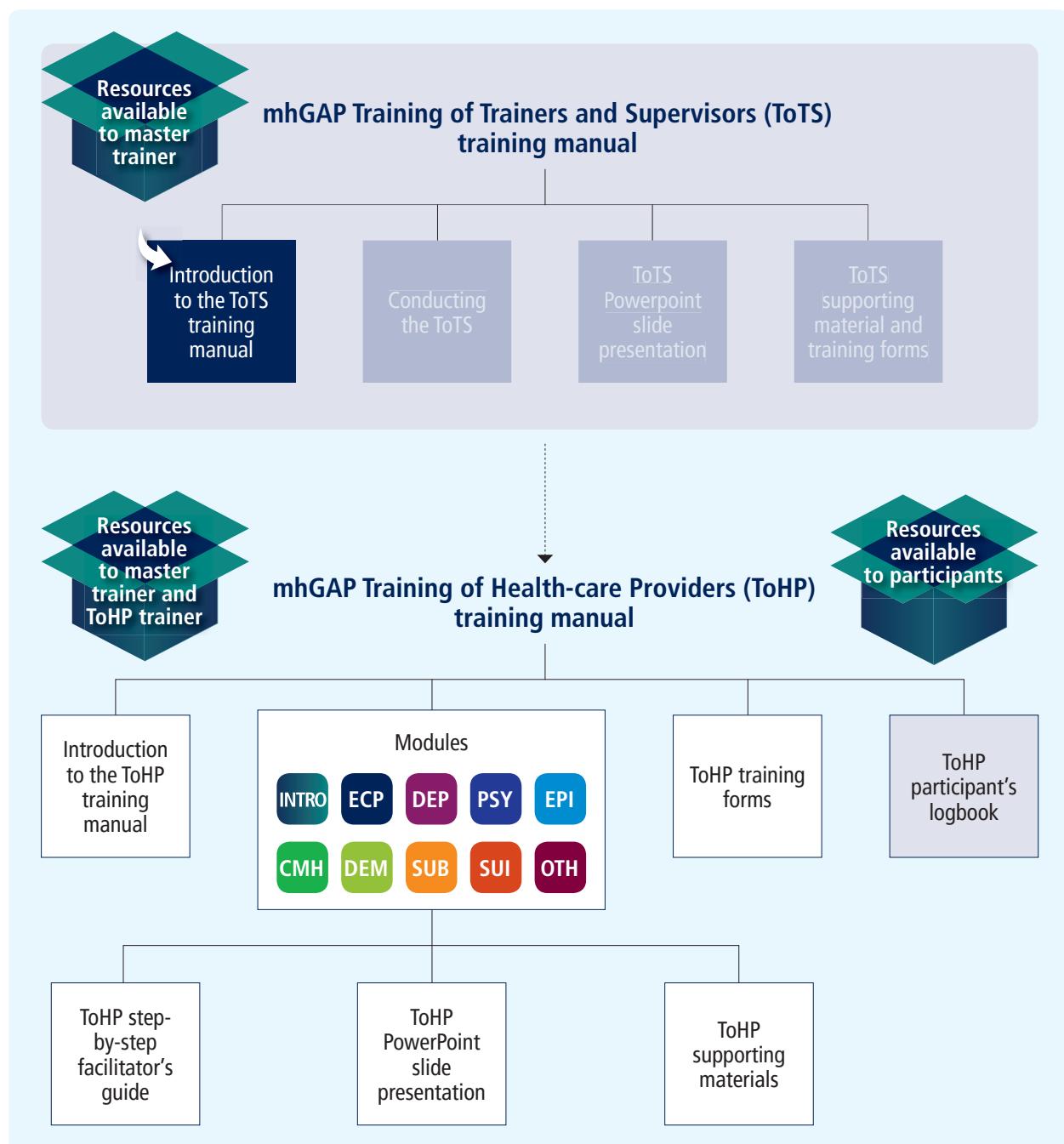
Day 2 topics covered: introduction to mhGAP-IG training methodology and competencies; preparing and evaluating a training course; training skills.

Day 3 topics covered: training skills (continued); competency-based education and assessment and feedback; participant facilitation exercise.

Day 4 topics covered: participant facilitation exercise and feedback; training skills review and other interactive training techniques.

Day 5 topics covered: supervision theory and practice; individual feedback and plan for running own course.

**Figure 1. Graphical representation of mhGAP training manuals, with the Training of Trainers and Supervisors (ToTS) training manual and the Introduction to the ToTS training manual highlighted**



# Who is this manual for

This manual is designed for use by master trainers to train future mhGAP-IG trainers and supervisors. Master trainers are specialist (psychiatry or neurology) physicians or nurses trained and experienced in using the mhGAP-IG, and/or existing supervisors within the non-specialized health setting.

## How to use this manual

This guide is a part of the mhGAP-IG training manuals and is designed to be used alongside components of the ToTS training.

This manual should also be used with the mhGAP Intervention Guide (mhGAP-IG), and the mhGAP-IG ToHP training manual, including the ToHP participant's logbook.

While this manual has been developed based on extensive feedback and expert consultation, we recognize that it will need to be adapted to each setting based on cultural context and feasibility.

This manual is available as a hard copy and electronically.

## Preparation and adaptation

Master trainers should conduct a brief training needs assessment (TNA) (see ToTS supporting material and training forms) before conducting the ToTS training. By gathering this information, the master trainer can adapt the ToTS training as needed, including:

- Determining the need for the mhGAP-IG ToHP training.
- Determining how experienced participants are in both teaching and using mhGAP-IG.
- Determining how to support participants to run the ToHP training and provide supervision.
- Using local context to adapt the schedule or content.

Material may need to be translated into the local language, and master trainers should be aware that this may change the timing of the modules. A timed run-through of the modules is recommended before the training.

When adapting the ToTS training to local context, care should be taken to avoid adding or removing slides, eliminating activities or interactive components, or removing the opportunities for participants to practise these skills. Instead, person stories, role plays, multiple choice questions (MCQs) and video demonstrations which best suit the local context should be chosen, or master trainers may wish to find or create their own.

There are several options available should the course need to be shortened. Importantly, interactive activities should not be removed, but instead:

- Days can be extended with earlier starts and later finish times.
- If the group is very familiar with mhGAP-IG, the introduction on Day 1 can be delivered quickly, and combined with the session on implementation. ECP can also be shorter and the day can finish with an introduction to mhGAP ToHP training methodology.
- If the group is experienced in teaching, the training skills modules can be shortened and/or combined.
- Homework can be set, particularly practising the training skills and preparing for the participant facilitation exercise (ie. Day 2 and 3).

- The participant facilitation exercise can be set for a shorter time, or the groups can be larger (so there are fewer presentations).

As competency-based education and assessment and supervision may be new concepts, it is recommended not to shorten these modules. If anything, more time may have to be allocated if these are new concepts to the participants.

When preparing for the ToTS training, the master trainer checklist (see table 1) can be used to ensure nothing is missed from the planning.

## ToTS participants

A group size of 15-16 is considered appropriate for ToTS training.

Participants attending the ToTS training should have the following:

- Postgraduate qualification in health care with specialized work in mental health.
- Show respect and dignity for people with priority mental, neurological and substance use (MNS) disorders.

Ideally all ToTS participants will be familiar with, and have experience using, mhGAP-IG in their clinical practice before attending a ToTS training. In many settings however, this may not be the situation. If the ToTS participants are not familiar with mhGAP-IG, consider:

- Conducting a separate mhGAP Training of Health-care Providers (ToHP) training
- Ensuring that all participants read the mhGAP-IG before attending the ToTS training.

Before attending the ToTS, participants should also complete a training needs assessment (see ToTS supporting material and training forms) of their own local context.

The following steps will help participants feel comfortable early on in the training:

1. Allow the participants some time to meet the master trainer and other participants before the training starts, ideally over a casual meal.
2. Explain expectations early, including how long the training will take, that some evening work will be required (particularly Day 3, or more if the training is condensed), and ongoing expectations about the ToHP training and supervision.
3. Reassure the participants that the interactive teaching style may seem daunting, but will be rewarding and invaluable for their skills and confidence-building.
4. Agree on common ground rules on how they will treat everyone in the group.

## Training guidelines

### 1. Understand the local health-care system

Master trainers should familiarize themselves with local systems to adapt the course, help with problem-solving, know local specialized services and which medications are available.

### 2. Model teaching techniques

The ToTS is designed for the master trainer to model teaching techniques, and have the participants practise them and see their benefit.

### 3. Use interactive activities, visuals and videos

Master trainers should demonstrate the learning value of interactive techniques, using those available or developing from the local context.

#### **4. Actively use mhGAP-IG**

The mhGAP-IG and ToHP manual should be used repeatedly throughout the course to help with familiarization.

#### **5. Allow enough time for feedback**

After every activity there should be time for peer and master trainer feedback to help with participant development.

#### **6. Evaluate the ToTS**

Master trainers should collect formal feedback through the evaluation forms (see ToTS supporting material and training forms), and informal feedback through discussions with the participants to ensure training meets participants' needs.

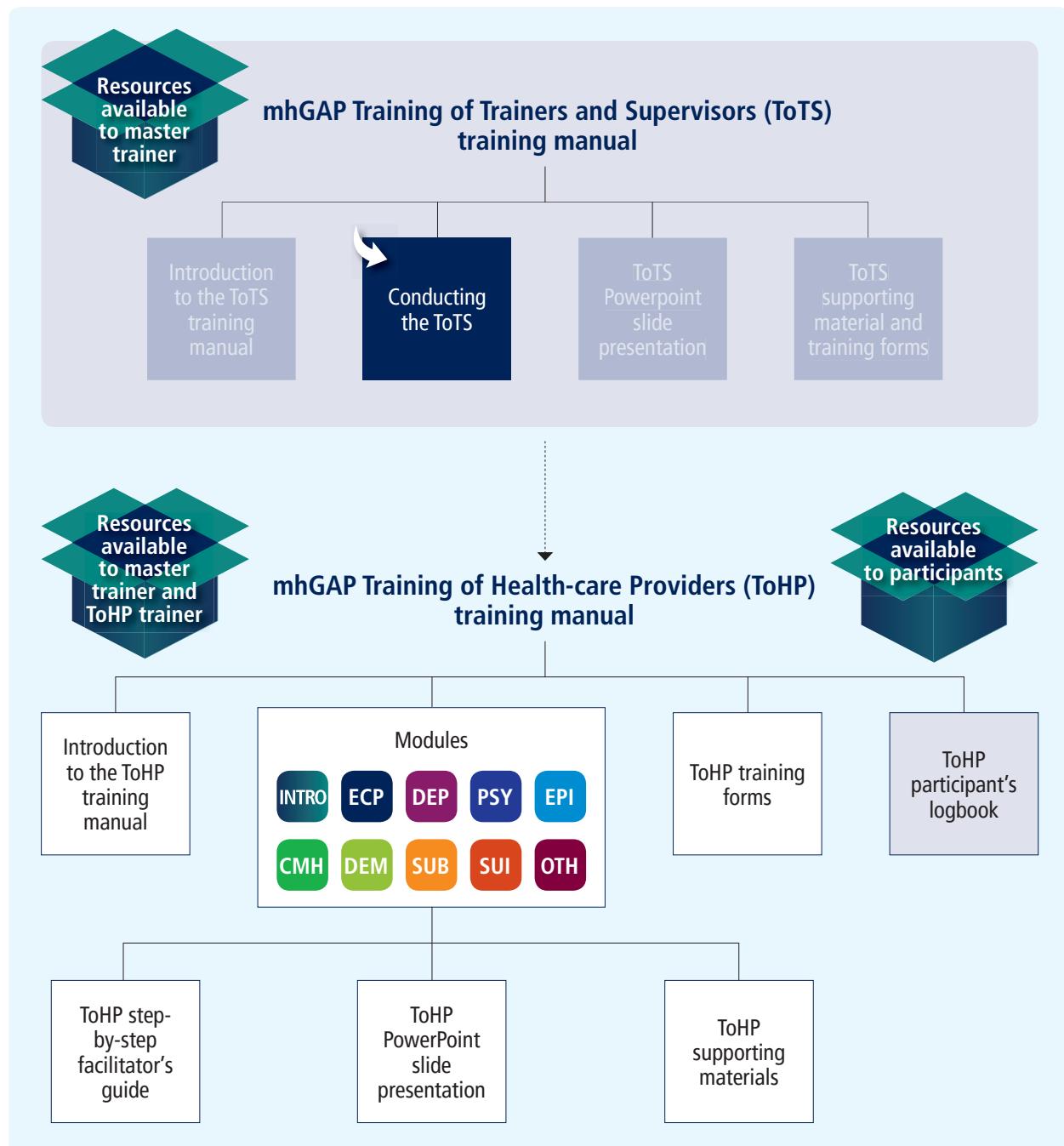
#### **7. Facilitate and develop future plans**

The ToTS should provide multiple opportunities for participants to plan their own ToHP and supervision sessions, with support and ongoing monitoring from the master trainer.

# Conducting the Training of Trainers and Supervisors (ToTS)

This section provides an overview of every module in the ToTS, including learning objectives, duration, slide numbers, key content and activities. There is more detailed information on each slide's notes on PowerPoint (see PowerPoint slide presentation: ToTS training).

Figure 2. Conducting the ToTS section within the ToTS training manual

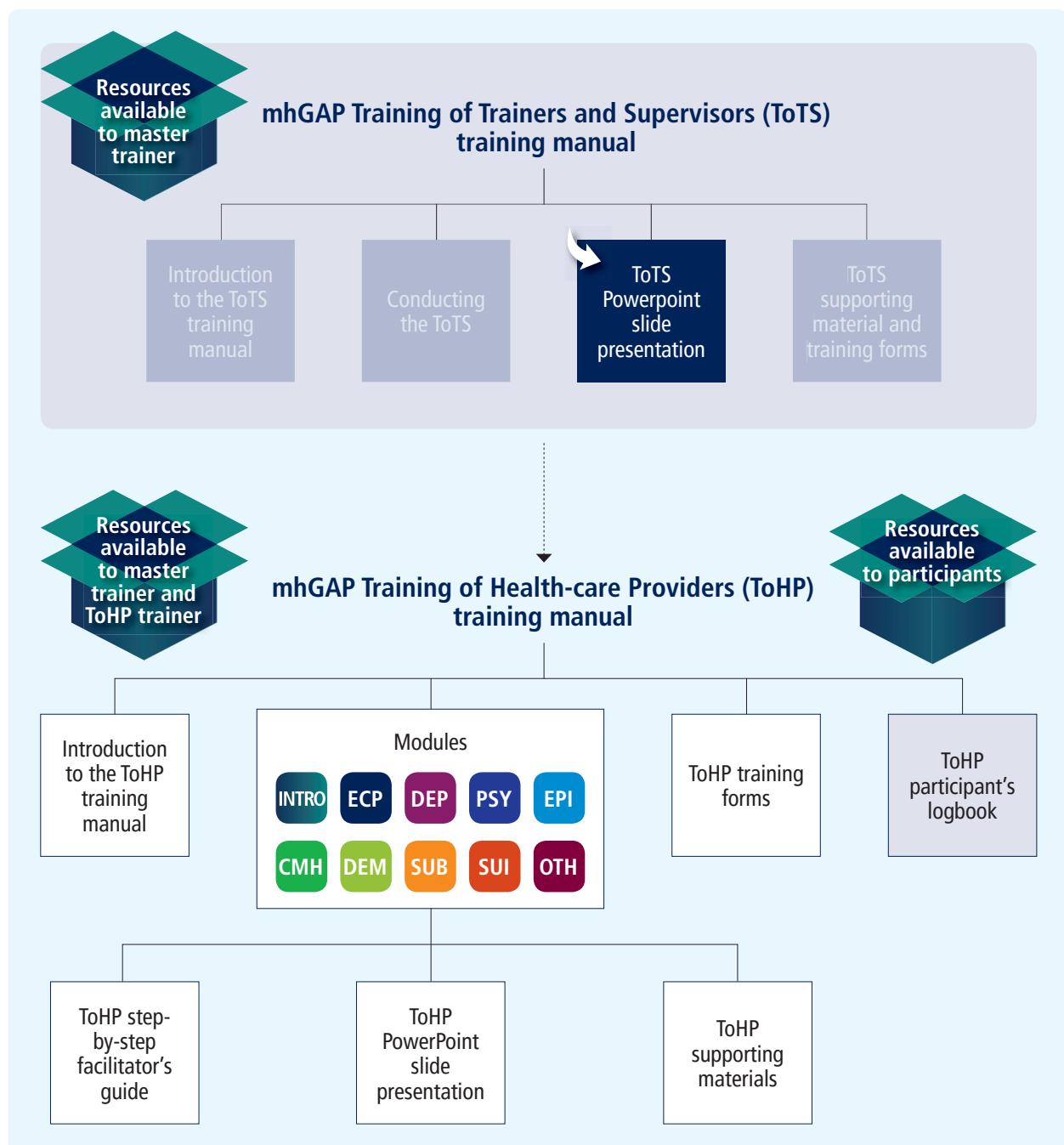


# ToTS PowerPoint slide presentation

The set of slides and the trainer's notes available online can be used by master trainers in conjunction with the conducting the ToTS training section. The notes accompanying the slides within Powerpoint provide discussion points to highlight key information and can be adapted for use by the master trainer.

Removing or adding slides should be avoided, even where there are concerns about time and length of the course. Instead, easier concepts can be covered in less time, if needed (see How to use this guide: Preparation and adaptation).

**Figure 3. Understanding the role of the PowerPoint slide presentation: within the ToTS training manual**



# ToTS supporting material and training forms

Please note that all ToTS training forms are also used in the ToHP training.

## Training needs assessment forms

Training needs assessment (TNA) forms are used for two purposes: the master trainer should complete a TNA before providing the ToTS, and future trainers should complete a TNA of their local context to use during the ToTS training. Further information is available under How to use this guide: Preparation and adaptation.

## Pre- and post-test

A pre- and post-test (MCQs) is available for both the ToTS and ToHP training. The master trainers should use it on the morning of the first day of training, and again at completion of training, to help with course evaluation but also to familiarize participants to the assessment methods.

## mhGAP familiarization exercise

Problem-based learning scenarios using the mhGAP-IG used during Activity 3 on Day 1 of training.

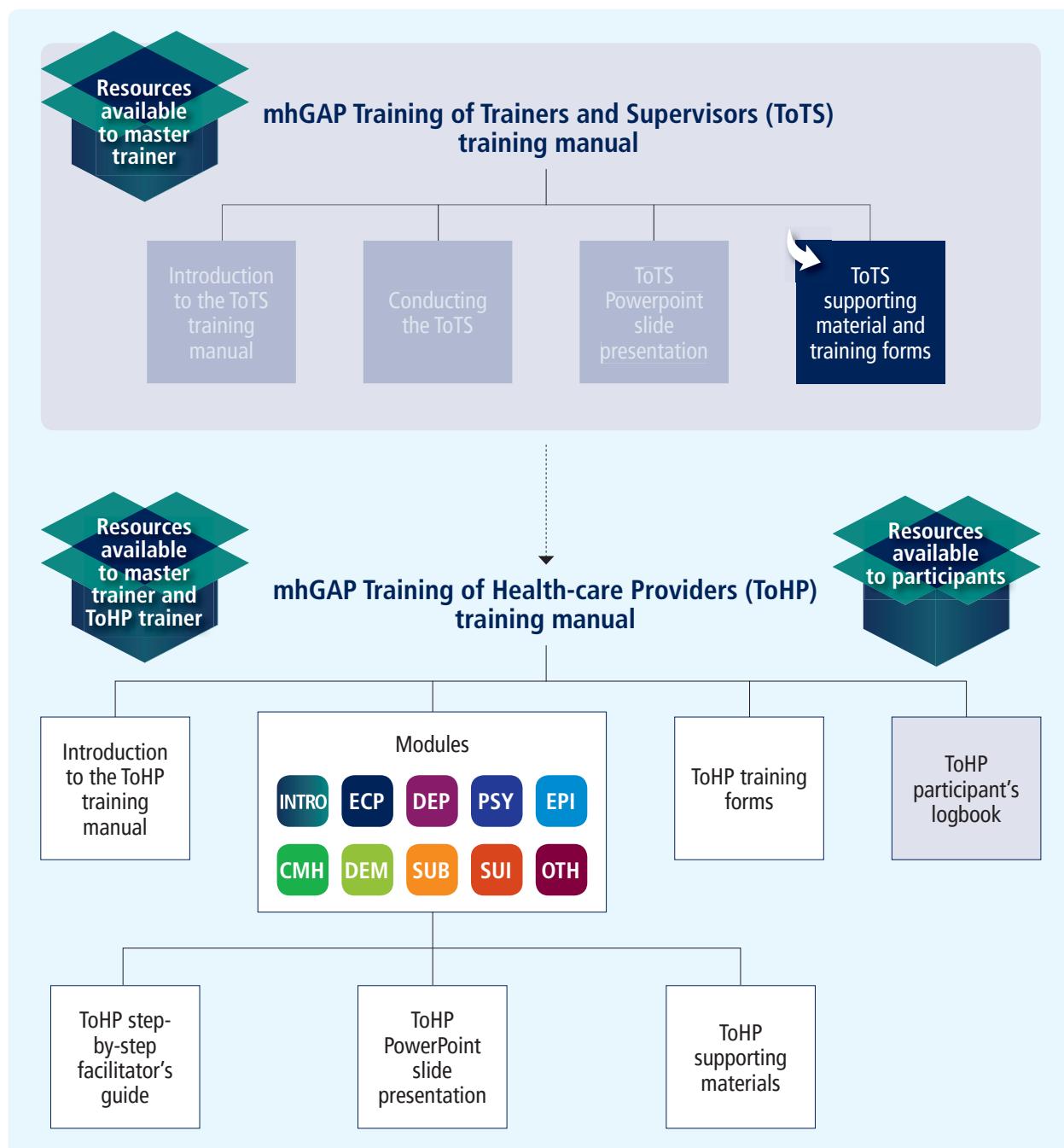
## Supervision role plays

Role plays are utilised in the ToTS training to help familiarize trainers with this specific teaching skill. Additionally, the role plays provided are an interactive and immersive method of teaching supervision, by allowing for demonstration of poor supervision technique, as well as an opportunity to practice good supervision.

## Evaluation forms

Evaluation forms have also been designed to be used across both the ToTS and ToHP training. They should be completed by both master trainers and participants for every module during the ToTS training, and feedback should be reviewed immediately to adapt the course if needed.

**Figure 4. Understanding the role of the ToTS supporting material and training forms within the ToTS training**



# Master trainer checklist (to be used when preparing for the ToTS training)

Table 1: A checklist tool to help the master trainer prepare for the ToTS training

Tasks completed <input checked="" type="checkbox"/>
<b>Review and familiarization of the following materials:</b> <input type="checkbox"/> Introduction to the ToTS training manual <input type="checkbox"/> Conducting the ToTS <input type="checkbox"/> ToTS PowerPoint slides presentation <input type="checkbox"/> ToTS supporting material and training forms <input type="checkbox"/> Introduction to the ToHP training manual <input type="checkbox"/> ToHP Modules (includes ToHP step-by-step facilitator's guide, ToHP PowerPoint slide presentation, ToHP supporting material) <input type="checkbox"/> ToHP training forms <input type="checkbox"/> ToHP participant's logbook
<b>Preparation of the following:</b> <input type="checkbox"/> Conduct training needs assessment (see ToTS supporting material and training forms) <input type="checkbox"/> Understand local context and existing specialized services <input type="checkbox"/> Adapt the ToTS training to suit local context and time restrictions
<b>Logistics:</b> <input type="checkbox"/> Send invitations <input type="checkbox"/> Book venue (seating, microphones, no noise, etc.) <input type="checkbox"/> Presentation materials (projector, computer, video, flip charts, pens, paper, etc.) <input type="checkbox"/> Printing of materials <input type="checkbox"/> Food and catering <input type="checkbox"/> Transportation +/- accommodation <input type="checkbox"/> Per diems <input type="checkbox"/> Pre- and post-test administration <input type="checkbox"/> Evaluation forms

# Conducting the Training of Trainers and Supervisors

mhGAP Training of Trainers and Supervisors (ToTS)  
training manual



# Conducting the mhGAP Training of Trainers and Supervisors (ToTS)

	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>
Session 1 ⌚ 9:00–10:30	Welcome and introduction to Mental Health Gap Action Programme  Importance of integrating mental health into non-specialized health settings	Introduction to mhGAP ToHP training methodology and competencies	Training skills: Using mhGAP ToHP person stories  Video demonstrations	Participant facilitation exercise and feedback	Supervision: Theory and technique
Session 2 ⌚ 11:00–12:30	Implementation of mhGAP-IG  Familiarization with mhGAP-IG Version 2.0	Preparing and evaluating a training course (including training needs assessment – TNA)	Training skills: Role play	Participant facilitation exercise and feedback	Supervision: Theory and practical
Session 3 ⌚ 13:15–15:00	Essential care and practice module	Training skills: Presentation skills	Competency-based assessments: structure and feedback	Participant facilitation exercise and feedback	Individual feedback and plan for running own course
Session 4 ⌚ 15:30–17:00	Essential care and practice (continued)	Training skills: Facilitating group discussions  Facilitator demonstrations	Participant facilitation exercise: Participants given time to prepare delivery of mhGAP ToHP training	Participant facilitation exercise and feedback	Individual feedback and plan for running own course (continued)  Finish and wrap-up

# Day 1

## Learning objectives

- Understand the mhGAP programme and its progression.
- Understand mhGAP-IG and its integration into non-specialized health settings.
- Understand implementation principles as they relate to mhGAP-IG.
- Promote mhGAP-IG use and training.
- Familiarize participants with mhGAP-IG and training manuals.

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### Session 1

#### Welcome, introduction to mhGAP, importance of integrating mental health into non-specialized health settings

 Duration:  
1 hour 30 minutes

 Slide numbers:  
1–14

**PURPOSE:** Welcome participants to the training; introduce them to the Mental Health Gap Action Programme and the importance of integrating mental health into non-specialized health settings.

**OVERVIEW:**

- Explain any housekeeping issues about the venue and/or administrative tasks for the training.
  - Begin with a brief introduction of yourself and invite participants to introduce themselves. Review the schedule of the next five days.
  - Administer the pre-test for mhGAP ToTS (See ToTS supporting material and training forms).
  - Introduction to mhGAP and mhGAP-IG Version 2.0. This session provides information on:
    - Mental Health Gap Action Programme, including a seven-minute video about mhGAP and why it is important to integrate mental health into non-specialized health settings. (<https://www.youtube.com/watch?v=TqlafjsOaoM&feature=youtu.be%29>)
    - Ensure you download this video before the training starts.
    - Introduce participants to the mhGAP-IG Version 2.0.
  - **Activity 1: Group brainstorming session** about non-specialized health settings in the local context and whether mental health has been integrated or not. If not, why not?
- Pre-training preparation:** Master trainers can include any information or photographs of non-specialized health settings in the country of training. This allows participants to discuss, understand and reflect on the non-specialized health setting in that environment.

- After discussing this topic, allow participants to reflect on the health-care systems and mental health systems in their local settings.
- End the session by summarizing the “seven good reasons” why mental health should be integrated in non-specialized health settings (source: WHO & World Family Doctors: Caring for People (Wonca) (2008). Integrating mental health into primary care: A global perspective).

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## Session 2

### Implementation of mhGAP and familiarization with mhGAP-IG Version 2.0

 Duration:  
1 hour 30 minutes

 Slide numbers:  
15–26

**PURPOSE:** Ensure that participants have an understanding and overview of how mhGAP-IG training and supervision fits into the wider roll-out of mhGAP (in the country). Conduct an exercise so participants can demonstrate their familiarity with mhGAP-IG procedures.

#### OVERVIEW:

- **Implementation of mhGAP-IG:** Introduce participants to the phases of mhGAP implementation as described in the mhGAP Operations Manual and PowerPoint slides 15–25. Explain briefly Phase I (plan mhGAP implementation) and the steps required, but focus on Phase II (prepare – build capacity) and Phase III (provide – deliver services). Emphasize that participants are currently in Phase II and have them reflect on what needs to happen in their settings in order to move to Phase III.
- **Activity 2: Phase III: Provide**
  - Divide participants into small groups.
  - Give each group a piece of flip chart paper and pens.
  - Ask the groups to discuss and identify the weaknesses and problems in current mhGAP provision in their area (10 minutes).
  - Ask the groups to map out on the flip chart paper how they could provide mhGAP services going forward (10 minutes).  
Which facilities can provide services and how?  
What community services can be offered?  
What can be done to prevent and promote mental health?
  - Have the groups feedback and/or hang their maps on the wall and present.
  - Explain that throughout the next five days of training, participants should continue to reflect on the practicalities of service provision after any mhGAP-IG training.
  - Hang at least three empty pieces of flipchart paper

## Session 2

(continued)

on the wall with the titles: community services/organizations; in health services; and referral services. Encourage participants to fill these pieces of paper throughout the training as they think of different services already available, in order to start creating a directory of organizations and ideas.

- **Activity 3: Familiarization with mhGAP-IG Version 2.0:** Problem-based learning scenarios using the mhGAP-IG (see ToTS supporting materials and training forms) (40 minutes).
  - Divide participants into groups.
  - Explain that each group will receive a scenario relating to a person presenting to the clinic with a priority MNS condition.
  - The groups will start by discussing the presentation of the case, and as a group will decide how they would assess and manage the person.

## Sessions 3 and 4

### Teaching a module from the mhGAP Training of Health-care Providers (ToHP) training manual

 Duration:  
3 hours 45 minutes

 Slide number: 27  
(See the step-by-step facilitator's guide – Essential care and practice module)

**PURPOSE:** Introduce participants to the style of mhGAP-IG Version 2.0 training and give them the experience of participating in an mhGAP-IG Version 2.0 training. Enable the master trainer to see the participants' level of clinical skills and ability to assess and manage priority MNS conditions.

#### OVERVIEW:

- Use the module Essential care and practice (ECP) from the mhGAP Training of Health-care Providers (ToHP) training manual.
- Teach parts of the module that you think are important depending upon the previous knowledge and skills of the participants
- At the end of the ECP module explain that the next four days' training will concentrate on discussing and practising training skills.

### Homework

Assign participants different short sections from the mhGAP Training of Health-care Providers (ToHP) training manual and ask them to prepare a three-minute presentation to deliver the next day.



# Day 2

## Learning objectives

- Understand teaching and competency principles as they relate to mhGAP ToHP training.
- Understand principles of adult education as they relate to mhGAP ToHP training including motivating learners, and the need for an interactive and experiential, not didactic, teaching style.
- Able to prepare, adapt and evaluate a training course for mhGAP ToHP training.
- Able to utilize a variety of teaching methods and skills for mhGAP ToHP training with confidence.
- Practise performing different teaching skills:
  - Making a presentation
  - Facilitating a group discussion
  - Facilitator demonstration.

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### Session 1 mhGAP ToHP training methodology and competencies

 Duration:  
1 hour 30 minutes

 Slide numbers:  
28–38

**PURPOSE:** Enable participants to reflect on their experience of training and the qualities of effective trainers. Introduce them to how experiential learning has been applied to mhGAP ToHP training, including the concept of giving and receiving feedback. Explain that throughout, the ToTS participants will be giving each other feedback and learning how to integrate it into their professional development.

**OVERVIEW:**

- Introduce participants to the mhGAP ToHP training using the PowerPoint slides.
- Explain how mhGAP ToHP training uses experiential learning techniques and competency-based learning. Discuss giving feedback and how it will be given in the form of competency-based checklists and assessments throughout the training.
- **Activity 4:** There is a five-minute activity on giving feedback.

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## Session 2

### Preparing and evaluating an mhGAP ToHP training

 Duration:  
1 hour 30 minutes

 Slide numbers:  
39–53

**PURPOSE:** Introduce participants to the principles of preparing for an mhGAP ToHP training; the need for brief training needs assessments (TNA), adaptation of the training material to fit the local training context, and steps needed to prepare for training. Introduce participants to the materials required to evaluate the training.

**OVERVIEW:**

- Introduce participants to a TNA and give an example of a brief TNA.
- Introduce participants to the need to adapt mhGAP training materials to fit their particular context and discuss ways this could be done. As the participants work with and use the mhGAP ToHP training manual (throughout the ToTS training), support them to begin this adaptation process.
- Introduce participants to the need to decide on the length and delivery method of mhGAP ToHP training.
- Introduce participants to the need to prepare themselves for delivering an mhGAP ToHP training.
- **Activity 5: In pairs, brainstorm the attributes of an effective trainer.**
- Introduce participants to the different ways of creating a comfortable learning environment.
- Introduce participants to the concept of course evaluations and give them the mhGAP evaluation tools with which to practise.

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## Session 3

### Training skills: Introduction to training methods and presentation skills

 Duration:  
1 hour 30 minutes

 Slide numbers:  
54–61

**PURPOSE:** Encourage participants to think of as many training methods as possible and reflect on what they have used before and why. Enable participants to practise delivering a presentation, giving and receiving feedback on their presentations. Introduce participants to the principles of effective presentations skills.

**OVERVIEW:**

- Use a brainstorming session to introduce participants to as many training methods as possible and have them briefly reflect on what they have used in the past.
- **Activity 6: Practical session: Delivering a presentation:**
  - Ask each participant to deliver their three-minute presentation on the mhGAP ToHP training manual material they were assigned on Day 1.
  - Allow other participants to give feedback following each presentation.
  - Ensure that each participant gets a chance to provide feedback at least once.

## Session 3

(continued)

- Introduce participants to the principles of effective presentation skills. When discussing presentation skills draw on what you witnessed during the presentations as well as explaining the general principles of delivering a presentation.

## Session 4

### Training skills: Facilitating a group discussion and using facilitator demonstrations

 Duration:  
1 hour 30 minutes

 Slide numbers:  
62–70

**PURPOSE:** Enable participants to practise facilitating group discussions. Teach them the use of group discussions in mhGAP ToHP training. Enable participants to understand the use of facilitator demonstrations.

#### OVERVIEW:

- Introduce participants to the principles of conducting large and small group discussions and how they are applied to the mhGAP ToHP training.
- **Activity 7: Practical session: Group discussion facilitation:**
  - The master trainer gives each participant a card with an instruction on how to behave (e.g. a participant who talks too much, a member who will not talk, a participant that turns the discussion into an argument, a person that keeps departing from the subject, a person that just wants to tell their own stories and experiences all the time).
  - The master trainer sits in the centre of the group and starts a discussion on a selected element of the mhGAP-IG, e.g. How are children with developmental disorders perceived in society? What are psychosocial interventions for people with substance use disorders? Participants behave according to their cards.
  - The master trainer demonstrates how to lead the discussion.
  - Participants are chosen to take over the role of the master trainer and continue the discussion, or start a different topic for discussion.
  - After a 15-minute discussion, and at least four participants volunteering to facilitate the discussion, stop the activity.
  - Facilitate a large group discussion (maximum 15 minutes) about the exercise. How did they find the activity? Was it helpful? Has it changed their view on how they would facilitate a group discussion?
- Introduce participants to the use of facilitator demonstrations in the mhGAP ToHP training.
- **Activity 8: Facilitator demonstration (45 minutes):**

# Session 4

(continued)

- The master trainer works with a co-facilitator (if appropriate) or a volunteer.
- The master trainer plays the role of a health-care provider.
- The co-facilitator or volunteer plays the role of a person seeking help for feeling sad and crying all the time.
- During the first role play, the master trainer gives an example of how to use poor communication skills (e.g. does not demonstrate active listening and other clinical skills; excludes the patient from the process and type of care they receive). The co-facilitator or volunteer playing the person seeking help should reflect non-verbal indicators that they are unsatisfied with the direction in which the session with the health-care provider is going.
- Stop the role play after five minutes.
- In the second role play the master trainer plays a health-care provider employing skills learned through mhGAP-IG to facilitate a successful assessment, including participatory input from the person, resulting in a satisfactory interaction and outcome of the visit in the opinion of both the person with the MNS condition and the health-care provider.
- Stop this role play after five minutes.
- Ask the participants to reflect on:
  - › How the second role play differed from the first?
  - › What it was like to experience the two interactions as an observer?
  - › How it might be to experience those types of interactions as a person seeking help?
  - › How this demonstration can be helpful to you as a facilitator?
- If there is time, have the participants practise a demonstration role play – either in front of the whole group or in small groups.



# Day 3

## Learning objectives

- Practise performing different teaching skills:
  - Person stories
  - Role plays
  - Video demonstrations.
- Able to give and receive feedback.
- Understand competency principles as they relate to mhGAP ToHP training.
- Give participants time to start planning their own mhGAP ToHP training.

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### Session 1

#### Training skills: Use of person stories and video demonstrations in mhGAP ToHP training

 Duration:  
1 hour 30 minutes

 Slide numbers:  
71–79

**PURPOSE:** Familiarize participants with the use of person stories technique in the mhGAP ToHP training. Give them the opportunity to practise using this, and explain why it is important.

**OVERVIEW:**

- Introduce participants to the person stories technique employed in the mhGAP ToHP training.
- **Activity 9: Person's story:**
  - Divide participants into groups and assign each group a different priority MNS condition.
  - Ask each group to look at the different person stories for their particular MNS condition in the mhGAP ToHP training manual.
  - Give them five minutes to read through the stories and briefly discuss them as a group.
  - Give each group eight minutes to present their story and group discussion, and two minutes to receive feedback.
  - Ensure that the participants all receive feedback, either written or verbal.
  - The participants should use the feedback to improve their facilitation skills.
- Introduce participants to the use of video demonstrations in the mhGAP ToHP training.
- **Activity 10: Video demonstrations in mhGAP ToHP training (45 minutes):**
  - Choose a module from the mhGAP ToHP training manual and the accompanying assessment video. Where possible, choose a module that

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# Session 1

(continued)

has an assessment and management video, i.e. depression, psychoses, disorder due to substance use (drug use).

- Play the video and follow the step-by-step instructions to model to the participants how they should use that video to discuss the use of the mhGAP-IG assessment and management algorithms.
  - Answer any queries that the participants may have about using videos at the end of the demonstration.
  - Explain that participants will have a chance to practise this skill when they deliver a part of the mhGAP ToHP training the next day.
- 

# Session 2

## Training skills: Use of role plays in mhGAP ToHP training

 Duration:  
1 hour 30 minutes

 Slide numbers:  
80–83

**PURPOSE:** Introduce participants to the use of role plays as part of skills development in the mhGAP ToHP training manual. Provide participants with the chance to practise facilitating a training session using role plays.

**OVERVIEW:**

- Introduce participants to role plays and how they are used as a training technique in mhGAP ToHP training manual.
- **Activity 11: Practise facilitating a training session using a role play (1 hour):**
  - Choose different role plays from the mhGAP ToHP training manual.
  - Divide participants into two groups and ask one person in each group to volunteer to be the facilitator with the rest being participants (health-care providers attending an mhGAP ToHP training).
  - The facilitator should use the mhGAP ToHP training manual material to introduce and instruct the participants to do the chosen role plays.
  - Allow 30 minutes for the participants to actually perform the role plays.
  - After the role plays ask the participants to provide feedback about how they found the experience and have the people playing the facilitator feedback on how they found the experience.

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## Session 3

### Competency-based learning, assessments and feedback

 Duration:  
1 hour 30 minutes

 Slide numbers:  
84–129

**PURPOSE:** Teach the participants how they will be using competency-based learning assessments throughout the mhGAP ToHP training, including the use of structured competency-based assessments.

#### OVERVIEW:

- Introduce participants to competency-based learning and assessments. Use the slides to give an overview and description of competency-based education and describe its key feature. Explain how the competencies for the mhGAP ToHP training will be assessed.
- Use Activity 12 to familiarize participants with role plays, competencies and assessment methods. Demonstrate that using competencies should make assessments a more standardized process. Practise giving feedback on both strengths and areas for improvement. Stimulate discussion about competency-based learning and assessments.
- **Activity 12: Role plays with a twist (30 minutes):**
  - For this activity, break the participants into groups of four.
  - Give each group a role play from the mhGAP ToHP training manual.
  - 1 person will play the role of the person seeking help.
  - 1 person will play the role of the healthcare provider.
  - 2 people will play the role of the observer.
  - The person playing the health-care provider should be instructed to do an imperfect job of their role to make this exercise more interesting.
  - They could have a bad attitude, they might just look at their mhGAP-IG and make no eye contact, or they might assess the wrong condition or make an error in management.
  - At the end, the observers should practise giving feedback on both strengths and areas for improvement.
  - Observers should also feedback on how they felt using the competency checklists.
  - After the role plays, bring the group back together for a period of reflection and summary.

# Session 4

## Participant training exercise

 Duration:  
1 hour 30 minutes

 Slide number:  
130

**PURPOSE:** Participants familiarize themselves with the mhGAP ToHP training manual, have the chance to practise all the training techniques they have learned throughout the ToTS, and receive individualized feedback and support from the master trainer and peers.

### INSTRUCTIONS:

- Divide participants into small groups and give them a section of the mhGAP ToHP training manual.
- Explain that they have the rest of the day to work together and familiarize themselves with the mhGAP ToHP training manual.
- Explain that tomorrow they will all take turns delivering their mhGAP-IG training to the whole group.
- Each group member must get a chance to demonstrate at least one teaching skill.
- Ensure that the participants have access to all the PowerPoint slides and additional materials that they require.
- Assign a time slot for each group to present the following day.



# Day 4

## Learning objectives

- Able to utilize the different teaching methods and skills required to deliver mhGAP ToHP training with confidence.
- Can give an assessment of, and feedback on, an mhGAP ToHP training.

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## Sessions 1, 2, 3 and 4

### Participant training exercise

 Duration:  
8 hours

**PURPOSE:** Participants practise, using the training techniques they have learned, to deliver a part of the mhGAP ToHP training to their peers. They receive feedback from the master trainer and their peers.

#### OVERVIEW:

- Ensure that every group presents their section of the mhGAP ToHP training manual and that every individual is observed delivering training.
- Ensure that every individual and group receives some feedback, including something constructive for them to work on and develop.
- At the end of the day, review and summarize the participants' training.
- Summarize the feedback given and the constructive points that participants need to work on and develop.
- Give the participants time to raise any concerns or queries they have with any of the mhGAP ToHP training techniques.



# Day 5

## Learning objectives

- Understand the importance of supervision, highlighting the role supervision plays in up-skilling participants and ensuring sustainability of skills learnt.
- Understand the theory and techniques of good supervision.
- Understand implementation of supervision principles as they relate to the mhGAP ToHP training.
- Able to utilize a variety of supervision models.
- Can organize and perform supervision.

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### Session 1 Supervision theory and technique

 Duration:  
1 hour 30 minutes

 Slide numbers:  
131–148

**PURPOSE:** Introduce participants to the importance and theory of supervision. Demonstrate examples of poor supervision through a demonstration role -play, and then provide teaching on the techniques and style found in good supervision. Enable participants to practise using good supervision techniques. Discuss the qualities of a supervisor and how supervisors and systems of supervision can be supported going forward.

**OVERVIEW:**

- Use a case study to introduce participants to the importance of ongoing supervision once training is complete.
- Have participants reflect on what supervision means and their own experiences of supervision.
- Introduce goals and theory of supervision including discussing examples of poor supervision.
- Use Activity 13: “Master trainer demonstration of poor supervision” to show how not to deliver supervision and discuss why.
- **Activity 13: Master trainer demonstration of poor supervision** (20 minutes, including discussion):
  - Work with a co-facilitator (if available) or a volunteer.
  - Use one of the scenarios from the supervisor role plays (see ToTS supporting material and training forms)
  - The master trainer plays the role of the supervisor.
  - The co-facilitator or volunteer plays the role of the supervisee.
  - The master trainer plays the role of the supervisor

# Session 1

(continued)

and uses as many of the qualities described in the “poor features of supervision” slide as necessary to demonstrate a poor example of supervision.

– The co-facilitator or volunteer plays the role of a supervisee who was trained one month previously in mhGAP-IG and is struggling with a case of depression that is not improving. In fact, they are currently receiving regular telephone calls from the person saying that they are feeling suicidal and have plans to kill themselves in the next few days. The supervisee is scared and wants support from the supervisor.

– After the demonstration, participants discuss what was poor about the interaction, identifying specific examples of poor supervision.

- Discuss the features of good supervision and give examples as necessary.

- **Activity 14: Role plays: Good supervision (30 minutes):**

– Divide participants into pairs with one participant playing the role of the supervisor and the other that of the supervisee. Ensure that the participants swap roles so both will have the opportunity to play the role of supervisor.

– The person playing the role of supervisor will imagine that they trained their supervisee one month previously in mhGAP-IG and they have arranged to meet with the supervisees to discuss difficult cases.

– The person playing the role of supervisee should be given their instructions (see ToTS supporting material and training forms) with a description of the cases they are presenting, or they can use examples from their own clinical practice, if the master trainer prefers.

– Allow the pairs to role play for 15 minutes.

– After 15 minutes bring the group back together and discuss what was done well from both a supervisor and supervisee perspective.

– If there is enough time ensure the participants swap roles and discuss a different case.

NB: An alternative to this activity is for the master trainer to demonstrate good supervision first and then have the participants practise.

- Introduce participants to the skill set desired in any supervisor and why. Discuss the ways supervisors should be supported.

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## Session 2

### Supervision: Practical

 Duration:  
1 hour 30 minutes

 Slide number:  
149–179

**PURPOSE:** Enable participants to plan and prepare for their local supervision.

**INSTRUCTIONS:**

- **Activity 15:** Discuss the barriers to supervision and how to troubleshoot them.
- Introduce the four different models of supervision, stressing that there is a model to suit every situation. Each model will be discussed in depth, with a case example.
- Introduce an approach to preparing for supervision by asking “who, what, when, where and how”.
- Introduce tools which are available in the participant logbook to help with supervision.
- **Activity 16: Discussion in small groups then present to larger group:**
  - Participants will break into pairs/small groups according to their service location.
  - As a group, they must answer the “who, what, when, where, how” questions to start preparing their own supervision.
  - Each small group then presents back to the larger group for discussion, feedback and problem-solving.

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## Sessions 3 and 4

### Individual feedback and planning sessions for delivering training/ supervision

 Duration:  
3 hour 45 minutes  
(Including a 30-minute tea break in the middle)

**PURPOSE:** Ensure that the master trainer can take (at least) five minutes with each participant to give them individual feedback on their progress during the course and their next steps. Give participants the opportunity to start planning when and how they will deliver their first mhGAP ToHP training of non-specialist health-care providers and plan the supervision component at the same time.

**OVERVIEW:**

- Begin the afternoon sessions by setting the participants the task of planning their own mhGAP-IG training. Include a brief TNA – contacting health managers and programme planners to learn more about training needs, and planning when and how to deliver the training.
- Emphasize that as they plan the training they must also plan how they will deliver supervision after the training – as supervision is as important as training.
- Allow them to do this in groups and/or pairs. If they work closely with another participant and are likely to deliver training together, then it is essential that they plan together.
- Ask them to think about how they could support each other? Could they develop their own peer supervision group to support each other?

- Ensure they have whatever materials they require; paper, pens etc.
- As the participants are working on this, take out each person individually and give them at least five minutes personal feedback on their progress during the course. Also spend time checking on their planning and help guide them.
- Once again, it might help to invite any health planners and managers to these sessions to ensure that they also understand the commitments required to deliver training and supervision.
- Take the last 25 minutes of the training to have each group/pair/individual feedback about the plans and steps they intend to take to deliver their first mhGAP ToHP training and supervision.



# ToTS PowerPoint slide presentation

mhGAP Training of Trainers and Supervisors (ToTS)  
training manual



# ToTS PowerPoint slide presentation



**PowerPoint slide presentation available online at:**  
[http://www.who.int/mental\\_health/mhgap/tots\\_slides.pdf](http://www.who.int/mental_health/mhgap/tots_slides.pdf)

# ToTS supporting material and training forms

mhGAP Training of Trainers and Supervisors (ToTS)  
training manual



# ToTS supporting material and training forms

- Training needs assessment form
- Pre- and post- test
- mhGAP familiarization exercise
- Supervision role plays
- Evaluation forms

# Training needs assessment form

Training needs assessment			
Location of training:	Contact person:		
<b>Please identify which of the following sources were used to complete this form:</b>			
<input type="checkbox"/> WHO/UN sources of information <input type="checkbox"/> National sources of information <input type="checkbox"/> Other published literature <input type="checkbox"/> Review of adverse events <input type="checkbox"/> Audit reviews	<input type="checkbox"/> Review of hospital admissions data <input type="checkbox"/> Discussion with management <input type="checkbox"/> Discussion with staff <input type="checkbox"/> Discussion with patients <input type="checkbox"/> Other: .....		
<b>Target population</b>			
Which MNS conditions should be managed in non-specialized health settings? (as per national level protocols and guidelines or discussions with stake holders):			
<input type="checkbox"/> Essential care and practice <input type="checkbox"/> Depression <input type="checkbox"/> Psychoses <input type="checkbox"/> Epilepsy <input type="checkbox"/> Child and adolescent mental and behavioural disorders	<input type="checkbox"/> Dementia <input type="checkbox"/> Disorders due to substance use <input type="checkbox"/> Self-harm/suicide <input type="checkbox"/> Other significant mental health complaints		
<b>Local Resources</b>			
Which medications are available in this area?			
<input type="checkbox"/> Acamprosate <input type="checkbox"/> Amitriptyline* <input type="checkbox"/> Benzhexol <input type="checkbox"/> Biperiden* <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Carbamazepine* <input type="checkbox"/> Chlorpromazine* <input type="checkbox"/> Cholinesterase inhibitors	<input type="checkbox"/> Clonidine <input type="checkbox"/> Diazepam* <input type="checkbox"/> Disulfiram <input type="checkbox"/> Fluoxetine* <input type="checkbox"/> Fluphenazine* <input type="checkbox"/> Haloperidol* <input type="checkbox"/> Lithium* <input type="checkbox"/> Lofexidine	<input type="checkbox"/> Methadone* <input type="checkbox"/> Methylphenidate <input type="checkbox"/> Midazolam* <input type="checkbox"/> Morphine* <input type="checkbox"/> Naloxone* <input type="checkbox"/> Naltrexone <input type="checkbox"/> Oxazepam <input type="checkbox"/> Phenobarbitol*	<input type="checkbox"/> Phenytoin* <input type="checkbox"/> Risperidone* <input type="checkbox"/> Sodium Valproate* <input type="checkbox"/> Thiamine* <input type="checkbox"/> .....
What are local prescribing regulations?			
What brief psychological treatments are available?			
Are mental health specialists available locally (i.e. psychiatrists, neurologists, mental health nurses)? Provide names and contact details			
Are other services available where people with MNS conditions can be referred? (i.e. gender-based violence support, financial support, aged-care)			

## Training needs assessment (continued)

### Training resources

What dates are available for training?

How much time is available for training?

How much funding, if any, is available for training?

What facilities are available for training? Includes rooms, electricity, PowerPoint, Wi-Fi etc.

### Health-care providers

What disciplines will attend the training?  
How many from each discipline are expected?

Specialist  
MNS  
providers

Doctors

Nurses

Allied Health

Other

What do the trainees "do" in their work and how will they use this learning?

What knowledge, skills and experiences do the trainees already have in MNS conditions?

### Expectations of training

What are the goals and expectations of the training according to the person(s) who requested it?

What are the trainees' expectations of the training?

## Training needs assessment (continued)

### Supervision

How much time and/or funding will be allocated to supervision after the course?

Who are potential local supervisors?

What is the preferred local supervision model?

### Barriers and enablers

What other potential obstacles may occur before, during or after training?

What other local solutions will help in the provision of the training and supervision?

### Other considerations

Please note anything else relevant to planning the training and supervision

### Conclusions

Dates for course:

Venue:

Modules to be completed:

- |  |   |
|--|---|
| <input type="checkbox"/> Essential care and practice                           | <input type="checkbox"/> Dementia                                   |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Disorders due to substance use             |
| <input type="checkbox"/> Psychoses   | <input type="checkbox"/> Self-harm/suicide                          |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Other significant mental health complaints |
| <input type="checkbox"/> Child and adolescent mental and behavioural disorders | <input type="checkbox"/> ToTS training                              |

Any additional considerations?

## Pre- and post-test

---

1. Which of the following is considered a core effective communication skill? Choose the best answer:
  - A Speaking to the person only and not the carer
  - B Start by listening
  - C Using an open space for safety
  - D Limited eye contact

---
2. Which of the following is consistent with promoting respect and dignity for people with an MNS condition? Choose the best answer:
  - A Making decisions on behalf of a person with an MNS condition, with their best interests in mind
  - B Using correct medical terminology to explain things, even if complicated
  - C Ensuring consent to treatment is received from the carer and/or family
  - D Ensuring privacy in the clinical setting

---
3. Which of the following cluster of symptoms best fits with an episode of depression? Choose only one answer:
  - A Marked behavioural change, agitated or aggressive behavior, fixed false beliefs
  - B Decline in memory, poor orientation, loss of emotional control
  - C Inattentive, over-active, aggressive behavior
  - D Low energy, sleep problems, and loss of interest in usual activities

---
4. Which of the following is a good combination treatment for depression?
  - A Vitamin injections and increasing exercise
  - B Psychosocial interventions and an antidepressant
  - C An antipsychotic medication and a mood stabilizer
  - D Hypnotherapy and relaxation

---
5. Which of the following cluster of symptoms fits best with an acute manic episode? Choose only one answer:
  - A Confusion, disorientation to time, place and person, marked functional decline
  - B Admits to consuming alcohol, has slurred speech and uninhibited behavior
  - C Has recently stopped taking regular benzodiazepines, and presents with agitation, sweating and poor sleep
  - D Decreased need for sleep, increased activity and reckless behaviour

---
6. Which of the following statements concerning psychosis and bipolar disorder is correct? Choose the best answer:
  - A People with psychosis or bipolar disorder do not need evaluation for medical conditions
  - B People with psychosis or bipolar disorder are best cared for with long-term hospitalization
  - C People with psychosis or bipolar disorder are unlikely to be able to work or contribute to society
  - D People with psychosis or bipolar disorder are at high risk of stigmatization and discrimination

---

7. Which of the following is part of a psychosocial intervention in psychoses? Choose the best answer:

- A Encourage participation in daily activities but recommend against work or serious relationships as they may be too stressful
  - B Discuss with the carer and family whether long-term institutionalization may be appropriate
  - C Provide psychoeducation, especially to avoid sleep deprivation, stress, and drugs and alcohol
  - D Discuss with the carer different ways that they might be able to challenge the delusions of the person
- 

8. Which of the following statements concerning epilepsy is correct? Choose the best answer:

- A Epilepsy is a communicable disorder of the brain
  - B Epilepsy is a sign of spirit possession
  - C Epilepsy is always genetic in cause
  - D Epilepsy is one of the most common neurological disorders
- 

9. Which of the following requires emergency medical treatment? Choose the best answer:

- A When someone starts to feel that a seizure is imminent
  - B If the seizure lasts for more than 1 minute
  - C If the seizure lasts for more than 5 minutes
  - D If the person is drowsy once the seizure is over
- 

10. Which of the following is the best description of a child developmental disorder? Choose only one answer:

- A Child developmental disorders have a relapsing and remitting course
  - B Child developmental disorders are always associated with abuse and neglect
  - C Child developmental disorders category includes attention deficit hyperactivity disorder and conduct disorder
  - D Child developmental disorders involve impaired or delayed functions related to central nervous system maturation
- 

11. Which of the following is good advice for any child and adolescent mental and behavioural disorder? Choose the best answer:

- A The carer can use threats or physical punishment if a child has problematic behaviour
- B The carer should remove the child from mainstream school as soon as possible
- C The carer can use other aids such as television or computer games instead of spending time with the child
- D The carer should give loving attention to the child every day and look for opportunities to spend time with them

---

12. Which of the following is the best first-line treatment for child and adolescent developmental disorders? Choose only one answer:

- A Psychosocial intervention
  - B Pharmacological treatment
  - C Referral to specialist
  - D Referral to outside agency
- 

13. Which of the following should be given as advice to an adolescent with a mental or behavioural disorder? Choose the best answer:

- A They should avoid community and other social activities as much as possible
  - B They should avoid the use of drugs, alcohol and nicotine
  - C They should avoid school if it makes them anxious
  - D They should avoid being physically active for more than 30 minutes each day
- 

14. Which of the following is a common presentation of dementia? Choose the best answer:

- A Low mood and loss of enjoyment in usual activities
  - B Fixed false beliefs and hearing voices
  - C Excessive activity and inattention
  - D Decline or problems with memory and orientation
- 

15. Which of the following is a common presentation of dementia? Choose the best answer:

- A Severe forgetfulness and difficulties in carrying out usual work, domestic or social activities
  - B Drowsiness and weakness down one side of the body
  - C Fluctuating mental state characterized by disturbed attention that develops over a short period of time
  - D Low mood in the context of major loss or bereavement
- 

16. Which of the following is the best description of dementia? Choose only one answer:

- A Dementia can have a large impact on the person, their carer, family and society at large
  - B Dementia can be cured through pharmacological interventions
  - C Dementia does not interfere with activities of daily living, such as washing, dressing, eating, personal hygiene and toilet activities
  - D Dementia is a normal part of aging
- 

17. Which of the following statements best describes treatment options in dementia? Choose only one answer:

- A All people with dementia should have access to pharmacological interventions, regardless of specialist availability
- B Pharmacological interventions, if started early enough, can cure dementia
- C With early recognition and support, the lives of people with dementia and their carers can be significantly improved
- D Psychosocial interventions for dementia should only be provided by a specialist, due to their complexity

---

18. Which of the following best describes symptoms of substance dependence? Choose only one answer:

- A Sedation, unresponsiveness, pinpoint pupils following use
  - B Current thoughts of suicide, bleeding from self-inflicted wound, extreme lethargy
  - C Strong cravings, loss of control over substance use, withdrawal state upon cessation of use
  - D Intravenous drug use once per month, but violent towards others when using
- 

19. Which of the following illnesses should you screen for in people who inject opioids? Choose the best answer:

- A HIV and hepatitis
  - B Wernicke's encephalopathy
  - C Epilepsy
  - D Thyroid disease
- 

20. Which of the following should you tell the carer of someone who has had an episode of self-harm or a suicide attempt? Choose the best answer:

- A Medication will be made available so that they can keep the person sedated
  - B Restrict the person's contact with family, friends and other concerned individuals in case it is too overwhelming
  - C Remove access to any means of self-harm and try and provide extra supervision for the person
  - D Forced vomiting is an emergency treatment option if they suspect any self-harm or suicide
- 

21. Which of the following is part of a psychosocial intervention where the person seeking help witnessed the death of a loved one to violence? Choose the best answer:

- A They should talk about the incident as much as possible, even if they do not want to
- B It is normal to grieve for any major loss, in many different ways, and in most cases grief will diminish over time
- C Avoid discussing any mourning process, such as culturally-appropriate ceremonies/rituals, as it may upset them further
- D Refer to a specialist within one week of the incident if they are still experiencing symptoms

---

22. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Bereavement

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

Emmanuel is a 20 year-old man who is brought to your clinic by his friends. They are very worried about him because he is afraid that the government are monitoring him, and keeps saying that he can hear people talking about him. When you ask them for more information, they say that he has not been himself for several months, at times does not make sense, and has not been coming to university much. He is about to fail the semester. There is nothing remarkable on physical history, examination or blood tests, and his urine drug screen is negative.

When you speak to him, he seems suspicious of you, does not make a lot of sense, and does not think that there is anything wrong with him. He wants to leave, and starts to become quite aggressive when you ask him to stay, saying that he is unsafe here and people are watching him.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Cara is a 17 year-old woman who is brought in by her family after having a period of shaking, rigidity and incontinence at home. She is currently confused and drowsy and does not know where she is. She reports she has always been happy and healthy, did well at school but left last year to start working, which is also going well. She is worried that she has been possessed by a spirit.

When you speak to Cara, she is still not sure what has happened and why she is in hospital. She complains of weakness down one side of her body and feeling sore all over.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Marc is a 14 year-old boy who is referred to you by his school teacher. The teacher tells you that Marc has always gotten into trouble at school as he is very disruptive to the other students. He does not seem to be able to concentrate for very long. The teacher wants you to see him in case there is something that can be done.

You meet with Marc, who does not want to sit still to talk to you. In the brief time that you talk he tells you that he hates school and finds it boring. In your assessment you do not think that he is depressed, or that he has any delusions or hallucinations. He denies using any substances. A physical examination is normal.

You meet with Marc's parents, who tell you that they have had trouble with Marc for years. He can never sit still when they take him somewhere, such as church or a friend's house, he is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

## Pre- and Post-Test Answer Key

- |        |         |         |         |                                 |         |         |        |
|--------|---------|---------|---------|---------------------------------|---------|---------|--------|
| 1. = B | 7. = C  | 13. = B | 19. = A | 22. A = II<br>B = III<br>C = IV | 12. = A | 18. = C | 6. = D |
| 2. = D | 8. = D  | 14. = D | 20. = C |                                 | 11. = D | 17. = C | 5. = D |
| 3. = D | 9. = C  | 15. = A |         |                                 | 16. = A |         | 4. = B |
| 4. = B | 10. = D |         |         |                                 | 21. = B |         |        |
| 5. = D |         |         |         |                                 |         |         |        |

# mhGAP familiarization exercise

Read the case example below and answer questions using mhGAP-IG.

## Case example

A 30-year-old woman is brought to the clinic because of her restless behaviour. The woman is not willing to sit down and is pushing her husband away from her. She seems afraid and looks behind constantly. She is refusing to let anyone examine her.

## What do you suspect using mhGAP-IG Master chart? Which module should you go to?

Her medical records were as follows:

Blood type O+, antibody screen negative, VDRL (syphilis) negative, PPD (tuberculosis) negative, HIV test negative, hepatitis B surface antigen negative, rubella immune, maternal serum triple screen normal, glucose challenge test normal, haemoglobin electrophoresis 97% haemoglobin A, no fever, not taking medication, no smell of alcohol.

Every time you ask her questions about her symptoms, she stops talking. When you insist on learning more about her symptoms she becomes silent.

When you offer her medication to help her feel more relaxed and calm, she becomes more agitated, saying that she is not crazy and will not take any medications.

You are able to speak to the woman's husband in a private room away from the woman after asking her if it is ok.

Her husband tells you that since the birth of their youngest child three months ago the woman has been having "mood swings and anger problems".

He says that she is neglecting her role as a mother and a wife. It is as if she has become a different person since the birth of her baby.

He says that he has seen her in the house talking to herself.

He also says that she is convinced that the neighbours want to hurt her and her children and as a result she does not want to leave the house.

The pregnancy was normal and there were no problems during delivery.

She has hardly left the house since the delivery but before that she was very sociable and had a lot of friends.

- » What symptoms do you see/suspect?
- » What additional questions do you want to ask the woman to learn more?
- » Which protocol do you go to according to mhGAP-IG?
- » What kind of management do you provide?

# Supervision role plays

## Introduction

These role plays are designed to demonstrate different styles of supervision, particularly how supervision can be done badly, and behaviours that future supervisors should avoid.

Each role play should take 40 minutes:

- 3 minutes – reading time
- 20 minutes – role play
- 15–20 minutes – group discussion.

If there is time, each role play can be performed a second time, with the “supervisor” using what they have learned to provide better supervision.

## Supervision role play 1

In this role play, the supervisee is struggling with a case of depression that is not improving. The supervisor is displaying generally “disliked qualities” of supervision – they are too busy, unskilled in this area, hierarchical, critical and do not demonstrate respect and dignity for people with a priority MNS condition.

## Supervision role play 2

In this role play, the supervisee is struggling with a number of complicated psychosocial and administrative challenges, beyond routine clinical care. The supervisor has strengths, but they are very authoritative in their approach.

## Supervision role play 3

In this role play, the supervisee is overconfident and has made a significant clinical error. The supervisor has strengths, but they are too facilitative in their approach, and not direct enough in telling the supervisee that they have made an error.

## Supervision role play 1

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISEE (NON-SPECIALIST HEALTH-CARE PROVIDER)

You are recently trained in mhGAP-IG Version 2.0. Imagine it is one month from now and you have gone back to your usual place of work. You have started seeing people with MNS conditions. Mostly you are enjoying the new work, but sometimes there have been some challenging situations.

You have brought a difficult case to discuss at supervision. You first met this lady three weeks ago and identified that she had depression. You provided psychosocial interventions, which you thought went well. She declined medication at the time.

However, she returned to see you one week ago and things seem to have deteriorated. Her mood is still low and she is not sleeping or eating. She is now hearing voices telling her she is a bad person. She is reluctant to take medication but might consider it, although you have never prescribed medication before and are anxious about doing this. She has said to you that if things do not improve she is thinking of taking an overdose of her husband's medication. She does not want you to tell her husband this.

You have come hoping that the supervisor will help you out. You want to know:

- Why is she hearing voices?
- What are the medication options and how should you prescribe them?
- What should you do about the suicidal thoughts?
- How should you deal with the fact she does not want her husband to know?

### INSTRUCTIONS

Ask the supervisor for help. Do not stop the interview until you feel you have the help you need.

» At the end, reflect on this episode of supervision.

## Supervision role play 1

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISOR (SPECIALIST)

You are the only neurologist in your city of 1 million people. You run outpatient clinics every week day, sometimes seeing up to 50 people in each clinic. You also look after the neurology ward of 20 beds, and sometimes have to help with hospital administration. You often work at the weekend.

You were asked to provide supervision for the mhGAP-IG Version 2.0 trainees. You did not particularly want to, but there was no one else available. You feel comfortable supervising regarding a patient with epilepsy or dementia, but you feel pretty "lost" when it comes to mental health or substance use.

You are meeting your supervisee today. Unfortunately, it has been a busy day – you were up all night on call, there are very unwell patients on the ward and you have double-booked this session. You are hoping it will be done in five minutes, and keep looking at your watch, your phone, yawning and asking "is that all?".

You are really hoping they do not bring a mental health or substance use problem. If they ask you about this, you will try and relate it to a case of epilepsy that you have treated, and you plan to keep your answers deliberately vague so they will not pick up that you are unsure of treatment.

Occasionally, you criticize the supervisee just to demonstrate that you know that you are the one in charge. You mention at least twice that you think they are wasting their time treating mental health, and they should try and treat more epilepsy, like you do.

### INSTRUCTIONS

Provide supervision as instructed, without using your prior mhGAP-IG knowledge except for epilepsy.

» At the end, reflect on this episode of supervision.

## Supervision role play 2

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISEE (NON-SPECIALIST HEALTH-CARE PROVIDER)

You are recently trained in mhGAP-IG Version 2.0. Imagine it is one month from now and you have gone back to your usual place of work. You have started seeing people with MNS conditions. Mostly you are enjoying the new work, but sometimes there have been some challenging situations. You have brought a difficult case to discuss at the supervision.

You first met this person seeking help two weeks ago. He is a 41-year-old man seeking help for a disorder of substance use. He has been using heroin intravenously for four years. You have been providing some psychosocial interventions to help stop his use, and he is now interested in considering opioid agonist maintenance treatment. You would like to start this next week, and feel quite confident in delivering the pharmacological intervention.

However, you are struggling with other aspects of this case.

- You know the patient has contracted HIV from his intravenous use, but he does not want to start treatment for the HIV.
- Even though you are able to deliver the pharmacological intervention, your hospital manager has told you they "don't want people like that attending every day", and is being obstructive about providing treatment.
- You feel very stressed and overwhelmed.

To complicate matters, you are a bit intimidated by your supervisor, who is very senior at the local hospital.

### INSTRUCTIONS

You have come hoping that the supervisor will help you out. You do not want any advice on psychosocial or pharmacological interventions, you feel quite confident in this.

You do want help around the untreated HIV, the obstructive hospital manager and your own levels of stress, however you will only raise these issues if the supervisor makes you feel comfortable to do so.

## Supervision role play 2

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISOR (SPECIALIST)

You are a psychiatrist who has agreed to be a supervisor for mhGAP-IG. You are very senior in your hospital and thought it would be good to volunteer your time to help with supervision, as you believe you have a lot that people can learn from you. You consider yourself very “no-nonsense”. You are efficient and direct, and do not like to waste time with unimportant things.

When someone asks for your help with mhGAP-IG you go straight to the right page and talk them through it at length. You do not like to be interrupted. You do not like to trouble yourself with matters that you do not see directly related to the issue in front of you.

Your supervisee has come today to discuss a disorder of substance use case.

### INSTRUCTIONS

Ask your supervisee what they want help with today. When she says she has a patient with a disorder of substance use, you turn to page 116. You stick to the algorithm and are not willing to discuss anything else, which you believe would be getting “off-track”. If the supervisee raises anything else, you direct her back to the algorithm.

## Supervision role play 3

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISEE (NON-SPECIALIST HEALTH-CARE PROVIDER)

Imagine it is one month from now and you have gone back to your usual place of work. You are a very experienced health-care provider dealing with physical conditions. You have started seeing people with MNS conditions. You feel very confident about your skills. You are hoping that with this extra experience you will get a promotion at the hospital soon.

Last week you saw a 32-year-old lady who appeared to have an acute episode of mania. She was irritable, elevated and had been behaving recklessly and spending a lot of money. Her husband confirmed that she had been talking a lot and not sleeping at night. She is also in her first trimester of pregnancy.

You didn't even have to look at the mhGAP-IG – you know that sodium valproate is used in mania, so you started that at a high-dose as she was so unwell.

### INSTRUCTIONS

You need to discuss a case for supervision. This is the most interesting case you have seen so far, so you decide to discuss it. You are also quite proud of having diagnosed and prescribed the medication without looking at the mhGAP-IG and you would like the supervisor to recognize how good you are.

You do not tolerate criticism and do not want anything to blemish your record. If the supervisor suggests you have done something wrong you disagree and change the subject back to discussing what you have done well.

## Supervision role play 3

To experience and better understand different styles of supervision

 Duration:  
40 minutes

### SITUATION: SUPERVISOR (SPECIALIST)

You are a psychiatrist with an interest in psychotherapy. You are very happy to be a supervisor for mhGAP-IG. You are well-liked as a supervisor, as you are very gentle and calm, and do not criticize your supervisees like some of the other supervisors do. You believe in allowing the supervisees a space to release tension in their time with you, and to reflect on their practice. You believe in validating the work a supervisee does. You never tell people outright that they have done the wrong thing, you try and get them to reflect and see for themselves what they could have done differently.

You have met your new supervisee before. You noticed that he seems a bit overconfident and does not take direction well. You are hoping that by taking a very gentle approach with him you can help him improve.

### INSTRUCTIONS

The supervisee will present a case to you. Use your mhGAP-IG psychoses module to help with supervision. Even if you do not think the supervisee has done the right thing, you do not say this outright – get them to reflect on what they have done and try and identify this themselves.

# Evaluation forms

Participant feedback form for each module				
Date of training:	Location of training:			
Name of facilitator(s):				
<b>The name of the training module (check only one):</b>				
<b>Training of health-care providers</b> <input type="checkbox"/> Essential care and practice <input type="checkbox"/> Depression <input type="checkbox"/> Psychoses <input type="checkbox"/> Epilepsy <input type="checkbox"/> Child and adolescent mental and behavioural disorders <input type="checkbox"/> Dementia <input type="checkbox"/> Disorders due to substance use <input type="checkbox"/> Self-harm/suicide <input type="checkbox"/> Other significant mental health complaints		<b>Training of trainers and supervisors</b> <input type="checkbox"/> Welcome and introduction <input type="checkbox"/> Implementation of mhGAP-IG <input type="checkbox"/> Introduction to mhGAP training <input type="checkbox"/> Preparing and evaluating a training course <input type="checkbox"/> Teaching skills (specify: .....) <input type="checkbox"/> Competency assessment and feedback <input type="checkbox"/> Participant facilitation exercise (specify: .....) <input type="checkbox"/> Supervision: Theory and technique <input type="checkbox"/> Supervision: Practical		
<b>Please rate the following:</b>	<b>Poor</b>	<b>Average</b>	<b>Excellent</b>	<b>Additional comments</b>
Quality of content and information – was it relevant, well-researched and organized?	1	2	3	
Quality of slides and handouts – were they easy to read and helpful in learning?	1	2	3	
Quality of trainer – were they engaging, enthusiastic and informed?	1	2	3	
Quality of activities/role plays and clarity of instructions	1	2	3	
Length of module – was it too long, too short or just right?	1	2	3	
Number of opportunities for active participation – too many, too few or just right?	1	2	3	
How confident do you now feel about using what you have learned in this module?	1	2	3	
<b>Overall quality of this module</b>	1	2	3	
<b>What was best about this module?</b>				
<b>What did you learn from this module that you anticipate using again?</b>				
<b>What would you suggest to improve this training module?</b>				

## Trainer feedback form for each module

Date of training: ..... Location of training: .....

Name of facilitator(s): .....

### The name of the training module (check only one):

#### Training of health-care providers

- Essential care and practice
- Depression
- Psychoses
- Epilepsy
- Child and adolescent mental and behavioural disorders
- Dementia
- Disorders due to substance use
- Self-harm/suicide
- Other significant mental health complaints

#### Training of trainers and supervisors

- Welcome and introduction
- Implementation of mhGAP-IG
- Introduction to mhGAP training
- Preparing and evaluating a training course
- Teaching skills  
(specify: ..... )
- Competency assessment and feedback
- Participant facilitation exercise  
(specify: ..... )
- Supervision: Theory and technique
- Supervision: Practical

Type of staff	Primary care doctors/ GPs	Nurses	Others (please specify)	Additional comments
Number of participants				
<b>Please rate the following:</b>	<b>Poor</b>	<b>Average</b>	<b>Excellent</b>	<b>Additional comments</b>
Amount of content – too much, too little or just right	1	2	3	
Quality of content – was it relevant, well-researched and organized?	1	2	3	
Quality of instructions and notes – were they helpful and easy to read?	1	2	3	
Quality of activities/role plays – were they engaging and helpful in teaching?	1	2	3	
Length of module – did you have too much, too little or just enough time?	1	2	3	
Engagement of participants	1	2	3	
How confident do you feel the objectives were met?	1	2	3	
<b>Overall quality of this module</b>	<b>1</b>	<b>2</b>	<b>3</b>	

### What was best about this module? When were the participants most engaged?

### What would you suggest to improve this training module?

# **mhGAP Training of Health-care Providers (ToHP) training manual**

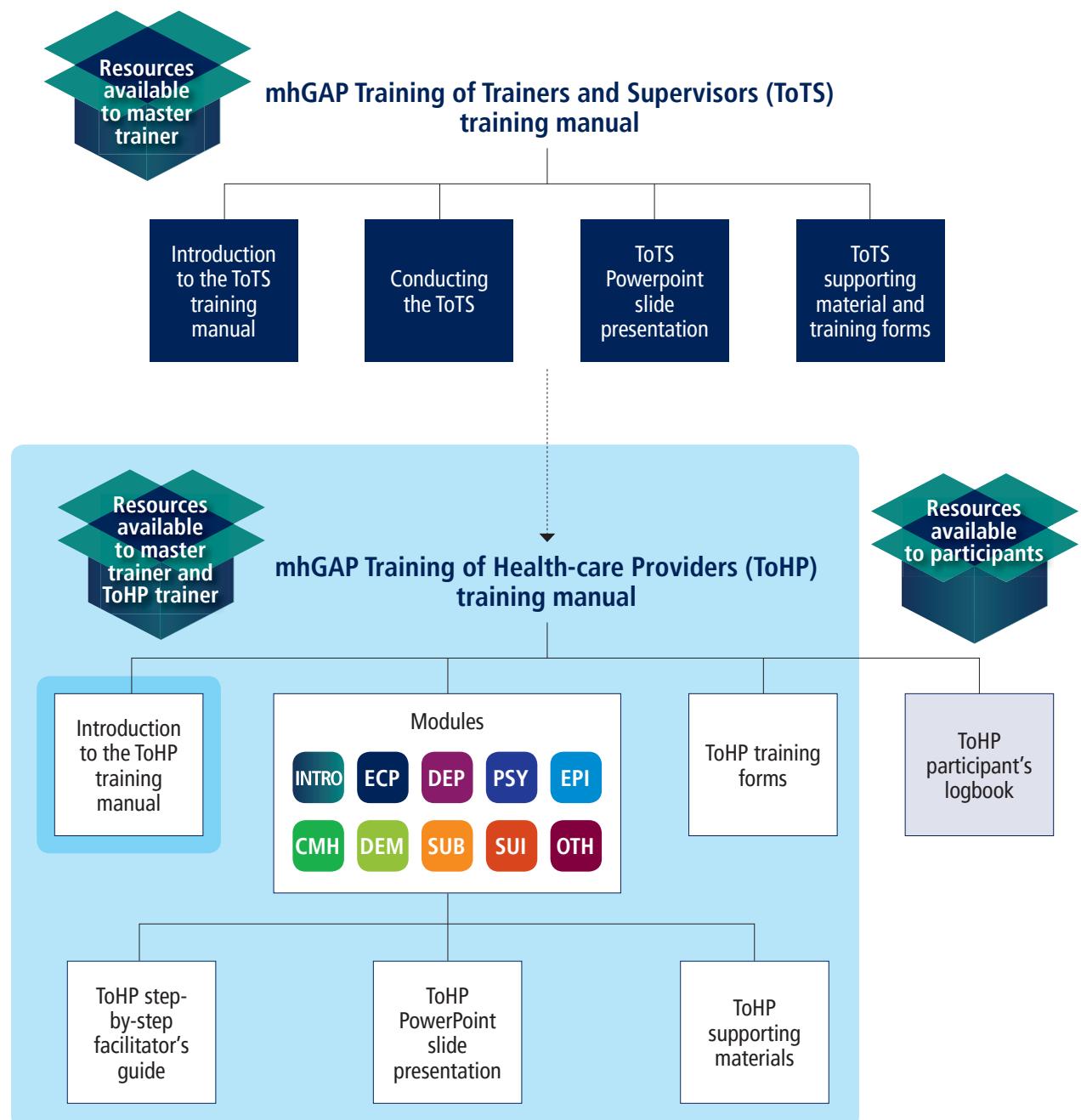
## ToHP



**World Health  
Organization**

# Introduction to the mhGAP Training of Health-care Providers (ToHP) training manual

Figure 1. Graphical representation of mhGAP-IG training manuals, with the mhGAP Training of Health-care Providers (ToHP) training manual and the Introduction to the ToHP training manual highlighted



# Overview of the ToHP training manual

The mhGAP Training of Health-care Providers (ToHP) training manual has been designed to teach health-care providers how to assess and manage priority mental, neurological and substance use (MNS) conditions, using the evidence-based mhGAP Intervention Guide (mhGAP-IG) in non-specialized health settings.

For the best results this training should be implemented as part of a multifaceted approach to scaling up mental health care in a country. Health planners, managers and policy-makers should be involved in the training to ensure that there are adequate resources made available to primary health-care providers to deliver mhGAP interventions. Regular supervision and refresher courses should also be provided.

## ToHP training learning objectives

The ToHP training aims to ensure that health-care providers attain core competencies in delivering care for people with MNS conditions. In the ToHP training manual, 12 core competencies have been developed, which cover all areas needed to assess and manage each priority MNS condition. The 12 core competencies match the learning objectives for each module, and include attitude, knowledge and skills, and are presented below (for greater detail of each competency see ToHP training forms):

1. Promotes respect and dignity for people with MNS conditions (attitude).
2. Knows common presentations of priority MNS conditions (knowledge).
3. Knows assessment principles of MNS conditions (knowledge).
4. Knows management principles of MNS conditions (knowledge).
5. Uses effective communication skills in all interactions with people with MNS conditions (skill).
6. Performs assessment for priority MNS conditions (skill).
7. Assesses and manages physical conditions of people with MNS conditions (skill).
8. Assesses and manages emergency presentations of priority MNS conditions (skill).
9. Provides psychosocial interventions to people with a priority MNS condition and their carer (skill).
10. Delivers pharmacological interventions as needed and appropriate in priority MNS conditions, considering special populations (skill).
11. Plans and performs follow-up for priority MNS conditions (skill).
12. Refers to specialists and links with outside agencies for priority MNS conditions, as appropriate and available (skill).

Each type of competency will be assessed differently:

- **Attitude:** Assessed by role play and observation by supervisor.
- **Knowledge:** Assessed by multiple choice questions (MCQs).
- **Skill:** Assessed through role plays.

## Suggested training schedule

The complete training involves completion of all ten modules i.e. Introduction module, Essential care and practice (ECP) module as well as the eight priority MNS conditions. However, there is flexibility in how the modules are taught and how the training is planned depending on the local context.

Some suggested schedules include:

All ten modules can be delivered over 5–6 consecutive days.

OR

The training can be delivered in three segments e.g. over three weekends according to participant schedules.

OR

Facilitators may decide to reduce the number of training days by choosing to teach the ECP module and those priority MNS conditions most relevant to the local context.

Participants may then complete the rest of the training through self-learning and e-learning.

Priority conditions	Abbreviations	⌚ Duration
Introduction to mhGAP	INTRO	1.75 hours
Essential care and practice	ECP	5.8 hours
Depression	DEP	4.5 hours
Psychoses	PSY	4.6 hours
Epilepsy	EPI	4.5 hours
Child and adolescent mental and behavioural disorders	CMH	5.8 hours
Dementia	DEM	4.5 hours
Disorders due to substance use	SUB	6 hours
Self-harm/suicide	SUI	3.75 hours
Other significant mental health complaints	OTH	4.5 hours

# How to use this guide

This guide is written to assist trainers to conduct training for health-care providers currently working in non-specialized health settings, and will be available as a hard copy and electronically. This guide is meant to be used alongside the mhGAP-IG.

The components of the ToHP training manual include the step-by-step facilitator's guides, PowerPoint slides and supporting materials available for each module (supporting materials include person stories, role plays, video links, and MCQs). Additionally, for assessment and evaluation, ToHP training forms can be used across every module.

This guide also contains the ToHP participant's logbook, which should be provided to each participant at the start of the training.

## Preparation and adaption

For the best results, this training should be delivered by two trainers who have completed the Training of Trainers and Supervisors (ToTS) training. Using two trainers will ensure that all participants are engaged in the training and learning from the trainers' expertise.

Trainers should make sure they are familiar with the mhGAP-IG and the ToHP training manual, as well as the participant's logbook. It is recommended that both trainers practise each module together before the training commences.

Trainers should have conducted a training needs assessment (TNA) (see ToHP training forms) during their ToTS training. If not already done, this should be completed at least one month before the training is due to begin. By gathering this information, the trainer can adapt the ToHP training manual as needed, by understanding:

- How much time is available for ToHP training.
- Which modules should be prioritized where there is limited time.
- What are the strengths and weaknesses in mental health knowledge amongst participants.
- What are the local referral pathways and health systems, and possible barriers and solutions.
- How much support participants will be offered after training in the form of supervision.

Material may need to be translated into the local language, and master trainers should be aware that this may change the timing of the modules. A timed run-through of the modules is recommended before the training.

When adapting the ToHP training manual to local context, care should be taken to avoid adding or removing slides, eliminating activities or interactive components, or removing the opportunities for participants to practise these skills. Instead, person stories, role plays, MCQs, and video demonstrations which best suit the local context can be chosen, or master trainers may wish to find or create their own.

There are a number of practical considerations when planning the ToHP training. The venue should have adequate accommodation and easy transportation options. Tables and chairs should be movable and a functional laptop/computer, LCD projector and large flip-charts or white/black boards should be available.

When preparing for the ToHP training use the trainer checklist (see checklist, below).

## ToHP training participants

The recommended number of participants for this training is 12–24 people. This allows participants to be easily divided into groups of three to four for skills building activities, and ensures that the facilitator is able to spend time supporting each participant. Participants will likely be nominated by their local health service to participate in the course.

The following steps will help participants feel comfortable early in the training:

1. Allow the participants some time to meet the trainers and other participants before the training starts, if possible over a casual meal.
2. Explain expectations early, including how long the training will take, and ongoing expectations about practice and supervision.
3. Reassure the participants that the interactive teaching style may seem daunting, but will be rewarding and invaluable for their skill and confidence building.
4. Agree on common ground rules on how they will treat everyone in the group.
5. Prepare the participants to give and receive feedback to help with their development.
6. Acknowledge that participants are health-care providers and already bring with them a large array of clinical skills.

## Training guidelines

### **1. Understand the local health-care system**

Trainers should familiarize themselves with local systems, to adapt the course, help with problem-solving, know local specialized services and which medications are available.

### **2. Be organized and professional**

Trainers set the tone for the training, and should understand the plan, keep to time, be prepared and organized, and show passion and enthusiasm for the content. Trainers should model supportive teamwork and good communication with each other.

### **3. Manage your time well**

There is a large amount of content to cover, and good time management is crucial. Trainers should schedule the arrival and registration prior to training, start and end on time (including breaks), set a clear agenda, discuss timing with the participants, and even appoint a participant as a timekeeper.

### **4. Model the skills and attitude you want to see**

The ToHP training manual is designed for the trainers to model the correct skills and attitude. Trainers should use effective communication skills, pay attention to their body language, speak clearly, using non-judgemental body language, use open-ended questions, and model respect and dignity to all persons with MNS conditions.

### **5. Embrace experiential learning**

Adults learn best by observing, doing and interacting, rather than more traditional didactic lectures. Trainers should not spend too much time on the PowerPoint slides – approximately 70% of training time should be spent practising skills and participating in activities.

### **6. Be encouraging and positive as participants practise new skills**

Trainers should use praise, and, where appropriate, humour, to put the participants at ease and build their confidence.

## **7. Encourage participants to come up with their own case examples**

Participants should draw on their own experiences and relate the material to their own work.

## **8. Actively use mhGAP-IG**

The mhGAP-IG should be used repeatedly throughout the course to help with familiarization.

## **9. Allow enough time for feedback**

After every activity there should be time for peer and trainer feedback, to help with participant development.

## **10. Evaluate the ToHP training**

Trainers should collect formal feedback through the evaluation forms (see ToHP training forms), and informal feedback through discussions with the participants, to ensure training meets participants' needs.

## **11. Facilitate and develop supervision**

Supervision is an essential part of the ToHP training. Trainers should ensure that every participant has a plan for supervision when they finish the course.

# **Specific training techniques**

Five specific experiential training techniques are used throughout the ToHP training to help consolidate and build on didactic teaching. These are:

## **Person stories**

**Purpose:** Person stories are designed to start each module, by introducing the priority MNS condition in a way which is likely to stay with participants much longer than facts or statistics.

**Objectives:** Stories will allow participants to:

- Practise being empathetic by considering another person's perspective and what it would be like to live with an MNS condition.
- Reflect on their own experience of caring for people with an MNS condition.
- Consider how priority MNS condition symptoms commonly present and how they impact on the person, family and community.

**Instructions:** The step-by-step facilitator's guides provide specific directions for each person story, but common aspects are:

- **Introduction:** Spend time explaining the process, provide paper and pens, keep track of time.
- **The story:** Tell the story without interruption, being creative with delivery. Stories can be adapted to local context if needed, but ensure they contain a description of the condition, the person's feelings and the effect on their lives.
- **Immediate first thoughts:** Participants take turns to give immediate reflections on the story, including sharing their own experience.
- **Local descriptions and terms:** Where the story does not match the local context, participants should spend time considering local descriptions and terms. Consideration should be given to whether terms are positive or negative, and a socially-acceptable term should be agreed-upon for ongoing use.

## Group discussion

**Purpose:** Small or large groups discussions encourage participants to share their knowledge and experience, explore and express their ideas and opinions, and to debate topics and problem-solve.

**Objectives:** Group discussions will allow participants to:

- Improve their communication and listening skills.
- Collectively debate and answer questions.

**Instructions:** The step-by-step facilitator's guides provide specific directions for each discussion, but common themes are:

- **Lead and direct the discussion:** Ensure discussions are planned and have a clear purpose at the start.
- **Keep focused and within time:** Do not be distracted by other topics. Where a topic not relevant to the discussion is raised, it should be "parked" until the end of the module or day, when it can be addressed. Ensure the discussion stays within time by wrapping up five minutes before allocated time is finished.
- **Keep the discussion accurate:** Trainers should correct any inaccurate information immediately, without embarrassing or deterring participants.
- **Ensure closure:** Trainers should summarize, reflect and repeat the key points of the discussion, and at the end connect it with the learning objectives of the module.

## Role plays

**Purpose:** Role plays provide an opportunity to practise skills which will be used in future clinical practice, and help consolidate didactic teaching. They should not be seen as an optional or disposable part of training.

**Objectives:** Role plays will allow participants to:

- Gain experience in using the mhGAP-IG in clinical scenarios.
- Build their skills in assessing, managing and following-up people with priority MNS conditions.

**Instructions:** The step-by-step facilitator's guides and role plays provide specific timing and instructions, but the general process is:

- **Introduction:** Explain how the role plays work. As the training progresses, this will require less time. In each role play, there is a person experiencing a priority MNS condition who is seeking help. Some role plays also have a carer seeking help. There is a health-care provider who will need to assess, manage or follow-up the person seeking help, depending on the instructions. Finally, there is an observer who will monitor the interaction, complete the competency assessment sheets (see ToHP training forms), keep to time and provide feedback.
- **Break into groups:** Participants should be broken into groups of three or four, depending on the module (instructions in the step-by-step facilitator's guides). Allocate the roles of the person seeking help, the carer seeking help (where applicable), the health-care provider, and the observer. If there is not an even split in numbers, some groups can have two observers. Over the course of the training, it is important that every participant has equal turns in playing the health-care provider.
- **Allow reading time:** Each participant should read their instructions. The person seeking help can use information from the person's story to inform their character. Participants can clarify anything of which they are unsure.
- **Perform role play:** As per instructions, the role play should begin. The trainer should move between groups to ensure participants understand the instructions and to monitor progress.

- **Feedback in small groups:** Stop the role plays by the allocated time, allowing the observer to provide feedback to their groups.
- **Group discussion:** Bring all participants back together to reflect on the exercise.

## Video demonstrations

**Purpose:** Videos are used to give examples of good clinical practice in assessment, management or follow-up of a person with a priority MNS condition.

**Objectives:** Videos will allow participants to:

- Learn how the mhGAP-IG algorithms work in clinical practice.
- Build confidence in using mhGAP-IG to perform assessment, management and follow-up of people with priority MNS conditions.

**Instructions:** The step-by-step facilitator's guides provide specific information, but general principles to facilitate a video demonstration are:

- **Technical aspects:** Ensure facilities are available to show the video, and that all participants can see and hear the video.
- **Introduction:** Explain that the video will show a clinical interaction of assessment, management or follow-up, and is an example of good clinical practice.
- **Follow the mhGAP-IG algorithm:** Participants should have their mhGAP-IG open at the relevant page, and should follow the algorithm as it occurs.
- **Group discussion:** The video can be paused at key points for clarification, otherwise there should be discussion at the end about the interaction and an opportunity to answer questions.

## Facilitator demonstrations

**Purpose:** In some of the modules, trainers will be asked to do a demonstration role play to show participants a particular skill. This demonstration can show both good and bad practice, and is a chance for participants to interrupt if they wish to clarify anything.

**Objectives:** Facilitator demonstrations will allow participants to:

- Observe difficult or unknown concepts or skills.
- Observe both good and poor clinical practice.
- Interrupt a clinical scenario to clarify uncertain concepts or skills.
- Build confidence in using mhGAP-IG to perform assessment, management and follow-up of people with priority MNS conditions.

**Instructions:** The step-by-step facilitator's guides provide specific information on facilitator demonstrations, but general principles are:

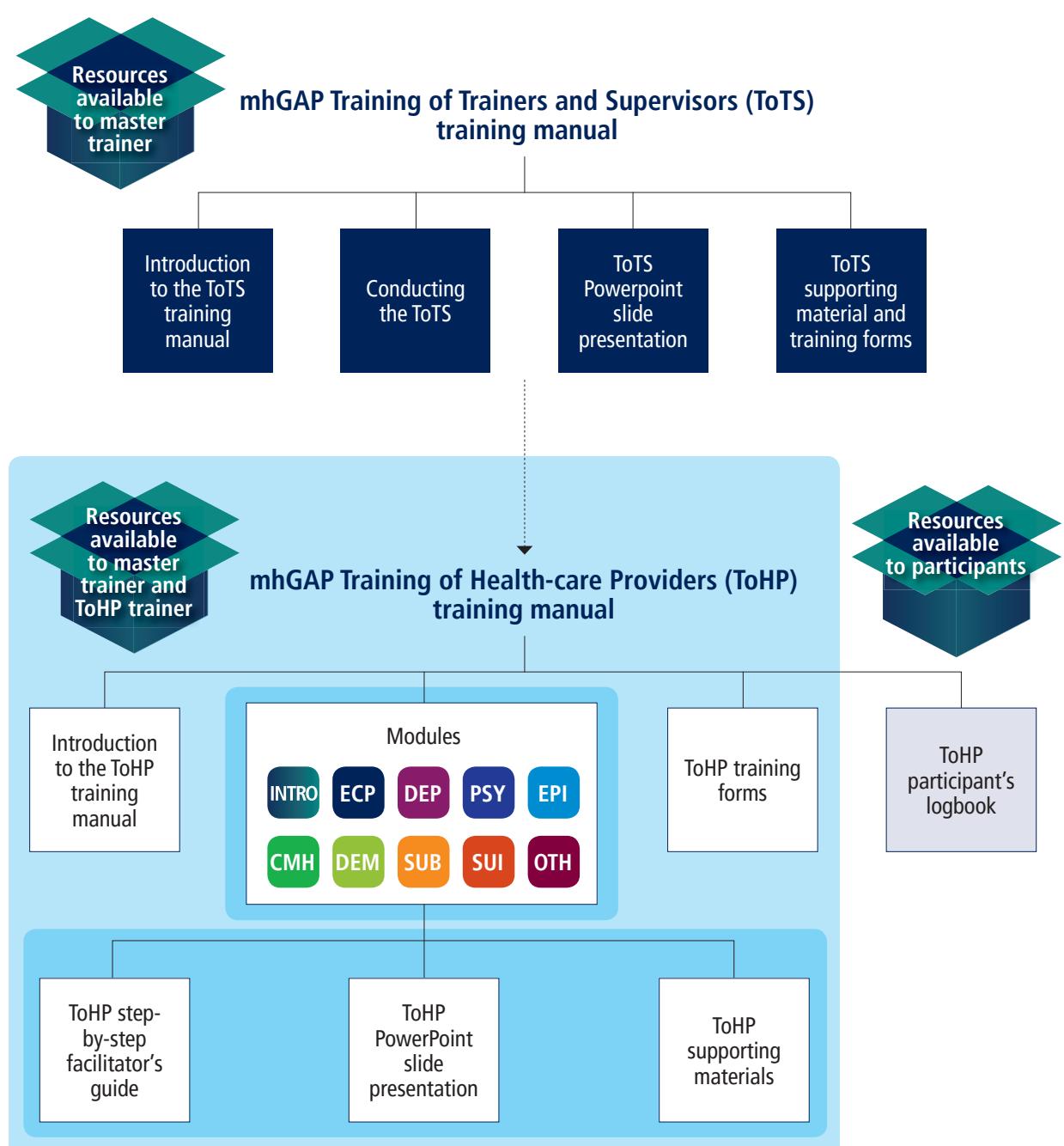
- **Introduction:** Trainers should clarify the specific purpose of the demonstration.
- **Allocate roles:** Trainers work with another trainer or a participant volunteer who will play the role of the person seeking help. The trainer always plays the role of the health-care provider.
- **Follow instructions for the role play:** Facilitator demonstrations usually utilize a role play for the characters. See the supporting material (role plays) for further instructions on individual roles.
- **Demonstration:** The trainer can either demonstrate good clinical practice by following mhGAP-IG, or poor practice by doing the opposite.
- **Group discussion:** The demonstration can be paused or interrupted for clarification, otherwise there should be discussion at the end about the interaction and an opportunity to answer any questions.

# ToHP step-by-step facilitator's guides

Each module has a step-by-step facilitator's guide, to direct the trainer/s in providing the teaching. Each guide starts with an outline of the learning objectives and key messages which should be covered by the module. There is an outline of the session times and activities, and how the learning objectives fit into this.

Once the teaching begins, every activity and slide has facilitator's notes to guide the trainer, to help explain the content and stimulate discussion or run activities, as needed. This will help avoid reading directly from the slides and ensure participants remain engaged in the training.

**Figure 2. Understanding the components available under every module, particularly the facilitator's guide, PowerPoint slide presentation, and supporting material (containing person stories, role plays, videos, and MCQs)**



# ToHP PowerPoint slide presentation

Each module has a set of slides to be used by trainers in conjunction with the step-by-step facilitator's guide. (These are available online.)

## ToHP supporting material

(These are available online.)

### Person stories

(See specific training techniques.)

### Role plays

(See specific training techniques.)

### Videos

(See specific training techniques.) Videos are used to give examples of good clinical practice in assessment, management or follow-up of a person with a priority MNS condition.

### Multiple choice questions (MCQs)

A bank of MCQs is available for the ToHP training. The trainer should choose all or some of these questions for each module, and administer them at the end of the module in the form of a quiz to assess knowledge competencies and also to recap the key messages of the training.

## ToHP training forms

This part of the package comprises a number of forms which can be used across all modules for planning, assessment and evaluation.

### Training needs assessment form

The training needs assessment (TNA) form should be completed by future trainers at least one month prior to the training. (For further information see HOW to use this guide: preparation and adaption.)

### Pre- and post- test MCQs

A selection of MCQs have been taken from the general bank to create a "pre- and post- test" which is to be delivered only on the first day of training, then again after the final session. This is to help in evaluation of the course to determine how effective the teaching has been.

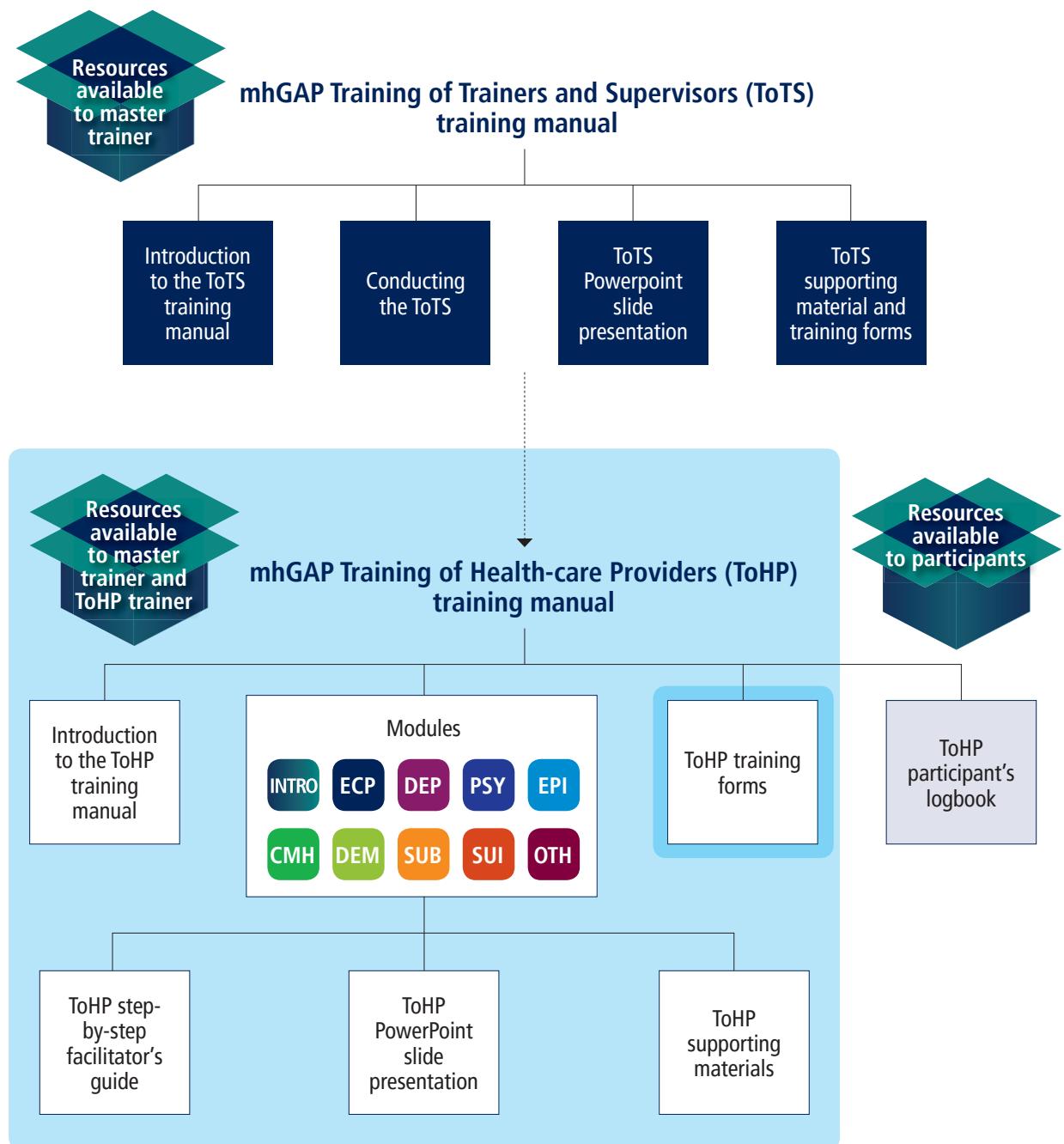
### Competency assessment forms

Competency assessment forms outline the key components needed to achieve each competency and therefore allow for detailed and constructive feedback on what was and was not achieved.

The forms are designed to be used across different modules, competencies and settings, and can be used in the following ways:

- **Role plays:** Each role play has instructions to the observer about which skill competencies are being assessed (and which parts of the form to use).

**Figure 3. Understanding the ToHP training forms, for use across all modules**



- **Supervisor observation and feedback during the course:** The competency assessment forms can be used to give more detailed feedback about attitude, knowledge and/or skill competencies during or at the end of the course by the supervisor to each participant.
- **During supervision:** The competency assessment forms can be used during direct observation of clinical practice to provide feedback on all or some of the core competencies.

Trainers are encouraged to bring enough competency assessment forms to the training to cover every group during each role play, and extra copies to provide individualized feedback to participants.

## Evaluation forms

Evaluation forms should be completed by both trainers and participants for every module during the ToHP training, and feedback should be reviewed immediately to adapt the course if needed.

## ToHP participant's logbook

The ToHP participant's logbook should be provided to all participants at the start of the training. It is meant to be used by the participants throughout the training and after and has been designed to be an interactive and dynamic document, to facilitate further development of their attitude, knowledge and skills in providing care to people with MNS conditions, using the mhGAP-IG.

Participants must be encouraged to use the logbook in different ways:

- During the training to collect any lecture notes, assessments or other handouts to help them revise later, add any information on priority MNS conditions that they find helpful, add in any competency assessment forms that peers and trainers have used to provide feedback during role-plays, write down useful local specialists and services, and any new contacts they make.
- After the course, to use the difficult case report form and personal reflection form to prepare for supervision and to use the MCQs provided to practice their knowledge and skills, even when the training has finished.

# Trainer checklist (to be used when preparing for the ToHP training)

## Tasks completed

### Begin at least three months before training:

- Familiarization with entire ToHP manual including the participant's logbook
- Compile a list of health-care staff nominated to participate in the course
- Conduct a training needs assessment by using the template provided (see ToHP training programme forms)
- Identify the best way to deliver the ToHP training (length and duration)
- Reserve precise locations for classrooms and lodging
- Send out letters of invitation to nominated health-care staff covering all requirements of the course. A copy should be sent to managers'/regional office
- Adapt the training materials as required (decide on person stories, choose and adapt role play scenarios)
- Determine supervisors and supervision method to commence after training
- Make arrangements for printing/sending/transporting necessary course materials, equipment and supplies to the course location
- Make arrangements for providing per diems (allowance), if applicable
- Make arrangements for providing transport, if applicable
- Make arrangements for catering (usually morning and afternoon tea and lunch every day, with coffee/tea facilities. Optional meal at start of training to provide icebreaker opportunity)
- Create a course directory (include names and affiliation of all participants, trainers and supervisors, with contact details) for all attendees

### At the venue, at least two days before the course:

- Confirm all lodging and transport arrangements for all involved
- Confirm all classroom bookings, including workshop rooms
- Confirm all catering
- Confirm availability of photocopier and printer
- Set up all classroom and workshop rooms once available, including equipment (computer/projector) and seating
- Ensure pens and paper available for all participants
- Print copies of all material, including:
  - Pre- and post-test MCQs (= no. participants x 2)
  - Module MCQs (= no. participants x 1 for each module)
  - Role plays (as per module directions)
  - Competency assessment forms (= no. of role plays and extras)
  - Participant's logbook (= no. participants)
  - Any other material
- Practise modules with co-trainer
- Finalize agenda and print copies for all participants and trainers

### First morning:

- Register all course participants
- Introduce all course participants and trainers to each other
- Conduct pre-test MCQs
- Provide all relevant material for that day

### After every module:

- Perform module MCQs
- Perform evaluation form by participants and trainers (see ToHP training forms)

### At end of training:

- Conduct post-test MCQs
- Evaluation form for every module has been completed and collected
- Course completion certificate prepared for each participant and provided
- Every participant has a clear plan for supervision and follow-up visit (where applicable)

### One to two months after training:

- Where possible, follow-up with participants to ask:
  - How many patients they have seen with a priority MNS condition?
  - Whether or not they have used mhGAP-IG?
  - Whether or not they have had ongoing supervision?
  - Any other feedback they would like to give about the course?

# Introduction

**mhGAP training of health-care providers  
Training manual**



# Module: Introduction to mhGAP

## Overview

### Learning objectives

- Understand the mental health treatment gap in low-, middle- and high-income countries.
- Understand the principles and aims of the Mental Health Gap Action Programme.
- Acquire an introduction to mhGAP Intervention Guide (mhGAP-IG).
- Learn about mhGAP ToHP training methodology and what to expect from mhGAP ToHP training.
- Prepare group training ground rules.
- Know the common presentations of mental, neurological and substance abuse (MNS) conditions.

### Key messages

- The burden of mental, neurological and substance abuse (MNS) disorders is large with a wide treatment gap.
- Between 75–90% of people with MNS conditions do not get the treatment they require.
- The aim of the mhGAP is to enhance access to non-specialized treatment for people with MNS conditions.
- mhGAP Intervention Guide is an evidence-based technical tool aimed at supporting non-specialized health-care providers to redistribute clinical tasks previously reserved for mental health specialists.
- mhGAP ToHP training is an interactive training designed to build clinical skills and introduce participants to ways to assess, manage and follow-up people with MNS conditions.
- mhGAP ToHP training does not end in the training room but skills building will continue through ongoing supervision.

Session	Learning objectives	⌚ Duration	Training activities
1. Welcome	Welcome participants	10 minutes	<b>Activity 1: Icebreaker</b> Run an icebreaker to welcome participants to the training and introduce participants to one another
	Administer mhGAP ToHP pre-test	15 minutes	<b>Activity 2: ToHP pre-test</b> Administer mhGAP ToHP MCQ pre-test
2. Introduction to mhGAP Action Programme and training	Understand the mental health treatment gap in low-, middle- and high-income countries	30 minutes	Presentation on mhGAP
	Introduction to mhGAP Intervention Guide (mhGAP-IG)	15 minutes	Introduction to structure of mhGAP ToHP training
	Introduction to mhGAP ToHP training methodology and what to expect from mhGAP ToHP training		<b>Activity 3: mhGAP ToHP training ground rules</b> Set ground rules for the mhGAP ToHP training
	Collectively agree on the group training ground rules		
3. Introduction to common MNS conditions	Introduction to common MNS presentations	30 minutes	<b>Activity 4: Using the mhGAP-IG master chart</b> Familiarize participants with the common MNS presentations described in the mhGAP-IG master chart
4. Review	Give participants a chance to ask questions and answer any concerns	5 minutes	<b>Brief discussion</b>
<b>Total duration (without breaks) = 1 hours 45 minutes</b>			

## Step-by-step facilitator's guide

# Session 1. Welcome

 25 minutes

### Activity 1: Welcome

- Find an individual you have not met before and partner with them.
- Find out the following and introduce your partner to the whole group:
  - name
  - profession
  - current posting
  - interest and experience in mental health.

2

## Activity 1: Icebreaker

Choose whatever icebreaker you like, but make it interactive. Here are two examples you can use.

### Icebreaker option 1

**Duration:** Five minutes for partner discussion. Depending on group size, 7–10 minutes for group introductions.

**Purpose:** To begin the process of becoming familiar with other individuals completing this training course.

#### Instructions:

- Provide each participant with a name tag.
- Have each person introduce themselves to the person seated next to them with the four pieces of information in the slide. Each person should then introduce their partner to the group.

**Icebreaker option 2**

**Duration:** Five minutes to discuss with groups, approximately two minutes per presentation for each group.

**Purpose:** Helps team members develop an understanding of shared objectives and understand, in a non-confrontational way, how their views differ from others in the group.

**Instructions:**

- Divide the group into teams of three or four and give them a large sheet of paper.
- Give each person a different coloured marker.
- Have each person draw a large oval such that each oval overlaps with the other ovals in the centre of the paper.
- Give the group(s) a question that pertains to the meeting objectives (e.g. what do you hope to learn over the course of this training? What do you think may be taught during this course?).
- Instruct people that they are to write down at least five answers to the question in the overlapping and non-overlapping areas of their ovals.
- Give them five minutes to talk about the similarities and differences and write them in their ovals.
- Compare results between groups and identify common themes in both parts of the diagram (e.g. what do these similarities and differences mean for the group when considering the purpose of the meeting?).

**Session outline**

Briefly describe the topics that will be discussed during this introduction module.

In this session we will discuss:

- pre-test
- introduction to the Mental Health Gap Action programme (mhGAP)
- Ground rules
- introduction to MNS conditions
- review

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**Activity 2: Pre-test****Activity 2: Pre-test**

Take five minutes to complete the pre-test multiple choice questions.

Give the participants the pre- and post-test MCQs (see the ToHP training forms).

This test is designed to establish participants' baseline knowledge and understanding of mhGAP-IG general principles and MNS conditions.

Give participants at least five minutes to complete the test.

Participants will be asked to repeat this test on the last day of the mhGAP ToHP training in order to measure knowledge gain.

# Session 2.

## Introduction to Mental Health Gap Action Programme (mhGAP) and training

⌚ 45 minutes

### What is mental health gap?

- Mental, neurological and substance use (MNS) conditions account for 13% of the global burden of disease.
- Yet between 75–90% of individuals with MNS conditions do not receive the treatment they require although effective treatment exists.
- This represents the **mental health treatment gap**.

Explain that worldwide, MNS conditions are major contributors to the global burden of disease accounting for 13% disability adjusted life years and rising, especially in low- and middle-income countries (LMIC).

MNS conditions commonly co-occur with other chronic health conditions (e.g. HIV/AIDS, diabetes, cardiovascular disease), and, if untreated, worsen the outcome of these conditions. People with MNS conditions and their families are also challenged by stigma that further worsens their quality of life, affects social inclusion, employability and interferes with help-seeking.

This public health concern is compounded by the fact that many individuals with MNS conditions remain untreated although effective treatment exists. This is called a treatment gap.

Currently between 75–90% of people with MNS conditions do not receive treatment. This represents the **mental health treatment gap**.



Explain that one reason for a large treatment gap is a lack of investment in human resources for mental health care.

Explain the statistics in the infographic.



Explain that another reason for such a significant treatment gap is that financial resources for developing and maintaining MNS services in LMIC are extremely low.

The level of public expenditure on mental health is less than US\$ 2 per capita in LMIC compared with US\$ 50 per person in high-income countries (HIC).

Explain that globally there is very little financial investment in mental health promotion and prevention programmes.

Talk through the statistics on the slide. Emphasize that globally approximately 800 000 people a year die from suicide yet no LMIC countries have a national suicide prevention strategy.

Source: WHO, 2015.

### Mental Health Gap (mhGAP) Action Programme

mhGAP is a WHO programme, launched in 2008, to scale up care for MNS disorders.

The programme asserts that, with proper care, psychosocial assistance and medication, tens of millions of people could be treated for depression, psychoses and epilepsy, prevented from suicide and begin to lead normal lives – even where resources are scarce.

Its focus is to increase non-specialist care, including non-specialized health care, to address the unmet needs of people with priority MNS conditions.

Play the [video](#).

#### Preparation note:

In case there is no high-speed internet connection in the workshop room, the video needs to be downloaded before the training. <https://www.youtube.com/watch?v=TqlafjsOaoM&feature=youtu.be%29>

Explain that to close the mental health treatment gap, WHO launched the Mental Health Gap Action Programme (mhGAP) for LMIC in 2008. The aim of mhGAP is to enhance access to non-specialized care for people with MNS conditions by training health-care providers in how to assess, manage and follow-up individuals with MNS conditions.

Increasing the number of health-care providers who can assess, manage and follow-up people with MNS conditions will reduce the mental health treatment gap.

mhGAP uses an evidence-based technical tool called the mhGAP Intervention Guide (mhGAP-IG).

It has been developed to facilitate the delivery of interventions in non-specialized health-care settings by health-care providers such as yourselves.

**Play the following seven-minute video:**

- **Overview of the video:** In LMIC, 75% of people do not get the mental health services they need. With costs as low as US\$ 2 per person per year, and with proper care, assistance and medication, millions can be treated.
- A person with epilepsy reflects on changes brought about by an epilepsy treatment programme in China: "When I first got the illness, everyone thought I was a wicked person or possessed by evil spirits. I could not get work because people didn't know what to do if I had a seizure. In 2001 I started to take this medicine and started feeling better. I started my own business and now sell these woollen carpets. Life is now good."
- As well as the epilepsy programme in China, the video features a project for children with intellectual disabilities in South Africa; a project on services for persons with psychoses; and a suicide prevention project in India.

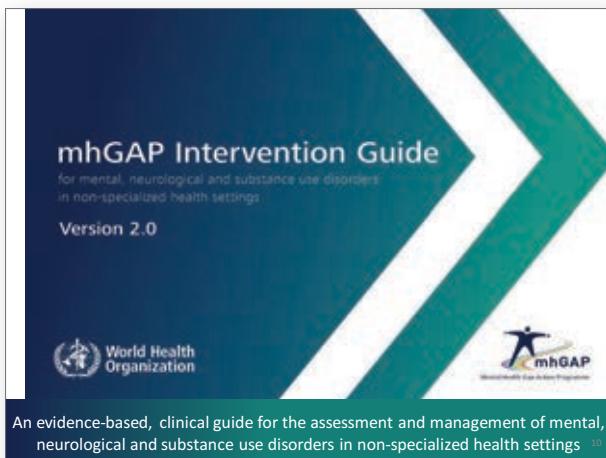
### Who is the target audience of mhGAP-IG?

- Staff not specialized in mental health or neurology:
- General physicians, family physicians, nurses.
  - First points of contact and outpatient care.
  - First level referral centres.
  - Community health workers.

Explain that this guide and training is aimed at non-specialized health-care providers.

The emphasis of the mhGAP-IG is to redistribute clinical tasks previously reserved for mental health specialists (psychiatrists, psychologists and psychiatric nurses) to non-specialized health-care providers. This is usually referred to as task-shifting or task-sharing.

Non-specialized health-care providers (people such as yourself) will be trained in basic mental health competencies to identify and assess MNS conditions, provide basic care and refer complex cases to specialist services. Mental health specialists will be equipped to work collaboratively with non-specialist health-care providers, and offer supervision and support.



## Introduce participants to Version 2.0 of the mhGAP-IG

This is the second version (2016) of the mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use (MNS) disorders in non-specialist health settings. It is for use by doctors, nurses, other health workers, as well as health planners and managers.

It presents the integrated management of priority MNS conditions using algorithms for clinical decision-making that are aimed to aid health-care providers to assess, manage and follow-up individuals with priority MNS conditions.

### Explain mhGAP-IG

- Is a technical tool.
- Contains assessment and management clinical decision-making algorithms for eight priority conditions.
- Is a model guide developed for use by non-specialist health-care providers.
- Can be used **after adaptation** for national and local needs.
- The 2016 update is based on new evidence as well as extensive feedback and recommendations from experts in all WHO regions who have used mhGAP-IG Version 1.0. The key updates include: content updates in various sections based on new evidence; design changes for enhanced usability; a streamlined and simplified clinical assessment that includes an algorithm for follow-up; inclusion of two new modules: Essential care and practice, that includes general guidelines; Implementation, to support the proposed interventions by necessary infrastructure and resources; and revised modules for Psychoses, Child and adolescent mental and behavioural disorders, and Disorders due to substance use.

### mhGAP-IG Version 2.0 modules

1. Essential care and practice
2. Depression
3. Psychoses
4. Epilepsy
5. Child and adolescent mental and behavioural disorders
6. Dementia
7. Disorders due to substance use
8. Self-harm/suicide
9. Other significant mental health complaints

The priority conditions covered in mhGAP-IG were included because they represent:

- large burden
- high economic costs
- an association with human rights violations.

## Mental health and non-specialized health care

- Five-minute group discussion.
- What is your current role and responsibility relating to the management of people with MNS disorders?
- What are the benefits of integrating MNS care into non-specialized health care?

### Plenary discussion

**Duration:** 5 minutes.

#### Process:

Ask each participant about their current role and responsibility related to the management of people with MNS disorders.

Then ask the entire group the second question about the benefits of integrating MNS care into non-specialized health care.

Encourage discussion.

## Seven good reasons for integrating mental health into non-specialized health care

1. The burden of mental disorders is great.
2. Mental and physical health problems are interwoven.
3. The treatment gap for mental disorders is enormous.
4. Enhance access to mental health care.
5. Promote respect of human rights.
6. It is affordable and cost-effective.
7. Generates good health outcomes.

To summarize, talk through the seven good reasons for integrating mental health into non-specialized health care.

1. The burden of mental disorders is great. Mental disorders are prevalent in all societies. They create a substantial personal burden for affected individuals and their families, and they produce significant economic and social hardships that affect society as a whole.
2. Mental and physical health problems are interwoven. Many people suffer from both physical and mental health problems. Integrated non-specialized health settings help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.
3. The treatment gap for mental disorders is enormous as we have already seen. In all countries, there is significant gap between the prevalence of mental disorders on one hand, and the number of people receiving treatment and care, on the other. Non-specialized health settings for mental health help close this gap.
4. Non-specialized health care for mental health enhances access. When mental health is integrated into non-specialized health settings people can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities. Non-specialized health care for mental health also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.
5. Non-specialized health care for mental health promotes respect of human rights. Mental health services delivered in non-specialized health-care settings minimize stigma and discrimination. They also remove the risk of human rights violations that can occur in psychiatric hospitals.

6. Non-specialized health care for mental health is affordable and cost effective. Non-specialized health-care services for mental health are less expensive than psychiatric hospitals, for patients, communities and governments alike. In addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations. Treatment of common mental disorders is cost-effective, and investments by governments can bring important benefits.
7. Non-specialized health care for mental health generates good health outcomes. The majority of people with mental disorders treated in non-specialized health care have good outcomes, particularly when linked to a network of services at secondary level and in the community.

Source: WHO & World Family Doctors: Caring for People (Wonca) (2008).

## How we learn to use the mhGAP-IG

**mhGAP-IG training of health-care provider (ToHP) (46 hours).**

- ToHP teaches **12 core competencies** relevant to assessing, managing and following-up people with MNS conditions.
- Training is interactive and enables participants to practise using the mhGAP-IG in the safety of the training room through:
  - role plays
  - large/small group discussions
  - interactive activities
  - familiarization with the mhGAP-IG.

**Supervision support starts after training and is ongoing.**

- Supervisors will offer support and specialist consultations to all trainees as they use the mhGAP-IG in their non-specialized health setting.

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Explain that the full mhGAP-IG ToHP course takes approximately 46 hours. Explain to participants the length of the training and what to expect.

The mhGAP-IG training teaches 12 core competencies needed to assess, manage and follow up people with MNS conditions.

Participants will be able to practise these competencies in the training room by doing role plays, having interactive discussions and activities.

The more the participants put into the activities and engage with them, the more they will gain from the training.

Reassure participants that everyone will be learning new skills during this training and there is no need to be embarrassed.

Support and help one another in order to build skills and become more comfortable with the mhGAP-IG.

The more time spent using it, the more comfortable participants will feel with it.

Encourage participants to ask any questions that they may have and share any concerns that they may have; by the end the participants should be motivated and ready to start using the mhGAP-IG in their clinical practice.

### After the training

Supervision and support is key to integrating mhGAP-IG into clinical practice and after this training explain that participants will be offered ongoing supervision with experienced/specialist mental health practitioners.

Explain to the participants the model of supervision that will be used in their settings and how it will be implemented.

## Activity 3: mhGAP ToHP training ground rules

### Activity 3: mhGAP ToHP training ground rules

- How would you like to be treated during this training? And would they like to treat others?
- How would you like to work together as a group?

15

**Duration:** 15 minutes.

**Purpose:**

- As a group, to set the training ground rules for the following days of training.
- To set the ground rules, ask participants: How would they like to be treated during this training? And how would they like to treat others? How would they like to work together as a group?
- Make a list of their responses.
- Once the list has been made and agreed upon by all participants make sure that it is hung somewhere visible on the wall throughout the training so that people can see it and remember to abide by the training ground rules.

# Session 3.

## Introduction to common MNS conditions

⌚ 30 minutes

### Activity 4: Using the mhGAP-IG master chart

#### Activity 4: Using the mhGAP-IG master chart

- Write down descriptions of people that you have seen in your work that you believe were living with an MNS disorder.
- Ensure that the descriptions are anonymous.
- Write down the symptoms and how they would present to you.

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**Duration:** 30 minutes.

**Purpose:**

To familiarize participants with the common MNS presentations described in the master chart.

**Purpose:**

- Before you introduce participants to the master chart, ask participants to write down a case scenario of a person they have seen in their clinic whom they suspect of having an MNS condition.
- Include in the case study a description of the person's symptoms.
- Ensure that the case studies are anonymous.
- The facilitator will then collect in the case studies.
- The facilitator will divide the group into small groups and give each group a selection of case studies.
- Ask the group to look at the master chart in the mhGAP-IG and decide if the case studies correspond to the presentations described there.
- After 20 minutes of discussion bring the group back together and ask the participants to briefly summarize their discussions including:
  - Which presentations were most common?

**① EMERGENCY Presentations of Priority MNS Conditions**

EMERGENCY PRESENTATION	CONDITION TO CONSIDER	GO TO
■ Acute or sustained acute onset of behaviour as a result of substance and/or substance withdrawal	MICHAELLY SERIOUS ACT OF SELF-HARM	SUICIDE
■ Current hospital, place of care or other residence, or place of temporary stay at risk of self-harm if unable to access support, advice, assessment or timely return to care	IMMINENT RISK OF SELF-HARM/SUICIDE	SUICIDE
■ Acute onset or an acute phase of hypo-mania or hypomania, depression, mania or hypomania	EPILEPSY STUNTING EPILEPSY ALCOHOL OR OTHER SUBSTANCE WITHDRAWAL	EPI, SUB
■ Acute onset or an acute phase of hypo-mania or hypomania, depression, mania or hypomania, or other acute mental health episode	ACUTE ALCOHOL INTOXICATION ALCOHOL WITHDRAWAL ALCOHOL INTOXICATION/WITHDRAWAL	SUICIDE
■ Acute onset or an acute phase of hypo-mania or hypomania, depression, mania or hypomania, or other acute mental health episode	STUNTING INTOXICATION OR INTOXICATION	SUICIDE
■ Acute onset or an acute phase of hypo-mania or hypomania, depression, mania or hypomania, or other acute mental health episode	ACUTE STIMULANT INTOXICATION OR INTOXICATION	SUICIDE

Direct participants to page 18 of the mhGAP-IG Version 2.0. Emergency Presentations of priority MNS conditions.

Explain that people with any MNS condition can present in a state of emergency at any time.

Have participants volunteer to read out loud the different emergency presentations.

Explain that as the participants progress through the training they will look at emergency presentations in more detail. However, for now it is worth reflecting on whether participants have cared for people with emergency MNS presentations in the past.

Facilitate a brief discussion.

# Session 4.

## Review

⌚ 5 minutes

### Review

- The mhGAP-IG is a technical tool for non-specialized health-care providers to assess, manage and follow-up people with MNS conditions.
- mhGAP-IG training of non-specialized health-care providers aims to integrate mental health care into non-specialized health settings.
- This training will build the skills and confidence required to use the mhGAP-IG in clinical workplaces.

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Reiterate that the mhGAP-IG is a technical tool for non-specialized health-care providers to use when they assess, manage and follow up people with MNS conditions.

By using the mhGAP-IG in their everyday clinical practice they will be offering much needed care to people whose needs, health and mental health usually go untreated.

Explain that during this training the participants will have an opportunity to practise using and developing the skills that they need to use the mhGAP-IG. They can use this opportunity to ask questions and answer any concerns they may have about any element of caring for people with MNS conditions.

The more they put into this training the more confidence they will have when they leave to start using the mhGAP-IG and making a difference to people's lives.

Answer any questions or concerns that the participants may have.

# Essential care and practice

mhGAP training of health-care providers  
Training manual



# Module: Essential care and practice

## Overview

### Learning objectives

- Name the general principles of essential care and practice.
- Name management principles of priority MNS conditions.
- Use effective communication skills in interactions with people with MNS conditions.
- Perform assessments for priority MNS conditions.
- Assess and manage physical health in MNS conditions.
- Know the impact of violence and gender-based violence on mental health.
- Provide psychosocial interventions to a person with a priority MNS condition and their carer.
- Deliver pharmacological interventions as needed and appropriate in priority MNS conditions considering special populations.
- Plan and perform follow-up for MNS conditions.
- Refer to specialists and links with outside agencies for MNS conditions as appropriate and available.
- Promote respect and dignity for people with priority MNS conditions.

### Key messages

- Effective communication skills should be used for everyone seeking health care, including people with MNS conditions and their carers.
- Effective communication skills enable health-care providers to build rapport and trust with people as well as enabling health-care providers to understand the health and social needs of people with MNS conditions.
- Health-care providers have a responsibility to promote the rights and dignity of people with MNS conditions.
- To conduct an assessment of people with suspected MNS conditions, you must assess the physical, psychological and social needs of the person.
- Gender-based violence is a global public health concern that causes great distress to the victims and perpetrators.
- Health-care providers must understand how important it is to assess individuals for the impact of gender-based violence on mental health.
- The management of MNS conditions includes psychosocial as well as pharmacological interventions.
- Follow-up is an essential part of the care and management of MNS conditions.

Session	Learning objectives	⌚ Duration	Training activities
1. General principles	<p>Name the general principles of essential care and practice</p> <p>Understand and practise using effective communication skills</p> <p>Promote respect and dignity for people with priority MNS conditions</p> <p>Use effective communication skills in interactions with people with MNS conditions</p>	<p>15 minutes</p> <p>15 minutes</p> <p>20 minutes</p> <p>10 minutes</p> <p>20 minutes</p> <p>20 minutes</p>	<p><b>Introducing general principles of care</b> <b>Group discussion</b></p> <p><b>Activity 1: Facilitator demonstration: Good vs poor communication skills</b></p> <p><b>Activity 2: Active listening: Hearing what is being said</b> Activity to help participants learn to understand the meaning underlying what is being said</p> <p><b>Presentation on effective communication</b></p> <p><b>Activity 3: Using good verbal communication skills</b> Practise using open and closed questions and summarizing points</p> <p><b>Activity 4: Facilitator demonstration: Using effective communication to de-escalate an aggressive/agitated person</b> How to manage a person with agitated and/or aggressive behaviour</p> <p><b>Activity 5: Promoting respect and dignity</b></p>
2. Essentials of mental health care and clinical practice: Assessments	<p>Perform an assessment for priority MNS conditions</p> <p>Assess and manage physical health in MNS conditions</p> <p>Assess and manage the impact of violence and gender-based violence on mental health</p> <p>Know the impact of violence and gender-based violence on mental health</p>	<p>30 minutes</p> <p>30 minutes</p> <p>10 minutes</p>	<p><b>Activity 6: Group discussion: General principles of MNS assessments</b> Ask participants to work in small groups and identify and name what they do during a clinical assessment</p> <p><b>Activity 7: Small group work: Conducting an MNS assessment</b> What type of information do we want to learn during an MNS assessment and how do we obtain it</p> <p>Brief presentation on how to conduct an MNS assessment for people who have experienced violence</p>
3. Essentials of mental health care and clinical practice: Management	<p>Name management principles of priority MNS conditions</p> <p>Provide psychosocial interventions to a person with a priority MNS condition and their carer</p> <p>Refer to specialists and links with outside agencies for MNS conditions as appropriate and available</p> <p>Deliver pharmacological interventions as needed and appropriate in priority MNS conditions considering special populations</p>	<p>40 minutes</p> <p>35 minutes</p> <p>30 minutes</p>	<p>Presentation on management principles for people with MNS conditions</p> <p><b>Activity 8a: Self-care – problem-solving</b> <b>Activity 8b: Strengthening social supports</b></p> <p>Presentation on the principles of using pharmacological interventions</p>

Session	Learning objectives	⌚ Duration	Training activities
4. Essentials of mental health care and clinical practice: Follow-up	Plan and perform follow-up for MNS conditions.	20 minutes	<b>Activity 9: Follow-up</b> Exploring the barriers to offering follow-up and identifying possible solutions
5. Review	Review knowledge and skills learnt during the session	15 minutes	Multiple choice questionnaire and discussion
<b>Total duration (without breaks) = 5 hours 50 minutes</b>			

## Step-by-step facilitator's guide

# Session 1. General principles

⌚ 2 hours 20 minutes

Session Outline	
<ul style="list-style-type: none"><li>• General Principles</li><li>• Essentials of mental health care and clinical practice: Assessments</li><li>• Essentials of mental health care and clinical practice: Management</li><li>• Essentials of mental health care and clinical practice: Follow-up</li><li>• Reviews</li></ul>	Begin the session by briefly listing the topics that will be covered.

Begin the session by briefly listing the topics that will be covered.

Primary health care	
 A photograph showing a medical professional in a white coat and stethoscope examining a young child. The child is being held by a woman wearing a striped headwrap and a green patterned top. Another young girl is visible in the background, looking towards the camera.	Facilitate a group discussion (maximum 10 minutes) on what participants consider to be the general principles and core skills used in providing clinical care.

Facilitate a group discussion (maximum 10 minutes) on what participants consider to be the general principles and core skills used in providing clinical care.

Write down the answers on a flip chart.

Highlight any answers which emphasize using effective communication skills, listening to people, treating people with respect, being empathetic and non-judgemental etc.

## General principles

1. Use effective communication skills.
2. Promote respect and dignity.

Explain that the mhGAP-IG highlights two general principles of clinical care:

1. Use effective communication skills
2. Promote respect and dignity

These principles aim to promote respect for the privacy of people seeking care for MNS conditions, foster good relationships between health-care providers, service users and their carers and ensure that care is provided in a non-judgemental, non-stigmatizing and supportive environment.

3

## Discussion

What constitutes effective communication?

What are the barriers to providing effective communication?

Ask participants to think about what effective communication really means (maximum five minutes) and make a list of the skills needed for it.

**Note:** If participants do not consider the role of body language in communication then prompt them to think about how body language affects communication.

List their answers on a flip chart or black/white board.

Ask participants what they perceive as barriers to providing effective communication.

**Note:** If participants struggle, encourage them to think of gender roles, stigma, power imbalance, etc.

4

# Activity 1: Facilitator demonstration: Good vs poor communication skills

## Activity 1: Facilitator demonstration

You are about to see two different clinical interactions

After each interaction discuss the effectiveness of the communication skills used

5

**Duration:** 15 minutes.

**Purpose:** To show examples of good and poor communication and stimulate discussion.

**Instructions:**

- Explain that participants are going to watch two demonstrations of two different clinical interactions.
- After each demonstration, they will discuss the effectiveness of the communication skills they observed.
- Show the demonstration of poor communication first.
- The facilitator will play the role of a health-care provider, and a co-facilitator (or volunteer) will play the role of a person seeking help.
- The co-facilitator will be attending the health-care clinic for help with persistent headaches.
- The facilitator will start the interaction by asking “What do you want?” and then will not listen to the person, speak over them, pay more attention to his or her phone or to others, turn away from the person half way through the interaction and start doing something else. The facilitator is judgemental and does not believe that the person has any problems at all, and instead believes that the person is just seeking medicines.
- After the demonstration of poor communication, ask:
  - What did the health-care provider do that made this communication a poor one?
  - What could the health-care provider have done to improve their communication?
- Do the second facilitator demonstration of good communication.
- In this interaction, the facilitator will continue to play the health-care provider and the co-facilitator will play a person seeking help for persistent headaches.
- The facilitator will start the interaction by introducing themselves and their role in the clinic, ensuring the person is safe, using active listening to understand what is happening to the person, using positive body language to ensure the person is comfortable etc.
- After watching the demonstration, ask participants to compare the behaviours they observed during the two demonstrations. Ask participants to think of what made the second demonstration more effective?
- Add anything pertinent to the list of good communication skills.

### Possible adaptations:

- This activity can be conducted by showing video demonstrations of good and poor communication.
- Participants can also work in pairs and play their roles accordingly to experience good and bad communication skills.



Explain that one of the main goals of effective communication is to build trust and rapport between the health-care provider, the individual and carers.

This trusting relationship between the health-care provider and the individual is essential, as it creates a comfortable environment where the person can share intimate or troubling thoughts, beliefs and emotions that underpin their symptoms.

ESSENTIAL CARE & PRACTICE	ECP
<b>A. GENERAL PRINCIPLES</b> <b>I. Use Effective Communication Skills</b> <ul style="list-style-type: none"> <li><b>COMMUNICATION TIP #1</b> Create an environment that facilitates open communication           <ul style="list-style-type: none"> <li>■ Create the environment as a safe space. Trustworthy.</li> <li>■ Be welcoming and establish if the person feels it is a culturally acceptable norm.</li> <li>■ Encourage the person to use basic, engage and focus on what they have to say.</li> <li>■ Encourage the person to speak openly about the mental health condition and not feel afraid of being stigmatized or discriminated against.</li> <li>■ Patients are experts. Listen to what the patient has to say. Encourage the person to take control of their own treatment plan.</li> <li>■ Other tips: avoid a leading question, consider no-longer questions, calm the person, etc.</li> </ul> </li> </ul>	<b>ECP</b> <ul style="list-style-type: none"> <li><b>COMMUNICATION TIP #2</b> Involve the person           <ul style="list-style-type: none"> <li>■ Involve the person from the very beginning. Step back and let the person take control of the assessment and management process. This includes shared decision-making and self-management.</li> </ul> </li> <li><b>COMMUNICATION TIP #3</b> Start by listening           <ul style="list-style-type: none"> <li>■ Activate listening. Be present and attentive.</li> <li>■ Allow the person to explain without interruptions.</li> <li>■ Encourage the person to continue their narrative and not feel like it is interrupted.</li> <li>■ Use language that they can understand. Try to avoid jargon and speak plain English (e.g. friends, stress, etc.).</li> <li>■ Ask questions, however, make sure that you understand their language and context.</li> </ul> </li> <li><b>COMMUNICATION TIP #4</b> Use good verbal communication skills           <ul style="list-style-type: none"> <li>■ Use simple language. Be clear and concise.</li> <li>■ Use open-ended questions, summarizing and clarifying statements.</li> <li>■ Summarize and repeat key points.</li> <li>■ Inquire the person to give an overview about the information provided.</li> </ul> </li> <li><b>COMMUNICATION TIP #5</b> Respond with sensitivity when people disclose difficult experiences (e.g. sexual assault, violence or self-harm)           <ul style="list-style-type: none"> <li>■ Show empathy and understanding.</li> <li>■ Let the person know that what they are experiencing is important.</li> <li>■ Avoid judgmental language.</li> <li>■ Avoid interrupting when people disclose difficult topics.</li> <li>■ Encourage the person to talk about what they need to talk about.</li> <li>■ Avoid to change the topic. If a person is afraid to tell their story, do not insist.</li> </ul> </li> </ul>

Direct participants to page 6 of mhGAP-IG Version 2.0.

Give time to read through the different communication tips and add to the list of good communication skills.

Emphasize the importance of using good communication skills for everyone visiting a primary health-care clinic. Stress that it is particularly important when assessing and caring for people with MNS conditions, as it is the only way to truly understand what is happening to the person.

## Activity 2: Active listening: Hearing what is being said

### Activity 2: Active Listening

Listen to the person you are working with and then answer these questions:

- While you were listening, how many times were you distracted?
- While listening, were you thinking other thoughts, or thinking about your “to do” list?
- That is normal and that is why active listening is a real skill.

8

**Duration:** 20 minutes.

**Purpose:** Enable participants to reflect on how they listen, consider what skills they use when they listen and whether or not they become distracted when listening. Introduce them to the concept of active listening.

**Instructions:**

- Divide participants into pairs.
- Spread the pairs around the room and ensure they face each other.
- Assign one as person A and the other as person B.
- Person A will have five minutes to talk about something important to them. This should be a topic they are passionate about and/or that they find interesting and care about.
- Person B will listen.
- After five minutes, they swap roles.
- Bring the whole group together and ask participants playing person A to briefly reflect on what they heard.
- Check with their pairs that the information is correct.
- Swap and ask participants playing person B to briefly describe what A told them, also checking that the information is correct.
- After the feedback, facilitate a quick discussion about the experience of listening. Ask participants to be honest and state how many times they were distracted when they were listening, and if they had other thoughts in mind while listening. Explain that it is normal to get distracted whilst listening to another person, but it can lead to missing out on a lot of information.
- Ask participants to reflect on how it felt to have someone listen to them.

## Active listening

- Listening without being distracted.
- Listening and paying attention:
  - Verbal messages (what is being said).
  - Non-verbal messages (what is being said with body language, pauses, facial expressions etc.).
- Allowing time:
  - Don't rush.
  - Allow for silences.

Explain that as a starting point for effective communication skills we will look at **active listening**.

Explain that active listening requires attention and focus on what is being said, while trying to understand the true meaning behind what is being said.

People often express their feelings through their actions, facial expressions and body language, but struggle to name or express those emotions.

Therefore, concentrating, listening, asking questions and taking time to really hear and clarify what people are telling you are core skills.

Give people time, don't rush them and don't be afraid of silences. Although 60 seconds of silence can feel like a long time to you, it can give the person enough time and space to begin talking about their experience.

It also requires a high level of **empathy**. Give participants two minutes to think about what empathy means.

## Empathy



Ask the group to share their thoughts and definitions and note their answers.

Look for answers similar to, "the ability to understand and share the feelings of another person".

## Why is empathy important?

- Recognizes the feelings of another person and *communicates* understanding in verbal or non-verbal ways.
- Shows respect.
- Provides emotional support to person.
- Builds rapport, encourages dialogue, builds relationship with the person.

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Explain why empathy is important by discussing the points on the slide.

Explain that:

- It enables you to recognize the feelings of another person and communicate understanding in verbal or non-verbal ways.
- Empathy enables you to understand the individual's perspective, thus ensuring that any clinical care they receive meets their needs and priorities.
- It also shows respect and provides emotional support to the person by letting them know that you really understand their feelings and therefore they are not alone.
- It builds rapport, encourages dialogue, and builds good relationships.

## Empathy

**"My husband has lost his job again, I don't know what we are going to do now."**

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Show participants the different quotes and ask them to give examples of how they could respond with empathy.

Following participants' answers, reveal the next slide.

## Empathy

**"My husband has lost his job again, I don't know what we are going to do now."**

**Response:** "That must be difficult for you. Can you tell me more about how you are feeling."

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Emphasize that this is just one example of an empathetic response, as there are lots of different ways to express empathy. With practice, they will develop their own way to express empathy.

## Empathy

**"I think my husband may have HIV.  
What should I do?"**

Ask the participants to give examples of how they could respond with empathy to this quote.

Give participants a few attempts before revealing a response on the next slide.

Emphasize again that this is just one example of how empathy can be expressed. There are many different ways and with practice they will develop their own ways to show empathy.

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## Empathy

**"I think my husband may have HIV.  
What should I do?"**

**Response:** "It sounds as if you are having a hard time. It is good you have come here because maybe talking it through will help".

Read the response out loud. This response recognizes that this is a difficult time and situation for the person. It gives emotional support by acknowledging that seeking help is good, while it also starts to build rapport with the person by inviting them to talk more.

In both examples, the person has been invited to talk more and explain more. This is a key point and the best way to do this is to use **open-ended questions**.

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## Open-ended questions

Open questions – open up communication

**Examples:** How are you feeling? How did you travel here? What is family life like for you? What do you like to do? Tell me about yourself?

Closed questions – shut down conversation

**Examples:** Are you feeling happy? Did you come here by bus? Do you enjoy time with your family? What is your name? Do you enjoy playing sport?

Explain that being able to actively listen is easier when using good verbal communication skills, including asking questions and summarizing.

Ask if participants know the difference between open and closed questions. Talk through the explanations on the slide.

Go on to explain that open questions and closed questions can work well together.

**Open questions can provide:**

- The basic structure for the first interview.
- A broad perspective on a person's life.

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## Open or closed?

- "What brought you in here today?"
- "How much did you have to drink when you last had an alcoholic drink?"
- "Did you tell your wife you had a drink yesterday?"
- "Could you tell me more about that?"
- "Is your husband a violent man?"
- "Can you describe to me why you are feeling this way?"
- "How would you like to plan this?"

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Closed questions can then be used to get more specific follow-up information:

- Closed questions can also be used when people are evasive, or become too detailed in their answers.

Talk through the examples of open and closed questions on the slide.

Ask participants to briefly reflect on which types of questions they usually use in their clinical practice.

Do they use open questions or closed questions? (Explain that there is no right or wrong answer to this, it is just useful to reflect on how they communicate with the people they see).

Read each question out loud and ask if it is open or closed.

## Summarizing

- Re-state the main (content) points of the person's problems.
- Don't just repeat – put into your own words how you have understood the person's situation.
- Don't state as fact – use words that show you are checking whether you have understood correctly.
- Summaries offered during the course of the session help us to keep our focus on the important areas and also to make transitions to other relevant topics.

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Explain that **summarizing** can be another very useful technique to use when trying to understand the details about what the person is experiencing and clarifying if you understood it correctly.

Talk through the steps of summarizing in the slide.

## Summarizing

You can start summarizing by using the phrases:

- "What I am understanding is..."
- "In other words..."
- "So what you are saying is...."
- "It sounds as if..."
- "I am not sure that I am understanding you correctly, but I hear you say...."
- "You sound..."

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Describe these examples of how people can start to summarize and clarify what a person says.

## Summarizing

"Last night my husband came home really late. He was drunk again. We started arguing but it is no use. I am so angry at him. He will never change."

Ask participants how they could summarize what the lady feels and tells them.

Show the response on the slide as an example once participants have attempted to give a summary.

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## Summarizing

"Last night my husband came home really late. He was drunk again. We started arguing but it is no use. I am so angry at him. He will never change."

**Response:** "You sound like you are feeling very frustrated by your husband's drinking which often leads to arguments. You also sound unsure of how to support him to change this situation which leaves you feeling hopeless."

In this summary, the response identifies that the lady is "frustrated" about her husband's use of alcohol and is frustrated that it leads to arguments. It also recognizes that she feels unable to change this situation, which makes her feel hopeless about their future.

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## Summarizing

"My husband passed away last month. He was sick for some time but he refused to be taken to the hospital. Now I have just found out that I am HIV+. So, now I feel so confused. I realize my husband had AIDS and he didn't tell me, and I must have got HIV from him."

Ask participants how they could summarize what the lady is feeling and telling them. Show the response on the slide as an example, once participants have tried to give a summary.

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## Summarizing

"My husband passed away last month. He was sick for some time but he refused to be taken to the hospital. Now I have just found out that I am HIV+. So, now I feel so confused. I realize my husband had AIDS and he didn't tell me, and I must have got HIV from him."

**Response:** "You sound like not only have you suffered a major loss, the death of your husband, but now you are left to cope with a life-changing illness. Also, you are left feeling a sense of betrayal that your husband did not tell you that he had AIDS."

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Explain that in this summary the person has listened and heard that not only is the person suffering a major loss – that of her husband. But she has found that she is HIV+ and that it must have been her husband who infected her. This news has left her feeling betrayed – because he did not tell her – and confused as she did not know that her husband had AIDS.

## Activity 3: Using good verbal communication skills

### Activity 3: Using good verbal communication skills

- Mary is a married woman with three children. She has been really struggling at home. She feels sad all the time and never leaves the house, despite the fact that she is usually an active member of her community.
- How would you talk to Mary about her problem?

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**Duration:** 20 minutes.

**Purpose:** Enable participants to practise using and developing their communication skills.

**Situation:** Mary is a married woman with three children. She has been really struggling at home. She feels sad all the time and never leaves the house, despite the fact that she is usually an active member of her community. How would you talk to Mary about her problem?

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play Mary; one person to play the role of a health-care provider aiming to find out more about Mary's problems; and one person to play the role of the observer.
- Explain that the person playing the role of the health-care provider should start the conversation.
- Explain that the person playing the role of the health-care provider should spend time welcoming Mary and trying to make her feel comfortable. They should use effective communication skills, such as open and closed questions, active listening, empathy and summarizing to find out more about Mary's current situation.

- Once the role play has finished, the observer can facilitate a brief discussion in small groups about the interaction using the effective communication skills on page 6 of mhGAP-IG Version 2.0 to guide the discussion.
- Participants should have:
  - two to three minutes' discussion on who is playing what part
  - around 10 minutes of role playing
  - five minutes' feedback and discussion with the observer.



Ask participants to reflect on experiences in the past when they have come into contact with agitated and/or aggressive behaviour in their clinics.

Take five minutes to facilitate a brief discussion in plenary about why participants think that people may become agitated and aggressive?

## Agitated and/or aggressive behaviour

- It is normal for people to become angry; anger can be positive as well as negative.
- People become angry for different reasons and show anger in different ways, e.g. one person might sulk and go quiet, while others might become agitated and aggressive.
- Anger can dissipate or escalate.

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Explain that it is normal to get angry and anger is not always a negative feeling – it is often a response to a perceived negative situation.

We all get angry at times and sometimes this can lead to positive outcomes, while in other cases outcomes may be negative.

Anger can dissipate or escalate and the progression of the anger may be determined by the actions and responses of the health-care provider.

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour		
ASSESSMENT	COMMUNICATION	SEDATION AND USE OF MEDICATION
<ul style="list-style-type: none"> <li>Initial assessment and orientation</li> <li>Assess for awareness</li> <li>Check vital signs: heart rate, blood pressure, respiratory rate, temperature, oxygen saturation, level of consciousness</li> <li>Assess for pain and mental status</li> <li>Assess for risk of self-harm or harm to others</li> <li>Assess for drug and alcohol use: does this contribute to the agitation? Does the patient have a history of substance abuse?</li> <li>Assess and manage acute mental health crises</li> <li>Assess for physical health problems</li> <li>If at all possible, have been assessed and the patient is not agitated or if necessary, no sedation or physical restraints are present</li> </ul>	<ul style="list-style-type: none"> <li>Safety: staff</li> <li>The staff who are interacting with the patient should be aware of the patient's behaviour and the potential risks involved.</li> <li>Use a calm and reassuring tone of voice.</li> <li>Use a simple language that the patient can understand.</li> <li>Use a neutral tone of voice.</li> <li>Use a calm and reassuring tone of voice.</li> <li>Use a simple language that the patient can understand.</li> <li>Use a neutral tone of voice.</li> </ul>	<ul style="list-style-type: none"> <li>Assess for symptoms of distress.</li> <li>Ask questions that the patient can answer, provide clear instructions and repeat them until the patient can understand them.</li> <li>Use a simple language that the patient can understand.</li> <li>Use a neutral tone of voice.</li> <li>Use a simple language that the patient can understand.</li> <li>Use a neutral tone of voice.</li> <li>Use a simple language that the patient can understand.</li> <li>Use a neutral tone of voice.</li> </ul>

Direct participants to page 45 of mhGAP-IG Version 2.0.

Explain that these are the steps for the management of agitated and/or aggressive behaviour.

Explain that in all cases effective communication is important and should be used in order to de-escalate the situation.

The next task is to look at ways one can de-escalate anger using effective communication skills.

# Activity 4: Facilitator demonstration: Using effective communication to de-escalate a person with aggressive/agitated behaviour

## Activity 4: Facilitator demonstration Using effective communication to de-escalate an aggressive/agitated person

A person becomes increasingly angry and impatient in the clinic waiting room. They have been waiting for a number of hours to see someone and believe that all of the other people are being seen before them, on purpose. They feel discriminated against and like no one is going to help them. They are very angry and do not want to listen to any “excuses” from any one about why they have not been helped. They refuse to leave the waiting room. They are upsetting and scaring the other people and children.

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**Duration:** 20 minutes.

**Purpose:** To show participants examples of good practice in the management of people with agitated and/or aggressive behaviour.

**Situation:**

- The facilitator will play the role of the health-care provider in a clinic.
- A participant or co-facilitator will play the role of a person coming to seek help in the clinic for aches, pains and tiredness (lack of sleep).
- The person becomes increasingly angry and impatient in the waiting room because they have been waiting for hours to see the health-care provider and believe that everyone else has been seen before them on purpose. The person feels discriminated against and uncared for, and they are very angry – not wanting to listen to any “excuses” from anyone. The person refuses to leave the waiting room and they begin to upset the other people and children in the clinic.

**Instructions:**

- You, the health-care provider, will use the tips given in the mhGAP-IG, including: remaining calm and keeping a calm and steady voice; asking the person to come and talk to you in a quiet and private space because you cannot hear them in this waiting room (e.g. “I really want to listen to what you are saying but I cannot hear you at the moment, perhaps if we go somewhere more quiet and private I can help you better”). Listen to the person. Devote time to the person. Try to find out the reason why they are feeling so angry. Rule out any other medical/physical reasons that may underlie anger. Rule out substance use/psychosis.
- Ask participants to reflect on the example. What worked well?
- Use the slides and the facilitator notes below to explain how to manage agitated and/or aggressive behaviour. Remember to use the facilitator demonstration you have just done to illustrate these management options. When explaining how to rule out other causes of aggression, remind them how you did so in the facilitator demonstration. When you instructed them to remain calm instead of getting angry and aggressive, remind them how you did this.

## Managing persons with agitated and/or aggressive behaviour

Assess the person for the underlying causes of the agitation and/or aggression.

Briefly talk through the following slides and give details on how to manage agitated and/or aggressive behaviour.

Use the facilitator demonstration as an example of how to do this.

Explain that the first step of the management of aggression and agitation is:

1. Assessing the person for the underlying causes of agitation and/or aggression.

### Assess for agitated and/or aggressive behaviour

- A common cause of anger is an unmet need – for control, information, to be listened to, to feel safe.
- It may also have psychological antecedents or be triggered by fear.
- It may have physical antecedents – blood glucose levels, vital signs, delirium, drug and alcohol use.
- Mental health condition, such as psychosis or bipolar episode.

Explain that on this slide there are some possible causes of agitated and/or aggressive behaviour:

- Unmet needs, feeling like you are not being listened to or not understood, feeling unsafe or uncomfortable, not having enough information.
- Fear.
- A symptom of a mental health condition such as psychosis and bipolar disorder.
- Physical health conditions may also cause agitation and aggression, e.g. check blood glucose (if low, give glucose).

Then work through the following steps.

2. Check vital signs (including temperature and blood pressure).
3. Rule out delirium and medical causes (including poisoning).
4. Rule out drug and alcohol use (specifically consider stimulant intoxication and/or alcohol/sedative withdrawal).
5. Rule out agitation due to psychosis or a manic episode in bipolar disorder.

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour ①		
ASSESSMENT ②	COMMUNICATION	SEDATION AND USE OF MEDICATION ③
<ul style="list-style-type: none"> <li>• Assess Comprehension and behaviour.</li> <li>• Assess for underlying cause.</li> <li>- Check blood glucose, Fasting or post-prandial</li> <li>- Check vital signs, including temperature, heart rate, blood pressure, oxygen saturation</li> <li>- Rule out dehydration and medical systems</li> <li>- Rule out dementia</li> <li>- Rule out drug and alcohol use</li> <li>- Rule out physical and environmental triggers (e.g. different temperature, light, noise, smells)</li> <li>- Rule out aggression due to psychosis or mental health conditions (e.g. delusions, hallucinations)</li> </ul>	<p><b>COMMUNICATION</b></p> <ul style="list-style-type: none"> <li>• SILENT ④</li> <li>• Listen with active listening skills to fully understand what the person is saying</li> <li>• Ask a series of questions to address the presenting symptoms</li> <li>• Listen actively. Silence time in the session</li> <li>• Listen without judgment</li> <li>• Use the right words</li> <li>• Ask questions about the person's history</li> <li>• Ask questions about the proposed care measures</li> <li>• Ask questions about the person's needs</li> <li>• Encourage the person to talk about their feelings</li> <li>• Be aware of triggers and how to manage them</li> <li>• Be aware of triggers that increase risk-taking, like anger</li> <li>• If the person is agitated, avoid physical contact and try to approach from behind if possible</li> <li>• If the person is agitated, avoid physical contact and try to approach from behind if possible</li> </ul>	<p><b>SEDATION AND USE OF MEDICATION ③</b></p> <ul style="list-style-type: none"> <li>• Assess for sedation and/or aggression</li> <li>• If the person has low responsiveness or intense, paroxysmal, violent, threatening, or aggressive behaviour, consider giving a short course of benzodiazepines or other sedatives</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> <li>• If the person has high risk of self-harm, suicidal, or violent behaviour, consider giving a short course of antipsychotics</li> </ul>

Read through the effective communication skills needed to manage agitated and/or aggressive behaviour.

When discussing the skills use the facilitator demonstration as an example of how you employed these skills.

Explain that **safety first** refers to safety of the person, the staff in the health clinic and any other people in the area.

**Remain calm and encourage the person to talk about their concerns.** For example, take a deep breath before speaking to keep yourself calm. If the person is shouting, you could calmly say, "I want to help you but I cannot understand you when you shout at me, maybe we could go somewhere quiet and you can tell me what is troubling you."

Encourage the person to talk about their problems, let them express their anger as long as it is safe.

**Use a calm voice and try to address the concerns if possible.** Use a calm, soft and gentle tone. Use sensitive language and, if relevant and appropriate, use humour. Be aware of your body language, your posture, movements etc.

**Listen attentively and actively.** Focus on the person and do not get distracted by other issues/people. Use active listening skills to listen to the person, be empathetic with the person and try to understand why the person is agitated and/or aggressive. Use active listening skills to let the person know that they are being listened to.

Never laugh at the person – be non-judgemental.

**Do not be aggressive.** Remaining calm is key to de-escalating agitation and aggression. By remaining calm, you can make the person feel safe. Focus on their anger and aggression rather than your own feelings.

**Try to find the source of the problem and solutions for the person.** By using active listening skills and remaining calm you can help the person manage their own aggression, understand the source of the problems and work with them to find some alternative solutions (solutions that do not involve aggression).

**Involve carers and other staff members.** Involve staff but be aware that involving too many people could be interpreted as a "show of force" and make the person feel more unsafe, thus escalating the anger.

**Remove anyone from the situation who may be a trigger for the aggression.** Try and take the person into a quiet room, separated from people who may trigger more aggression and make the situation worse.

In case none of the above-mentioned strategies work and the person is still aggressive, medication may be necessary.

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour ①		
ASSESSMENT ②	COMMUNICATION	DESCRIPTION AND USE OF MEDICATIONS ③
<ul style="list-style-type: none"> <li>• Start by communicating with the person.</li> <li>• Check for underlying cause:</li> <ul style="list-style-type: none"> <li>- Check blood glucose</li> <li>- Check for signs of hypomania or mania (e.g. racing thoughts)</li> <li>- Check for signs of depression (e.g. low mood, lack of motivation)</li> <li>- Check for delusions and visual hallucinations</li> <li>- Check for drug and alcohol use</li> <li>- Check for physical health conditions (e.g. dehydration, infection, heart attack, stroke)</li> <li>- Check for cognitive decline due to medication or mental health conditions (e.g. dementia, Alzheimer's disease)</li> </ul> </ul>	<ul style="list-style-type: none"> <li>• Listen to the person</li> <li>• Encourage the person to talk about what they are experiencing</li> <li>• Ask questions to clarify what the person is saying</li> <li>• Avoid challenging the person</li> <li>• Avoid giving commands or instructions</li> <li>• Avoid physical contact with the person</li> <li>• Avoid confrontational language</li> <li>• Avoid statements such as "you must" or "you have to"</li> <li>• Avoid statements such as "you're being difficult" or "you're being aggressive"</li> </ul>	<ul style="list-style-type: none"> <li>• Assess for aggression or harm risk</li> <li>• If no aggression or harm risk, consider non-pharmacological interventions (e.g. talking to the person, offering choices, removing triggers, providing reassurance, etc.)</li> <li>• If aggression or harm risk, consider pharmacological interventions (e.g. sedatives, antipsychotics, mood stabilizers, etc.)</li> <li>• If aggression or harm risk, consider hospital admission (e.g. if the person poses a danger to themselves or others)</li> <li>• If aggression or harm risk, consider police involvement (e.g. if the person poses a danger to themselves or others)</li> </ul>

Ask participants if they have ever used medication in the past to sedate an agitated or aggressive person.

Talk through different considerations for using medication in the mhGAP-IG.

## Aggression against adults and children with priority MNS conditions

- Both children and adults with priority MNS conditions are nearly four times more likely to be victims of violence than the general population.
- This can include aggression and violence by:
  - family members
  - community members
  - health-care providers.

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Explain that both children and adults with priority MNS conditions are at a much higher risk of aggression and violence than the general population.

This can include aggression and violence by:

- family members
- community members
- health-care providers.

## Aggression against adults and children with priority MNS conditions

- People with priority MNS conditions are at higher risk of violence due to:
  - Stigma.
  - Discrimination.
  - Ignorance about the condition.
  - Lack of social support for the individual and those who care for them.
  - Placement of people with MNS conditions in institutions.
  - People with MNS conditions are unable to disclose abuse/violence.

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Explain that factors which place people with priority MNS conditions at higher risk of violence include stigma, discrimination, and ignorance about the condition as well as a lack of social support for the individual and those who care for them.

Placement of people with priority MNS conditions in institutions also increases their vulnerability to violence. In these settings, and elsewhere, people with communication impairments are unable to disclose their abuse and often are not believed if they do.

## Aggression and violence against people with MNS condition

- What can you do if you see a health-care provider being aggressive/violent towards a person with a priority MNS condition?

Facilitate a brief discussion in plenary:  
What can you do if you see a health-care provider being aggressive/violent towards a person with a priority MNS condition?

Have participants reflect on what steps they could take to manage this situation.

**Note:** Emphasize that the safety of the person with MNS conditions is paramount, therefore the first step is to ensure that the person is safe.

- Discuss if there are any reporting lines within their health-care systems they could use to ensure that the health-care provider is reported and stopped. Where appropriate, report the abuse to the police.
- Talk to the health-care provider and explain how vulnerable people with MNS conditions are.
- Spend time training the staff in the non-specialized health setting in how to effectively communicate with people with MNS conditions.
- Address any stigma and misunderstandings health-care providers may have about people with MNS conditions.

Explain that the next activity will focus on how to promote respect and dignity for people with MNS conditions.

## Activity 5: Promoting respect and dignity

**Duration:** 40 minutes.

**Purpose:** Give participants a better understanding of the stigma and discrimination that people with priority MNS conditions face.

**Instructions:**

- Split participants into small groups.
- Ask each group to answer the following questions:
  1. How are people with MNS treated in your community?
  2. Break this discussion down to distinguish between disorders – for example, how are people with epilepsy perceived versus how people with psychoses or depression are treated? How are children with developmental disorders treated? How are people with substance use disorders treated?
- Allow 10 minutes for discussion and then ask each group to nominate a spokesperson to share their lists with the rest of the group.
- The facilitator should make a list of the participants' responses.
- Explain briefly that negative name calling, labelling and marginalization are all forms of stigma.
- Ask the groups to discuss:
  1. What impact does stigma have on the individual?
  2. What impact does it have on the family?
  3. What impact does it have on the community?
- Allow 10 minutes for discussion and then ask each group to briefly feedback to the rest of the group.

### Activity 5: Promoting Respect and Dignity

Promoting human rights, respect and dignity.

How are people with MNS conditions treated in your community?

How are people with epilepsy treated in comparison with people with psychoses or depression?

How are people with substance use disorders treated as compared with people with developmental disorders?

Use these questions to stimulate a discussion and ensure participants think about all the ways people with different MNS conditions are treated.

**Note:** In some societies, it may be necessary to mention that people hearing voices are revered and respected. So, their treatment may not always be negative.

## Activity: Stigma

Negative labelling, name calling and marginalization is a form of stigma.

1. What impact does stigma have on the individual?
2. What impact does it have on the family?
3. What impact does it have on the community?

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Keep the participants in the same groups as they were for the previous discussion and ask them to discuss the following three questions.

1. What impact does stigma have on the individual?
2. What impact does it have on the family?
3. What impact does it have on the community?

## What impact does stigma have?

- Stigma has serious and long lasting consequences.
- It brings the experience of:
  - shame
  - blame
  - hopelessness
  - distress
  - reluctance to seek or accept help
  - fear.

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Summarize the key discussion points highlighted by the participants and explain that stigma can bring a sense of shame, blame, hopelessness, distress, reluctance to seek and/or accept help, and fear.

## What are the effects of stigma and discrimination?

- Emotional state:
  - Affects sense of self-worth.
- Symptoms:
  - Contributes to shortened life expectancy.
  - Slows recovery.
- Access and quality of treatment:
  - Limits access and quality of health care.
- Human rights:
  - Can lead to abuse.
- Family:
  - Disrupts relationships.

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Explain that stigma can impact on your emotional state by affecting your sense of self and self-confidence.

It can affect symptoms of the MNS condition – it can shorten life expectancy and slow down recovery.

It means that people cannot access the health care and treatment that they need and deserve.

It can lead to an abuse of human rights.

It can lead to disruptions in family life.

## Group discussions

Return to your groups and discuss what health-care providers can do to address stigma and stop discrimination.

Ask participants to return to their groups and briefly discuss what health-care providers can do to address stigma and stop discrimination.

After five minutes' discussion, ask the spokesperson to give feedback to the rest of the group with ideas on what they could do.

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## As health providers we can

- Change our own perception and attitude towards people with MNS disorders.
- Respect and advocate for the implementation of relevant international conventions, such as the United Nations **Convention on the Rights of Persons with Disabilities**.
- Reaffirm that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.
- Play a large part in fulfilling these rights.

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Explain the points on the slide. Ask participants if they think they could implement these changes.

Inform participants that the full convention is available if they wish to see it.

Consider reading aloud the following three examples of articles from the convention:

1. The right to good quality, affordable and accessible mental health services in the community (Art. 25).

2. The right to rehabilitation services in the community (Art. 26).
3. The right to live in the community and participate in community life (Art. 19).

### Background knowledge:

- Adopted in 2006 at the United Nations headquarters in New York.
- The convention has already been ratified by 110 countries.

### Note:

- On the following website, you can see which countries have ratified the convention: <http://www.un.org/disabilities/countries.asp?navid=17&pid=166>
- If the country in which you are training has ratified it, then you should mention this in the training.

## Promote Respect and Dignity

DOs
■ Treat people with MNS conditions with respect and dignity.
■ Respect the confidentiality of people with MNS conditions.
■ Ensure privacy in the clinical setting.
■ Always provide access to information and explain the anticipated treatment risks and benefits in writing, if possible.
■ Make sure the person gives consent to treatment.
■ Promote autonomy and independent living in the community.
■ Provide persons with MNS conditions with access to supported decision-making options.

DON'Ts
■ Do not discriminate against people with MNS conditions.
■ Do not ignore the priorities or interests of people with MNS conditions.
■ Do not make decisions for, or dominate, or instead of the person with MNS conditions.
■ Do not use overly technical language in explaining anticipated treatments.

Direct participants to page 7 of mhGAP-IG Version 2.0 and compare the list of do's and don'ts with those created by the groups.

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# Session 2.

## Essentials of mental health care and clinical practice: Assessments

⌚ 1 hours 10 minutes



### Activity 6: Group discussion: General principles of MNS assessments

**Duration:** 30 minutes.

**Purpose:** Give participants time to reflect on how they conduct a routine assessment.

**Instructions:**

- Split the participants into groups.
- Ask each group to create a list explaining how they conduct a routine assessment in their clinic.
- Ask them to think about what type of questions and communication skills they use to conduct an assessment.
- What topics do they discuss with the person seeking help? Why do they discuss those topics? What do they learn?

## Activity 6: Discussion General Principles of MNS Assessments

- What type of communication skills do you use in your assessments?
- What topics do you ask about during an assessment?
- What do you want to learn from an assessment and why?

Ask the groups to make the lists as comprehensive as possible to ensure it covers all aspects of their clinical assessment.

Ask each group to present their lists.

Facilitate a discussion and seek group consensus to create one list of agreed topics covered in a primary health-care assessment.

Direct participants to page 8 mhGAP-IG Version 2.0.

Compare the descriptions on page 8 with the lists created by the participants.

Explain that people with severe MNS conditions are two or three times more likely to die from preventable diseases, such as infections and cardiovascular disorders, than the normal population. This may be because people with MNS conditions and their carers are hesitant to seek help due to high levels of stigma and discrimination experienced, even from health-care providers.

It may be that there is a lack of focus on physical health during assessment and treatment and/or the symptoms of the MNS condition contribute to them neglecting their physical health care (e.g. people with severe depression do not take the medication prescribed for their physical health condition).

Therefore, when assessing a person with possible MNS conditions, always assess for physical health as well.

**B. ESSENTIALS OF MENTAL HEALTH CLINICAL PRACTICE**

**I. Assess Physical Health**

Physical health assessments are a logical part of assessment, leading to high-quality treatment and recovery. It is important to approach a physical health assessment as part of a comprehensive mental health assessment, rather than as a separate process. This slide is a clinical health assessment to identify assessment priorities and facilitate the delivery of interventions. It is not intended to be a substitute for the primary clinical activities.

**Assessment of Physical Health**

- Take a detailed history and ask about risk factors.
- Identify common mental health problems that may have physical health consequences.
- Perform a physical examination.
- Consider environmental determinants.
- Identify physical health problems.

**Management of Physical Health**

- Encourage communication about physical health between the health professional and the patient.
- Refer the individual to other health-care professionals if necessary.
- Encourage self-management of physical health.
- Encourage education about mental illness (e.g., antidepressants).
- Encourage regular physical health exercise and nutrition.
- Encourage self-care and social support.
- Encourage the appropriate and continuous treatment of mental health conditions.

**Patient Day Plan**

Patients with severe mental illnesses are 2–3 times more likely to die of preventable diseases (e.g., diabetes and cardiovascular disorders). Focus on reducing risk through assessment and reporting.



Explain that the principles of conducting an MNS assessment are going to be discussed.

Direct the participants to page 9 of mhGAP-IG Version 2.0.

Emphasize that conducting an MNS assessment is not an extra burden but should be an extension of their routine assessments.

## Activity 7: Small group work: Conducting an MNS assessment

### Activity 7: Conducting an MNS assessment

Divide into three groups.

Each group takes different elements of an MNS assessment and answers the questions:

1. What information do you want to find out and why is it important information to learn?
2. What questions can you ask to find this out?

**Duration:** 30 minutes.

**Purpose:** Give participants the opportunity to learn the steps required to conduct an MNS assessment.

**Instructions:**

- Divide participants into three groups.
- Give Group 1 the heading **Presenting complaint** and **Family history of MNS conditions**.
- Give Group 2 the heading **General health history and past MNS history**.
- Give Group 3 the heading **Psychosocial history**.
- Give each group pieces of flip chart paper and pens.
- Ask each group to create two lists:
  1. What information do you want to find out? Why do you want to find out this piece of information?
  2. What questions can you ask to find it out?
- Give each group 20 minutes to discuss and create the lists, hang the lists on the wall, bring the groups back together and ask the plenary group to discuss the lists of questions.
- Use the explanations and suggested questions in the slides below to provide any clarification.
- Add any of the questions discussed below to the lists created by the participants.

**Note:** Keep the lists of questions visible throughout the rest of the training so participants can use them in upcoming activities.

## Presenting complaint

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

Ask:

- Why have you come to see me today?
- When did this start?
- How long has this been happening – how many years, months, weeks, days?
- How did this start?
- What do you think is happening to you?

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Explain what **presenting complaint** means (as described below).

Presenting complaints are the issues or issue that the person is presenting with, and these are the primary reasons for the visit. Try to understand them in the person's own words.

You may find that the person's presenting complaint is minor compared with what you discover in the rest of the assessment, but clearly it is important to them.

Then talk through the questions and points on the slide.

## Past MNS history

- Has anything like this happened to you before?
- Have you ever felt this way before?
- When you felt this way in the past did you seek help? What happened? (Explore if they went to hospital etc.)
- When you felt like this in the past how did you cope? What did you do? (Explore alcohol, drugs tobacco usage.)
- When you felt like this in the past did you ever try to harm yourself or kill yourself?

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Explain what we want to learn in the **past MNS history** (as described below).

Past MNS history means the past history of these complaints or other complaints which happened to the person before – any hospitalizations, any history of alcohol or drug use (they may not see that as an MNS history).

Then talk through the questions on the slide.

## General health history

Find out if they have had any other health concerns or been taking any medication over the past few years.

- Find out if they have any allergies to medications.
- If they have been taking medication, do they know what it is for?

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Explain what we mean by **general health history** (as described below).

Asking the person about their beliefs about their own health and any medication they are on can give a useful insight to learning what they think the problem is.

Then talk through the points and questions on the slide.

## Family history of MNS conditions

Do you know if anyone in your family has ever felt the same way as you/experienced the same feelings/sensations/emotions as you?

Asking about family history gives you an opportunity to learn who is who in the family (who the person is close to, any family discord, insight into the family relationships).

MNS conditions can be caused by social, psychological and genetic factors, so do not be afraid to explore family history.

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Explain what we mean by **family history of MNS conditions** (as described below).

This is an opportunity for health-care providers to start to explore relationships within the family. To whom is the person close, with whom do they not interact and are those relationships strained? They may also reveal if there have been major stressful life events in the family, such as bereavement and divorce etc.

This is also a good opportunity for discovering any genetic risk factors making the person prone to developing an MNS condition.

Then talk through the points and questions on the slide.

## Psychosocial History

Aim of the psychosocial history is to understand the psychological, social and environmental history of the person:

- Are you currently able to work/study/attend school? How is work/School/university?
- Who do you live with? What is your home life like at the moment?
- Have you experienced any stress in your life at the moment?
- What do you do in your spare time?
- Who do you have in your life to support you?

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Define what we mean by **psychosocial history** (as described below).

It gives you an opportunity to learn about the person's social, environmental, psychological and occupational life:

1. Understand how the person's symptoms have an impact on their ability to function in everyday life.
2. Understand how the person's social, environmental and psychological states have an impact on the person's symptoms, e.g. in the case of violence, abusive relationships (gender-based violence), war, distressing events and psychosocial stressors.
3. Try to understand who their social network includes and if they feel supported.

You can continue to explore any stressors that the person is currently experiencing and that were discussed when exploring the presenting complaint.

This should give you a holistic understanding of the person's life and current situation.

Explain that individuals (adults and children) cannot be isolated from their environment and environmental pressures. To truly understand a person, you need to understand what is happening around them.

It is also an opportunity to ask about positive events in the person's life, i.e. how they have been dealing with this situation so far. Who supports them and how?

Then talk through the points and questions on the slide.

Ask participants to brainstorm questions they could use to explore psychosocial stressors that people might be facing.

## Psychosocial Stressors

Violence and abuse constitute significant psychosocial stressor for individuals, families and communities

Gender based violence (GBV) is now widely recognized as a global public health and human rights concern

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Explain that violence and abuse is a reality for many people and many families.

It is a significant psychosocial stressor for all the people involved and can have significant impacts on an individual's mental health.

This includes impacting the mental health of:

- the survivor of the violence,
- observers of the violence
- and perpetrators of the violence.

Gender-based violence is now widely recognized as a global public health and human rights concern.

## Violence against men and women

- 1 in 3 women (35%) worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime
- During any MNS assessment understand the impact of different kinds of violence:
  - Violence between men
  - Violence between women
  - Child abuse
  - Violence against women by other family members (mother in laws etc.)
  - Violence by women against men

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Explain that 1 in 3 women (that represents 35% of women) worldwide have experienced either physical and/or sexual intimate partner violence or violence outside of their relationship in their life.

This statistic denotes the global prevalence of violence against women and highlights the fact that it is an urgent public health concern.

However, during any MNS assessment it is important to learn about all different types of violence that a person may experience and this can also be violence by women against men, violence between men, child abuse and violence against women by other family members such as mothers in law or fathers.

## Impact of Violence on mental health

- Violence and abuse can lead to:
  - depression
  - post-traumatic stress and other anxiety disorders
  - Sleep difficulties
  - Self-Harm/Suicide attempts
- Sexual violence particularly during childhood can lead to increased smoking, substance use, risky sexual behaviours in later life.
- It is also associated with perpetration of violence (for males) and being a victim of violence for females

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Explain the points on the slide stating that violence and abuse can lead to depression, post traumatic stress and anxiety disorders, sleep problems, self-harm/suicide attempts.

Sexual violence, particularly in childhood, can lead to increased substance use and risky sexual behaviours later in life.

Males experiencing sexual abuse in childhood are more likely to perpetrate violence against others when they grow up.

Sexual violence in females during childhood is associated with an increased likelihood of being victims of violence as adults.

## Impact of Violence on Mental Health

- Many people who survive acts of violence and abuse will have severe emotional reactions such as feeling fear, stress, sadness, shame and guilt. It is normal.
- In many these emotions will pass once the violent situation passes.
- However others will need more help therefore it is important to use the mhGAP-IG to assess for possible priority MNS conditions.

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Talk about the first point on the slide and emphasize that most people who are subjected to violence will have an emotional reaction of some sort. This can include fear, sadness, shame, guilt, stress, etc.

Emphasize that this is normal and that these reactions will pass once the violent situation has passed and they feel safe again.

However, for some people these feelings remain and they need more help.

In those cases, it is important to use the mhGAP-IG to assess people for possible depression, substance use, self-harm/suicide, other (stress/anxiety disorders), and CMH (specifically emotional disorders in children and adolescents).

## Common Presentations

- You may suspect a person has been subjected to violence if they have:
  - Stress, anxiety, depression
  - Substance use disorders
  - Thoughts, plans or acts of self-harm/suicide
  - Injuries that are repeated and unexplained
  - Repeated sexually transmitted infections
  - Unwanted pregnancies
  - Unexplained chronic pain or conditions (Pelvic pain, gastrointestinal problems, kidney or bladder infections etc)
  - Other unexplained mental health complaints

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Explain the points on the slide describing common presentations of people who have experienced violence and state that: You may also suspect a problem of violence if:

- a woman's partner or husband (or father or mother in law) is intrusive in consultations, if she often misses her own or her children's appointments, or if her own children have emotional or behavioural disorders.

- a child's caregiver or parent is intrusive in consultations, dismissive of the child's problems and injuries, talks for them and does not allow the child to speak, the child appears scared of them or uncomfortable with them.

**Stress that:**

**WHO does NOT recommend universal screening for violence of women attending health care. WHO does encourage health-care providers to raise the topic with women who have injuries or conditions that they suspect are related to violence.**

### What can you do if you suspect violence?

- Try and speak to the person alone
- Do not raise the issue of potential partner violence unless the woman is alone
- If you do ask about violence be empathic and non-judgmental. Use sensitive and culturally appropriate language
- Do not seek to blame anyone but seek to listen and understand.

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Give participants a few minutes to brainstorm some answers and then explain the points on the slide

Emphasize that it is important to ensure the persons safety at all time, your safety and the safety of your colleagues.

### Principles of offering first line support

- First line support providers practical care and responds to a person's emotional, physical, safety and support needs without intruding on privacy.
- Often first line support is the most important care you will provide.

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Explain that if a person does disclose that they are experiencing violence and abuse then the first line support that you offer can be the most important care you can provide.

First line support provides practical care and responds to a person's emotional, physical, safety and support needs without intruding on their privacy.

L	ISTEN	Listen to the woman closely, with empathy, and without judging.
I	NQUIRE ABOUT NEEDS AND CONCERNs	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)
V	ALIDATE	Show her that you understand and believe her. Assure her that she is not to blame.
E	NHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
S	UPPORT	Support her by helping her connect to information, services and social support.

Introduce participants to LIVES intervention (from the WHO Healthcare for women subjected to intimate partner violence and sexual violence A Clinical Handbook; 2014).

First line support involves 5 simple tasks.

(This document refers to offering first line support to women but the same principles applies for men and children).

It responds to both emotional and practical needs.

Explain the 5 simple tasks as described on the slide.

## Do

- Identify needs and concerns
- Listen and validate those concerns and experiences (be empathic)
- Connect the person with other people, groups, organisations
- Empower the person to feel safe
- Explore what options are available to the person
- Respect their wishes
- Help connect them to social, physical and emotional support
- Enhance their safety

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Explain the points on the slide stressing what health-care providers can do to support someone who discloses violence and abuse.

Explain that these actions are similar to the principles of Psychological First Aid (PFA)

## Do Not

- Try to solve the persons problems
- Convince them/force them to leave a violent partner/family
- Convince/force them to go to the police
- Ask detailed questions that force them to relive painful events
- Ask them to analyze what has happened and why
- Pressure them to talk to you

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Explain what actions to avoid as described on the slide.

Highlight that if you try and solve the person's problems and force them to take certain actions then you are taking away their control and potentially putting them in more danger.

You may never know all of the details and you do not want to do anything that would put the person, yourself, colleagues or anyone else in more danger.

## Tips for offering first line support

- Choose a private place to talk , where no one can overhear (but not a place that indicates to others why you are there)
- Assure confidentiality but explain what would happen if you had to break confidentiality
- Use the principles of active listening
- Encourage the person to talk but do not force them
- Allow for silences. Allow the person to cry, give them the time that they need

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Talk through the points on the slide

Engage participants in a brief discussion about confidentiality and how they would explain confidentiality to a person who has just disclosed abuse.

Explain that during the rest of the training and in other modules we will continue to discuss the impact of violence and abuse on an individual's mental health and how to manage it.

# Session 3.

## Essentials of mental health care and clinical practice: Management

⌚ 1 hours 45 minutes

III. Manage MNS Conditions

MANAGEMENT STEPS FOR MNS CONDITIONS

Most MNS conditions are chronic and require long-term monitoring and follow-up. Managing a MNS disorder over time involves the following steps:

- 1 Develop a treatment plan in collaboration with the person and their care.
- 2 Refer to specialists or hospital when indicated and available.
- 3 Ensure that appropriate user for follow-up is in place.
- 4 Work together with carer and families in assessing the perspective of the MNS disorder.
- 5 Foster strong links with employment, education, social services (including Young and other relevant sectors).
- 6 Modify treatment plans for special populations.
- 7 Always offer psychosocial interventions.
- 8 Refer the MNS disorder using pharmacological interventions when indicated.

CLINICAL TIP

Written treatment plan should cover:

- Pharmacological intervention(s)
- Psychosocial intervention(s)
- Referrals
- Patient care plan

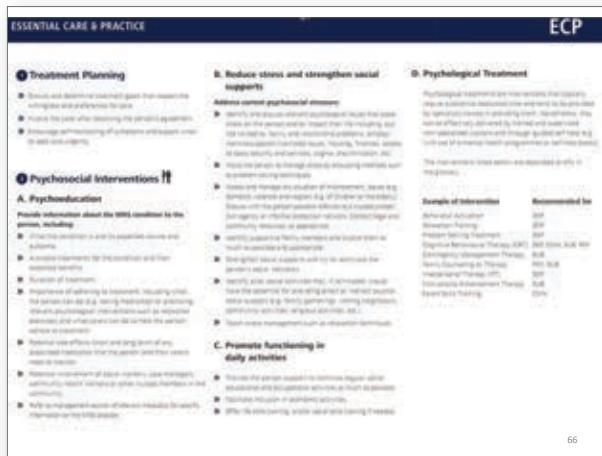
Each module has its own management steps and interventions for specific MNS conditions, which we will learn about throughout the training. Therefore, this session aims to introduce the general guidelines and steps that can be taken to manage priority MNS conditions.

Explain the first step:

1. Develop a written treatment plan in collaboration with the person and their carer.
2. Always offer psychosocial interventions.
3. Use pharmacological interventions when indicated.
4. Refer to specialists and hospitals when indicated.
5. Ensure appropriate follow-up.
6. Work together with carers and families.
7. Foster strong links with employment, education and social services.
8. Modify treatment plans for special populations.

Ask the group what they understand by the term **treatment plan**.

Before moving on to the next slide, let participants answer.



Explain that treatment planning is a collaborative process which represents a plan of action discussed with the person and the health-care provider to meet the person's health and social needs.

Give participants a copy of the treatment plan (see ECP Supporting material) to follow as you describe it, using the explanation below.

Begin the treatment plan with a brief explanation of the **presenting problem** (i.e. the person has been feeling sad for two months, they have lost contact with family and friends and feel very lonely and isolated. This makes the person feel even more sad. Their friends are important to them and they want to reconnect but feel sad and tired all the time).

**What interventions** will you use and why? Briefly explain what the treatment plan aims to achieve (i.e. to improve their mood by increasing their social activities and strengthening their relationships with friends and family).

Make an **action plan** – list the steps, goals, actions behaviours needed to happen to achieve the goal (i.e. the person is going to meet friends who make them feel supported and cared for twice this week for at least 30 minutes each time).

Whenever you agree that an action should be taken, you should also decide **who** will take action and agree on **when** the action is going to happen.

The final section of the treatment plan should have clear decisions made about what a person can do in a **crisis**. For example, if a person feels overwhelmed by negative emotion or thoughts of self-harm/suicide, where should they go? Who can they talk to? What can they do? Ensure there are clear instructions, which the person can use in times of crisis.

This has to be collaborative as it must meet the needs, goals and priorities identified by the individual. If the person is not involved in treatment planning then they are less likely to adhere to the treatment plan.

It is good practice to involve carers in a treatment plan but it should always be with the consent of the individual.

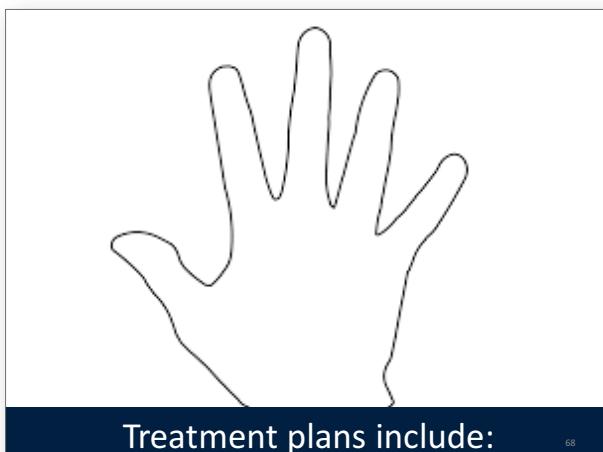


Explain that treatment plans for managing priority MNS conditions can include:

1. Psychosocial Interventions:
  - psychoeducation
  - reduce stress and strengthen social supports
  - promote functioning in daily activities.
2. Psychological interventions.
3. Pharmacological interventions.

Explain again that in each priority MNS training module there will be time to practise delivering interventions relevant to the given condition.

For now, we will look at the general principles behind different types of interventions.

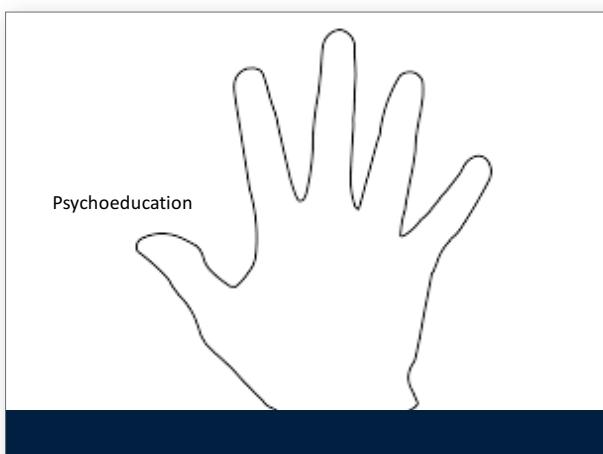


Treatment plans include:

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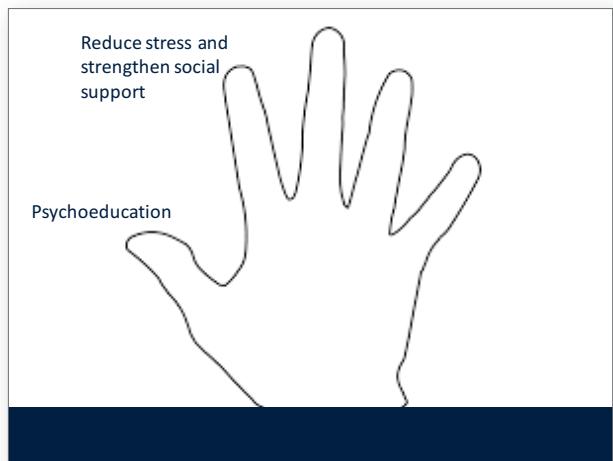
Explain that these interventions can create the basis of any written treatment plan.

Raise your open hand to the participants.

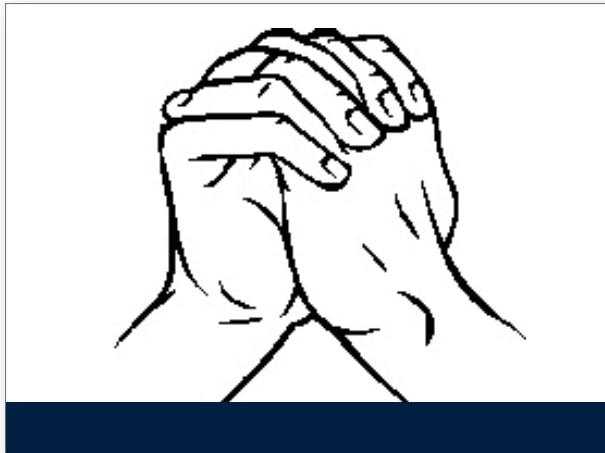


Explain that you can list the five interventions on your fingers to ensure that you always remember them.

Psychoeducation



By placing **referral** in the palm of your hand you know that you always have the option to make a referral where a mental health specialist is available.



Explain that this treatment plan only becomes collaborative when you develop it together with the person living with the MNS condition and explain it to the person, their family and carers.

### What do we communicate in psychoeducation?

#### 1. Empowerment

- Focus on what the person and family can do now to improve their situation.
- Emphasize the importance of involving the person with the disorder in all decisions.

#### 2. Facts

- Take time to explain the prognosis. Be realistic but emphasize that with proper management, many people improve.

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### What do we communicate in psychoeducation?

#### 3. Coping strategies

- Recognize and encourage things people are doing well.
- Discuss actions that have helped in the past.
- Discuss local options for community resources.

#### 4. Advice on overall well-being

- Encourage a healthy lifestyle including a good diet, regular physical exercise and routine health checks at the doctor.
- Advise the person and the carers to seek help when needed.

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Use these slides to explain the general principles behind why these five different interventions are commonly used.

### **Psychoeducation**

Explain that many individuals who have a mental health condition know little or nothing about the condition they have, what they might expect from psychosocial interventions or the positive and negative effects of pharmacological interventions.

Moreover, literature on these topics may be confusing or otherwise difficult to comprehend.

Therefore, the first role of the health-care provider is to explain to the person, and (with consent) to their carer or family members, what the condition means and what they can expect to happen.

This can alleviate the anxiety of the person and that of their carer.

It can empower the person to take control of the condition.

It can keep the person safe and enable them to make a choice about different treatment options.

## Self-care

- Working in health-care is a stressful job and at times everyone can feel overwhelmed and unable to cope.
  - The best way to learn about the influence of psychosocial interventions is to try them on yourself as part of your own self-care.

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**Reduce stress and strengthen social supports.** Explain that there are different ways of reducing stress. For example, breathing exercises and relaxation techniques are common and effective but exercising, singing, cooking, doing something enjoyable are also good ways to reduce stress. The chosen technique depends on the individual's interests, situation and personality.

Similarly, there are different ways to strengthen social supports. Some people may have a social network they can reconnect to, while others may be seeking new people and new social supports. Explain that during the training there will be a chance for participants to practise/discuss all these strategies. However, the best way to learn them and feel comfortable with them is to start using them. Practise different techniques on yourself as part of your own **self-care**.

Working in health-care is a stressful job and at times everyone can feel overwhelmed and unable to cope.

Psychosocial interventions designed to reduce stress and strengthen social supports and positive coping methods can be beneficial.

Familiarize yourself with these interventions by practising them at home yourself or with your family and friends.

## Activity 8: Self-care activity



Explain that this is a technique for reducing psychosocial stressors.

Explain that it cannot solve all problems instantly, especially if the psychosocial stressors are ongoing and/or complicated. It can help to alleviate and reduce some of the stress that a person is feeling.

Six steps to problem-solving:

1. Identify and define the problem.
2. Analyze the problem.
3. Identify possible solutions.
4. Select the best solution and plan for action.
5. Implement the solution.
6. Evaluate the solution.

**Note:** The following are two examples of psychosocial interventions for reducing stress and strengthening social support. These are interventions, recommended in the mhGAP-IG Version 2.0, for health-care providers to use as part of a treatment plan for people living with different MNS conditions. However, so that health-care providers feel confident using and understanding the benefits of these psychosocial interventions, this is an opportunity to practise using them as part of their own self-care.

Depending on time, either allow participants to practise both interventions during the ECP module or choose one and encourage them to practise the other one at home.

## Activity 8a: Self-care – problem solving

**Duration:** 15 minutes.

**Purpose:** Enable participants to practise using a brief problem-solving strategy, thus increasing their confidence and understanding of how to use this technique to help other people.

**Instructions:**

- Instruct participants to think of a current stressor in their life.
- This should not be the most stressful thing that they are facing, nor the biggest problem they are struggling with at the moment, as those will need more than 15 minutes.
- It should, rather, be a problem that causes them some stress.
- Ensure that all participants have a piece of paper in front of them.
- Ask them to write down the chosen problem.
- Ask them to analyze the problem: what is it about, why is it causing them stress?
- Write down as many solutions as possible to that problem.
- The solutions can be as creative as they wish but the aim is to write down as many as possible.
- Once they have a list of solutions, ask them to identify the solution that is the most realistic.
- Ask them to break the solution down into small steps and write them down, including how the different steps could be implemented.
- Then they will need to implement that solution and once implemented evaluate how effective the solution was or was not.
- Explain that this is something that they can do with people very quickly and easily in their sessions and follow-up sessions. It can be a very useful way of supporting people to address some of the problems in their lives that are causing them harm and suffering.

## Activity 8b: Strengthening social supports

**Duration:** 20 minutes.

**Purpose:** Enable participants to practise using a strategy to strengthen social supports in their own lives, thus increasing their confidence and understanding of how to use this technique to help other people.

**Situation:**

- It is normal for people to sometimes feel very alone and/or isolated especially when stressed, anxious, overwhelmed and low in mood.
- Strengthening social support networks is a quick activity that aims to identify all the important people/friendships/support activities the person has in their life.
- Variations in the length of this activity mean that people can explore social supports from the past that have been lost and identify future goals through an in-depth conversation between the person and the health-care provider.

**Instructions:**

- Give each participant a piece of paper and a pen.
- Instruct the participants to draw themselves or write their name down in the centre of the paper.
- Ask participants to think about:
  - Who are the people in my life?
  - What social activities do I do?
- Write down each person and activity on the concentric map (example below), showing closeness, i.e. put those people that are closest to you in the circles closest to you. Put those that you are more distant from you in the circles further away.
- Put the social activities that you do most often closest to you and put those activities that you do less frequently further away.



- Once drawn, ask the participants to think about:
  - Are you happy with your social network?
  - Does this social network give you strength?
  - Is there anybody you could move closer to you who could offer you more support?
  - Is there anyone you want to make a closer connection with?
  - Is there anyone who is close to you who is causing you stress?
  - How could you move those people further away?
- Ask them to reflect on the social activities that they have identified:
  - Are there any activities that give you joy and strength? Could you do those activities more often?
  - Are there social activities that cause you stress/problems? Could you engage with those activities any less? How could you change those activities to give you more strength?
- If participants can re-imagine a way to strengthen their social networks in the ways described above, give them another clean sheet of paper and have them re-write their ideal social network.
- Ask them to think about:
  - What changes in my life do I need to make to strengthen my social network?
- Ask them to make a list of those actions required and think how they could implement them.
- Encourage participants to implement these actions in order to strengthen their social support network especially if they feel this is a useful way to manage their stress.
- Explain that social network mapping is a useful way of helping a person understand their social network and find ways to strengthen it.
- It contributes to reducing stress and building a support network for people living with MNS conditions.
- It can also help people develop a social routine in their day-to-day life which can promote functioning in their daily activities.

- When using this with a person who has a priority MNS condition it can be useful to create a detailed list of manageable actions to improve a person's social support network in their treatment plan.

### Possible adaptations

There are different ways of mapping an individual's social network (see below).

	Who supports you?	How does that support help?
<b>Practical support</b> (Who helps you in the house? Helps you with medication, etc.)		
<b>Advice or information</b> (Where do you go for advice and information?)		
<b>Friendship</b> (Who do you enjoy spending time with?)		
<b>Emotional support</b> (Who do you share your feelings with? Who encourages you, helps you?)		

Other variations can include a more freehand approach whereby the person places themselves in the centre of a piece of paper (writes names or draws a picture). They then draw or write their social network (people and activities) with arrows connecting them to the person or activity. The arrows can be different colours to demonstrate how positive, neutral or negative the person's or activity's influence is on the person's life. Together the health-care provider and individual can then discuss ways that to improve their social support network.

### Promote functioning in daily activities

- Support the person to continue their regular social, educational, occupational activities as much as possible.
- Establish daily routines involving daily activities.
- Link the person with other appropriate services.

### Promoting functioning in daily activities

Carrying out daily activities and tasks is very important for a person with a priority MNS condition.

Routines may help people improve their mental well-being because they structure everyday life and give a sense of purpose. They ensure that a person eats and sleeps on a regular basis – important to maintaining well-being. Routines do not need to be complicated; even simple habits are useful. It could be cooking and eating at a certain time every day and shopping once a week. Or it can be more involved and include more activities during the day or week, depending on the person.

Money, debt and housing options can cause high levels of stress. Therefore, it is important that people with priority MNS conditions are involved in occupational and economic activities. This is important to ensure that they do not have financial difficulties and they can afford to take care of themselves.

## Link with other services and supports

Other sectors and services have a role to play in the complete care of the person, for example:

- housing
- employment
- education
- child protection and social services.

In addition, there are people in the community who may be of help, for example:

- community leaders
- women's groups
- self-help and family support groups.

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Supporting people in developing routines and engaging in educational and occupational activities can be done effectively by linking them with other organizations working in this field.

Discuss the ideas on the slide and ask participants to think what is available in their local area.

## Psychological treatment

- Psychological treatments typically require substantial dedicated time and tend to be provided by specialists trained in providing them.
- They can be delivered by non-specialists who are trained and supervised.

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### Psychological treatment

Instruct participants to go to the glossary in the mhGAP-IG Version 2.0, find and read the descriptions for the different psychological treatments.

Answer any questions/concerns they may have.

Psychological interventions must be delivered by appropriately trained and supervised health-care providers.

Trained health-care providers may not be available in each and every area, however, supervised health-care workers could effectively administer some psychological interventions through guided self-help and/or e-mental health programmes.

## Pharmacological interventions

## Prescribing principles

Medication treatment depends on the condition:

- Worldwide more than 50% of all medicines are prescribed, dispensed or sold inappropriately, while 50% of patients fail to take them correctly (WHO, 2002).

### Safe prescribing:

- Follow the guidelines on psychopharmacology in each module.
  - Select appropriate essential medication – consider the:
    - Population (special populations), consult a specialist when necessary.
    - Side-effect profile (short and long term).
    - Efficacy of past treatment.
    - Drug-drug interactions.
    - Drug-disease interactions.

## **Pharmacological interventions**

Explain that there are detailed guidelines on pharmacological interventions for specific MNS conditions in the corresponding modules, however, for now, describe the general principles of pharmacological interventions.

Stress that the risks of medications often increase with polypharmacy, which should be avoided as far as possible.

Reference WHO. Promoting rational use of medicines: Core components. Geneva: World Health Organization; 2002.

Read through the points on the slides.

## Prescribing principles

- Educate the person and their carers about the risks and benefits of treatment
  - Educate them and their carers on how to take the medication (how often, for how long).
  - Educate them and their carers on the potential side-effects.
  - Educate them and their carers on the importance of taking the medication regularly.

Stress the importance of educating the person and their carer on medication adherence: what to expect, how to take medication and for how long, what the side-effects may be.

Emphasize the importance of choosing medication according to the condition and taking the needs of special populations into account.

# Session 4.

# Essentials of mental health care and clinical practice: Follow-up

⌚ 20 minutes



Describe the principles of follow-up outlined in the mhGAP-IG Version 2.0.

Emphasize the importance of follow-up. Explain that MNS conditions do not appear suddenly and therefore they will not disappear suddenly. Instead it takes time, flexibility and commitment from the individual to try different treatment options until they find one that works and enables them to manage their own condition.

This can be a long journey for some and one that requires frequent support and follow-up.

## Activity 9: Follow-up

### Activity 9: Follow-up

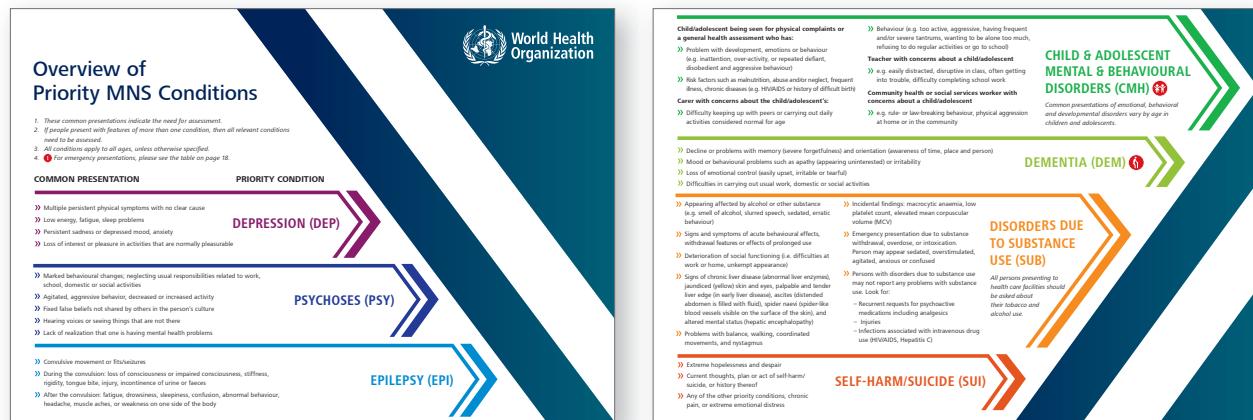
- What are the barriers to providing follow-up?
- What are possible solutions to those barriers?
- What can you do if you cannot provide follow up? How can you still help the person?

**Duration:** 20 minutes.

**Purpose:** Enable participants to discuss the barriers and identify solutions to providing follow-up in their clinical settings.

## Instructions:

- Divide the participants into small groups.
- Give each group flip chart, paper and pens.
- Ask each group to identify and discuss any barriers or obstacles they may have when providing follow-up care for persons with MNS conditions.
- Ask them to write down the barriers.
- Give them 10 minutes.
- After 10 minutes, ask them to identify and write down possible solutions to those barriers.
- Once the groups have identified some solutions, ask each group to present their barriers and solutions to the larger group.
- Seek group consensus on possible solutions and try to agree with the groups on a plan of action for providing follow-up.
- Finally, as a large group, discuss briefly what you can do if follow-up is not possible. What can you do if there is no medication? What can you do if the person refuses to return for follow-up sessions?
- Explain that if the person cannot commit to follow-up, medication should not be prescribed.



<b>! EMERGENCY Presentations of Priority MNS Conditions</b>		
<b>EMERGENCY PRESENTATION</b>	<b>CONDITION TO CONSIDER</b>	<b>GO TO</b>
<ul style="list-style-type: none"> <li>» Act of self-harm with signs of poisoning or intoxication, bleeding from self-inflicted wound, loss of consciousness or stupor, or altered level of consciousness.</li> <li>» Current thoughts, plan, or act of self-harm or suicide, or history of thoughts, plan, or act of self-harm or suicide in a person who is now extremely agitated, violent, distressed or confused.</li> <li>» Acute convulsion with loss of consciousness or impaired consciousness.</li> <li>» Continuous convulsions.</li> <li>» Agitated and/or aggressive behavior.</li> <li>» Smell of alcohol on the breath, slurred speech, uninhibited behavior, disturbance at the level of consciousness, cognitive impairment, and behavioral changes.</li> <li>» Tremor in hands, sweating, vomiting, increased pulse and blood pressure, agitation, headache, nausea, anxiety, seizure and confusion in severe cases.</li> <li>» Unusually responsive, slow respiratory rate, pinpoint pupils.</li> <li>» Dilated pupils, excited, racing thoughts, disoriented thinking, strange behavior, recent use of cocaine or other stimulants, increased pulse and blood pressure, aggressive, erratic or violent behavior.</li> </ul>	<b>MEDICALLY SERIOUS ACT OF SELF-HARM</b> <b>IMMINENT RISK OF SELF-HARM/SUICIDE</b> <b>EPILEPSY</b> <b>STATUS EPILEPTICUS</b> <b>ALCOHOL OR OTHER SEDATIVE WITHDRAWAL</b> <b>ACUTE ALCOHOL INTOXICATION</b> <b>ALCOHOL WITHDRAWAL</b> <b>ALCOHOL WITHDRAWAL DELIRIUM</b> <b>SEDATIVE OVERDOSE OR INTOXICATION</b> <b>ACUTE STIMULANT INTOXICATION OR OVERDOSE</b>	<b>SUI</b> <b>EPI, SUB</b> <b>DEM, PSY, SUB</b> <b>SUB</b>

# Session 5. Review

 15 minutes

**Duration:** Minimum 15 minutes (depending on participants' questions)

**Purpose:** Review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the ECP Multiple Choice Questionnaires (MCQs) (See ECP Supporting Materials) to participants
- Discuss the answers as a group
- Facilitate a brief discussion answering any queries or concerns the participants may have

# ECP PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/ecp\\_slides.pdf](http://www.who.int/mental_health/mhgap/ecp_slides.pdf)

## ECP supporting material

- Treatment plan
- ECP Multiple choice questions



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/ecp\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/ecp_supporting_material.pdf)

# Essential care and practice

mhGAP training of health-care providers  
Training manual



DEP

# Depression

**mhGAP training of health-care providers  
Training manual**



**World Health  
Organization**

# Module: Depression

## Overview

### Learning objectives

- Promote respect and dignity for people with depression.
- Recognize common symptoms of depression.
- Know the assessment principles of depression.
- Know the management principles of depression.
- Perform an assessment for depression.
- Use effective communication skills in interactions with people with depression.
- Assess and manage physical health conditions as well as depression.
- Assess and manage emergency presentations of depression (see Module: Self-harm/suicide).
- Provide psychosocial interventions for people with depression and their carers.
- Deliver pharmacological interventions as needed and appropriate, considering special populations.
- Plan and perform follow-up for depression.
- Refer to specialists and link with outside services where appropriate and available.

### Key messages

- Depression commonly presents with:
  - Multiple persistent physical conditions with no clear cause.
  - Low energy, fatigue and sleep problems.
  - Persistent sadness or depressed mood and anxiety.
  - Loss of interest in activities that are normal and pleasurable.
- Depression results from a combination of biological, psychological and social factors which significantly impact on a person's ability to function in daily life.
- You can use the mhGAP-IG to assess and manage people with depression.
- You can use effective communication skills to deliver psychosocial interventions to everyone with depression including:
  - Psychoeducation for the person and their carer/family.
  - Strategies to reduce stress and strengthen social support.
  - Promoting functioning in daily activities and community life.
- Many people with depression benefit from brief psychological interventions if available.
- Many people with depression benefit from being prescribed antidepressants that need to be continued for at least 9–12 months after the resolution of symptoms.
- Special populations to consider are children, adolescents and women who are pregnant or breastfeeding.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to depression	Recognize the common symptoms of depression  Promote respect and dignity for people with depression	50 minutes	<b>Activity 1: Person's story followed by group discussion</b> Use the person's story to introduce depression  <b>Presentation on depression</b> Use the person's story to illustrate the presentation on: <ul style="list-style-type: none"><li>• Symptoms of depression</li><li>• Contributing factors to depression</li><li>• How depression impacts on a person's life</li><li>• Why it is a public health priority</li></ul>
2. Assessment of depression	Know the assessment principles of depression  Use effective communication skills in interactions with people with depression  Perform an assessment for depression  Assess and manage physical health conditions in depression  Assess and manage emergency presentations of depression (see Module: Self-harm/suicide)	40 minutes  30 minutes	<b>Activity 2: Video demonstration: Assessment</b> Use videos/demonstration role play to show an assessment and allow participants to note: <ul style="list-style-type: none"><li>• Principles of assessment (all aspects covered)</li><li>• Effective communication skills (what and how this is done)</li></ul> <b>Activity 3: Role play: Assessment skills</b> Participants practise how to assess for depression Feedback and reflection
3. Management of depression	Know the management principles of depression  Provide psychosocial interventions for persons with depression and their carers  Deliver pharmacological interventions where appropriate, considering special populations  Refer to specialists and link with outside services where appropriate and available	50 minutes  30 minutes  30 minutes	<b>Activity 4: Management of depression – which interventions?</b> Poster presentations and discussions on delivering management interventions  <b>Activity 5: Video demonstration: Managing depression</b> Use video/demonstration role play to evaluate a management session discussing use of pharmacological and psychosocial interventions  <b>Presentation and quiz on pharmacological interventions</b>  <b>Activity 6: Role play: Psychosocial interventions</b> Feedback and reflection
4. Follow-up	Plan and perform follow-up for depression	30 minutes	<b>Activity 7: Video demonstration: Follow-up</b> Video with an improving patient at follow-up
5. Review		15 minutes	Multiple choice questions
<b>Total duration (without breaks) = 4 hours 30 minutes</b>			

## Step-by-step facilitator's guide

# Session 1. Introduction to depression

 50 minutes

### Session outline

- **Introduction to depression**
- **Assessment of depression**
- **Management of depression**
- **Follow-up**
- **Review**

Begin the session by briefly listing the topics that will be covered.

2

## Activity 1: Person's story followed by group discussion

### Activity 1: Person's story followed by group discussion

- Present the first person account of a person living with depression.
- First thoughts.

### How to use the **person story technique**.

Introduce the activity (DEP supporting material person stories 1/2/3) and ensure participants have access to pens and paper. Choose one story and tell it – be creative in how you tell the story to ensure the participants are engaged.

First thoughts – give participants time to give their immediate thoughts on what they have heard. Encourage them to reflect on what it may feel like to live with depression and how depression impacts on a person's life.

3

## Core symptoms of depression

- Persistent depressed mood.
- Markedly diminished interest in or pleasure from activities.

5

Facilitate a brief group discussion in plenary (maximum five minutes) about local terms and descriptions used to describe depression.

Gather a consensus about how people with depression are treated and perceived by the local community.

Make a note of the group's answers on a flip chart or black/white board.

Remind participants of the descriptions of symptoms they heard in the person story at the beginning of the session.

Highlight the two core symptoms of depression:

- Persistent depressed mood.
- Markedly diminished interest in, or pleasure from, activities.

Encourage participants to think of any presentations and then show the next slide.

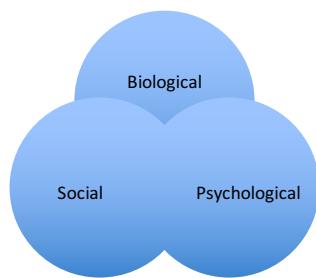
## Common presentations of depression

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Multiple persistent physical symptoms with no clear cause</li> <li>• Low energy</li> <li>• Fatigue</li> <li>• Sleep problems (sleeping too much or too little)</li> <li>• Anxiety</li> </ul> | <ul style="list-style-type: none"> <li>• Significant change in appetite or weight (weight gain or loss)</li> <li>• Beliefs of worthlessness</li> <li>• Excessive guilt</li> <li>• Indecisiveness</li> <li>• Restlessness/agitation</li> <li>• Hopelessness</li> <li>• Suicidal thoughts and acts</li> </ul> |
|---|---|

6

Encourage participants to think of any presentations that are not included in the list and/or expand on any of these presentations from personal/professional experiences of interacting with someone with depression.

## Contributing factors



Explain that depression results from a complex interaction of social, psychological and biological factors.

For example, explain that people who have gone through adverse life events (unemployment, bereavement, psychological trauma) are likely to develop depression. Their depression can, in turn, lead to the person experiencing more stress and dysfunction (such as social isolation, indecisiveness, fatigue, irritability, aches and pains), thus worsening the person's life situation and the depression itself. Biological factors may contribute to a person developing depression, such as a person with a family history of depression.

## Identifying depression

The length of time that a person experiences the symptoms is one of the distinctions between depression and general low mood.

How long do you think symptoms should be present?

### Identifying depression

Explain that differentiating between depression and low mood is an important skill. Low mood is normal and transient; many people can experience low mood from time to time. Depression lasts longer and has a profound impact on a person's ability to function in everyday life.

Therefore, when identifying depression, it is important to consider both:

- The duration of the symptoms.
- The effect on daily functioning.

Ask the participants to think back to the story they heard at the beginning of the session and any knowledge they have from their own experience of working with people with depression and consider how long the symptoms have been present. Explain that they can use their mhGAP-IG to find the answer.

Explain that to identify depression, symptoms must be present for at **least two weeks**.

## Identifying depression

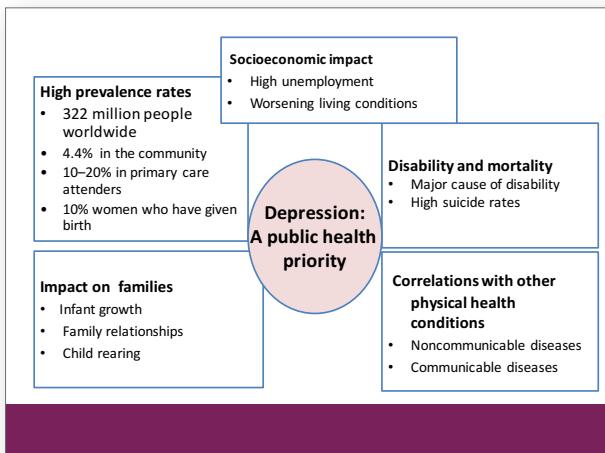
- Depression means that there is a considerable impairment in a person's ability to function in daily life.
- Some people may experience a persistent depressed mood but they are able to continue functioning in daily life. Therefore, their symptoms do not amount to depression and can be managed via the Module: Other significant mental health complaints in mhGAP-IG Version 2.0.

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### Identifying depression

Explain that depression has a significant impact on the person's ability to function in daily life. In many cases depression can reduce a person's ability to carry out daily tasks such as cooking, cleaning, washing etc. Those with depression may struggle with getting out of bed and/or engaging in any activities of daily living.

If a person is experiencing persistent low mood but continues to function in their everyday life then they have symptoms not amounting to depression, which is covered within the Module: Other significant mental health complaints in the mhGAP-IG.



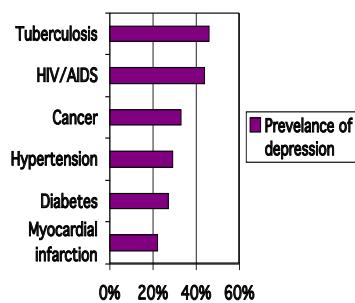
Explain to participants that depression is a public health priority. Explain the prevalence rates stated in the slide:

1. It is estimated that more than 322 million people worldwide suffer from depression, resulting in a prevalence rate of 4.4% in the general community and accounting for 10–20% of people who attend primary health-care clinics.

There is at least a 10% prevalence rate of depression amongst women who have given birth. This is called post-partum depression.

2. Emphasize that by 2030, depression is expected to be among the diseases with the highest burden everywhere in the world. The term "burden" reflects both mortality and disability. Mental disorders are extremely disabling, causing many people not to function well in their daily lives.
3. Explain that depression impacts on family life, including: child development (infant growth), family relationships and the way parents raise their children.
4. Explain the socioeconomic impacts. People with depression are often unable to work, leading to high levels of unemployment; families may lose the main household earner, therefore the family's living conditions may deteriorate. Also, as will be discussed in the next slide, depression is correlated with other physical health conditions. All this makes depression an important public health concern in all countries.

Average prevalence of depression in people with physical diseases (70 countries)



11

Explain that the relationship between depression and physical health is particularly important to focus on in non-specialized health settings.

Physical conditions can often manifest themselves first, and, if health-care providers only focus on the physical symptoms, the real cause of the problem may go undetected.

Describe the findings on the slide.

Highlighting the prevalence of:

- Co-occurring conditions such as diabetes, TB, HIV/AIDS, cancer, hypertension, myocardial infarction.

Explain that research has also shown that depression can:

- Predispose people to other conditions, e.g. myocardial infarctions.
- Depression can also reduce adherence to treatment for chronic diseases including HIV and TB.

Ask the group to share experiences in their clinics of times when they observed someone with depression and a co-morbid physical condition.



Direct participants to the master chart in the mhGAP-IG Version 2.0 (page 16).

Review the common presentations.

Ask participants to think about how easy or hard it would be to identify depression in their practice.

# Session 2.

# Assessment of depression

⌚ 1 hour 10 minutes

## Activity 2: Video demonstration: Assessment



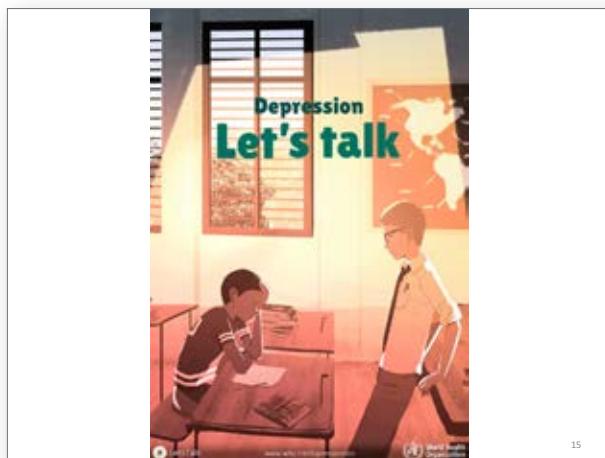
Instruct participants to turn to the assessment page in the mhGAP-IG Version 2.0 page 20.

Describe the principles of assessment for depression as on the slide.

### Activity 2: Video demonstration: Assessment

- Show the mhGAP-IG depression assessment video.

Explain to participants that you are going to show them a video of "Sarah" being assessed for depression (<https://www.youtube.com/watch?v=hgNAySulsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>). During the video, ask the participants to scan the depression assessment algorithm in the mhGAP-IG Version 2.0 (page 21) to follow the assessment and then discuss it.



After the video explain that:

- Depression may not always be obvious.
- The person often does not know about their condition.
- It is not always necessary to use the term depression to explain what they are experiencing; rather use their own words and their own descriptions to make it easier for them.
- Patience, trust and a good relationship with the person is essential to identifying depression. Use effective communication skills to understand what is happening to them (remind them of the skills taught in Module: Essential care and practice).
- Although depression is common, it can be hard to identify.

#### Process of assessment in the video



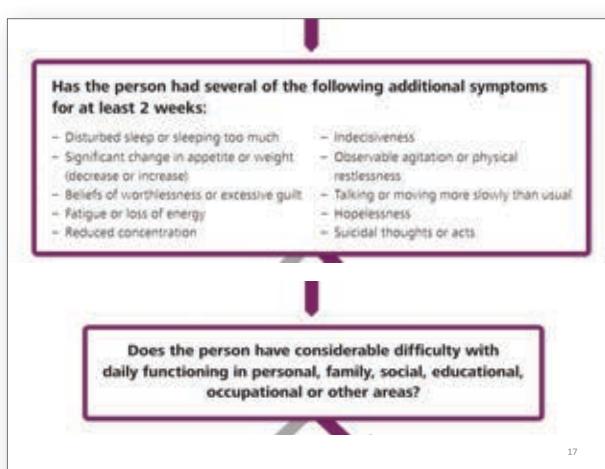
16

In plenary, use the mhGAP-IG algorithm to decide:

- Does Sarah have depression?
- Did Sarah have at least one of the core symptoms of depression in the past two weeks?

Seek group consensus.

Ask the group how the health-care provider found out how long the symptoms lasted?



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Ask the group if Sarah had any of the additional symptoms in the past two weeks?

Concepts such as “reduced concentration” can be difficult to express. During assessment, ask about activities that require good concentration, such as cooking a meal, reading, listening, watching TV, reciting prayers etc.

Did Sarah have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

### Sarah's case

- Sarah is 23 years old and has a baby at home.
- What else do we want to know:
  - Is she breastfeeding?
  - Is she pregnant?
  - Is the baby developing well?

If participants struggle to identify difficulties with daily functioning in the video, remind them that Sarah said, "The little one is only one. I hardly feed and clean her or play with her anymore! Not only that but I am not cooking or cleaning the house either."

Ask participants to suggest questions they could ask to find out this information.

Highlight to the group that in Sarah's case we learned that she had a baby at home.

Ask the following question before revealing the answers:

*With that knowledge, what other information do we want to know about Sarah?*

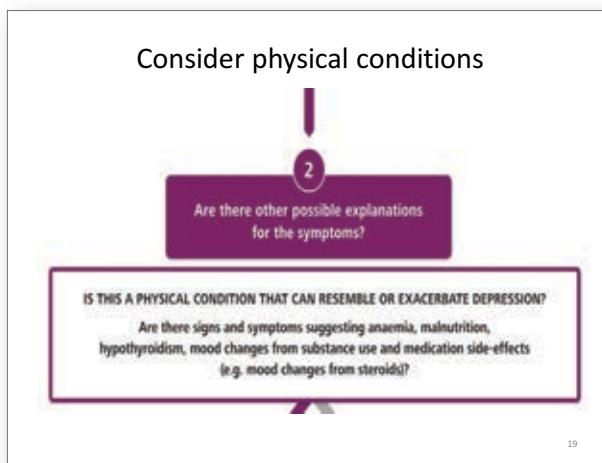
After receiving a few answers from the participants, reveal the answers on the slide and then explain that:

If the woman is breastfeeding or pregnant, it may change the decision regarding medications.

Explain that there are "special populations" (turn to page 26 of mhGAP-IG Version 2.0) for whom interventions may differ, such as women who are pregnant or breastfeeding.

Ask participants why they think that is?

Explain that children and adolescents are considered a special population and to understand the presentation and management of depression in children and adolescents you need to go to the Module: Child and adolescent mental and behavioural disorders in the mhGAP-IG Version 2.0.



Ask the group: How did the health-care provider rule out other possible explanations for the symptoms?

Remind participants that Sarah had her own understanding of what might be happening to her – that she had cancer.

Is this possible? How would you check for this?

Physical conditions that resemble depression	
Condition	Symptoms
• Anaemia	Tiredness, loss of energy, problems sleeping, physical aches and pains, problems concentrating.
• Malnutrition	Tiredness, loss of energy, loss of appetite, lack of interest in food and drinks, poor concentration, low mood, feeling weak.
• Hypothyroidism	Tiredness, muscle aches and feeling weak, changes in appetite (weight gain), low mood, problems with memory and concentration (slowed thinking), loss of libido, loss of energy.

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Emphasize again that there are challenges in identifying depression.

Explain that there are several other conditions that resemble depression. Therefore, it may take a number of meetings to establish if the person has depression.

Describe the symptoms of anaemia, malnutrition and hypothyroidism and how they resemble depression (as described in the slides).

Ask participants to reflect on ways they could mitigate the risk of missing depression.

Explain that a thorough psychosocial, medical and mental health assessment is essential. Regular follow-up will help to ensure that the correct identification is made.



Continue with the assessment algorithm in the mhGAP-IG.

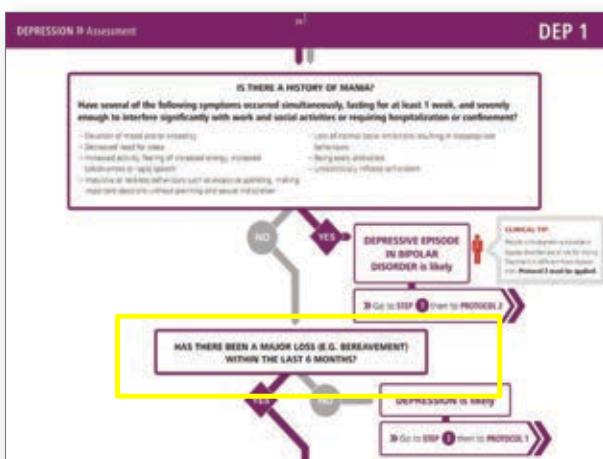
Explain that depression can be present as a part of bipolar disorder.

Explain that bipolar disorder is characterized by episodes in which a person's mood and activity level are significantly disturbed. The symptoms are reflected on the slide and in page 24 of the mhGAP-IG Version 2.0.

Ask if participants have taken care of someone with mania in the past. What are the symptoms?

Give an example of the common presentation of someone with mania – in the form of a person's story (see DEP supporting material person story 4). After the person's story, discuss the symptoms of mania that the person demonstrated.

Explain that depression and mania can follow one another together in the form of bipolar disorder. This will be discussed in more detail in the Module: Psychoses.



Explain that in addition to ruling out a history of mania, assess whether there has been a major loss (bereavement) in the past six months. A normal grief reaction could account for the symptoms the person is experiencing.

## Grief

- Low mood, anxiety, fear, guilt, self-blame, irritability, loneliness, crying.
- Negative thinking, rumination, low self-esteem, hopelessness, pessimism about the future.
- Social withdrawal, loss of interest, restlessness, agitation.
- Loss of appetite, problems sleeping, loss of appetite/appetite gain, physical aches and pains, tiredness, loss of energy.

23

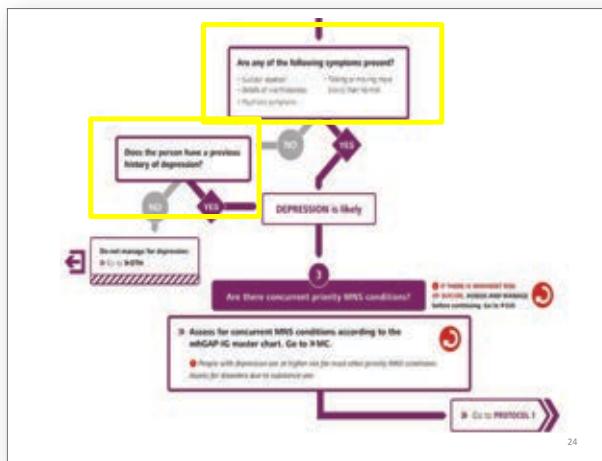
## Depression and grief

Explain that grief is a normal reaction to loss. Many people who experience grief report feeling similar symptoms to depression.

Describe the common experiences of grief as shown on the slide.

Explain that grief and people who are grieving are examples of why it is important to be open, non-judgemental and attentive to the other person's experience to fully understand the problem.

Responding to a significant loss with grief is normal and the person should be supported to grieve in culturally appropriate ways.



Emphasize that grief must be considered if:

- Symptoms last more than six months;
- Severe symptoms are present – as listed in the slide and mhGAP-IG Version 2.0 page 25; and
- There is previous history of depression.

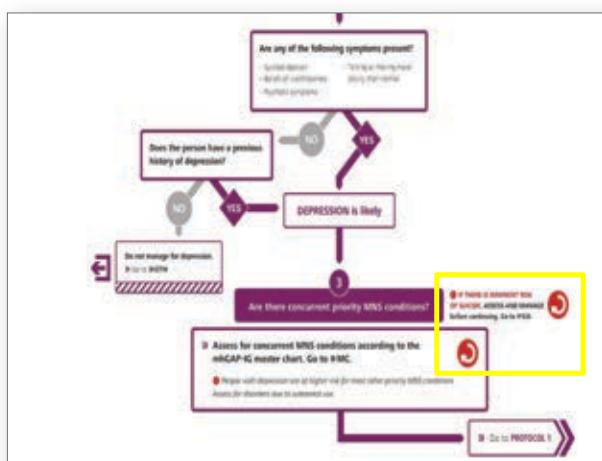
### Sarah's case

- Did the health-care provider assess if Sarah had a history of mania?
- What questions could they have used to explore whether she had experienced any of these symptoms?
- Did the health-care provider assess if Sarah had experienced a major loss in the past six months? If so what questions could have been asked?

25

Bring the group's focus back to the assessment of Sarah that they saw in the video and ask the questions on the slide.

Make a note of any appropriate questions suggested by participants, as they can use these during the role plays.



### Assessing for self-harm/suicide

Point out the instruction in the algorithm to ask and assess for an imminent risk of suicide and ask participants: How did the health-care provider address suicide?

Explain that depression can be associated with suicide.

The assessment and management of self-harm/suicide will be covered in detail later in the training.

## Assess for imminent risk of suicide

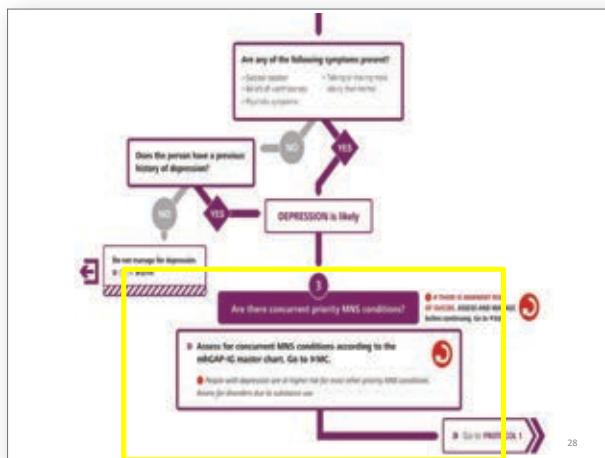
- Talking about self-harm/suicide is **ESSENTIAL**.
- Talking about self-harm/suicide **DOES NOT** increase the risk that the person will commit self-harm/suicide.
- If there is a risk of self-harm/suicide then **GO IMMEDIATELY TO MODULE: SELF-HARM/SUICIDE IN THE mhGAP-IG AND FOLLOW THE STEPS TO MANAGE SELF-HARM/SUICIDE.**

27

For now, it is important to know the three points in the slide.

Having emphasized these points, return to discussing Sarah's case and say:

In Sarah's case she has emotional distress, she is very tearful and feels hopeless. Should we ask about suicide?



28

Continue discussing the video assessment with Sarah and ask participants:

Did Sarah have any other co-occurring priority MNS conditions?

Explain that if participants suspect any other concurrent priority MNS conditions, they should use the master chart and identify which condition they suspect and use the mhGAP-IG to assess and manage that condition.



29

Recognize that during the discussion about Sarah, the group has already been made aware of special populations, such as women who are pregnant or breastfeeding, but take this chance to choose a volunteer to read through the mhGAP-IG Version 2.0 for working with special populations (page 26).

Answer any queries that the participants may have.

## Activity 3: Role play: Assessment skills

### Activity 3: Depression role play 1 Assessment

A person with fatigue, poor sleep and weight loss comes to see a health-care provider.

Practise using the mhGAP-IG to assess a person for possible depression.

See DEP supporting material role play 1.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

30

**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to assess for possible depression.

**Situation:**

- A person with fatigue, poor sleep and weight loss comes to see health-care provider.

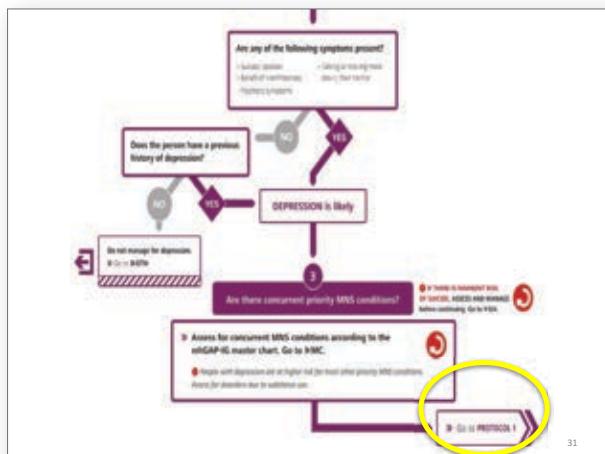
**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one to play the role of the person seeking help and one to play the role of the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 3.

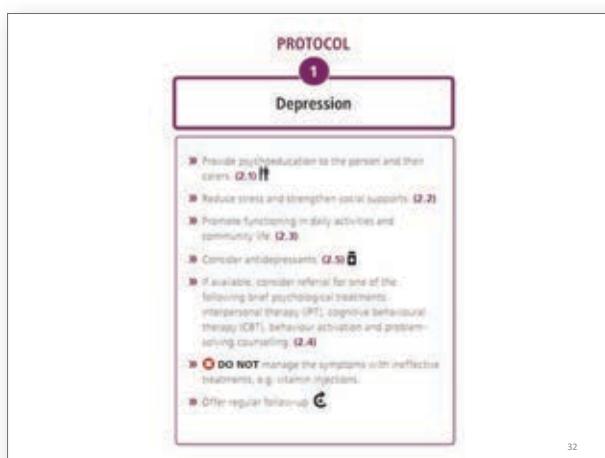
# Management of depression

⌚ 1 hour and 50 minutes

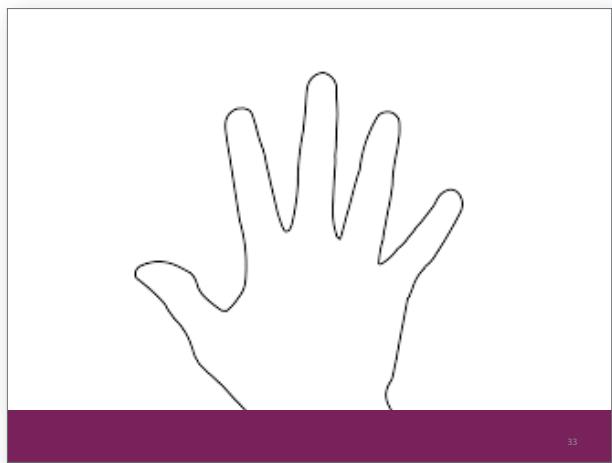


Direct participants back to the final stage of the assessment algorithm in the mhGAP-IG Version 2.0 (page 25).

Explain that if the assessment leads to the conclusion that the person has depression they should “Go to Protocol 1” in the mhGAP-IG Version 2.0 (page 26).



Briefly let the participants read through Protocol 1 and move on to the next slide.

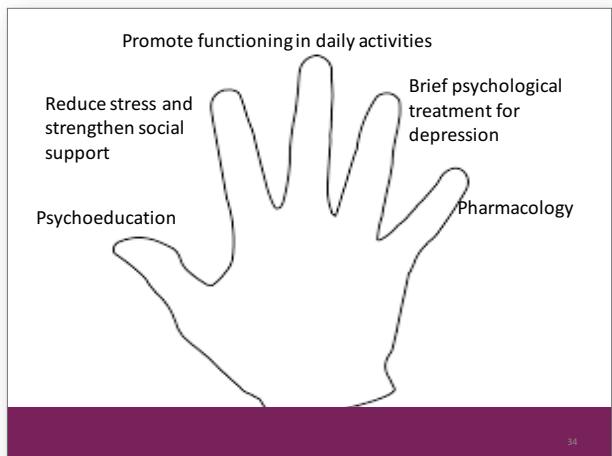


Remind participants how the management “hand” works (described when teaching the Module: Essential care and practice).

Explain that choosing the appropriate intervention is the first step to developing a treatment plan with the person.

Ask participants to name some of the interventions they could use for depression according to the Module: Essential care and practice.

Give the participants a few minutes to suggest some interventions before moving on.



Explain the management for a person with depression.

Explain that depending on the person you are caring for, you can use one or two of these interventions, or you can use all five.

The choice of intervention will depend on a collaborative discussion with the person.

### Treatment plans should include:

- **Presenting problem:** **What** are the person’s health and social needs?
- **Which** interventions best meet the person’s health and social needs?
- **Action plan:** Record the steps, goals and behaviours that need to happen, who will do them and when?
- **Manage** risks (plans for what people can do in a crisis).
- **Involve** the person and the carers to ensure ownership of the treatment plan.

35

Explain to participants that for the best results, it is essential to involve the person in developing the treatment plan (remind participants of the discussion on treatment planning from the Module: Essential care and practice).

Talk through each point on the slide using the following notes.

A treatment plan sets out:

- The presenting problem, including the person’s health and social needs. For example, does the person have a physical condition in addition, which needs medical attention; does the person need help in accessing social supports, etc.
- Which interventions will be used for which needs and why.

- Actions – record what actions and behaviours need to happen and who will do them.
- Plans for managing risk – plan for what people can do in a crisis and a plan which can be used and understood by the individual and their families, carers and other agencies, as well as colleagues, in a crisis.
- Involve the person so it is something which people feel they own and can engage with. If the person with depression and their carer understands what you are trying to do, they are more likely to do it. So, involve them.

A treatment plan must be based on a thorough assessment of need. This is true for both psychosocial and pharmacological interventions.

# Activity 4: Management of depression – which interventions?

## Activity 4: Management of depression – which interventions?

- This is an opportunity to familiarize yourself with the psychosocial interventions for depression.
- In your groups identify the:
  - Key elements of a particular psychosocial intervention.
  - Barriers and risks of using that interventions.
  - Identify solutions to those barriers and risks.

Present the information in the form of a poster. Be as creative as you wish.

**Duration:** 50 minutes.

**Purpose:** This activity aims to familiarize participants with different management interventions (as described in the mhGAP-IG). In three groups the participants will:

- Present the basics elements of the management interventions.
- Identify possible barriers and/or risks of using these interventions.
- Identify solutions to these barriers.

### Setting up the activity:

- Set up the room with three distinct areas with a table in the middle of each area.
- In each area put pieces of flip chart paper, pens and sticky notes on the table.
- Label the distinct areas according to three management interventions:
  - Psychoeducation.
  - Reducing stress and strengthening social supports.
  - Promoting functioning in daily activities and community life.
- Split the group into three smaller groups.
- Assign different groups to different areas.
- Ask each group to:
  - Identify the basic elements of the particular intervention.
  - Identify any barriers and/or risks to providing that intervention.
  - Identify solutions to those barriers and risks.

Ask the participants to present the basics, barriers and solutions in a poster format. They can be as creative as they want, as long as they remember that their posters will be used to teach the rest of the group about that particular intervention.

Once the posters have been completed, put them on the wall and have the groups come back together as a whole and talk through each poster – teaching the rest of the group about that intervention and evaluating the messages.

### Instructions:

In your groups you have 15 minutes to think of:

- The basic elements of the particular management interventions.
- Any barriers and/or risks to using that intervention.
- Solutions to those barriers and/or risks:
  - Psychoeducation: Provide information about depression to the person and/or carer.
  - Reduce stress and strengthen social supports: Offer strategies to address current psychosocial stressors to a person and/or carer. This can include linking people with different social organizations and activities that may offer activities that engage a person.

- Promote functioning in daily activities: Offer strategies to help a person resume daily activities and chores. This can include linking the person with different organizations including education, social and legal organizations.

Ensure the posters include some of the following messages when they are discussing the basic elements.

#### **Psychoeducation:**

- What depression is, and its expected course and outcome.
- Depression is very common and it does not mean that the person is lazy or weak.
- Other people may not understand depression because they cannot see it and they may say negative things to you (insert any local stereotypes) but depression is not your fault.
- People with depression often have negative thoughts about their life and their future, but these are likely to improve once the depression is treated and starts to improve.
- What carers and families can do to support the person.
- Range of available treatments and their expected risks and benefits.
- Potential side-effects of any medication and how the person and/or family/carer can monitor it.
- Any potential referrals to other organizations that may support them, why this would be done and how it might help.
- Importance of the person being involved in the treatment, i.e. what the person can do to reinforce feeling better.

#### **Reducing stress and strengthening social supports:**

- Using psychoeducation to explain that when people are depressed they often stop doing the things that make them feel good. This can make the depression worse.
- Activities that used to be fun can help people recover from depression.
- Problem-solving to reduce stress with examples of how they would do that.
- Relaxation activities.
- Activities such as seeking further support from friends/family members that they are close to. Use activities that they know help them. Use reading, religion, inspiring phrases that give them strength.
- Linking people to different organizations to encourage engagement.

#### **Promoting functioning in daily activities:**

- Use psychoeducation to explain that when people are depressed they often have problems engaging in daily activities.
- Discuss activities and tasks that the person could do to give them a routine and structure to their day.
- Explain that although it may be difficult to get back to the activities the patient enjoys, it is important to slowly start to engage in them again. Discuss with the person and their carer activities that they used to enjoy and how to re-engage with them.
- Try spending time with trusted friends and family members.
- Try to participate in community and other social activities.
- Sleep hygiene messages to promote good sleep.
- Discuss diet and the importance of eating regularly despite change in appetite.
- Discuss the benefits of regular exercise.
- Linking the person to different organizations for educational, social, legal, educational or livelihood support.

## When to refer

Consider a referral to a mental health specialist (where available):

- If a person with depression shows any signs of psychotic symptoms (e.g. hallucinations and delusions).
- If the person presents with bipolar disorder.
- If the person is pregnant or a breastfeeding woman.
- In the cases of people with self-harm/suicide.

Consider a referral to a hospital:

- If a person is non-responsive to treatment.
- If a person shows serious side-effects of any pharmacological interventions.
- If a person needs further treatment for any comorbid physical condition.
- There is a risk of self-harm/suicide.

Before showing this slide, ask participants: When should they consider a referral to a mental health specialist? Wait to hear a few answers from participants and then discuss the points described in the slide.

Then ask participants: When would they consider referring someone with depression to a hospital? Wait for a few answers then discuss the points of the slide.

It is also useful to ask participants to identify relevant specialists and hospitals in their area.

## Link with other sectors

- Linking people with other sectors ensures:
  - That the person receives a comprehensive package of care.
  - It fulfils parts of the psychosocial interventions, e.g. in order to *promote functioning in daily activities and community life*. If the person has identified that they would like to return to their studies and/or start a livelihood activity, it is important to link them to livelihood organizations.

Explain that delivering psychosocial interventions requires linking people with other organizations, especially if the person indicated an interest in engaging with any educational, social, legal, educational or livelihood support.

Ask the participants to brainstorm and come up with organizations in their local setting that they could refer to. Give them five minutes to do this.

## Brief psychological treatments

- As first-line therapy, health-care providers may select psychological treatments and/or antidepressant medication.
- When deciding, they should keep in mind the:
  - Possible adverse effects of antidepressant medication.
  - The ability to deliver either intervention (in terms of expertise, and/or treatment availability).
  - Individual preferences of the person.

Explain that mhGAP-IG recommends **brief psychological treatments** as frontline treatments for depression.

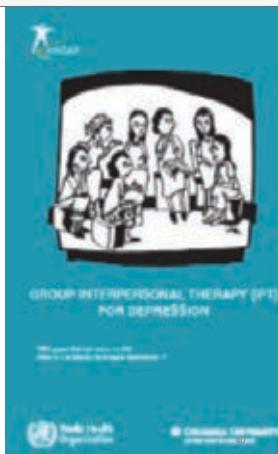
These interventions need to be delivered by trained individuals and the person should be supervised.

Explain that next we will have a look at brief psychological treatments recommended by WHO.

Explain that such brief interventions are not available in many settings yet. Ask the participants what psychological treatments are available in their setting. Then provide a description of WHO brief psychological treatments – from the next few slides.

## Group interpersonal therapy (IPT)

- Assumes that depression is triggered by interpersonal difficulties in one or more problem area:
  - grief
  - interpersonal disputes
  - role transitions
  - Interpersonal deficits.
- By understanding the relationship between interpersonal events and stress, and by helping the person improve their skills to handle these events, we can help the person recover.



Using the points on the slide explain what **group interpersonal therapy** is.

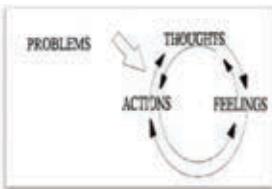
## Multi-component behavioural treatment (PM+)

- Problem-solving counselling
- Managing stress (slow breathing)
- Behavioural activation
- Strengthening social supports



Explain that **problem management plus (PM+)** includes a variety of strategies, such as the principles of **behavioural activation** to have people schedule activities that they may have been avoiding in order to improve their mental well-being.

## Thinking healthy – cognitive behavioural therapy for perinatal depression



Explain that “**thinking healthy**” uses the principles of **cognitive behavioural therapy (CBT)** – identifying the relationship between thoughts, behaviour and feelings) to treat women with perinatal depression.

# Activity 5: Video demonstration: Managing depression

## Activity 5: Video demonstration: Managing depression

You will now see a video which shows the health-care provider managing Sarah's depression. Whilst watching the video think about:

- How did the health-care provider explain the treatment options available?
- Did the health-care provider explain the risks and benefits of different treatment interventions?

Show part 2 of the mhGAP-IG video "managing depression" (<https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2>). While watching, ask participants to think about the questions on the slide.

43

## Presentation on pharmacology

Direct participants to mhGAP-IG Version 2.0 page 28 point 2.5 (Consider antidepressants).

Have a participant read aloud the points described.

Highlight the importance of discussing whether to start antidepressants or not, together with the person.

The person should be involved in the decision-making process and understand the risks and benefits of taking medication.

Explain how important it is that people understand how to take medication properly and safely.

They should know what to expect when taking medication, e.g. any side-effects, when to expect to see an improvement, etc.

## Pharmacological interventions: When NOT to prescribe

- **Do not** prescribe an antidepressant if there is no depression. For example:
    - When the symptoms do not last two weeks and/or do not involve impaired functioning).
    - If the symptoms are part of a normal grief reaction.
    - If the symptoms are due to a physical cause.
  - **Do not** prescribe an antidepressant if the person is pregnant/breastfeeding. As first-line treatment, offer psychosocial intervention first.
  - **Do not** prescribe if the child is younger than 12.
  - **Do not** prescribe to adolescents aged 12–18 as first-line treatment. Offer psychosocial interventions first.

45

Discuss the points on the slide individually, ensuring that people understand when NOT to prescribe antidepressants.

Explain that antidepressants can have adverse side-effects. Refer to Table 1 on page 29.

Antidepressants require that the person stays on them for a long time, as advised by the health-care provider, and this does not suit everyone.

Direct participants to page 29 of mhGAP-IG Version 2.0 (Table 1: Antidepressants). Look through the lists of WHO essential medications.

Ask participants to read the table carefully and ask any questions. Give this 10 minutes if needed.

Gain an understanding from participants on how often they have used these medications and if there is a regular supply in their primary health care facility.

Make a note of their answers as this is useful information to follow-up with in supervision.

## Precautions for tricyclic antidepressants (TCAs)

Avoid use in:

- The elderly, people with cardiovascular disease and people with dementia.
  - People with ideas, plans or previous acts of self-harm or suicide – to minimize the risk of overdosing.

Use the points on the slide to explain when to avoid using tricyclic antidepressants (TCAs).

- The elderly, people with cardiovascular disease and people with dementia.
  - People at risk of self-harm. Explain that the participants should ask the family to monitor the doses of TCAs in people with a risk of self-harm/suicide, as people may hide the tablets and take them all at once as a way of overdosing.

## Choosing an appropriate antidepressant

### Quiz time

48

Direct participants to pages 28 and 29 in the mhGAP-IG and answer these questions:

## Q&A

### Which antidepressant would you recommend for adolescents 12 years and older?

Consider **fluoxetine** (but no other selective serotonin reuptake inhibitors [SSRIs] or TCAs) only when symptoms persist or worsen despite psychosocial interventions.

49

Ask the participants the question written on the slide.

Give them one minute to find the answers in the mhGAP-IG.

Then reveal the answer.

## Q&A

### Which antidepressant would you recommend for children under the age of 12?

**NO** antidepressants. Use only psychosocial techniques.

50

Ask the participants the question written on the slide.

Give them one minute to find the answers in the mhGAP-IG.

Then reveal the answer.

**Q&A****Which antidepressant would you recommend for pregnant or breastfeeding women?**

Avoid antidepressants if possible. Consider antidepressants at the lowest effective dose if there is no response to the psychosocial interventions. If the woman is breastfeeding, avoid fluoxetine. Consult a specialist, if available.

51

Ask the participants the question written on the slide.

Give them one minute to find the answers in the mhGAP-IG.

Then reveal the answer.

**Q&A****In what groups should you avoid and/or not prescribe amitriptyline?**

Avoid in elderly people.

Do not prescribe it to people with cardiovascular disease.

Like all antidepressants, it should not be prescribed to children, and be avoided in pregnant women.

Avoid in people with thoughts or plans of suicide (SSRIs are the first choice).

52

Ask the participants the question written on the slide.

Give them one minute to find the answers in the mhGAP-IG.

Then reveal the answer.

**Q&A****How should you prescribe fluoxetine to someone who has an imminent risk of suicide?**

If there is an imminent risk of self-harm or suicide, give only a limited supply of antidepressants (e.g. one week's supply at a time).

Ask carers to monitor medicines and to follow-up frequently to prevent medication overdose.

53

Ask the participants the question written on the slide.

Give them one minute to find the answers in the mhGAP-IG.

Then reveal the answer.

## Activity 6: Depression role play 2: Psychosocial interventions

### Activity 6: Depression role play 2: Psychosocial interventions

A 27-year-old was identified as having depression one week ago. One year ago he was employed in a busy bank in line for a promotion and engaged to be married.

Then his fiancée left him, unexpectedly, for another person. He felt that the stress of work and started to feel very anxious and worried all the time. He stopped being able to sleep or eat well. He felt more and more sad and depressed. His personality started to change; he was irritable, forgetful, socially isolated and unable to spend time with family and friends as he felt ashamed and guilty. He had no work and no income and blamed himself for everything that had happened in his life.

- Use the mhGAP-IG to develop a treatment plan using psychosocial interventions.

See DEP supporting material role play 2.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency checklist (ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** This role play will give participants an opportunity to practise delivering psychosocial management interventions to a person suffering with depression.

**Situation:**

- A 27-year-old was identified as having depression one week ago.
- One year ago he was employed in a busy bank and really enjoyed the job.
- He was in line for a promotion.
- He was in a relationship, engaged to be married and was really excited about the future.
- Then his fiancée left them, unexpectedly, for another person.
- He felt that the stress of work and the impending promotion was too much, and he started to feel very anxious and worried all the time.
- He stopped being able to sleep or eat well.
- As his mood deteriorated and he felt more and more sad and depressed, his personality started to change. He was irritable, forgetful and within weeks he had damaged his reputation at work to the point that he was fired.
- That was one year ago.
- Since then he has been very depressed. He is socially isolated, feeling unable to spend time with friends and family as he is embarrassed and ashamed about how his life has changed.
- He has no work and has money problems.
- He blames himself for everything that has happened in his life.

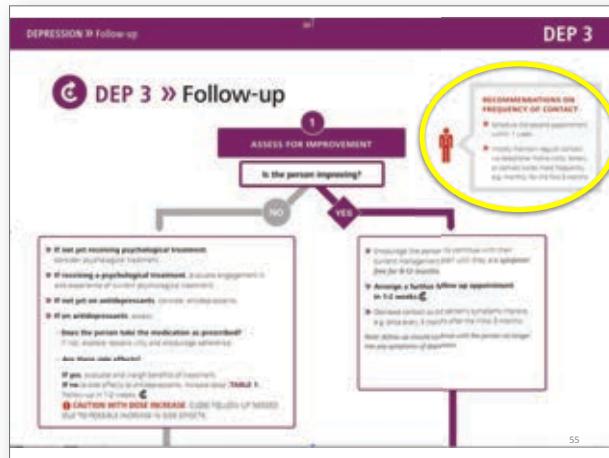
**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one to play the role of the person seeking help and one to play the role of the observer.
- Distribute the role play instructions and competency assessment form to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 4. Follow-up

 30 minutes

## Activity 7: Video demonstration: Follow-up



Ensure participants have their mhGAP-IG Version 2.0 open on page 30.

Emphasize that a crucial part of managing depression is ensuring that the participants are able to monitor and follow-up with the person with depression.

Highlight the clinical tip and explain the recommended frequency of contact.

Explain that at every follow-up session they must assess for any improvement or deterioration in the person's condition.

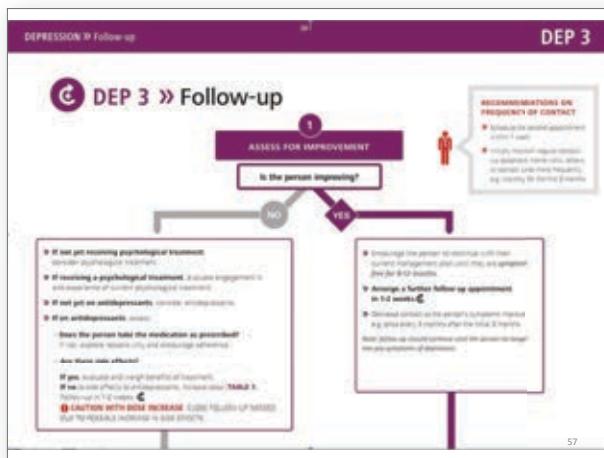
### Possible presentations at follow-up

At follow up you may see people:

1. Improving (actively engaging with management interventions and their symptoms are improving).
2. Remaining the same (actively engaged in management interventions but their symptoms are remaining the same) or deteriorating (the symptoms are deteriorating and the person is feeling worse).

Explain that at each follow-up session they may see the person either improving or remaining the same/deteriorating.

Whichever is the case, it is essential to keep communicating with the person and be flexible, adapting the intervention options as much as possible.



Direct participants to mhGAP-IG Version 2.0 (page 30) and ask them to follow the algorithm as they watch the video.

<https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3>.

### Activity 7: Video demonstration: Follow-up

Show the final video of Sarah returning for a follow-up appointment with the health-care provider.

1. Which of Sarah's symptoms had improved at follow-up?
2. What new information did the health-care provider learn?
3. Why was that information important?

Show the final part of the mhGAP-IG depression video which involves Sarah returning for a follow-up appointment.

Ask the participants the questions on the slide.

### Monitoring people on antidepressants

It is expected that people will have a positive response, but there are some results that will require action – if the person shows:

- symptoms of mania
- inadequate response
- no response.

Explain that if prescribing antidepressants, the participants should use the principles of psychoeducation to ensure that the individual and the carer understand the risks, benefits, how to take the medication, and what signs to look out for and monitor. Talk through the points on the slide.

## What do you do when symptoms worsen or do not improve after four to six weeks (inadequate response)?

Take three important steps before increasing the dose:

1. Ensure that the assessment is correct.
2. Ensure that the person is taking the medication as prescribed.
3. Ensure that the dose is adequate.

If there is no improvement after four to six weeks at maximum dose, consult a specialist.

60

Explain that it usually takes approximately four to six weeks to feel the benefits of the medication.

If, however, a person does not experience any improvement in symptoms four to six weeks after starting antidepressants, you should consider:

- If the original assessment of depression was correct.
- If the person is taking the medication as prescribed.
- Ensure that the dose is adequate.

## When and how to stop an antidepressant

If after 9–12 months of therapy the person reports no or minimal symptoms:

- Discuss the plan with the person before reducing the dose.
- Describe early symptoms of relapse.
- Plan routine and emergency follow-up.
- Reduce dose gradually over at least four weeks.

61

Explain that, just as in the case of Sarah, quite often people want to stop taking antidepressant medication as soon as they start to feel better – state that it is recommended that people continue to take antidepressants for up to 9–12 months after resolution of symptoms.

Some people want to stop because they suffer from side-effects.

It is important to ensure that proper psychoeducation has been given to the person about antidepressant medication before they start so that they understand the risks and benefits.

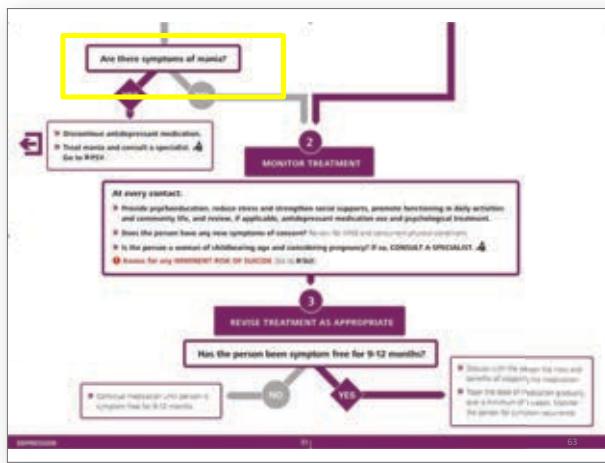
If the person chooses to stop taking medication after 9–12 months (a period of time that you would expect the medication to have been effective) then you must follow the steps explained on the slide.

## Antidepressants: Summary

- Time for response to antidepressants four to six weeks.
- Treatment should continue for 9–12 months.
- Taper slowly if ceasing medication.
- Do not prescribe antidepressants to:
  - A functioning person.
  - Someone recently bereaved.
  - Children (under 12) and pregnant/breastfeeding women.
- Avoid TCAs if:
  - The person is elderly, has dementia or has cardiovascular disease.

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Briefly talk through the summary on the slide.



Ask participants what type of management plan was developed at the end of Sarah's visit?

Emphasize the importance of assessing any changes in mental state and monitoring if any signs of mania are present.

Participants may explain to you that follow-up is not possible in their clinical setting because they have too many people to see and they are too busy.

Be empathetic and explain that you understand and explain again why follow-up is so important when treating depression. Remind participants of discussions they had during the Module: Essential care and practice, about identifying barriers and solutions to providing follow-up. Remind participants that an important part of managing depression is linking people to different organizations that can help them. This is also a crucial area to explore in follow-up. Ask participants to start to plan how they can make follow-up more likely in their clinics. What would need to happen? How could they start to make this happen?

# Session 5. Review

DEP

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** Review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the depression MCQs (see supporting material DEP MCQs) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# DEP PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/dep\\_slides.pdf](http://www.who.int/mental_health/mhgap/dep_slides.pdf)

DEP

## DEP supporting material

- Person stories
- Role plays – role plays 3 and 4 are extra material for supplementary activities
- Multiple choice questions
- Video links

Activity 2: mhGAP DEP module – assessment

<https://www.youtube.com/watch?v=hgNAySulsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Activity 5: mhGAP DEP module – management

<https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2>

Activity 7: mhGAP DEP module– follow-up

<https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3>



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/dep\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/dep_supporting_material.pdf)

PSY

# Psychoses

mhGAP training of health-care providers  
Training manual



World Health  
Organization

# Module: Psychoses

## Overview

### Learning objectives

- Promote respect and dignity for people with psychoses.
- Name common presentations of psychoses.
- Name assessment principles of psychoses.
- Name management principles of psychoses.
- Perform an assessment for psychoses.
- Use effective communication skills when interacting with a person psychoses.
- Assess and manage physical health concerns in psychoses.
- Assess and manage emergency presentations of psychoses.
- Provide psychosocial interventions to persons with psychoses and their carers.
- Deliver pharmacological interventions as needed and appropriate in psychoses considering special populations.
- Plan and performs follow-up sessions for people with psychoses.
- Refer to specialist and links with outside agencies for psychoses as appropriate and available.

### Key messages

- Psychoses includes psychosis and bipolar disorder.
- Common presentations of psychosis include:
  - Marked behavioural changes, neglecting usual responsibilities.
  - Agitation, aggression or decreased activity.
  - Delusions – a fixed false beliefs.
  - Hallucinations – hearing voices or seeing things that are not there.
- Bipolar disorder is often characterized by significant disturbance in mood and activity levels with manic episodes (in which the person's mood is elevated and their activity levels increase) and depressive episodes (in which the person's mood is lowered (depressive) and their energy levels decrease).
- Psychoses can be managed in non-specialized health settings.
- When assessing for psychoses make sure you assess for and rule out other medical conditions (i.e. delirium).
- Provide both psychosocial and pharmacological interventions as first-line treatments for people with psychoses.
- Most people with psychoses can make a full recovery.
- Seek specialist support when needed.
- The best way to reduce the stigma and discrimination against people with psychoses is to treat them with respect and dignity and integrate them into the community.

Session	Learning objectives	Duration	Training activities
1. Introduction to psychoses	<p>Name common presentations of psychoses</p> <p>Promote respect and dignity for people with psychoses</p> <p>Understand that psychoses can be treated in non-specialized health settings</p>	30 minutes	<p><b>Activity 1: Person's story followed by group discussion</b></p> <ul style="list-style-type: none"> <li>• Use the person's story to introduce psychoses</li> <li>• Encourage participants to reflect on local understandings of psychoses</li> </ul>
		20 minutes	<p><b>Presentation to supplement the story</b></p> <p>Use the story as a basis for discussions on:</p> <ul style="list-style-type: none"> <li>• Common presentations of psychosis and bipolar disorder</li> <li>• How psychoses impact on a person's life</li> <li>• Human rights and psychoses</li> <li>• Why it is a public health priority and how can it be managed in non-specialized health settings</li> </ul>
2. Assessment of psychoses	<p>Perform an assessment for psychoses</p> <p>Use effective communication skills when interacting with people with psychoses</p> <p>Assess and manage emergency presentations of psychoses</p> <p>Assess and manage physical health in psychoses</p>	40 minutes	<p><b>Activity 3: Video demonstration: Assessment</b></p> <p>Use video/demonstration role play to show an assessment and allow participants to note the principles of assessment (all aspects covered)</p> <p><b>Activity 4: Role play: Assessment</b></p> <p>Feedback and reflection</p>
3. Management of psychoses	<p>Provide psychosocial interventions to persons with psychoses and their carer</p> <p>Deliver pharmacological interventions as needed and appropriate in psychoses considering, special populations</p> <p>Refer to specialists and links with outside agencies as appropriate and available</p>	30 minutes	<p><b>Activity 5: Video demonstration: Management</b></p> <p>Use video/demonstration role play to evaluate a management session discussing use of pharmacological interventions and psychosocial interventions</p>
		20 minutes	<p><b>Activity 6: Delivering psychoeducation</b></p> <p>Enable participants to practise delivering key psychoeducation messages</p>
		25 minutes	<p><b>Activity 7: Promoting functioning in daily activities</b></p> <p>Give participants practical experience in understanding how important daily routines and functioning are to recovery</p>
		35 minutes	<p><b>Discussion on psychosocial and pharmacological Interventions</b></p> <ul style="list-style-type: none"> <li>• Use the mhGAP-IG to introduce participants to psychosocial and pharmacological interventions and how to deliver them</li> <li>• Use case scenarios as examples</li> </ul>

Session	Learning objectives	⌚ Duration	Training activities
4. Follow-up	Plan and perform follow-up sessions for people with psychoses	5 minutes	<b>Discussion on the principles of follow-up</b> Use the mhGAP-IG to discuss follow-up for people with psychoses
		30 minutes	<b>Activity 8: Role play: Follow-up</b>
5. Review		15 minutes	Quiz

**Total duration (without breaks) = 4 hours 40 minutes**

## Step-by-step facilitator's guide

# Session 1. Introduction to psychoses

 50 minutes

### Session outline

- Introduction to psychoses.
- Assessment of psychoses.
- Management of psychoses.
- Follow-up.
- Review.

Begin the session by briefly listing the topics that will be covered.

### Activity 1: Person's story followed by group discussion

#### Activity 1: Person's story

- Present the person's story of what it feels like to live with psychoses.
- First thoughts.

#### How to use the person's story

- Introduce the activity and ensure participants have access to pens and paper.
- Tell the story – be creative in how you tell the account to ensure the participants are engaged.
- First thoughts – give participants time to give their immediate reflections on the story. Give participants time to reflect on how living with psychoses can impact on a person's life.

## What do local people believe?

- What are the local names for people with psychoses?
- How are individuals with psychoses treated in the local community? How are their family treated?
- Where can the individual and their family seek help?

### Presentation on psychoses

Ask the participants these questions and give them time to discuss (5–10 minutes).

Emphasize that:

- Local names and terms may imply the person with psychoses is mad, possessed, stupid, cursed, dangerous etc.
- Explain why you want to avoid using those terms (emphasize how damaging those names can be for people who live with them).
- Discuss with the participants the impact that negative names can have on the individual and their family.
- With the participants seek a sensitive and non-judgemental term that can be applied when talking about psychoses.

**Note:** In some countries there may not be an equivalent term for psychoses and participants will only know the term schizophrenia. In this case, you will need to communicate that psychoses is a syndrome that occurs in people with schizophrenia but also in other mental disorders.

## Symptoms

### PSYCHOSES

The psychoses module covers management of less severe mental health conditions, psychoses and bipolar disorder. People with psychoses or bipolar disorder are at high risk of exposure to stigma, discrimination and violation of their right to live with dignity.

Psychosis is characterized by distorted thoughts and perceptions, as well as distorted emotions and behaviours. Incoherent or irrelevant speech may also be present. Symptoms such as hallucinations – hearing voices, seeing things that are not there, delusions – fixed beliefs, thoughts, feelings, sensations, or perceptions of behaviour, disorganized behaviour, agitation, inattention, inactivity, or hyperactivity; disturbances of emotion – masked apathy, or disconnect between reported emotion and observed affect, such as facial expression and body language, may often be detected.

Bipolar disorder is characterized by periods in which the person's mood and activity levels are significantly disturbed. This disturbance consists of some occasions of an elevation of mood and increased energy and activity (mania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is complete between episodes. People who experience only minor episodes are also classified as having bipolar disorder.

Direct participants to page 33 mhGAP-IG Version 2.0 and read through the common symptoms of someone with psychosis and bipolar disorder.

Refer back to the story used at the beginning of the session to compare the common presentations with the descriptions in the story.

Ask participants to give examples of any other presentations that they have seen in people with psychosis and people with bipolar disorder in their non-specialized health setting.

## Symptoms of psychosis

### Disturbed perceptions:

- Hallucinations
- Altered perception, i.e. hearing voices, seeing or feeling things that are not there.

### Disturbed thinking:

- Delusions:
- False belief that the person is sure is true, i.e. person believes family are poisoning her. Or person believes he is royalty. Or person may believe his family are aliens in disguise.

### Disturbed behaviours and emotions:

- Disturbances of behaviour: social withdrawal, agitation, disorganized behaviour, inactivity or hyperactivity, self-neglect, loss of interest and motivation.
- Disturbances of emotions: marked apathy, poor speech, one word answers, slowed speech, thoughts may be disorganized and hard to follow, disconnect between reported emotion and facial expressions or body language.

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## Symptoms of psychosis

Now take a look at the symptoms of psychosis in more detail. Explain that psychosis is characterized by **disturbed perceptions** (give examples of hallucinations) and **disturbed thinking** (give examples of delusions).

### Disturbed behaviour and emotions:

Explain that people with psychosis may show very little emotion on their faces or in the body language and instead appear to be detached and disconnected from their surroundings.

Quite often they do not interact with family and friends and become socially withdrawn preferring to spend time alone.

Their speech may be slow, and their interactions short. Their thoughts and ideas about what is happening to them as well as their behaviour may be disorganized, erratic and confusing to follow.

## Symptoms of bipolar disorder

### Disturbed mood:

- Person has episodes where they are manic and other episodes where they are depressed
- Characteristically recovery between the episodes is complete.

### Manic episode:

- Increased activity levels, elevation of mood (potentially very happy and very agitated). They may talk very rapidly, have lots of different ideas and increased levels of self-worth and self-importance. They may have hallucinations and delusions, i.e. hear voices and/or believe that they are powerful, that their ideas can change the world. Engage in risk taking behaviours (gambling, spending money, promiscuity etc.).

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## Symptoms of bipolar disorder

Describe the symptoms on the slide and explain that people with bipolar disorder may experience hallucinations and delusions during a manic episode. But they can also have features of depressive episodes.

Although bipolar disorder is normally characterized by the changes in mood (mania to depression), people who experience only manic episodes are also classified as having bipolar disorder.

## Natural history of psychosis

- First onset typically between age 15 and 29 years.
- There are three possible clinical courses:
  - The person recovers completely or partially with some symptoms.
  - The person recovers but has a future episode (relapse).
  - Symptoms continue for a longer period.

Explain that the first symptoms of psychosis usually start between the ages of 15–29 years old. Sometimes this first experience can be called a **psychotic episode**.

How long the episode lasts depends on the causes of the psychosis but they can last for a few weeks, months or even years.

## Natural history of bipolar disorder

- First onset typically between the ages of 15–29 years.
- The pattern of mood swings can vary widely between people:
  - Some will have a couple of bipolar episodes in their life time and stay stable in between.
  - Others will have many episodes.
  - Some will only experience manic episodes.
  - Some will experience more depressed episodes than manic episodes.

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Explain that after the first episode the person can either recover completely or partially (and never have another episode) or recover but have future episodes. Alternatively, symptoms continue for a longer period.

Explain that usually people will experience their first symptoms of bipolar disorder between the ages of 15–29 years old.

The changes in mood and symptoms of associated with those changes in mood can vary widely between people.

Explain that sometimes people have a couple of bipolar episodes in their lifetime while others have many episodes.

Some people will have just one manic episode in their life and others will experience one manic episode but many more depressed episodes.

## Impact of psychoses

### **Impact on the individual:**

- Break up of relationships
- Negative and at times scary experience of symptoms.
- Loss of employment, studies, opportunities.
- Financial consequences.
- Stigma and rejection by community.

### **Impact on the family:**

- Medical costs.
- Time and energy looking after the person (carer burden).
- Emotional distress.

Ask the participants how they think psychoses impacts on a person's life?

Allow a brief discussion before revealing the slide.

Psychoses impacts dramatically on all areas of a person's life.

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## Impact of psychoses

### Impact on society:

- Loss of workforce.
- Costly medical interventions and (unnecessarily) lengthy hospitalizations.

### Human rights violations:

- People with psychoses maybe chained and confined.
- They may be beaten as punishment or treatment.
- They may receive treatments that are ineffective and dangerous due to misunderstanding the causes of psychoses.

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Explain the points in the slide. Add that although people with psychoses can work they are usually marginalized from the workforce because of the stigma and discrimination attached to the disorder.

Because of fear about the disorder, people with psychoses are often admitted to hospital and often abandoned by their families.

This is costly and quite often human rights are abused in the hospital.

Talk through the human rights abuses.

## Human rights violations

Asdila is a young woman who hears voices. As she was wandering on the street and talking out loud, the police arrested her. She had not committed any offence but while in custody she was told that she would be transferred to a psychiatric hospital.

In the hospital she was forced to take high doses of psychotropic drugs which made her extremely unwell. She was bullied and attacked by staff and other male patients. She has no way to challenge her detention.

12

Ask the participants to read this example and decide which human rights have been violated?

**Answers:** Adsila is detained in prison and then a psychiatric hospital although she has not committed any offence. Therefore her right to liberty and security (Article 14) in the Convention on the Rights of Persons with Disabilities, to equal protection before the law (Articles 5 and 12) and her right not to be arbitrarily arrested or detained (Article 15) have been violated. The fact that she cannot challenge her detention violates her right to a fair hearing (Article 13). The fact she is bullied and attacked violates her right to not be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Article 15).

**Note: Convention on the Rights of Person with Disabilities:** Articles related to the treatment of person with psychosis.

The right not to be locked up or detained in mental health facilities against your will (Article 14).

The right to be free from violence and abuse, the right not to be restrained or put in seclusion (Articles 15 and 16).

The right to make decisions and choices rather than having others make decisions for you (Article 12).

## Discussion

- What stigma and discrimination do people with psychoses face in your community?
- What can you do to reduce the stigma?

13

The right to give informed consent to treatment and the right to refuse treatment (Article 25).

### Brief discussion (20 minutes)

Ask participants to think about ways that the human rights of people with psychoses are violated in their community?

Ask participants to think what they can do to stop these human rights violations?

### What you can do to decrease stigma, discrimination and human rights violations

- Treat people with respect and dignity.
- Avoid making assumptions, e.g. The person is dangerous or the person lacks capacity.
- Do not assume that the person is unable to make choices or decisions concerning treatment. Involve the person in the development of their treatment plan.
- Avoid involuntary admission and treatment, seclusions and restraints and other coercive practices.
- Treat psychoses at the non-specialist level which is less stigmatizing, more acceptable and accessible for people.

14

Emphasize that the participants have a unique role, because they can treat psychoses.

Showing that psychoses can be treated is an important method to reduce stigma.

Talk through the points on the slide.

Emphasize that the person with mental disabilities and their carers must be involved in the decision-making process about their treatment.

### What you can do to decrease stigma, discrimination and human rights violations

- Provide accurate and supportive information to the person concerned and their family:
  - About psychoses as well as treatment and recovery options.
  - Dispel myths about psychoses.
  - Raise awareness on the rights of people with mental disorders including psychoses.
- Raise awareness among other health professionals and colleagues, family members and the wider community in order to dispel the stigma, myths and misconceptions about psychoses.
- Involve people with mental disabilities and their carers in any awareness raising activities. Empower them to speak for themselves.

15

Explain that to decrease stigma, discrimination and human rights abuses participants can:

- Provide families, individuals and communities with accurate information about psychoses.
- Ensure people understand what they can expect from treatment and recovery; support them and give them hope.
- Explain clearly that people can recover from psychotic episodes and that with treatment and support they can lead fulfilling and productive lives.
- Dispel any myths about psychoses and correct any misinformation.
- Raise awareness about human rights abuses and advocate for rights of people with psychoses.
- Involve people with psychoses and their carers in any awareness raising activities. Empower them to speak for themselves.

## Global impact of psychoses

- Affects 21 million people globally (more common among men – 12 million than women – 9 million).
- Has an early onset in many (15–29 years old).
- People with psychoses are two and a half times more likely to die early than the general population, due to physical illness such as cardiovascular, metabolic and infectious diseases.

16

Talk through the points on the slide.

Acknowledge that psychoses does not affect as many people worldwide as other priority MNS conditions. But the impacts that it has on the individual (including human rights violations) and the burden it places on the family make it a critical public health concern.

## Why it is important to treat in non-specialized health settings

- Psychoses is treatable.
- Medicines and psychosocial interventions are effective at treating psychoses.
- People with psychoses can be cared for outside of hospitals – in non-specialized health settings and the community.
- Engaging the family and community in the care of people with psychoses is important.

17

Talk through the points of the slides and add the information below to expand on the points.

Emphasize that available treatment is effective and can be carried out in non-specialized health settings.

Non-specialized treatment is more accessible and less stigmatizing than institutional care.

Explain that there is clear evidence that old-style mental hospitals are not the best way to treat people with psychoses and often violate basic human rights.

Therefore, caring for people through non-specialized health settings and in the community is essential.

## Activity 2: Case scenarios: Hallucinations and delusions

### Activity 2: Exploring the symptoms of psychoses

1. Identify whether the person is experiencing a hallucination or delusions? Explain your decisions.
2. Identify how the hallucination or delusion impact on the person's life? Explain your decisions.

18

**Duration:** 20 minutes.

**Purpose:** An interactive discussion using case scenarios that enables participants to explore the experiences of hallucinations and delusions.

**Instructions:**

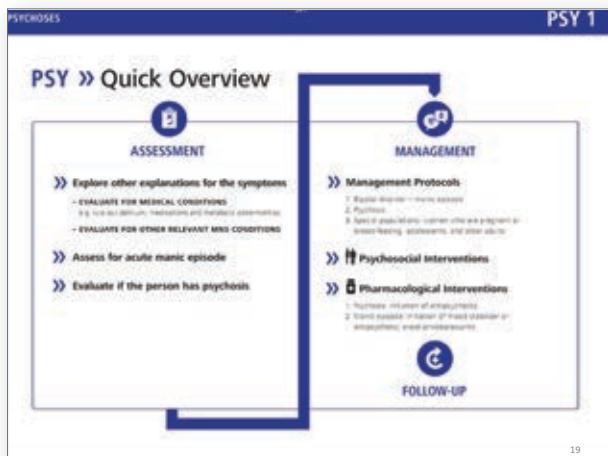
- Divide participants into three small groups.
- Give each group a different case scenario (see PSY supporting material) to discuss and analyse.
- Have participants analyse the case scenarios using the instructions on the card which include:
  - Identify whether the person is experiencing a hallucination or delusion. Why did the group come to that decision?
  - Identify how that hallucination or delusion is impacting on the person's life. Give as many details as possible.
- Instruct each group to briefly present their case scenario and findings to the rest of the group.
- Facilitate a discussion.

# Session 2.

# Assessment of psychoses

⌚ 1 hour 10 minutes

## Activity 3: Video demonstration: Assessment



Instruct participants to turn to the assessment page in the mhGAP-IG Version 2.0 (page 34).

Talk through the principles of assessment:

- Explore other explanations for symptoms:
  - Evaluate for medical conditions
  - Evaluate for other relevant MNS conditions
- Assess for acute manic episode
- Evaluate if the person has psychosis

Ask participants to give their immediate thoughts about why these particular assessment principles are important?

### Factors influencing communication

- The person's thoughts might be disorganized and unclear.
- The person might be sharing unusual beliefs.
- The person might refuse to speak.
- The person might avoid any eye contact.
- The person may not feel that they need medical care.
- Often the family will report the issue, not the person.

Now we will discuss how these issues affect your interaction with the person.

Explain that they are going to watch a video of an assessment for psychoses.

Explain that many clinicians are unnecessarily uncomfortable in communicating with people with psychoses.

And as we learned from the “hearing voices, seeing things” person story (Activity 1), we know that it can be difficult for the clinician and for the person.

Talk through the points on the slide that highlight why these factors influence communication.

The person may be distracted by their symptoms and may find it hard to concentrate on what is being asked of them.

## Establish communication and build trust

- Treat the person with respect and dignity.
- Try to understand the person's perspective.
- Introduce your questions in a respectful way.
- Do not rush; it may take several sessions to build trust.
- Do not challenge false beliefs or mock the person.
- Ask how the person's life has been affected.
- Advocate on the person's behalf.

21

Describe the points on the slide and highlight that these are ways to help improve communication with a person with psychoses.

Be patient, treat the person with respect and dignity, use active listening skills to really understand what the person is trying to tell you and establish trust and a rapport with the person.

- Explain that building trust is an extremely important step for helping a person with possible psychoses.
- One goal of the first session is to make the person comfortable enough to return for follow-up.
- Give the following example of how to pose questions without making the person uncomfortable.

"I would like to ask you a question that might sound strange but is a routine question: Do you hear voices that no one else can hear even when you're with other people?"

## Activity 3: Video demonstration: Assessment

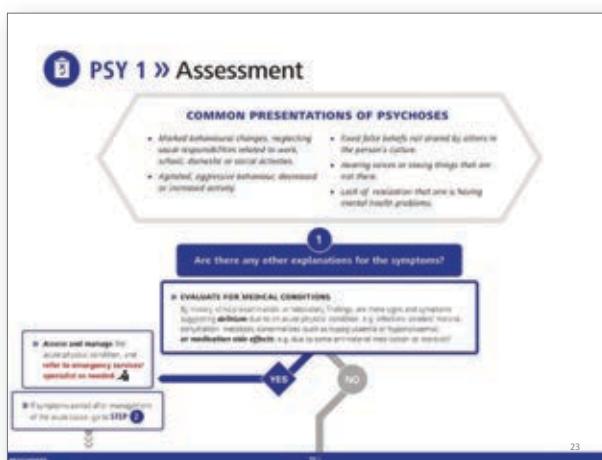
Show the mhGAP-IG psychoses assessment video.

22

Explain to participants that they are going to watch a video of Amir being assessed for possible psychoses. <https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>.

During the video, ask participants to scan the psychoses assessment algorithm in the mhGAP-IG to follow the assessment and then discuss it.

After the participants have watched the video ask the group:  
What symptoms does Amir have?



Use the mhGAP-IG algorithm to decide: Are there any other explanations for Amir's symptoms?

Seek group consensus.

How did the health-care provider assess if there were other explanations?

## Delirium

- An organic brain syndrome characterized by acute onset of:
- Confusion (person appears confused, struggles to understand surroundings).
  - Difficulty in focusing, shifting or maintaining attention.
  - Changes in feeling (sensations and perceptions).
  - Changes in level of consciousness or awareness.
  - Disturbance in orientation to time, place and sometimes person.
  - Disorganized thinking – speech does not make sense.
  - Changes in mood – anger, agitation, anxiety, irritability, anxiety to apathy and depression.

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Delirium can present in a similar way to psychoses. Therefore, it is crucial to make sure that there are no acute physical conditions resulting in delirium, i.e. infection, cerebral malaria, dehydration, metabolic abnormalities or medication side-effects.

Explain the key features of delirium that differentiate it from psychoses i.e. diurnal variation, acute onset, medical history, clouding of consciousness, disorientation.

## Management of delirium

If you think that a person has delirium:

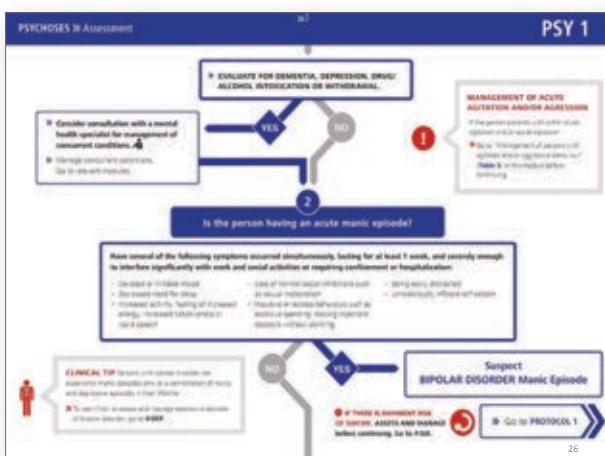
- Try to identify and manage underlying cause.
- Assess for dehydration and give fluid.
- Ensure that the person is safe and comfortable.
- Continue to reassess and monitor the person after initiating management.
- Refer the person to a specialist (e.g. neurologist, psychiatrist, or internal medicine specialist).

25

Talk through the points on the slide.

Emphasize that if you do suspect delirium then assess and manage the acute physical condition and refer to emergency services and specialists as needed.

Continue to reassess the person after initial management in order to monitor the state of the person.



Did the health-care provider assess Amir for dementia, depression, substance use (alcohol/drug intoxication or withdrawal)?

If you suspect any other MNS conditions, then consider consultation with a mental health specialist and/or assess and manage the concurrent conditions by using the relevant modules in the mhGAP-IG.

## Managing concurrent MNS conditions and psychoses

Psychoses can occur with:

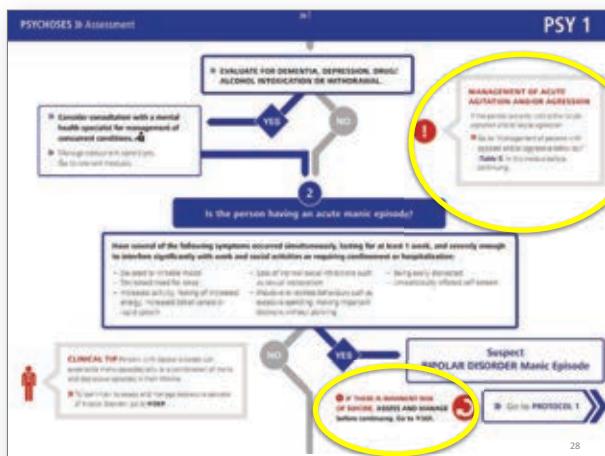
- Depressive episodes – people can experience hallucinations and delusions when depressed.
  - Post-partum psychosis – in the days and weeks after giving birth women can experience changes in mood (including mania and depression). They can experience hallucinations and delusions and significant confusion in their thinking and behaviour.
  - Substance use disorders – **intoxication** due to substance use can produce significant disturbances in mood and changes in levels of consciousness, confusions and erratic behaviour. **Withdrawal** from substances can also cause confusion, erratic behaviour, changes in consciousness and perception.
  - Dementia – people living with dementia can report experiencing changes in perceptions (hallucinations and delusions).

For the management of depression see the Module: Depression in the mhGAP-IG.

For the management of substance use disorders see the Module: Disorders due to substance use in the mhGAP-IG.

To manage psychoses in dementia, see the Module: Dementia.

When considering the needs of special populations like pregnant women or women who have just given birth always refer to a specialist where available.



Explain that people with psychoses can present "in crisis" and as emergency cases in a number of ways.

- With thoughts, plans, attempts of self-harm/suicide.
  - Acute agitation and/or anger.

Explain that assessing for self-harm/suicide will be covered in the Module: Self-harm/suicide.

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour ①	
<b>ASSESSMENT ②</b>	<b>COMMUNICATION</b>
<ul style="list-style-type: none"> <li>■ Assess for underlying causes</li> <li>■ Assess for safety concerns</li> <li>■ Check vital signs, including oxygen saturation, blood glucose, and electrolytes</li> <li>■ Rule out delirium and mental illness, including psychosis</li> <li>■ Rule out drug and alcohol use</li> <li>■ Rule out medical conditions (e.g., hypoglycaemia, hypothyroidism, hypotension, hypoxia, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul>	<p><b>ASSESSMENT ②</b></p> <ul style="list-style-type: none"> <li>■ Safety: 1-2 min</li> <li>■ Assess for underlying causes (e.g., patient self-harm, safety concerns, etc.)</li> <li>■ Rule out delirium and mental illness (e.g., psychosis)</li> <li>■ Assess for drug and alcohol use.</li> <li>■ Assess for physical health.</li> <li>■ Assess for social support and resources.</li> <li>■ Rule out other causes (e.g., hypoglycaemia, hypoxia, hypotension, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul>
	<b>SEDATION AND USE OF MEDICATION ③</b>
	<p><b>ASSESSMENT ②</b></p> <ul style="list-style-type: none"> <li>■ Assess for underlying causes (e.g., patient self-harm, safety concerns, etc.)</li> <li>■ Rule out delirium and mental illness (e.g., psychosis)</li> <li>■ Assess for drug and alcohol use.</li> <li>■ Assess for physical health.</li> <li>■ Assess for social support and resources.</li> <li>■ Rule out other causes (e.g., hypoglycaemia, hypoxia, hypotension, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul> <p><b>SEDATION AND USE OF MEDICATION ③</b></p> <ul style="list-style-type: none"> <li>■ Assess for underlying causes (e.g., patient self-harm, safety concerns, etc.)</li> <li>■ Rule out delirium and mental illness (e.g., psychosis)</li> <li>■ Assess for drug and alcohol use.</li> <li>■ Assess for physical health.</li> <li>■ Assess for social support and resources.</li> <li>■ Rule out other causes (e.g., hypoglycaemia, hypoxia, hypotension, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul> <p><b>SEDATION AND USE OF MEDICATION ③</b></p> <ul style="list-style-type: none"> <li>■ Assess for underlying causes (e.g., patient self-harm, safety concerns, etc.)</li> <li>■ Rule out delirium and mental illness (e.g., psychosis)</li> <li>■ Assess for drug and alcohol use.</li> <li>■ Assess for physical health.</li> <li>■ Assess for social support and resources.</li> <li>■ Rule out other causes (e.g., hypoglycaemia, hypoxia, hypotension, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul> <p><b>SEDATION AND USE OF MEDICATION ③</b></p> <ul style="list-style-type: none"> <li>■ Assess for underlying causes (e.g., patient self-harm, safety concerns, etc.)</li> <li>■ Rule out delirium and mental illness (e.g., psychosis)</li> <li>■ Assess for drug and alcohol use.</li> <li>■ Assess for physical health.</li> <li>■ Assess for social support and resources.</li> <li>■ Rule out other causes (e.g., hypoglycaemia, hypoxia, hypotension, hypothermia, constipation, etc.)</li> <li>■ Rule out agitation due to psychogenic or organic causes</li> </ul>

Remind participants of the principles of managing acute agitation and/or aggression (discussed in the Module: Essential care and practice).

## Case scenario

- A 22-year-old woman is brought to the clinic by her parents. They are concerned about her bizarre behaviour and strange speech. They explain the young woman keeps getting very agitated and angry and states that she wishes to “escape from a terrible monster taking the shape of her father”. Today she violently attacked her father.

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## Case scenario continued

- Her father has multiple cuts and bruises on his face and body from where he was attacked.
- The young woman is obviously still agitated and restless. She cannot stay still and keeps trying to get away from her father. She is shouting at him to “go away” “get out” “leave me”.
- What can you do to manage the situation?

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Talk through the case scenario.

Using the guidelines in the mhGAP-IG page 45.

Facilitate a brief discussion about how participants could manage this scenario? Would they consider medication? (Five minutes.) Make a note of their answers on a piece of flip chart paper.

Explain that the first step is **safety first!** Therefore, participants should make sure that the girl, her father, mother and themselves are all safe. As the focus of the young woman’s agitation is the father, the safest thing to do is ask the father to leave. Or ask the father to see another colleague so they can check his injuries.

**Remain calm and encourage the young woman to talk** by removing the father see if the young woman calms down.

It is important that you remain calm. Ask the woman to tell you why she is feeling so agitated.

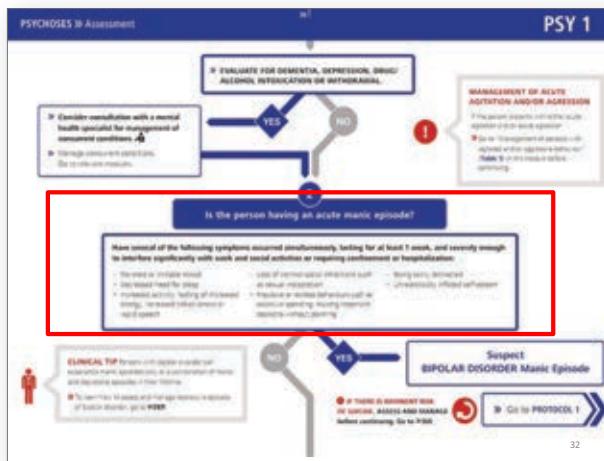
**Use a calm voice and try and address any of her immediate concerns.**

Listen attentively – devote time to this young lady as she is clearly very upset.

**Do not laugh at her, do not be aggressive and do not argue with her beliefs about her father.**

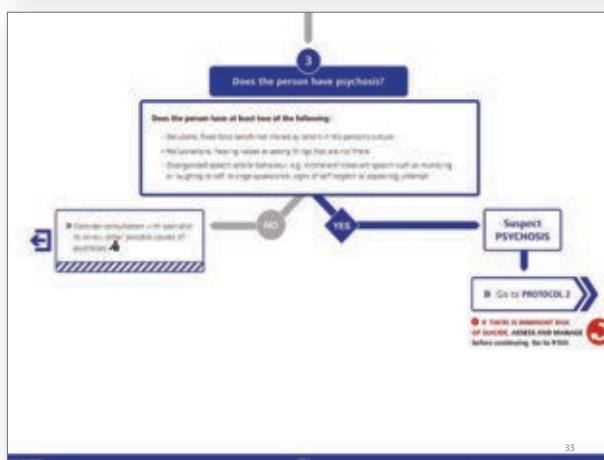
**Involve the mother (if the young woman allows it)** ask the mother why she thinks this is happening?

**If the young woman calms down enough then try and assess her for psychosis.**



Bring the participants attention back to the video of Amir. Seek group consensus as to whether Amir is having an acute manic episode?

In this case, Amir is **not** having an acute manic episode. Therefore, continue to step 3.



Does Amir have psychosis?

The answer should be **yes** as he has hallucinations (hearing voices), signs of self-neglect or appearing unkempt, mumbling speech and reports (from his parents) about laughing to himself.

How to ask about hallucinations and delusions?		
Symptoms	Person	Family
Hallucinations	e.g. Do you hear voices or see things that no one else can?	e.g. Do you see the person talking to someone else when alone? As if the person is talking to someone?
Delusions	e.g. Do you believe that someone is planning to hurt you? Do you feel that you are under surveillance?	e.g. Did the person share any ideas that you found strange and unlikely to be true?

Read out the examples on the slide and ask participants to comment.

Discuss for five minutes and establish culturally appropriate questions you could use to ask whether people are experiencing hallucinations and delusions?

**Note:** Write those questions and leave them in clear view so that participants can use them when they are doing role plays.

## Activity 4: Role play: Assessment

### Activity 4: Role play: Assessment

- A man who is well known to you is homeless and lives under the tree opposite your practice. He has been seen talking to himself and laughing to himself, is unkempt and ungroomed.
- Assess him according to the psychoses assessment algorithm on page 35 mhGAP-IG.

35

See PSY supporting material role play 1.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

PSY

**Duration:** 30 minutes.

**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to assess for psychoses.

**Situation:**

- You are a health-care worker in a clinic
- A man who is well known to you, is homeless and lives under the tree opposite your practice, he has been seen talking to himself and laughing to himself, is unkempt and un-groomed.
- Assess him according to the psychoses assessment algorithm on page 35 mhGAP-IG Version 2.0.

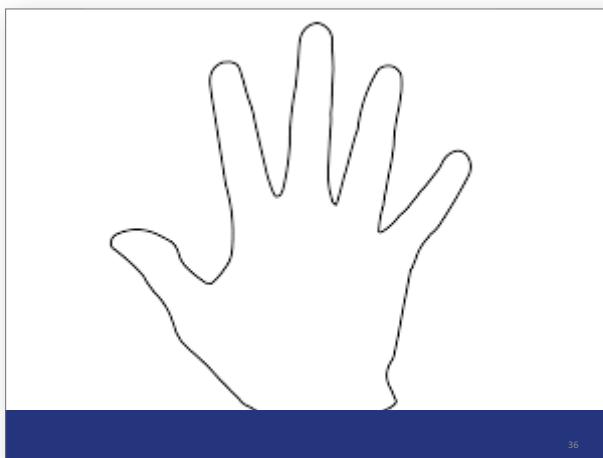
**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 3.

# Management of psychoses

⌚ 1 hours 50 minutes



Hold up your hand and ask participants to tell you which management interventions should be used when treating people with psychoses.



Briefly talk through the different interventions that could be used in a treatment plan.

**PSY 2 » Management**

**PROTOCOL 1**

**Manic Episode in Bipolar Disorder**

- Provide psychosocial interventions to the person and carers. 2.1
- Pharmaco-therapeutic interventions. 2.2
- If patients are at high-risk – implement:

  - Regular treatment continuation, use brief interventions to reduce relapse risk. Consider a short-term QI-evaluations to evaluate effectiveness for brief-risk-reduction or aggression.
  - Improve functioning in daily activities. 2.3
  - Ensure safety of the person and others. 2.4
  - Provide regular follow-up. 2.5
  - Support relatives in the community. 2.6
  - Institute stress and strengthen links to supports. 2.7

**PROTOCOL 2**

**Psychosis**

- Provide psychosocial interventions to the person and carers. 2.1
- Pharmaco-therapeutic interventions. 2.2
- If there is a low-risk, consider the intensity of target interventions to reduce effects closer to baseline, the risk of side-effects.
- Provide psychosocial interventions in daily activities. 2.3
- Ensure safety of the person and safety of others. 2.4
- Provide regular follow-up. 2.5
- Support relatives in the community. 2.6
- Reduce stress and strengthen social supports. 2.7

Direct participants to the management protocols on page 38 of the mhGAP-IG Version 2.0.

Choose volunteers to read them out loud.

Ask participants how confident they would feel using these management interventions.

## Activity 5: Video demonstration: Management

### Activity 5 Video demonstration: Managing psychoses

- How did the health-care provider explain the treatment options?
- Were the risks and benefits of medication explained?
- Were the benefits of psychosocial interventions explained?

**Duration:** 30 minutes.

**Purpose:** To enable participants to watch how a health-care provider could offer basic management to an individual with psychoses. <https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5>.

While watching ask participants to think about these questions:

- How the health-care provider explains the treatment options?
- Were the risks and benefits of medication explained?
- Were the benefits of psychosocial interventions explained?

**PSYCHOSES & Management**

**PSY 2**

**PSYCHOSOCIAL INTERVENTIONS**

**2.1 Psychosocial interventions**

Any message for the person and their carers:

- Ensure that the symptoms are due to a mental health condition and not other medical conditions, and that the person can benefit from psychosocial interventions and regular treatment.
- If the patient is not able to make decisions on account of the effects of the psychosis.
- Encourage the person and their family to access local support groups and self-help groups.
- Encourage the person to take part in activities and continue with hobbies they enjoy.
- Encourage the patient to have a healthy diet, exercise regularly, and manage health risks.
- Encourage the patient to have a good night's sleep.
- Encourage the patient to avoid alcohol and illegal substances.

**Clinical tip:** *Reassurance and support for the person and their carers:* Encourage the patient to have a healthy diet, exercise regularly, and manage health risks. Encourage the patient to have a good night's sleep. Encourage the patient to avoid alcohol and illegal substances.

**2.2 Reduce stress and strengthen social supports**

– Encourage the person to have a healthy diet, exercise regularly, and manage health risks.

– Identify the person's support network and encourage them to stay in touch with family and friends. Encourage the patient to keep in touch with their support network.

– Encourage the patient to have a good night's sleep.

**Clinical tip:** *Encouraging social support:* Encourage the patient to have a healthy diet, exercise regularly, and manage health risks. Encourage the patient to have a good night's sleep. Encourage the patient to avoid alcohol and illegal substances.

**2.3 Promote functioning in daily living activities**

– Encourage the person to have a healthy diet, exercise regularly, and manage health risks.

– Encourage the person to have a good night's sleep.

– Encourage the patient to have a healthy diet, exercise regularly, and manage health risks.

– Encourage the patient to have a good night's sleep.

**2.4 General advice for carers**

- Encourage the carer to have a healthy diet, exercise regularly, and manage health risks.
- Encourage the carer to have a good night's sleep.
- Encourage the carer to have a healthy diet, exercise regularly, and manage health risks.
- Encourage the carer to have a good night's sleep.
- Encourage the carer to have a healthy diet, exercise regularly, and manage health risks.
- Encourage the carer to have a good night's sleep.

Give the participants time to read through the psychosocial interventions on page 40 mhGAP-IG.

Emphasize to participants the importance of delivering psychosocial interventions to people with psychoses and their carers.

Explain that focusing on a person's recovery and taking time to ensure that they start to take part in activities of daily living and reconnect with their family and communities is an essential and crucial part of treatment.

## Activity 6: Delivering psychoeducation

### Activity 6: Psychoeducation

- Group 1: Key messages in psychoeducation for psychosis.
- Group 2: Key messages in psychoeducation for bipolar disorder.

41

**Duration:** 20 minutes.

**Purpose:** To enable participants to familiarize themselves with key psychoeducation messages and practise delivering those messages to the rest of the group.

**Instructions:**

- Divide the participants quickly into two groups.
- Give each group paper, pens, flip chart paper, sticky notes etc.
- Give one group the topic: **Psychoeducation for psychosis**.
- Give the other group the topic: **Psychoeducation for bipolar disorder**.
- Give each group 10 minutes to use the mhGAP-IG and come up with a creative way to deliver the key psychoeducation messages to the other group.
- After 10 minutes of planning. Give each group five minutes to present the key psychoeducation messages.

Correct any misinformation.

Emphasize the importance of delivering clear psychoeducation to carers, including advising carers:

- Not to try and convince the person that their beliefs or experiences are false and not real. Explain that instead carers should be open to listening to the person talk about their experience but should not have a judgement or opinion about the experiences. Instead stay neutral.
- Remind carers to stay calm and patient and not to get angry with the person.

Explain that participants are now going to focus on how to promote functioning in daily living activities for people with psychoses.

# Activity 7: Promoting functioning in daily living activities

## Activity 7: Promoting functioning in daily living activities

Promoting functioning in daily living activities is a crucial step in their journey to recovery. It will:

- Help a person cope with and manage their symptoms.
- Reconnect the person with their community.
- Empower the person to take back some control of their life.
- Give the person the opportunity to learn and/or earn an income so they can live independently in the future.
- Give the person hope that they will recover and have a better future.

42

**Duration:** 25 minutes.

**Purpose:** To introduce participants to the importance of promoting functioning in daily living activities for people with psychoses as a way of helping their recovery.

**Instructions:**

- Explain to participants that promoting functioning in daily living activities for people with psychoses is a crucial step in their journey to recovery.
- It is crucial because it will:
  - Help the person cope with and manage their symptoms.
  - Reconnect the person with their community.
  - Empower the person to take back some control of their life.
  - Give the person the opportunity to learn and/or earn an income so they can live independently in the future.
  - Give the person hope that they will recover and have a better future.
- Ask participants to:
  - **Think about a time when you had to recover from something – it can be now or in the past** (two minutes). For example, losing someone you loved, battling a difficult illness, being the survivor of abuse, losing an important opportunity or job? It can be anything you can think of, not necessarily related to mental health.
- Ask participants to:
  - **Think what was difficult about recovering from that situation?**
- After a brief discussion, ask participants the following questions:
  - **Think what helped you get better/overcome this situation?**
- Give participants two minutes to think about or write down their personal recovery experiences and journeys. Ask for one or more volunteers to share their experience. The goal is to let the group think about what is involved in recovery in general. Highlight how important continued functioning and participation in everyday activities were for their own recovery.
- Then ask participants to:
  - **Think what might make recovery more difficult for people with psychoses?**
- Ask the group to brainstorm ideas and write them on the flip chart. Some possible answers are:
  - Major losses of social support – being isolated from friends and family/being physically restrained and isolated.
  - Distress from being abused and mistreated.

- Negative effects of medication.
  - Loss of trust in the mental health system.
  - Loss of trust in the community and family.
  - Not being allowed to make decisions for yourself anymore.
  - Feeling that your opinion is not respected.
  - Negative attitudes from health-care providers.
  - Devaluing and disempowering practices attitudes and environments.
  - Stigma and discrimination from the family and the community.
  - Lack of education, income generating, social and other opportunities.
  - Lack of sense of identity, self-respect and hope.
  - Lack of access to treatment and support.
  - Lack of access to other people who have gone through similar things.
  - Lack of information about your condition and situation.
  - Demeaning remarks and maltreatment from others.
  - Being told you will never recover.
  - Being overprotected by family.
- Now that the group has thought about their own personal recovery, identified how important everyday functioning was and identified what might make it difficult for people with psychoses to recover, ask the group to:
    - **Create a treatment plan of steps they could take to promote functioning in daily living activities for people with psychoses in their own communities.**
  - Give the participants five minutes to write an individual plan and then ask for volunteers to share their ideas with the rest of the group.
  - Discuss any barriers and obstacles that participants identify and try and brainstorm solutions as a group.

## Initiating antipsychotic medication

Are antipsychotics better started early or late?

**Early!**

For prompt control of psychotic symptoms, health-care providers should begin antipsychotic medication immediately after assessment. The sooner the better.

## Pharmacological interventions

Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is **early**.

Early identification and early intervention is linked to better treatment outcomes.

## Initiating antipsychotic medication

Is it better to start with a low dose or a high dose?

**Low!**

Start with a low dose within the therapeutic range and increase slowly to the lowest effective dose in order to reduce the risk of side-effects. Start low, go slow.

Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is a **low dose**.

Explain that severe side-effects from antipsychotic medication can reduce adherence, therefore to minimize those side-effects we want the lowest therapeutic dose.

## Initiating antipsychotic medication

Which route is preferable?

- oral
- intramuscular.

**Oral!**

Consider intramuscular treatment only if oral treatment is not feasible. Do not prescribe long-term injections (depot) for control of acute psychotic symptoms.

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Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is **oral**.

Oral medication can be more dignified than using intramuscular treatment. It is also empowering as it means the person has to take responsibility in their own recovery by taking medication every day. Only use intramuscular treatment if oral routes are not possible.

## Initiating antipsychotic medication

How many antipsychotic medications should we prescribe at a time?

- one
- more than one.

**One!**

Try the first medication at an optimum dose for at least four to six weeks before considering it ineffective.

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Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is **one**.

Try one medication and give it time to work before considering it ineffective.

### PHARMACOLOGICAL INTERVENTIONS

**2.5 Psychosis:**

- Antipsychotic should normally be offered to a patient.
- Most antipsychotic medication immediately. (See Table 2.)
- Monitor the side effects as it may cause.
- Try to avoid these side effects as they may cause the side effects.
- If the medication is not effective, then after about 4-6 weeks, before considering it ineffective.
- Consider the side effects as frequently as possible and consider the side effects as they may cause depression, and follow-up (see Table 2).
- Monitor weight, dehydration, and eating habits (monitoring and loss of weight, or psychopathology). (Refer to section 2.6)

**CAUTION:**

If side effects are noted:

- Antipsychotic side effects (EPS): patients are at risk of developing extrapyramidal side effects (EPS), such as dystonia, tardive dyskinesia, and akathisia. These can cause significant impairment in daily functioning and quality of life. (Refer to section 2.6)
- Metabolic changes (metabolic syndrome): metabolic changes, such as hypertension, high cholesterol, and diabetes. (Refer to section 2.6)
- ECG changes (prolonged QT interval): monitor ECG.

**2.6 Manic Episode in Bipolar Disorder:**

- Antipsychotic medications:
- Dose: same as for depression, avoid sedation, reduce risk of antipsychotic side effects.
- Major treatment with lithium, valproate, carbamazepine, or with antipsychotics (see Table 2).
- Lithium: consider as a first-line treatment for manic episodes, and as a maintenance treatment for bipolar disorder. It may increase the risk of relapse. Be highly suspicious of lithium toxicity, as it may be responsible for death. (Refer to section 2.6)
- Valproate: consider as a second-line treatment for manic episodes, and as a maintenance treatment for bipolar disorder.
- Carbamazepine: consider as a third-line treatment for manic episodes, and as a maintenance treatment for bipolar disorder.
- Antidepressants and psychostimulants: consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.
- Antipsychotic and psychostimulants: consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.
- Antipsychotic and antidepressants: consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.
- Antipsychotic and mood stabilizers: consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.
- Antipsychotic and benzodiazepines: consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.
- Antipsychotic and antidepressants (with caution): consider these medications to treat coexisting symptoms, such as anxiety, depression, and mania.

**CAUTION:**

If side effects are noted:

- Antipsychotic side effects (EPS): patients are at risk of developing extrapyramidal side effects (EPS), such as dystonia, tardive dyskinesia, and akathisia. These can cause significant impairment in daily functioning and quality of life. (Refer to section 2.6)
- Metabolic changes (metabolic syndrome): metabolic changes, such as hypertension, high cholesterol, and diabetes. (Refer to section 2.6)
- ECG changes (prolonged QT interval): monitor ECG.

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Explain that antipsychotic medication should be offered routinely to a person with psychosis.

Highlight the importance of regular monitoring and follow-up of anyone started on antipsychotic medication.

Especially important is monitoring for health considerations: weight gain, blood pressure, fasting sugar, cholesterol changes, ECG changes, and extrapyramidal side-effects such as: akathisia, acute dystonic reactions, tremor, muscular rigidity etc.

**PHARMACOLOGICAL INTERVENTIONS**

**2.5 Psychosis**

- If psychosis is due to antidepressants:
- If antipsychotic administration causes significant side effects:
- Stop antipsychotic immediately. See Table 5.
- Replace antipsychotic with aripiprazole to reduce side effects.
- If psychosis is a typical effect after the first 6–8 weeks, continue using it indefinitely.
- Consider or repeat an MRI scan if following a suicide attempt or if there is a history of drug-induced psychosis. Follow up over Table 4.
- Normal weight, disorganized, or hallucinatory psychosis may be due to:

**2.6 Manic Episode in Bipolar Disorder**

- If patient is on antidepressants:
- If antidepressant administration causes significant side effects:
- Stop antidepressant immediately. See Table 5.
- Lithium, valproate, carbamazepine, or risperidone may be effective. Antipsychotics are available and preferred only under specific circumstances. If antidepressants are ineffective and available, consider adding lithium, valproate, carbamazepine, or risperidone. If lithium, valproate, carbamazepine, or risperidone are ineffective, consider adding aripiprazole. If lithium, valproate, carbamazepine, or risperidone are effective, consider adding aripiprazole. If aripiprazole is effective, consider adding lithium, valproate, carbamazepine, or risperidone.
- CAUTION:**
  - Do not use in the diagnosis or treatment of manic episodes in the context of substance abuse. Use antidepressants in the context of substance abuse only if aripiprazole is ineffective.
  - Antidepressants increase the risk of suicide and generally lead to increased mental health problems, so reassess use carefully.
  - Continuous monitoring is required for at least 6 weeks after the last antidepressant.
- Lithium or valproate can be offered for the management of manic episodes. Consider adding aripiprazole if lithium or valproate is not available or does not fully control symptoms.
- Consider a short-term (2–4 weeks) antidepressant discontinuation for behavioral disturbances or agitation:**
  - Antidepressants can cause behavioral disturbances and generally lead to increased mental health problems, so reassess use carefully.
  - Antidepressants increase the risk of suicide and generally lead to increased mental health problems, so reassess use carefully.

**Case Scenario**

Yosef is 21 years old has been brought to you by his mother. His mother says that recently Yosef "is not the same." He is no longer studying and prefers to stay home doing nothing. You notice that Yosef is wearing summer clothes although it is cold and raining. He looks like he has not washed for weeks. When you talk to him, Yosef avoids eye contact. He gazes at the ceiling as if looking at someone. He mumbles and gestures as if he is talking to someone.

He does not want to see his friends, he seems disconnected from his family and has no energy. He is refusing to eat food in the home as he believes his mother is trying to poison him. You assess Yosef and decide to start him on antipsychotic medication to see if that improves his symptoms.

Direct participants' attention to the instructions in the mhGAP-IG for managing manic episodes with pharmacological interventions.

Ask participants:  
Why a person with mania would be on antidepressants?

Remind them that people with bipolar disorders can experience episodes of mania and depression. In fact, remind them that often people with bipolar may experience more episodes of depression, therefore they may have already been prescribed an antidepressant.

If they have then point out that if they have had a manic episode, their antidepressants should be stopped.

Treatment with lithium, valproate and carbamazepine, haloperidol and risperidone should be considered.

Introduce participants to the story of Yosef and explain that after carrying out a thorough assessment you decided to start him on antipsychotic medication as well as delivering psychoeducation and psychosocial interventions.

## Case scenario

Yosef is 21 years old has been brought to you by his mother. His mother says that recently Yosef "is not the same." He is no longer studying and prefers to stay home doing nothing. You notice that Yosef is wearing summer clothes although it is cold and raining. He looks like he has not washed for weeks. When you talk to him, Yosef avoids eye contact. He gazes at the ceiling as if looking at someone. He mumbles and gestures as if he is talking to someone.

He does not want to see his friends, he seems disconnected from his family and has no energy. He is refusing to eat food in the home as he believes his mother is trying to poison him. You assess Yosef and decide to start him on antipsychotic medication to see if that improves his symptoms.

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## Antipsychotic medications

- What are the starting doses for haloperidol, chlorpromazine and risperidone?
- What are the effective doses?
- What are the side-effects for each drug?

50

Instruct participants to look at tables 1–4 pages 42–44 mhGAP-IG Version 2.0.

Find the answers to the following questions on the slide.

## Case scenario

Maria is a 35-year-old woman. She is married and has two children (10 and 8 years old). For the last five years she has held a management level position in a local bank and has been enjoying her career. In the last two months she has been experiencing changes in her mood. She has been arguing with people at work and her family at home. She is getting frustrated as she does not feel people are listening to her or understanding her. Her speech is very fast and confusing as she is having so many ideas at the same time. She is spending a lot of money and that is causing arguments with her husband. She is active all the time and is not sleeping well.

After a thorough assessment you decide she is experiencing a manic episode.

Introduce participants to the story of Maria. After a thorough assessment, you decide that she is having a manic episode and decide to start her on a mood stabilizer.

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## Mood stabilizers

- What are the starting doses for lithium, sodium valproate and carbamazepine?
- When should you not use lithium?
- What are the effective doses?
- What are the side-effects of each drug?

52

Instruct the participants to use the mhGAP-IG to answer these questions.

## Review and adherence

- What should you do if Yosef complains of muscle rigidity and stiffness, and you notice that he has involuntary repetitive lip smacking?
- What could you do if a person who has started to take risperidone complains that they feel it is not doing anything to help them?
- How would you help someone who stopped taking sodium valproate because they were gaining too much weight and felt uncomfortable?

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Discuss these answers using Table 4 (page 44 mhGAP Version 2.0).

## Case scenario

A 28-year-old woman called Fatima gave birth to her second child two weeks ago. Her husband explains that she is not sleeping at all and she is struggling to feed the baby. She believes that her baby is in danger but she does not know how to protect it. Sometimes she thinks it would be better if she and the baby were both dead. On one occasion the husband has stopped her from being violent towards the baby.

Introduce participants to the case study and ask them to use the mhGAP-IG to decide what management options are available to them.

Ask them to refer to page 39 of the mhGAP-IG.

**Special populations**

Many interventions may differ for **PYCHOSES** in these populations.

**WOMEN WHO ARE PREGNANT OR BREASTFEEDING**

- Refer to maternal health specialists for regular care.
- Consider consultation with mental health specialist if available.
- Explain the risk of adverse consequences for the mother and the baby, including serious complications and psychiatric hospitalisation. Particularly if medication required.
- Consider pharmacological intervention – for suppression and avoidance. See below.

**Pharmacological Interventions**

**PSYCHOSIS**

- If a woman with psychosis is pregnant or breastfeeding, a psychiatrist or therapist to assess foetus, discontinuing or suspending or chlorpromazine may be considered.
- Anticholinergics:** **NOT** recommended due to a range of potential side effects or side effects of anticholinergics, especially in cases of acute myopathy see.
- Anticholinergics should not be routinely prescribed to women with psychotic disorders unless following a emergency, pregnancy, or breastfeeding because there is relatively little information on their safety in these populations.

**MANIC EPISODE IN BIPOLAR DISORDER**

- AVOID VALPROATE, LORAZEPAM AND CARBAMAZEPINE** during pregnancy and breastfeeding due to the risk of birth defects.
- Consider low-dose haloperidol with caution and in consultation with a specialist. A cautionary note is present.
- Explain the risks and benefits of medications to women of childbearing age.
- If a pregnant woman develops acute mania while taking these treatments, consider switching to low dose haloperidol.

**ADOLESCENTS**

- Consultation with mental health specialist.
- If adolescent with psychosis or bipolar disorder **imipramine** can be offered as a treatment option only under supervision of a specialist.
- If treatment with risperidone is not feasible, haloperidol or chlorpromazine may be used only under supervision of a specialist.

**OLDER ADULTS**

- Low doses of medication.
- Anticipate an increased risk of drug-drug interactions.

**CAUTION**

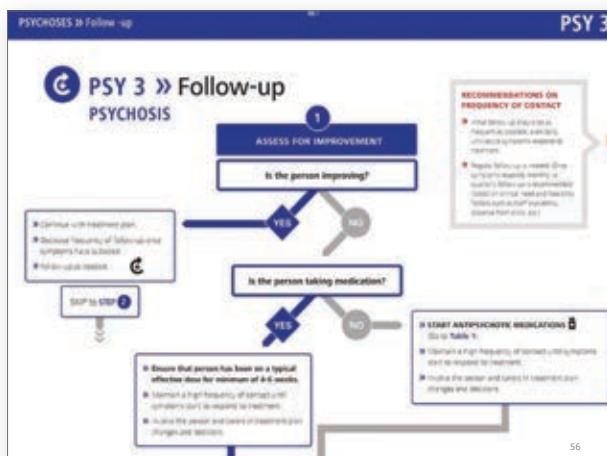
Anticholinergics carry an increased risk of cardiovascular events and death in older adults – refer to the related document.

## Special populations

- Ask participants to read through the differences in special populations.
- Then ask for a volunteer to give a brief summary of the differences in management of:
  - women who are pregnant or breastfeeding
  - adolescents
  - older adults.

# Session 4. Follow-up

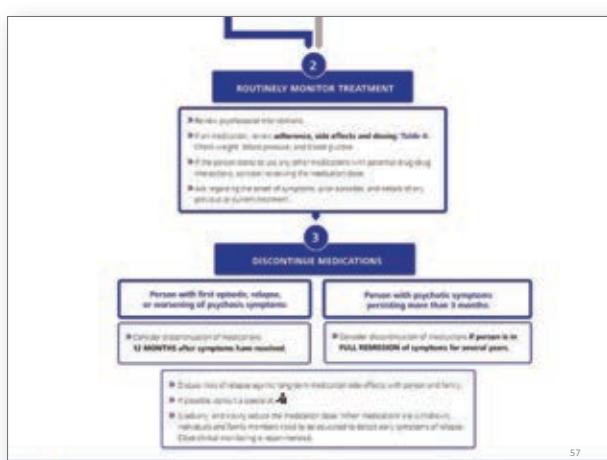
⌚ 35 minutes



Ask for a volunteer from the participants to read out loud step 1 of the follow-up algorithm and possible outcomes to that step.

Ask participants to reflect on how they will know if the person is improving or not and the reasons why the person may not be taking their medication.

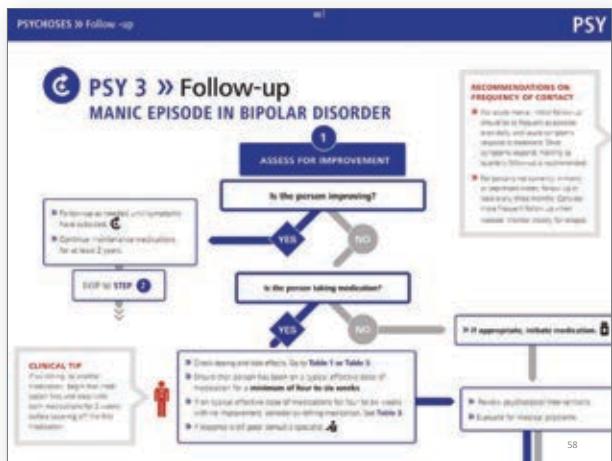
Reflect on how they might support a person to take their medication.



Ask another volunteer to read out loud steps 2 and 3 of the follow-up algorithm.

Ask participants to reflect on how could they routinely monitor treatment? What could they do? Who could they ask?

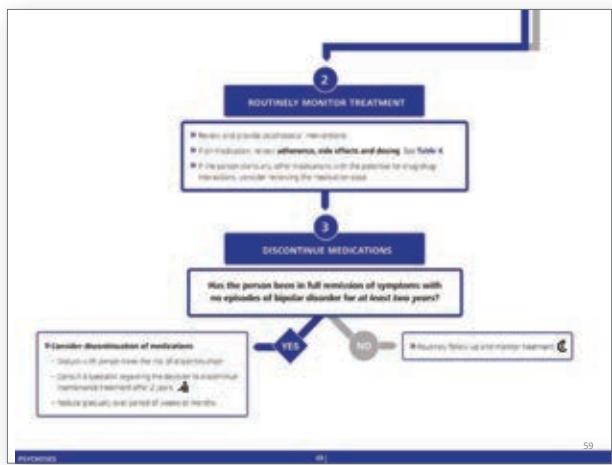
Clarify any concerns or questions they may have about step 3 and the discontinuation of medication.



Ask a volunteer to read out loud step 1 and possible outcomes in the follow-up of bipolar disorder.

Ask participants to reflect on how will they know if the person is improving?

How will they know if the person is taking medication?



Ask another volunteer to read through steps 2 and 3 of the algorithm and possible outcomes.

Clarify any queries or concerns the participants may have with these steps and outcomes.

Ask participants to reflect on how they will know if the person is in full remission?

Ask participants to consider how they would learn about the number of manic or depressive episodes the person has had?

Explain that people with bipolar disorder may have more depressive episodes than manic episodes. Therefore it is important to explore their mental state.

## Activity 8: Role play: Follow-up

### Activity 8: Role play: Follow-up

- Follow-up with a person with psychosis.
- Focus on reassessment of the symptoms.
- Assessment of side-effects of medication.
- Assessment of psychosocial interventions specifically strengthening social support, reducing stress and life skills.

See PSY supporting material role play 2.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

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**Duration:** 30 minutes.

**Purpose:** Gives participants the opportunity to practise conducting a follow-up appointment with a person who is being managed for psychosis.

**Situation:**

Follow up with a person with psychosis.

Focus on re-assessment of the symptoms.

Assessment of side-effects of medication.

Assessment of psychosocial interventions specifically strengthening social support, reducing stress and life skills.

**Instructions**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 5.

## Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the psychoses MCQs (see PSY supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# PSY PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/psy\\_slides.pdf](http://www.who.int/mental_health/mhgap/psy_slides.pdf)

## PSY supporting material

- Person stories
- Case scenarios
- Role plays
- Multiple choice questions
- Video links

Activity 3: mhGAP PSY module – assessment

<https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Activity 5: mhGAP PSY module – management

<https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5>



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/psy\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/psy_supporting_material.pdf)

EPI

# Epilepsy

**mhGAP training of health-care providers  
Training manual**



# Module: Epilepsy

## Overview

### Learning objectives

- Promote respect and dignity for people with epilepsy.
- Know common presentations of epilepsy.
- Know the assessment principles of epilepsy.
- Use effective communication skills in interactions with people with epilepsy.
- Know the management principles of epilepsy.
- Perform an assessment for epilepsy.
- Assess and manage physical health in epilepsy.
- Assess and manage emergency presentations of epilepsy.
- Provide psychosocial interventions to persons with epilepsy and their carers.
- Deliver pharmacological interventions as needed and appropriate in epilepsy considering special populations.
- Plan and perform follow-up for epilepsy.
- Refer to specialists and link with outside agencies for epilepsy as appropriate and available.

EPI

### Key messages

- Epilepsy is not inherited or contagious.
- Assessment includes:
  - Assessing and managing an acute/emergency presentation.
  - Assessing for epilepsy and any other underlying causes of the seizures.
- Seizures are symptoms and not the cause, therefore underlying causes should always be explored and assessed.
- To be considered epileptic there must be two or more unprovoked, recurrent seizures.
- Epilepsy can be treated effectively with antiepileptic drugs in non-specialized health settings.
- Psychoeducation and psychosocial interventions to promote functioning in daily activities are empowering for the person with epilepsy to enable them to manage their condition.
- Adherence to treatment and regular follow-up are critical.
- People with epilepsy can lead normal lives.
- Children with epilepsy can go to a normal school.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to epilepsy	Know the common presentations of Epilepsy Understand the impact of epilepsy on a person's life Promote respect and dignity for people with epilepsy	20 minutes  20 minutes	<b>Activity 1: Person's story followed by group discussion</b> Tell the person's story to introduce participants to what it feels like to live with epilepsy  <b>Presentation on epilepsy</b> <ul style="list-style-type: none"> <li>• Signs and symptoms of epilepsy</li> <li>• Causes of epilepsy</li> <li>• How epilepsy impacts a person's life</li> <li>• Why it is a public health priority</li> </ul>
2. Assessment of epilepsy	Know the assessment principles for epilepsy Perform an assessment for epilepsy Use effective communication skills in interactions with people with epilepsy Assess and manage emergency presentations of epilepsy Assess and manage physical health in epilepsy Refer to specialists and links with outside agencies for epilepsy, as appropriate and where available	30 minutes  40 minutes  30 minutes	<b>Activity 2: Group discussion: Emergency presentations</b>  <b>Activity 3: Video demonstration: Assessment</b> Use videos/demonstration role play to show an assessment and allow participants to note: <ul style="list-style-type: none"> <li>• Principles of assessment (all aspects covered)</li> <li>• Effective communication skills (what and how this is done)</li> </ul> <b>Activity 4: Role play: Assessment</b> Feedback and reflection
3. Management of epilepsy	Know the management principles of epilepsy Provide psychosocial interventions to persons with epilepsy and their carers Deliver pharmacological interventions, as needed and appropriate in epilepsy, considering special populations	45 minutes  30 minutes	Presentation on interventions for emergency presentation (acute convulsions, status epileptics)  Presentation on psychosocial and pharmacological interventions for people with epilepsy  <b>Activity 5: Role play: Management</b> Feedback and reflection
4. Follow-up	Plan and perform follow-up for epilepsy	10 minutes  30 minutes	Presentation on the principles of follow-up  <b>Activity 6: Group discussion: How to reduce stigma and discrimination</b>
5. Review		15 minutes	Multiple choice questions and discussion

**Total duration (without breaks) = 4 hours 30 minutes**

## Step-by-step facilitator's guide

# Session 1. Introduction to epilepsy

 40 minutes

## Session outline

- Introduction to epilepsy.
- Assessment of epilepsy.
- Management of epilepsy.
- Follow-up of a person with epilepsy.
- Review or materials and skills.

Begin the session by briefly listing the topics that will be covered.

EPI

## Activity 1: Person's story followed by group discussion

### Activity 1: Person's story

- Present a person's story of what it feels like to live with epilepsy.
- First thoughts.

Using the person's story to:

- Introduce the activity and ensure participants have access to pens and paper.
- Tell the person's story – be creative in how you tell the story to ensure the participants are engaged.
- Immediate first thoughts – give participants time to give their immediate reflections on the story.

Ask participants to think about people they have cared for in the past with epilepsy? Can they think of any cases? How did the person with epilepsy behave, how did their family and carers cope?

## Local descriptions and understanding of epilepsy

- What are the names and local terms for epilepsy?
- How does the community understand epilepsy? What causes seizures and epilepsy?

4

Write a list of local terms and descriptions for epilepsy and compare those with common presentations described in the mhGAP-IG.

(Maximum five minutes.)

### Overview of Priority MNS Conditions

**COMMON PRESENTATION**

- Unusual persistent physical symptoms with no clear cause
- Low energy, fatigue, stress or anxiety
- Persistent sadness or diminished mood, anxiety
- Loss of interest in pleasure in activities that previously interested them

**PRIORITY CONDITION**

- DEPRESSION (DEP)
- PSYCHOSES (PSY)
- EPILEPSY (EPI)**

5

Read through the common presentations of people with epilepsy.

### WHAT IS epilepsy?

A NEUROLOGICAL CONDITION characterized by *recurrent seizures*

Seizures are due to *brief disturbances in the electrical functions of the brain*

Epilepsy affects people of all ages

CAUSES

- NEUROLOGICAL INFECTIONS
- STROKE
- HEAD INJURIES
- DISEASE STATES
- SUBSTANCE ABUSE
- BRAIN TUMORS OR CYSTIC LESIONS
- EPILEPSY (GENETIC PREDISPOSITION)
- UNKNOWN CAUSE

Epilepsy is not contagious

Talk through the points on the slide by explaining that epilepsy is a neurological condition characterized by recurrent seizures.

Seizures are brief disturbances in the electrical functions of the brain.

There are potentially many different causes of epilepsy but it is not always easy to identify one.

Talk through the possible causes.

## Signs and symptoms of epilepsy

- Epilepsy is a chronic disorder of the brain.
- It is characterized by recurrent unprovoked seizures (at least 2 in the past 12 months).
  - Recurrent = usually separated by days, weeks or months.
  - Unprovoked = there is no evidence of an acute cause of the seizure (e.g. febrile seizure in a young child).

Explain the signs and symptoms of epilepsy.  
It is typified by seizures.

In order to receive a diagnosis of epilepsy, there needs to have been two or more recurrent unprovoked seizures (in the past 12 months):

- Recurrent = usually separated by days, weeks or months.
- Unprovoked = there is no evidence of an acute cause of the seizure (e.g. febrile seizure in a young child).

Seizures are brief disturbances of the electrical function of the brain.

Characteristics of seizures vary and depend on where in the brain the disturbances first start and how far it spreads.

## Types of epilepsy

- There are two types of epilepsy: convulsive and non-convulsive.
- **Convulsive epilepsy** has features such as sudden abnormal movements including stiffening and shaking the body (due to a convulsive seizure).
- **Non-convulsive epilepsy** has features such as changes in mental status (due to non-convulsive seizures).

Describe the two types of epilepsy as described on the slide.

Explain that this module will focus on **convulsive epilepsy**, as that is the type associated with more fear, stigma and discrimination.

## What are seizures?

- Seizures are episodes of brain malfunction due to abnormal surges of electrical activity.
- A seizure usually affects how a person appears or acts for a short time.
- 70% of all seizures are convulsive.

Talk through the points on the slide and briefly explain what a seizure is.

Highlight again that in this module we will concentrate on convulsive seizures as 70% of all seizures are convulsive.

Convulsive seizures have a high mortality rate, but they can be treated.

## Signs and symptoms of a convulsive seizure

<b>During the seizure:</b>	<b>After the seizure:</b>
<ul style="list-style-type: none"> <li>• Loss of awareness or consciousness.</li> <li>• Convulsive movements (involuntary shaking of the body).</li> <li>• Incontinence of urine or stool.</li> <li>• Tongue-biting.</li> <li>• Loss of vision, hearing and taste.</li> </ul>	<ul style="list-style-type: none"> <li>• Low mood, anxiety, worry.</li> <li>• Injuries sustained during seizures.</li> <li>• Muscle aches.</li> <li>• Tiredness/sleepiness.</li> <li>• Abnormal behaviour.</li> <li>• Confusion.</li> <li>• Fatigue.</li> <li>• Pains on one side of the body.</li> </ul>

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Use the slide to explain:

- What a person is likely to experience during a seizure.
- What the person is likely to experience after the seizure.

## Causes of epilepsy

- Brain damage from prenatal or perinatal injuries (e.g. a loss of oxygen or trauma during birth, low birth weight).
- Congenital abnormalities or genetic conditions with associated brain malformations.
- A severe head injury.
- A stroke that restricts the amount of oxygen to the brain.
- An infection of the brain such as meningitis, encephalitis, neurocysticercosis.
- Certain genetic disorders.
- Brain tumour.

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Explain that epilepsy is **not** contagious.

Talk through the points on the slide.

Facilitate a brief discussion about which of these conditions is a common cause of epilepsy in their local community.

It is important to know and discuss local environmental factors that could contribute to seizures and epilepsy.

Encourage participants to participate in the discussion to make sure they are aware of the local causes.

## Epilepsy and non-specialized health settings

- **70%** of children and adults with epilepsy can be successfully treated (i.e. their seizures completely controlled with anti-epileptic medication).
- **Two to five years:** After two to five years of successful treatment and being seizure-free, medication can be withdrawn in 70% of children and 60% of adults.
- **US\$ 5:** This medication costs US\$ 5 per year.

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Emphasize the first point on the slide indicating that epilepsy can be treated effectively in non-specialized health settings.

When people are treated they have a good prognosis. Two to five years' successful treatment and being seizure-free means medication can be stopped in 70% of children and 60% of adults.

Antiepileptic medication is affordable – US\$ 5 per year.

In low- and middle-income countries about 75% of people with epilepsy may not receive the treatment they need.

In fact, in low- and middle-income countries there is a low availability of antiepileptic drugs (AEDs) – this may act as a barrier to accessing treatment.

## Local names for epilepsy

- Are the names/local descriptions of epilepsy negative?
  - Some of the local terms may imply a person is mad, possessed, stupid or cursed.
  - How might this impact on a person and their family?
  - How might this impact on their likelihood to seek help?

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Here are some other reasons (although not exhaustive) for the high treatment gap:

- Epilepsy is a low priority for many countries.
- Limited capacity of health-care systems to address epilepsy and inequitable distribution of resources.
- Lack or severe shortage of appropriately trained staff.
- Inadequate and inconsistent access to affordable medicines.
- Societal misconceptions.
- Poverty.

Generate a brief discussion. Revisit the list of local names and terms produced for a person with epilepsy.

Ask the group if some of the names and terms are negative?

How might that make the person/family feel?

How might that impact on their likelihood to seek help?

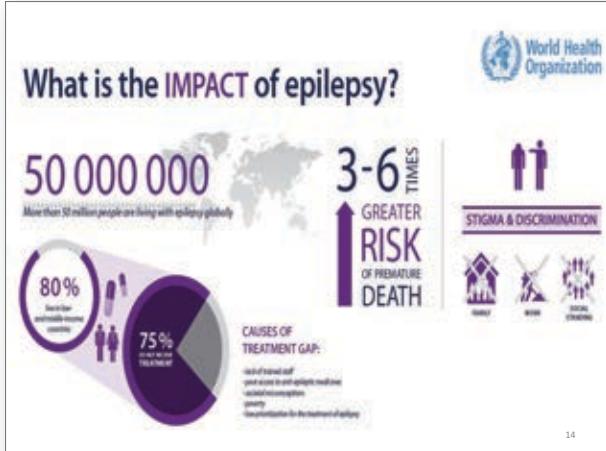
Explain that people living with epilepsy around the world are quite often stigmatized and discriminated against.

Common misconceptions about epilepsy are that it is contagious, and people must be avoided and feared; and that they are possessed by evil spirits and/or bad in some way.

People are denied access to health care and treatment, or they are too afraid to seek help.

Often children are withdrawn from schools. People with epilepsy are overlooked for jobs (impacting on their ability to earn money and support themselves and their family). People with epilepsy are often unable to get married and sometimes prevented from driving.

To summarize, even though epilepsy is a very treatable condition, people with epilepsy are not receiving the help they need and instead are being stigmatized and discriminated against.



Approximately 50 million people worldwide have epilepsy, making it one of the most common neurological diseases globally.

Nearly 80% of the people with epilepsy live in low- and middle-income countries.

People with epilepsy respond to treatment approximately 70% of the time.

Nearly 75% of people with epilepsy living in low- and middle-income countries do not get the treatment they need. In some regions of the world, like Africa, this can be as high as 85%.

Those with epilepsy have a three to six times greater risk of dying prematurely **but** epilepsy can be treated effectively in primary health care.

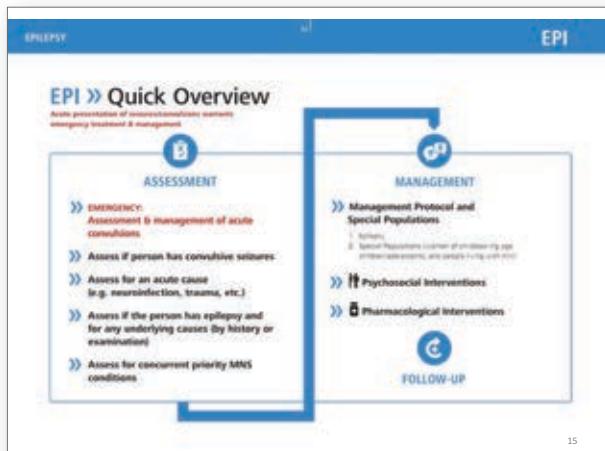
Treatment is simple, inexpensive and effective. Some 70% can be seizure-free for life after two years of treatment.

# Session 2.

# Assessment of epilepsy

⌚ 1 hour 40 minutes

The first part of the session focuses on the management of acute seizures and emergency presentations. The second half of the session focuses on how to assess someone for epilepsy.



Explain that there are two ways that people with epilepsy enter health care services:

- During a seizure – as an emergency presentation.
- After a seizure.

Have participants read through the assessment principles for epilepsy.

mhGAP-IG has an assessment algorithm for both and in this training we will start with how to manage seizures which present as emergencies.

## Why are seizures treated as an emergency?

- Treatment can end seizures or shorten seizure duration, which limits the damage they can cause.
- Prolonged or repeated seizures can result in brain injury.
- Prolonged or repeated seizures can result in death if not treated immediately.
- Seizures can be a symptom of a life threatening problem, like meningitis.

Emphasize why managing seizures is an emergency.

Talk through the points on the slide.

## Activity 2: Group discussion: Emergency presentations

### Group discussion

A person is brought into the clinic and is unconscious after a reported seizure.

What are your first actions?

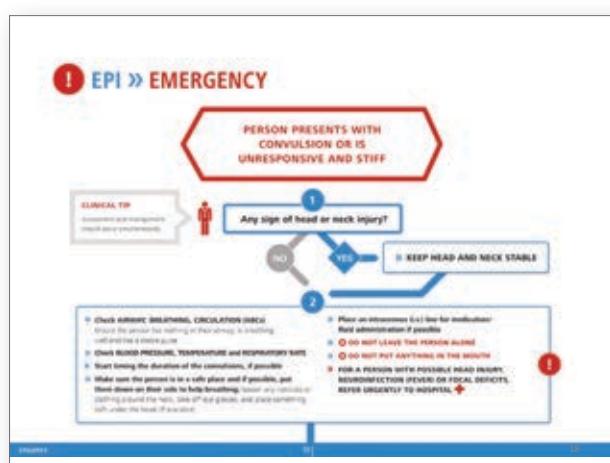
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**Duration:** 10 minutes.

**Purpose:** To learn how much participants know about managing acute seizures.

**Instructions:**

- Give individuals a few minutes to think individually about what they would do in this situation.
- Facilitate a group discussion and seek group consensus to create a comprehensive list of steps they would take to help the person.



Talk through steps 1 and 2 in the algorithm as shown on page 53 of mhGAP-IG Version 2.0.

Emphasize that participants need to understand that they cannot wait until they establish a complete diagnosis to start managing the seizure. Management and assessment must happen at the same time.

Ensuring the A, B, C (airways, breathing, circulation) is crucial, even if they do not have a clear idea about the cause yet.

First action in all cases: Check ABCs

- Airway
- Breathing
- Circulation
  
- DO NOT leave the person alone.
- Place in recovery position.
- Make sure **NOTHING** is in the mouth.

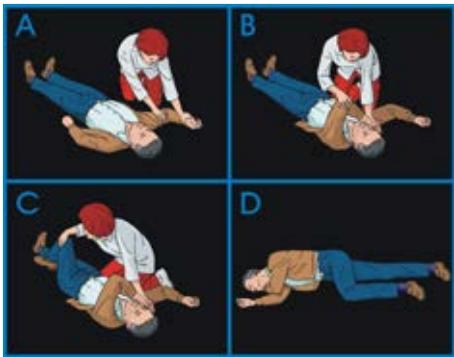


Check with participants if they've already had training on this topic.

If this is a new topic then ensure you give sufficient time to ensure participants understand how to manage acute seizures.

If they have received training in this then explain that this is an opportunity for them to refresh their knowledge.

If the person is still unconscious, use the recovery position



Ask participants to explain and then demonstrate how they put a person in the recovery position (20 minutes).

Divide the participants into pairs and have them practise putting each other into the recovery position (15 minutes).

#### Recovery position

- A. Kneel on the floor to one side of the person. Place the person's arm that is nearest you at a right angle to their body, so it is bent at the elbow with the hand pointing upwards. This will keep it out of the way when you roll them over.
- B. Gently pick up their other hand with your palm against theirs (palm to palm). Now place the back of their hand onto their opposite cheek (for example, against their left cheek if it is their right hand).
- C. Now use your other arm to reach across to the person's knee that is furthest from you, and pull it up so that their leg is bent and their foot is flat on the floor.
- D. Now, with your hand still on the person's knee, pull their knee towards you so they roll over onto their side, facing you.

## Measure and document vital signs

1. Blood pressure.
2. Temperature.
3. Respiratory rate.

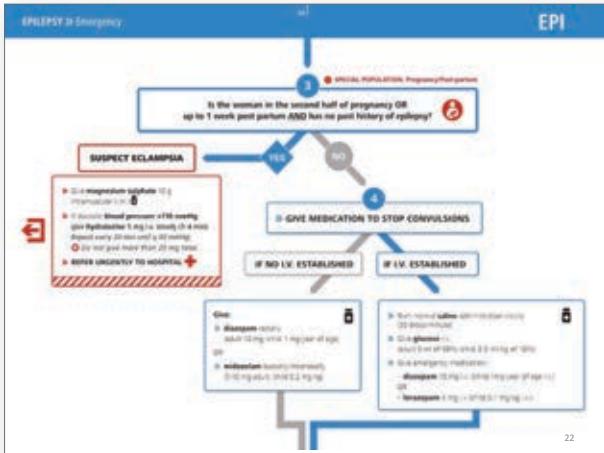
These must be measured and documented.

In particular, the respiratory rate should be counted. You may be using drugs that cause respiratory depression.

Emphasize that these vital signs need to be **measured and documented**.

Respiratory rate actually needs to be counted, not estimated, since trends in respiratory rate become quite important if the person has recurrent seizures and requires aggressive treatment with multiple doses of medications, which can suppress the respiratory drive.

- Time the duration of the convulsions.
- Make sure the person is in a safe place – ensure that nothing is likely to fall on them and/or they can't hit anything if they convulse.
- If possible place in an i.v. line for medication/fluids.
- Know when to **refer** – if a person has a head injury, a neuroinfection or focal neurological deficits then **refer to hospital**.



Direct participants to page 54 of mhGAP-IG Version 2.0.

Talk through the next steps highlighting the special population: pregnancy/post-partum and when to suspect eclampsia.

A pregnant woman who has no history of epilepsy and presents with seizures may have **eclampsia**.

Eclampsia is a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure.

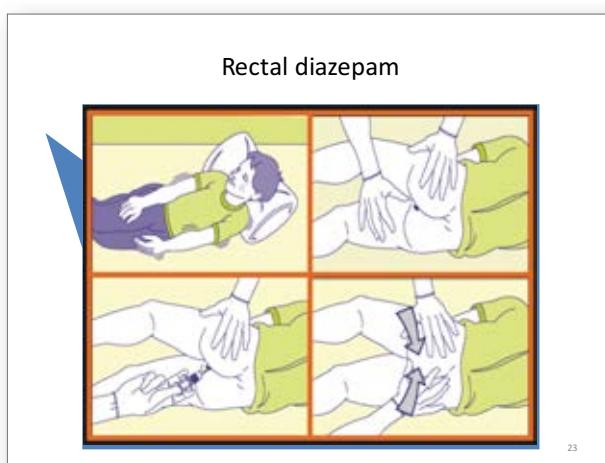
The condition poses a threat to the health of the mother and the baby.

If there is a midwife in your clinic call them to assist. They may have training in how to support people with eclampsia.

**Refer immediately to a hospital.**

**Step 4 (give medication to stop convulsion)**  
 – if you cannot establish an i.v., **do not give diazepam intramuscularly (i.m.)**. Ask participants if they know why they should not give i.m. diazepam?

Explain that i.m. diazepam is poorly and unpredictably absorbed and diazepam should only be given rectally.

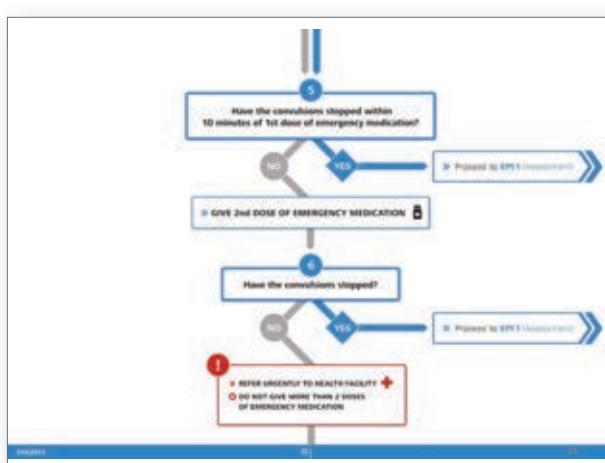


Explain how to give rectal diazepam. Mention to participants that they need to teach this to the carers of people with seizures for them to be able to do it at home.

#### Instructions:

- Draw up the dose from an ampoule of diazepam into a tuberculin (1 ml) syringe.
- Base the dose on the weight of the child, where possible.
- Remove the needle.
- Insert the syringe into the rectum 4 to 5 cms and inject the diazepam solution.
- Hold buttocks together for a few minutes.
- If the convulsion continues after 10 minutes, give a second dose of diazepam rectally (or give diazepam intravenously (0.05 ml/kg) if i.v. infusion is running).

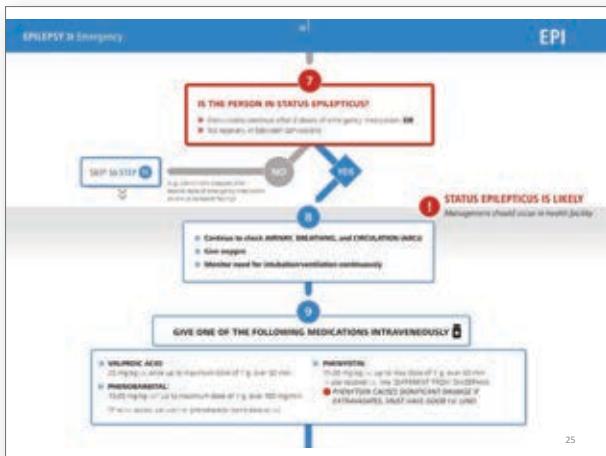
Ask participants what should they do if the convulsions have not stopped within 10 minutes of the first dose of medication?



Direct the participants to page 55 mhGAP-IG Version 2.0. Talk through steps 5 and 6.

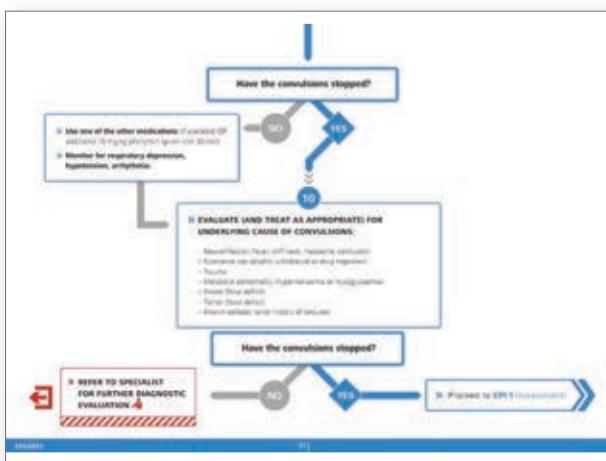
Explain that we will look at the management protocols in the next session but for now we will concentrate on the assessments.

Ask participants if they know when a person is in status epilepticus?



Direct the participants to page 56 mhGAP-IG Version 2.0.

- Explain the definition of status epilepticus and emphasize that management should occur in a health facility.
- Continue talking through the steps of the algorithm if a person is in status epilepticus.
- Explain that i.v. antiepileptic medicines such as i.v. phenytoin and phenobarbital should always be administered in a health care setting.



Once the convulsions have stopped, take step 10 (page 57 mhGAP-IG) – evaluate (and treat as appropriate) for underlying cause of convulsions.

Remind participants that seizures are symptoms not causes, so you always need to look for the cause.

If the person presents convulsing, it is an emergency and needs to be treated urgently as:

- Seizures can be a sign of a life-threatening problem.
- Seizures can result in brain injury or death.

Explain that we are now going to look at some possible causes in more detail.

## What if you suspect a brain infection?

- If there are signs and symptoms (e.g. fever, vomiting, rash):
  - Manage the seizure as we have discussed.
  - Initiate treatment for the underlying brain infection (such as i.v. antibiotic for meningitis).
  - Refer to hospital as this is an emergency.

### Underlying causes

Explain that if you suspect a **brain infection** is causing the seizures, establish if there is a fever, vomiting or a rash.

If there are then manage the seizure as discussed.

Initiate treatment for underlying brain infection (such as i.v. antibiotic for meningitis).

Briefly mention specific treatments or national guidelines for common infections such as cerebral malaria, meningitis, neurocysticercosis (WHO is currently developing guidelines for the treatment of neurocysticercosis), etc.

## What if you suspect trauma?

1. Manage the seizure as we have discussed.
2. Stabilize the neck:
  - DO NOT move the neck.
  - There could be a cervical spine injury.
  - Log roll the person when moving.
3. Assess for other evidence of trauma.
4. Refer to the hospital as this is an emergency.

Explain that another cause of the seizure could be **trauma**.

If they suspect trauma they should talk through the points on the slide.

This may be a good opportunity to ask participants which methods they might use to stabilize the neck.

If there seems to be some confusion or inappropriate ideas, find a volunteer and show them with a hands-on example.

Ask the group what they have available to stabilize the neck or what they might be able to make with local materials. The participants may be able to offer each other advice.

## How to check for other evidence of trauma ?

1. Remove all clothing and check whole body for evidence of trauma.
2. Look/feel for deformity of the skull.
3. Check if pupils are not equal or not reactive to light.
4. Check for blood/fluid from the ears or nose.
5. Look for associated traumatic injuries (spine, chest, pelvis).

From: IMAI District Clinician Manual: Vol 1, section 2 page 7.

Ask participants how they would check for evidence of trauma before revealing the answers.

Ask participants how they would check for evidence of trauma:

- stroke and tumour
- drug ingestion or alcohol withdrawal
- metabolic abnormality.

## What if the person is a child with fever?

- It could be a febrile seizure.
- Febrile seizures are events occurring in children (three months to five years of age), who are suffering from fever and don't have any neurological illness or brain infection.
- There are two types of febrile seizure:
  - Complex (these need to be ruled out).
  - Simple febrile seizures.

Remind participants that we have already discussed what to do if we suspect eclampsia in pregnant or post-partum women.

But ask the participants what they would do if the person is a child with fever?

Then reveal the answers.

**Febrile seizures** are common in primary health-care settings.

Ask the participants to explain the difference between febrile seizures and epilepsy.

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## What is a complex febrile seizure?

It is a complex febrile seizure if one of the following criteria is present:

- **Focal:** Starts in one part of the body.
- **Prolonged:** More than 15 minutes.
- **Repetitive:** More than one episode during the current illness.

A complex febrile seizure needs to be referred to hospital.

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**Answer:** In epilepsy the person has recurrent, unprovoked seizures **without** fever.

Febrile seizures occur when the child has a high fever.

Make it clear that febrile seizures are not epilepsy.

Clarify that it is important to rule out complex febrile seizures as these are at a higher risk of serious underlying pathology and generally need hospital admission, CT scan and lumbar puncture.

Explain the criteria for complex febrile seizures:

- **Focal:** For example, the seizure starts in the arm and then generalizes to the entire body.
- **Prolonged:** Even if it is due to fever with no signs and symptoms suggestive of neurological illness or brain infection, if the duration is more than 15 minutes, it is considered a complex seizure.
- **Repetitive:** If seizures are repetitive, it is considered to be complex.

Emphasize that you **must refer the person to hospital**.

## Management of simple febrile seizures

1. Look for possible causes and manage fever according to the local IMCI guidelines.
2. Observe for 24 hours.
3. Follow-up in one to two months to assure no further seizures.

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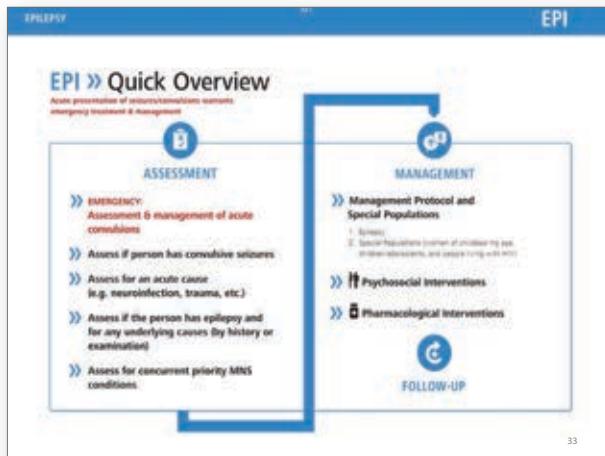
Talk through the points on the slide.

Simple febrile seizures usually last for less than five minutes. The child will:

- Become stiff and their arms and legs may begin to twitch.
- Lose consciousness and may wet or soil themselves.
- If there is only one seizure, it can leave the child feeling sleepy for up to an hour afterwards.

A simple febrile seizure like this will only happen once during your child's illness.

Refer to the WHO Integrated Management of Childhood Illness (IMCI) guidelines, if needed, for more details. If the community does not use or is not aware of the IMCI guidelines, refer to:  
[http://whqlibdoc.who.int/publications/2008/9789241597289\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241597289_eng.pdf)



Explain to participants that they have looked at the emergency assessment and management of acute convulsions.

Once the convulsions have stopped and the person has had sufficient time to rest and recover, the next step is to assess for epilepsy.

## Activity 3: Video demonstration: Assessment

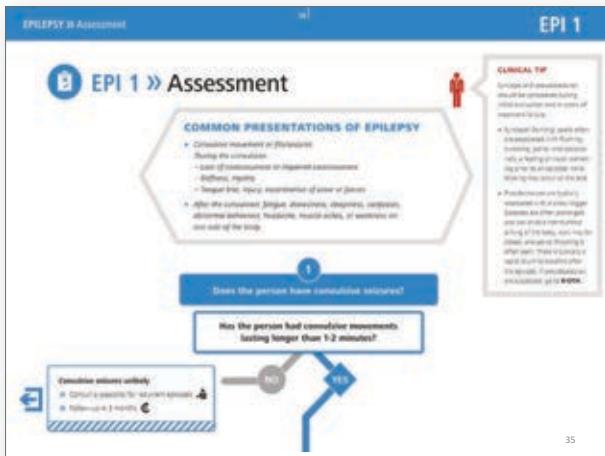
### Activity 3: Video demonstration

- Watch the mhGAP-IG video.
- During the video follow the epilepsy assessment algorithm on page 58 mhGAP-IG Version 2.0.

Explain to the participants that they are about to watch a video of a person being assessed for epilepsy by a primary health-care professional.

During the video participants should look at the epilepsy assessment on page 58 of the mhGAP-IG Version 2.0 and use the clinical decision-making points to decide if the person has epilepsy.

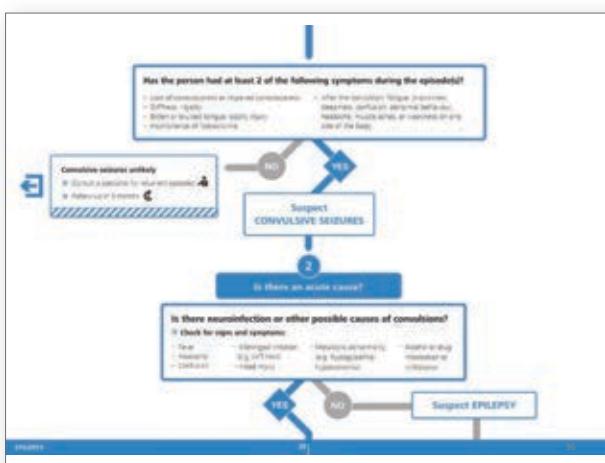
<https://www.youtube.com/watch?v=RUIRg555xI0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>.



After watching the video ask participants:

- Does Faten's presentation match that described in the common presentation of epilepsy?
- Does Faten have convulsive seizures?

Seek a group consensus.



Ask the participants:

- Has Faten had at least two of the symptoms described during an episode?

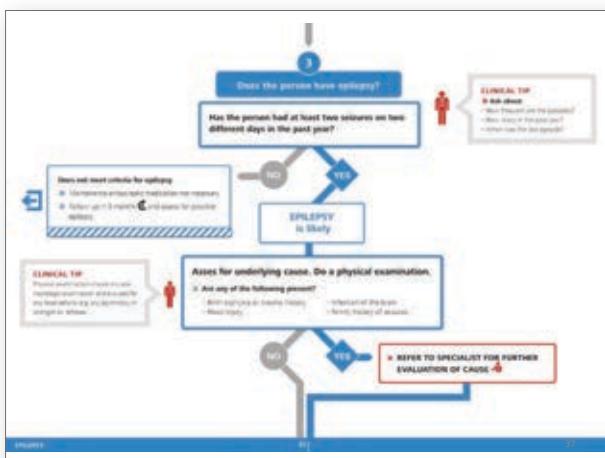
Seek group consensus.

If yes, then suspect convulsive seizures.

Explain that the next step in the assessment is to find out if there is an acute cause?

How did the health-care provider assess if there was a neuroinfection or other possible cause?

**Note:** Replay the video as many times as necessary to ensure participants provide an answer.



Ask the participants:

- Does Faten have epilepsy?
- How did the health-care provider assess if Faten had had at least two seizures on two different days in the past year?
- How did the health-care provider do a physical examination? What did he look for?

## What to look for on physical examination?

- Signs of head and/or spinal trauma.
- Pupils: Dilated? Pinpoint? Unequal? Unreactive?
- Signs of meningitis: stiff neck, vomiting.
- Weakness on one side of body or in one limb.
  - In unconscious people who are unresponsive to pain, you may notice that one limb or side of the body is “floppy” compared with the other.

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Talk through the points on the slide.

If there are conditions in the region especially likely to cause seizures, discuss these here, e.g. cerebral malaria or Japanese encephalitis, neurocysticercosis.

## Ask about other medical conditions

1. Are they diabetic? Are they on any medications?
  - Could this be low blood sugar?
2. Are they HIV positive? Are they on any medications?
  - Could this be an infection (e.g. meningitis)?
3. Is there any chance of poisoning?
4. Is this person a drug user or a heavy drinker?
  - If yes, in addition to managing their acute seizures, you will need to do an assessment according to the drug and alcohol use sections of the mhGAP-IG.

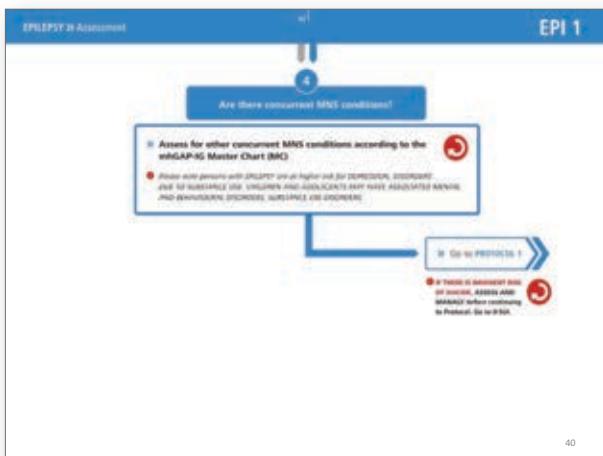
39

Talk through the points on the slide and ask these questions to try and find out about any other medical conditions that could be causing the seizure.

Mention common causes of poisonings and drugs used in the environment, e.g. in farming communities organophosphate poisoning is common.

It may be worthwhile discussing other signs and symptoms of common exposures in the environment.

This added information makes the training more relevant and may help the participants remember what you taught them next time they see such a case.



40

Ask the participants:

- Did the health-care provider assess for concurrent priority MNS conditions?
- Do you suspect Faten has any symptoms of different MNS conditions?
- Does Faten show any imminent risk of suicide?

## Activity 4: Role play: Assessment

### Activity 4: Role play

- A person comes to a primary health-care clinic for the first time after they had a fainting spell the week before.
- The person comes with their spouse.
- The health-care provider conducts an assessment using the algorithm on page 58 of the mhGAP-IG Version 2.0.

See EPI supporting material role play 1.

Print off four different instruction sheets for the participants playing different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

EPI

**Situation:**

- A person comes to a non-specialized health setting for the first time after they had a fainting spell the week before.
- The person comes with their spouse.
- The health-care provider conducts an assessment using the algorithm on page 58 of the mhGAP-IG Version 2.0.

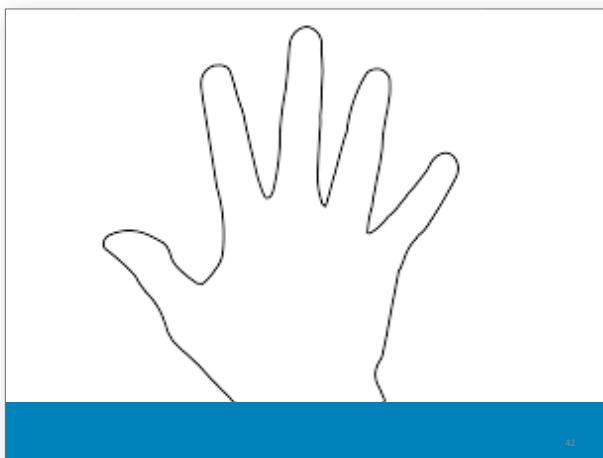
**Instructions:**

- Divide the participants into groups of four.
- Instruct one person to play the role of the health-care provider, one the person seeking help, one person the spouse and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

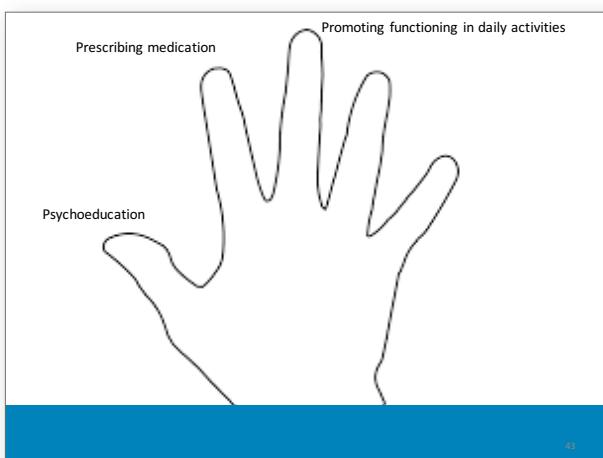
# Session 3.

# Management of epilepsy

⌚ 1 hour 15 minutes



Begin by asking participants what management intervention strategies they think might be appropriate for people suffering with epilepsy.



Explain that if the person and the family are also experiencing high levels of discrimination and/or stress then relaxation strategies and strengthening social support strategies can also be used.



Explain that managing epilepsy with pharmacological interventions and in special populations will be discussed soon, but first psychoeducation will be considered.

This page from the EPI 2 Management guide focuses on psychosocial interventions. It includes two main sections: '2.1 Psychoeducation' and '2.2 Promote functioning in daily activities and community life'. Each section provides information and practical tips for managing epilepsy, such as 'How to explain epilepsy to a child' and 'How to promote functioning in the community'.

Ask participants to read through page 64 mhGAP-IG Version 2.0 (psychosocial interventions).

Clarify any concerns/questions participants may have.

**Group activity:** In plenary, ask participants to adapt any psychoeducation messages to be culturally appropriate in the local context.

### Example of a seizure diary

Ask the person (and carer) to keep a record of seizure history

What happened? (description of seizure)	When? (day, time)	What medication did the person take?	
		Yesterday	Today

Emphasize that a seizure diary can be very helpful in managing epilepsy.

It is useful because it gives a clear idea about the person's problems and how they are progressing.

It also empowers the individual to gain some control over their epilepsy and learn:

- When their seizures happen and what triggers them.
- How medication is having an effect on them.

Make it clear that the diary does not have to be exactly as displayed.

Any record will suffice as long as it includes the details of the event:

- Whether the person was taking the medicines regularly.
- What happened.
- When it happened.
- What/if any triggers were present.

Explain that people with epilepsy can also learn to manage their seizures and understand them better by seeking witness accounts of their seizures. Also, discussing the lead up to their seizures with carers, family members etc. can help.

**Group discussion:** First, ask participants what medications they use to manage epilepsy and discuss in the group.

Give the participants five minutes to read through point 2.3 (Initiate antiepileptic medication) and look at Table 1.

Ask participants to share what key messages they found most important?

Point out the risks of prescribing medication to special populations.

Highlight that once the appropriate medication has been chosen, ensure that it is consistently available.

- Only start one medication.
  - Start at the lowest dose.
  - “Go slow”, increase the dose slowly until convulsions are controlled.
  - Consider monitoring blood count, blood chemistry and liver function, if available.

## Group discussion

- What drugs are available in your setting?
  - How much does the medication cost?
  - How can you ensure medication adherence?
  - What can you do if the medication is not consistently available?

Remind participants of the instruction in the mhGAP-IG to choose a medication that will be **consistently available**. Ask them to reflect whether that is realistic in their settings?

Facilitate a discussion about:

- What drugs are available in your setting?
  - How much does the medication cost?
  - How can you ensure medication adherence?
  - What can you do if the medication is not consistently available?

## Psychoeducation for medication management

Explain to the person and the family:

- The need for prompt medical treatment.
- Explain that this is a chronic condition and the medication must be taken as prescribed.
- If you take the medication as prescribed then the majority of people find that the seizures are fully controlled.
- Explain the potential side-effects and what to do if they occur.
- Explain the risk of further seizures if doses are missed
- Plan for regular follow-ups.

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### Psychoeducation for medication management

Talk through the points on the slide and use the below for extra emphasis.

#### Key messages:

- Explain to the person and the carer the need for medication.
- Explain the importance of taking the medication as prescribed.
- Explain that if they take the medication as prescribed they can expect to control the seizures.
- Explain the potential side-effects and what to look out for and what to do.
- Explain the risk of further seizures if doses are missed.
- Plan for a follow-up session to show that you are still there to support them.

**EPI 2 » Management**

**PROTOCOL**

**Special populations**

Identify that management may differ for SLEP/HIV in these populations

**WOMAN OF CHILDBEARING AGE** (Leave off of antiepileptic medication in pregnancy)

- Avoid folic acid 0.4 mg daily to prevent neural tube defects. > 4000 women of childbearing age.
- Avoid calipers
- **Class 1 or 2 Pregnant:**
  - Avoid folic acid 0.4 mg daily to prevent neural tube defects. > 4000 women of childbearing age.
  - If medication is required during pregnancy, they should be used sparingly.
  - If possible, avoid folic acid 0.4 mg daily to prevent neural tube defects. > 4000 women of childbearing age.
- **Planning:** (containing points 41 to 44)

**CHILD/ADOLESCENT** (Leave off of antiepileptic medication in adolescence)

- High risk of **adolescent disorder** - manage this condition. See 1-10
- The adolescent with epilepsy should receive as little guidance on it as possible. Manage this condition. See 1-10
- **Indication:** Indication due to brain injury, history of abuse, etc.
- **Caution:** Avoid polypharmacy.

**PERSON LIVING WITH HIV** (Leave off of antiepileptic medication in persons living with HIV)

- Other drugs, refer to specific drug monographs. No generic substituted regimen for antiepileptic medications.
- **Indication:** Indication due to brain injury, history of abuse, etc.
- **Caution:** Avoid polypharmacy.

Ask participants to read through the management options for special populations.

#### Ask participants:

- Why these groups are considered special populations?
- What are the concerns for:
  - Women of childbearing age?
  - Children and adolescents?
  - Persons living with HIV?

## Activity 5: Role play: Management

### Activity 5: Role play

- A health-care provider assessed this person and their spouse and decided that the person has epilepsy.
- The health-care provider now has the responsibility of developing a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to the spouse on how to help the person if they have a convulsive seizure at home and when to refer for medical help.

See EPI supporting material role play 2.

Print off the four different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 40 minutes.

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Situation:**

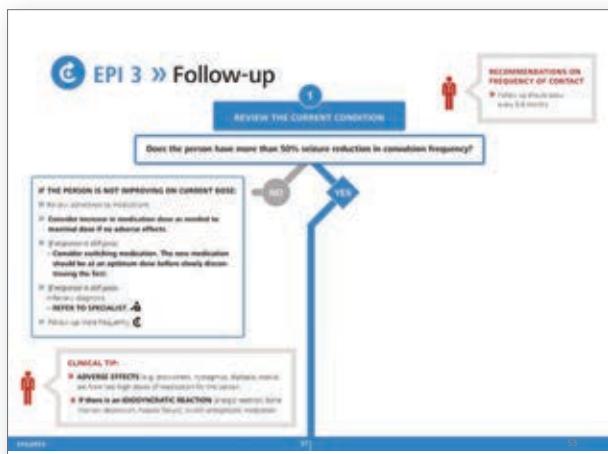
- A health-care provider assessed this person and their spouse and decided that the person has epilepsy.
- The health-care provider now has the responsibility to develop a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to the spouse on how to help the person if they have a convulsive seizure at home and when to refer for medical help.

**Instructions:**

- Divide the participants into groups of four.
- Instruct one person to play the role of the health-care provider, one the person seeking help, one the spouse and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 4. Follow-up

⌚ 40 minutes



Highlight the recommendations on frequency of contact (page 67 mhGAP-IG Version 2.0) and explain that follow-up should occur every three to six months.

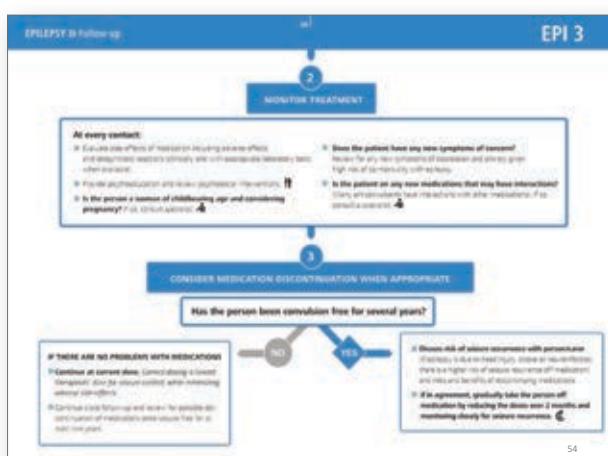
Ask participants why they think that is?

Talk through step 1 of the follow-up algorithm and ask participants to brainstorm what questions they could ask at follow-up?

Possible questions could include:

- Has the person been keeping a seizure diary?
- Have there been any drug specific side-effects?
- Are they taking their medication as prescribed? If not, why not?
- Are they having any other issues?

Describe what to do if the person is not improving on their current dose, highlighting when they should refer.



Describe what should be monitored at regular follow-ups.

Focus on asking about how well they are being accepted and treated by the community.

Describe when to consider stopping medication and why.

## Activity 6: Group discussion: How to reduce stigma and discrimination

### How to reduce stigma and discrimination?

1. Why is it important that you respect, protect and promote the rights of people with epilepsy?
2. Can you think of some concrete actions that you could undertake to make the rights of people with epilepsy a reality?
3. What would be the positive impact of these actions for all the groups concerned?

**Duration:** 30 minutes.

**Purpose:** To have participants reflect and plan what they can do to help reduce stigma and discrimination against a person with epilepsy and their carer.

#### Instructions:

- Divide the participants into three groups.
  - One group will represent people with epilepsy.
  - One group will represent non-specialized health-care providers.
  - One group will represent the family and carers of people with epilepsy.
- Give each group three pieces of flip chart paper and pens.
- You are going to ask the groups three different questions.
- They should write down their answers to the questions on three separate pieces of flip chart paper.
- Instruct the participants to write down their answers imagining that they are a person from the group they represent.

**Question 1:** Why is it important that **you** respect, protect and promote the rights of people with epilepsy?

**Question 2:** Can you think of some concrete actions that you could undertake to make the rights of people with epilepsy a reality?

**Question 3:** What would be the positive impact of these actions for all the groups concerned?

Possible answers to look for:

**Question 1:** Why is it important that **you** respect, protect and promote the rights of people with epilepsy?

**Potential answers from people with epilepsy:**

- We can contribute a wide array of expertise, skills and talents and these can benefit everyone.
- We are human beings and should have the same opportunities as everyone else.
- We know what is best for us; what is helpful and what is not helpful.
- We have the right to participate in all actions and issues that affect us.

**Potential answers from health-care providers:**

- I want to give the people under my care the respect they deserve.
- It is my legal obligation.
- This is part of my job and responsibility.
- It is the right thing to do.
- By providing care and support that respects people's rights, people are more likely to accept the service we provide, respond well to our care and support and to recover.

**Potential answers from family members and carers:**

- I can help voice the wishes and preferences of my relative and help explain these to others when needed.
- I want what is best for my relative and these rights give them the best opportunities to live a good life.
- I can have an important role in enabling my relative to live a more fulfilling life by respecting their rights, being more accepting and changing some of my own actions.

**Question 2:** Can you think of some concrete actions that you could undertake to make the rights of people with epilepsy a reality?

**Potential answers from people with epilepsy:**

- I can learn my rights and understand them.
- I can explain my rights to my peers, family and the community members.
- I can speak with local officials about the need to change.
- I can help other people in the same situation as me.
- I can talk about my experience to raise awareness about disability and human rights.

**Potential answers from health-care providers:**

- I can make sure that my clinical practice promotes respect and dignity and the rights of people with epilepsy.
- I can train and inform other staff about human rights and make sure that my colleagues also promote respect and dignity.
- I can talk to people about epilepsy in my work place so that they understand.
- I can speak to service management about taking action to improve treatment for people with epilepsy.
- I can speak with local officials about the need to change.
- I can make sure that people with epilepsy are involved and participate in decisions concerning running services for them.

**Potential answers from family members and carers:**

- I can explain their rights to my relative.
- I can make my relative feel that I respect them.
- I can try not to over protect my relative.
- I can make sure I listen and respect their views and decisions.
- I can support and encourage my relative to make decisions and become independent.

- I can make sure other family members/community members respect the rights of my relative.
- I can speak with local officials about the need for change and for the creation of the services that meet the needs of my relative and other people with epilepsy.
- I can raise awareness in the community to break down stigma, stereotypes and prejudices.

**Question 3:** What would be the positive impact of these actions for all the groups concerned?

**Potential benefits for people with epilepsy:**

- I would have greater independence and be less dependent on my family, friends and health-care provider.
- I would feel more empowered to take control of my own life and recovery.
- I would feel stronger.
- I would be able to develop new skills.
- I would be able to contribute my skills and talents to society and be more included.

**Potential benefits for health-care providers:**

- I would be able to provide better quality of care for individuals.
- I would see better outcomes for people so I would feel happier in my job.
- I would be able to improve services provided.
- The people to whom I provide care and support would be empowered.
- Relapse and dependency would be reduced.
- I can make the service a better place to work.
- People to whom I provide care would lead more fulfilling and independent lives.

**Potential benefits for family members and carers:**

- I would feel better and happier because my relative was better and had a better quality of life.
- I would have more time to pursue my own goals as I would need to spend less time caring for my relative.
- I would feel empowered to be able to support my relative and start breaking down prejudice and stereotypes.
- I would feel less stressed and have better mental well-being.
- I would feel empowered to be able to talk to local community leaders and decision-makers about respecting the rights of people with epilepsy.
- I would have a happier family as my relative would be able to engage more in family life.

# Session 5. Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the MCQs (see EPI supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# EPI PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/epi\\_slides.pdf](http://www.who.int/mental_health/mhgap/epi_slides.pdf)

## EPI supporting material

- Person stories
- Role plays
- Multiple choice questions
- Video links

Activity 3: mhGAP EPI module – assessment

<https://www.youtube.com/watch?v=RUIRg555xI0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/epi\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/epi_supporting_material.pdf)

CMH

# Child and adolescent mental and behavioural disorders

**mhGAP training of health-care providers  
Training manual**



**World Health  
Organization**

# Module: Child and adolescent mental and behavioural disorders

## Overview

### Learning objectives

- Promote respect and dignity for children and adolescents with mental and behavioural disorders.
- Know common presentations of children and adolescents with mental and behavioural disorders.
- Know assessment principles of child and adolescents with mental and behavioural disorders.
- Know management principles of child and adolescents with mental and behavioural disorders.
- Use effective communication skills in interactions with children and adolescents with mental and behavioural disorders.
- Perform an assessment for children and adolescents with mental and behavioural disorders.
- Assess and manage physical conditions of children with mental and behavioural disorders.
- Provide psychosocial interventions to children and adolescents with mental and behavioural disorders and their carers.
- Deliver pharmacological interventions as needed and appropriate to children and adolescents with mental and behavioural disorders.
- Plan and perform follow-up for children and adolescents with mental and behavioural disorders.
- Refer to specialists and link children and adolescents with mental and behavioural disorders with outside agencies where available.

## Key messages

- When assessing children and adolescents, always keep in mind the child's age (developmental stage) and the impact the problem is having on their ability to function in daily life.
- Developmental disorders present as the child showing delayed development in at least one domain of development.
- Behavioural disorders present as excessive over-activity, excessive inattention, disobedient, defiant and/or disturbed behaviours.
- Emotional disorders present as excessive sadness, fear, anxiety and/or irritability.
- In any assessment always assess the home environment and school environment to explore any stressors at home or in school that could be contributing to the child or adolescent's difficulties. Also, to assess if there are any external factors that may be causing the child's behaviour.
- Pay attention to the needs and the resources of the carer. Ensure that carers are supported enough so that they can help the child/adolescent.
- Link and coordinate with community resources and organizations including schools during the assessment and management of children and adolescents.
- Use psychosocial interventions to manage children and adolescents with mental and behavioural disorders.
- Follow-up with the children and their carers regularly as life can change quickly for a child.
- Remember that what happens in early childhood and adolescence can impact on that person for the rest of their lives.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to child and adolescent mental and behavioural disorders	Promote respect and dignity for children and adolescents with mental and behavioural disorders  Know common presentations of children and adolescents with mental and behavioural disorders	30 minutes  30 minutes  50 minutes  15 minutes	<b>Activity 1: Person's story</b> Use a person's story to introduce common presentations of child and adolescent mental and behavioural disorders  <b>Activity 2: Group work: Common presentations of developmental, behavioural and emotional disorders</b> How do they impact on the individual, family and society?  Presentation on developmental, behavioural and emotional disorders  <b>Activity 3: Group work: Developmental milestones</b>
2. Assessment of child and adolescent mental and behavioural disorders	Know assessment principles for children and adolescents with mental and behavioural disorders  Use effective communication skills in interactions with children and adolescents with mental and behavioural disorders  Perform an assessment for children and adolescents with mental and behavioural disorders  Assess and manage physical conditions of children with mental and behavioural disorders	40 minutes  40 minutes  30 minutes	<b>Understanding the assessment algorithm</b> Use the mhGAP-IG and PowerPoint presentation to explain the CMH assessment algorithm  <b>Activity 4: Video demonstrations: Assessment</b> Use videos/demonstration role play to show an assessment and allow participants to follow it according to: mhGAP-IG assessment algorithm  <b>Activity 5: Demonstration role play: Assessment (conduct disorder)</b> Assessing a child/adolescent for mental and behavioural disorders
3. Management of child and adolescent mental and behavioural disorders	Know management principles of child and adolescents with mental and behavioural disorders  Provide psychosocial interventions to children and adolescents with mental and behavioural disorders and their carer  Deliver pharmacological interventions as needed and appropriate to children and adolescents with mental and behavioural disorders  Refer to specialists and link children and adolescents with mental and behavioural disorders with outside agencies as appropriate and where available	15 minutes  45 minutes	<b>Management interventions for child and adolescent mental and behavioural disorders</b>  <b>Activity 6: Role play: Psychosocial interventions</b> Skills, feedback and reflection
4. Follow-up	Plan and perform follow-up for children and adolescents with mental and behavioural disorder	40 minutes	Follow-up algorithm and brief discussion  <b>Role play: Follow-up</b> Following up with an adolescent with depression
5. Review		15 minutes	<b>Quiz</b>
<b>Total duration (without breaks) = 5 hours 50 minutes</b>			

# Step-by-step facilitator's guide

## Session 1: Introduction to child and adolescent mental and behavioural disorders

⌚ 2 hours 5 minutes

### Session outline

- Introduction to child and adolescent mental and behavioural disorders
- Assessment of child and adolescent mental and behavioural disorders
- Management of child and adolescent mental and behavioural disorders
- Follow-up
- Review

Begin the session by briefly listing the topics that will be covered.

CMH

## Activity 1: Person's story

### Activity 1: Person's story

- Present the person's story of what it feels like to live with child and adolescent mental and behavioural disorders
- First thoughts

Choose just one story for this activity.

- Introduce the activity and ensure participants have access to pens and paper.
- Tell the story – be creative in how you tell the story to ensure the participants are engaged.
- First thoughts – give participants time to give their immediate reflections on the accounts they heard.

## Local perspectives

- How do the community perceive and understand children and adolescents with mental and behavioural disorders?
- What treatment and care do the children/adolescents receive? How does it impact on them?
- How are the families treated? How does it impact on them?

Ask participants to explain how the community perceives and understands children and adolescents with mental and behavioural disorders.

Ask participants to reflect on the sort of treatment and care children and adolescents with mental and behavioural disorders receive.

**Note:** Ensure that through this discussion you emphasize that children and adolescents with mental and behavioural disorders will often have difficulties with:

- development
- sense of well-being
- education
- social activities
- employment
- exposure to abuse, neglect and violence.

The families and carers will often experience overwhelming amounts of stress and financial strain.

## Child and adolescent mental health: A public health concern

- Mental health problems affect 10–20% of children and adolescents worldwide.
- Depression is the number one cause of illness and disability in young people aged 10–19 years old and suicide ranks number three among causes of death.



Explain that children and adolescents constitute almost a third (2.2 billion individuals) of the world's population and almost 90% live in low- and middle-income countries.

Currently 10–20% of children and adolescents worldwide live with mental and behavioural disorders.

If participants challenge this statistic, recognize that childhood and adolescence are developmental phases and it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are not.

Some studies have identified much higher rates of MNS disorders.

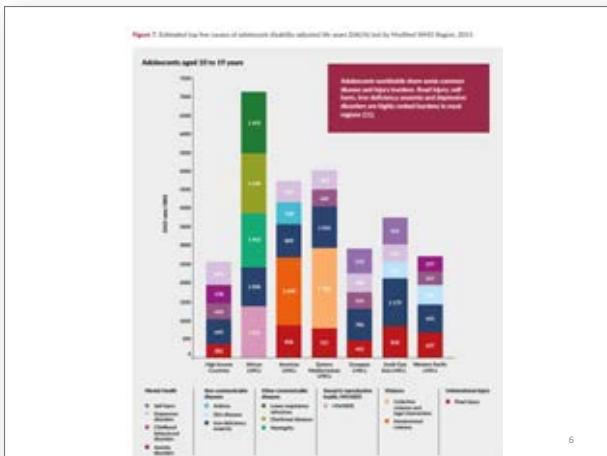


Figure 7 from the Global Accelerated Action for the Health of Adolescents (AA-HA!) shows the top five estimated causes of disability-adjusted life years (DALYs) lost for each modified WHO region, 2015.

As you can see, adolescents worldwide share some common disease and injury burdens. Road injury, self-harm/suicide, iron deficiency anaemia and depressive disorders are highly-ranked burdens in most regions.

Adolescence is also a period when many risky or protective behaviours start or are consolidated. Examples include diet and physical activity, substance use and sexual risk behaviours. These will have major effects on future adult health and well-being.

For 10–14 year olds, unsafe water, unsafe sanitation and inadequate hand-washing are major health risks for both boys and girls.

For 15–19 years olds, health risk factors such as alcohol and tobacco use, unsafe sex and drug use also become very important, along with intimate partner violence and occupational hazards.

Not enough attention has been paid to health in children and adolescents, to the detriment of the development of nations.

### Public health concern

- Some studies show that half of all people who develop mental disorders have their first symptoms by the age of 14, and 75% have had their first symptom by their mid 20s.
- If these early symptoms are left untreated they impact on:
  - Child/adolescent development.
  - Educational attainments.
  - Potential to live fulfilling and productive, healthy lives.

Explain that some studies have shown that 50% of all people who develop mental disorders have their first symptoms by the age of 14, and 75% have had their first symptoms by their mid 20s.

Explain that if these first symptoms at age 14 and above are left untreated or are missed it will seriously influence the child/adolescent's development, their educational attainments, and their potential to live fulfilling, productive and healthy lives.

## Early identification

- Early identification and early treatment can literally change the course of a person's entire life.
- Healthy early child development strongly influences well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality and economic participation throughout life.

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Emphasize that with early identification and treatment, the prognosis for a child/adolescent with mental and behavioural disorders can improve drastically and change the course of a person's entire life.

Healthy early child development, which includes physical motor skills, social/emotional and language/cognitive domains of development – all equally important – strongly influences well-being, obesity/stunting, mental health, heart disease, competence in literacy and numeracy, criminality and economic participation throughout life.

What happens to the child in the early years is critical for the child's development trajectory and life course.

## Stigma and discrimination

- Children/adolescents with mental and behavioural disorders face major challenges with stigma, isolation and discrimination.
- They lack access to health care and educational facilities.

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Explain that children/adolescents with mental and behavioural disorders face major challenges with stigma, isolation and discrimination as well as lack of access to health care and educational facilities.

**Note:** Depending on the discussion of "local perspectives" held at the beginning of the session, you can highlight how children/adolescents with mental and behavioural disorders are discriminated against in the local community.

## Forms of stigma and discrimination and abuse

- They may be bullied by siblings or others.
- They may be excluded from schools.
- They may not be brought for vaccination/essential health care.
- They may be tied up, abandoned or left alone in the house.
- They may receive less food in poor families.
- They may be subject to harmful forms of traditional healing (e.g. beating the spirit out).
- They may be harshly beaten by frustrated parents.

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Talk through the points on the slide and add any other examples of stigma, discrimination and abuse that participants think of. For example, are children able to go to school or are they isolated? What names they are called? How are they and their families treated?

Ask participants to reflect on how often they see children and adolescents in their health-care practices.

Do the participants feel that children/adolescents with mental and behavioural disorders have fair access to treatment and care in their local settings?

Facilitate a brief discussion (maximum five minutes).

## Social impact of stigma and discrimination

- Poor school performance.
- Reduced community participation.
- Impaired capacity to live independently.
- Limited employment opportunities.
- High carer burden (socially, financially, emotionally).
- Mothers or families may also be stigmatized or become isolated.

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Explain that the impact of this stigma and discrimination is long lasting.

Talk through the points on the slide.

Emphasize that the stigma and discrimination not only impacts on the individual but the family and the wider community as well.

It can limit outcomes for the individual in terms of poor school performance, social isolation, loss of confidence and lack of self-esteem.

It can also limit the outcomes of the family, in terms of parents and siblings being marginalized, loss of job opportunities, financial strain and stress for the carer.

## What challenges do you face in assessing and managing mental and behavioural disorders in children and adolescents?

- Carer/adolescent refuses to talk about mental health.
- Carer/adolescent has unrealistic expectations about management outcomes.
- Carers present mental health or substance abuse problems.
- Child/adolescent is being neglected or abused.
- Carers and their children are victims of stigma and isolation.

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Ask the question on the slide and allow participants to answer before revealing the answer.

- Once the answers have been revealed, explain that child/adolescents can present with multiple and overlapping symptoms which can make it difficult to determine what kind of mental health difficulty they may have.
- Now provide feedback to the points on the slide according to the answers under the **note** below.

**Note:** It can be time-consuming to assess and treat children and adolescents.

Possible tips to overcome the problems include:

### If the carer/adolescent refuses to talk about mental health:

- Do not force them to talk.
- Provide generic suggestions for improving children's development and well-being.
- Ensure that you are open and non-judgemental in your communication and encourage them to come back in the future.

### If the carer/adolescent has unrealistic expectations about management outcomes:

- Explain the limitations of what you can do.
- Emphasize that the carer/adolescent needs to be patient as improvements will be seen over a long period of time.

Carers present with mental health or substance abuse problems:

- Assess and manage the carer's MNS problems.
- Ask about any children and adolescents in the family and ensure that they are not at risk.
- Ask about other family members who can help.
- Link with outside agencies if appropriate.

**Child/adolescent is being neglected or abused:**

- Explain to the carer that good care, adequate education and a positive environment are essential for the child/adolescent to learn, feel happy and behave well.
- Consult a specialist if the situation is severe or does not improve over time.
- Link the family with outside organizations if appropriate, including access to legal services and social services.

**Carers and their children are victims of stigma and isolation:**

- Listen to carers and children.
- Emphasize that these behaviours are caused by people's ignorance and false beliefs.
- Link them with other people and families with similar problems to create peer support groups.

### Special considerations for assessment of children

- Expectations about what is "normal" vary according to stage of development.
  - Symptoms for disorders may vary according to age and stage of development.
- The capacity to understand the problem and to participate in decision-making for treatment evolves with age.
  - It will be necessary to adapt your language to the developmental stage.
  - When talking to adults, never forget that the child is in the room! Be conscious of the child's level of understanding.
  - Allow opportunities for the child to express concerns in private and, if possible, express themselves in front of the carer.

13

Talk through the first point on the slide and emphasize that what is a normal behaviour or normal capacity to perform tasks (e.g. moving, speaking, interacting with others) at one age may be not be normal at another point in time.

Then explain the second point and show participants how they can modify their own behaviours when they are assessing children.

### Special considerations for assessment of children

- The mental health of children is closely related to the mental health of the carer. Assess carers' mental health needs.
- Explore available resources within the family, school and community. Carers and teachers are often your best allies!
- Explore negative factors affecting mental health and well-being.
- Children and adolescents are vulnerable to human rights violation. Ensure access to education and appropriate health care

14

Read through the first point on the slide and explain that whenever we assess children's development and psychological well-being, we also need to assess:

- The carers' capacity to provide a caring environment.
- The availability of other people who can support the child and carers.

Talk through the rest of the slide and emphasize that it is important to assess both resources and negative factors in the child's environment.

Examples of "resources" are: a caring mother/father, a grandmother available to take care of the child or a teacher trained to manage children with special needs.

## Special considerations for assessment of adolescents

- It can be “normal” for adolescents to have distressing and disruptive emotions, thoughts and behaviours and are only a disorder when they persist over time and affect daily functioning.
- Adolescents may be difficult to reach as they often do not seek help.
  - Always offer adolescents the opportunity to be seen on their own without a carer present.
  - Clarify the confidential nature of the discussion.
  - Indicate in what circumstances parents of adults will be given information.
  - Explore the presenting complaint with the adolescent directly.

15

Examples of “negative factors” are a stressed or depressed mother, a violent family environment, emotional abuse and neglect, bullying at school or a child who spends long hours alone.

Explain that in some cases it may be important to talk with other relatives or one of the child’s teachers.

Explain that this slide introduces special considerations for the assessment of adolescents.

Read through the slide.

Emphasize the need to provide care to adolescents in non-stigmatizing and confidential settings.

## Activity 2: Group work: Common presentations of developmental, behavioural and emotional disorders

### Activity 2: Group work: Common presentations

You are going to hear different case histories.

Use the mhGAP-IG to identify which child and adolescent mental and behavioural disorders are being described in the case histories.

16

**Duration:** 30 minutes.

**Purpose:** Create an interactive discussion between participants whereby participants use the master chart in the mhGAP-IG to learn about the common presentations of children and adolescents with developmental, behavioural and emotional disorders.

#### **Instructions:**

- In plenary discussions, show the participants the following four case histories.
- Show one case history at a time and after reading through the history, and ask the participants to match the descriptions in the case history with those in Table 1: Common presentations of child and adolescent mental and behavioural disorders by age group (page 71 mhGAP-IG).

## Case history 1

*My son is now five years old. I noticed that he was late in both sitting and walking compared with other children in the family.*  
*He also started talking late and still is using very simple words to describe things that he wants.*  
*When he is hungry he will rub his tummy and say "hungry" or "food" but finds it difficult to say complete sentences.*  
*He is able to say his own name when asked, but often needs me to help him. He is a really loving child who likes to be hugged.*

17

Read the case history out loud or ask a volunteer to read it.

## Case history 1 continued

*Often he will forget where he put his toy, and then he will cry till I comfort him and find it for him.*  
*He loves to go out to play with the children in the playground and kick the football around, but he is often left out of the games since he is not able to follow the rules.*  
*Even now he needs help with all his daily activities including dressing and eating, though he can manage dry biscuits. He should have started in the local school. I feel he is not ready, since he is not yet toilet trained.*  
**Developmental delay/disorder (intellectual disability)**

18

Only reveal the answers (in red) after the participants have had a chance to use the mhGAP-IG to identify what they think the presentation is.

Once you have revealed the disorder described in the case history, explain that this boy is five years old yet it sounds like he has not met the expected developmental stages for a five-year old, e.g. he is still finding it difficult to use complete sentences, he was late to sit and walk compared with other children, he is not toilet trained and still needs help feeding and dressing himself. His learning and play are also delayed, e.g. he cannot follow the rules of football when playing with the other kids. He struggles to play with toys.

This presentation is one of developmental disorder (intellectual disability).

## Case history 2

Mother of three-year-old boy:

*I am concerned about my son. He is a bit of a slow learner...  
(pause).*

*I've been thinking about coming to the clinic for a while but it was really my sister-in-law who told me I should bring him in. It's taken him longer to learn things than his older brothers and sisters. He's three years old now but he's not talking much yet.*

*His younger sister is two and she can say things like, "More water mama" and "Come here", but he can't really speak. He does make sounds as if he's talking but he's not saying any real words. Sometimes, he will make sounds like "Aah-da-aah-da-aah-da" when he's excited. I can also tell that he's excited because he flaps his hands like this....*

19

Read the case history out loud or ask a participant to read it out.

## Case history 2 continued

*He doesn't really like to play with other kids or even with his brother or sisters. He often plays by himself by rolling his toy cars back and forth on the ground. He also really likes to line up his cars in rows – he can do that for hours! Little cars and trucks are his favourite toys. He doesn't really play with any other toys and sometimes he doesn't even want to put them down to eat meals! He really likes toy cars but he doesn't play with them the same way as his brother.*

*He doesn't really try to get my attention like my other children. He seems not to notice the world around him. It's like he's in his own world.*

**Developmental disorder (autism spectrum disorder)**

20

Only reveal the answers (in red) after the participants have had a chance to identify what they think the presentation is.

Once you have revealed the answers explain that this boy also has delays in reaching developmental milestones, e.g. he is still not talking and has problems communicating including not communicating with his mother. He has difficulties with social interactions and prefers to spend time on his own. He is showing repetitive patterns of behaviour (lining up his cars in a row for hours).

This is a presentation of a developmental disorder (autism spectrum disorder).

## Case history 3

*My daughter is 12 years old. This last month or so she has been crying about the smallest thing.*

*If you say anything to her, she is likely to snap back at you. A few times I've heard her being really grumpy with her friends when they call her to play. They don't call her any more.*

*She used to have many interests, like playing board games, helping with the housework, drawing. But now she's just not interested in any of it.*

*She just sits alone in the house. She won't wake up for school unless I ask her several times to get out of bed.*

21

Read the case history out loud or ask a participant to read it.

## Case history 3 continued

*She's stopped eating even her favourite meals, and she looks a lot thinner.  
I don't know if it's due to being tired or eating less, but she doesn't have her usual energy any more.*

Emotional disorder (depression)

Only reveal the answers (in red) after the participants have had a chance to identify what they think the presentation is.

Once you have revealed the answer explain that this girl is sad all the time and she is irritable (snapping at her friends). She has lost interest in activities that she used to get enjoyment from. She has lost weight and her appetite.

This presentation is one of an emotional disorder (depression) in an adolescent.

## Case history 4

*He is all over the place – always on the move. He won't sit still at the table while we are eating – it's fidgeting the whole time. He'd get up between mouthfuls if I let him. If there is some work that needs doing, he'll start willingly but within a few minutes he's been distracted and begun doing something else instead.*

*The teachers complain too that he is very naughty and disturbs other children. also, he doesn't do as well as he used to in his studies.*

*He breaks things in the house.*

*He has frequent falls and injuries.*

Behaviour disorder (attention deficit hyperactivity disorder)

Read out the case history out loud or ask a participant to read it

Only reveal the answers (in red) after the participants have had a chance to identify what they think the presentation is.

Once you have revealed the answer explain that this boy shows excess over activity (he is always on the move – all over the place). He has problems remaining seated. He shows excessive inattention – he will start a task but will not finish.

Teachers report that his behaviour disturbs others – a sign that this behaviour is happening in multiple settings because teachers are also noticing.

This presentation is one of attention deficit hyperactivity disorder (ADHD) – behavioural disorders

## What is child development?

- The process of growing and acquiring new skills (i.e. walking and grasping objects, communicating, playing, interacting with others).
- It is a complex process, determined by the biological brain development, influenced in part by the quality of interactions with others (i.e. carers).
- Child development is not just about growing, but what happens to the child in the early years is critical for the child's development trajectory and life course.

Explain that child development is the process of growing and acquiring new skills.

It is complex and largely determined by biological brain development, but it is also influenced by the quality of the child's interactions with others (their parents and carers), their environment (safe, clean, stimulating), their nutrition etc.

What happens to the child in the early years is critical for the child's development trajectory and life course.

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## Different domains of child development

Examples in each domain:

- Motor (movement) skills:
  - Sitting up, walking, skipping.
  - Picking up objects, using a spoon, drawing.
- Communication and speech:
  - Babbling (e.g. say “bababa”), pointing, using words.
- Social interaction:
  - Smiling, waving goodbye, taking turns with others.
- Play and learning (cognitive):
  - Problem-solving, exploring the environment, doing maths.

25

Explain that these are the different domains of child development.

During childhood and adolescence these are the domains in which people grow, develop, acquire new skills and learn. All of which prepare them for adulthood.

Talk through the points of the slide.

**Note:** The last bullet refers to what is commonly known as *cognition*.

It is not important participants learn the word cognition.

## Activity 3: Group work: Developmental milestones

### Developmental milestones

- By the age of one month the child should be able to.....
- By the age of six months the child should be able to.....
- By the age of 12 months the child should be able to.....
- By the age of 18 months the child should be able to.....
- By the age of 24 months the child should be able to.....

26

**Duration:** 15 minutes including discussion.

**Purpose:** Check and strengthen participants' knowledge about developmental milestones.

**Materials:** Each group has a blank developmental milestones flip chart on the floor (that looks like this slide) (facilitator may want to prepare this in advance to save time).

#### Instructions:

- Divide participants into small groups.
- Explain that the exercise will involve finding out how much you know about what children are able to do at different ages.
- Each group will receive an envelope containing cards with developmental milestones written on them (see CMH supporting material).
- Give 10 minutes to sort the cards by the age at which most children should be able to do the task.
- After 10 minutes, stop the exercise. Do not discuss results but move on to next slide, which will address correct answers.

## Developmental milestones

**By the age of ONE MONTH a child should be able to:**

- Bring both hands towards her or his mouth.
- Turn towards familiar voices and sounds.
- Suckle the breast.

**By the age of SIX MONTHS a child should be able to:**

- Reach for dangling objects.
- Sit with support.
- Smile.

Not all children develop at the same rate; each child is unique.

It may be that not all aspects of a child's development are at the same stage (e.g. a child's motor development may be more advanced than their language development).

There are cultural differences that may influence development.

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## Developmental milestones – cont'd

**By the age of 12 MONTHS a child should be able to:**

- Crawl on hands and knees and pull up to stand.
- Try to imitate words and sounds and respond to simple requests.
- Enjoy playing and clapping.
- Pick things up with thumb and one finger.

**By the age of TWO YEARS a child should be able to:**

- Walk, climb and run.
- Point to objects or pictures when they are named (e.g. nose, eyes).
- Scribble if given a pencil or crayon.
- Imitate the behaviour of others.
- Make sentences of two or three words.
- Learn to defecate in an appropriate place (18 months).

28

As a group, summarize the key developmental milestones by age.

Remind the participants about the limitations of milestones described in the previous slide.

## Developmental milestones - cont'd

**By the age of THREE YEARS a child should be able to:**

- Walk, run, climb, kick and jump easily.
- Say own name and age.
- Use make-believe objects in play.
- Feed herself or himself.

**By the age of FIVE YEARS a child should be able to:**

- Speak in sentences and use many different words.
- Play with other children.
- Dress without help.
- Answer simple questions.
- Count 5 to 10 objects.

29

## What is developmental disorder?

- Not all children develop at the same rate; each child is unique.
- Only when there is a substantial delay in learning skills in more than one domain do we suspect a **developmental disorder**.
- Remember these are the four domains:
  - motor (movement) skills
  - communication and speech
  - social interaction
  - play and learning (cognitive).

30

Talk through the points on the slide and emphasize that developmental disorders are only suspected when there is a substantial delay in learning skills in **more than one domain**.

## Additional core signs of developmental disorder

- For older children, school performance or everyday household activities.
- Oddities in communication and behaviour, for example:
  - Use of non-meaningful words.
  - Repetition of words or sentences that someone else has said.
  - Repetitive movements like flapping hands, always playing with the same object.

31

Stress that one should also assess a child's overall functioning, and the extent to which delays in specific skills affect the child's daily life and school performance.

Recall from the case histories, that oddities in communication and restricted and repetitive behaviours and interests are common in children with autism and other pervasive developmental disorders.

## Developmental disorders

- Substantial delay in development.
- Childhood onset, steady course, often persist into adulthood.
- Children with developmental disorders can learn new skills, but they develop much more slowly than other children.
- Development disorders include:
  - intellectual disability
  - autism and other pervasive developmental disorders.

32

Stress that developmental disorders are defined by a **substantial delay**.

Remind participants of the cases they heard at the beginning of the session in order to remember the level of impairment that a person with developmental disorder may feel.

Direct participants to the definition of developmental disorders given in the mhGAP-IG (page 69).

Two common types of developmental disorder are:

- intellectual disability
- autism and other pervasive developmental disorders.

The next slides will look at intellectual disability and autism separately.

## Intellectual disability

- Substantial difficulty/delay in skills across most developmental domains:
  - motor (movement) skills
  - communication and speech
  - social interaction
  - play and learning (cognitive).
- There are different degrees of intellectual disability, ranging from mild to profound.

Talk through the points on the slide and emphasize that an intellectual disability is an impairment of skills across most **developmental domains**.

This is distinct from autism, which is a more specific set of impairments which we will discuss next.

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## Autism and other pervasive developmental disorders

- Major delays and difficulties in communication, speech and social skills.
- Frequent preoccupation with a single object for long periods.
- Repetitive gestures (e.g. hand or finger flapping or twisting).
- Oddities in communication
  - inappropriate loudness, intonation, and rhythm
  - endless repetition of phrases
  - incomprehensible speech.

Talk through the points on the slide and emphasize (in the first point) that delay is a feature of all developmental disorders, including autism.

Children with autism are often preoccupied with a single object for long periods of time.

They can use repetitive gestures (i.e. hand flapping or twisting).

They also have problems with communication.

34

## Main risk factors for developmental delay

### Biological factors:

- Nutritional deficiencies (malnutrition, iron deficiency, iodine deficiency)
- Hearing and visual impairment
- Recurrent/chronic illness (HIV/AIDS)
- Alcohol use during pregnancy
- Certain complications during delivery
- Consanguineous parents (parents who are related to each by blood)

### Psychosocial factors:

- Depression in mothers
- Insufficient child care/poorly stimulating environment
- Harmful traditional beliefs (e.g. not talking to small children)

Talk through the main risk factors as listed on the slide and emphasize that carers and the family environment play an important role for children's development.

Stress that this is not only after the baby has been born but during pregnancy as well.

Emphasize that the main risk factors that can be managed in non-specialist health settings are:

- nutritional deficiencies and chronic illnesses
- hearing and visual deficits
- carer depression and poorly stimulating environment
- maternal mental health.

35

## Person's story

Hear what it is like to live with developmental disorders.

**Note:** Choose to read a person's story on living with developmental disorder and/or living with intellectual disability (see CMH supporting material – person stories 1 and/or 2).

This will consolidate learning by giving participants a real life experience of what it feels like to live with developmental disorders.

36

## Problem behaviours and behavioural disorders

- Problems related to over-activity, inattention or dissocial behaviour are common among children and adolescents.
- Only when these behaviours are very severe and influence children's ability to perform daily activities (e.g. learning, playing and interacting with peers) they may be defined as "behavioural disorders".

37

Emphasize that there is a difference between problem behaviours and behavioural disorders. Having some degree of problem behaviour is normal for most children and adolescents. It can be a normal part of growing.

Behavioural disorders are an umbrella term that includes specific disorders such as ADHD and conduct disorders.

Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be identified as having behavioural disorders.

## These problem behaviours can be defined as:

- **Excessive over-activity:**  
Excessive running around, extreme difficulties remaining seated, excessive talking or making continuous movements with fingers or feet.
- **Excessive inattention:**  
The child is often unable to complete one task and is frequently switching to others.

38

Explain that problem behaviours can be defined as:

- excessive over-activity
- excessive inattention
- excessive impulsivity
- repeated and continued behaviour that disturbs others
- sudden changes in behaviour or peer relations.

It is important to stress that excessive means that it is **not age-appropriate** behaviour (e.g. excessive activity in a toddler compared with a school-aged child or adolescent is different).

## Behavioural disorder related to attention deficit and hyperactivity (attention deficit hyperactivity disorder – ADHD)

- The main features are impaired attention and over-activity that affect a child's functioning in daily life and learning.
- It is common: 5–8 %, especially in boys.
- What is the cause?  
ADHD may have a genetic component, but it is not clear exactly what causes it.

Explain that the behavioural disorder characterized by impaired attention and over activity is also called **attention deficit hyperactivity disorder** (or ADHD).

Talk through the points on the slide.

39

## What you need to know about ADHD?

- When children with ADHD are not recognized, they may be mislabelled naughty and irresponsible and be blamed and punished for their behaviours.
- Punishment can worsen their behaviour.
- When children with ADHD do not receive care and support, they may drop out from school.

Talk through the points on the slide

At the end, emphasize that early identification and interventions to support the parents and carers can and will help the child.

40

## Behavioural disorder related to dissocial, aggressive and disobedient behaviour (conduct disorder)

- Main features are repetitive and persistent dissocial, aggressive or defiant conduct.
- Is conduct disorder common?  
4–10%, especially in boys.
- Caused by both genetic vulnerability and difficult psychosocial environments (exposure to violence, neglect, parents' mental or substance use disorder).

Explain that the behavioural disorder characterized by dissocial, aggressive and disobedient behaviour is also called "conduct disorder".

Talk through the points on the slide.

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## Why do you need to know about conduct disorder?

- When children/adolescents with conduct disorder do not receive appropriate care and support, they may drop out of school.
- They are at increased risk for depression.
- They are also at increased risk of having alcohol, drug use and criminal problems.

Emphasize again that early identification and support can change the course of a child/adolescent's entire life.

42

## Why is treatment for behavioural disorders in young people important?

### Early intervention is important to:

- Reduce suffering and disability.
- Improve educational and health outcomes.
- Improve the child's relationship with their family, teachers and peers, thus improving their outcomes.
- Help parents and teachers to better understand the behaviour of the child/adolescent with a behavioural disorder.

43

Discuss with participants why they think treatment for behavioural disorders is important. Then talk through the point on the slide.

## Person's story

Living with behavioural disorders.

44

Choose to read person story 1 – living with ADHD or conduct disorder (see CMH supporting material).

This will consolidate learning by giving participants a real life experience of what it feels like to live with behavioural disorders.

## Emotions and emotional disorders

- Feelings of fear, anxiety, sadness and or irritability in children and adolescents is normal and healthy as they grow and develop.
- Only when these emotions are felt for prolonged periods of time, cause disabling distress and impact on the child or adolescents ability to function in everyday life should it be considered a disorder.

45

Emphasize that emotional disorders are characterized by increased levels of anxiety, depression, fear and somatic symptoms (such as aches and pains felt in the body) that impact on the child/adolescent's ability to function and cause severe levels of distress.

## Emotional disorders

Main features of emotional disorders are:

- Prolonged (intense emotions felt for prolonged period of time).
- Disabling: impedes the child/adolescents ability to function in everyday life.
- Distress: intensely feeling emotions such as sadness, fearfulness, anxiety and irritability.

46

Direct participants to page 71 mhGAP-IG for a description of common presentations of children and adolescents with emotional disorders and talk through the points on the slide.

Emphasize that it is normal for children and adolescents to experience all of these emotions.

There are age-appropriate fears and anxieties in children and adolescents.

S

### CLINICAL TIP: AGE-APPROPRIATE FEARS AND ANXIETIES IN CHILDREN AND ADOLESCENTS

Babies & Toddlers (age 9 months - 2 years)	- Fear of strangers, distress when separating from caregivers
Young Children (age 2-5)	- Fear of storms, fire, water, darkness, nightmares, and animals
Middle Childhood (age 6-12)	- Fear of monsters, ghosts, germs, natural disasters, physical illness, and being badly injured - Anxiety about school or about performing in front of others
Adolescents (age 13-18)	- Fear of rejection by peers, performing in front of others, physical illness, medical procedures, catastrophes (e.g. war, terrorist attack, disasters)

47

Explain that learning how to manage emotions is an important part of any child development.

Here are a list of age-appropriate emotions, fears, and anxieties.

(Ask participants to find this box in the Module: Child and adolescent mental and behavioural disorders.)

Have participants read through the box.

Explain that if a child or adolescent experiences these emotions at an inappropriate stage in their development and/or experiences them to a point that they are unable to function in their daily life, then they may have an emotional disorder.

## Early identification and intervention

- Globally depression is the number one cause of illness and disability in young people aged 10–19 years.
- Suicide ranks as the third leading cause of death among young people aged 10–19 years.
- Half of people who will develop MNS conditions will experience their first symptoms by age 14.
- If young people get the care they need early then it can prevent death and avoid suffering throughout adult life.

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Explain that depression among young people aged 10–19 is the leading cause of illness and disability.

**Suicide is the third biggest killer of young people.**

Half of all adults with priority MNS conditions had their first symptoms when they were adolescents (14 years old).

Explain that if those 14 year olds had been identified and cared for at that age, the prognosis for their MNS conditions may have changed and they may have been saved from a lifetime of suffering and/or their life may have been saved.

## Depression in adolescence

- Core features of depression:
  - Feeling sad, irritable or down.
  - Lost interest or enjoyment in activities.
- Additional symptoms include:
  - Disturbed sleep, change in appetite, feeling worthless and excessive guilt, loss of energy, reduced concentration, problems making decisions, irritability, hopelessness, suicidal thoughts and acts.
  - These symptoms must be present **most of the day for at least two weeks.**

49

Describe the core features of depression as stated in the slide.

Emphasize that the symptoms must be felt **most of the day for at least two weeks.**

## Emotional disorders in adolescents

Omar is a 14-year-old boy who lives with his parents and his two brothers and sisters. He has always been an active boy, doing well at school and interested in sports. His mother fell ill three months ago and has had to have an operation. She is unable to do much since she needs to rest for long hours. Omar has been helping his elder sister with household tasks. Since one month ago, his father reports that Omar has become withdrawn, preferring to stay at home rather than playing sports or visiting his friends, he has become irritable and quarrelsome with his siblings and cannot concentrate on his studies. He is worried about his forthcoming exams and does not think he will be able to do well, fearing failure. He cannot fall asleep at night and remains awake until late, making him very tired during the day. He blames himself for his mother's ill health and thinks he should have helped her more in the past.

50

Have a participant volunteer to read this case study out loud.

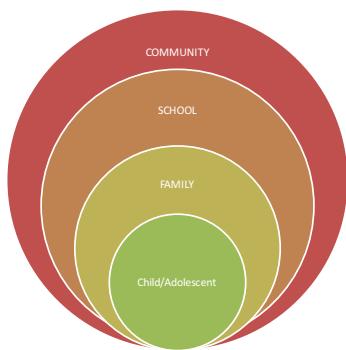
Facilitate a brief discussion with the group about whether Omar has emotional problems and/or should he be identified as having an emotional disorder?

Remind participants to consider the severity of the emotions, the impact they are having on Omar's ability to function and any physical condition that could be creating these emotional reactions.

### Special considerations for assessment of children

Children do not grow and develop in isolation.

Their immediate and broader environment plays an important role



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Emphasize that:

- Children/adolescents cannot be assessed and treated in isolation.
- The well-being of children/adolescents is closely related to their environment (physical and social).
- Carers, families, teachers, and health-care workers play an important role.

**Note:** Use the diagram on the slide to show how it is impossible to understand a child/ adolescent in isolation – their environment must always be considered.

Explain that once a thorough assessment has been carried out and if a disorder has been identified, then some of the symptoms of developmental, behavioural and emotional disorders can be managed in non-specialized health settings.

As part of that management, it is essential to activate other support structures such as:

- parents/families/caregivers/grandparents
- schools – teachers
- community workers
- peers.

Once again, the management of a child/ adolescent cannot be done in isolation – it must consider support networks, social environment etc.

# Session 2: Assessment of child and adolescent mental and behavioural disorders

⌚ 1 hour 50 minutes

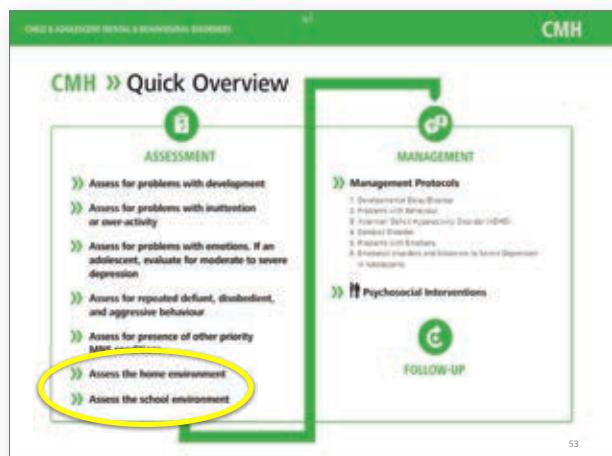


Instruct participants to open their mhGAP-IG to page 70, the beginning of the assessment algorithm for child and adolescent mental and behavioural disorders

Read through the assessment principles:

Explain that we are going to look at the assessments individually and try and understand what core pieces of information we want to learn from each assessment.

Although we will look at the assessments individually, for now it is important to understand that many children or adolescents who present may have multiple and overlapping symptoms, therefore it is important to carry out a thorough assessment that looks at all areas of the child/adolescent's behaviour and environment.



Explain to participants that this is particularly true for the assessment of the home environment and school environment.

When caring for children and adolescents with mental and behavioural disorders it is important to assess the role that the home and family environment may be having on the child/adolescent.

Explain that we will look at these assessments in more detail later on, but it is important that participants understand that when working with children and adolescents they must always consider the child/adolescent and their home/familial/social and school environments, because mental health problems can be precipitated and perpetuated by stressors in the home/school/community environment. For example, a teenager with behavioural issues (such as theft or truancy) may well have a depressed mother and father with substance use disorders who punishes them harshly and routinely does not give them enough food to eat at home.

Learning about the home/school/community environment helps to understand the child/adolescent.

## Assess for developmental disorder

Three core pieces of information to learn at assessment:

1. Does the child/adolescent have problems/difficulties in different developmental domains (motor, cognitive, social, play and learning)?
2. Are there any physical conditions that could be contributing to that delay?
3. Are there any visual and/or hearing impairments?

54

Explain to participants that there are three core pieces of information that should be understood when assessing a child/adolescent for developmental disorders.

As you reveal the three core pieces of information, ensure participants are also looking at page 73 of mhGAP-IG to see how these pieces of information are being described in the mhGAP-IG.

1. Does the child/adolescent have problems/difficulties in developmental domains? Remind participants what the developmental domains are (from the discussions at the beginning of the session).

If there are problems/difficulties across developmental domains then they should suspect developmental delay/disorder and assess for:

2. Any physical conditions that could explain these problems/difficulties in developmental domains.
3. Any visual and/or hearing impairments.

If the findings for **points 2 and 3** are yes then those conditions should be treated, and the person should be referred to a specialist as appropriate.

If the answers to **point 1** is yes then there are signs of developmental disorder and the participants should manage the disorder using the principles described in Protocol 1 (page 85).

Possible questions
<ul style="list-style-type: none"> <li>• What questions could you ask to find out this information?</li> <li>• Who could you ask to find out this information?</li> </ul>

55

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out if a child has problems reaching developmental milestones?

Create a list of the possible questions.

Hang those questions up on the wall in full view so that participants can use them when they are doing role plays.

**1**

## ASSESS FOR DEVELOPMENTAL DISORDERS

<ol style="list-style-type: none"> <li>1) Motor (movement) skills           <ul style="list-style-type: none"> <li>• How does your child move her/his head, upper-body and legs (holding head up, sitting, walking)?</li> </ul> </li> <li>2) Communication and speech           <ul style="list-style-type: none"> <li>• How does your child communicate with you?</li> </ul> </li> <li>3) Social interaction           <ul style="list-style-type: none"> <li>• How does your child interact with you and others, how does he/she play?</li> </ul> </li> <li>4) Play and learning           <ul style="list-style-type: none"> <li>• What kinds of things can your child do alone now (like eating or dressing)?</li> </ul> </li> </ol>
--

56

Here is a list of possible questions you could ask.

Add these questions to the list created by participants, or, if participants struggled to think of questions, show them these.

Note that assessing developmental skills will result in a profile of children's strengths and weaknesses.

Emphasize that developmental milestones are used as indicators (targets) of development.

**Developmental milestones** refer to age ranges by which most children have learned specific skills (sitting up, standing up alone, walking, understanding instructions, using words, etc.).

**Note for preparing the training:**  
If there is any simple, locally validated questionnaire or monitoring chart being used to monitor child development, then adapt the training session to include these materials.

Source of the four questions: Modified from Ertem et al, 2008.

## Assess for problems with behaviours: Inattention and hyperactivity

1. Does the child/adolescent have problems with inattention or hyperactivity?
2. Do these problems remain in different settings, e.g. home, school, social etc?
  - a. Have they lasted for at least six months?
  - b. Are they appropriate for the child/adolescents level of development?
  - c. Do they severely impact on the child/adolescent's ability to function in daily life (at school in the family etc.)?
3. Are there physical conditions that could resemble these symptoms?

57

As you reveal the core pieces of information that need to be understood in order to assess for problems with behaviours, ensure that participants are looking at page 74 mhGAP-IG (Step 2) and following the algorithm.

1. Explain that to assess for problems with inattention and hyperactivity the participants need to understand if the child is overactive, unable to sit still for long, easily distracted, has difficulties completing tasks, moves restlessly?
2. Do those problems remain in all settings or do they only happen at home? Or at school?
3. Are there physical conditions that could resemble these symptoms?

If the answer to **point 3** is **yes** then the physical condition needs to be treated.

If the majority of the answers to these questions are yes then ADHD should be suspected and participants should go to Protocol 3 (page 85).

If the majority of the answers to these questions are **no** then ADHD is unlikely but there remains a problem with behaviours, so participants should go to Protocol 2 (page 85).

## Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out the information they need.

Create a list of the possible questions.

Hang those questions up on the wall in full view so that participants can use them when they are doing role plays.

58

Assess for behavioural problems: Conduct disorder
<ol style="list-style-type: none"> <li>1. Does the child/adolescent show repeated aggressive, disobedient or defiant behaviour?</li> <li>2. Are those behaviours persistent, severe, and inappropriate:             <ol style="list-style-type: none"> <li>a. Present across multiple settings (home, school, social groups etc.)?</li> <li>b. Present for at least six months?</li> <li>c. Age appropriate (more severe than childishness or rebelliousness)?</li> <li>d. Severely impact on the child/adolescent's ability to function?</li> </ol> </li> </ol> <p style="text-align: center;">59</p>

As you reveal the points of the slide, ensure that participants are following the assessment algorithm on page 76 mhGAP-IG Step 3.

1. Explain that to assess for conduct disorder the participants need to learn if the child shows repeated aggressive, disobedient or defiant behaviour?
2. Are these behaviours persistent, severe and inappropriate?

If the majority of the answers to these questions are **yes** then conduct disorder is suspected and participants should go to Protocol 4 (page 86).

If the majority of the answers to these questions are **no** then conduct disorder is unlikely, but there remains a problem with behaviours and participants should go to Protocol 2 (page 85).

Possible questions
<ul style="list-style-type: none"> <li>• What questions could you ask to find out this information?</li> <li>• Who could you ask to find out this information?</li> </ul> <p style="text-align: center;">60</p>

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out the information they need, especially questions they could ask to find out about the different behaviours.

Create a list of the possible questions. Hang those questions up on the wall in full view so that participants can use them when they are doing role plays.

How to ask the child about conduct disorder
<ul style="list-style-type: none"> <li>• Do you find yourself arguing with your parents?</li> <li>• Do you get irritated if your parents ask you to do something?</li> <li>• Have you been feeling extremely angry and irritable recently?</li> <li>• Are you having difficulties getting on with other people?</li> </ul> <p style="text-align: center;">61</p>

Briefly talk through these examples of questions to the child and add them to the list produced by the participants.

## How to ask a carer about conduct disorder

- Do they have severe temper tantrums?
- Do they repeatedly defy reasonable requests?
- Do they show provocative behaviour?
- Do they show excess bullying or excess levels of fighting?
- Do they show cruelty to other people and animals?
- Have they shown destructiveness to property?
- Have they been repeatedly truanting?

Briefly talk through these examples of questions for the carer. Add them to the list produced by the participants.

62

## Assess for emotional disorders

1. Is the child/adolescent experiencing prolonged, disabling distress involving sadness, fearfulness, anxiety and irritability?
2. Do these symptoms severely impact on the child/adolescent's ability to function in daily life?
3. Are there physical conditions that can resemble or exacerbate these emotional symptoms?

63

As you reveal the points of the slide, ensure that participants are following the assessment algorithm on page 78 mhGAP-IG (Step 4).

If the answer to **point 3** is **yes** then the physical condition should be treated.

If the majority of the answers to **points 1 or 2** are **yes** then the participants should go to Protocol 6 for the management of emotional disorders (page 86).

If you suspect depression then go to the Module: Depression in the mhGAP-IG.

If the child/adolescent has problems with emotions but they are not severely impacting on the child/adolescent's ability to function then they should go to Protocol 5 (page 86).

## Possible questions

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out the information they need. Create a list of the possible questions

Hang those questions up on the wall in full view so that participants can use them when they are doing role plays.

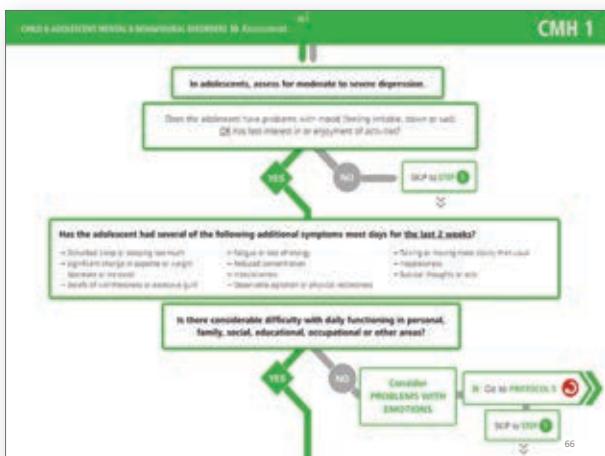
64

## Asking adolescents/carers about emotions

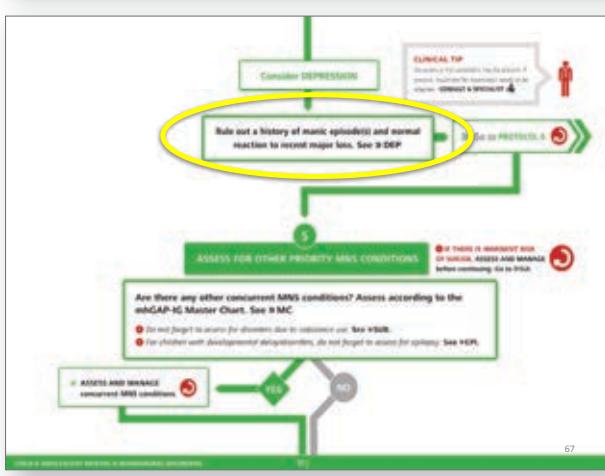
- Do they often feel irritable, sad, annoyed, down?
- Have they lost interest in activities they used to get enjoyment from?
- Do they have many worries or often seem worried?
- Do they have many fears and are they easily scared?
- Do they complain of headaches, stomach aches or sickness?
- Are they often tearful or down-hearted?
- Do they avoid or strongly dislike certain situations?

65

Read through the list of possible questions and add them to the list produced by the participants.



Talk the participants through the assessment algorithm questions for assessing depression. (mhGAP-IG page 80).



Highlight again that participants should always rule out a history of mania or manic episodes when assessing for depression. They should also explore if there has been a major loss in the past six months.

Although depression is common amongst adolescents it is important to also assess for other MNS conditions as well.

Ask participants what other priority MNS conditions they believe children and adolescents can experience?

Give them two or three minutes to answer before revealing the answers in the next slide.

What other priority MNS conditions occur in children and adolescents
<ul style="list-style-type: none"><li>• Depression (most common)</li><li>• Epilepsy</li><li>• Developmental disorders</li><li>• Behavioural disorders</li><li>• Psychoses</li><li>• Substance use disorder</li><li>• Self-harm/suicide</li><li>• Anxiety.</li></ul>

Emphasize that most mhGAP priority disorders also occur in children and/or adolescents.

68

## Activity 4: Video demonstration: Assessment

Activity 4: Video demonstration: Assessment
Show the videos of Rania and Aziz being assessed.  After the videos, discuss the assessments with participants,

69

**Duration:** 20 minutes.

**Purpose:** Having discussed the assessment algorithms, to give participants the opportunity to watch a demonstration of an assessment.

**Instructions:**

- Ensure the participants can see and hear the videos.
  - Watch the assessment of Rania (<https://www.youtube.com/watch?v=GKSTkyv3wAM&index=8&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>),
  - Watch the assessment of Aziz (<https://www.youtube.com/watch?v=H6Nte7IxGlc&index=9&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>) being assessed by a health-care provider.
- The videos last for approximately 10 minutes.
- At the end of the video ask participants to reflect on the assessment they have watched.

## Rania

- How did the health-care provider assess Rania's development? (Did she ask about all four developmental domains?)
- How did the health-care provider assess Rania's visual and/or hearing impairments?
- Why did the health-care provider refer Rania to a specialist?
- How did the health-care provider assess for any other problem behaviours?

After the video of Rania, ask the following questions:

1. How did the health-care provider assess Rania's development? Did she ask about all domains – motor, cognitive, social, communication skills?

Explain that she asked about:

**Motor skills:** *Have you noticed any difficulties in Rania's capacity to move around and use her hands?*

Play and social interaction: *Is she playing with her brother or friends?*

Communication: *Is Rania using any words? You told me that Rania doesn't seem to be listening to you. Is she turning her head when you call her name?*

She asked about developmental milestones: *Is Rania eating by herself?*

How did the health-care provider ask about any signs/symptoms suggesting: nutritional deficiency, anaemia, malnutrition, acute chronic infections?

2. How did the health-care provider assess Rania for visual and/or hearing impairments?
3. Why did the health-care provider refer Rania to a specialist?
4. How did the health-care provider assess for any other problem behaviours?

*Do you have any other concerns about her behaviour? For example, repetitive behaviours, spinning her body around, moving her fingers repeatedly or any repetitive behaviours?*

## Aziz

- How did the health-care provider assess Aziz for problems with inattention or hyperactivity?
- How did the health-care provider establish if Aziz's symptoms were present across multiple settings?
- How did the health-care provider rule out other physical conditions that resemble ADHD?

After the video of Aziz, ask the following questions:

1. How did the health-care provider assess Aziz for problems with inattention or hyperactivity?

Explain that she was able to observe his behaviour from their interaction. She set him a small task so that she could observe further. She asked questions and listened to the mother.

2. How did the health-care provider establish if Aziz's symptoms were present across multiple settings?

Explain that the health-care provider asked about Aziz's performance at school, any recent changes at home, family relationships, developmental milestones, social interactions. She was also able to observe the behaviours in the clinic.

3. How did the health-care provider rule out other physical conditions that resemble ADHD?

## Assess the home environment

Aim of the home environment assessment is to understand:

Are the emotional, behavioural or developmental problems a reaction to, or aggravated by, a distressing or frightening situation at home?

How can you assess this?

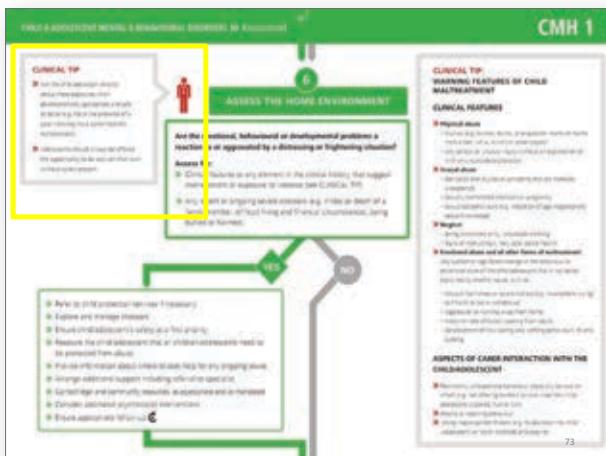
Talk through the points on the slide and explain that no matter whether you suspect developmental disorders, behavioural disorders or emotional disorders in a child/adolescent you should **always** conduct an assessment of the home and school environment.

Children/adolescents do not grow up in isolation – they have so many competing influences on their environment at home, in school and in the community and these influences need to be understood and included when assessing the child/adolescent.

Explain the first aim of the home environment assessment.

Ask participants how they could assess for this? What questions could they ask? Who could they ask? How could they find this out?

Give them a few minutes to answer and then direct them to the clinical tips on page 82 mhGAP-IG.



The clinical tip suggests that you ask the child/adolescent directly about their home environment.

Ask who they live with? What are the family relationships like? Does it feel like a safe environment?

Ask them to describe a typical day at home, what do they do, who are they with etc. That is a useful way to establish what happens in the home environment.

Establish as well if there have been any recent losses and recent stressors that have happened in the family.

### Example questions for the child/adolescent

- How are things at home?
- Has anything stressful or difficult been happening recently?
- Has anyone at home or outside the home hurt or upset you in anyway?
- What happens when you do something your parent/carer doesn't like?
- What happens in your home when people get angry?

74

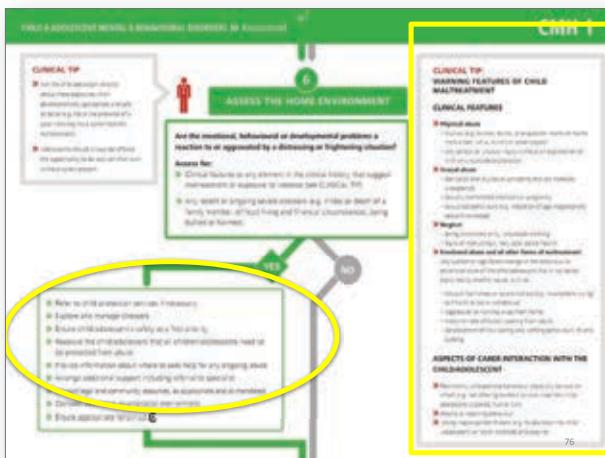
Talk through the different examples of questions that participants could use to ask the child/adolescent about their home environment.

### Example questions for carers

- Are there any difficult or painful situations at home that may be affecting how your child/adolescent feels or behaves? These could be situations happening now or that have happened in the past.
- Has anyone at home been hurt or upset by anything recently?
- Did the child/adolescent's difficulties begin after a new or stressful event?
- How do you discipline your child?
- How do other family members discipline your child?

75

Talk through the examples of questions that participants could use to ask carers about the home environment.



Give the participants time to read through the clinical tip and what can be done if they identify maltreatment (mhGAP-IG page 82).

## Assess the home environment

If the home environment is **not** aggravating or causing the problems then:

- Ensure that the child can be properly supported at home. Does the carer have priority MNS conditions? Can they care for the child/adolescent?
- Is the child getting adequate opportunities for play/social interaction/communication?

77

Talk through the points on the slide and emphasize that if the home environment is not distressing and there is no evidence of maltreatment then try and understand if the carer is capable of offering care and support to a child/adolescent with mental and behavioural disorders?

Does the carer have an MNS condition?

Does the carer need further support?

If the carer is able to offer care then is the home environment set up well? Does the child have opportunities to play, socialize, communicate, learn etc.

CMH



Ask the questions:

With whom does the child spend most of their time?

How did you/they play with the child? How often?

How do you/they communicate with the child?

WHO has released training on parenting skills – would that be of use to the carer (where the training is available)?

## Assess the school environment

- Establish if the child/adolescent is attending school? **If not why not?**
- Is the child/adolescent being bullied, not able to participate in learning, refusing to attend?

If the answer to these is **yes** then (with consent) talk to the teachers. Find out what is happening. Support the staff to help manage the child/adolescent.

79

Direct participants to page 84 mhGAP-IG.

Talk through the points on the slide as the participants follow the assessment algorithm.

Answer any questions or concerns they may have.

## Assess the school environment

- How practical would it be to carry out an assessment of school environment in your setting?
- How would the school and teachers respond?
- What could they do to strengthen those links?

80

Facilitate a brief discussion around these questions.

Have the participants think of practical steps they could take to create stronger links with schools and teachers in their areas.

## Activity 5: Demonstration role play (conduct disorder)

### Activity 5: Demonstration role play (conduct disorder)

- Does John have a conduct disorder? If so, why?
- How the health-care provider assessed for any repeated aggressive, disobedient or defiant behaviours?
- How did the health-care provider assess for those symptoms across multiple settings?
- Were the symptoms present for at least six months?
- Was there considerable difficulty in daily functioning in personal, family, social, educational and occupational life? If so, what was that?

81

**Duration:** 30 minutes.

**Purpose:** To give participants an opportunity to observe and reflect on an assessment of a child with a conduct disorder.

**Instructions:**

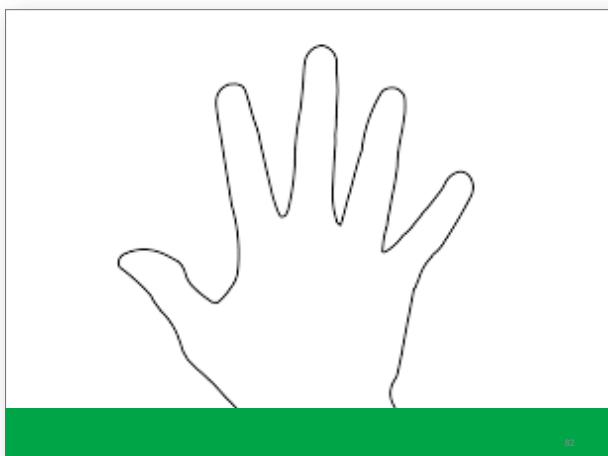
- The facilitator will play the role of the health-care provider.
- The co-facilitator (if there is no co-facilitator use a volunteer) will play the role of the mother.
- A volunteer participant will play the role of 13-year-old John.

- Each person reads has two minutes to read through their scripts (see CMH supporting materials – demonstration role play).
- Then the other participants watch the demonstration role play.
- At the end of the role play ask the participants to reflect on:
  - Does John have a conduct disorder? If so, why?
  - How the health-care provider assessed for any repeated aggressive, disobedient or defiant behaviours?
  - How did the health-care provider assess for those symptoms across multiple settings?
  - Were the symptoms present for at least six months?
  - Was there considerable difficulty in daily functioning in personal, family, social, educational and occupational life? If so, what was that?

**Note:** Instead of a demonstration role play, you can use role play 4 (CMH supporting material) and allow them to practise assessing and managing an adolescent with conduct disorder.

# Session 3: Management of child and adolescent mental and behavioural disorders

⌚ 1 hour



Ask participants to briefly brainstorm what management interventions they think they could use to manage child and adolescent mental and behavioural disorders.



Explain that there are different protocols for specific disorders in the mhGAP-IG which they will look at next.

However, the protocols have a few interventions in common:

- Psychoeducation to the child/adolescent and psychoeducation to the carer/family.
- Promote well-being (including strategies to improve child behaviour).
- Carer support.
- Manage stressors.
- Link with community resources/liaise with teachers.

## mhGAP recommendations

<b>Psychosocial interventions for treatment of behavioural disorders</b>	Behavioural interventions for children and adolescents, and caregiver skills training.
<b>Psychosocial interventions, treatment of emotional disorders</b>	Psychological interventions, such as CBT, IPT for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers
<b>Caregiver skills training for the management of developmental disorders</b>	Caregiver skills training should be provided for management of children and adolescents with developmental disorders, including intellectual disabilities and pervasive developmental disorders
Antidepressants among adolescents with moderate-severe depressive disorder for whom psychosocial interventions have proven ineffective	Fluoxetine (but not other Selective Serotonin Reuptake Inhibitors or Tricyclic Antidepressants) may be offered. The intervention should only be offered under supervision of a specialist. <small>84</small>

Explain each recommendation individually and answer queries.

Explain that first-line treatment should always be psychosocial interventions.

Only use medication in adolescents with depression if psychosocial interventions have proven ineffective.

Where possible refer to specialist for any pharmacological intervention.

## Psychosocial interventions

- Psychoeducation can be given to all carers even if their children/adolescents do not have mental and behavioural disorders.
- Guidance on improving behaviour can be given to all carers.
- The more people that are aware of the importance of healthy childhood development the better the outcomes for children and adolescents.

85

Explain that psychoeducation and support in improving child/adolescent behaviours can be given to all carers irrespective of if their children/adolescents have mental and behavioural disorders.

The more people that are aware of the importance of healthy early childhood development, the better the outcomes for young people in those communities.

Explain that what happens to children/adolescents in their early years is critical to the kind of adult that they will become.

Psychoeducation messages should emphasize the importance of the child/adolescent:

- getting enough sleep
- eating healthily
- taking the time to be physically active and play
- the importance of education
- the importance of building friendships with people they trust
- avoiding the use of substances.

## Psychoeducation messages to the carer

- Strongly emphasize that the child/adolescent should not be blamed for their disorder and/or behaviour.
- It is not their fault, nor is it because they are cursed or evil.
- Acknowledge how hard and stressful it is for the carer.
- But stress that the child/adolescent needs kindness, patience, love and support.

86

Acknowledge how difficult and stressful it is to care for a child/adolescent with mental and behavioural disorders but state that the child/adolescent is not to blame. They are not evil or cursed or even doing this deliberately.

They need patience, love, kindness and support.

It is vital to ensure that the carers understand how to protect the dignity and human rights of the child/adolescent and know which agencies they can approach if human rights are being breached.

Explain that we will now do an activity to practice using psychosocial interventions.

## Activity 6: Role play: Psychosocial interventions

### Activity 6: Role play: Psychosocial interventions

- Read through and familiarize yourself with the psychosocial interventions in the mhGAP-IG (pages 87–89).
- Aziz (six) and his mother Fatima have just heard that Aziz has ADHD.
- The health-care provider will develop a treatment plan and deliver psychosocial interventions to Aziz and his mother, including psychoeducation.

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See role play 2 (CMH supporting material).

**Duration:** 45 minutes.

**Purpose:** To give participants the opportunity to read through, reflect on and practise using psychosocial interventions to care for a child and their carer.

**Situation:**

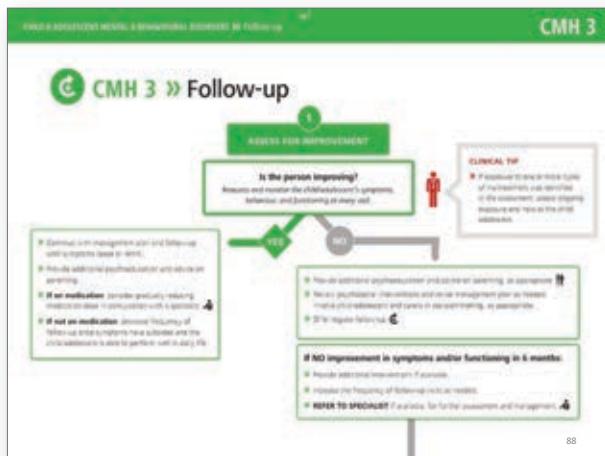
- Aziz (six) and his mother Fatima have just heard that Aziz has ADHD.
- The health-care provider will develop a treatment plan and deliver psychosocial interventions to Aziz and his mother including psychoeducation.

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 4: Follow-up

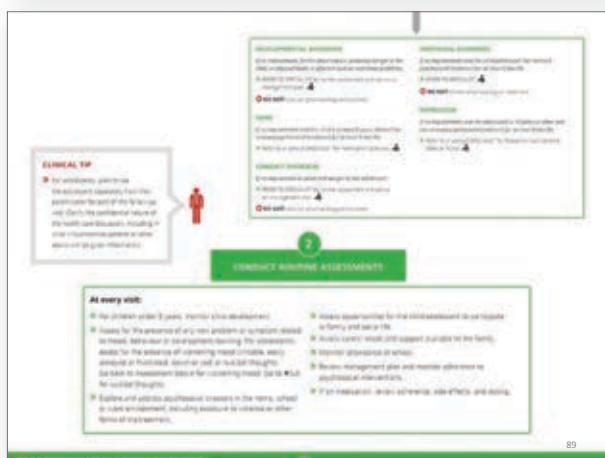
 40 minutes



Describe the follow-up algorithm.

Ask when they think someone should be referred to a specialist?

What could they do if a specialist is not available?



Emphasize the importance of conducting routine assessments at every follow-up visit.

Things can change very quickly in the life of a child/adolescent, so it is important to keep regularly monitoring what is happening to them, in their home life, in their social life, at school, etc.



If a child/adolescent has been started on any pharmacological treatments, ensure that they are being monitored closely.

Ensure that parents and carers and teachers know and understand what side-effects to look out for.

Facilitate a brief brainstorming session (maximum five minutes). Can participants identify any barriers to providing follow-up care to children/adolescents?

How could they overcome those barriers?

## Activity 7: Role play: Follow-up

### Activity 7 Role play: Follow-up

- An adolescent was diagnosed with depression three months ago.
- After trying to get the adolescent to return for a follow-up visit for six weeks they finally agree to attend.
- This is the first time they have seen a health-care provider in three months.

See role play 5 (CMH supporting material).

**Duration:** 30 minutes.

**Purpose:** To give participants the opportunity to practise developing the skills necessary to deliver a follow-up assessment for an adolescent with depression.

**Situation:**

- An adolescent was identified as having depression three months ago.
- After trying to get the young person to come for a visit for over six weeks they finally agree.
- They have not been seen by a health-care provider for three months.

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 5: Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the MCQs (see CMH supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# CMH PowerPoint slide presentation



PowerPoint slide presentation available online at:

[http://www.who.int/mental\\_health/mhgap/cmh\\_slides.pdf](http://www.who.int/mental_health/mhgap/cmh_slides.pdf)

## CMH supporting material

- Person stories
- Developmental milestones
- Role plays
- Demonstration role play: Conduct disorder
- Multiple choice questions
- Video links

Activity 4: mhGAP CMH module – assessment (developmental disorders)

<https://www.youtube.com/watch?v=GKSTkyv3wAM&index=8&list=PLU4ieskOli8GicaEndweSQ6-yaGxhes5v>

Activity 4: mhGAP CMH module – assessment (behavioural disorders)

<https://www.youtube.com/watch?v=H6Nte7IxGlc&index=9&list=PLU4ieskOli8GicaEndweSQ6-yaGxhes5v>



Supporting material available online at:

[www.who.int/mental\\_health/mhgap/cmh\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/cmh_supporting_material.pdf)

DEM

# Dementia

mhGAP training of health-care providers  
Training manual



World Health  
Organization

# Module: Dementia

## Overview

### Learning objectives

- Promote respect and dignity for people with dementia.
- Know common presentations of dementia.
- Know the assessment principles of dementia.
- Know the management principles of dementia.
- Perform an assessment for dementia.
- Use effective communication skills in interactions with people with dementia.
- Assess and manage physical health concerns in dementia.
- Provide psychosocial interventions to persons with dementia and their carers.
- Deliver pharmacological interventions as needed and where appropriate.
- Plan and perform follow up for dementia.
- Refer to specialists and link with outside agencies where appropriate and available.

### Key messages

- Dementia is not a normal part of ageing.
- Dementia is usually progressive – it gets worse over time.
- Symptoms of depression and delirium in older adults can mimic symptoms of dementia, therefore, a thorough assessment and regular follow-up is essential.
- It is critical to assess the carer's stress and psychosocial well-being and provide psychosocial support.
- There is much that can be done to improve symptoms and the living situation of people with dementia and their carers.
- Psychosocial interventions are the first-line treatment options for people with dementia; pharmacological interventions should not be routinely considered.
- Behavioural and psychological symptoms of dementia can be very distressing for the person and carer; therefore, developing treatment plans that address these symptoms are essential.
- Follow-up should be planned, at minimum, every three months.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to dementia	Promote respect and dignity for people with dementia  Know the common presentations of dementia  Understand how dementia can impact a person's life and the life of their carer and family  Know why dementia is a public health concern and understand how it can be managed in non-specialized health settings	30 minutes  30 minutes	<b>Activity 1: Person's story</b> Tell the person's story to introduce participants to what it feels like to live with dementia  <b>Presentation to supplement the person's story</b> Use the PowerPoint presentation to facilitate a structured discussion on: <ul style="list-style-type: none"><li>• Symptoms of dementia</li><li>• Causes of dementia</li><li>• How dementia impacts on a person's life</li><li>• Why it is a public health priority</li></ul>
2. Assessment of dementia	Know the assessment principles of dementia  Perform an assessment for dementia  Use effective communication skills in interactions with people with dementia  Assess the needs of carers  Assess and manage physical health concerns in dementia  Refer to specialists and link with outside agencies where appropriate and available	60 minutes  30 minutes	<b>Activity 2: Reflecting on caring for people with dementia</b> Give participants the opportunity to use the mhGAP-IG master chart to reflect on times they have cared for people with dementia  <b>Activity 3: Video demonstration: Assessing for dementia</b> Use videos/demonstration role play to show an assessment and allow participants to note: <ul style="list-style-type: none"><li>• Principles of assessment (all aspects covered)</li><li>• Effective communication skills (what and how this is done)</li></ul> <b>Activity 4: Role play: Assessment</b> Feedback and reflection
3. Management of dementia	Know the management principles of people with dementia  Provide psychosocial interventions to persons with dementia and their carers  Deliver pharmacological interventions as needed and where appropriate	30 minutes  30 minutes  20 minutes	<b>Presentation on management interventions</b>  <b>Activity 5: Case scenarios: Treatment planning</b> In three groups, participants practise developing a psychosocial treatment plan for a person with dementia and their carer  <b>Presentation on pharmacological interventions</b>
4. Follow-up	Plan and perform follow-up	30 minutes	<b>Activity 6: Role play: Follow-up</b> Feedback and reflection
5. Review		15 minutes	Multiple choice questions and discussion

**Total duration (without breaks) = 4 hours 35 minutes**

## Step-by-step facilitator's guide

# Session 1. Introduction to dementia

 1 hour

Session outline	Begin the session by briefly listing the topics that will be covered.
<ul style="list-style-type: none"><li>• <b>Introduction to dementia</b></li><li>• <b>Assessment of dementia</b></li><li>• <b>Management of dementia</b></li><li>• <b>Follow-up</b></li><li>• <b>Review</b></li></ul>	

## Activity 1: Person's story

Activity 1: Person's story	How to use the person's story: <ul style="list-style-type: none"><li>• Introduce the activity and ensure participants have access to pens and paper.</li><li>• Tell the person's story – be creative in how you tell the story to ensure the participants are engaged.</li><li>• First thoughts – give participants time to give their immediate reflections of the story. Have they cared for people with dementia in the past?</li></ul>
<ul style="list-style-type: none"><li>• Present a person's story of what it feels like to live with epilepsy.</li><li>• First thoughts.</li></ul>	

## Local terms for people with dementia

- What are the names and local terms for dementia?
- How does the community understand dementia? What do they think causes it?
- How does the community treat people with dementia?

4

Write a list of local terms and descriptions for dementia and compare those with the presentations described in the mhGAP-IG Version 2.0.

(Maximum five minutes.)

## What is dementia?

- Dementia is a term used to describe a large group of conditions affecting the brain which cause a progressive decline in a person's ability to function.
- It is **not** a normal part of ageing.

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Explain the points on the slide.

Emphasize that dementia is **not** a normal part of ageing. Although it generally affects people over 65, people as young as 30, 40 or 50 can have dementia.

Explain that quite often people, and especially carers, think that their loved one's decline in functioning (i.e. starting to lose their memory and their ability to carry out daily tasks) is a normal part of ageing and so rarely seek care and support.

This can cause carers and family members a lot of stress as they often do not understand why their loved one is behaving the way they are and they do not know how to manage and help the person.

Therefore, it is important to stress from the beginning of the module that caring for someone with dementia requires that you care for the carer as well.

## Common presentations

People with dementia can present with problems in:

- **Cognitive function:** Confusion, memory, problems planning.
- **Emotion control:** Mood swings, personality changes.
- **Behaviour:** Wandering, aggression.
- **Physical health:** Incontinence, weight loss
- **Difficulties in performing daily activities:** Ability to cook, clean dishes.

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Explain that dementia is caused by changes in the brain.

The changes are usually chronic and progressive.

People with dementia can present with problems in different aspects of functioning, as listed on the slide.

## Video

Show Alzheimer's video:

<https://www.youtube.com/watch?v=9Wv9jrk-gXc>

Explain that the most common type of dementia is **Alzheimer's disease**.

Play a short video on Alzheimer's disease (<https://www.youtube.com/watch?v=9Wv9jrk-gXc>). The video lasts three minutes.

At the end of the video, note that Alzheimer's is the most common type of dementia (60–70% of cases). Vascular dementia (reduced blood flow to the brain) is also common, as is dementia with Lewy bodies (tiny deposits of a protein that appear in nerve cells in the brain).

## Stages of dementia: Early stage

- Becoming forgetful, especially of things that have just happened.
- Some difficulty with communication (e.g. difficulty in finding words).
- Becoming lost and confused in familiar places – may lose items by putting them in unusual places and be unable to find them.
- Losing track of the time, including time of day, month, year.
- Difficulty in making decisions and handling personal finances.
- Having difficulty carrying out familiar tasks at home or work – trouble driving or forgetting how to use appliances in the kitchen.
- Mood and behaviour:
  - Less active and motivated, loses interest in activities and hobbies.
  - May show mood changes, including depression or anxiety.
  - May react unusually angrily or aggressively on occasion.

Explain that dementia can generally be described in stages.

Talk through the points on the slide. Emphasize that these are general descriptions and will vary from person to person, but in the early stages people may present with these symptoms.

At this stage, carers may notice these symptoms but minimize or ignore them, believing they are a normal part of ageing.

Therefore, in non-specialized health settings, you may not see people with dementia until they are already in the middle stages.

Ask participants to imagine how this early stage may impact on the person's life?

## Stages of dementia: Middle stage

- Becoming very forgetful, especially of recent events and people's names.
- Having difficulty comprehending time, date, place and events.
- Increasing difficulty with communication.
- Need help with personal care (i.e. toileting, dressing).
- Unable to prepare food, cook, clean or shop.
- Unable to live alone safely without considerable support.
- Behaviour changes (e.g. wandering, repeated questioning, calling out, clinging, disturbed sleeping, hallucinations).
- Inappropriate behaviour (e.g. disinhibition, aggression).

Talk through the points on the slides emphasizing that these are general descriptions, and behaviours may vary.

Explain that because the dementia is progressing, limitations and restrictions on what the person can and can't do are much clearer in the middle stage.

Ask participants to imagine how this stage may impact on the person's life?

## Stages of dementia: Late stage

- Unaware of time and place.
- May not understand what is happening around them.
- Unable to recognize relatives and friends.
- Unable to eat without assistance.
- Increasing need for assisted self-care.
- May have bladder and bowel incontinence.
- May be unable to walk or be confined to a wheelchair or bed.
- Behaviour changes may escalate and include aggression towards carer (kicking, hitting, screaming or moaning).
- Unable to find their way around in the home.

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Talk through the points on the slide and briefly explain that the presentations in the late stage are of near total dependence and inactivity.

Memory disturbances and emotion regulation is not only distressing for the person but is challenging for family members.

By the later stages the physical impact of dementia becomes more obvious.

Ask participants to imagine how this may impact on the person's life?

## Human rights abuses

- People with dementia are frequently denied their human rights and freedoms.
- In many countries physical and chemical restraints are used on people with dementia.
- This is an abuse of human rights.
- Chemical and physical restraints should not be used; instead people with dementia should be treated with dignity, and psychosocial interventions should be first-line treatment.

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Explain that people with dementia are frequently denied their basic human rights and the freedoms available to others.

In many countries, physical and chemical restraints are used extensively in care facilities for elderly people and in acute-care settings, even when regulations are in place to uphold the rights of people to freedom and choice.

## Impact on families and carers

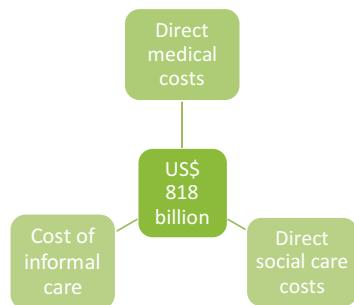
- Dementia is overwhelming for the families of affected people and their carers. Physical, emotional and economic pressures can cause great stress to families and carers, which has far reaching impacts on the wider society and community. Support for families of people with dementia is required from the health, social, financial and legal systems.

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### Impact on the carers

Explain that dementia is overwhelming for the person and their family and carers. Therefore, when treating individuals with dementia we have a responsibility to support the families and carers as well. The emotional and physical stress of looking after a person with dementia (especially in the middle and later stages) is difficult.

## Socioeconomic impact of dementia



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Explain that the socioeconomic impact of dementia is also overwhelming, including:

- direct medical costs
- direct social care costs
- costs of informal care (including carers having to take time off work etc.)

In 2015, the total global societal cost of dementia was estimated to be US\$ 818 billion.

## Why is dementia important?

- Worldwide, around 47 million people have dementia with nearly 60% in low- and middle-income countries.
- Every year there are 9.9 million new cases.
- By 2030 there is projected to be 75 million people with dementia and 132 million by 2050.



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## Dementia as a public health concern

Worldwide around 47 million people have dementia. Every year there are 9.9 million new cases.

Explain that:

- Dementia is one of the major causes of disability in later life.
- Dementia is prevalent worldwide but is often misdiagnosed.
- 58% of all people with dementia worldwide live in low- and middle-income countries. By 2030, 75 million people will be living with dementia. By 2050 that number will rise to 132 million. Much of the increase is attributable to the rising number of people with dementia living in low- and middle income countries.

## DEMENTIA A public health priority



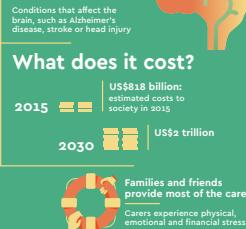
### What are the symptoms?



### Who is affected?



### What is the cause?



## Dementia in non-specialized health settings

Talk through the infographic and highlight the major findings.

Explain that although there is no cure, but with early recognition, especially in non-specialized health settings, and supportive treatment, the lives of people with dementia and their carers can be significantly improved. Physical health, cognition, activity and the well-being of the person with dementia can also be optimized.

## Principles of dementia care

- Early diagnosis in order to promote early and optimal management.
- Optimizing health, cognition, activity and well-being.
- Identifying and treating accompanying physical illness.
- Detecting and treating behavioural and psychological symptoms.
- Providing information and long-term support to carers.

Talk through the points on the slide.

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# Session 2.

# Assessment of dementia

 1 hour 30 minutes

## Activity 2: Reflecting on caring for people with dementia

**Duration:** 15 minutes.

**Purpose:** Have participants reflect on times when they may have cared for someone with dementia (even if they did not know it at the time).

## Instructions:

- Individually ask participants to think about people they have seen in the past that they now suspect may have had symptoms of dementia.
  - Ask them to quickly write down a description of the person and how they presented.
  - After five minutes have them turn to the person next to them and discuss their cases.
  - Direct them to the master chart in the mhGAP-IG Version 2.0 to compare the common presentations described with their cases.
  - After five minutes' discussion bring the group together.
  - In plenary, ask participants to evaluate how they managed to communicate with someone with dementia?
  - Facilitate a discussion (five minutes).



Ask the participants to imagine they are in their clinic.

## Communication during the assessment

- People with dementia may have cognitive impairments that will limit the communication they can have with you.
- Therefore, make an effort to communicate with the person **and** their carer.
- Make sure you sit in a way that the person can see and hear you properly.
- Speak clearly, slowly and with eye contact.
- Look at the body language and non-verbal cues.
- Give the caregiver and family a chance to talk and listen to their concerns. You may need to be flexible in how you do this.

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## Communication during the assessment

Read out the description on the slides and explain that it may be hard for a person with dementia to follow a conversation, so you will need to talk to the carer and the person about the symptoms to gain a full understanding.

## Communicating with the person with dementia

- The progressive nature of dementia means that over time the person may experience:
  - Problems finding the right words.
  - Their fluency when talking may deteriorate.
  - They may interrupt, not respond, ignore others, appear self-centred.
  - They may have trouble understanding the questions put to them. They may be confused when answering.
  - Their reading and writing skills may deteriorate.
  - The way they express their emotions will change.
  - They may have hearing and visual problems as well.

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Explain that as dementia progresses it will become harder to communicate. List the ways in which it is harder to communicate as stated on the slide.

Therefore, it is important to find other ways to build a relationship and communicate with the person with dementia.

This can be done by changing your verbal communication to non-verbal communication, e.g. being calm with the person, putting the person at ease wherever possible, and thinking about the environment in which you see the person (can it be familiar, somewhere where they feel safe).

Give the person time and do not make them feel rushed.

Ensure that you are visible and that they can see you clearly and hear you clearly. Spend time with the person or work with the carer to understand the person's facial expressions and body language.

When asking questions:

- Use closed questions.
- Give clear simple instructions.
- Give clues to try and help them find the words that they forget or allow them the time to find the words if they are forgetting them.

## Establish communication and build trust with carers

- Provide the carer and family with opportunities to express their worries and concerns about the person's illness.
- Listen carefully to the concerns of the carer and family members.
- Highlight the positive aspects of the family:
  - Congratulate the family for taking such good care of the person, if appropriate.
- Be flexible in your approach with the carer and family. The family may come to you with needs you did not expect.

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Explain that listening to the concerns and experiences of the carer is an effective way of understanding the person's presentation and symptoms.

The carers may be overwhelmed and feel exhausted from caring for their loved ones.

Therefore, it is important to give them the time and space they need to explain the person's symptoms and explain what has been happening.

Talk through the points on the slide.

Ask participants to think of some assessment questions they could ask the carer to assess if a person has dementia? Allow five minutes maximum and make a note of their answers and feedback to the group.

## Ask the carer

- Have you noticed a change in the person's ability to think and reason?
- Does the person often forget where they have put things?
- Does the person forget what happened the day before?
- Does the person forget where they are?
- Does the person get confused?
- Does the person have difficulty dressing (misplacing buttons, putting clothes on in the wrong way)?

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Talk through the questions on the slide and explain that the answers to these questions can help identify if the person's cognitive functioning has deteriorated.

How well are they performing their everyday activities (compared with a few years ago)?

Talk through the questions on the slides, asking for the group's views.

## Get more information about the symptoms

Ask the carer:

- How has the person changed since having these symptoms (changed behaviours, ability to reason, changed personality, changed emotion control)?
- What does the person do in a typical day? How do they behave? Is this different from what they used to do?

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Ask the group to provide alternative, culturally appropriate, questions.

Make a note of their suggestions.

## Get more information about the symptoms

Ask the person or their carer:

- When they first noticed the symptoms?
- How old was the person when they first noticed the symptoms?
- Did the symptoms start suddenly or gradually?
- How long have the symptoms been present for?
- Are the symptoms worse at night?
- Is there associated drowsiness, impairment of consciousness?

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Finally, talk through the final list of questions on the slide.

Ask the participants to give their opinions on what the answers may be.

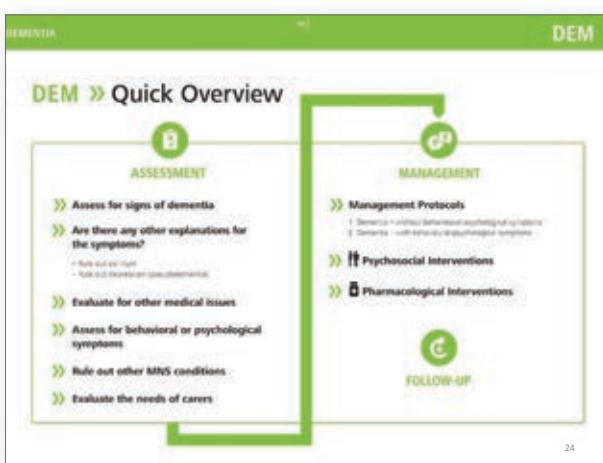
Then explain the key information learned from these questions:

Dementia usually starts later in life (e.g. 60 and 70 years old) although people in their 30s, 40s and 50s can also develop dementia. So, it is important to know when it started.

Onset is gradual over months to years. So, again, it is important to know when they first noticed the symptoms and whether the onset has been slow or fast?

Dementia is progressive. Once it starts it continually deteriorates, although the decline may be slow. Usually, consciousness is not impaired in people with dementia.

Explain that **impairment of consciousness** can mean a number of different presentations, including fluctuating attention, to coma with only primitive responses to stimuli. The important aspect of an impairment of consciousness is that it is a change from what is normal for that person.



Instruct participants to turn to the assessment page 94 in the mhGAP-IG Version 2.0 and note the principles of assessment for dementia.

1. Assess for signs of dementia.
2. Are there any other explanations for the symptoms:
  - rule out delirium
  - rule out depression (pseudo-dementia).
3. Evaluate for other medical issues.
4. Assess for behavioural or psychological symptoms.
5. Rule out other MNS conditions.
6. Evaluate the needs of carers.

Re-emphasize that dementia is commonly misdiagnosed and therefore requires a thorough assessment.

Ask participants to reflect on why it is important to cover these steps in an assessment?

## Activity 3: Video demonstration: Assessing for dementia

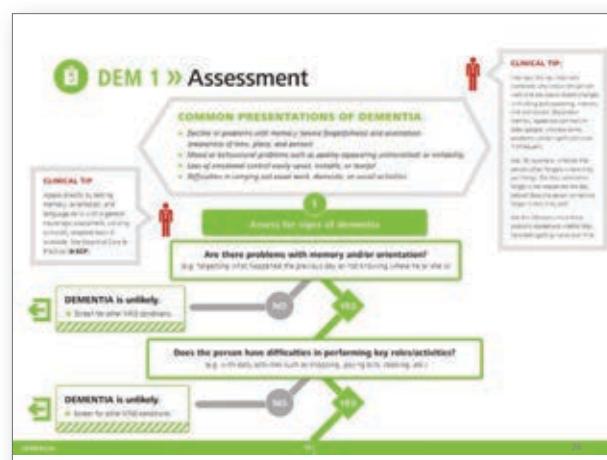
Video demonstration:  
Assessing for dementia

Show mhGAP video

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Explain that they are about to see a video of an assessment for someone with suspected dementia (<https://www.youtube.com/watch?v=fO9nwqF1OJE&index=11&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>).

Ensure that whilst watching the video participants have a look through the assessment algorithm in mhGAP-IG Version 2.0 (page 95).



Remind participants of the stories they heard and explain that cognitive decline is a common symptom of dementia. Therefore, if you suspect dementia start by assessing for signs of dementia by testing memory and/or orientation.

## Testing orientation, memory and language

**Example of questions:**

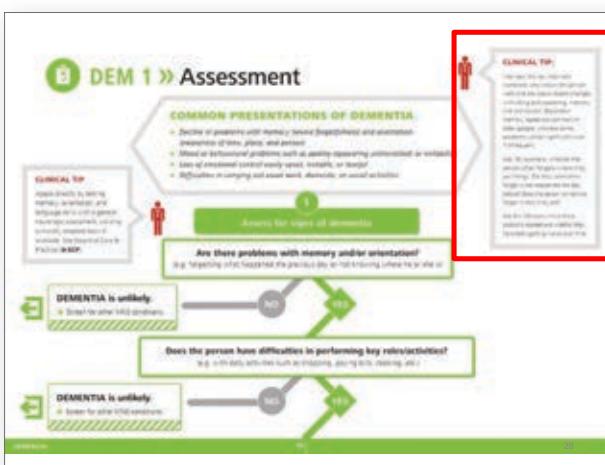
1. Tell them three words (e.g. boat, house, fish) and ask them to repeat after you.
2. Point to their elbow and ask, "What do we call this?"
3. Ask below questions:
  - What do you do with a hammer? (*Acceptable answer: "Drive a nail into something"*).
  - Where is the local market/local store?
  - What day of the week is it?
  - What is the season?
  - Please point first to the window and then to the door.
4. Ask, "Do you remember the three words I told you a few minutes ago?"

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At the end of the video, show participants the short example on the slide of how they can formally test for orientation, memory and language.

Have a few participants volunteer to take the test.

Talk through the questions in the test and answer any questions participants may have.



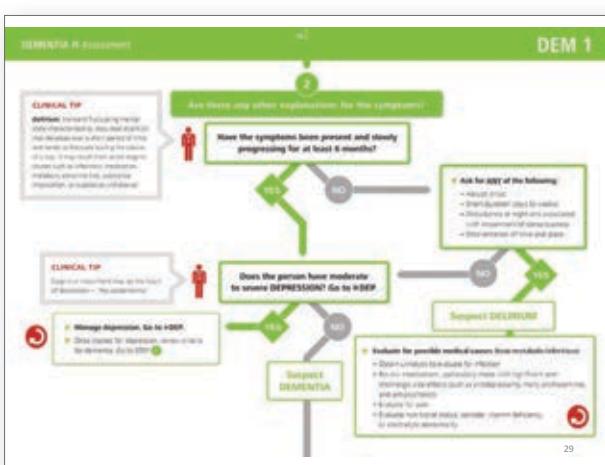
Start at the beginning of the assessment algorithm.

Draw the participants' attention to the clinical tip that advises clinicians to interview key informants.

Explain that we have looked at some questions that could be asked of carers in order to understand more about the person's symptoms.

Discuss how the health-care provider (in the video) asked/found out about any problems with memory and/or orientation?

How did the health-care provider find out if the man was having difficulties performing key roles/activities?



How did the health-care provider examine if there are any other explanations for the symptoms?

## Delirium resembling dementia

- Delirium is a state of mental confusion that develops quickly and usually fluctuates in intensity. It has many causes, including medications and infections.
- Delirium can be confused for dementia.
- Suspect delirium if it is acute onset, short duration and the person has impaired level of consciousness.
- If you think that a person has delirium;
  - Try to identify and manage underlying cause
  - Assess for dehydration and give fluid
  - Ensure that the person is safe and comfortable
  - Refer the person to a specialist (e.g. neurologist, psychiatrist, or internal medicine specialist).

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Delirium resembling dementia is a possible explanation for symptoms.

Talk through the points on the slide.

Emphasize that it is possible for someone with dementia to have delirium at the same time. In which case treat the delirium and continue to assess and monitor for symptoms of dementia.

## Depression resembling dementia

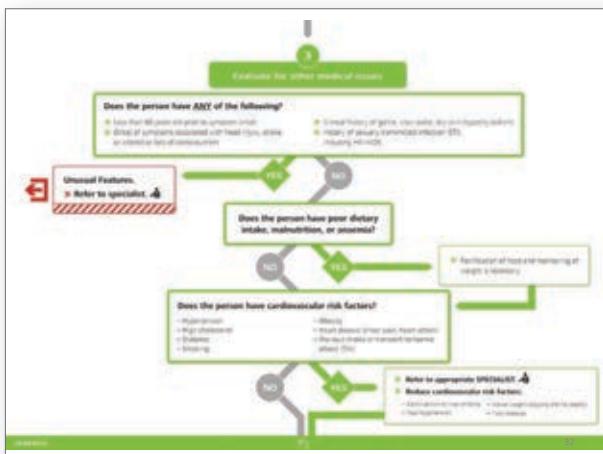
- In older people, depression can sometimes resemble dementia.
- Older people with depression can often be confused, irritable, lose interest and motivation, stop functioning well (be unkempt and neglect personal hygiene) and generally present in ways similar to dementia.
- If you suspect depression then go to the Module: Depression and manage the depression but the person should be re-assessed for dementia 12 weeks later.

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Ask group how depression can resemble dementia?

Give them a few minutes to answer and then reveal the explanation on the slide.

Explain that depression is common amongst the elderly but if they do not have depression they should also be screened for other priority MNS conditions such as psychoses.



Ask participants:

How did the health-care provider evaluate the person for other medical issues?

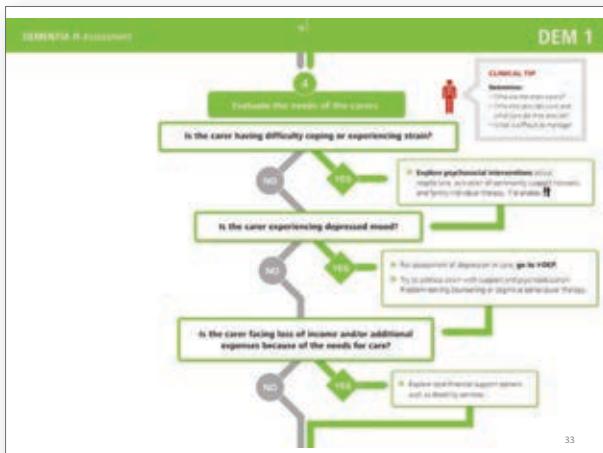
Instruct the participants to read through step 3 of the assessment for dementia.

Highlight that:

Looking for cardiovascular risk factors is very important considering that vascular dementia is the second most common cause of dementia.

You can take this opportunity to explore the risk factors for cardiovascular disease.

Explain that managing these risk factors as well as any other medical conditions is crucial for managing dementia.

**Emphasize that:**

- Signs of hypothyroidism can present as dementia.
- Head injury and stroke can cause dementia-like symptoms
- Syphilis and HIV can cause dementia
- Anaemia and B12 deficiency can cause dementia

Remind participants of their responsibility to assess stress in the carer.

In fact, the well-being of the person will be influenced by the resilience of their family and carer, so it is essential to go through the following steps:

In order to allow the carer a chance to speak freely, find a time and space when you can speak alone.

Ask the carers the questions that are on the slide to establish how they are coping.

Explain to participants that they need to emphasize to carers that even the best carers get frustrated.

Some carers may get so frustrated that some may resort to physical and psychological abuse.

Give examples of what they should be looking for during the physical exam – bruises with different colours (black, green-yellow) or in unusual places (inner sides of arms and thighs, abdomen, eyes). It is important to protect the person, but also to support the carer to prevent this situation.

Link the carers with appropriate services to help them cope better with the situation.

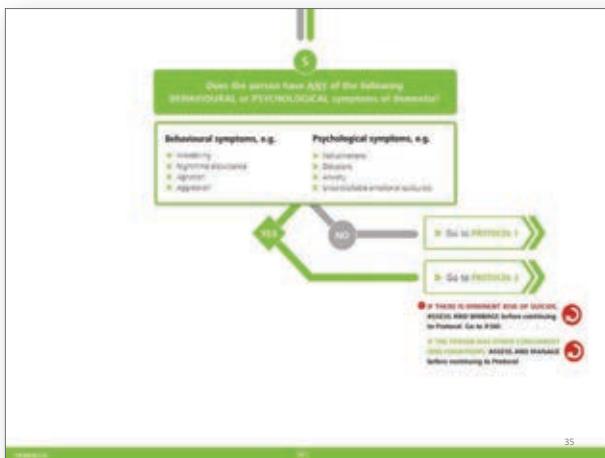
### Assessing the carer

**Assess:**

- Who is the main carer?
- Who else provides care and what care do they provide?
- Is there anything they find particularly difficult to manage?
- Are the carers coping? Are they experiencing strain? Are they depressed?
- Are they facing loss of income and/or additional expenses because of the need for care?

It is important to make sure that the carer is coping because they will ensure the well-being of the person with dementia.

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Around 90% of people affected by dementia will experience behavioural and psychological symptoms.

Behaviours such as wandering, night-time disturbance, agitation and aggression can put the person at risk. They can also be very exhausting for carers to manage.

Try to learn as much as possible about these symptoms from the carers.

Behavioural and psychological symptoms of dementia	Work with the carers to help manage these behaviours and minimize any risks that the behaviour may cause.
<ul style="list-style-type: none"> <li>• Apathy</li> <li>• Aggression</li> <li>• Wandering</li> <li>• Restlessness</li> <li>• Eating problems</li> <li>• Agitation</li> <li>• Disinhibition</li> <li>• Pacing</li> <li>• Screaming</li> </ul>	<p>Explain that in addition to the symptoms described in the mhGAP-IG, some people may experience apathy, eating problems, disinhibition, pacing and screaming.</p> <p>Explain that these symptoms are usually seen in later stages of dementia.</p>

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## Activity 4: Role play: Assessment

### Activity 4: Role play: Assessment

- Farah, 45 years old, brings her mother Ingrid, 73 years old, to your clinic.
- Farah reports that her mother has been acting strangely over the last few months.
- Her mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people that she has known for years.
- Assess Ingrid for possible dementia.
- Also assess Farah's well-being.

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See DEM supporting material role play 1.

Print off the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** To practise using the mhGAP-IG algorithm to assess an older person for dementia and their carer.

**Situation:**

- Farah, 45 years old, brings her mother Ingrid, 73 years old, to your clinic.
- Farah reports that her mother has been acting strangely over the last few months.
- Her mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people that she has known for years.
- Assess Ingrid for possible dementia.
- Also assess Farah's well-being.

**Instructions:**

- Divide the participants into groups of four – one person to play the role of the health-care provider, one the role of Farah, one Ingrid and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

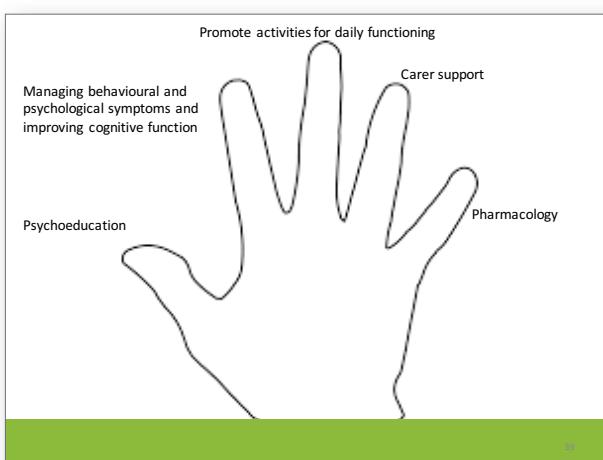
# Session 3.

# Management of dementia

⌚ 1 hour 20 minutes



Ask the participants to name which management interventions they think could be used for people with dementia and their carers?



Explain that the management interventions for dementia differ slightly from other MNS conditions. Specifically, there is a focus on improving cognitive functioning; behavioural and psychological symptoms; and supporting the person to live well *with* their condition.

Management interventions should aim to enhance the person's independence as well as ensure that the carer's needs are supported.



Talk through the different protocols.

Emphasize the importance of delivering psychoeducation messages to the person and their carers.

**Psychoeducation:** Explain the need to tailor and adapt the language when talking to the person with dementia so that they understand and are not overwhelmed.

**Carer support:** Ensure when delivering management interventions, to focus on the individual with dementia and the carer.

## Carer support

- 1. Empathize:** Acknowledge how difficult and frustrating it is to care for someone with dementia:
  - Remind them to keep calm and avoid hostility.
  - Explain how scared the person with dementia may be feeling and the importance of treating them with respect and dignity and thinking of them as a person.

Explain that participants should find the time to see the carer alone.  
Offer them support.

**Empathize:** acknowledge their frustrations but remind them to respect the dignity of the person.

Support them to find ways to manage their frustrations such as relaxation strategies, taking a short break etc.

## Carer support

- 2. Encourage carer to seek help and support.**
- 3. Provide information** to carers about dementia and the symptoms.
- 4. Train** the carers and support them to learn to tackle difficult behaviours like wandering and aggression (use role plays).
- 5. If possible offer respite care** for the carer.
- 6. Explore any financial support** or benefits the carer and person may be entitled to.

List the different ways in which the health-care provider can support carers.

Ensure that participants read through the interventions as you discuss them and that participants have their mhGAP-IG Version open to page 102.

## Managing behavioural and psychological symptoms of dementia

Following are common problems faced by caregivers in managing care for older person with dementia:

1. Personal hygiene
2. Dressing
3. Toileting and incontinence
4. Repeated questioning
5. Clinging
6. Aggression
7. Wandering
8. Loss of interest and activity
9. Hallucinations

Explain that the list of behaviours on this slide are a common set of behaviours, psychological symptoms and difficulties with activities of daily living that many people with dementia experience.

Not paying attention to personal hygiene, dressing, having problems toileting and with incontinence can be embarrassing and undignified for the person with dementia and very distressing for the carer. However, there are psychosocial strategies that can help support a person with dementia take back some control in these areas.

Similarly, explain that repeated questioning, wandering, aggression etc. are very challenging behaviours and cause the person and the carer distress.

Research has shown that pharmacological interventions are largely ineffective or have serious side-effects for people with dementia. Therefore, psychosocial interventions must be used as first-line treatment options.

Explain that during the next activity participants will be given a set of handouts (see DEM supporting material case scenarios and handouts) with explanations of these behaviours and suggestions about how to manage them.

## Activity 5: Case scenarios: Treatment planning

### Activity 5: Case scenarios: Treatment planning

In small groups:

- Practise choosing different management interventions to help manage someone with dementia.
- Specifically focus on managing psychological and behavioural symptoms.

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**Duration:** 50 minutes.

**Purpose:** To allow participants to practise developing a treatment plan for people with dementia and their carers. The exercise will enable them to: practise choosing which management interventions to use; to decide whether to refer; and to think about how to follow-up.

**Instructions:**

- Divide participants into four groups.
- Give each group a different case scenario which describes an older adult and their carer's experience of dementia (see DEM supporting material).
- Ask the groups to develop a treatment plan.
- Instruct the groups to use the clinical tips and ideas given in the mhGAP-IG Version 2.0 Module: Essential care and practice as well as the management interventions in the dementia module and other relevant modules. Give the groups nine handouts on behavioural, psychological and daily activity symptoms.
- Give each group 10 minutes to start identifying if the person in the case study is experiencing any behavioural, psychological and daily activity symptoms. If so, which ones?
- After 10 minutes, give them the lists of suggestions for managing behavioural symptoms of a person with dementia. Then ask them to start developing a treatment plan for the person and their carer.
- After a further 15 minutes, come back together as a large group and have each group present their case scenario, the behavioural, psychological and daily activity symptoms identified and the treatment plan.

DEM 2	DEM 3
<p><b>PSYCHOSOCIAL (CONT.)</b></p> <ul style="list-style-type: none"> <li>3.3 Carer support:           <ul style="list-style-type: none"> <li>• Assess the impact of the dementia on the carer (financial, emotional, physical) and resources for their family, dg, employer, social care, and health care <b>QUESTION 1</b></li> <li>• Advise/advocate for carers to receive training and support to manage the challenges of caring. It is important to remember that the carer's need to be encouraged to respect the dignity of the person with dementia and avoid hostility towards the person, or neglect of the person.</li> <li>• Encourage the carer to seek help if they are experiencing difficult feelings or coping with their role.</li> <li>• Encourage carers to take time for themselves, especially if they are caring for more than one person in general.</li> <li>• Provide family support and practical advice, e.g. managing difficult behaviours. Encourage carers to seek advice from a professional, e.g. respite.</li> <li>• Encourage practical problem solving (with family, e.g. home-based respite, another family member, carer support group, etc.). Encourage carers to seek advice from a professional, e.g. respite, to see what other services are available.</li> <li>• Encourage carers to seek support for their stability (e.g. carer support group, financial support, government services, respite).</li> </ul> </li> </ul>	<p><b>PHARMACOLOGICAL INTERVENTIONS</b></p> <ul style="list-style-type: none"> <li>3.3 For dementia without behavioural and/or psychological symptoms           <ul style="list-style-type: none"> <li>• If no cognitive impairment in place, CDA and dementia are considered as alternative diagnosis for all cases of dementia.</li> <li>• Assess medication risk in relation to a clear diagnosis of dementia. Drugs can be made CDR aware through <b>support and supervision by a specialist</b> and <b>monitoring</b> the side effects of anticholinergics. <b>Non-pharmacological interventions</b> are recommended.</li> </ul> </li> <li>3.3 Antipsychotic medication for behavioural and/or psychological symptoms           <ul style="list-style-type: none"> <li>• Assess psychotropic medication <b>QUESTION 2</b></li> <li>• If there is evidence of behaviour or anxiety, consider non-pharmacological interventions. See <b>NPV 1. Management of behavioural and psychological symptoms</b>.</li> <li>• Identify the principles of:           <ul style="list-style-type: none"> <li>- "less is better" - reduce and delay the need for drugs by:               <ul style="list-style-type: none"> <li>- use the least when possible</li> <li>- minimise the use of psychotropic drugs</li> </ul> </li> <li>• <b>QUESTION 3</b></li> <li>• <b>QUESTION 4</b></li> </ul> </li> </ul> </li> </ul>

## **Pharmacological interventions**

Emphasize that medication should **not** be routinely considered for all cases of dementia.

State that the participants should **not** consider acetylcholinesterase inhibitors (like donepezil, galantamine and rivastigmine) or memantine routinely for all cases of dementia.

Explain that they should only consider medications in settings where the specific diagnosis of Alzheimer's disease can be made **and** where adequate support and supervision by specialists and monitoring (for side-effects) from carers is available.

Emphasize that even if no medications are prescribed, there is much that can be done to improve the quality of life of the person with dementia and their carers.

**Point out the three principles:**

- “Start slow, go slow” (titrate) and review the need regularly.
  - Use the lowest effective dose.
  - Monitor the person for side-effects, such as extrapyramidal symptoms (EPS).

**Avoid i.v. haloperidol.**

**Avoid diazepam.**

Special populations	Adolescents
<p>Note that interventions may differ for <b>PREGNANCY</b> or <b>BREASTFEEDING</b> in these populations.</p>	
<h3 data-bbox="271 1405 512 1417">WOMEN WHO ARE PREGNANT OR BREASTFEEDING</h3> <ul style="list-style-type: none"> <li>■ <b>Liaise with maternal health specialists to organize care.</b></li> <li>■ <b>Consider consultation with mental health specialist if available.</b></li> <li>■ <b>Explain the risk of adverse consequences for the mother and her baby, including substance exposure and psychosis, relative to medication stopped.</b></li> <li>■ <b>Consider pharmacological interventions:</b> check appropriateness and availability. See <a href="#">Section 8</a>.</li> </ul>	<h3 data-bbox="657 1405 725 1417">ADOLESCENTS</h3> <ul style="list-style-type: none"> <li>■ <b>Consider co-ordination with mental health specialist.</b></li> <li>■ <b>For adolescents with psychiatric or bipolar disorder, <b>disability can be different</b>, as a result of developmental factors under supervision of a specialist.</b></li> <li>■ <b>For adolescents with depression:</b> self-harm and suicidal behaviour is not unusual.</li> </ul>
<h3 data-bbox="247 1495 428 1513">Pharmacological interventions</h3>	
<h4 data-bbox="247 1513 428 1527">Psychosis</h4> <ul style="list-style-type: none"> <li>■ In women with psychosis who are planning a pregnancy or are pregnant, antipsychotic drugs, particularly atypical, or clozapine, may be considered.</li> <li>■ <b>Anticholinergics</b> should <b>NOT</b> be prescribed in women who are pregnant due to increased risks of birth defects, medications, doses, or types of effects, unknown.</li> <li>■ <b>Depot neuroleptic injections</b> should not be prescribed to women with psychosis who are planning a pregnancy, pregnant, or breastfeeding because there is relatively little information on their safety in this population.</li> </ul>	<h4 data-bbox="385 1513 566 1527">MANAGE EPISODES IN BIPOLAR DISORDER</h4> <ul style="list-style-type: none"> <li>■ <b>AVOID ULTRASPLETIC, LETHARGIC and CATASTROPHIC</b> (see <a href="#">Section 4</a>) symptoms, and consider the use of mood stabilizers in addition to antidepressants.</li> <li>■ <b>Consider brief doses haloperidol</b> (or valproate) and/or carbamazepine for a specifier, if adequate.</li> <li>■ <b>weigh the risks and benefits of medications in context of life threatening risk.</b></li> <li>■ If a drug and common side-effects do not manage taking mood stabilizer(s), consider switching to less toxic alternatives.</li> </ul>
<h3 data-bbox="247 1574 428 1592">OLDER ADULTS</h3>	
<ul style="list-style-type: none"> <li>■ <b>Use lowest doses</b> of medication.</li> <li>■ <b>Anticholinergics are associated with drug-drug interactions.</b></li> </ul> <p><b>CAUTION</b></p> <p>Antipsychotics to early onset associated with all anti-psychotic drugs and heart and liver toxicity with dopamine-related psychoses.</p>	

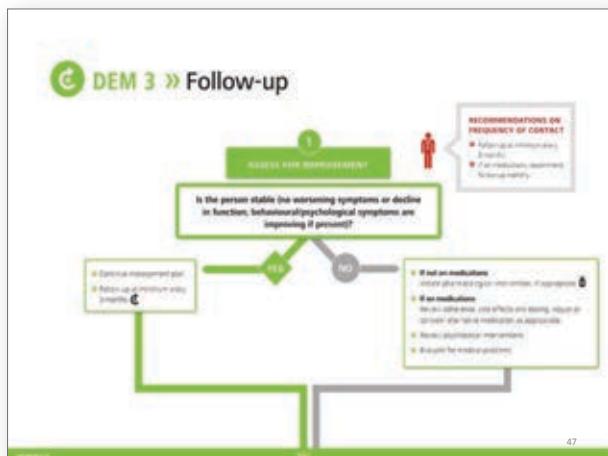
Explain that the behavioural and psychological symptoms can be very distressing for the person and the carer but that mhGAP recommends psychosocial interventions as the first-line treatment option, **not** pharmacological interventions.

Antipsychotics should only be considered if:

- Symptoms persist despite providing psychosocial interventions.
  - You assess that there is imminent risk for the person and/or carer.

# Session 4. Follow-up

 30 minutes



As a large group, discuss the follow-up algorithm

Ask volunteers to read out the first decision-making step and options.

Have them suggest questions they could use to find out this information out?

Emphasize that the person **MUST** be followed up regularly, every three months.

There is currently no cure for dementia, therefore long-term monitoring is the best form of treatment.



Have a different volunteer read out steps 2 and 3 of the follow-up algorithm.

Ask participants to suggest possible questions they could use to find this information out.

Emphasize that due to the progressive and degenerative nature of dementia, at each follow-up appointment the participants **must assess all the areas** as described on page 104 of mhGAP-IG Version 2.0. This way they can assess if there has been deterioration in the person's cognitive, emotional, behavioural and physical functioning and how well they are managing to carry out the activities of daily living.

Explain that they will be practising doing this in a role play.

## Activity 6: Role play: Follow-up

### Activity 6: Role play: Follow-up

- Farah and Ingrid return to your clinic three months later for a follow-up appointment.
- Ingrid explains that Farah's behaviour has deteriorated. She is now waking up at night and wandering around the house. One night last week she fell over a piece of furniture in the house and hurt her leg.
- Farah has also been going out of the house during the day and getting lost.
- One day it took Ingrid over 12 hours to find Farah and when she did Farah had not eaten or drunk anything all day and was weak and dizzy. Ingrid worries about what could have happened to her.

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See DEM supporting materials role play 2.

Print off three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:**

To practise using the mhGAP-IG follow-up algorithm to conduct a routine follow-up appointment including:

- Using effective communication skills.
- Offering routine follow-up assessments.
- Offering new psychosocial interventions to the person and their carer.

**Situation:**

- Farah and Ingrid return to your clinic three months later for a follow-up appointment.
- Ingrid explains that Farah's behavior has deteriorated. She is now waking up at night and wandering around the house. One night last week she fell over a piece of furniture in the house and hurt her leg.
- Farah has also been going out of the house during the day and getting lost.
- One day it took Ingrid over 12 hours to find Farah and when she did Farah had not eaten or drunk anything all day and was weak and dizzy. Ingrid worries about what could have happened to her.

**Instructions:**

- Divide the participants into groups of four; one person is to play the role of the health-care provider, one Farah, one Ingrid and one the role of the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time

# Session 5. Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the MCQs (see DEM supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# DEM PowerPoint slide presentation



PowerPoint slide presentation available online at:

[http://www.who.int/mental\\_health/mhgap/dem\\_slides.pdf](http://www.who.int/mental_health/mhgap/dem_slides.pdf)

## DEM supporting material

- Person stories
- Role plays
- Case scenarios
- Treatment planning handouts
- Treatment planning suggestions
- Multiple choice questions
- Video link

Activity 3: mhGAP DEM module – assessment

<https://www.youtube.com/watch?v=fO9nwqF1OJE&index=11&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>



Supporting material available online at:

[www.who.int/mental\\_health/mhgap/dem\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/dem_supporting_material.pdf)

DEM

# Disorders due to substance use

mhGAP training of health-care providers  
Training manual

SUB



World Health  
Organization

# Module: Disorders due to substance abuse

## Overview

### Learning objectives

- Promote respect and dignity for people with disorders due to substance use.
- Know the common presentation of disorders due to substance use.
- Know the assessment principles of disorders due to substance use.
- Know the management principles of disorders due to substance use.
- Perform an assessment for disorders due to substance use.
- Use effective communication skills in interactions with people with disorders due to substance use.
- Assess and manage physical health in disorders due to substance use.
- Assess and manage emergency presentations of disorders due to substance use.
- Provide psychosocial interventions to persons with disorders due to substance use and their carers.
- Deliver pharmacological interventions as needed and appropriate in disorders due to substance use, considering special populations.
- Plan and perform follow up for people with disorders due to substance use.
- Refer to specialists and link with outside agencies when appropriate.

### Key messages

- Substance use disorders are associated with health and social problems.
- People with substance use disorders can present as:
  - acute intoxication
  - overdose
  - withdrawal from substance use
  - harmful uses
  - dependence.
- All health-care providers can make a difference. It is important to ask people about their substance use.
- The withdrawal features from alcohol and benzodiazepines can be life threatening. Ensure that you closely monitor and help people who are withdrawing from substance use and refer to hospitals when required.
- Assess and treat the physical health of people with disorders due to substance use.
- Use psychosocial interventions, including brief motivational interviewing to explore a person's motivation to stop using substances.
- Provide pharmacological interventions when appropriate.
- Offer care and support to the family and carers of people with disorders due to substance use.
- Offer regular follow-up to people with disorders due to substance use.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to disorders due to substance use	<p>Know the common presentations of disorders due to substance use</p> <p>Know the impact of disorders due to substance use of individuals and the family</p> <p>Understand the importance of managing substance use in primary health-care settings</p> <p>Promote respect and dignity for people with disorders due to substance use</p>	30 minutes 20 minutes 60 minutes	<b>Activity 1: Group brainstorm: What substances?</b> Group brainstorm about different psychoactive substances
2. Assessment of disorders due to substance use	<p>Perform an assessment for disorders due to substance use</p> <p>Assess and manage physical health in disorders due to substance use</p> <p>Use effective communication skills</p> <p>Refer to specialists and link with outside agencies for people with disorders due to alcohol use</p>	40 minutes 30 minutes	<b>Activity 3: Video demonstration: Assessment</b> Use videos/demonstration role play to show an assessment and allow participants to discuss the principles of assessment, including when to refer
3. Management of disorders due to substance use	<p>Provide psychosocial interventions to persons with disorders due to substance use and their carers</p> <p>Deliver pharmacological interventions as needed and appropriate in disorders due to substance use, considering special populations</p>	45 minutes 30 minutes 45 minutes	<b>Presentation on the principles of managing disorders due to substances</b> <b>Activity 5: Video demonstration: Motivational interviewing</b> <b>Activity 6: Role play: Motivational interviewing</b> Practise using motivational interviewing
4. Follow-up	Plan and perform follow-up for people with disorders due to substance use	10 minutes	<b>Presentation on principles of follow-up</b>
5. Emergency presentations	Perform assessment and management of emergency presentations including when to refer	30 minutes	<b>Activity 8: Role play: Assessing and managing emergency presentations</b>
6. Review	Review the information and skills taught during the training	15 minutes	<b>Multiple choice questions and discussion</b>
<b>Total duration (without breaks) = 5 hours 55 minutes</b>			

# Step-by-step facilitator's guide

## Note

When planning and adapting this module for training remember to select the substances that are most relevant to the local area. If alcohol is not consumed then leave out the slides that relate to alcohol. If khat is not consumed then leave out any slides about khat etc.

# Session 1. Introduction to disorders due to substance use

 1 hour 50 minutes

## Session outline

- Introduction to disorders due to substance use.
- Assessment of disorders due to substance use.
- Management of disorders due to substance use.
- Follow-up.
- Emergency presentations.

Begin the session by briefly listing the topics that will be covered.

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SUB

# Activity 1: Group brainstorm: What substances?

## Reflection

1. Is substance use common in your society?
2. What are the benefits of substance use?
3. What are the harms of substance use?
4. How does the community/society try to balance those benefits and harms?
5. Do you agree with the approach taken by the community/society?

### Group discussion

Allow people to have an open discussion rather than telling everyone whether they are right or wrong.

Try to get a sense of the range of views.

**Note:** Answers to the second question should explore the role the substance plays in social cohesion, accepted social activities etc.

**Duration:** 30 minutes.

**Purpose:** To introduce participants to different substances and reflect on substances used in the local society.

### Instructions:

- Explain that disorders due to substance use include both drug and alcohol use disorders and certain conditions including acute intoxication, overdose withdrawal, harmful use and dependence.
- Explain that before we start to discuss ways to assess and manage disorders due to substance use we need to understand what substances people use.
- Ask participants to brainstorm the most common substances used in their setting (10 minutes).
- Make a list of their contributions, including local types of alcohol and the most commonly used drugs.
- Direct participants to use Box 1 on page 115 of mhGAP-IG Version 2.0 and have participants reflect on the different ways people use those substances. Ask:
  - Is substance use common in your society?
  - What are the benefits of substance use?
  - Are there harms?
  - How does your community/society try to balance these benefits and harms?
  - Do you agree with the approach taken by your society/community?

Take the opportunity now to define what we mean by alcohol and other substances.

As you discuss the different types of substances direct participants to read Box 1 (page 115 mhGAP-IG). As you describe the different substances briefly look at the long-term effects of the substances on health and behaviour.



© Commonwealth of Australia

## Alcohol

- Alcohol is a psychoactive substance with intoxicating effects.
- When we talk about alcohol we are talking about alcoholic drinks.
- State that a standard drink is usually equivalent to 8–12 grams (10 ml) of alcohol, although different countries use different definitions.
- Alcohol is a depressant, which means it slows down the body's responses including brain activity.
- A small amount can reduce feelings of anxiety and reduce inhibitions which can help you feel more relaxed and sociable.
- Short-term effects of alcohol can last for a day or two, depending on how much you drink and can include a hangover (often including dehydration, headaches, nausea).
- Long-term effects include damage to the brain and other organs such as the liver.

## Note:

- Find out if there is a local definition of a standard drink.
- Also, if the most common type of alcohol is not in this slide, consider adding it, calculating the amount needed for a standard drink (8–10 grams of alcohol).
- It may be possible to have the local drink analysed in advance of the training to find out how much alcohol is in it.



## Opioids

## Opioids

- Opioids includes heroin, opium and prescription drugs such as oxycodone, codeine, morphine and many others.
- Heroin can be smoked, snuffed and/or injected.
- Opioids generally produce pain relief and euphoria and for that reason they are often misused (taken in large quantities).
- Regular use can lead to a physical dependence and if overused they can lead to overdoses and death.

## Benzodiazepines



© <http://www.serenityranch.ca/blog/bid/79580/Benzodiazepines-are-they-safe-Serenity-Ranch>

### Benzodiazepines

Explain that this is an example image of what benzodiazepines may look like. However, there are many formulations that may not look like these.

Benzodiazepines are tranquilizers and they include rohypnol, valium (called diazepam), alprazolam, temazepam and phenazepam.

They can induce periods of calmness, relaxation and sleep and are used to treat anxiety and insomnia.

Benzodiazepines depress the nervous system and slow the brain and the body down. They relieve tension and anxiety and can induce sleep.

People can become dependent on them, especially for sleep, and find that if they stop using them they experience opposite effects to those of the substance.

## Cannabis



© [www.talktofrank.com](http://www.talktofrank.com)

### Cannabis

Explain that cannabis can come in many forms.

These are just some examples.

Cannabis is naturally occurring – it is made from the cannabis plant.

The main active ingredient in cannabis is tetrahydrocannabinol (THC).

Smoking, eating or drinking cannabis can produce a sense of relaxation and euphoria.

It can make a person hallucinate.

It can also make a person feel very anxious and paranoid and increase the risk of psychosis.

A long -term effect can be problems with concentration and decision-making and loss of motivation.

## Stimulants: Cocaine, metamphetamines and amphetamines



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### Stimulants

Stimulants include: amphetamines, cocaine, speed, crystal meth.

People take stimulants to keep awake, energized and alert.

They can make a person overactive, agitated and even produce psychotic symptoms.

Stimulants are available in pill or powder form.

## Khat



© http://www.talktofrank.com/sites/default/files/drugs/Khat%201.JPG

### Khat

Khat is a leafy green plant containing two main stimulant drugs which speed up your mind and body. Their main effects are similar to, but less powerful than, amphetamine.

A person may feel more alert, social and talkative.

It suppresses the appetite as well.  
It can cause disrupted sleep and make a person prone to developing mental health problems or exacerbate existing mental health problems.

## Tobacco



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### Tobacco

Explain that tobacco comes from the leaves of the tobacco plants and is mixed with other chemicals such as nicotine.

Nicotine is addictive.

Regular smokers believe that tobacco helps them to relax and handle stress better and feel less hungry.

Long-term health effects of tobacco cause serious damage.

# Activity 2: Person's story followed by group discussion

## Activity 2: Person's story

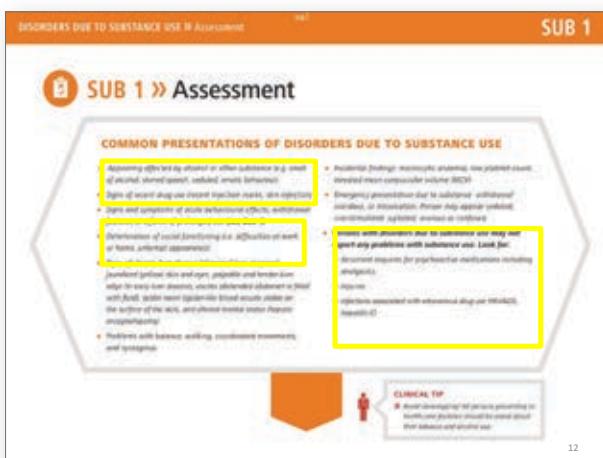
- You are now going to hear a person's story of what it is like to live with substance use disorder.
- After listening spend some time thinking what are the common presentations of people with substance use disorders in primary health care?

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Use a person's story to:

- Introduce the activity (SUB supporting material) and ensure participants have access to pens and paper.
- Choose a story – be creative in how you tell the story to ensure the participants are engaged (five minutes maximum).
- First thoughts and common presentations – give participants time to summarize what they think are the most common presentations of people with substance use disorders.
- Encourage them to think of people that they have worked with in the past who may have had disorders due to substances.

Make a note of their answers.



Direct participants to the common presentations described on page 114 mhGAP-IG Version 2.0 and in the master chart (disorders due to substance use).

Summarize the types of common presentations that participants have already identified.

Stress that in general people with substance use disorders will present with immediate concerns about their health or social problems. They will rarely state that they have a problem with substances.

- People will present with physical health problems: liver disease, gastrointestinal problems, aches and pains.
- People will present with deterioration in their social functioning and often having many social problems – with work, school, in their studies, with their family and relationships.
- Often, they can smell of alcohol, cannabis or tobacco. There may also be other signs of recent substance use including recent injection marks, skin infections etc.).
- Emphasize that often people with disorders due to substances may not present with any problems at all, instead they may return frequently requesting prescriptions for psychoactive medications, they may present with injuries (that they obtained whilst using substances) and, in some cases, they may have infections associated with intravenous drug use such as HIV/AIDS, hepatitis C.

Explain that at times people will also present as an emergency presentation.

## Emergency presentations

### Acute intoxication

A transient condition following the intake of a psychoactive substance, resulting in disturbances of consciousness, cognition, perception and affecting behaviour.

Explain that one emergency presentation is **acute intoxication**.

Ask participants for a definition of what we mean by acute intoxication before revealing the answer.

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## Emergency presentations

### Overdose

The use of any drug in such an amount that acute adverse physical or mental effects are produced.

A second emergency presentation is **overdose**.

Ask participants for a definition of an overdose before revealing the answer.

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## Emergency presentations

### Withdrawal

The experience of a set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance. It has been consumed in high enough doses and for a long enough duration for the person to be physically or mentally dependent on it. Withdrawal symptoms are, essentially, opposite to those that are produced by the psychoactive substance itself.

The third emergency presentation is **withdrawal**.

Ask participants to give a definition or description of withdrawal before revealing the answer.

Explain that we will spend more time looking at how to assess and manage emergency presentations later in the sessions; but for now we are going to look at the reasons why people use substances.

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## Why people use substances

People often use substances:

- To relax and feel calm.
- To feel happy.
- For pain relief.
- To cope with stress.
- Pressure from peers.
- To help with sleep.
- To feel more confident in social situations.

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Before revealing the list ask participants to think of the reasons why people use substances.

Reveal the list on the slide and add these point to those highlighted by the participants.

## When does substance use become a problem?

Not everyone who uses substances will have a problem but some will.

There are two types behaviours that would denote someone has a problem with their substance use:

- harmful use
- dependence.

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Explain that the fact that people use substances does not always mean that they have a substance use disorder.

Some people can use substances such as alcohol or tobacco without developing a disorder.

However, if a person's substance use starts to negatively affect their life then they may have a problem.

There are two types of behaviours that would denote a person has a problem with their substance use:

- harmful use
- dependence.

## What is harmful use?

Harmful use is a pattern of substance use which is causing harm to health:

- The harm may be physical (e.g. liver disease) or mental (e.g. episodes of depressive disorder).
- Harmful use is often associated with social consequences, e.g. family or work problems.

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Encourage a discussion about what people think harmful use is before revealing the answers.

## What is dependence?

Dependence is a cluster of physiological, behavioural and cognitive phenomena in which the use of substances takes on a much higher priority for a given individual than other behaviors that once had greater value. It is characterized by:

- Strong craving to use the substance.
- Loss of control over consumption of the substance.
- High levels of substance use.
- Presence of withdrawal state upon cessation.

Encourage a discussion about what people think dependence/addiction is before revealing the answer.

Explain that dependence (sometimes called addiction) is a pattern of symptoms that include:

- Strong cravings – cravings are both physical and mental urges to take the substance – they can be very intense and very difficult to ignore.
- Long-term high level of use associated with: (a) increased tolerance (you need to take more to get the same effect); and (b) withdrawal symptoms if alcohol is stopped.
- Loss of control over alcohol consumption.
- Reduction in other activities which used to have meaning.

## What causes drug withdrawal symptoms?

- Our bodies and brains have mechanisms to minimize the impact of drug use on our ability to function.
- When we use sedating substances like opioids and benzodiazepines over a prolonged period of time, one of the ways our body adapts is to release endogenous stimulants to keep us alert.
- A common effect is increased tolerance to a substance, which means that increased doses of the substance are needed to get the same sedative effect.
- When we stop taking the sedating substance, it takes about a week for our bodies to stop releasing the endogenous stimulants. In the meanwhile, we experience the unbalanced effects of the endogenous stimulant. This is why the symptoms of sedative withdrawal are similar to stimulant intoxication.

Then talk through the example of what causes the body to experience withdrawal symptoms. In this case, this is a description of how the body reacts to drug use. However, it can be applied to alcohol as well.

Explain that the neuroscience of substance tolerance, dependence and withdrawal is complicated.

This slide presents an extremely simplified explanation.

Participants will not need to exactly remember the contents of this slide but they should remember that there is a neuroscientific basis for substance use problems.

Explain that substance dependence is a disease.

## Health effects of psychoactive substances include

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Intoxicating effects</li><li>• Toxic effects</li><li>• Immunosuppressant effects</li><li>• Teratogenic effects</li></ul> | <ul style="list-style-type: none"><li>• Accidents, injuries</li><li>• Liver fibrosis</li><li>• Brain injury</li><li>• Cancer</li><li>• Infections including HIV/AIDS and hepatitis C</li><li>• Hypertension/stroke</li><li>• Fetal alcohol syndrome</li><li>• Dependence/addiction</li><li>• Depression, psychosis</li></ul> |
|--|--|

21

Explain that alcohol and drugs can affect the body and brain in numerous ways.

**Note:** The list on the left shows the mechanisms by which health is affected, the list on the right are the end results. Some results are due to more than one mechanism, i.e. cancer is due to both toxic effects and to immune suppression.

## Effects of substance use on the family

Parents	Children
<b>Familial breakdown</b> Problems/violence between spouses	<b>Familial breakdown</b> Parents fighting, disowning child
<b>Neglect of children</b> Leading to malnourishment, delayed development, abuse, violence	<b>Loss of opportunities</b> Dropping out of school, employment, parents unable to work
<b>Poverty</b> Loss of income through missed employment, cost of substance use	<b>Risk of criminal activity</b> Stealing from parents to pay for substances

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Explain by talking through the lists on the slide that these are some of the effects that substance use can have on a family.

These effects look at whether the parent is the person with the substance use disorder or the child.

In both scenarios, the family environment can be destabilized which can negatively affect any siblings and the wider family and community.

**Note:** If alcohol is not consumed in the country you work in then this slide can be omitted.

## Global impact of alcohol use

- Harmful use of alcohol results in 3.3 million deaths each year or 5.9% of all global deaths were attributed to alcohol consumption.
- in 2012 139 million DALYs (disability-adjusted life years) or 5.1 % of the global burden of disease and injury were attributable to alcohol consumption.
- Alcohol-related harm is determined by the volume of alcohol consumed, the pattern of drinking, and, on rare occasions, the quality of alcohol consumed.

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Talk through the statistics on the slide explaining that alcohol is widely used in many cultures. The harmful use of alcohol causes a large disease, social and economic burden in societies.

The harmful use of alcohol is a component cause of more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries.

3.3 million global deaths each year can be attributed to alcohol use.

In 2012, 5.1 % of the global burden of disease and injury were attributable to alcohol consumption.

The level and severity of alcohol related harm is influenced by the quantity of alcohol available in a country, and, in some cases, the quality of that alcohol.

## Global impact of drug use

- An estimated 250 million people (1 out of 20) people between 15–64 years used illicit drugs in 2014.
- 1 in 10 of those people are suffering from a form of drug use disorder including drug dependence.
- Almost half of people with drug dependence inject drugs and more than 10% are living with HIV and the majority are infected with hepatitis C.
- Stigma and discrimination have prevented these people from receiving the care they need.

Talk through the points on the slide, explaining that it is estimated that a total of 250 million people, or one out of 20 people between the ages of 15–64, used illicit drugs in 2014.

One in 10 of those people are suffering from a form of drug use disorder including drug dependence. Almost half of those people with drug dependence inject drugs, more than 10% are living with HIV and the majority are infected with hepatitis C.

Drug use disorders are a major global health problem.

## Role of health care

- Stigma and discrimination are commonly applied to substance dependent individuals (including discrimination by health-care providers).
- In many countries, people with substance use disorders managed by the criminal justice service.
- Research shows us that substance dependence is best treated in primary health care.
- A question in a routine assessment such as, “Do you drink? Have you used drugs?” can save a life.

### Role of primary health-care providers

Explain that unfortunately outdated views about substance use disorders persist in many parts of the world.

The stigma and discrimination that is commonly applied to substance dependent individuals and professionals working with them have significantly compromised the implementation of quality treatment interventions, undermining the development of treatment programmes and training of health-care professionals.

Even though the evidence clearly shows that substance use disorders are best managed in a public health system, the inclusion of substance use treatment programmes in health care is very difficult.

In some countries, substance use disorders are still seen as a primarily criminal justice problem and agencies of the ministry of justice and/or defence are still responsible for affected individuals without supervision or engagement with the ministry of health. Using only law enforcement strategies and methods is unlikely to result in sustained positive effects. Only treatment that has at its core an understanding of substance dependence as a primarily multifactorial biological and behavioural disorder that can be treated using medical and psychosocial approaches can improve chances of recovery from the disorder and reduce substance related social consequences.

**Note:** The slide is used to summarize the points made in the notes above.

# Session 2.

# Assessment of disorders due to substance use

⌚ 1 hour 10 minutes

Explain to participants that there are two ways that people can present with disorders due to substance use in primary health care:

1. As an **emergency presentation** in a state of:

- withdrawal
- intoxication
- overdose.

2. With signs and symptoms of **prolonged, harmful patterns and/or dependence**.

The assessment of these different presentations follow different algorithms in the mhGAP-IG Version 2.0 (page 106).

Explain that we will discuss emergency presentations and management of emergency presentations later in the session. For now, we will focus on assessing whether the person has harmful patterns of substance use and/or dependence.



SUB

Talk through the principles of assessment. Explain that if it is not an emergency presentation then the assessment seeks to establish:

- Does the person use psychoactive substances?
- Is there harmful use?
- Does the person have substance dependence?

## Brainstorming session

Reiterate that asking about substance use can be a sensitive topic. Ask participants to suggest open-ended questions they could use to initiate a conversation about someone's substance use.

Make a list of their questions.

If they struggle, suggest that alcohol can be raised in the context of other risk factors for health (smoking, inactivity, poor diet, social problems, occupational problems, relationship problems).

Reiterate that there is a lot of shame and stigma attached to substance use therefore people may be very reluctant to talk about it. Ask participants to think what they could do to overcome that reluctance?

## Asking about substance use

If you suspect substance use continue to:

- Address the person's immediate expectations:
  - What problem or concern has prompted the person to come to the health service today?
  - Listen carefully and with respect.
- Manage the person's expectations:
  - If they are unreasonably high, be honest about what you can and cannot do.
- Assess the impact of substance use on the person's life:
  - The health-care worker should ask everyone about alcohol and tobacco use.
  - How have their home and work life been affected.

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Describe the steps on the slide and then ask participants to brainstorm other ways that they can learn more about a person's substance use?

If they struggle, explain that they can:

- Carry out thorough physical examinations especially on the liver.
- Talk to a family member or a carer (with their consent).
- Conduct an assessment into the person's social history, psychosocial stressors and coping mechanisms.



## Asking about substance use

• Look for common ground:

- There is a shared interest in improving the person's health.
- Do not judge.
- Challenge misconceptions but avoid confrontation.

• Use good communication skills:

- Start by asking open questions.
- Remain neutral.
- Explain your understanding of the situation to the person.
- Always be honest.
- Expect that it will take multiple appointments to build trust.

Use this slide to summarize how to ask people about their substance use.

Start by reminding the person that you are both interested in improving their health.

## Activity 3: Video demonstration: Assessment

### Activity 3: Video demonstration

Show the mhGAP-IG assessment videos for substance use.

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Choose an appropriate mhGAP-IG video (alcohol or cannabis).

mhGAP SUB module (alcohol) assessment:  
<https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=15>.

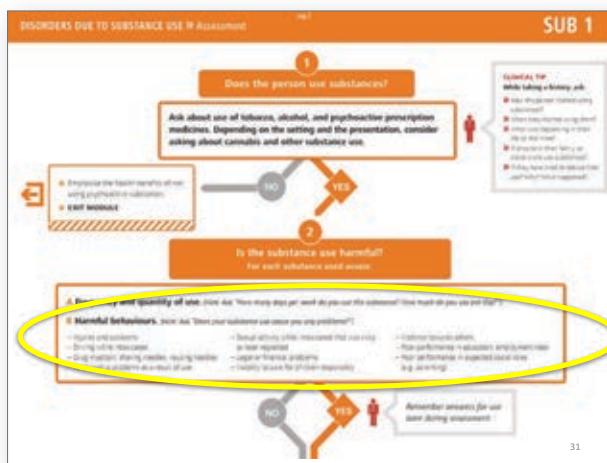
mhGAP SUB module (cannabis) assessment:  
<https://www.youtube.com/watch?v=sccCxFfMGzk&index=13&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>.

Before showing the alcohol video, explain that this video was made during the mhGAP workshop and involved two experienced clinicians. The lady at the back was trying to summarize the situation during the workshop.

or

Before showing the drug assessment video explain that this young man is being assessed for his cannabis use.

Show the video.



After showing the video:

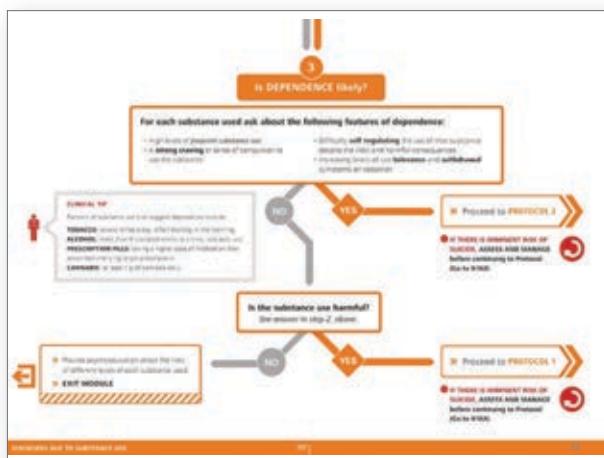
1. Discuss how the health-care provider established whether the person uses substances?

In the alcohol assessment, the lady asked about his alcohol use in the context of discussing his health.

In the cannabis assessment, the doctor found out because of discussions with his family.

2. Ask participants if they think the man's substance use is **harmful**:
- How many days per week does the person use the substance? How much do you use per day?
  - Does the substance cause any problems for the person?

Give participants time to answer. Show them the video again if they do not know the answer.



Once you have gathered this information the next step is to establish if dependence is likely.

Ask the participants to answer the following questions:

- *Does the man have high levels of frequent use?* (Direct participants to the clinical tip on page 117 – frequent alcohol consumption is more than six standard drinks at a time and daily use, frequent cannabis use is 1 gram a day.)
- *Does he have a strong craving?* Alcohol video: If participants struggle remind them that he stated his head does not feel right until he has had a drink.  
Drug video: The health-care provider did not find out but she could have asked, “What happens if you do not smoke during the day – how do you feel?”
- *Is there difficulty self-regulating?* Did the health-care provider find out? Can the men control how much they consume?
- *Has he noticed that he is becoming more tolerant of the substance (e.g. does he need a bigger quantity of substance to feel the same affects than before)?* Did the health-care provider find out?
- *Does he show any signs of withdrawal?* Alcohol video: remind them that there was a tremor when he was asked to raise his arms.

Highlight that if dependence or harmful use is likely it is important to consider if there is an imminent risk of suicide. Why do you think that is?

## Activity 4: Role play: Assessment

### Activity 4: Role play: Assessment

- The person has come to a primary health clinic with hypertension.
- This is their second visit to the clinic, during the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart.
- The primary health-care provider at the time suspected that there may be alcohol use but was unable to conduct a thorough assessment.
- The person was asked to return and this is their second visit. Their medical records require that the person is assessed for patterns of alcohol use.

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See SUB supporting material role play 1.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to assess for possible substance use.

**Situation:**

The person has come to a primary health clinic with hypertension. This is their second visit to the clinic. During the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart. The primary health-care provider at the time suspected that there may be alcohol use but was unable to conduct a thorough assessment. The person was asked to return and this is their second visit. Their medical records require that the person is assessed for patterns of alcohol use.

**Instructions:**

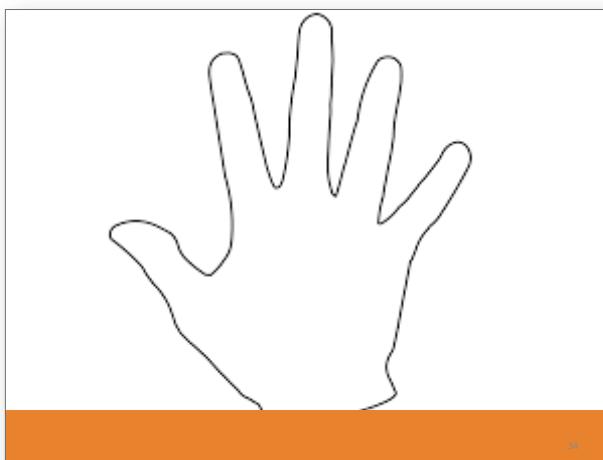
- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

**Note:** The clinical scenario and notes below are only an example. In the supporting material there are other assessment role plays that involve someone being assessed for their drug use. Please use those if alcohol is not a problem substance in your country.

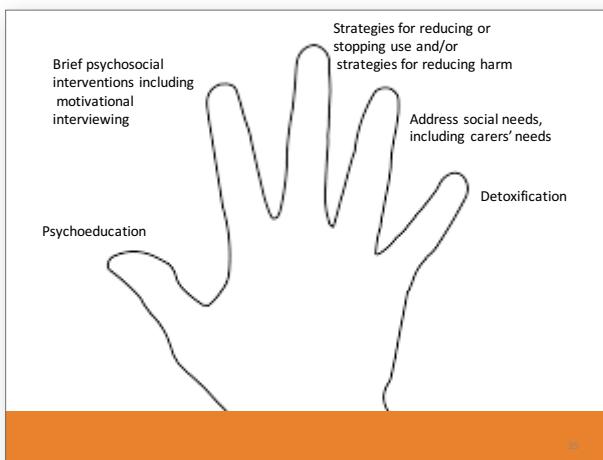
# Session 3.

## Management of disorders due to substance use

⌚ 2 hours



Ask participants to suggest any management interventions they can think of or they have used to try and help a person with a substance use disorder?



Explain the management options available and emphasize that the success of any intervention is dependent on how willing the person is to change and/or reduce and stop their consumption of substances.

**Ask participants to think why the motivation of the person is so important in treating substance use?**

Explain that no one can force someone to do something if they do not want to do it. If you forbid someone from doing something then they may just do it in secret which can be more dangerous.

Explain that, as discussed at the beginning of the session, many people use substances because they are socially acceptable, or it is part of their social life and social activities. Therefore, stopping using these substances can represent a huge loss for the person.

**SUB 2 Management**

**Harmful use**

**PROTOCOL**

**1 Provide psychoeducation**

**2 Assess the person's motivation to reduce their substance use**

**3 Encourage the person to increase their social support network**

**4 Encourage the person to increase their self-esteem and resilience**

**5 Encourage the person to increase their physical activity**

**6 Encourage the person to increase their spirituality**

**7 Encourage the person to increase their social support network**

**8 Encourage the person to increase their self-esteem and resilience**

**9 Encourage the person to increase their physical activity**

**10 Encourage the person to increase their spirituality**

Ask a participant to read out loud the management interventions for **harmful use** (Protocol 1) (page 118) explaining that these are the options in any treatment plan for someone with harmful substance use.

Explain that, as with all MNS conditions, psychoeducation is a priority. Explain how the substances are harming the person physically, socially and psychologically as they may not be aware of it.

As we learned from the stories at the beginning, harmful substance usage is complex and impacts all areas of a person's life.

Support the person to address any immediate social needs and ensure they are safe, i.e. if they need access to food, shelter, clothing etc.

**PROTOCOL**

**2 Dependence**

**IF THE PERSON IS DEPENDENT ON OPIOIDS:**

- Provide psychoeducation
- Assess the person's motivation to reduce their substance use
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network

**IF THE PERSON IS DEPENDENT ON BENZODRUGS:**

- Provide psychoeducation
- Assess the person's motivation to reduce their substance use
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network

**IF THE PERSON IS DEPENDENT ON ALCOHOL:**

- Provide psychoeducation
- Assess the person's motivation to reduce their substance use
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network

**FOR ALL OTHER SUBSTANCES:**

- Provide psychoeducation
- Assess the person's motivation to reduce their substance use
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network

**IN ALL CASES:**

- Provide psychoeducation
- Assess the person's motivation to reduce their substance use
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network
- Encourage the person to increase their self-esteem and resilience
- Encourage the person to increase their physical activity
- Encourage the person to increase their spirituality
- Encourage the person to increase their social support network

Ask another participant to read out loud **dependence** (Protocol 2) (page 119). Explain that the management options available for harmful use and dependence are similar, except in people with dependence there is an option to facilitate a safe withdrawal and detoxification.

Explain that we will return to the protocols for **alcohol withdrawal** and **opioid withdrawal** but for now we are going to concentrate on psychosocial interventions and motivational interviewing, in particular.

**PYSCHOSOCIAL INTERVENTIONS**

**2.1 Psychoeducation**

- Show the person what they are doing that is causing them harm.
- Discuss the consequences of their behaviour.
- Help the person see that their behaviour is causing them harm.
- Encourage the person to change their behaviour.
- Encourage the person to reduce their risk of harm.
- Encourage the person to seek help if they are experiencing problems.
- Encourage the person to take steps to reduce their risk of harm.
- Encourage the person to seek help if they are experiencing problems.
- Encourage the person to take steps to reduce their risk of harm.

**2.2 Motivational Interviewing (Brief Intervention)**

- Briefly assess the person's motivation to change their behaviour.
- Ask the person what they want to do differently.
- Assess the person's motivation to change their behaviour.
- Encourage the person to change their behaviour.
- Encourage the person to take steps to reduce their risk of harm.
- Encourage the person to seek help if they are experiencing problems.
- Encourage the person to take steps to reduce their risk of harm.
- Encourage the person to seek help if they are experiencing problems.
- Encourage the person to take steps to reduce their risk of harm.

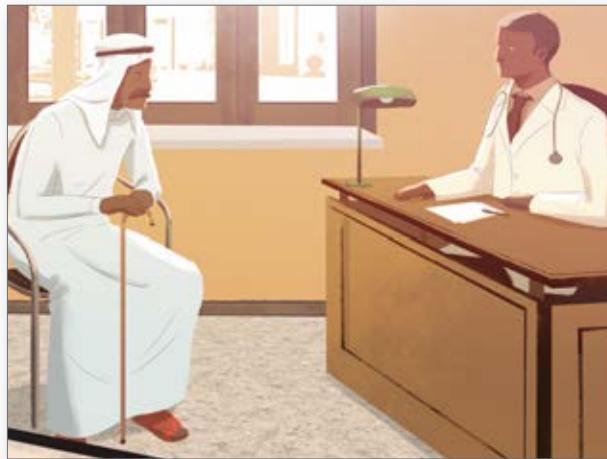
**Examples of questions to ask:**

- “Would you like to make some changes in your life?”
- “What would you like to do differently?”
- “What are the reasons why you have this job?”
- “What are the reasons why you have this job?”
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- “What are the reasons why you have this job?”

Give the participants time to read through the psychoeducation interventions and motivational interviewing (page 123).

Stress that brief interventions using motivational interviewing are typically 5–30 minutes long and aim to assist an individual cease or reduce their use of a psychoactive substance and or deal with other life issues that may be supporting their use of substances.

It seeks to empower and motivate the person to take responsibility and change their substance use behaviour. It can be extended for one or two sessions to help people develop the skills and resources to change or be used in follow-up.



Stress the importance of using effective communication skills to build trust and empathy with the person. But also, creating a comfortable space where you can challenge any false beliefs the person may have and point out any contradictions in their narratives and explanations (this may be especially necessary if the person is not even ready to think about changing their substance use and does not recognize that their substance use is harming them and other people).

## Activity 5: Video demonstration: Motivational interviewing

### Activity 5: Video demonstration: Motivational interviewing

An example of how to use brief motivational interviewing.

**Duration:** 10 minutes.

<https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>.

**Purpose:** To show participants an example of a health-care provider using the principles of motivational interviewing. Give them time to reflect afterwards.

#### Instructions:

- Depending on time, show the video from 4:11 (4 minutes and 11 seconds), which shows the young man being assessed by the health-care provider) or just show the brief motivational interviewing intervention from 09:11 seconds until the end.
- After you have shown the video allow the participants two minutes to reflect on how effective they thought motivational interviewing was with the young man? Is it a technique they have used before?
- After a brief time for reflection continue with the presentation on motivational interviewing.

## Motivational interviewing

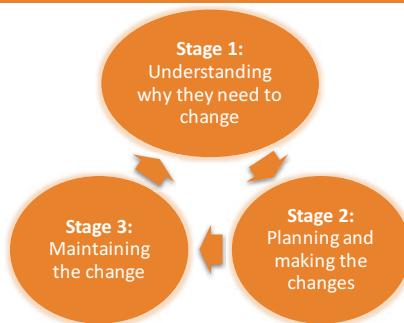
- The aim of motivational interviewing is to empower and motivate individuals to take responsibility and change their substance use behaviour.
- It can be used as a way of supporting and motivating people to travel through the different stages of change.

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Describe the points on the slide.

State that we are now going to look at the different techniques that can be used in motivational interviewing.

## Motivation to change



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A person's motivation to change any pattern of behaviour can be complicated and pass through different stages.

- Stage 1 is understanding why the person wants or needs to change.
- Stage 2 is planning and making the changes.
- Stage 3 is maintaining those changes and coping with any lapses or relapses.

### Stage 1: Understanding the need to change

- Help the person explore their desire to change.
- Do they want to change?
- Do they need to change?
- What can the health-care provider do?

See page 123 of mhGAP-IG.

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#### Stage 1

Explain that stage 1 involves helping the person explore their desire to change.

Explain that we will now look at what the health-care provider can do to help at this stage.

Ensure participants are following the **eight steps** on page 123 of mhGAP-IG Version 2.0.

## Step 1: Give feedback

Give feedback about the person's personal risk or impairment (e.g. how is the substance use harming them/impacting on them and how it is harming others?).

You can start giving feedback by discussing the person's health/social problems that have brought them to the clinic in the first place.

Thus, you place the person at the centre of the intervention and can use effective communication skills like reflection and summarizing to give feedback.

**Step 1:** Explain that initially the health-care provider will introduce the issue of substance use in the context of the person's health and well-being or in the context of the problem that brought them to the clinic in the first place.

Place the person at the centre of the discussion. Do not give your opinion on why their substance use is damaging – *your* opinion will not convince them to change.

They need to make the choice themselves.

Use communication techniques like summarizing, so that you give feedback using **their** own words about the impact and risks the substance use is having on the person whether that be on their physical health or their social problems.

## Step 2: Take responsibility

Encourage them to **take responsibility** for their substance use choices. For example you could say:

"You have told me that you use cannabis because you find it is the only thing that can relax you. Has that ever worried you before?"

or

"You say that your parents want you to stop using drugs but have **you** ever been worried about your drug use?"

**Step 2:** Encourage the person to start taking responsibility for their substance use choices.

This includes their choice to engage with treatment or not.

Taking responsibility is the first step in the person accepting that there is something in their life that they want to change.

Talk through the examples given on the slide.

## Step 3: Reasons for their substance use

Ask them about the reasons for their substance use.

*Can you tell me why you started using alcohol?*

*Do you know why you use drugs?*

*What are the benefits of using substances?*

**Step 3:** If the person recognizes that they use substances as a response to other priority MNS conditions and/or psychosocial stressors in their life, then continue to explore why they use substances in a response to those. What does the substance do? How does it help them? What are the perceived benefits of substance use?

Talk through the examples on the slide.

## Step 4: Consequences of their substance use

Ask about both the perceived positive and negative consequences of their substance use.

*How does your substance use help you?  
Can you think of any negative consequences of your substance use?*

Use effective communication skills to challenge any overstatements of the benefits and understatements of the risks/harm.

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**Step 4:** Ask participants to think about the consequences of their substance use. Having explored their reasons why, ask them what are the consequences of their substance use on themselves (physically, mentally and socially)? What are the consequences on other people (their family, friends, spouse, at work, in their studies etc.)?

## Stage 2: Planning and making changes

Supports the person to make changes.  
What do they need to do to make the changes they want?  
What can the health-care provider do?

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### Stage 2

Explain that once the person has decided to make a change then we move to stage 2, which involves supporting the person to plan and to make the changes they need to.

Help them set realistic goals and targets.  
Keep them motivated to make those changes.

Discuss the different options that the person has – to make the changes they need to.

Explain that in the next few slides we will look at what the health-care provider can do.

## Step 5: Personal goals

Ask them about their personal goals for their future.  
Support them to explore whether their substance use is helping them reach those goals or not?

*"You say you would like to progress at work and achieve a promotion to a management position but at the same time you have said that your alcohol use makes it difficult for you to concentrate at work. So do you think your alcohol use will help you reach the goal of a promotion?"*

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**Step 5:** Explain the points on the slide.

## Step 6: Have a discussion

Discuss the reasons, consequences, benefits, harms and goals the person has so they gain a deeper understanding of how their substance use is impacting on them.

By using their words and descriptions you can gently highlight any contradictions in their explanations and motivate them to want to change their behaviour.

**Step 6:** Explain the points on the slide and emphasize that throughout motivational interviewing, it is important to use communication skills such as summarizing to help people explore how their substance use is impacting them.

By using their words and their descriptions you can gently highlight any contradictions in their explanations and motivate them to want to change their behaviour.

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## Step 7: Discuss options

Discuss options with the person.

Discuss realistic changes the person could make to change.

Work together to create a choice of options.

Support them to come up with an agreed upon realistic plan of action.

**Step 7:** If someone is very motivated and enthusiastic to change they can easily state that they are going to make some unrealistic changes. For example, a person with a dependence on alcohol explaining that they will just stop drinking for good the next day.

Although their motivation should be supported they need to have more realistic goals or else they could be setting themselves up for failure.

Instead, work with them to find some strategies they could do to reduce their substance use or discuss with them the option of doing a controlled substance withdrawal.

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## Step 8: Support the person enact the changes

Support them to enact that plan.

What steps do they need to take to make that plan a reality?

Arrange a follow up session with them so you can see how that plan is going and make necessary changes to it if they have lapsed.

**Step 8:** Explain the points on the slide.

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## Stage 3: Maintaining the change

The person has achieved the change they want but it can be easy to lapse or relapse and start using old patterns of behaviour.

What can the health-care provider do?

Support the person, if they relapse be non-judgemental and acknowledge how difficult it can be to change a behaviour.

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### Stage 3

Explain that once the person has planned and implemented the changes they want, the final stage is maintaining the change.

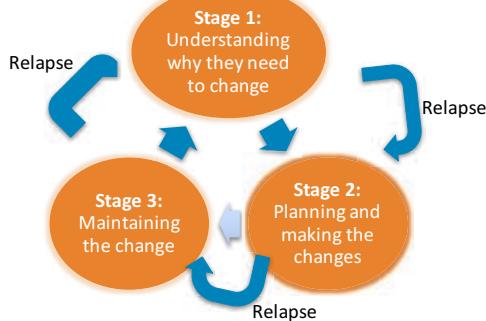
Changing a pattern of behaviour (especially a behaviour that has been happening for years, decades and lifetimes) can be very difficult.

It is very common for a person to relapse and slip back into their old behaviour patterns. This is especially so if they are still seeing the same triggers (social events, people, places) where they used to drink alcohol, smoke or use drugs.

Therefore, the maintenance stage is about supporting the person to cope with the relapses, being non-judgemental and helping them make the changes again.

People can spend years in this stage.

## Motivation to change



54

Describe again that relapse can happen at any stage, but if a person does fully relapse (i.e. they go back for a long period of time to their old behaviour and pattern of substance use) they will need to go back to stage 1 if they want to start making the changes again.

That is because they may need to explore again the reasons why they use substances and whether they perceive the substance as a positive or negative part of their life.

Emphasize that the success and failure of any intervention will depend upon how motivated the person is to change.

## Activity 6: Role play: Motivational interviewing

### Activity 6: Role play: Motivational interviewing

- A person describes himself as a social smoker (tobacco), but actually smokes more often than just social situations.
- He occasionally has 50–70 cigarettes in one weekend and another 20 cigarettes during the week.
- He has terrible asthma and struggles to breathe the next day. He also has a painful and persistent cough that often means he has to take time off work.
- The health-care provider will perform motivational interviewing, following the steps on page 123 of mhGAP-IG.

See SUB supporting material role play 2.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

55

**Duration:** 30 minutes.

**Purpose:** To enable the participants to practise using the principles of motivational interviewing.

**Situation:**

A person describes himself as a social smoker (tobacco) but you suspect he smokes more often than just social situations. He has terrible asthma and struggles to breathe. He also has a painful and persistent cough that often means he has to take time off work. Talk to him about his smoking using the principles of motivational interviewing and learn how motivated he is to change.

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one to play the role of the person seeking help and one to play the role of the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

DISORDERS DUE TO SUBSTANCE USE IN Management	161	SUB 2
<h2>2.1 Strategies for Reducing and Stopping Use</h2>	<p>Always try reducing or stopping the use of all substances:</p> <ul style="list-style-type: none"> <li>• If it's causing problems, then try to reduce it.</li> <li>• If it's causing serious problems, then stop it.</li> <li>• If it's causing no problems, then leave it alone.</li> </ul>	<p>For some patients (but not all):</p> <ul style="list-style-type: none"> <li>• Stop all drugs as soon as possible if they're causing serious problems.</li> <li>• Stop all drugs as soon as possible if they're causing moderate problems.</li> <li>• Stop all drugs as soon as possible if they're causing minor problems.</li> <li>• Stop all drugs as soon as possible if they're causing no problems.</li> </ul>
<h2>2.2 Mutual Help Groups</h2>	<p>Mutual help groups (such as Alcoholics Anonymous) can be useful for people who are trying to stop using substances. These groups are self-help groups, not professional treatment programs. They are free.</p>	<p>Helpful information and education about disorders due to substance use:</p> <ul style="list-style-type: none"> <li>• Online support groups for people who are recovering from substance use disorders.</li> <li>• Online support groups for their families.</li> <li>• Online support groups for professionals.</li> </ul>
<h2>2.3 Strategies for Preventing Harm from Drug Use and Treating Related Conditions</h2>	<p>Encourage the patient to take steps to keep themselves safe:</p> <ul style="list-style-type: none"> <li>• Encourage them to take care of themselves.</li> <li>• Encourage them to take care of their relationships.</li> <li>• Encourage them to take care of their physical health.</li> <li>• Encourage them to take care of their mental health.</li> </ul>	<p>Encourage the patient to take steps to prevent harm from drug use:</p> <ul style="list-style-type: none"> <li>• Encourage the patient to take care of themselves.</li> <li>• Encourage the patient to take care of their relationships.</li> <li>• Encourage the patient to take care of their physical health.</li> <li>• Encourage the patient to take care of their mental health.</li> </ul>
<h2>2.4 Care Support</h2>	<p>Supporting family and carers:</p> <ul style="list-style-type: none"> <li>• Encourage the carer of someone due to substance use or abuse to seek support, ideally with the patient's family or carers.</li> </ul>	<p>CLINICAL TIP: <b>MONITORING AND MANAGING USE</b></p> <ul style="list-style-type: none"> <li>• Assess the risk of drug use to the patient's physical health, family, and social life.</li> <li>• Encourage the patient to take steps to prevent harm from drug use.</li> <li>• Encourage the patient to take steps to treat related conditions.</li> <li>• Encourage the patient to take steps to keep themselves safe.</li> </ul>

## **Strategies for reducing and stopping use**

Explain that if after using motivational interviewing the person identifies that they want to try reducing or stopping their substance use, discuss with them how they might do that.

- Listen to them to help them identify triggers for their use, e.g. social settings in which they use the substance.
  - Listen and help them identify emotional cues for their use, e.g. they use substances when they are depressed, they use substances when they are stressed.
  - Encourage them to not have any substances in their home at all.

Ask the group to brainstorm what open and closed questions they could ask to find out a person's trigger or emotional cue?

If they struggle ask, "When do you feel the greatest urge to use the substance? When you last used the substance what was happening in your life? Were you having any problems?".

## Mutual help groups

If, after motivational interviewing, a person identifies that they feel support from peers would help them to stop using substances then explain that there are mutual help groups such as Alcoholics Anonymous and Narcotics Anonymous.

Ask participants to brainstorm any local resources that could offer support in the form of mutual help groups.

## **Strategies for preventing harm**

If, after motivational interviewing, a person feels that they are not ready to stop or reduce their alcohol consumption then encourage them to look for ways to minimize the risks involved. For example, they must not drive when intoxicated. They should try and eat food when they use alcohol. They could try changing the type of alcohol they drink to something less strong. If they are injecting opioids, they should ensure the needles are clean, and they should never share a needle with other people.



## Carer support

Remind participants of the stories at the beginning of the session and of the stress and impact that alcohol use has on the family, friends and community. As a result, carer support is essential.

Offer psychoeducation to carers and family members.

Assess the immediate needs of the family members including their health, mental health and social needs. If possible, try to meet those needs or link carers and families with other organizations that can meet those needs.

<p><b>Special populations</b></p> <p><b>ADOLESCENTS</b> </p> <p><b>How to Assess the Adolescent:</b></p> <ul style="list-style-type: none"> <li>• Focus on the adolescent nature of the young person's behaviour. Adolescence is a time of transition and the adolescent brain is still developing and changing.</li> <li>• Ask others who are getting on in life to assessments. Not everyone can have important understanding about the adolescent's way of living and functioning, but the older or long-term carers may be able to help assess the young person.</li> <li>• Open ended questions may be useful in assessing phenomena in the following areas: Mental Health and Behaviour, Family, Activities, though and interests, School, Work, Safety, and Health.</li> <li>• Adolescents are often very good at hiding their true feelings and what they are experiencing. Mental Health and Behaviour, Family, Activities, though and interests, School, Work, Safety, and Health.</li> <li>• Any family histories are also useful, as these may be reflected in the young person's behaviour.</li> </ul> <p><b>Pre-Intervention for the Adolescent:</b></p> <ul style="list-style-type: none"> <li>• Involve the adolescent and their parents with other health care professionals and other adolescents with similar problems.</li> <li>• Adolescents are often very good at hiding their true feelings and what they are experiencing. Mental Health and Behaviour, Family, Activities, though and interests, School, Work, Safety, and Health.</li> <li>• Adolescents are often very good at hiding their true feelings and what they are experiencing. Mental Health and Behaviour, Family, Activities, though and interests, School, Work, Safety, and Health.</li> <li>• Adolescents are often very good at hiding their true feelings and what they are experiencing. Mental Health and Behaviour, Family, Activities, though and interests, School, Work, Safety, and Health.</li> </ul> <p><b>WOMEN WHO ARE OF CHILD-BEARING AGE, PREGNANT, OR BREASTFEEDING</b> </p> <p><b>Alcohol Use</b></p> <ul style="list-style-type: none"> <li>• Adolescents and pregnant women are at increased risk of developing problems with alcohol use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with alcohol use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with alcohol use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with alcohol use.</li> </ul> <p><b>Drug Use</b></p> <ul style="list-style-type: none"> <li>• Adolescents and pregnant women are at increased risk of developing problems with drug use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with drug use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with drug use.</li> <li>• Adolescents and pregnant women are at increased risk of developing problems with drug use.</li> </ul>
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Explain that we will discuss assessing adolescents in more detail during the Module: Child and Adolescent Mental Health.

For now, ask them to reflect on:

- Why adolescents may use substances and how would they assess for that?
- How involved should their parents/carers be?
- Why pregnant and breastfeeding women are considered a special population?
- What warnings would you give to this group when discussing their substance use?

Check the participants answers and explanations with the instructions given in the mhGAP-IG Version 2.0 (page 125).

## Activity 7: Group work: Understanding the role of pharmacology in substance use disorders

### Activity 7: Group work: Understanding the role of pharmacology in substance use disorders

In your groups use the mhGAP-IG to learn about the processes and pharmacological interventions required to:

- Facilitate a safe withdrawal.
- Side-effects and contraindications.

60

**Duration:** 40 minutes (30 minutes of preparation and 10 minutes of presenting).

**Purpose:** To enable participants the opportunity to read through and understand the role of pharmacology in treating people with substance use disorders.

#### Instructions:

- Divide the participants into three groups.
- Instruct one group concentrate on alcohol withdrawal (Protocol 3) (if alcohol is not consumed in the country then divide participants into two groups and only focus on opioid and benzodiazepine).
- One group is to concentrate opioid withdrawal (Protocol 4).
- One group is to concentrate on benzodiazepine withdrawal (Protocol 6).
- Ask each group to read through their respective protocol and Table 1 (page 126 mhGAP-IG version 2.0).
- Once they have read and understood the protocol as a group they can use flip charts, sticky notes, pens, paper and anything they wish to describe and present the:
  - Process needed to support a safe withdrawal.
  - Pharmacological interventions including any side-effects and contraindications.
- They will then show those steps and use them to teach the rest of the group.
- As the facilitator, be available to help the groups and clarify any queries they may have.
- Ensure that as the groups present the different protocols you use the mhGAP-IG to correct any misinformation and ensure the description stay true to those described in the mhGAP-IG.

If necessary use these slides to talk through the different protocols and make sure that the participants understand how to support a planned withdrawal and which pharmacological interventions to use and when.

**Highlight Protocol 5 and explain that in some countries research is beginning to show the positive results of using opioid agonist maintenance treatment programmes such as methadone programmes on reducing opioid dependence and improving the quality of life of people with opioid use disorder.**

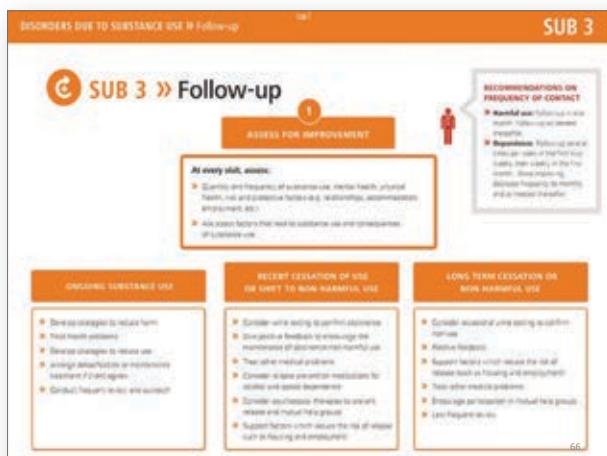
Emphasize that although there is a growing evidence base for this sort of intervention, it requires a national framework and guidelines.

Emphasize the importance of understanding which medications should be used in which intervention.

Emphasize the importance of understanding dosing and side-effects.

# Session 4. Follow-up

⌚ 10 minutes



Explain that it is important to follow-up regularly with people who have a disorder due to substance use. This is especially important if they have decided to reduce or cease using substances. Remember to be non-judgemental, especially if they have lapsed.

At every visit, it is important to consider the individual's level of motivation to stop or reduce their substance use.

Changing a person's relationship with a substance requires a daily level of commitment and determination, as it can mean a person changing their normal behaviours. For example, someone may have decided not to mix with a certain social group. They may decide to avoid places, social occasions, activities that they usually do.

And, therefore, they need support replacing those activities, finding new things to do, and the emotional support to make the commitment every day to not use substances.

Caring for people with disorders due to substance use can seem intensive and slow but with encouragement people can recover.

# Session 5.

# Emergency presentations

⌚ 30 minutes



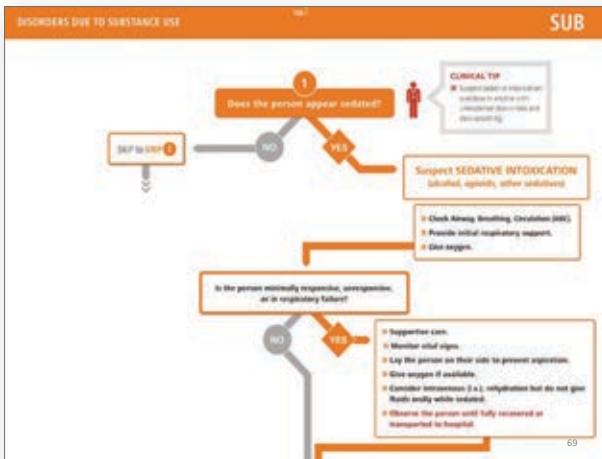
Explain that the principles of conducting an emergency presentation:

- Does the person appear sedated?
- Does the person appear overstimulated, anxious or agitated?
- Does the person appear confused?

Remind participants that as with any emergency presentation then assessment and management must happen quickly and simultaneously.

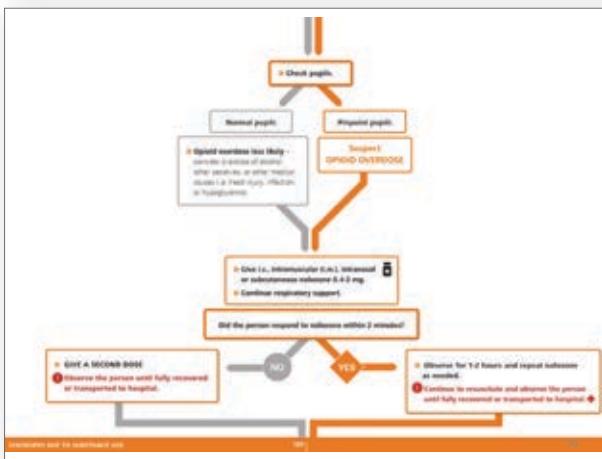


Give the participants time to read through common emergency presentations of people with disorders due to substance use.



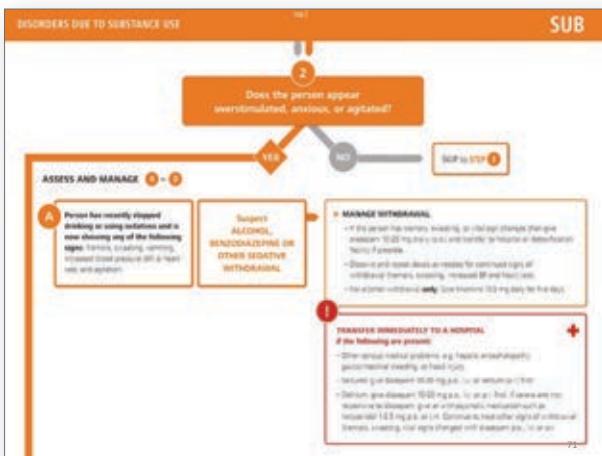
**Does the person appear sedated?**

Talk through the steps in the algorithm describing what to do if a person is sedated.



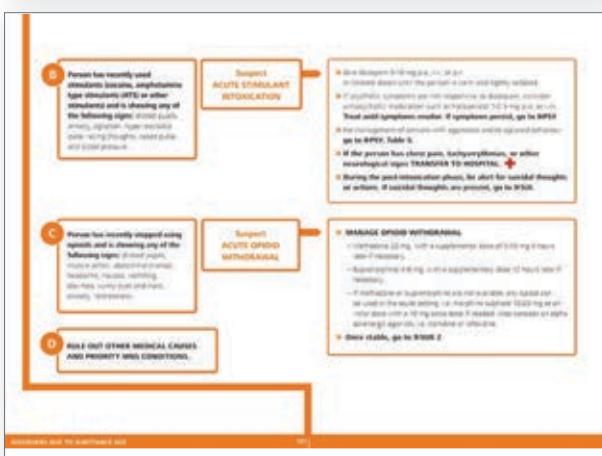
**Does the person appear overstimulated, anxious or agitated?**

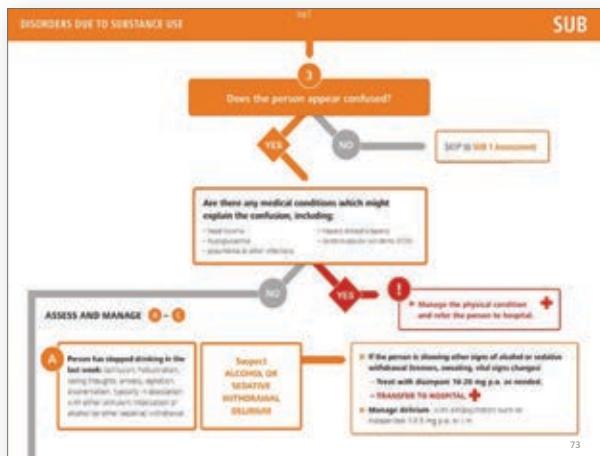
Talk through the steps describing what to do to assess someone who presents in a state of overstimulation, anxiety or agitation.



Highlight the different assessment and management steps for different substances.

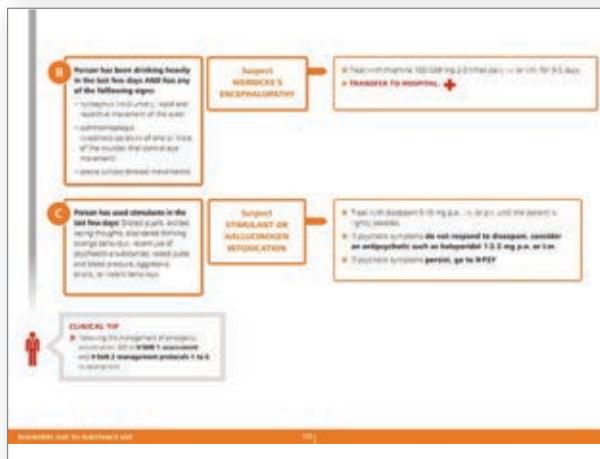
For example, somebody appearing overstimulated, anxious or agitated due to alcohol use, opioid use or stimulant use.





**Does the person appear confused?**

Talk through the steps describing what to do to assess someone who presents in a state of confusion.



Highlight the different assessment and management steps for different substances.

Explain that when responding to an emergency it can be very easy to become focused on a single task and neglect other tasks.

But remember that, where possible, find out if the person has been using substances.

If the person has presented by themselves then ask if other people in the area know them.

Try and find out which substance they may have used and how much.

Asking these questions could save a life.

Explain that we are now going to practise assessing and managing people with emergency presentations.

## Activity 8: Role play: Assessing and managing emergency presentations

### Activity 8: Role play: Assessing and managing emergency presentations

Practise using the mhGAP-IG emergency assessment algorithm in the following case scenarios.

75

**Duration:** 30 minutes.

**Purpose:** To give the participants time to practise using the emergency assessment and management algorithms in the mhGAP-IG Version 2.0 (page 106–113).

**Instructions:**

- You can choose to do this activity as small group work or in plenary. (See SUB supporting material role play 3.)
- If you chose to do this as small group work divide participants into three groups and ask them to nominate one person to play the role of the health-care provider, one the person seeking help and one the observer.
- The health-care provider should use the mhGAP-IG to assess and manage the person according to mhGAP-IG decision making algorithms.
- The person seeking help should follow the instructions given to them on a piece of paper.
- The observer should follow the instructions given to them on a piece of paper and when directed they should add in the extra pieces of information given to them.
- If you decide to do this activity in plenary: you play the role of the observer and follow the instructions for the observer including giving the extra information when required.
- Ask for participants to volunteer to play the role of the health-care provider and person seeking help.
- There are three different scenarios all of which involve the presentation of a person as either sedated, overstimulated or confused.

# Session 6.

## Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the MCQs (SUB supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# SUB PowerPoint slide presentation



PowerPoint slide presentation available online at:

[http://www.who.int/mental\\_health/mhgap/sub\\_slides.pdf](http://www.who.int/mental_health/mhgap/sub_slides.pdf)

## SUB supporting material

- Person stories
- Role plays
- Emergency presentations role plays
- Multiple choice questions
- Video links

Activity 3: mhGAP SUB module (alcohol) assessment

<https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=15>

Activity 3: mhGAP SUB module (cannabis) assessment

<https://www.youtube.com/watch?v=sccCxFfMGzk&index=13&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Activity 5: mhGAP SUB module (cannabis) management

<https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>



Supporting material available online at:

[www.who.int/mental\\_health/mhgap/sub\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/sub_supporting_material.pdf)

# **Self-harm/suicide**

**mhGAP training of health-care providers  
Training manual**

sui



**World Health  
Organization**

# Module: Self-harm/suicide

## Overview

### Learning objectives

- Promote respect and dignity for people with self-harm/suicide.
- Know the common presentations of self-harm/suicide.
- Know the principles of assessment of self-harm/suicide.
- Know the management principles of self-harm/suicide.
- Perform an assessment for self-harm/suicide.
- Assess and manage co-morbid physical health conditions in a person with self-harm/suicide.
- Assess and manage emergency presentations of self-harm/suicide.
- Provide psychosocial interventions to persons with self-harm/suicide.
- Provide follow-up sessions for people with self-harm/suicide.
- Refer to mental health specialists and links to outside agencies for self-harm/suicide as appropriate.

### Key messages

- Common presentations of self-harm/suicide:
  - Extreme hopelessness and despair.
  - Current thoughts/plan/acts of self-harm/suicide or history thereof.
  - Act of self-harm with signs of poisoning/intoxication, bleeding from self-inflicted wounds, loss of consciousness and/or extreme lethargy.
- Anyone with other priority MNS conditions must be assessed for self-harm/suicide.
- Anyone with self-harm/suicide must be assessed for other priority MNS conditions, chronic pain, and emotional distress.
- You can use effective communication skills to provide psychosocial interventions to the person and to the whole family.
- Refer a person with self-harm/suicide to a mental health specialist, if available.
- It is essential to offer regular follow-up care to a person with self-harm/suicide.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to self-harm/suicide	<p>Know the common presentations of self-harm/suicide</p> <p>Promote respect and dignity for people with self-harm/suicide</p>	40 minutes	<p><b>Activity 1: Person stories followed by group discussion</b> Use the person stories to introduce self-harm/suicide</p> <p><b>Presentation to supplement first person accounts discussion</b> Use the person stories as a basis for discussions on:</p> <ul style="list-style-type: none"> <li>• Common presentations of self-harm/suicide</li> <li>• Risk factors</li> <li>• Why it is important to learn how to manage self-harm/suicide in non-specialized health settings</li> </ul>
2. Assessment of self-harm/suicide	<p>Know the principles of assessment of self-harm/suicide</p> <p>Perform assessments for self-harm/suicide</p> <p>Assess and manage co-morbid physical health in self-harm/suicide</p> <p>Assess and manage emergency presentations of self-harm/suicide</p> <p>Refer to specialists and links to outside agencies for self-harm/suicide, as appropriate</p>	40 minutes     	<p><b>Activity 2: Video demonstration: Assessment</b> Use videos/demonstration role play to show an assessment of self-harm/suicide and allow participants to follow the process according to the mhGAP-IG assessment algorithm</p> <p><b>Activity 3: Role play: Assessment</b> How to assess someone for self-harm/suicide</p>
3. Management of self-harm/suicide	<p>Know the management principles of self-harm/suicide</p> <p>Provide psychosocial interventions to a person with self-harm/suicide</p>	30 minutes  	<p><b>Presentation on psychosocial interventions and brief group discussion</b></p> <p><b>Activity 4: Role play: Management interventions</b></p>
4. Follow-up	Offer follow-up for self-harm/suicide, as appropriate	40 minutes	<b>Activity 5: Role play: Follow-up</b>
5. Review	Review knowledge and skills from the session	15 minutes	Multiple choice questions and discussion

**Total duration (without breaks) = 3 hours 45 minutes**

## Step-by-step facilitator's guide

# Session 1. Introduction to self-harm/ suicide

⌚ 40 minutes

### Session outline

- Introduction to self-harm/suicide.
- Assessment of self-harm/suicide.
- Management of self-harm/suicide.
- Follow-up.

Begin the session by briefly listing the topics that will be covered.

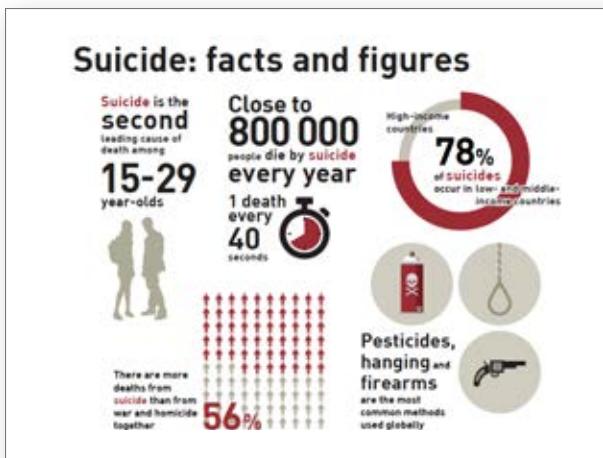
### Activity 1: Person stories followed by group discussion

#### Activity 1: Person stories

- Present the person stories of self-harm/suicide.
- First thoughts.

Use the person stories (one or more) to discuss self-harm/suicide:

- Introduce the activity and ensure participants have access to pen and paper.
- Tell the stories – be creative in your storytelling to ensure the participants are engaged.
- Immediate thoughts – give participants time to give their immediate reflections on the person stories.
- Discuss local perceptions/understanding of self-harm/suicide.



Why is suicide a public health concern? Explain the statistics on the slide.

Explain that globally, close to 800 000 people die due to suicide every year. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind.

State that it was the second leading cause of death in 15–29 year-olds globally in 2015.

There are indications to suggest that for every suicide there are more than 20 other people attempting suicide.

Some 78% of global suicides occurred in low- and middle-income countries in 2015.

In high-income countries, men are three times more likely to die from suicide than women. In low- and middle-income countries men are one and a half times more likely to die from suicide than women.



Direct participants to the master chart and read through the common presentations of people with self-harm/suicide.

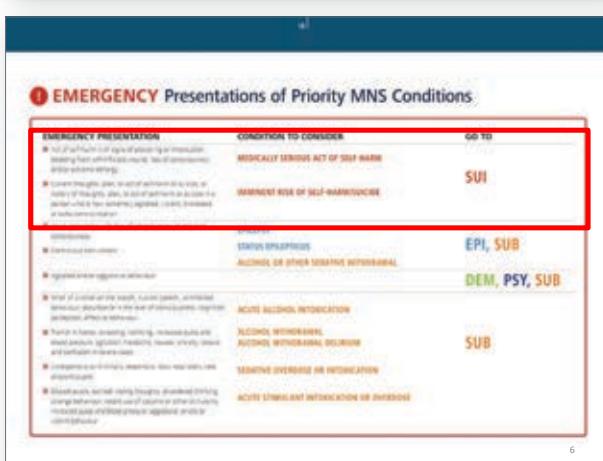
Emphasize that there are two ways that people with self-harm/suicide access non-specialized health settings:

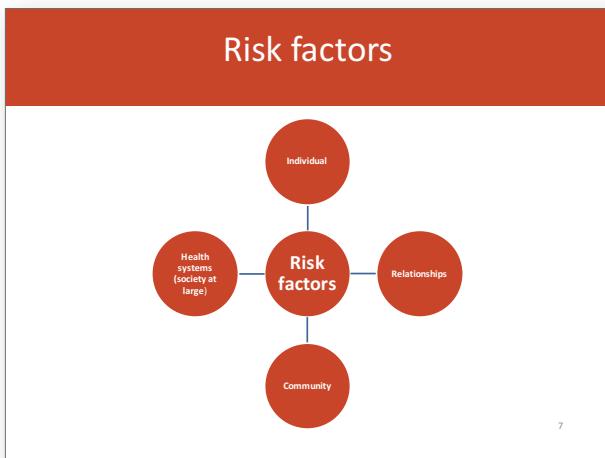
- As an emergency presentation of self-harm/suicide.
- During an assessment for other MNS conditions, chronic pain or extreme emotional distress.

Assessing someone in an emergency state requires that you medically stabilize them first and ensure their safety before conducting a detailed assessment.

Assessing someone with thoughts, plans or acts of self-harm/suicide requires that you explore:

- any plans
- risk factors
- protective factors.



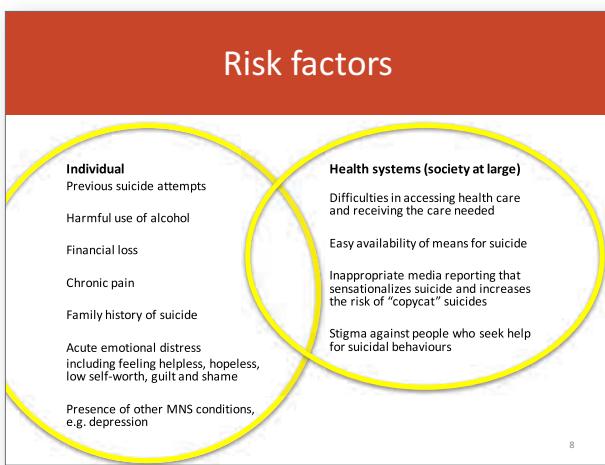


### Risk factors

Ask participants to turn to the person sitting on their right.

In pairs, ask participants to list two risk factors under each of the following headings:

- individual risk factors
- relationship risk factors
- community risk factors
- health systems risk factors.



Give participants 10 minutes to discuss and 10 minutes to present back to the group. Then show the slides and discuss.

Explain that individual risk factors include:

- If the person has previous self-harm/ suicide attempts.
- Have they experienced losses – personal or financial?
- Do they use substances?
- Do they have a family history of suicide?
- Are they experiencing acute emotional distress – feeling hopeless, helpless, shame etc.?
- Are they suffering with chronic pain?
- Do they have another priority MNS condition?

State that the risk of suicidal behaviour increases with co-occurring mental disorders, i.e. individuals with more than one mental disorder have significantly higher risk of self-harm/suicide. (Source: WHO: Preventing suicide: A global imperative; 2014.)

Ask the group to reflect on why these may be risk factors.

Explain that health systems and people's experiences of health systems also impact on their risk of self-harm/suicide. As you talk through the points on the slide (as described below) facilitate a group discussion on why these may be risk factors?

- If people have thoughts/plans of self-harm/suicide, it is a risk if they cannot access health care when needed.
- There is a greater risk of self-harm/suicide if in society there is easy access to means of suicide (pesticide, guns etc.).
- Society's attitude and stigma towards suicide and people who seek help for self-harm/suicide can also act as a risk factor for self-harm/suicide.

(Source: WHO: Preventing suicide: A global imperative; 2014.)

Risk factors	
<b>Relationships</b>	<b>Community</b>
A person having a sense of isolation and/or social withdrawal	War and disaster
Abuse	Stress of acculturation (such as among indigenous or displaced persons)
Violence	Discrimination and stigmatization
Conflictual relationships	

Explain that relationship problems are a risk factor for self-harm/suicide including:

- a sense of isolation
- abuse
- violence
- fights/conflicts.

Explain that what is happening in the wider community can also act as a risk factor for self-harm/suicide – such as war, disaster, stress and discrimination.

(Source: WHO: Preventing suicide: A global imperative; 2014.)

Ask participants to reflect on why these may be risk factors and facilitate a brief discussion.

Stress that risk factors can change over time. Therefore, they should be reviewed at follow-up visits, especially when the symptoms and/or the situation worsens.

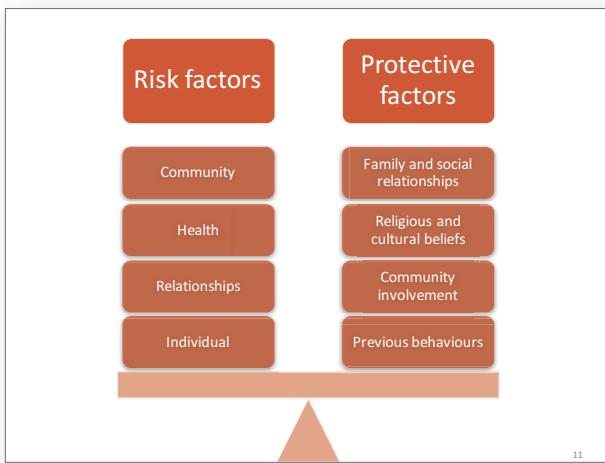


Explain that if risk factors increase, the risk of self-harm/suicide increases.

**Protective factors** help protect a person from self-harm/suicide.

In the same pairs as before, ask participants to spend five minutes brainstorming possible protective factors.

After five minutes of discussion ask for feedback from the pairs.



Talk through the list of protective factors as described on the slide:

- Previous coping strategies – have they felt like this before? If so, how did they cope, what did they do? What helped them? Will it help them again?
- Community involvement – are there family members, friends, community members who can help, listen, and support them?
- Religious, cultural beliefs – do they have access to spiritual/religious leaders, important leaders in a community who can support them? Do they have beliefs that give them hope?
- Family and social relationships – are there relationships or people in their lives who give them hope and a sense of having a future?

# Session 2.

# Assessment of self-harm/suicide

⌚ 1 hour 10 minutes

## Activity 2: Video demonstration: Assessment

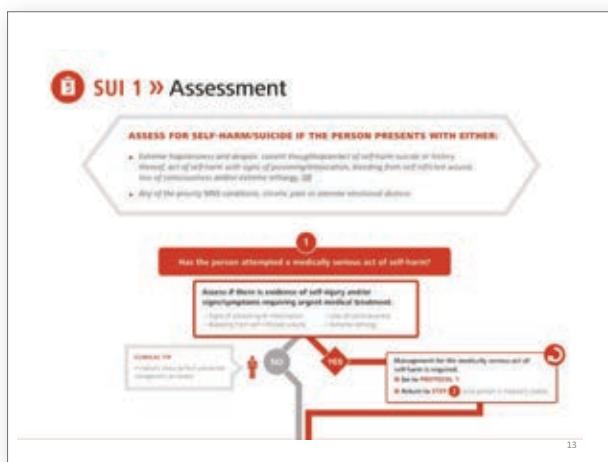


Explain that participants are going to watch a video about a young lady called Nada who has been brought to a non-specialized health setting (clinic) by her parents.

Instruct participants to turn to page 132 in the mhGAP-IG Version 2.0. Emphasize the principles of assessment:

1. Assess if the person has attempted a medically serious act of self-harm/suicide.
2. Assess for imminent risk of self-harm/suicide.
3. Assess for any of the priority MNS conditions.
4. Assess for chronic pain.
5. Assess for emotional distress.

Show the video mhGAP-IG SUI video (<https://www.youtube.com/watch?v=4gKleWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>).



Instruct the participants to use the mhGAP-IG algorithm to facilitate a discussion to decide if Nada attempted a medically serious act of self-harm?

Explain that in an emergency situation assessment and management must happen quickly and at the same time.

**SUICIDE MANAGEMENT**

**SUI 2**

## SUI 2 » Management

PROTOCOL 1 Medically Serious Act of Self-Harm	PROTOCOL 2 Imminent Risk of Self-Harm/Suicide	PROTOCOL 3 Risk of Self-Harm/Suicide
<ul style="list-style-type: none"> <li>For all Levels: Place the person in a safe and supportive environment at a health facility.</li> <li>Or if not possible, have the person leave.</li> <li>Assess if the person has a history of self-harm or suicide.</li> <li>If there is such a history, measure risk: "Intergenerational pattern of self-harm/suicide?" (S1-S3)</li> <li>If a safety lesson is needed, continue to monitor the person closely to prevent suicide.</li> <li>Care for the person with self-harm (S1-S3)</li> <li>Offer and ensure compassionate support (S1-S3)</li> <li>Offer communication (S1-S3)</li> <li>Consult a mental health specialist, if available (S1-S3)</li> <li>Maintain regular contact and Follow-up (S1-S3)</li> </ul>	<ul style="list-style-type: none"> <li>Minimize risks of self-harm/suicide.</li> <li>Create a safe and supportive environment. If possible, offer a respite. Avoid rooms offering privacy for the treatment.</li> <li>Or if not possible, have the person leave.</li> <li>Supervise and assign a named staff in charge, someone to ensure demands of self-harm are met.</li> <li>Admit to mental health and emotional distress.</li> <li>Transfer patient care to the person and their family (S1-S3)</li> <li>Offer care and compassion (S1-S3)</li> <li>Offer safety support (S1-S3)</li> <li>Consult a mental health specialist, if available (S1-S3)</li> <li>Maintain regular contact and Follow-up (S1-S3)</li> </ul>	<ul style="list-style-type: none"> <li>Offer and ensure compassionate support (S1-S3)</li> <li>Consult a mental health specialist, if available (S1-S3)</li> <li>Maintain regular contact and Follow-up (S1-S3)</li> </ul>

Direct participants' attention to Protocol 1: Managing medically serious acts of self-harm/suicide (page 136).

Talk through the steps:

In case of medically serious acts of self-harm/suicide, the person should be put in a secure and supportive environment in the health-care facility.

Nada cut her wrist in the video but what are the other methods of self-harm/suicide people may use?

Wait to hear a few ideas from participants before moving on to the next slide.

## Emergency assessment of suicide attempt

### Observe for evidence of self-injury

#### Look for:

- Signs of poisoning or intoxication.
- Signs/symptoms requiring urgent medical treatment such as:
  - bleeding from self-inflicted wounds
  - loss of consciousness
  - extreme lethargy.

#### Ask about:

- Recent poisoning or self-inflicted harm.

Explain that ingestion of pesticides, hanging and firearms are the most common methods of suicide globally.

Therefore, in an emergency assessment of self-harm/suicide attempts look for:

- Signs of poisoning.
- Bleeding, loss of consciousness and extreme lethargy.

## Recognizing pesticide poisoning

- Be aware of the possible smell of a pesticide.
- The person may be unconscious, with slow breathing and low blood pressure.
- People who are initially well need to be watched carefully for new signs (sweating, pinpoint pupils, slow pulse and slow breathing).

Explain that the next topic is specifically about pesticide poisoning.

Read through the points on the slide

Emphasize that it is a suicide method with a high fatality rate and globally, it is one of the most common methods.

## Emergency medical treatment: General principles

- Treat medical injury or poisoning immediately.
- If there is acute pesticide intoxication, follow the WHO pesticide intoxication management document.



Refer participants to the Clinical management of acute pesticide intoxication: Prevention of suicidal behaviours (WHO, 2008).

## Treating pesticide poisoning

- A person with possible pesticide poisoning must be treated immediately.
- For a pesticide-poisoned person to be safe in a health-care facility, a minimum set of skills and resources must be available. If they are not available, TRANSFER the person immediately to a facility that has the minimum set of skills and resources.
- We will discuss the minimum requirements on the next slide.

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Read out the points on the slide.

## Treating pesticide poisoning

### Minimum set of skills and resources:

- Skills and knowledge about how to resuscitate people and assess for clinical features of pesticide poisoning.
- Skills and knowledge to manage the airway, in particular to intubate and support breathing until a ventilator can be attached.
- Atropine and means for its intravenous (IV) administration if signs of cholinergic poisoning develop.
- Diazepam and means for its IV administration if the person develops seizures.

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Talk through the minimum set of skills and resources as described on the slide.

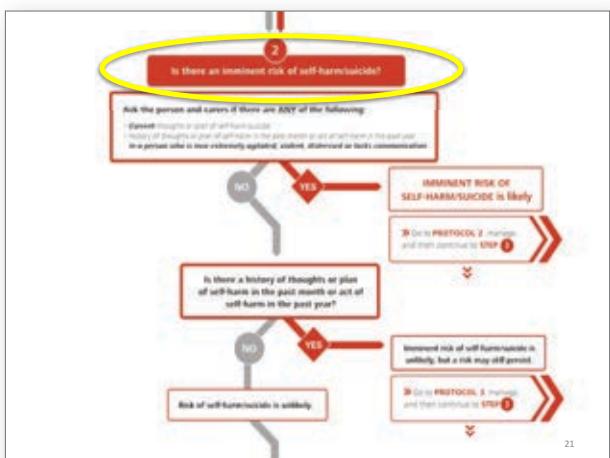
Stress that if the health-care facility/provider does not have ALL FOUR of these resources, then the person should be transferred to a facility with these minimum resources immediately.

## Treating pesticide poisoning: What NOT to do

- **DO NOT** force the person to vomit.
- **DO NOT** give oral fluids.
- **DO NOT** leave the person alone.
- You may give activated charcoal if:
  - The person is conscious.
  - The person gives informed consent.
  - The person presents within one hour of the poisoning.

Stress the importance of avoiding the actions displayed in the slide.

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Once the person is medically stable in a safe environment, return to the assessment algorithm and continue with the following steps of the assessment.

Does Nada have an imminent risk of self-harm/suicide?

Facilitate a brief group discussion to answer this question.

## Asking about self-harm/suicide

- When asking the person about self-harm/suicide, the question should be asked with an appropriate transition from a previous point which leads into the issue.
- You may want to explore their negative feelings first and then ask if they have any plans to kill themselves:
  - *I can see that you are going through a very difficult period. In your situation many people feel like life is not worth it. Have you ever felt this way before?*

Explain to the group that questions about self-harm/suicide must follow an appropriate line of questioning. For example, do not ask, "Do you have a headache?" and next, "Do you want to kill yourself?" Instead, when the person is talking about their feelings of sadness or hopelessness, make the transition to asking about any thoughts or plans of self-harm/suicide.

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## General questions about thoughts and plans

- What are some of the aspects in your life that make it not worth living?
- What are some of the aspects in your life that make it worth living?
- Have you ever wished to end your own life?
- Have you ever thought about harming yourself?
- How would you harm yourself? What would you do?

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Talk through the suggested questions on the slide.

Facilitate a brief brainstorming discussion to ensure that these examples of general questions are culturally appropriate.

## Specific questions

- What thoughts specifically have you been having?
- How long have you been having these thoughts?
- How intense have they been? How frequent? How long have they lasted?
- Have these thoughts increased at all recently?
- Do you have a plan for how you would die or kill yourself?
- What is it? Where would you carry this out? When would you carry it out?
- Do you have the means to carry out this plan?
- How easy is it for you to get hold of the gun/rope/pesticide etc. (the means)?
- Have you made any attempts already? If yes – what happened?

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Read out the list of specific questions on the slide.

Have participants generate their own list of specific questions. Make a note of their questions. Keep the list in full view so participants can use those questions in upcoming role plays.

## Questions to explore protective factors

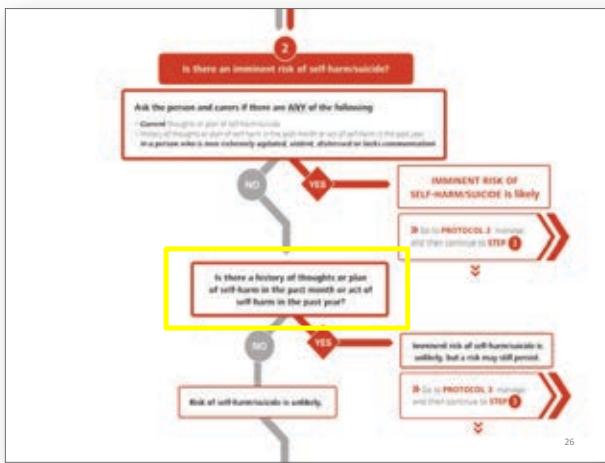
- What are some of the aspects of your life that make it worth living?
- How have you coped before when you were under similar stress?
- What has helped you in the past?
- Who can you turn to for help? Who will listen to you? Who do you feel supported by?
- What changes in your circumstances will change your mind about killing yourself?

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During an assessment, at the same time as asking about any thoughts/plans of self-harm/suicide, also ask about any possible protective factors.

Brainstorm culturally relevant questions with the group.

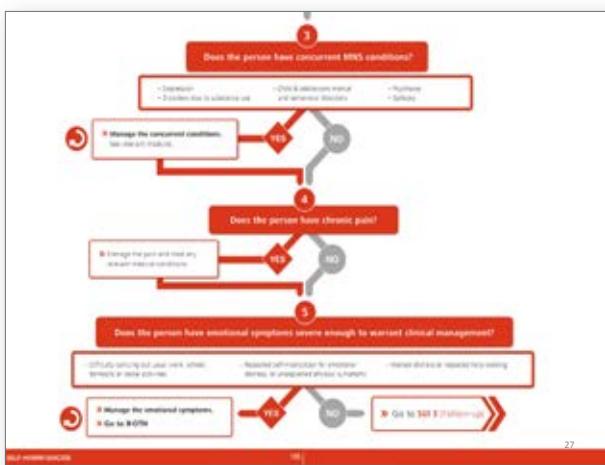
Continue with the assessment algorithm.



Explain that previous behaviour is a strong predictor of future behaviour, therefore it is important to ask about any previous acts of self-harm or suicide attempts.

If they have had previous acts of self-harm/suicide then this is also an opportunity to ask what helped them survive those previous act/attempts.

How did they cope with those feelings? Can they do the same thing this time?



Emphasize that while assessing for suicide, it is essential to assess for:

- Other concurrent MNS conditions.
- Chronic pain such as pain due to HIV/AIDS, cancer etc.
- Emotional distress – this can be due to the loss of a loved one, loss of employment, intense family conflict, problems at school, intimate partner violence, physical or sexual abuse or uncertainty about gender and sexual orientation etc.

If there are other concurrent MNS conditions, chronic pain or acute emotional distress, then treat these conditions and go to the relevant modules in the mhGAP-IG.

## Activity 3: Role play: Assessment

### Activity 3: Role play: Assessment

A young man has come to be checked over after having a motorcycle accident. The health-care provider is worried he may have been suicidal at the time of the accident.

Practise using the mhGAP-IG to assess someone for self-harm/suicide

See SUI supporting material role play 1.

Print the three different instruction sheets for the participants playing different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to assess for possible self-harm/suicide.

**Situation:** A young man has come to be checked over after having a motorcycle accident. The health-care provider is worried he may have been suicidal at the time of the accident.

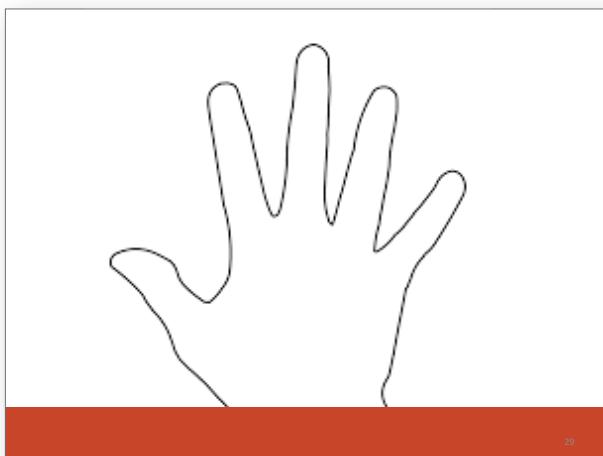
**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

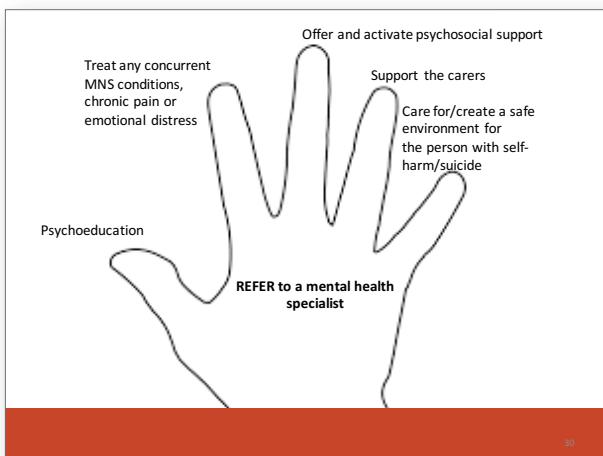
# Session 3.

## Managing self-harm/suicide

⌚ 1 hours



Ask the group what interventions could be used in the management of self-harm/suicide.



Explain that the key to the management of self-harm/suicide is to:

- Ensure the person does not have access to means.
- Support the carers.
- Mobilize family and friends to support and make the person feel safe.
- Focus on protective factors.
- Offer psychoeducation to ensure the person understands how useful it is to talk about negative feelings and how important it is to identify people to turn to when feeling this way.

It is important to treat any underlying MNS condition, chronic pain and emotional distress.

As self-harm/suicide is always serious, refer the person to a mental health specialist when available and consult them regarding next steps.

## Management: Co-occurring conditions

- If there is a concurrent MNS condition, e.g. depression, alcohol use disorder, manage according to the mhGAP-IG for the self-harm/suicide and also for the mhGAP condition.
  - If there is chronic pain, you need to manage the pain. Consult a pain specialist if necessary.
  - If the person has no mhGAP condition, but has nonetheless has severe emotional symptoms, then manage as explained in the Module: Other significant mental health complaints.

Talk through the points on the slide.

Direct participants to mhGAP-IG Version 2.0 (page 137) and ask a volunteer from the participants to briefly talk through the different interventions in detail, answering any questions the group may have.

Remind participants that it is essential to ensure that the person is in a safe and quiet environment when talking about self-harm/suicide.

Remind participants to involve carers, where possible, in the assessment and management of the person with self-harm/suicide.

SELF HARM / SUICIDE In Management	SUI 2
<b>PSYCHOSOCIAL INTERVENTIONS</b>	
<b>2.3 Offer and activate psychosocial support</b>	
<b>Offer support to the person</b>	
- Express interest and care for the client.	
- Focus on the client's strengths, abilities, and coping skills, rather than on the client's past history or recent setbacks.	
- Encourage problem-solving by the client, to help clients to work out what they want to do and how to do it.	
- Encourage clients to seek support from family members, friends, and professionals.	
<b>Offer emotional support and practical help</b>	
- Listen, comfort, reassure, and provide practical help.	
<b>Offer psychological support</b>	
- Establish rapport, honesty, reassurance, and trust while offering a non-judgmental, accepting, and empathetic attitude.	
- Encourage the client to express their thoughts and feelings, reducing the client's emotional isolation.	
- Encourage the client to explore and express as much as possible in their own words, without fear of judgment, contradiction, or criticism.	
- Encourage the client to identify and explore their own strengths and resources.	
- Encourage the client to seek support from family members, friends, and professionals.	
<b>2.4 Careers support</b>	
<b>Career support</b>	
- Offer career and leisure advice and planning, and identify available resources.	
- Offer career and leisure information, advice, and support.	
- Offer career and leisure opportunities, advice, and support.	
<b>2.5 Psychoeducation</b>	
<b>Offer psychoeducation to the person and the carer</b>	
- Offer brief, one-off sessions of psychoeducation, such as help to manage a crisis or a crisis learning module, to help clients and their carers understand mental health issues.	
- Encourage carers to take an active role in learning about mental health issues.	
- Encourage carers to take an active role in learning about mental health issues.	
<b>Offer psychoeducation to professionals</b>	
- Offer psychoeducation to professionals, such as help to manage a crisis or a crisis learning module, to help professionals understand mental health issues.	
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- Offer psychoeducation to professionals, such as help to manage a crisis or a crisis learning module, to help professionals understand mental health issues.	
<b>Offer psychoeducation to the public</b>	
- Offer psychoeducation to the public, including the family and friends of clients, to support the delivery of service support.	

Direct participants to continue to read through the psychosocial interventions in the mhGAP-IG. Ask for a different volunteer to continue reading out loud.

**Highlight the points listed under activating psychosocial support.**

Explain that by assessing for protective factors, they have already started to “explore reasons and ways to stay alive”.

When exploring for reasons and ways to stay alive, one should really listen to the person and try to understand what is the most important for them and avoid giving your own opinions.

## Activity 4: Role play: Management

### Activity 4: Role play: Management

A 30-year-old woman was brought urgently to the centre by her husband after having drunk a bottle of pesticide.

You managed to save her life (the minimum set of skills and resources were available in your facility).

Now, you, the health-care provider, have come to see her on the ward after she has become stable.

Practise using the mhGAP-IG to deliver psychosocial interventions to a person with self-harm/suicide.

See SUI supporting material role play 2.

Print the three different instruction sheets for the participants playing different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to manage self-harm/suicide with psychosocial interventions.

**Situation:**

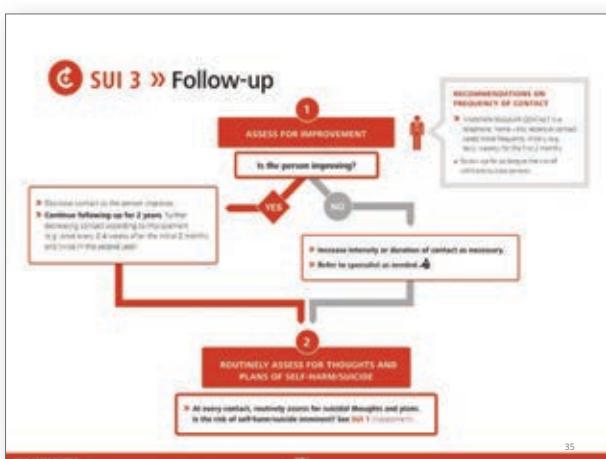
- A 30-year-old woman was brought urgently to the centre by her husband after having drunk a bottle of pesticide.
- You managed to save her life (the minimum set of skills and resources were available in your facility).
- Now, the health-care provider has come to see her on the ward after she has become stable.

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 4. Follow-up

⌚ 40 minutes



Talk through the follow-up assessment steps as described on the slide and in the mhGAP-IG.

Explain that a person needs to be followed-up closely as long as there is still a risk of self-harm/suicide.

Different methods can be used to follow-up: scheduling another appointment at the centre, home visits, phone calls, text messages.

The appropriateness of these different methods varies depending on cultural acceptability and on the resources available.

Facilitate a brief group discussion about:

- Different ways that they could follow-up with a person with self-harm/suicide.
- Identify any barriers/solutions to providing follow-up.

## Case scenario

A 25-year-old woman sees you in a clinic. She is very upset and tearful. She explains that she is scared because she is fighting with her mother all the time, who demands that she gets married to a man that she does not love.

The young woman does not know what to do, she feels desperate and believes her only option is to kill herself. She has specific plans about what she will do. She asks you not to tell anyone about her plans especially her mother and family.

Use this case scenario to raise participants' awareness about issues of confidentiality.

Read the scenario out loud and ask participants:

- How would participants respond in this scenario?
- Would they break confidentiality?
- If yes, what would they do?
- If not, why not?

## Activity 5: Role play: Follow-up

### Activity 5: Role play: Follow-up

- You first met this lady after she had intentionally ingested a bottle of pesticide in order to kill herself.
- After she was medically stabilized you offered her support by using psychoeducation, activating psychosocial support networks and problem-solving.
- You explained to her that you wanted to stay in regular contact to monitor her progress.
- She has now returned for follow-up.

See SUI supporting material role play 3.

Print off the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 40 minutes.

**Purpose:** To show participants how to work with people during a follow-up session for self-harm/suicide.

**Situation:**

You first met this lady after she had intentionally ingested a bottle of pesticide in order to kill herself. After she was medically stabilized, you offered her support by using psychoeducation, activating psychosocial support networks and problem-solving. You explained to her that you wanted to stay in regular contact to monitor her progress. She has now returned for follow-up.

**Instructions:**

- Facilitator plays the role of the health-care provider.
- Participants watch.
- After five minutes of the role play, stop and ask participants to suggest ways that the health-care provider could work with the person returning for a follow-up session.
- Then ask a participant volunteer to take over from the facilitator to continue the follow-up interaction.
- This is repeated three times so that at least three participants can play the role of health-care provider.
- After the third change, stop the exercise.
- Reflect as a group on the benefits of follow-up.

# Session 5. Review

 15 minutes

**Duration:** Minimum 15 minutes (depending on participants' questions).

**Purpose:** Review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the SUI MCQs (see SUI supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# SUI PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/sui\\_slides.pdf](http://www.who.int/mental_health/mhgap/sui_slides.pdf)

## SUI supporting material

- Person stories
- Role plays
- Multiple choice questions
- Video link

Activity 2: mhGAP SUI module – assessment and management

<https://www.youtube.com/watch?v=4gKleWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/sui\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/sui_supporting_material.pdf)

# Other significant mental health complaints

mhGAP training of health-care providers  
Training manual



World Health  
Organization

# Module: Other significant mental health complaints

## Overview

### Learning objectives

- Promote respect and dignity for people with other significant mental health complaints.
- Know the common presentation of other significant mental health complaints.
- Know the assessment principles of other significant mental health complaints.
- Know the management principles of other significant mental health complaints.
- Perform an assessment for other significant mental health complaints.
- Use effective communication skills in interaction with people with other significant mental health complaints.
- Assess and manage physical health in other significant mental health complaints.
- Provide psychosocial interventions to persons with other significant mental health complaints and their carers.
- Know there are no specific pharmacological interventions for other significant mental health complaints.
- Plan and perform follow-up for other significant mental health complaints.
- Refer to specialists and links with outside services for other significant mental health complaints where appropriate and available.

### Key messages

- Common presentations of other significant mental health complaints include: depressed mood, irritability, anxiety, stress, extreme tiredness, unexplained physical complaints.
- Other significant mental health complaints are frequently seen in non-specialized health settings, but are often treated inappropriately, with excess investigations and inappropriate medications.
- When assessing a person for other significant mental health complaints ensure to rule out any physical causes for the symptoms.
- Ensure that the person does not have another priority MNS condition.
- Exposure to extreme stressors such as major loss or traumatic events can create acute stress and grief reactions in individuals. Those reactions are normal but if they impact on a person's ability to function or last for longer than is culturally expected the person may need to be referred to a specialist.
- In all people with other significant mental health complaints, reduce stress, strengthen social supports and teach stress management such as relaxation techniques.
- Symptoms of depression that do not amount to a depression should not be treated with antidepressants but with psychosocial interventions.
- Be non-judgemental and empathetic when caring for people with other significant mental health complaints.

Session	Learning objectives	⌚ Duration	Training activities
1. Introduction to other significant mental health complaints	Promote respect and dignity for people with other significant mental health complaints  Know the common presentation of other significant mental health complaints  Understand the impact of living with other significant mental health complaints on the individual	60 minutes  15 minutes  20 minutes	<b>Presentation on other significant mental health complaints</b> Use case studies to present common presentations of depression symptoms not amounting to depression, stress/PTSD, grief and medically unexplained symptoms  <b>Reflection</b> During the presentation have participants reflect on people they have cared for in the past who fit the description of other significant mental health complaints  <b>Activity 1: Discussion: What is violence?</b> Reflect on types of violence.  <b>Activity 2: Discussion: Stressors through the life course</b> Reflect on the impact of exposure to stressors
2. Assessment of other significant mental health complaints	Know the assessment principles for other significant mental health complaints  Perform an assessment for other significant mental health complaints  Assess and manage physical health in other significant mental health complaints	10 minutes  20 minutes  30 minutes	<b>Activity 3: Communication skills: Dos and don'ts</b> How to communicate with people with other significant mental health complaints  <b>Activity 4: Video demonstration: Assessment</b> Use videos/demonstration role play to show an assessment and allow participants to note the principles of assessment (all aspects covered)  <b>Activity 5: Role play: Assessment after exposure to extreme stressors</b>
3. Management of other significant mental health complaints	Know there are no pharmacological interventions in other significant mental health complaints  Provide psychosocial interventions  Provide interventions for people who have been exposed to extreme stressors  Refer to specialists and links with outside agencies for other significant mental health complaints	20 minutes  30 minutes  10 minutes  30 minutes	<b>Presentation on management of other significant mental health complaints</b>  <b>Activity 6: Addressing psychosocial stressors</b> Enable participants to practise using a brief problem solving strategy  <b>Activity 7: Relaxation and stress management</b> Either in plenary or small groups practise different breathing and relaxation techniques  <b>Activity 8: Role play: Assessment and management</b> Feedback and reflection
4. Follow-up	Plan and perform follow up for other significant mental health complaints	10 minutes	<b>Brief presentation and brainstorm on follow-up principles and activities</b>
5. Review		15 minutes	<b>Multiple choice questions and discussion</b>
<b>Total duration (without breaks) = 4 hours 30 minutes</b>			

## Step-by-step facilitator's guide

# Session 1. Introduction to other significant mental health complaints

⌚ 1 hour 35 minutes

This module aims to provide basic guidance on management of a range of mental health complaints not covered elsewhere in the guide. Some of these complaints may be similar to depression, but some other comorbidities are distinct from the conditions covered in this guide.

Other mental health complaints are considered significant when they impair daily functioning or when the person seeks help for them. Other mental health complaints can be due to stress.

▪ This module should not be considered for people who meet the criteria for any of the mhGAP priority conditions (except self-harm).  
▪ This module should only be used after explicitly ruling out depression.  
▪ This module should be used when helping adults. In case the person is a child or adolescent, go to 4 CAA.

Read through the description and then explain that the mhGAP-IG covers a range of priority MNS conditions. However, there remain other significant mental health complaints that you will see in your clinical practice that may appear similar to priority MNS conditions (such as depression) but are actually distinct.

### Session outline

- Introduction to other significant mental health complaints
- Assessment of other significant mental health complaints
- Management of other significant mental health complaints
- Follow-up
- Review

Begin the session by briefly listing the topics that will be covered.

## Common presentations

- Feeling extremely tired, depressed, irritated, anxious or stressed.
- Frequently returning with unexplained somatic complaints.

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The most common presentations of people with other significant mental health complaints are as listed in the slide.

These are complaints frequently seen in non-specialized health settings.

## Depression and other significant mental health complaints

- To identify someone with depression requires that the person's life and ability to carry out everyday tasks is severely affected.
- People can, however, suffer with symptoms of depression but remain able to function in their everyday life
- This module will cover the latter group of people. For the management of depression see the Module: Depression.

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Explain that the distinction between other significant mental health complaints and depression needs to be explored carefully.

Read out the points on the slide.

Emphasize that the Module: Depression covers the treatment of depression, whereas this module includes symptoms of depression not amounting to depression.

Explain that people can experience symptoms of depression but not have considerable difficulty with daily functioning. Thus, their symptoms do not amount to depression and they can be assessed and managed using this module.

Emphasize that the distinction is important as symptoms of depressed mood that do not amount to depression should not be treated with antidepressants but only with the psychosocial interventions described in this module.

## Case scenario: Symptoms of depression not amounting to depression

A 69-year-old woman presents with physical aches and pains all over her body, frequent headaches and low mood. She states that she has been crying a lot recently because of the pains.

She says she feels lonely as her family and grandchildren have moved to a different city.

She is staying active and spend times with friends.

She is able to cook and attend to her daily chores but she has low motivation for trying anything new, she feels sad and in pain.

Talk through the case scenario and emphasize that these symptoms do not amount to depression because the woman is still able to function in her daily life.

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## Reflection

- Think of people you have cared for in the past who may fit this description?
- How did they present to you?
- What did you do to care for them? Did it help?

Ask participants to reflect on people they have cared for in the past who may fit the description of having symptoms of sadness not amounting to depression.

Have participants think about how these people presented in the non-specialized health setting. What did the participant do to care for them? Did it help?

Ask a few participants to share their reflections and facilitate a brief discussion (limit this discussion to 10 minutes).

## Stress

- Stress is a common response to stressors
- Every one can feel stressed and if it is not managed well it can become overwhelming and debilitating
- Presents as:
  - Sleep problems
  - Behavioural changes (crying spells, social isolation)
  - Physical changes (aches, pains and numbness)
  - Extreme emotions (extreme sadness, anxiety, anger, despair) or being in a daze
  - Cognitive changes (racing thoughts, unable to concentrate or make decisions)

Explain that stress is a normal reaction to stressors. Everyone can feel stressed. Stress can be a useful response as it can be a motivator that drives people to focus, take action and make decisions in their life.

However, many people can become overwhelmed by stress and that starts to impact on their ability to cope in daily life.

In non-specialized health settings, stress can present with emotional, cognitive, behavioural and physical symptoms.

## Case scenario: Stress

A 45-year-old man attends a primary health-care clinic with stomach aches. He describes the pain as so bad that when it comes on he has problems catching his breath. He has had to take a lot of time off work because of his stomach aches and as a result he has fallen behind in his work.

He is the main breadwinner in the family but feels very anxious as he has a demanding boss and so much work to catch up on he does not know where to start. He is struggling to sleep at night as he is always thinking about what he has to do.

Talk through the case scenario and emphasize that this man may be experiencing quite a physical reaction to stress from work (stomach aches and problems breathing). He is the breadwinner for his family and there must be a pressure to ensure he keeps his job. He explains that he has a very demanding boss and as his workload increases he feels anxious that he will not be able to complete the work. He cannot sleep as his mind is constantly thinking and making lists about what he should be doing.

If he is not getting sufficient rest then that will be affecting him physically and contributing to the stomach aches and the anxious feelings.

## Reflection

- Think of someone you have cared for in the past who may have been suffering with stress?
- How did this person present to you?
- How did you care for them? Did it help?

10

Ask participants to reflect on people they have cared for in the past who may fit the description of having symptoms of stress.

Have participants think about how these people presented in the non-specialized health setting. What did the participant do to care for them? Did it help?

Ask a few participants to share their reflections and facilitate a brief discussion (limit this discussion to five minutes).

## Exposure to extreme stressors

- Extreme stressors are events that are potentially traumatic and/or involve severe loss.
- What extreme stressors have people who visit your clinic faced?

11

Explain that in the case scenario above we discussed reactions to stressful situations, i.e. pressure at work. However, people can also experience more extreme stressors.

### Facilitate a brief brainstorming session

Ask participants to think of what sort of extreme stressors people in their primary health-care clinics might have faced? Make a note of their answers.

## Extreme stressors

- Serious accidents
- Physical and sexual violence
- Humanitarian disasters (war, epidemics, earthquakes)
- Forced displacement
- Loss of loved one
- Major losses (including loss of identity/income/job/role/country/family etc.)

12

Compare the list made by the participants with the list on the slide.

Explain that this is not an exhaustive list of stressors.

# Activity 1: Discussion: What is violence?

## Activity 1: What is violence?

- Violence and abuse is a reality for many people.
- Not all violence has visible consequences.
- When assessing someone for exposure to violence it is important to think of the different sorts of violence people experience?

13

**Duration:** 15 minutes.

**Purpose:** To understand and be able to identify the various types of violence.

**Instructions:**

- Ask participants to discuss what is violence and share their thoughts with the group. Write the thoughts generated by the group on post-its and place them on a flip chart.
- Present the group with another flip chart paper – a square with four types of violence written in each corner (physical violence, sexual violence, economic violence and emotional violence).
- Ask the group to rearrange the first list according to the corners on the flip chart.
- Ask the participants if certain harmful traditional practices in their communities would fit into any of the lists above? Adapt this list to fit the community you are in, such as:
  - early/forced marriage
  - honour killings
  - dowry abuse
  - widow ceremonies
  - female genital mutilation
  - punishments directed at women for crimes against culture
  - denial of education/food for girls/women due to gender roles/expectations.

## Exposure to extreme stressors

Emphasize the first point on the slide by saying that it is to be expected for people to experience distress after being exposed to a distressing event such as violence.

Most people will recover with no intervention at all.

Explain that if people have been exposed to extreme stressors and display symptoms it is important to assess them for priority MNS conditions.

- After exposure to extreme stressors most people will experience distress – that is normal and to be expected – but they will not all develop conditions that need clinical management.
- Exposure to extreme stressors increases the likelihood of a person developing a priority MNS conditions.
- Exposure can mean that people can experience acute stress reactions and even PTSD.

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## Symptoms of acute stress (within one month of the event)

- After recent exposure to stressors reactions are diverse.
- We use the term symptoms of acute stress (within one month of the distressing event) to cover a wide range of symptoms such as:
  - Feeling tearful, frightened, angry or guilty, depressed mood.
  - Juminess or difficulty sleeping, nightmares or continually replaying the event in one's mind.
  - Physical reactions (hyperventilation, palpitations).

15

Re-emphasize that most symptoms of acute stress are normal and transient. People tend to recover from them naturally. However, sometimes there is a need to intervene when they impair day-to-day functioning or if people seek help for them.

## Core symptoms of PTSD (at least one month after a potentially traumatic event)

- Re-experiencing symptoms.
- Avoidance symptoms.
- Symptoms that relate to a sense of heightened current threat.
- Difficulties carrying out usual work, school, domestic or social activities.

16

In mhGAP-IG we do not consider post-traumatic stress disorder (PTSD) until one month after the event.

Talk through the points on the slide.

Explain that for PTSD the person should also be experiencing these core symptoms with impaired functioning. Provide examples – recollections might occur through intrusive memories, frightening dreams or, in more severe cases, through flashbacks.

Avoidance symptoms include: avoiding situations, activities, thoughts or memories that remind them of the event.

Heightened sense of current threat results in increased alertness to danger and being easily startled or jumpy.

## Case scenario: Post-traumatic stress disorder

A 23-year-old woman presents to the primary health-care provider with racing heart and problems breathing.

After spending some time listening to her the health-care provider learns that she was raped one year ago at a party. She has flashback memories of that attack and nightmares that stop her from sleeping. She avoids spending time with people as she feels frightened by them. If she is in social situations she feels very jumpy and uncomfortable and always seek to leave early. She is exhausted.

Explain that this lady is suffering with PTSD after surviving a rape. PTSD is present due to the presence of re-experiencing symptoms such as flashbacks and nightmares.

She has avoidance symptoms of not wanting to attend social situations as this is where the rape occurred.

She is hypervigilant when in social situations – feeling jumpy and wanting to leave.

The symptoms are interfering with her studies and thus her daily functioning.

These symptoms have been present for a year. However, she did not seek help for the emotional, behavioural or cognitive symptoms instead she sought help for the physical symptoms, demonstrating once again the importance of taking your time and using effective communication skills to understand the reasons for people's physical health problems.

## Reflection

- Think of people in the past you have cared for who may have been experiencing PTSD?
- How did they present to you?
- How did you care for them? Did it help?

Ask participants to reflect on someone they have cared for in the past who may fit the description of having symptoms PTSD?

Have participants think about how the person presented in the non-specialized health setting?

What did the participant do to care for them? Did it help?

Ask a few participants to share their reflections and facilitate a brief discussion (limit this discussion to five minutes).

## Bereavement

- Grief is a normal response to loss.
- People's responses to loss can be overwhelming and wide ranging, including:
  - Low mood, despair, anxiety, fear, irritability, anger, loneliness, yearning, shock.
  - Hopelessness, low self-esteem, preoccupation with the person that died, negative thinking, self-blame.
  - Social withdrawal, loss of interest, loss of appetite, problems sleeping, aches and pain.

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Explain that grief is a normal response to loss. People's responses to loss can be overwhelming and wide ranging. Explain the list of common presentations of people grieving as listed on the slide.

Ask participants to add any other culturally relevant descriptions of how people grieve in the local culture.

## Case scenario: Bereavement

A 22-year-old girl attended primary health-care clinic complaining of aches and pains all over her body. She explained that she is socially isolated and does not want to see people as they just make her very angry and she finds them unhelpful. She feels sad all the time.

After some time she explains that her father died four months ago. She was close to her father and misses him and is angry and does not understand how people can carry on as normal.

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Read the case scenario out or have a participant read it out loud.

Explain that, once again, in this scenario the girl attended a non-specialized health setting because of aches and pains all over her body. However, she soon explained that she was feeling hopeless and bereaved.

## Reflection

- Think of people you have cared for in the past who may fit this presentation of someone bereaved?
- How did they present to you?
- What did you do to care for them? Did it help?

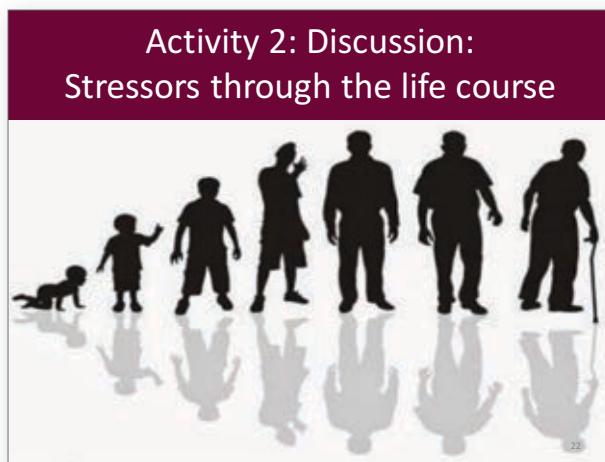
21

Ask participants to reflect on someone they have cared for in the past who may fit the description of suffering after a bereavement?

Have participants think about how they presented in the non-specialized health setting? What did the participant do to care for them? Did it help?

Ask a few participants to share their reflections and facilitate a brief discussion (limit this discussion to five minutes).

## Activity 2: Discussion: Stressors through the life course



**Duration:** 20 minutes.

**Purpose:** Allow participants to discuss how exposure to stressors can impact on an individual, their growth and experiences throughout the life course.

**Instructions:**

- Facilitate a group brainstorming session.
- On six separate pieces of flip chart paper write the headings:
  - pre-natal
  - infancy
  - childhood
  - adolescence
  - adulthood
  - elderly.
- Ask the group to brainstorm which forms of stressor can occur at the different stages of a life course and give examples.
- Once you have passed through the life course once return to the beginning and ask participants to brainstorm:
  - How might those experiences impact on the health and mental health of the person?
  - Are those impacts likely to be acute or long lasting?

### Medically unexplained somatic symptoms

- People can experience multiple persistent physical complaints – mainly pains – that are not associated with another physical health problem.
- These complaints can be associated with:
  - excessive negative thinking, worries and anxieties
  - tiredness
  - low mood
  - hopelessness
  - loss of interest
  - weight loss/changes in appetite.

Explain the points on the slide which are the common presentations of someone with medically unexplained somatic symptoms.

Much of the experience that someone with medically unexplained symptoms feels is **pain**.

But, they can also be characterized by: excessive negative thinking, worries and anxieties about what is happening to them and what is happening in their life; tiredness, low mood, hopelessness, loss of interest, weight loss and changes in appetite.

## Case scenario: Medically unexplained somatic symptoms

- A 35-year-old man presents with a pain in the middle of his body, problems breathing, dizziness and nausea when he bends forward. He says that he has been experiencing these problems for approximately four years and has seen countless doctors and specialists.
- He had to leave his job as a mechanic because he could no longer bend forward.
- He says the severity of the symptoms have stayed the same over the four years but he has become increasingly frustrated and tired of living with them and trying to find out what is wrong with him.

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Explain that the man in the case scenario is experiencing unexplained pains, breathing problems, dizziness and nausea when he bends forward.

These symptoms have stopped him from working.

They have been present for four years but no doctor has been able to find a reason for them and therefore there has been no treatment. Over the years, he has become increasingly frustrated and stressed as he feels no one can help him.

## Impact of medically unexplained somatic symptoms



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### Impact of medically unexplained somatic complaints on the individual

Explain to participants that also when a physical explanation for their symptoms cannot be found the symptoms that people experience are real to the person.

To understand the symptoms and the level of distress it is essential to be patient, use effective communication strategies and ask about how they impact on the person's ability to function and in their daily life.

It is also important to be empathic and think how hard and stressful it must be to not know what is wrong with you yet continue to feel unwell.

## Reflection

- Think of people you have cared for in the past who had unexplained medical somatic symptoms?
- How did they present to you?
- What did you do to care for them? Did it help?

26

Ask participants to reflect on people they have cared for in the past who may fit the description of someone suffering with medically unexplained somatic symptoms?

Have participants think about how they presented in the non-specialized health setting?

What did the participant do to care for them? Did it help?

Ask a few participants to share their reflections and facilitate a brief discussion (limit this discussion to five minutes).

## Summary of common presentations

People with other significant mental health complaints may present with:

- Symptoms of depression not amounting to depression.
- Acute stress.
- PTSD.
- Bereavement.
- Medically unexplained somatic symptoms.

Summarize the common presentations of people with other significant mental health complaints as listed in the slide.

It is important to ensure that another priority MNS condition is not present.

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# Session 2.

# Assessment of other significant mental health complaints

 1 hour

Participants will be introduced to the principles and steps involved in assessing a person for other significant mental health complaints. They will watch a video of a person being assessed and use the mhGAP-IG Version 2.0 to follow the assessment and discuss how the health-care provider conducted the assessment.

## Assessing someone with other significant mental health complaints

- They may return to seek help multiple times.
- They may take a lot of time.
- They may insist on tests and medications.
- You may become frustrated.
- Your attempts to help may fail.

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Start this session by explaining that assessing people with other significant mental health complaints can be challenging, especially if they are returning frequently with medically unexplained somatic symptoms.

Talk through the list of challenges listed on the slide.

Facilitate a brief discussion (maximum five minutes) about why people with other significant mental health complaints may behave like this.

## Activity 3: Communication skills: Dos and don'ts

### How to communicate with people with other significant mental health complaints

- Try not to judge the person or yourself.
- Make the person feel welcome and accepted.
- Listen carefully.
- Do not dismiss the person's concerns.
- Acknowledge that the symptoms are real.
- Be conscious of your feelings in case you become frustrated.

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How to communicate with people with other significant mental health complaints.

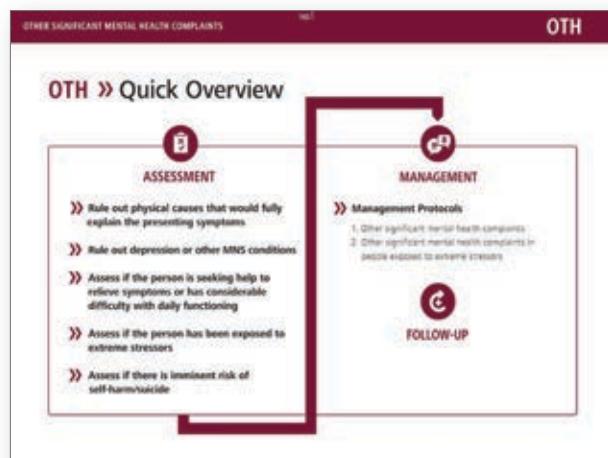
Do the activity before showing the answers on the slide.

**Duration:** 10 minutes maximum.

**Materials:** Flip chart and markers.

#### Instructions:

- Make a two-column table on the flip chart with the headers: DOs, DON'Ts.
- Ask participants to share their thoughts, record their answers (do not record wrong answers), then show the answers on the slide.



Describe the principles of assessing someone for other significant mental health complaints as on the left side of the slide.

## Activity 4: Video demonstration: Assessment

### Activity 4: Video demonstration

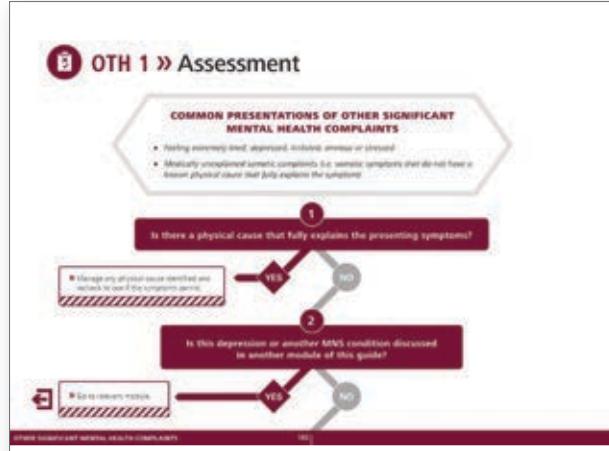
Watch the video of Zeina being assessed for other significant mental health complaints.

Whilst watching the video follow the assessment algorithm on mhGAP-IG Version 2.0 page 143.

Ask participants to watch the video and at the same time to scan the assessment algorithm in the mhGAP-IG Version 2.0 page 143.

<https://www.youtube.com/watch?v=t6EP24FTzn8&index=17&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

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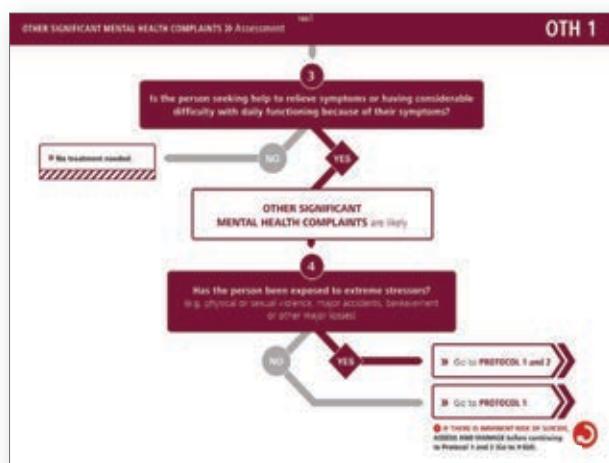
The **first step** is to assess if there is a physical cause that fully explains the presenting symptoms. Ask the participants how the health-care provider explored if there is a physical cause that fully explained Zeina's presenting symptoms?

Explain that:

- The doctor asked Zeina to explain the pain in her own words.
- The doctor looked at previous test results from other doctors.
- The doctor conducted her own routine physical tests.

The **second step** is to assess for another priority MNS condition. Ask participants if they think Zeina could have depression? Or any other priority MNS condition?

If they decide Zeina does not have depression, ask them to explain why they think this is so?



The **third step** is to assess for impact of symptoms on daily functioning. How did the health-care provider assess the impact the symptoms were having on Zeina's ability to function in daily life?

What questions could health-care providers ask to learn more about this?

Explain that participants could ask:

- How are these symptoms impacting on your ability to carry out your daily tasks?
- Are you still able to cook, visit with friends, work, etc?

The **fourth step** is to explore exposure to extreme stressors. How did the health-care provider explore if Zeina had been exposed to extreme stressors?

**Finally**, it is important to ask about plans or thoughts of self-harm/suicide.

Ask the participants, how the health-care provider assessed if Zeina had any plans or thoughts of self-harm/suicide?

# Activity 5: Role play: Assessment after exposure to extreme stressors

## Activity 5: Role play: Assessment

- A woman arrived at the health-care clinic with her children this morning.
- She was brought in by her husband who was complaining that she was "crazy".
- The children looked malnourished and unwell.  
The wife looked sick and tired.
- The health-care provider smelt alcohol on the husband's breath.
- They decided that they wanted to talk to the woman alone so they politely asked the man to wait in the waiting room. They asked a colleague to look after the children and spend time playing with them giving them water and something to eat.
- They were finally able to speak to the woman alone.
- They suspect the woman has been exposed to violence specifically by the husband.
- They are very concerned about the health of the children.

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**Duration:** 30 minutes.

**Purpose:** To enable the participants to practise using the mhgAP-IG to assess and manage people with other significant mental health complaints.

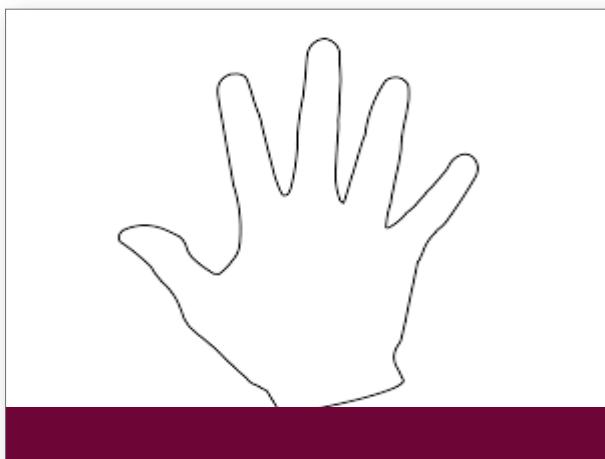
**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Distribute the LIVES intervention (Listen, Inquire, Validate, Enhance safety, Support) to the person playing the health-care provider (see also module: Essential care and practice for details).
- Ensure that the participants keep to the allotted time.

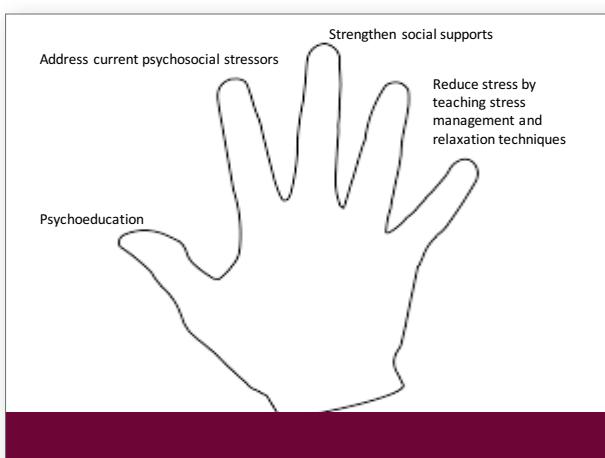
# Session 3.

# Management of other significant mental health complaints

⌚ 1 hour 30 minutes



Ask participants to suggest which management principles they could use to manage a person with other significant mental health complaints?



List the possible interventions as they appear on the hands.

Highlight that there are no pharmacological interventions in mhGAP-IG for the management of other significant mental health complaints.

Explain that for everyone with other significant mental health complaints use Protocol 1 for management.

For people who have been exposed to extreme stressors use Protocols 1 and 2.

## OTH 2 » Management

Direct participants to page 145 mhGAP-IG Version 2.0 (Protocol 1). Read through the first two bullet points in the protocol and facilitate a brief discussion on why it is important not to prescribe anti-anxiety or antidepressant medication.

Why is it important **not** to prescribe vitamin injections?

The answer is on the next slide.

Ask the participants to think back to the video they saw and recall how the health-care provider discussed vitamin injections with Zeina.

Avoid inappropriate medications

- Correct inappropriate **self-medication**.
  - Do not prescribe:
    - antidepressants
    - benzodiazepines
    - placebos
    - irrelevant injections or treatments (e.g. vitamins).
  - These medications can have significant side-effects and contribute to the person's idea of being sick .

Emphasize that some self-medication can lead to dependency (e.g. certain painkillers, benzodiazepines) or cause harm to the person through worsening of symptoms or side-effects.

Explain that vitamin injections work as a placebo and do not help the person get to the root cause of what is happening to them and therefore should not be prescribed either.

The health-care provider should discuss self-medication with the person and deliver appropriate advice.

**Self-medication is typically not advisable.**

Explain that there is a growing body of evidence to show that psychosocial interventions are more effective than medications in managing other significant mental health complaints.

## Protocol 1: Treatment plan



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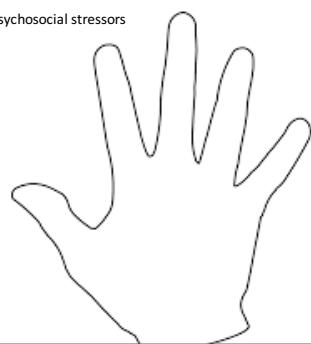
Direct participants to read through the mhGAP-IG Version 2.0 Protocol 1 (page 145) as you discuss the possible interventions. Remind participants **not** to prescribe medications and **not** to prescribe unnecessary vitamin injections and placebos.

In **all** cases address current psychosocial stressors, strengthen social supports and teach stress management.

Move on to the next slide to discuss how to address current psychosocial stressors.

## Protocol 1: Treatment plan

Address psychosocial stressors



40

Direct participants to read through the mhGAP-IG Version 2.0 Protocol 1 (page 145) as you discuss the possible interventions.

## Address current psychosocial stressors

- Offer the person an opportunity to talk in private.
- Ask about current psychosocial stressors – assess and manage the risks of any situation of abuse (domestic violence) and neglect (child neglect).
- Brainstorm together for solutions or for ways of coping/overcoming the stressor.
- Involve supportive family members as appropriate.
- Encourage involvement in self-help and family support groups.

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Talk through the points on the slide.

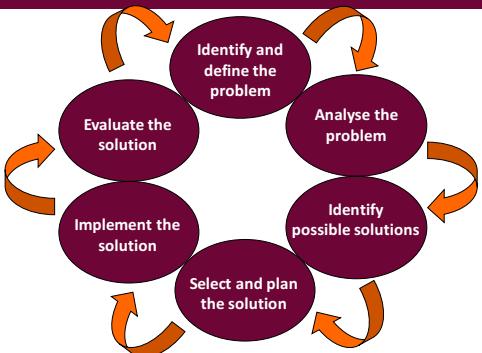
Explain that some psychosocial stressors can be ongoing (e.g. sexual violence, domestic abuse) and sometimes they can help stop it. Problem-solving and relaxation exercises should be tried and strengthening social supports may also help reduce suffering.

Explain that providing assistance with current psychosocial stressors may help to relieve some of the symptoms.

Explain that the health-care worker should involve community services and resources as appropriate (e.g. with the person's consent). It may be necessary and appropriate to contact legal and community resources (e.g. social services, community protection networks) to address any abuse (e.g. with the person's consent).

Ask the group if there are trustworthy, accessible services or protection mechanisms for child abuse and neglect.

### Problem-solving in six steps



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Remind participants of the problem-solving technique they learned in the Module: Essential care and practice.

Explain that this is a very useful and quick technique that they can use to support people to address many psychosocial stressors.

## Activity 6: Addressing psychosocial stressors

### Activity 6: Addressing psychosocial stressors

- Individually or in pairs ask participants to think of the case scenarios they wrote about at the beginning of the session.
- Apply the problem-solving strategy discussed in Module: Essential care and practice.

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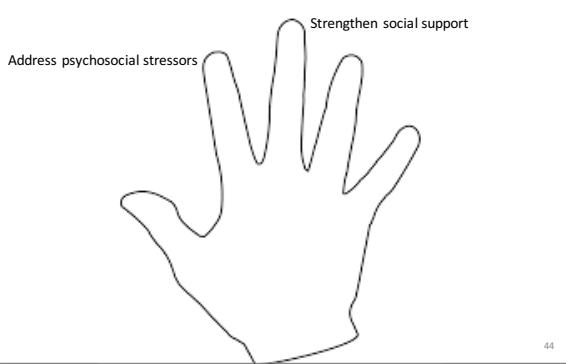
**Duration:** 45 minutes.

**Purpose:** To enable participants to practise using the problem-solving technique to address psychosocial stressors.

**Instructions:**

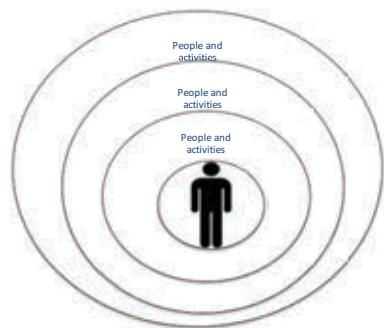
- Individually or in pairs ask participants to think of the case scenarios they discussed earlier in this session.
- If they struggle to remember then hand out some of the case scenarios for people to use.
- Ask them to identify a psychosocial stressor that person is facing.
- Once they have identified a psychosocial stressor give them five minutes to apply the first four steps of problem-solving to that problem:
  1. Identify and define the problem.
  2. Analyse the problem.
  3. Identify possible solutions.
  4. Select and plan the solution.
- Stop the participants at this point. Using a flip chart/white/black board. Explain that when participants are planning the solution they must ensure that the plans are:
  - Specific: What exactly does the solution hope to achieve?
  - Measurable: What will you see, feel, experience when you reach your goal?
  - Achievable: Is this realistic – can the solution actually happen?
  - Relevant: Is this solution relevant to you? Is this what you want?
  - Timed: When are you going to implement these plans?
- Give participants another 10 minutes to plan their solutions.
- Ask a few participants to share their solutions with the rest of the group.

## Protocol 1: Treatment plan



Alongside addressing current psychosocial stressors, it is important to help the person strengthen social supports.

## Strengthening social supports



Remind participants of the strengthening social supports activity from the Module: Essential care and practice.

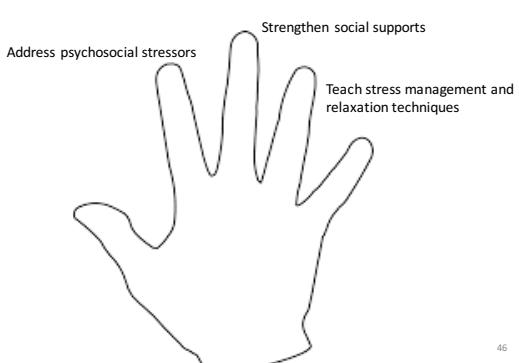
This is an example of what a social support mapping may look like.

Ask the participants to use the same case scenario as they did for the problem-solving activity (Activity 6).

Ask participants to explain a brief activity they could use to support a person increase their social supports?

Remind them of the technique they practised in the Module: Essential care and practice.

## Protocol 1: Treatment plan



Alongside addressing current psychosocial stressors and strengthening social supports, it is important to teach individuals stress management and relaxation techniques.

## Activity 7: Relaxation and stress management

## Activity 7: Relaxation and stress management

Practise using relaxation techniques discussed in the mhGAP-IG Version 2.0 (Box 1, page 149).



**Duration:** 20 minutes.

**Purpose:** To have participants practise using different relaxation techniques and support them to find techniques that they feel comfortable with and find helpful.

## Instructions:

- Explain that using breathing and relaxation techniques are short and effective interventions that anyone can use anywhere.
  - Explain that working in non-specialized health settings is a very stressful job and there are probably many moments throughout the day when they find themselves feeling very stressed and unable to cope.
  - If that happens, encourage the participants to use these breathing/relaxation activities on themselves and learn how beneficial they can be.
  - Practise using the relaxation exercise on page 149 mhGAP-IG Version 2.0 (Box 1) in plenary.

## Protocol 1: Treatment plan



Use psychoeducation to explain what you are doing at every stage of the treatment plan.

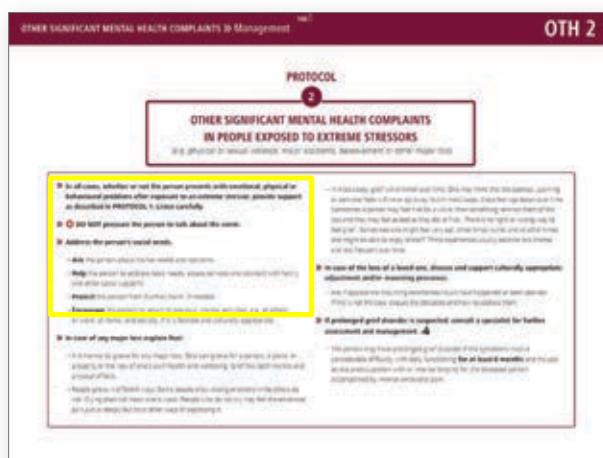
Instruct participants to continue reading the instructions on page 145 of mhGAP-IG Version 2.0.

Psychoeducation is particularly important when managing physical conditions and somatic complaints with no physical cause.

In such cases it is important to:

- Avoid ordering more laboratory or other investigations unless there is a clear medical reason.
  - In case further investigations are ordered anyway ensure that you reduce any unrealistic expectations that the person may have and prepare them for the fact that the test results may be normal.

- Support the person to understand that no serious physical condition has been identified, which is a good thing, remember to communicate that even though there is no physical condition there are still psychosocial interventions that can help.
- If the person insists on more tests gently explain that running unnecessary tests can potentially cause the person harm and create worrying side-effects.
- It is important to acknowledge that the symptoms are not imaginary and that it is still important to address symptoms that cause significant distress.
- Ask the person for their own explanation of the cause and the symptoms and listen to their concerns. This can give you clues about the source of the distress and how the person is understanding what is happening to them. Build a supportive and trusting relationship with the person.
- Explain that emotional suffering/stress often involves the experience of bodily sensations, such as stomach aches, muscle tension, etc. Ask the person about potential links between psychological distress and physical distress.
- Encourage the person to engage in daily activities
- Remember to address current psychosocial stressors, strengthen social support and relaxation techniques.



Direct participants to page 146 in the mhGAP-IG Version 2.0 (Protocol 2). Emphasize that if a person has been exposed to an extreme stressor you will follow Protocols 1 and 2.

It is essential **not** to pressure the person to talk about the potentially traumatic event. If they want to talk about it then you can listen but do not force them to talk.

Explain that the first steps are to:

#### **Ask about social needs:**

Ensure that the person's social needs – ensure that they have access to food, shelter, safety, clothes, water and all the basics that a person requires to survive.

#### **Help:**

If they do not have their basic needs met, then link them with agencies and people that can help them and ensure that those needs are met.

#### **Protect:**

Make sure that the person is safe. Talk with them about where they feel safe, discuss risk plans, telephone numbers they can call and link them with family members, other organizations, etc. than can help ensure they are not exposed to more harm.

#### **Encourage:**

Talk to them about the importance of trying to engage with their normal activities as a way of making them feel better; keeping to a routine and/or engaging with other people, being distracted by work and school, all of these things are important for the person.



Direct participants to page 146. In case of the loss of a loved one, discuss and support culturally appropriate adjustments and/or mourning processes.

Ask participants to brainstorm ways that they could support a person to mourn?

How could they make it culturally appropriate?



Ask a different volunteer to read out the steps to manage a person in the case of reactions to exposure to a potentially traumatic event.

Highlight that they should refer to a mental health specialist for PTSD, if available.

Answer any queries the participants may have about Protocol 2.

## Activity 8: Role play: Assessment and management

### Activity 8: Role play: Assessment and management

- Ms Wafica is a 55-year-old woman who presents asking for medication for her backache.
- The results of the physical examination were entirely normal.
- She has been coming in a lot lately with physical symptoms that do not seem to have a cause, and the health-care provider suspects there might be an other significant mental health complaint.
- She is living alone now, as her daughter recently moved out, and she has felt very lonely at times.

53

**Duration:** 30 minutes.

**Purpose:** To practise performing assessment and management for other significant mental health complaints specifically.

**Scenario:**

Ms Wafica is a 55-year-old woman who presents asking for medication for her backache. The results of the physical examination were entirely normal.

She has been coming in a lot lately with physical symptoms that do not seem to have a cause, and the health-care provider suspects there might be an other significant mental health complaint.

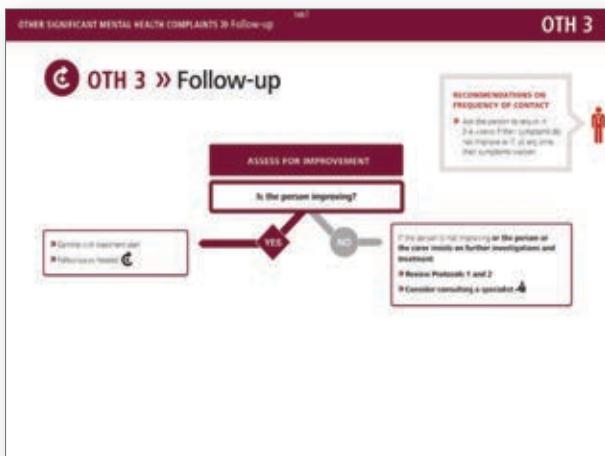
She is living alone now, as her daughter recently moved out, and she has felt very lonely at times.

**Instructions:**

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

# Session 4. Follow-up

⌚ 10 minutes



Ask a participant to read out loud the assessment algorithm.

Ask participants to reflect on how they would react if the person insists on further tests and investigations.

## Follow-up

- Regular follow-up is essential.
- The person may have an as yet undiagnosed disorder.
- The person may need referral if things are not improving.
- Regular follow-up helps the person feel secure and may reduce presentations to your clinic.
- Regular follow-up builds trust.

Emphasize that it is important that participants follow-up with the person even if they did not prescribe medication.

Feeling cared for and accepted can help the person.

It is not failure if the symptoms do not improve.

You can help the person by simply showing understanding and building trust.

## What would you do at follow-up?

- Ask about well-being and symptoms.
- Explore psychosocial stressors.
- Discuss problems and brainstorm for solutions.
- Link with other available support resources.
- Assess progress and refer as needed.

**Refer:** If there is no improvement **or** if the person or family asks for more intense treatment then refer to mental health specialist if available.

Ask for ideas from the participants about what to do at follow-up before revealing the answer.

56

# Session 5. Review

 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

**Purpose:** To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

**Instructions:**

- Administer the other MCQs (see OTH supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# OTH PowerPoint slide presentation



**PowerPoint slide presentation available online at:**

[http://www.who.int/mental\\_health/mhgap/oth\\_slides.pdf](http://www.who.int/mental_health/mhgap/oth_slides.pdf)

## OTH supporting material

- Role plays
- LIVES intervention
- Case scenarios
- Alternative relaxation exercises
- Multiple choice questions
- Video link

Activity 4: mhGAP OTH module – assessment, management and follow-up

<https://www.youtube.com/watch?v=t6EP24FTzn8&index=17&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>



**Supporting material available online at:**

[www.who.int/mental\\_health/mhgap/oth\\_supporting\\_material.pdf](http://www.who.int/mental_health/mhgap/oth_supporting_material.pdf)

# ToHP training forms

**mhGAP training of health-care providers  
Training manual**



# Contents

## ToHP training forms

- Training needs assessment form
- Pre- and post- test
- Multiple choice questions
- Competency assessment form
- Evaluation form

# Training needs assessment form

Training needs assessment			
Location of training:	Contact person:		
<b>Please identify which of the following sources were used to complete this form:</b>			
<input type="checkbox"/> WHO/UN sources of information <input type="checkbox"/> National sources of information <input type="checkbox"/> Other published literature <input type="checkbox"/> Review of adverse events <input type="checkbox"/> Audit reviews	<input type="checkbox"/> Review of hospital admissions data <input type="checkbox"/> Discussion with management <input type="checkbox"/> Discussion with staff <input type="checkbox"/> Discussion with patients <input type="checkbox"/> Other: .....		
<b>Target population</b>			
Which MNS conditions should be managed in non-specialized health settings? (as per national level protocols and guidelines or discussions with stake holders):			
<input type="checkbox"/> Essential care and practice <input type="checkbox"/> Depression <input type="checkbox"/> Psychoses <input type="checkbox"/> Epilepsy <input type="checkbox"/> Child and adolescent mental and behavioural disorders	<input type="checkbox"/> Dementia <input type="checkbox"/> Disorders due to substance use <input type="checkbox"/> Self-harm/suicide <input type="checkbox"/> Other significant mental health complaints		
<b>Local Resources</b>			
Which medications are available in this area?			
<input type="checkbox"/> Acamprosate <input type="checkbox"/> Amitriptyline* <input type="checkbox"/> Benzhexol <input type="checkbox"/> Biperiden* <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Carbamazepine* <input type="checkbox"/> Chlorpromazine* <input type="checkbox"/> Cholinesterase inhibitors	<input type="checkbox"/> Clonidine <input type="checkbox"/> Diazepam* <input type="checkbox"/> Disulfiram <input type="checkbox"/> Fluoxetine* <input type="checkbox"/> Fluphenazine* <input type="checkbox"/> Haloperidol* <input type="checkbox"/> Lithium* <input type="checkbox"/> Lofexidine	<input type="checkbox"/> Methadone* <input type="checkbox"/> Methylphenidate <input type="checkbox"/> Midazolam* <input type="checkbox"/> Morphine* <input type="checkbox"/> Naloxone* <input type="checkbox"/> Naltrexone <input type="checkbox"/> Oxazepam <input type="checkbox"/> Phenobarbitol*	<input type="checkbox"/> Phenytoin* <input type="checkbox"/> Risperidone* <input type="checkbox"/> Sodium Valproate* <input type="checkbox"/> Thiamine* <input type="checkbox"/> .....
What are local prescribing regulations?			
What brief psychological treatments are available?			
Are mental health specialists available locally (i.e. psychiatrists, neurologists, mental health nurses)? Provide names and contact details			
Are other services available where people with MNS conditions can be referred? (i.e. gender-based violence support, financial support, aged-care)			

## Training needs assessment (continued)

### Training resources

What dates are available for training?

How much time is available for training?

How much funding, if any, is available for training?

What facilities are available for training? Includes rooms, electricity, PowerPoint, Wi-Fi etc.

### Health-care providers

What disciplines will attend the training?  
How many from each discipline are expected?

Specialist  
MNS  
providers

Doctors

Nurses

Allied Health

Other

What do the trainees "do" in their work and how will they use this learning?

What knowledge, skills and experiences do the trainees already have in MNS conditions?

### Expectations of training

What are the goals and expectations of the training according to the person(s) who requested it?

What are the trainees' expectations of the training?

## Training needs assessment (continued)

### Supervision

How much time and/or funding will be allocated to supervision after the course?

Who are potential local supervisors?

What is the preferred local supervision model?

### Barriers and enablers

What other potential obstacles may occur before, during or after training?

What other local solutions will help in the provision of the training and supervision?

### Other considerations

Please note anything else relevant to planning the training and supervision

### Conclusions

Dates for course:

Venue:

Modules to be completed:

- |  |   |
|--|---|
| <input type="checkbox"/> Essential care and practice                           | <input type="checkbox"/> Dementia                                   |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Disorders due to substance use             |
| <input type="checkbox"/> Psychoses   | <input type="checkbox"/> Self-harm/suicide                          |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Other significant mental health complaints |
| <input type="checkbox"/> Child and adolescent mental and behavioural disorders | <input type="checkbox"/> ToTS training                              |

Any additional considerations?

## Pre- and post-test

---

1. Which of the following is considered a core effective communication skill? Choose the best answer:
  - A Speaking to the person only and not the carer
  - B Start by listening
  - C Using an open space for safety
  - D Limited eye contact

---
2. Which of the following is consistent with promoting respect and dignity for people with an MNS condition? Choose the best answer:
  - A Making decisions on behalf of a person with an MNS condition, with their best interests in mind
  - B Using correct medical terminology to explain things, even if complicated
  - C Ensuring consent to treatment is received from the carer and/or family
  - D Ensuring privacy in the clinical setting

---
3. Which of the following cluster of symptoms best fits with an episode of depression? Choose only one answer:
  - A Marked behavioural change, agitated or aggressive behavior, fixed false beliefs
  - B Decline in memory, poor orientation, loss of emotional control
  - C Inattentive, over-active, aggressive behavior
  - D Low energy, sleep problems, and loss of interest in usual activities

---
4. Which of the following is a good combination treatment for depression?
  - A Vitamin injections and increasing exercise
  - B Psychosocial interventions and an antidepressant
  - C An antipsychotic medication and a mood stabilizer
  - D Hypnotherapy and relaxation

---
5. Which of the following cluster of symptoms fits best with an acute manic episode? Choose only one answer:
  - A Confusion, disorientation to time, place and person, marked functional decline
  - B Admits to consuming alcohol, has slurred speech and uninhibited behavior
  - C Has recently stopped taking regular benzodiazepines, and presents with agitation, sweating and poor sleep
  - D Decreased need for sleep, increased activity and reckless behaviour

---
6. Which of the following statements concerning psychosis and bipolar disorder is correct? Choose the best answer:
  - A People with psychosis or bipolar disorder do not need evaluation for medical conditions
  - B People with psychosis or bipolar disorder are best cared for with long-term hospitalization
  - C People with psychosis or bipolar disorder are unlikely to be able to work or contribute to society
  - D People with psychosis or bipolar disorder are at high risk of stigmatization and discrimination

- 
7. Which of the following is part of a psychosocial intervention in psychoses? Choose the best answer:
- A Encourage participation in daily activities but recommend against work or serious relationships as they may be too stressful
  - B Discuss with the carer and family whether long-term institutionalization may be appropriate
  - C Provide psychoeducation, especially to avoid sleep deprivation, stress, and drugs and alcohol
  - D Discuss with the carer different ways that they might be able to challenge the delusions of the person
- 
8. Which of the following statements concerning epilepsy is correct? Choose the best answer:
- A Epilepsy is a communicable disorder of the brain
  - B Epilepsy is a sign of spirit possession
  - C Epilepsy is always genetic in cause
  - D Epilepsy is one of the most common neurological disorders
- 
9. Which of the following requires emergency medical treatment? Choose the best answer:
- A When someone starts to feel that a seizure is imminent
  - B If the seizure lasts for more than 1 minute
  - C If the seizure lasts for more than 5 minutes
  - D If the person is drowsy once the seizure is over
- 
10. Which of the following is the best description of a child developmental disorder? Choose only one answer:
- A Child developmental disorders have a relapsing and remitting course
  - B Child developmental disorders are always associated with abuse and neglect
  - C Child developmental disorders category includes attention deficit hyperactivity disorder and conduct disorder
  - D Child developmental disorders involve impaired or delayed functions related to central nervous system maturation
- 
11. Which of the following is good advice for any child and adolescent mental and behavioural disorder? Choose the best answer:
- A The carer can use threats or physical punishment if a child has problematic behaviour
  - B The carer should remove the child from mainstream school as soon as possible
  - C The carer can use other aids such as television or computer games instead of spending time with the child
  - D The carer should give loving attention to the child every day and look for opportunities to spend time with them

---

12. Which of the following is the best first-line treatment for child and adolescent developmental disorders? Choose only one answer:

- A Psychosocial intervention
  - B Pharmacological treatment
  - C Referral to specialist
  - D Referral to outside agency
- 

13. Which of the following should be given as advice to an adolescent with a mental or behavioural disorder? Choose the best answer:

- A They should avoid community and other social activities as much as possible
  - B They should avoid the use of drugs, alcohol and nicotine
  - C They should avoid school if it makes them anxious
  - D They should avoid being physically active for more than 30 minutes each day
- 

14. Which of the following is a common presentation of dementia? Choose the best answer:

- A Low mood and loss of enjoyment in usual activities
  - B Fixed false beliefs and hearing voices
  - C Excessive activity and inattention
  - D Decline or problems with memory and orientation
- 

15. Which of the following is a common presentation of dementia? Choose the best answer:

- A Severe forgetfulness and difficulties in carrying out usual work, domestic or social activities
  - B Drowsiness and weakness down one side of the body
  - C Fluctuating mental state characterized by disturbed attention that develops over a short period of time
  - D Low mood in the context of major loss or bereavement
- 

16. Which of the following is the best description of dementia? Choose only one answer:

- A Dementia can have a large impact on the person, their carer, family and society at large
  - B Dementia can be cured through pharmacological interventions
  - C Dementia does not interfere with activities of daily living, such as washing, dressing, eating, personal hygiene and toilet activities
  - D Dementia is a normal part of aging
- 

17. Which of the following statements best describes treatment options in dementia? Choose only one answer:

- A All people with dementia should have access to pharmacological interventions, regardless of specialist availability
- B Pharmacological interventions, if started early enough, can cure dementia
- C With early recognition and support, the lives of people with dementia and their carers can be significantly improved
- D Psychosocial interventions for dementia should only be provided by a specialist, due to their complexity

---

18. Which of the following best describes symptoms of substance dependence? Choose only one answer:

- A Sedation, unresponsiveness, pinpoint pupils following use
  - B Current thoughts of suicide, bleeding from self-inflicted wound, extreme lethargy
  - C Strong cravings, loss of control over substance use, withdrawal state upon cessation of use
  - D Intravenous drug use once per month, but violent towards others when using
- 

19. Which of the following illnesses should you screen for in people who inject opioids? Choose the best answer:

- A HIV and hepatitis
  - B Wernicke's encephalopathy
  - C Epilepsy
  - D Thyroid disease
- 

20. Which of the following should you tell the carer of someone who has had an episode of self-harm or a suicide attempt? Choose the best answer:

- A Medication will be made available so that they can keep the person sedated
  - B Restrict the person's contact with family, friends and other concerned individuals in case it is too overwhelming
  - C Remove access to any means of self-harm and try and provide extra supervision for the person
  - D Forced vomiting is an emergency treatment option if they suspect any self-harm or suicide
- 

21. Which of the following is part of a psychosocial intervention where the person seeking help witnessed the death of a loved one to violence? Choose the best answer:

- A They should talk about the incident as much as possible, even if they do not want to
- B It is normal to grieve for any major loss, in many different ways, and in most cases grief will diminish over time
- C Avoid discussing any mourning process, such as culturally-appropriate ceremonies/rituals, as it may upset them further
- D Refer to a specialist within one week of the incident if they are still experiencing symptoms

---

22. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Bereavement

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

Emmanuel is a 20 year-old man who is brought to your clinic by his friends. They are very worried about him because he is afraid that the government are monitoring him, and keeps saying that he can hear people talking about him. When you ask them for more information, they say that he has not been himself for several months, at times does not make sense, and has not been coming to university much. He is about to fail the semester. There is nothing remarkable on physical history, examination or blood tests, and his urine drug screen is negative.

When you speak to him, he seems suspicious of you, does not make a lot of sense, and does not think that there is anything wrong with him. He wants to leave, and starts to become quite aggressive when you ask him to stay, saying that he is unsafe here and people are watching him.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Cara is a 17 year-old woman who is brought in by her family after having a period of shaking, rigidity and incontinence at home. She is currently confused and drowsy and does not know where she is. She reports she has always been happy and healthy, did well at school but left last year to start working, which is also going well. She is worried that she has been possessed by a spirit.

When you speak to Cara, she is still not sure what has happened and why she is in hospital. She complains of weakness down one side of her body and feeling sore all over.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Marc is a 14 year-old boy who is referred to you by his school teacher. The teacher tells you that Marc has always gotten into trouble at school as he is very disruptive to the other students. He does not seem to be able to concentrate for very long. The teacher wants you to see him in case there is something that can be done.

You meet with Marc, who does not want to sit still to talk to you. In the brief time that you talk he tells you that he hates school and finds it boring. In your assessment you do not think that he is depressed, or that he has any delusions or hallucinations. He denies using any substances. A physical examination is normal.

You meet with Marc's parents, who tell you that they have had trouble with Marc for years. He can never sit still when they take him somewhere, such as church or a friend's house, he is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

## Pre- and Post-Test Answer Key

- |        |        |         |         |                                 |         |         |        |
|--------|--------|---------|---------|---------------------------------|---------|---------|--------|
| 1. = B | 7. = C | 13. = B | 19. = A | 22. A = II<br>B = III<br>C = IV | 12. = A | 18. = C | 6. = D |
| 2. = D | 8. = D | 14. = D | 20. = C | 10. = D                         | 16. = A | 17. = C | 5. = D |
| 3. = D | 9. = C | 15. = A | 21. = B | 11. = D                         | 18. = C | C = IV  |        |
| 4. = B |        |         |         |                                 |         |         |        |

# Multiple choice questions

---

1. 42-year-old man presents with gastrointestinal problems and low energy. On examination, there is no cause for his physical symptoms, but he also reports low mood, not sleeping or eating properly, and not enjoying time with his family as much as he used to, over a two-month period.

Which is the most likely condition?

- A Depression
  - B Epilepsy
  - C Dementia
  - D Other significant mental health complaints
- 

2. A 31-year-old woman is brought in by her husband. He reports she has not been sleeping for the last two weeks, has been talking very fast and spending lots of money. On review, she is irritable, and tells you she is writing a book that will make her famous. You perform a physical examination and blood tests, which are normal. She tells you she does not use drugs or alcohol, and her husband agrees with that. Her last menses was two weeks ago.

Which is the most likely condition?

- A Alcohol Intoxication
  - B Mania
  - C Complication of early pregnancy
  - D Epilepsy
- 

3. A 49-year-old man is being treated at your clinic. Unexpectedly he collapses and starts having convulsive movements, which last about 30 seconds. Afterwards he seems drowsy, and starts complaining that he has a headache. As far as you know, he is otherwise well, does not have any complications.

Which is the most likely condition?

- A Psychosis
  - B Disorder due to substance use
  - C Epilepsy
  - G Dementia
- 

4. A six-year-old girl is seen in your clinic. Her parents have brought her in as they are worried about her. She has not been able to start school, as she does not talk, and her mother has to help her with all her eating, dressing and self-care. When you ask about her younger years, her father tells you that she only learned to walk much later than her brothers and sisters, and does not interact with other children her own age.

Which is the most likely condition?

- A Developmental disorder
- B Behavioural disorder
- C Emotional disorder
- D Psychosis

- 
5. A 63-year-old man is brought in by his daughter who is worried about him. He was always a very quiet and kind man, but lately seems more irritable and is having uncontrollable emotional outbursts. He seems to be more forgetful than usual. She tells you that he has never had any depression and is otherwise healthy. When you talk to him you do not think he has any hallucinations or delusions, although he does not know what the date is.

Which is the most likely condition?

- A Depression
  - B Psychoses
  - C Epilepsy
  - D Dementia
- 

6. A 33-year-old woman presents to the clinic in an agitated state, with dilated pupils, raised pulse and blood pressure, and recent injection marks on her arms. She is behaving strangely, is erratic, pacing, and looking around the room. You met her one week ago in the clinic when she asked for screening for HIV. At the time she was otherwise healthy, logical in conversation and denied any history of an MNS condition. She will not tolerate a long review with you, but you do not think there are any hallucinations or delusions and her brief physical examination was normal.

What is the most likely condition?

- A Psychoses
  - B Stimulant intoxication
  - C Opioid overdose
  - D Epilepsy
- 

7. A 24-year-old woman is brought into your clinic by family with reduced consciousness and trouble breathing. Her family states they observed her having a seizure earlier, at which point they realized she had consumed pesticides that they had available on their farm. They tell you she has not seemed herself since her engagement ended four months ago. She is sleeping a lot, always crying and not helping out as much on the farm.

Which two conditions are the most likely?

- A Epilepsy and depression
  - B Depression and other significant mental health complaint
  - C Self-harm/suicide and depression
  - D Self-harm/suicide and psychosis
- 

8. A 42-year-old man presents to your clinic after the death of his wife and child one week earlier. His friends are worried as he has suddenly lost the ability to walk properly, and he seems tired and depressed. You do a physical examination and find that his medical symptoms cannot be explained by any physical conditions. Further investigation is also normal, and you are convinced that there is no physical cause for his symptoms. His friends say that up until the deaths he was happy and cheerful, worked every day and had no health concerns.

Which is the most likely diagnosis?

- A Depression
- B Epilepsy
- C Dementia.
- D Bereavement.

---

9. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Post-traumatic stress disorder

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

John is a 72-year-old man who has come to see you for low mood. On review, he also tells you that he has not been sleeping properly, and he also thinks he has lost some weight. These symptoms have been going on for about four to five months. He denies any delusions, hallucinations or history of mania. He has not had any trouble with his memory, but you test it anyway, and find it is in the normal range. A physical examination and basic blood tests are normal.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Rashida is a 69-year-old woman who comes to see you with her husband. He is worried that she is not well. He reports that she seems to forget and lose things. Once he came home from work and she was not there, and he found her wandering around the neighbourhood looking lost. She used to always dress immaculately, but lately is not looking after herself as much. When you ask Rashida, she tells you there is nothing wrong, she is fine and certainly "not depressed or mad". You test her memory, and she does not know the current date, or the dates of her children's birthdays.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Sebastian is a 61-year-old man whom you normally treat for diabetes. You have noticed on several occasions over the past two years that he seems to smell of alcohol and is unsteady on his feet. You know that he has not been able to keep a job for a long time, even though he would like to still be working, and his wife left him one month ago. At the time, you assessed him for depression or dementia but you did not think he had either of those, and his mental state has not changed since that review. On today's review, you examine him for complications for diabetes, and notice he has signs of chronic liver disease, including jaundiced skin and ascites.

---

10. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Bereavement

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

Emmanuel is a 20-year-old man who is brought to your clinic by his friends. They are very worried about him because he is afraid that the government are monitoring him, and keeps saying that he can hear people talking about him. When you ask them for more information, they say that he has not been himself for several months, at times does not make sense, and has not been coming to university much. He is about to fail the semester. There is nothing remarkable on physical history, examination or blood tests, and his urine drug screen is negative. When you speak to him, he seems suspicious of you, does not make a lot of sense, and does not think that there is anything wrong with him. He wants to leave, and starts to become quite aggressive when you ask him to stay, saying that he is unsafe here and people are watching him.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Cara is a 17-year-old woman who is brought in by her family after having a period of shaking, rigidity and incontinence at home. She is currently confused and drowsy and does not know where she is. The family reports she has always been happy and healthy, did well at school but left last year to start working, which is also going well. The family are worried that she has been possessed by a spirit. When you speak to Cara, she is still not sure what has happened and why she is in hospital. She complains of weakness down one side of her body and feeling sore all over.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Marc is a 14-year-old boy who is referred to you by his school teacher. The teacher tells you that Marc has always been into trouble at school as he is very disruptive to the other students. He does not seem to be able to concentrate for very long. The teacher wants you to see him in case there is something that can be done. You meet with Marc, who does not want to sit still to talk to you. In the brief time that you talk he tells you that he hates school and finds it boring. In your assessment, you do not think that he is depressed, or that he has any delusions or hallucinations. He denies using any substances. A physical examination is normal. You meet with Marc's parents, who tell you that they have had trouble with Marc for years. He can never sit still when they take him somewhere, such as church or a friend's house, he is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

## Multiple choice questions answers

- |                  |                 |                  |                      |
|------------------|-----------------|------------------|----------------------|
| 1. = A<br>A = i  | 5. = D<br>B = V | 9. = D<br>C = Vi | 4. = A<br>B = III    |
| 2. = B<br>B = V  | 6. = B<br>B = V | 7. = C<br>C = vi | 10. A = II<br>C = iv |
| 3. = C<br>C = VI |                 |                  |                      |

		Needs work	Achieved	N/A
<b>Competency assessment</b> (Only use competencies which apply to task)				
<b>1. Promote respect and dignity</b>				
Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner				
Promote inclusion and collaborative care of people with MNS conditions and their carers				
Protect the confidentiality and consent of people with MNS conditions				
<b>2. Know common presentations</b>				
Know common presentations of priority MNS conditions				
Know other symptoms that may present as part of priority MNS conditions				
<b>3. Know assessment principles</b>				
Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history				
Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition				
Name two or three key points under each of the assessment principles for MNS conditions				
<b>4. Know management principles</b>				
Understand importance of integrating care for priority MNS conditions into primary practice				
Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations				
Name one or two key points under each of the management principles of priority MNS conditions				
<b>5. Use effective communication skills</b>				
Create an environment that facilitates open communication in priority MNS conditions				
Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions				
Actively listen to the person with an MNS condition				
Is friendly, respectful and non-judgemental at all times in interactions with a person with an MNS condition				
Use good verbal communication skills in interactions with a person with an MNS condition				
Respond with sensitivity when people with MNS condition disclose difficult experiences				
<b>6. Perform assessment</b>				
Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history				
Consider and exclude other conditions to priority MNS conditions				
Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions				
Consider other concurrent conditions, both MNS and physical conditions				
<b>7. Assess and manage physical conditions</b>				
Understand importance of assessing physical health in assessment for priority MNS conditions				
Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions				
Perform a physical examination and investigations for priority MNS conditions, as appropriate and available				
Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions				

	Needs work	Achieved	N/A
<b>Competency assessment</b> <i>(Only use competencies which apply to task)</i>			
<b>8. Assess and manage emergency presentations</b>			
Recognize emergency presentations of priority MNS conditions			
Perform emergency assessment of priority MNS conditions, including risk-assessment			
Manage emergency presentation of priority MNS conditions using non-pharmacological interventions			
Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available			
<b>9. Provide psychosocial interventions</b>			
Perform psychoeducation, including about the priority MNS condition and treatment available			
Address current psychosocial stressors to reduce stress and strength social supports, as appropriate for the priority MNS condition			
Promote functioning in daily activities, as appropriate to the priority MNS conditions			
Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate			
Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)			
<b>10. Deliver pharmacological interventions as needed and appropriate</b>			
Identify if there is a need for medication in priority MNS conditions			
Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence			
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available			
Consider needs of special populations when prescribing for priority MNS conditions			
Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped			
<b>11. Plan and perform follow-up</b>			
Understand importance of follow-up for priority MNS conditions			
Know when and how to plan for follow-up for priority MNS conditions			
Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition			
Manage crisis presentations and deviations from treatment plan in priority MNS conditions			
<b>12. Refer to specialist and link with outside agencies</b>			
Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available			
Link with other services and outside agencies for priority MNS conditions, as appropriate and available			

## OVERALL

**Areas of strength:**

**Areas for improvement:**

# Evaluation forms

Participant feedback form for each module				
Date of training:	Location of training:			
Name of facilitator(s):				
<b>The name of the training module (check only one):</b>				
<b>Training of health-care providers</b>	<b>Training of trainers and supervisors</b>			
<input type="checkbox"/> Essential care and practice <input type="checkbox"/> Depression <input type="checkbox"/> Psychoses <input type="checkbox"/> Epilepsy <input type="checkbox"/> Child and adolescent mental and behavioural disorders <input type="checkbox"/> Dementia <input type="checkbox"/> Disorders due to substance use <input type="checkbox"/> Self-harm/suicide <input type="checkbox"/> Other significant mental health complaints	<input type="checkbox"/> Welcome and introduction <input type="checkbox"/> Implementation of mhGAP-IG <input type="checkbox"/> Introduction to mhGAP training <input type="checkbox"/> Preparing and evaluating a training course <input type="checkbox"/> Teaching skills (specify: ..... ) <input type="checkbox"/> Competency assessment and feedback <input type="checkbox"/> Participant facilitation exercise (specify: ..... ) <input type="checkbox"/> Supervision: Theory and technique <input type="checkbox"/> Supervision: Practical			
<b>Please rate the following:</b>	<b>Poor</b>	<b>Average</b>	<b>Excellent</b>	<b>Additional comments</b>
Quality of content and information – was it relevant, well-researched and organized?	1	2	3	
Quality of slides and handouts – were they easy to read and helpful in learning?	1	2	3	
Quality of trainer – were they engaging, enthusiastic and informed?	1	2	3	
Quality of activities/role plays and clarity of instructions	1	2	3	
Length of module – was it too long, too short or just right?	1	2	3	
Number of opportunities for active participation – too many, too few or just right?	1	2	3	
How confident do you now feel about using what you have learned in this module?	1	2	3	
<b>Overall quality of this module</b>	1	2	3	
<b>What was best about this module?</b>				
<b>What did you learn from this module that you anticipate using again?</b>				
<b>What would you suggest to improve this training module?</b>				

## Trainer feedback form for each module

Date of training:	Location of training:			
Name of facilitator(s): .....				
<b>The name of the training module (check only one):</b>				
<b>Training of health-care providers</b> <input type="checkbox"/> Essential care and practice <input type="checkbox"/> Depression <input type="checkbox"/> Psychoses <input type="checkbox"/> Epilepsy <input type="checkbox"/> Child and adolescent mental and behavioural disorders <input type="checkbox"/> Dementia <input type="checkbox"/> Disorders due to substance use <input type="checkbox"/> Self-harm/suicide <input type="checkbox"/> Other significant mental health complaints		<b>Training of trainers and supervisors</b> <input type="checkbox"/> Welcome and introduction <input type="checkbox"/> Implementation of mhGAP-IG <input type="checkbox"/> Introduction to mhGAP training <input type="checkbox"/> Preparing and evaluating a training course <input type="checkbox"/> Teaching skills (specify: .....) <input type="checkbox"/> Competency assessment and feedback <input type="checkbox"/> Participant facilitation exercise (specify: .....) <input type="checkbox"/> Supervision: Theory and technique <input type="checkbox"/> Supervision: Practical		
Type of staff	Primary care doctors/ GPs	Nurses	Others (please specify)	Additional comments
Number of participants				
<b>Please rate the following:</b>	<b>Poor</b>	<b>Average</b>	<b>Excellent</b>	<b>Additional comments</b>
Amount of content – too much, too little or just right	1	2	3	
Quality of content – was it relevant, well-researched and organized?	1	2	3	
Quality of instructions and notes – were they helpful and easy to read?	1	2	3	
Quality of activities/role plays – were they engaging and helpful in teaching?	1	2	3	
Length of module – did you have too much, too little or just enough time?	1	2	3	
Engagement of participants	1	2	3	
How confident do you feel the objectives were met?	1	2	3	
<b>Overall quality of this module</b>	1	2	3	
<b>What was best about this module? When were the participants most engaged?</b>				
<b>What would you suggest to improve this training module?</b>				

# ToHP participant's logbook

**mhGAP training of health-care providers  
Training manual**



# Contents

## Introduction

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Getting started

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Which form when?

## Clinical resources

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Personal reflection (FORM)

Supervision report and feedback (FORM)

Competency assessment (FORM)

## Notes

## Assessments

General bank of multiple choice questions (with answers)

# Introduction

During the training you receive, your facilitator will explain to you how to use this logbook. It will be your companion throughout the course and after, and has been designed to be an interactive and dynamic document, to facilitate further development of your attitude, knowledge and skills in providing care to people with mental, neurological and substance use (MNS) conditions using the Mental Health GAP Intervention Guide (mhGAP-IG) Version 2.0.

## How to use this logbook

- **Add to it:** During the course, collect any lecture notes, assessments or other handouts to help you revise later. After the course, add any information on priority MNS conditions that you find helpful, and add in any competency assessment forms or other forms you use in supervision.
- **Write on it:** This logbook is designed to be written on. During the course, write down useful local specialists and services, and any new contacts you make. After the course, use the difficult case report form and personal reflection form to prepare for supervision.
- **Practise with it:** This logbook contains multiple choice questions (MCQs), and you will receive role plays as you move through the training. Use these to practise your knowledge and skills, even when the course has finished.
- **Read it:** This will be your unique resource for all things mhGAP-IG. During your clinical practice come back to it to help with difficult cases and situations.

## Getting started

### During the course:

- Add any handouts.
- Add any role plays that you use.
- Add any competency assessment forms that you use.
- Use the MCQs to improve your knowledge.
- Complete the local referral points forms.
- Complete the 12 steps to set up supervision form.

### After the course:

- Use the participant's logbook to supplement the mhGAP-IG in your future practice.
- Refer back to any handouts, role plays and assessment forms.
- Use the treatment plan form to work collaboratively with people with MNS conditions and their carers.
- Use the supervision forms to prepare for supervision.
- Store any forms you receive in supervision.
- Add any additional notes or resources that you find to help use mhGAP-IG.

# Which form should I use?

**Table 1: Summary of the purpose of each form**

Title	Purpose
<b>Clinical resource forms</b>	
Local referral points – clinicians	Complete this form during mhGAP-IG training to compile a list of specialists that you can refer to when treating people with priority MNS conditions.
Local referral points – services	Complete this form during mhGAP-IG training to compile a list of services that you can use and refer to when treating people with priority MNS conditions.
Treatment plan	As per page 11 of the mhGAP-IG Version 2.0, use this form to complete a written treatment plan in collaboration with the person seeking help and their carer. You can also copy this form and keep a copy as notes.
<b>Supervision forms</b>	
12 steps to set up supervision	This form is to help set up supervision. It should be completed with the help of your trainer and/or supervisor at the end of your training course, so that you know your supervision plans.  If no supervisor is allocated, use the form with other peers to create a peer supervision group.
Difficult case report form	This form is for you to prepare for supervision by documenting details of a difficult case you wish to discuss with your supervisor/peer supervision group.
Personal reflection form	This form is for you to prepare for supervision by reflecting on your strengths and weaknesses, and any other difficulties you are having in working with people with MNS conditions. It should be completed once every three to six months.
Supervision report and feedback form	This form is for your supervisor to provide you with feedback. Have a copy ready whenever you are doing the apprenticeship or on-site model of supervision, or if requested by your supervisor for case conference supervision.
Competency assessment form	This form will be used to provide assessment and feedback during the role plays throughout the course, but can also be used to assess your competency through direct observation. Have a copy ready whenever you are doing the apprenticeship or on-site model of supervision, or if requested by your supervisor for case conference supervision.

# Which form when?

Table 2: The time at which different forms should be completed

	During course	End of course	During ongoing supervision and practice			
			Apprenticeship model	On-site supervision	Case conference	Peer supervision
<b>Clinical resource forms</b>						
Local referral points – clinicians	✓					
Local referral points – services	✓					
Treatment plan			✓	✓	✓	✓
<b>Supervision forms</b>						
12 steps to set up supervision		✓				
Difficult case report form				✓	✓	✓
Personal reflection form			✓ (Every 3–6 months)	✓ (Every 3–6 months)	✓ (Every 3–6 months)	✓ (Every 3–6 months, can be done for own reflection)
Supervision report and feedback form					✓ (Supervisors may wish to use this form to give feedback)	
Competency assessment form	✓	✓	✓	✓	✓ (Supervisors may wish to use this form to give feedback)	✓

# Clinical resources

Start completing the local referral points forms during your course, to gather information on local specialists and services.

Use the treatment plan form to provide written treatment plans to persons seeking help and their carers.

Add any other resources you find that will help you clinically.

Local referral points – clinicians			
<b>Psychiatrist/s</b>			
Name	Services offered	Address	Contact details
<b>Mental health nurse/clinician/s</b>			
Name	Services offered	Address	Contact details
<b>Neurologist/s</b>			
Name	Services offered	Address	Contact details
<b>Drug and alcohol clinician/s</b>			
Name	Services offered	Address	Contact details
<b>Other</b>			
Name	Services offered	Address	Contact details
Name	Services offered	Address	Contact details

## Local referral points – psychosocial services

### Mental health services

Name	Services offered	Address	Contact details
------	------------------	---------	-----------------

### Drug and alcohol services

Name	Services offered	Address	Contact details
------	------------------	---------	-----------------

### Gender-based violence services

Name	Services offered	Address	Contact details
------	------------------	---------	-----------------

### Housing services

Name	Services offered	Address	Contact details
------	------------------	---------	-----------------

### Other (legal, employment, refugee etc.)

Name	Services offered	Address	Contact details
Name	Services offered	Address	Contact details

## Treatment plan

Name:	Number/ID:
Date:	Name of health-care provider:
<b>Presenting problem</b> Brief summary of the reason the person is seeking help	
<b>Written treatment plan</b> Pharmacological interventions (if any)	
Psychosocial interventions	
Referrals	
Management of any concurrent physical and/or other MNS conditions	
Crisis plan	
Follow-up plan	
Other	

# Supervision

This section provides an introduction to supervision and the types of models of supervision that can be adopted. Complete the 12 steps to set up supervision form at the end of the course. Use the other forms to help with supervision.

## Introduction to supervision

Supervision should be seen as an essential and ongoing component of mhGAP-IG training. Without supervision, there will not be significant change in attitude, knowledge and skills required to care for people with MNS conditions.

### Goals of supervision

Post-training supervision has many purposes and goals:

- **Clinical:** Ensure fidelity with mhGAP-IG and further develop skills in its use.
- **Administrative:** Address administrative difficulties and monitor a service's overall implementation of mhGAP-IG (e.g. processes, supplies, staffing).
- **Personal growth and support:** Ensure self-care and ongoing commitment, whilst reducing stress and burnout for health-care providers.

### Supervision techniques

There are a number of different methods and skills that can be used in supervision. Table 3 outlines many of these.

Table 3: Supervision techniques and interventions

Supervision techniques	Intervention
Coaching	Supervisor and/or peer/s enhance or build skills of supervisee/s to improve their performance.
Collaboration	Supervisor and/or peer/s work together with supervisee/s to achieve a beneficial outcome in patient care.
Discussion	Based on either direct or indirect observation, or a case presentation, key elements of the case are deliberated with a supervisor and/or peer/s to arrive at the best course of action.
Encouragement	Supervisor and/or peer/s provide support to supervisee/s in difficult cases, particularly by commanding things they have done well in the case, and problem-solving any obstacles or challenges.
Explanation	Supervisor and/or peers clarify aspects of case, skills or knowledge which are not clear.
Feedback	Supervisor and/or peer/s provide honest appraisal of attitudes, knowledge and skills of supervisee, both strengths and weaknesses.
Formulating	Gaining greater depth of understanding of a case by summarizing why this person has presented with this problem at this time.
Goal-setting	Supervisee/s set/s a goal, generally improvement of competency, and works towards this with help of supervisor and/or peer/s.
Guidance	Supervisor and/or experienced peer/s help direct the supervisee/s along correct course of action.
Instruction	Supervisor provides very clear direction on a course of action.
Listening	Supervisor and/or peer/s allow supervisee/s to present a case for discussion.

<b>Supervision techniques</b>	<b>Intervention</b>
Modelling	Supervisor teaches correct behaviour/attitude by demonstrating this in their daily practice.
Monitoring and evaluation	Predetermined areas are measured repeatedly at set intervals to determine progress. Can refer to competencies, treatment outcomes or supervision itself.
Observation (direct or indirect)	Supervisee/s is/are observed whilst interviewing a person seeking help. In direct observation, the supervisor is present at the time of the interview. In indirect observation, the interview is recorded by video or tape and played back to the supervisor and/or peer/s.
Question and answer session	A topic is identified and an opportunity is available to either ask questions of the supervisor to deepen understanding; or for the supervisor to ask questions of the supervisees, to test knowledge.
Problem-solving	When faced with a problem in clinical practice, the supervisor and/or peer/s help identify a number of potential solutions, and work with the supervisee/s to identify the best course of action.
Prompts	The supervisor does not give an answer, but provides clues to the supervisee/s to help them arrive at the correct answer or course of action themselves.
Reflection	In supervision, this is defined as the supervisee considering their own practice, and identifying strengths and areas for improvement. Where available the reflection should be discussed with the supervisor at regular intervals.
Rehearsal of skills	Where a particular skill requires improvement, the supervisor leads the supervisee/s through repeated practice of the skills in a controlled environment (i.e. role play).
Reinforcement/praise	Supervisor and/or peer/s give only positive feedback on something the supervisee/s has done well.
Self-disclosure	Supervisor and/or peer/s share a personal experience of practice that is limited, appropriate and relevant to an issue raised by the supervisee.
Self-monitoring	As per monitoring and evaluation, but conducted by a supervisee on their own practice, rather than performed by the supervisor.
Specific skills training	Where a particular skill requires improvement, the supervisor leads the supervisee/s through the components of the skill.
Summarizing	Salient features of a case either presented by the supervisee for discussion, or repeated by the supervisor to check understanding.
Support	Supervisor and/or peer/s use listening and encouragement to help the supervisee/s, particularly in challenging situations.

### **Supervisee role**

The supervisee (i.e. the health-care provider) will need to be an active participant for supervision to have maximum benefit. Regardless of the method, supervisees should always:

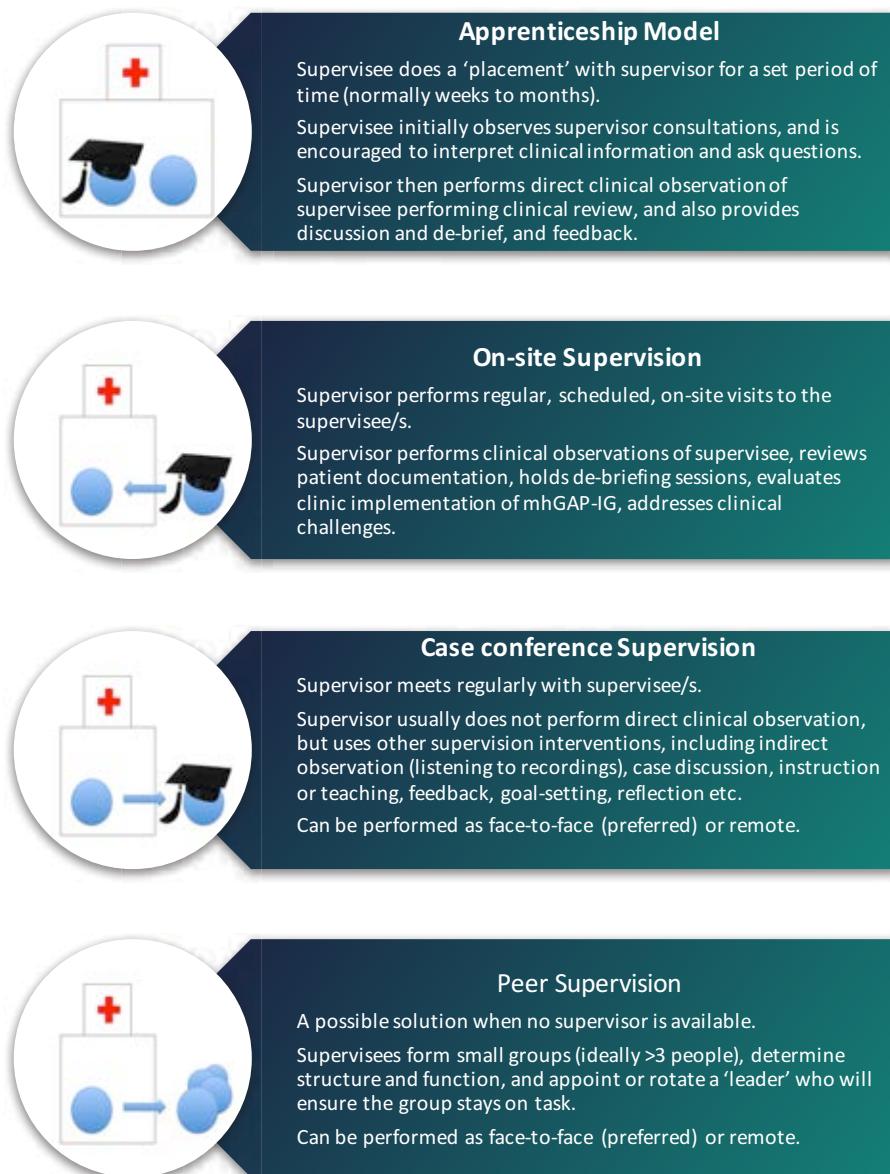
- Be punctual for supervision.
- Adhere to the structure and agenda.
- Be prepared to discuss at least one or two cases you have seen recently, ideally one which has been challenging in some way. Complete and bring the difficult case report form to your supervision.
- Contribute to feedback and discussion on peers' cases in an appropriate and respectful manner.
- Consider other issues you may wish to bring to supervision, e.g. administrative difficulties, stress and anxiety caused by the work.
- Use the personal reflection form at least every three months to review your progress with your supervisor.

Supervision is a chance to receive support for your work, particularly issues which are affecting your work or care, to ensure you are adhering to the mhGAP-IG, and improve the care you provide to people with MNS conditions.

# Models of supervision

There is a model of supervision to suit every context, based on preferences and resources of each setting. Each model of supervision has its own advantages and disadvantages. These are summarized in Figure 1.

Figure 1: Models of supervision



12 Steps to set up supervision		Comments
<b>Who?</b>		
1	Who will be the supervisor? Specialist, peer, clinician with mhGAP-IG experience.	
2	Who will be the supervisees? Aim for a small group (three to eight), consider availability and location.	
<b>What?</b>		
3.	What model of supervision will you use? Apprenticeship/on-site/case conference/peer.	
<b>When?</b>		
4.	When will your supervision occur? Consider whether it is during or after work hours.	
5.	What is the date of your first supervision session?	
6.	How long will your supervision sessions last? One to three hours is an average.	
7.	How frequent will your supervision session last? At least once a month is recommended, starting within four weeks of training completion.	
<b>Where?</b>		
8.	Where will your supervision occur? Will it rotate or be in the same place? Will it be face-to-face or remote?	
<b>How?</b>		
9.	At or before your first session, decide on how the group will function: <ul style="list-style-type: none"><li>• Determine an agenda.</li><li>• Determine which forms you will use, and when.</li><li>• Determine who will "lead" the group to stay on agenda, and whether this person will stay the same or rotate (this is normally supervisor except in peer supervision).</li><li>• Determine who will keep records and be the primary contact person.</li></ul>	
10.	At or before your first session, decide on the "ground rules". <ul style="list-style-type: none"><li>• What is everyone's responsibility in regard to attendance and participation?</li><li>• Should everyone prepare a case for every session, or will it rotate?</li><li>• How will feedback and discussion occur in a constructive and respectful manner?</li></ul>	
11.	Consider what supervision methods and skills you will use (see Table 3). <ul style="list-style-type: none"><li>• Generally, start with direct observation, indirect observation or case discussion.</li><li>• This is likely to prompt other interventions, such as encouragement, guidance, problem-solving, reinforcement, reflection etc.</li><li>• Plan for other interventions such as formulating, rehearsal of skills and specific skills training.</li></ul>	
12.	How will you evaluate supervision and know that it is working? <ul style="list-style-type: none"><li>• Look for opportunities to bring in an outside expert to evaluate.</li><li>• Discuss progress and what is working and not working at least six-monthly as a group.</li><li>• Other methods of evaluation or documentation may be required by your local area.</li></ul>	

## Difficult case report

Facility: \_\_\_\_\_ Supervisee name: \_\_\_\_\_

Date: \_\_\_\_\_ Supervisor name: \_\_\_\_\_

### Case details

History

Current situation/problem

Your assessment and management plan (consider psychosocial and pharmacological interventions)

Points you want to discuss

Suggestions from supervisor or peers (consider psychosocial and pharmacological interventions)

Next steps

## Personal reflection

Facility: ..... Supervisee name: .....

Date: ..... Supervisor name: .....

**Please complete the following every three to six months, then discuss with supervisor**

Personal strengths

Areas for development

Administrative or other challenges

Future plans (to be filled in with supervisor)

## Supervision report and feedback

Facility: ..... Supervisee name: .....

Date: ..... Supervisor name: .....

### Clinical feedback

Strengths (e.g. attitude, knowledge, communication, assessment, interventions, referrals, follow-up)

Areas for improvement

### Administrative/programmatic feedback

Strengths (e.g. processes, supplies, staffing)

Areas for improvement

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
<b>1. Promote respect and dignity</b>			
Treat all persons with MNS conditions with respect and dignity in a culturally appropriate manner			
Promote inclusion and collaborative care of people with MNS conditions and their carers			
Protect the confidentiality and consent of people with MNS conditions			
<b>2. Know common presentations</b>			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
<b>3. Know assessment principles</b>			
Name steps of history-taking for an MNS assessment and key features of each: presenting complaint, past MNS history, general health history, family history of MNS conditions, psychosocial history			
Name assessment principles for MNS conditions: physical examination, mental status examination, differential diagnosis, basic laboratory tests, identify the MNS condition			
Name two or three key points under each of the assessment principles for MNS conditions			
<b>4. Know management principles</b>			
Understand importance of integrating care for priority MNS conditions into primary practice			
Name management principles of priority MNS conditions, i.e. develop treatment plan in collaboration, psychosocial interventions, pharmacological interventions when indicated, refer to specialist, appropriate plan for follow-up, work together with carer and families, foster strong links with other services, modify treatment plans for special populations			
Name one or two key points under each of the management principles of priority MNS conditions			
<b>5. Use effective communication skills</b>			
Create an environment that facilitates open communication in priority MNS conditions			
Involve the person, and their carer when appropriate, in all aspects of assessment and management of priority MNS conditions			
Actively listen to the person with an MNS condition			
Is friendly, respectful and non-judgemental at all times in interactions with a person with an MNS condition			
Use good verbal communication skills in interactions with a person with an MNS condition			
Respond with sensitivity when people with MNS condition disclose difficult experiences			
<b>6. Perform assessment</b>			
Perform an MNS assessment using history-taking, including: presenting complaint, past MNS history, general health history, family history of MNS conditions and psychosocial history			
Consider and exclude other conditions to priority MNS conditions			
Perform collateral assessment (i.e. carer, school), as appropriate, in priority MNS conditions			
Consider other concurrent conditions, both MNS and physical conditions			
<b>7. Assess and manage physical conditions</b>			
Understand importance of assessing physical health in assessment for priority MNS conditions			
Take a detailed history of physical health, including asking about physical risk factors, in priority MNS conditions			
Perform a physical examination and investigations for priority MNS conditions, as appropriate and available			
Manage physical health conditions and risk factors or refer to specialist if needed in people with MNS conditions			

		Needs work	Achieved	N/A
<b>Competency assessment</b> (Only use competencies which apply to task)				
<b>8. Assess and manage emergency presentations</b>				
Recognize emergency presentations of priority MNS conditions				
Perform emergency assessment of priority MNS conditions, including risk-assessment				
Manage emergency presentation of priority MNS conditions using non-pharmacological interventions				
Manage emergency presentation of priority MNS conditions using pharmacological interventions, as appropriate and available				
<b>9. Provide psychosocial interventions</b>				
Perform psychoeducation, including about the priority MNS condition and treatment available				
Address current psychosocial stressors to reduce stress and strength social supports, as appropriate for the priority MNS condition				
Promote functioning in daily activities, as appropriate to the priority MNS conditions				
Involve carer and others in psychosocial intervention for priority MNS conditions, as appropriate				
Recognize role of other psychological treatments in priority MNS conditions, and either provide or refer on, as appropriate, (i.e. brief psychological treatments for depression; specific advice regarding child and adolescent mental and behavioural disorders; interventions to improve cognitive functioning in dementia; motivational interviewing in disorders of substance use; relaxation training in other significant mental health complaints)				
<b>10. Deliver pharmacological interventions as needed and appropriate</b>				
Identify if there is a need for medication in priority MNS conditions				
Work collaboratively with person with priority MNS condition to educate them about risks and benefits of treatment, potential side-effects, duration of treatment, and importance of adherence				
Select and prescribes medication for priority MNS conditions (if has prescribing rights), as appropriate and available				
Consider needs of special populations when prescribing for priority MNS conditions				
Follow-up medications for priority MNS conditions, including monitoring for side-effects and adherence, considering special populations, and knowing when medications can be safely reduced and/or stopped				
<b>11. Plan and perform follow-up</b>				
Understand importance of follow-up for priority MNS conditions				
Know when and how to plan for follow-up for priority MNS conditions				
Perform a follow-up assessment for priority MNS conditions, determining management dependent on progress of priority MNS condition				
Manage crisis presentations and deviations from treatment plan in priority MNS conditions				
<b>12. Refer to specialist and link with outside agencies</b>				
Know when to refer to a specialist at any stage of assessment or management of a priority MNS condition, as appropriate and available				
Link with other services and outside agencies for priority MNS conditions, as appropriate and available				

<b>OVERALL</b>
<b>Areas of strength:</b>
<b>Areas for improvement:</b>

# Notes

Use this section to store any handouts you receive from the course, as well as any other notes that you find useful.

# Assessments

Use this section to store any assessments, including practice MCQs, role plays or competency assessment forms.

## General bank of multiple choice questions

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1. 42-year-old man presents with gastrointestinal problems and low energy. On examination, there is no cause for his physical symptoms, but he also reports low mood, not sleeping or eating properly, and not enjoying time with his family as much as he used to, over a two-month period.

Which is the most likely condition?

- A Depression
  - B Epilepsy
  - C Dementia
  - D Other significant mental health complaints
- 

2. A 31-year-old woman is brought in by her husband. He reports she has not been sleeping for the last two weeks, has been talking very fast and spending lots of money. On review, she is irritable, and tells you she is writing a book that will make her famous. You perform a physical examination and blood tests, which are normal. She tells you she does not use drugs or alcohol, and her husband agrees with that. Her last menses was two weeks ago.

Which is the most likely condition?

- A Alcohol Intoxication
  - B Mania
  - C Complication of early pregnancy
  - D Epilepsy
- 

3. A 49-year-old man is being treated at your clinic. Unexpectedly he collapses and starts having convulsive movements, which last about 30 seconds. Afterwards he seems drowsy, and starts complaining that he has a headache. As far as you know, he is otherwise well, does not have any complications.

Which is the most likely condition?

- A Psychosis
  - B Disorder due to substance use
  - C Epilepsy
  - D Dementia
- 

4. A six-year-old girl is seen in your clinic. Her parents have brought her in as they are worried about her. She has not been able to start school, as she does not talk, and her mother has to help her with all her eating, dressing and self-care. When you ask about her younger years, her father tells you that she only learned to walk much later than her brothers and sisters, and does not interact with other children her own age.

Which is the most likely condition?

- A Developmental disorder
- B Behavioural disorder
- C Emotional disorder
- D Psychosis

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5. A 63-year-old man is brought in by his daughter who is worried about him. He was always a very quiet and kind man, but lately seems more irritable and is having uncontrollable emotional outbursts. He seems to be more forgetful than usual. She tells you that he has never had any depression and is otherwise healthy. When you talk to him you do not think he has any hallucinations or delusions, although he does not know what the date is.

Which is the most likely condition?

- A Depression
  - B Psychoses
  - C Epilepsy
  - D Dementia
- 

6. A 33-year-old woman presents to the clinic in an agitated state, with dilated pupils, raised pulse and blood pressure, and recent injection marks on her arms. She is behaving strangely, is erratic, pacing, and looking around the room. You met her one week ago in the clinic when she asked for screening for HIV. At the time she was otherwise healthy, logical in conversation and denied any history of an MNS condition. She will not tolerate a long review with you, but you do not think there are any hallucinations or delusions and her brief physical examination was normal.

What is the most likely condition?

- A Psychoses
  - B Stimulant intoxication
  - C Opioid overdose
  - D Epilepsy
- 

7. A 24-year-old woman is brought into your clinic by family with reduced consciousness and trouble breathing. Her family states they observed her having a seizure earlier, at which point they realized she had consumed pesticides that they had available on their farm. They tell you she has not seemed herself since her engagement ended four months ago. She is sleeping a lot, always crying and not helping out as much on the farm.

Which two conditions are the most likely?

- A Epilepsy and depression
  - B Depression and other significant mental health complaint
  - C Self-harm/suicide and depression
  - D Self-harm/suicide and psychosis
- 

8. A 42-year-old man presents to your clinic after the death of his wife and child one week earlier. His friends are worried as he has suddenly lost the ability to walk properly, and he seems tired and depressed. You do a physical examination and find that his medical symptoms cannot be explained by any physical conditions. Further investigation is also normal, and you are convinced that there is no physical cause for his symptoms. His friends say that up until the deaths he was happy and cheerful, worked every day and had no health concerns.

Which is the most likely diagnosis?

- A Depression
- B Epilepsy
- C Dementia.
- D Bereavement.

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9. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Post-traumatic stress disorder

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

John is a 72-year-old man who has come to see you for low mood. On review, he also tells you that he has not been sleeping properly, and he also thinks he has lost some weight. These symptoms have been going on for about four to five months. He denies any delusions, hallucinations or history of mania. He has not had any trouble with his memory, but you test it anyway, and find it is in the normal range. A physical examination and basic blood tests are normal.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Rashida is a 69-year-old woman who comes to see you with her husband. He is worried that she is not well. He reports that she seems to forget and lose things. Once he came home from work and she was not there, and he found her wandering around the neighbourhood looking lost. She used to always dress immaculately, but lately is not looking after herself as much. When you ask Rashida, she tells you there is nothing wrong, she is fine and certainly "not depressed or mad". You test her memory, and she does not know the current date, or the dates of her children's birthdays.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Sebastian is a 61-year-old man whom you normally treat for diabetes. You have noticed on several occasions over the past two years that he seems to smell of alcohol and is unsteady on his feet. You know that he has not been able to keep a job for a long time, even though he would like to still be working, and his wife left him one month ago. At the time, you assessed him for depression or dementia but you did not think he had either of those, and his mental state has not changed since that review. On today's review, you examine him for complications for diabetes, and notice he has signs of chronic liver disease, including jaundiced skin and ascites.

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10. For the following scenarios, choose the best diagnosis. Choose only one:

- i. Depression
- ii. Psychoses
- iii. Epilepsy
- iv. Child and adolescent mental and behavioural disorders
- v. Dementia
- vi. Disorders due to substance use
- vii. Self-harm/suicide
- viii. Bereavement

**Scenario A:**  i  ii  iii  iv  v  vi  vii  viii

Emmanuel is a 20-year-old man who is brought to your clinic by his friends. They are very worried about him because he is afraid that the government are monitoring him, and keeps saying that he can hear people talking about him. When you ask them for more information, they say that he has not been himself for several months, at times does not make sense, and has not been coming to university much. He is about to fail the semester. There is nothing remarkable on physical history, examination or blood tests, and his urine drug screen is negative. When you speak to him, he seems suspicious of you, does not make a lot of sense, and does not think that there is anything wrong with him. He wants to leave, and starts to become quite aggressive when you ask him to stay, saying that he is unsafe here and people are watching him.

**Scenario B:**  i  ii  iii  iv  v  vi  vii  viii

Cara is a 17-year-old woman who is brought in by her family after having a period of shaking, rigidity and incontinence at home. She is currently confused and drowsy and does not know where she is. The family reports she has always been happy and healthy, did well at school but left last year to start working, which is also going well. The family are worried that she has been possessed by a spirit. When you speak to Cara, she is still not sure what has happened and why she is in hospital. She complains of weakness down one side of her body and feeling sore all over.

**Scenario C:**  i  ii  iii  iv  v  vi  vii  viii

Marc is a 14-year-old boy who is referred to you by his school teacher. The teacher tells you that Marc has always been into trouble at school as he is very disruptive to the other students. He does not seem to be able to concentrate for very long. The teacher wants you to see him in case there is something that can be done. You meet with Marc, who does not want to sit still to talk to you. In the brief time that you talk he tells you that he hates school and finds it boring. In your assessment, you do not think that he is depressed, or that he has any delusions or hallucinations. He denies using any substances. A physical examination is normal. You meet with Marc's parents, who tell you that they have had trouble with Marc for years. He can never sit still when they take him somewhere, such as church or a friend's house, he is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

## Multiple choice questions answers

- |                  |                 |                  |                   |
|------------------|-----------------|------------------|-------------------|
| 1. = A<br>A = i  | 5. = D<br>B = V | 9. = D<br>C = Vi | 4. = A<br>B = III |
| 2. = B<br>B = V  | 6. = B<br>B = V | 7. = C<br>C = vi | 10. A = II        |
| 3. = C<br>C = iv |                 |                  |                   |

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# Essential care and practice

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# ECP supporting material

- Treatment plan
- ECP Multiple choice questions

<b>Treatment plan</b>	
Name:	Number/ID:
Date:	Name of healthcare provider:
<b>Presenting problem</b>	
Brief summary of the reason the person is seeking help	
<b>Written treatment plan</b>	
Pharmacological Interventions (if any)	
Psychosocial Interventions	
Referrals	
Management of any concurrent physical and/or other MNS conditions	
Crisis plan	
Follow-up plan	
Other	

# ECP multiple choice questions

- 
1. Which of the following is considered a core effective communication skill? Choose the best answer:
    - A Speaking to the person only and not the carer
    - B Start by listening
    - C Using an open space for safety
    - D Limited eye contact

---

  2. Which of the following would you do immediately when a person seeking help discloses a difficult experience of violence or assault? Choose the best answer:
    - A Call your supervisor and/or manager
    - B Discuss with the carer/family, particularly about management
    - C Acknowledge, show sensitivity and maintain confidentiality
    - D Reassure the person that they have escaped the attacker so there is nothing to fear

---

  3. Which of the following is a helpful way to start an assessment for an MNS condition? Choose the best answer:
    - A Be welcoming, introduce yourself in a culturally appropriate manner.
    - B Explain that confidentiality is limited, and may need to be broken.
    - C Ask several closed questions to efficiently elicit the main reason for presentation.
    - D Spend time assessing appearance and behaviour, to help identify the MNS condition.

---

  4. Which of the following is consistent with promoting respect and dignity for people with an MNS condition? Choose the best answer:
    - A Making decisions on behalf of a person with an MNS condition, with their best interests in mind.
    - B Using correct medical terminology to explain things, even if complicated.
    - C Ensuring consent to treatment is received from the carer and/or family.
    - D Ensuring privacy in the clinical setting.

---

  5. Which of the following is consistent with promoting the respect and dignity of people with a priority MNS condition? Choose the best answer:
    - A Involving them and their carers in making a plan for their treatment.
    - B Discrimination against people with an MNS condition.
    - C Breaking the confidentiality when a difficult experience is disclosed.
    - D Declining the option of a female chaperone, if asked.

---

  6. Which of the following is true about people with MNS conditions? Choose the best answer:
    - A They are most likely to die from suicide or self-harm.
    - B They are most likely to die from injury from risky behaviour.
    - C They are most likely to die from preventable physical diseases.
    - D They are most likely to die from a brain tumour.

---

7. How should you approach an assessment of physical health in a person with an MNS condition? Choose the best answer:

- A Ask about physical health, but leave physical examination to another clinician.
  - B Ask about physical health and perform a physical examination.
  - C Perform a physical examination and extensive laboratory testing.
  - D Perform basic and extensive laboratory testing.
- 

8. Which of the following is a feature of history-taking as part of an MNS assessment? Choose the best answer:

- A Psychoeducation
  - B Basic laboratory tests
  - C Presenting complaint
  - D Collaborative treatment plan
- 

9. Which of the following might you include when taking a psychosocial history? Choose the best answer:

- A Perform a physical examination and basic laboratory tests
  - B For a young woman, have another female staff member present
  - C For an adolescent, have the carer present
  - D Ask about current stressors, coping methods and social support
- 

10. What should you always do once an MNS disorder is suspected? Choose the best answer:

- A Provide pharmacological interventions
  - B Assess for self-harm/suicide risk
  - C Consult the WHO Essential Medicine List to know what medications are available
  - D Perform Behavioural Activation
- 

11. Which of the following are parts of a Mental Status Examination (MSE)? Choose the best answer:

- A Mood and affect
  - B Information on use of tobacco, alcohol or substances
  - C Basic laboratory tests
  - D Psychosocial history
- 

12. Which of the following are steps in the management of MNS conditions? Choose the best answer:

- A Physical Examination and Basic Laboratory Tests
- B Performing a Mental Status Examination (MSE) and a Differential Diagnosis
- C Family History of MNS Conditions and Psychosocial History
- D Psychosocial Interventions and an appropriate plan for follow-up.

---

13. Which of the following is true about psychological treatment (ie. Cognitive Behavioural Therapy, Interpersonal Therapy, etc.)? Choose the best answer:

- A They should only be provided by specialists trained in providing them
  - B They are single-session therapies that do not require significant time
  - C Interpersonal Therapy should be offered to all people with an MNS condition
  - D Non-specialized workers can be trained to deliver these interventions
- 

14. Which of the following is true about pharmacological interventions? Choose the best answer:

- A They should always be offered to people with MNS conditions
  - B The side-effect profile and efficacy of past treatments should be considered
  - C They should be determined based on healthcare provider preference
  - D The drug-drug interactions are not relevant in MNS conditions
- 

15. Which of the following is true about Follow-up? Choose the best answer:

- A It is only necessary in Psychoses
- B It should occur more frequently initially
- C If the person does not attend once then there will be no further follow-up.
- D It is only necessary if there is adequate time in the clinic

## ECP multiple choice answers

- |        |        |         |        |         |         |
|--------|--------|---------|--------|---------|---------|
| 1. = B | 6. = C | 11. = A | 5. = A | 10. = B | 15. = B |
| 2. = C | 7. = B | 12. = D | 4. = D | 9. = D  | 14. = B |
| 3. = A | 8. = C | 13. = D |        |         |         |

# Depression

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# DEP supporting material

- Person stories
- Role plays – role plays 3 and 4 are extra material for supplementary activities
- Multiple choice questions
- Video links

Activity 2: mhGAP DEP module – assessment

<https://www.youtube.com/watch?v=hgNAySulsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Activity 5: mhGAP DEP module – management

<https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2>

Activity 7: mhGAP DEP module – follow-up

<https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3>

## DEP person stories

These are a collection of personal stories describing what it feels like to live with depression (or in the case of person story 4, mania). Each story should last between three to five minutes. The stories can be adapted as required to fit the context and setting of the training.

You can choose to read out the stories in a creative and engaging manner. Or, where available, you can show videos of a person's story by downloading the videos attached to this document.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who have lived with depression (or mania) and would like to share their experiences then ask them to share their story with you. Ask them to describe to you how it feels to live with depression (or mania) and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

### Person story 1: I had a Black Dog

I had a Black Dog and his name was depression.

Looking back, Black Dog had been in and out of my life since my early twenties. Whenever he made an appearance, I felt empty and life just seemed to slow down.

Black Dog could surprise me with a visit for no apparent reason or occasion. He could make me look and feel older than my years.

When the rest of the world seemed to be enjoying life, I could only see it through the Black Dog.

Activities that usually bought me pleasure suddenly ceased to. Black Dog liked to ruin my appetite. He chewed up my memory and my ability to concentrate. Doing anything and going anywhere with Black Dog required superhuman strength. If Black Dog accompanied me to a social occasion, he would sniff out what confidence I had and chase it away.

My biggest fear was being found out. I worried that people might judge me. Because of the shame and stigma associated with Black Dog, I became a champion at fooling everyone, both at home and at work.

Keeping up an emotional lie takes an incredible amount of energy. It is like trying to cover up epilepsy, a heart attack or diabetes.

Black Dog could make me say negative things. He could make my voice weak and without conviction. Black Dog could make me irritable and difficult to be around. Black Dog thought nothing of taking my love and burying my intimacy. He liked to wake me up with very repetitive, negative thinking.

Having a Black Dog in your life isn't so much about feeling a bit down, sad or blue. At its worst, it is about being devoid of feeling altogether.

As the years went by, Black Dog got bigger and he started hanging around all the time. I would say "THAT'S IT!!!" and attack him with whatever I thought might send him running. But more often than not he would come out on top. Going down became easier than getting up again.

(continued)

### Person story 1: I had a Black Dog (continued)

Eventually, I became quite good at self-medication ... which never really helped. I began to feel totally isolated from everything and everyone. Black Dog finally succeeded in hijacking my life; he brought me to my knees. My will to go on had deserted me.

This was about the time I sought professional help and got a clinical diagnosis. This was my first step towards recovery and was a major turning point in my life.

I discovered that there are many different breeds of Black Dog affecting millions of people from all walks of life. The Black Dog is an equal opportunity mongrel. I learnt that there are many different ways to treat Black Dog. I also learnt that there is no quick fix.

Medication can be a necessary part of the treatment for some; others may need a different approach altogether.

Black Dog had me believe that if I ever told anyone about him, I would be judged. The truth is, being emotionally genuine with close friends and family can be an absolute life-saver.

Letting the Dog out is far better than keeping him in. I learnt not to be afraid of the Black Dog and taught him a few tricks of my own. Black Dog feeds on stress and fatigue; the more stressed you get, the louder he barks. It is important to learn how to rest properly and quiet your mind. Yoga, meditation, and being in nature can help shout out Black Dog.

Black Dog is fat and lazy, he would far rather you lie on your bed and make you feel sorry for yourself. He hates exercise mostly because it makes you feel better. When you least feel like moving is when you should move the most. So, go for a walk or run and leave the mutt behind.

Keeping a mood journal can be very useful. Getting your thoughts on paper is highly liberating and often insightful. Working out some sort of symbol for ranking how you are feeling each day is a good way to keep track of Black Dog.

The important thing to remember is that no matter how bad it gets ... if you take the right steps, Black Dog days can and will pass.

I wouldn't say that I am grateful for having Black Dog in my life but what I have lost to him, I have gained in other ways. He forced me to re-evaluate and simplify my life.

He taught me that rather than running away from problems, it is better to acknowledge and even embrace them.

Black Dog may always be a part of my life. But I have learnt that with patience, humour, knowledge and discipline, even the worst Black Dog can be made to heel.

Written by Matthew Johnstone  
<https://www.youtube.com/watch?v=XiCrniLQGYc>

This short video tells the story of writer and illustrator Matthew Johnstone's depression and how he overcame it. It was produced by Matthew, in collaboration with the World Health Organization.

## Person story 2: Men – speak out about your mental health

My story began eight years ago but only really became clear to me three years ago, after I had a heart attack.

Eight years ago, I lost my mum to cancer and my nephew to meningitis within two weeks of each other. I was grieving, but there was more going on than that. I wouldn't speak to anyone about how I was feeling and I became more and more isolated. I was scared that if I told people what I was feeling or what I was going through, they wouldn't understand. I was trying to earn a wage to pay the bills and had two young children; I didn't want them worrying about their dad.

Being a male, I decided to bury my head in the sand and carry on regardless - spending a lot of time on my own, working more hours to keep myself busy and out of the house. My family thought I was grumpy and moody as I was always snapping at people. In reality, I was slipping into depression and couldn't speak to anyone. I didn't want my bosses thinking I couldn't do my job – I was a manager running a busy sales office; I needed my job.

Work was becoming more and more stressful as targets were getting harder to achieve. I didn't pass on the stress to my staff and soaked up more and more, becoming anxious on a regular basis. I was worrying about debts, so everything was getting on top of me. I still didn't speak to anyone. I didn't really understand stigma, but in my mind I was scared of admitting that I had a problem. I was definitely self-stigmatizing.

Eventually everything came to a head and I had a heart attack. The doctors can't say for sure that stress and anxiety caused it, but that it was a definite factor as I had no other risk factors. My blood pressure and cholesterol were both normal. My poor mental health eventually affected my physical health.

At first I again tried to deal with this on my own, but soon realized I needed help. I visited my doctor who suggested medication, but I didn't want tablets! We discussed counselling and decided cognitive behaviour therapy was the way forward. I had six sessions, which helped massively. I spoke to my family and friends about how I was feeling and what had been going on. Talking about it and facing my problems definitely helped me to come to terms with everything.

The best piece of advice I can give is to speak out. Especially men: don't hide away, because you may not be as lucky as me.

Adapted from Andrew's blog encouraging men to speak out about mental health.  
<https://www.time-to-change.org.uk/blog/50260>

## Person story 3: Let's talk – Angelo's story

<https://www.youtube.com/watch?v=PYbuB-Ateus>

Published on 5 June 2017.

In this video, watch as Angelo shares his experience with depression, and how he was able to successfully overcome it.

## Person story 4: Bipolar disorder – remembering my first manic episode

I am currently in my late 30s and I was diagnosed with bipolar disorder three years ago. Ever since a doctor told me that I have bipolar disorder, my memories have started to make sense. Now I can see why I behaved in certain ways. I just wish I had found out sooner so I could have done something about it.

My depression dates back from as long as I can remember. I remember in my early 20s having intense feelings of sadness that would not go away. Internally I was begging for someone to notice how sad I felt and offer me help, but externally I would smile and go through the motions of my life. I couldn't find the words to explain how sad I felt and how terrible life was – I often wished that I could disappear from earth all together. These periods would last for a number of months and then the fog would lift and I would start to feel more alive and more positive again.

The first manic episode that I can recognize happened in my final year at university. I was studying politics and philosophy. I remember the stress and pressure of the impending exams and staying awake for days at a time to study. I was chatty, and I thought witty and interesting. My mind was working overtime and I thought my studying was going very well. I was reading the work of some of the greatest philosophers and thinkers of our time, and I was feeling inspired and content. I would go and sit up on my roof at night smoking cigarettes and reading. I could be lost up there for days. I did not feel like I needed to come down and eat or drink like normal people. I felt like I had a higher purpose. In fact, I remember clearly the day that I finally felt I understood what my life had all been about and why I was here. The philosophers and books I had been reading were finally helping me. I was convinced that I understood how to achieve world peace and that I, alone, could make the world a better place.

It all seemed so logical to me. Now I had this knowledge, I needed people to help me. I tried desperately to get my friends to understand. I would interrupt them in the middle of the night and talk at them about my ideas. It felt like I could not get my ideas out fast enough.

I became increasingly angry with my friends - the fact that they did not understand what was happening. So, I tried to convince my family and asked my family for money. I was spending money on plane tickets and bus tickets to travel the country and the world as I wanted to speak to world leaders. I spent so much money and found myself in huge amounts of debt. I had neglected to take my final exams and was called in to speak to the staff at the university.

That was the day I crashed. I was trying to explain what had been happening to me and I broke down in tears. I was sobbing and could not get the words out. I spent the night in a hospital as the university thought that would help me. I slept for the first time in weeks. The next day I started a rapid descent into depression. It felt achingly lonely and sad and continued to feel that way for months. The high had been so intense: I was going to save the world. But the low that followed eclipsed any feelings I had had previously.

(continued)

#### Person story 4: Bipolar disorder – remembering my first manic episode (continued)

This began a cycle of depressive and manic episodes that I have only started learning to manage in the last three years with medicines and regular visits to the doctor. I managed to re-take my university exams and I work in publishing, which I love. I owe a debt to my friends and family who continue to support me and have even helped me repay debts when things have gotten very bad. I will probably stay on this rollercoaster for the rest of my life but with support I can learn new ways to cope with it that keep me safe and stable.

# DEP role plays

## Role play 1: Assessment

**Purpose:** To assess a person for possible depression.

**Duration:** 30 minutes total or less.

**Situation: PERSON SEEKING HELP**

- You feel sad all day and you don't know why.
- You don't enjoy any of the things you used to do.
- You have been feeling this way for two months now.
- You're exhausted all the time and can't seem to concentrate at work, but you can't sleep!
- You have missed a lot of time at work and you are worried that you will lose your job.
- You are never hungry and you think you've lost weight.
- You are not suicidal.
- You feel very hopeless about the future as about three months ago you separated from your spouse and you feel very alone.
- You are not pregnant or breast-feeding.

**Instructions:**

Allow the health-care provider to start the conversation.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** After you have been talking for about 10 minutes, you suddenly remember that you have had an episode of mania five years ago. You don't remember much except that you were not sleeping, you were writing a lot and had strange ideas that you owned lots of property. You don't really understand what the term "mania" means.

**Option 2:** After you have been talking for about 10 minutes, you also mention that you have a family history of thyroid disease. Lately you have noticed that you feel the cold a lot more, and your skin feels "scaly". You have not had any tests done or seen a doctor about this.

## Role play 1: Assessment

**Purpose:** To assess a person for possible depression.

**Duration:** 30 minutes total or less.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care provider in a clinic.
- A person with fatigue, poor sleep, weight loss and feelings of sadness has come to see you.
- Assess the person according to the mhGAP-IG Version 2.0 Module: Depression.

**Instructions:**

You are to start the conversation.

At the end, take a few minutes to explain to the person what you suspect they may be suffering with.

---

**Extended version (only read this if instructed by facilitator)**

If there is an extended version, you will get new information from the person seeking help towards the end of the interview. You may need to revise your assessment based on the new information.

## Role play 1: Assessment

**Purpose:** To assess a person for possible depression.

**Duration:** 30 minutes total or less.

**Situation: OBSERVER**

- You will observe a health-care provider in a clinic.
- A person with fatigue, poor sleep, weight loss and feelings of sadness has come to see them.
- They will assess the person according to the mhGAP-IG Version 2.0 Module: Depression.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' interview
- 5–10 minutes for feedback and small-group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
6. Assesses and manages physical condition
7. Assesses and manages emergency presentation

Grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** After about 10 minutes, the person seeking help will suddenly remember that they have had an episode of mania five years ago. They don't remember much except that they were not sleeping, they were writing a lot and had strange ideas that they owned lots of property. They don't really understand what the term "mania" means.

**Option 2:** After about 10 minutes, the person seeking help will also mention that they have a family history of thyroid disease. Lately they have noticed that they feel the cold a lot more, and their skin feels "scaly". They have not had any tests done or seen a doctor about this.

## Role play 2: Psychosocial interventions

**Purpose:** To practise delivering psychosocial interventions to help manage a person with depression.

**Duration:** 30 minutes total or less.

**Situation: PERSON SEEKING HELP**

- You are a 27-year-old young professional.
- One year ago you were employed in a busy bank and you really enjoyed your job.
- You were in line for a promotion.
- You were in a relationship and engaged to be married. You were really excited about the future.
- Then your fiancée left you, unexpectedly for another person.
- You felt that the stress of work and the impending promotion was too much and you started to feel very anxious and worried all the time.
- You stopped being able to sleep or eat well.
- As your mood deteriorated and you felt more and more sad and depressed, your personality started to change. You were irritable, forgetful and within weeks you damaged your reputation at work to the point that you were fired.
- That was one year ago. Since then you have been very depressed. You are socially isolated, feeling unable to spend time with friends and family as you are embarrassed and ashamed about how your life has changed.
- You have not worked and you have money problems.
- You blame yourself for everything that has happened in your life.
- You started getting help one week ago when you were identified as having depression.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 2: Psychosocial interventions

**Purpose:** To practise delivering psychosocial interventions to help manage a person with depression.

**Duration:** 30 minutes total or less.

**Situation: HEALTH-CARE PROVIDER**

- A 27-year-old was identified as having depression one week ago.
- One year ago he was employed in a busy bank and really enjoyed the job.
- He was in line for a promotion.
- He was in a relationship, engaged to be married and was really excited about the future.
- Then his fiancée left him, unexpectedly, for another person.
- He felt that the stress of work and the impending promotion was too much and he started to feel very anxious and worried all the time.
- He stopped being able to sleep or eat well.
- As his mood deteriorated and he felt more and more sad and depressed, his personality started to change. He was irritable, forgetful and within weeks he had damaged his reputation at work to the point that he was fired.
- That was one year ago.
- Since then he has been very depressed. He is socially isolated, feeling unable to spend time with friends and family as he is embarrassed and ashamed about how his life has changed.
- He has no work and has money problems.
- He blames himself for everything that has happened in his life.

**Instructions:**

- You are to start the conversation.
- You do not need to re-assess for depression.
- Offer psychoeducation and develop a treatment plan using psychosocial interventions.

## Role play 2: Psychosocial interventions

**Purpose:** To practise delivering psychosocial interventions to help manage a person with depression.

**Duration:** 30 minutes total or less.

**Situation: OBSERVER**

- A 27-year-old was identified as having depression one week ago.
- One year ago he was employed in a busy bank and really enjoyed the job.
- He was in line for a promotion.
- He was in a relationship, engaged to be married and was really excited about the future.
- Then his fiancée left him, unexpectedly, for another person.
- He felt that the stress of work and the impending promotion was too much and he started to feel very anxious and worried all the time.
- He stopped being able to sleep or eat well.
- As his mood deteriorated and he felt more and more sad and depressed, his personality started to change. He was irritable, forgetful and within weeks he had damaged his reputation at work to the point that he was fired.
- That was one year ago.
- Since then he has been very depressed. He is socially isolated, feeling unable to spend time with friends and family as he is embarrassed and ashamed about how his life has changed.
- He has no work and has money problems.
- He blames himself for everything that has happened in his life.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–12 minutes' interview
- 5–8 minutes for feedback and small-group discussion.

Please assess the following competencies:

- 4. Uses effective communication skills
- 8. Performs psychosocial interventions

Grade the level of competency the health-care provider achieves.

## Role play 3: Pharmacology

**Purpose:** This role play gives participants an opportunity to discuss pharmacological risks and benefits with a person who needs an antidepressant for moderate-severe depression.

**Duration:** 20 minutes or less.

**Situation: PERSON SEEKING HELP**

- Your name is Sarah.
- You have been diagnosed with moderate-severe depression.
- You and the health-care provider have decided to try out an antidepressant medication.
- You are nervous about taking medication, but you are willing to give it a try.
- You have not had any ideas, plans or acts of self-harm or suicide.
- You have no other significant medical history.
- You have no history of cardiovascular disease.
- You have no history of mania.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** This case can be made more complex by saying that Sarah does have a history of mania. You can say that you had an episode three years ago where you spent a lot of money, didn't sleep and had a big plan for a business idea. You required a short hospital admission and medication, which you were able to stop one year ago. You cannot remember the name of the medication.

## Role play 3: Pharmacology

**Purpose:** This role play gives participants an opportunity to discuss pharmacological risks and benefits with a person who needs an antidepressant for moderate-severe depression.

**Duration:** 20 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- Recall the case of Sarah, as seen in the video in this module.
- Sarah has moderate-severe depression.
- The health-care provider and Sarah have decided to try out an anti-depressant medication.
- Educate Sarah about the options for pharmacological management:
  - What drugs are available?
  - Which drug may be most appropriate for Sarah and why?
  - What are the benefits and drawbacks of each type?
  - What are the potential side-effects and what should she watch out for?
  - When she can expect to see results?
  - How long she will need to take the medication?

**Instructions:**

You are to start the conversation.

You do not need to re-assess for depression.

You are to focus on discussing pharmacological interventions.

---

### Extended version (only read this if instructed by facilitator)

If there is an extended version, you will get new information from the person seeking help towards the end of the interview.

You may need to revise your management based on the new information.

## Role play 3: Pharmacology

**Purpose:** This role play gives participants an opportunity to discuss pharmacological risks and benefits with a person who needs an antidepressant for moderate-severe depression.

**Duration:** 20 minutes or less.

**Situation: OBSERVER**

- Recall the case of Sarah, as seen in the video in this module.
- Sarah has moderate-severe depression.
- The health-care provider and Sarah have decided to try out an anti-depressant medication.
- The health-care provider will need to educate Sarah about the options for pharmacological management about:
  - What drugs are available?
  - Which drug may be most appropriate for Sarah and why?
  - What are the benefits and drawbacks of each type?
  - What are the potential side-effects and what should she watch out for?
  - When she can expect to see results?
  - How long she will need to take the medication?

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–12 minutes' interview
- 5–8 minutes for feedback and small-group discussion.

Please assess the following competencies:

4. Uses effective communication skills
9. Delivers pharmacological intervention

Grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** This case can be made more complex by Sarah saying that she was diagnosed with mania in the past.

## Role play 4: Psychoeducation and psychosocial stressors

**Purpose:** To practise delivering psychoeducation to help manage psychosocial stressors in a person with depression.

**Duration:** 30 minutes or less.

**Situation: PERSON SEEKING HELP**

- You are a 17-year-old boy.
- You have been having a lot of trouble with a bully at school.
- He is constantly harassing you and is sometimes physically aggressive.
- He makes it hard to spend time with your normal group of friends.
- You love playing football (soccer), but the bully plays as well and you haven't been going as often.
- At first it wasn't too bad, but now you are very sad because you're having trouble in your classes.
- Your relationship with your parents is fine, but you don't think that they can help.
- You have not had any ideas of self-harm or suicide.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 4: Psychoeducation and psychosocial stressors

**Purpose:** To practise delivering psychoeducation to help manage psychosocial stressors in a person with depression.

**Duration:** 20 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- Javier is a 17-year-old male who you believe has moderate-severe depression.
- He has been feeling sad for three months.
- His parents say he does not sleep or eat well.
- Javier tells you that he has been finding it very difficult to concentrate in school, and he doesn't enjoy playing with his friends as he used to do.
- He feels tired all the time.

**Instructions:**

- You are to start the conversation.
- You do not need to re-assess for depression.
- Offer psychoeducation and address current psychosocial stressors.

## Role play 4: Psychoeducation and psychosocial stressors

**Purpose:** To practise delivering psychoeducation to help manage psychosocial stressors in a person with depression.

**Duration:** 30 minutes or less.

**Situation: OBSERVER**

- Javier is a 17-year-old male who has moderate-severe depression.
- He has been feeling sad for three months.
- His parents say he does not sleep or eat well.
- Javier tells the health-care provider that he has been finding it very difficult to concentrate in school, and he doesn't enjoy playing with his friends as he used to do.
- He feels tired all the time.
- The health-care provider will start the conversation.
- They do not need to re-assess for depression.
- They should offer psychoeducation and address current psychosocial stressors.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–12 minutes' interview
- 5–8 minutes for feedback and small-group discussion.

Please assess the following competencies:

- 4. Uses effective communication skills
- 8. Performs psychosocial intervention

Grade the level of competency the health-care provider achieves.

## DEP multiple choice questions

1. Which of the following is a core symptom of depression? Choose the best answer:

- A Lack of realization that one is having mental health problems.
- B Loss of enjoyment in activities that are normally pleasurable.
- C Fatigue, sleepiness and abnormal behaviour after having a seizure.
- D Using alcohol or other substances.

2. Which of the following is a core symptom of depression? Choose the best answer:

- A An attempt to harm oneself
- B Delusions or hallucinations.
- C Persistent low mood.
- D An episode of mania.

3. Which of the following statements concerning depression is correct? Choose the best answer:

- A It is a common mental health condition.
- B It is commonly the sufferer's fault for being weak or lazy.
- C It is commonly expected after a bereavement.
- D It is commonly caused by drug and alcohol use.

4. Which of the following statements concerning depression is correct? Choose the best answer:

- A Depression often presents with multiple persistent physical symptoms with no clear cause.
- B Depression often presents with delusions and hallucinations.
- C Depression often presents with confusion and disorientation.
- D Depression often presents with reduced need for sleep and increased activity

5. Which of the following cluster of symptoms best describes what can occur in depression? Choose only one answer:

- A Elevated mood, decreased need for sleep, increased activity, loss of normal social inhibitions.
- B Delusions, hearing voices, disorganized thinking, showing signs of neglect.
- C Poor appetite, feeling worthless and guilty, having suicidal thoughts.
- D Severe forgetfulness and disorientation to place and time, behavioural problems.

6. Which of the following cluster of symptoms best fits with an episode of depression? Choose only one answer:

- A Marked behavioural change, agitated or aggressive behaviour, fixed false beliefs.
- B Decline in memory, poor orientation, loss of emotional control.
- C Inattentive, over-active, aggressive behaviour.
- D Low energy, sleep problems, and loss of interest in usual activities.

7. Which of the following is the best combination treatment for depression?

- A Vitamin injections and increasing exercise.
- B Psychosocial interventions and an antidepressant.
- C An antipsychotic medication and a mood stabilizer.
- D Hypnotherapy and relaxation.

8. Which of the following is the best psychosocial intervention for someone with depression?

- A Telling them to reduce their physical activity as much as possible.
- B Telling them to participate in social activities as much as possible.
- C Telling them to try and sleep as much as possible.
- D Telling them to try and "toughen up" as much as possible.

9. Which of the following might you tell someone with newly diagnosed depression?

- A Try to be stronger and you will be able to "pull yourself out of this".
- B If you experience any suicidal thoughts, it is probably best to keep them to yourself.
- C The only thing you can do for yourself is take the medication I prescribe.
- D This is a common condition and there are several treatments available.

10. Which of the following psychosocial interventions might you work on with a person with depression? Choose the best answer:

- A Avoid telling them too much about depression in case they get more depressed.
- B Suggest they take time off work if they can afford to.
- C Work with them to reduce stress and activate supports, including involving carers.
- D None – better just to refer them to an expert for IPT or CBT.

## DEP multiple choice answers

- |        |         |        |        |
|--------|---------|--------|--------|
| 1. = B | 2. = C  | 3. = A | 4. = A |
| 5. = C | 6. = D  | 7. = B | 8. = B |
| 9. = D | 10. = C |        |        |

# Psychoses

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# PSY supporting material

- Person stories
- Case scenarios
- Role plays
- Multiple choice questions
- Video links

## Activity 3: mhGAP PSY module – assessment

<https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

## Activity 5: mhGAP PSY module – management

<https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5>

## PSY person story

This is a personal story describing what it feels like to live with psychoses. The story should last between three to five minutes. The story can be adapted as required to fit the context and setting of the training.

You can choose to read out the story in a creative and engaging manner. Or, where available, you can show the video of the person's story.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who have lived with psychoses and would like to share their experiences then ask them to share their story with you. Ask them to describe to you how it feels to live with psychoses and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

## Person story 1: Hearing voices, seeing things

The voices were telling me how worthless I was and how nobody cared, and how pointless my existence was, and that I would be better off not on this earth. And, I thought, well, you know, nobody's listening to me so maybe the voices are right.

I didn't want to die. I just wanted to be rid of the voices. I mean, I heard the voices in my sleep. I've had no respite for nearly 15 years of voices. And that's so tiring. That just grinds you down. And they are horrible. Some people's voices are mildly derogatory, mine are abusive and threatening. There are four men. I don't know who they are. I just know they are my voices, and they are just vile.

To start with they were always outside, so if I was in a building I could hear them outside the window. That's how they started. I would hear them outside – they are very clever – sometimes they would take on the form of another person's voice. And when you don't realize that they are the voices you think that the person is abusing you. You can't understand why the person has started to abuse you – you are completely taken in by the voices.

And then you know, as things got worse and worse I'd hear them on the phone when I was speaking to friends and family. I would hear them in the background which led me to believe that things were being done electronically.

It is so tiring because as things got worse I was constantly questioning what was happening to me – asking myself how am I hearing these things? Where are they coming from? Who is doing this to me? This lasted for 10 years – hearing these voices and asking why.

It was just my mind trying to rationalize and reason with what was happening. My mind never realized that the voices were coming from inside my head. That just seemed too unrealistic. Instead, the voices came from various electronic devices – If there was a lamp in the corner of the room the voices would come from there. So, it is the voices – they are very clever and they could come from anywhere.

I knew that the voices I was hearing could think for themselves and tried to trick me and play games with me. Every step of the way they were manipulating me. There's no doubt about that.

Recently, I actually started hearing the voices inside my head. The first time that happened was really scary. So my mind started to try to understand what was happening and I started to believe that my mind was being tracked by satellites and bugging devices. I felt like somehow people had managed to get inside my brain and started listening to my thoughts and manipulating me that way. I could not understand how that was happening but it was the only explanation I had.

Read more: <http://www.healthtalk.org/people-experiences/mental-health/experiences-psychosis/hearing-voices-seeing-things-and-unusual-beliefs#ixzz4mh9t35HS>

# PSY case scenarios

Groups should read through the case scenario they've been given.

Groups should then discuss the person in the case scenario and, as a group, decide:

- If the person is experiencing a hallucination or delusion? Explain the decision.
- What impact does the hallucination or delusion have on the person's life? Explain the decision.

## Case scenario 1: Hallucination or delusion?

Mr X, 23-year-old male, presented to the non-specialized health setting with the complaint of general aches and pains all over his body. A physical examination revealed bruising to different parts of his body including the face, arms and legs. When asked what had happened, the man said that the bruises were self-inflicted and that he had been forced to do them.

The man explained that over the past six months his life had been very stressful. He was in his final year at university but was worried about whether he would pass his exams or not. He was also worried that if he failed his exams he would not be able to get the job that he wanted and that his family expected him to get. He explained that one of his greatest fears is to embarrass his family.

As a way to cope with his stress, he admits that he has been using marijuana and alcohol and has been going to parties rather than studying. He explains how angry he is with himself and how disappointed he feels with himself. He admits to feeling overwhelmed.

He explained that two months ago he started to hear people talking to him. Originally, he thought it was his friends teasing him but when he looked outside his house to see where his friends were, he could not see them. As the days went on he explained that the voices kept taunting him and calling him bad names, embarrassing him, calling him stupid and threatening him. Every time he heard the voice he tried to look for the source but he could not see anyone.

After two months, he explained that the voices became even more aggressive and started to tell him that he should hurt himself. He explained that he felt so depressed that he started to do what they told him because he did not feel like he had the strength to resist them. After he harmed himself the voices were happy for some time but soon they would become angry again.

He said that he does not understand what is happening to him and he is scared. He explained that he has been too scared to leave his house and often spends his days in his room alone. He has not been attending university and has been asked to leave the university.

He explains that he feels he cannot cope anymore. He stated that he has not slept well since he started hearing the voices and he does not want to eat as he does not feel that he deserves it and if he does eat he suffers with terrible stomach aches and pains.

Routine bloods and urine analysis were all normal.

## Case scenario 2: Hallucination or delusion?

Mrs Z, a 35-year-old, uneducated, married woman presents at a non-specialized health facility complaining of problems sleeping, feeling fatigued and experience headaches. After spending time with the woman, the health-care provider discovers that the woman is also experiencing some social problems. She is fighting quite severely with her neighbours. She complains that her neighbours are spying on her. She says that they listen into her conversations, they watch her through the windows and the doors. And in the last few months they have started to repeat out loud what she is doing and what she has said that day. She explains that the house is a three-storey house, split into two flats. Her family live in the flat on the first and second floor and the neighbours live in the ground floor flat.

She believes that the neighbours started to spy on her and shout out her actions because they know how much it annoys her. She explained that she believes they are jealous of her because her life is better than hers and her husband makes more money than they do. She says that the neighbours are very clever as they do it in a way so that her husband does not hear them. She is happy to give examples of what they say. She says that she could be sitting on a chair and when she goes to stand up the neighbours will shout out "she is standing" "she is walking about". She says that sometimes they can be rude and they call her names such as "ugly", "stupid", "worthless", "dumb", but other times they just repeat exactly what she is doing. She explains that the neighbours are never inside the house they are always outside the windows or the doors. She says that sometimes she has put her own ear to the floor to try and hear what her neighbours are doing but she can't always hear them.

She says that she has confronted her neighbours about this but they deny it. In fact, they get angry with her and have even become quite aggressive and violent with her in the past. This, she believes, is proof that they are the ones doing it. She says her husband has become very angry with her when she talks about the neighbours.

After a brief family history, she explains that there is a long standing legal dispute between her family and the neighbour's family over ownership of the piece of land the house is standing on. The case is being decided on in court the law courts.

She says she is so worried about this situation with her neighbours that she struggles to sleep at night because she thinks about it all the time. In fact, she says that at night the neighbours are at their worst and shout really loudly.

She says her husband no longer shares the same room as her as he cannot cope anymore.

She does not want to leave the house any more in case she sees the neighbours and this is affecting her children who are really worried about her.

Her routine blood and urine tests were normal, as was her physical examination.

## Case scenario 3: Hallucination or delusion?

Mr Y is a 30-year-old man who has come to see a health-care provider with his uncle. Mr Y is complaining of a headache that he has in the centre of his head. He explains that he has had the pain for about a year. He explains that the headache occurs once a week every month. He describes the pain as coming from the very centre of his head between his eyes. He is very calm during the interview although he does look suspicious sometimes and explained that he has asked his uncle to accompany him so that he has a "witness" to the interaction. He did not explain why that is necessary.

Mr Y admits to feeling anxious and nervous at times but he explains that is because he has recently returned to the country after living abroad for five years. Since returning he has not found work, he is not married and he is nervous about where his life is headed. He says that he is used to the headache now and it does not stop him from sleeping or enjoying his life. His health is good otherwise and his weight is good. His blood and urine tests were normal. His self-care is good and he appears well dressed and well groomed. He explains that he knows when he is anxious and nervous because his heart rate increases and he starts to sweat.

He said the last time he felt anxious was about two weeks ago when he was in town with his aunt. He said he started to feel anxious because he saw two men that he thought he knew from his time living abroad. As soon as he saw them he started to get a headache, his heart started beating faster and he felt dizzy. He said that he had to run away and just wanted to go back to his room to stay safe.

His uncle explained that when Mr Y lived abroad he was involved in a street fight which turned violent. The uncle explained that some of the attackers were work colleagues. Following the attack, Mr Y had quit his job and returned home.

Mr Y explains that he is working in a local government office. He says that even though he has returned home his attackers are still following him. The attackers were leaving messages for him all over the office. He said that the messages would be threatening and they would be hidden in the posters, leaflets and the literature in the office. He describes getting messages and text messages on his mobile phone that he knows are from them. He explained that sometimes the messages scare him so much that he has thrown his phone across the room to try and destroy it. Although he knows that it won't make any difference he feels like he has to do something to protect himself.

His uncle explains that sometimes Mr Y can be violent and impulsive.

Mr Y understands that the headaches are caused by his attackers. He thinks that the headaches are a way of them tracking him all over the world. He does not believe that the health-care provider can treat the headache. He does not believe anyone can help him. He says that he is only safe if he is in his bedroom at home. That is where he spends most of the days and nights. He does not like to be outdoors at all. He does not think he can work again as then he will alert his attackers as to where he is.

# PSY role plays

Note: Role plays 3 and 4 are additional to those supplied for the activities – for those wanting to extend training.

## Role play 1: Assessment

**Purpose:** To assess a person for possible psychosis.

**Duration:** 30 minutes or less.

**Situation: PERSON SEEKING HELP**

- You are Mr Fadel, a man who is homeless and normally stays in a park outside the clinic.
- You already know the health-care provider and you accept to talk to them.
- You are poorly groomed and keep scratching your head.
- You drink excessive amounts of alcohol.
- You are struggling to concentrate on what the person is saying to you and you find it very difficult to answer their questions.
- You start to get quite annoyed and frustrated by their questions.
- When they ask you about hallucinations you don't understand the question and do not give a clear answer but you are hearing a voice. You are hearing a voice that is telling you not to talk to the health-care provider because he wants to harm you.
- You do not believe the voice but the voice is very insistent and you feel the need to tell the voice to "shut up" or "be quiet" at several points during the interview.

**Instructions:**

You ask for food and money as soon as you enter the room.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** After 10 minutes, you start to get very angry with the questions being asked and with this voice that keeps talking to you. You start to yell at the health-care provider, you stand up and start kicking and throwing things. You only settle down when the health-care provider speaks to you calmly and listens to your worries.

**Option 2:** After about eight minutes of the interview, you clutch your chest and start complaining of chest pain. You remain calm, but it feels as though you are being crushed. **Only if the health-care provider asks,** you let them know that your father died of a heart attack at 47 years old, you have smoked all your life, and you have never been checked for any other health problems before so you do not know about any other conditions. You get this pain occasionally when you are walking up hills.

## Role play 1: Assessment

**Purpose:** To assess a person for possible psychosis.

**Duration:** 30 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care worker in a clinic.
- Mr Fadel, a person known to you, is homeless and lives under the tree opposite your practice. He has been drinking excessive amounts of alcohol, been seen talking and laughing to himself, and is unkempt and ungroomed.
- You suspect psychosis.
- Assess Mr Fadel according to the psychoses module.

**Instructions:**

- Mr Fadel will start the conversation.
  - At the end, you are to explain to Mr Fadel his diagnosis.
- 

**Extended version (only read this if instructed by facilitator)**

If there is an extended version, you will get new information from the person seeking help towards the end of the interview.

You may need to revise your assessment based on the new information or focus on additional aspects.

## Role play 1: Assessment

**Purpose:** To assess a person for possible psychosis.

**Duration:** 30 minutes or less.

**Situation: OBSERVER**

- You will observe a health-care provider in a clinic
- Mr Fadel, a person known to the health-care provider, is homeless and lives under the tree opposite the practice. He has been drinking excessive amounts of alcohol, been seen talking and laughing to himself, and is unkempt and ungroomed.
- The health-care provider suspects psychosis.
- The health-care provider will assess Mr Fadel according to the psychoses module.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
6. Assesses and manages physical condition (**extended version option 2 only**)
7. Assesses and manages emergency presentation (**extended version option 1 only**)

And grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** After 10 minutes, Mr Fadel will start to get very angry with the questions being asked and with the voice that keeps talking to him. He will start to yell at the health-care provider, stand up and start kicking and throwing things. He will only settle down when the health-care provider speaks calmly and listens to his worries.

**Option 2:** After about eight minutes of the interview, Mr Fadel will clutch his chest and start complaining of crushing chest pain. **Only if the health-care provider asks,** he will let them know that his father died of a heart attack at 47 years old, that he has smoked all his life, and has never been checked for any other health problems. He gets this pain occasionally when walking up hills.

## Role play 2: Follow-up

**Purpose:** To give participants the opportunity to practise conducting a follow-up appointment with a person who is being managed for psychosis.

**Duration:** 30 minutes or less.

**Situation: PERSON SEEKING HELP**

- This health-care worker previously diagnosed you with psychosis and started you on medication.
- There have not been any further symptoms or signs of psychosis but you do continue to hear voices.
- The voices continue to scare you and you feel the need to talk to them and tell them to be quiet.
- You have been taking the medication regularly as directed.
- Your mother has been helping to make sure that no doses are missed.
- The only possible side-effect has been a slight tremor in your hands.
- This tremor has not had a significant effect on your life, but it is quite irritating.
- You are struggling to increase your social support as part of your care plan because people in your social circle do not want to be around you while your behaviour seems so strange to them.
- You want to discuss ways that you can improve that with the health-care provider.

**Instructions:**

Allow the health-care provider to start the conversation.

---

**Extended version (only read this if instructed by facilitator)**

Instead of reporting that you have been regular in taking the medication, you report that even though your mother has been trying to supervise you, you didn't like the tremor that the medication gave you, so you have actually not been swallowing the medication and then later putting it down the toilet. You don't really see the point of the medication, but if the health-care provider can make the side-effects go away and explain why you need it then you will take it again.

## Role play 2: Follow-up

**Purpose:** To give participants the opportunity to practise conducting a follow-up appointment with a person who is being managed for psychosis.

**Duration:** 30 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are following up a person that you already diagnosed with psychosis and started on medication.
- Follow-up with a person with psychosis.
- Focus on reassessment of the symptom.
- Assessment of side-effects and adherence of medication.
- Assessment of psychosocial interventions specifically strengthening social support, reducing stress and life skills.

**Instructions:**

- You are to start the conversation.
- Please use the mhGAP-IG page 46 to perform a follow-up assessment and determine ongoing management.

---

### Extended version (only read this if instructed by facilitator)

If the extended version of this role play is used, continue to perform a follow-up assessment as per mhGAP-IG page 46.

## Role play 2: Follow-up

**Purpose:** To give participants the opportunity to practise conducting a follow-up appointment with a person who is being managed for psychosis.

**Duration:** 30 minutes or less.

**Situation: OBSERVER**

- The health-care provider is following up a person that they have already diagnosed with psychosis and started on medication.
- The person does not have any ongoing symptoms of psychosis except that they are hearing voices.
- They have a minor tremor from the medication.
- They are struggling to increase their social support because people in their social circle do not want to be around them while their behaviour seems so strange to them.
- They want to discuss ways that they can improve that with the health-care provider
- The health-care provider should:
  - Focus on reassessment of the symptoms.
  - Assessment of side-effects and adherence of medication.
  - Assessment of psychosocial interventions specifically strengthening social support, reducing stress and life skills.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

- 7. Provides psychosocial intervention
- 10. Plans and performs follow-up

And grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

In this version, the person seeking help has not been compliant with the medication as they did not like the tremor. If the health-care provider can make the side-effects go away and explain why the person needs the medication then they will take it again.

## Role play 3: Pharmacology

**Purpose:** To practise using the mhGAP-IG to prescribe medications for mania.  
To practise communication skills with someone with mania.

**Duration:** 30 minutes or less.

**Situation: PERSON SEEKING HELP**

- You are Maria, a lady in her 30s.
- You have just been diagnosed with a manic episode by the health-care provider, after your husband brought you in for review.
- You have not been sleeping, been up all night singing and cleaning the house, and you keep telling people that you are going to become a famous opera singer.
- You don't really think there is anything wrong, but you are happy to do what your husband and the doctor tell you, even if this means taking medication.
- You have no other health conditions.
- You are not suicidal or aggressive.
- You talk a lot and are difficult to interrupt.
- You already have four children. You are no longer breastfeeding.
- If the health-care worker asks for any other information, reply in the negative.

**Instructions:**

Start talking immediately about how you are going to become a famous opera singer.

---

**Extended version (only read this if instructed by facilitator)**

In addition to your four children, you are also around eight weeks pregnant. You are still willing to take medication, but only if it doesn't harm your unborn baby. If the doctor recommends that you go to a specialist you say that you will not go as you cannot afford it and you need to look after the children.

## Role play 3: Pharmacology

**Purpose:** To practise using the mhGAP-IG to prescribe medications for mania.  
To practise communication skills with someone with mania.

**Duration:** 30 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care worker in a clinic.
- You have just assessed Maria and diagnosed her with mania.
- You now need to discuss medication options with Maria.
- Educate Maria about the options for pharmacological management:
  - What drugs are available.
  - Which drug may be most appropriate for Maria and why.
  - What are the benefits and drawbacks of each type.
  - What are the potential side-effects and what should she watch out for.
  - When she can expect to see results.
  - How long she will need to take the medication.

**Instructions:**

- Maria will start the conversation.
- You do not need to reassess for mania but go straight into providing pharmacological intervention.

---

**Extended version (only read this if instructed by facilitator)**

If there is an extended version, you will get new information from the person seeking help towards the end of the interview.

You may need to revise your management based on the new information.

## Role play 3: Pharmacology

**Purpose:** To practise using the mhGAP-IG to prescribe medications for mania.  
To practise communication skills with someone with mania.

**Duration:** 30 minutes or less.

**Situation: OBSERVER**

- You will observe a health-care provider in a clinic.
- The health-care provider has just assessed Maria and diagnosed her with mania.
- They will now need to discuss medication options with Maria, including:
  - What drugs are available.
  - Which drug may be most appropriate for Maria and why.
  - What are the benefits and drawbacks of each type.
  - What are the potential side-effects and what should she watch out for.
  - When she can expect to see results.
  - How long she will need to take the medication.
- Maria will be talk a lot and be quite difficult to interrupt.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

- 4. Uses effective communication skills
- 9. Delivers pharmacological interventions

And grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

In addition to her four children, Maria is also around eight weeks pregnant. She is still willing to take medication, but only if it doesn't harm her unborn baby. If the doctor recommends that she go to a specialist she says that you will not go as she cannot afford it and needs to look after her children.

## Role play 4: Psychosocial intervention

**Purpose:** To perform a psychosocial intervention with the carer of a person with psychosis.

**Note:** there is no person seeking help in this role play.

**Duration:** 30 minutes or less.

**Situation: CARER SEEKING HELP**

- You are the mother of Tavi, a 23-year-old man who was diagnosed with psychosis one week ago.
- Tavi has been unwell for some time, with increasing aggression towards family members, including his younger siblings, yourself and your husband.
- He was working in a shop but was fired six months ago.
- He often talks to himself and mutters under his breath.
- He seems fearful at times, looking suspiciously around the room or out the window of the house.
- He was started on medication when assessed one week ago, but it has not made much difference at present.
- You and your family are not coping.
- Your husband insists that Tavi is locked in his bedroom. He has also suggested that you start feeding Tavi less, as when he is more tired he seems less likely to hit out at family members.
- You feel so ashamed of Tavi. Your husband is ashamed that he lost his job, and you feel ashamed of his behaviour, and you do not want any relatives to know how unwell he is.
- You do not understand what psychosis is.
- You are desperately hoping that the medication works, and have crushed up three times as many tablets in Tavi's food to try and help get him better quicker.
- The health-care provider asked you to come in again to discuss what was happening.

**Instructions:**

Allow the health-care provider to start the conversation.

## Role play 4: Psychosocial intervention

**Purpose:** To perform a psychosocial intervention with the carer of a person with psychosis.  
**Note:** there is no person seeking help in this role play.

**Duration:** 30 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care provider at a local service. Last week you assessed Tavi, a 23-year-old man, and felt he had psychosis. He had experienced at least a six-month deterioration, with increased aggression towards all family members, auditory hallucinations and paranoia.
- You started an antipsychotic, being cautious with the dose to start low.
- You asked Tavi's mother to return in a week as you felt she and the family would need extra support. Last week she said that they keep him locked in his room and don't feed him very much to try and control his behaviour. You are worried that she may not understand what psychosis is, or how the medication should be used.

**Instructions:**

- You do not need to reassess Tavi or his mother.
- Start with performing a psychosocial intervention for psychosis, targeted towards the carer.

## Role play 4: Psychosocial intervention

**Purpose:** To perform a psychosocial intervention with the carer of a person with psychosis.  
**Note:** there is no person seeking help in this role play.

**Duration:** 30 minutes or less.

**Situation: OBSERVER**

- Tavi is a 23-year-old man assessed as having psychosis last week. He had presented with a six-month deterioration, with increased aggression towards all family members, auditory hallucinations and paranoia.
- The health-care provider started an antipsychotic, being cautious with the dose to start low.
- The health-care provider asked Tavi's mother to return today as they felt that she and the family would need extra support. The mother said that they keep him locked in his room and don't feed him very much to try and control his behaviour. She does not seem to understand what psychosis is, or how to use the medication.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

- 4. Uses effective communication skills
- 8. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

# PSY multiple choice questions

- 
1. Which of the following best describes a common presentation of psychosis? Choose only one answer:
    - A Hearing voices or seeing things that are not there.
    - B Fixed beliefs which are seen as culturally acceptable.
    - C Low mood and lack of interest in usual activities.
    - D Confusion and disorientation.

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  2. Which of the following best describes a common presentation of an acute manic episode? Choose only one answer:
    - A Hearing voices or seeing things that are not there.
    - B Elevated or irritable mood.
    - C Acute intoxication with a psychoactive substance.
    - D Decline or problems with memory.

---

  3. Which of the following cluster of symptoms fits best with an episode of psychosis? Choose only one answer:
    - A Confusion, disorientation to time, place and person, marked functional decline.
    - B Marked behavioural changes, fixed false beliefs, lack of realization that one is having mental health problems.
    - C Persistent sadness or depressed mood, low energy, fatigue.
    - D Malnutrition, frequent illness, problems with development.

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  4. Which of the following cluster of symptoms fits best with an acute manic episode? Choose only one answer:
    - A Confusion, disorientation to time, place and person, marked functional decline.
    - B Admits to consuming alcohol, has slurred speech and uninhibited behaviour.
    - C Has recently stopped taking regular benzodiazepines, and presents with agitation, sweating and poor sleep.
    - D Decreased need for sleep, increased activity and reckless behaviour.

---

  5. Which of the following statements concerning psychoses is most correct? Choose only one answer:
    - A Psychoses can be caused by witchcraft and possession by demons.
    - B Psychoses are severe mental health conditions, but can be treated and the person can recover.
    - C Psychoses are more common in older people, but can occasionally happen in younger people.
    - D Psychoses always present with aggression and violence.

- 
6. Which of the following statements concerning psychosis and bipolar disorder is correct? Choose the best answer:
- A People with psychosis or bipolar disorder do not need evaluation for medical conditions.
  - B People with psychosis or bipolar disorder are best cared for with long-term hospitalization.
  - C People with psychosis or bipolar disorder are unlikely to be able to work or contribute to society.
  - D People with psychosis or bipolar disorder are at high risk of stigmatization and discrimination.
- 
7. Which of the following should always be done when starting a medication for psychoses? Choose the best answer:
- A Start an anticholinergic medication as well.
  - B Refer to a local spiritual or faith healer.
  - C Give the medication to a family member to control supply.
  - D Provide psychoeducation about side-effects and adherence.
- 
8. Which of the following is part of a psychosocial intervention in psychoses? Choose the best answer:
- A Promote function in daily activities but recommend against work or serious relationships as they may be too stressful.
  - B Discuss with the carer and family whether long-term institutionalization may be appropriate.
  - C Provide psychoeducation, especially to avoid sleep deprivation, stress, and drugs and alcohol.
  - D Discuss with the carer different ways that they might be able to challenge the delusions of the person.
- 
9. Which of the following might you say to a carer for someone with psychoses? Choose the best answer:
- A The person needs to take the medications regularly and return for follow-up.
  - B The person will learn that their delusions are wrong if family members are critical when they discuss their unusual beliefs.
  - C The person can be settled down when they are agitated by giving them a small amount of alcohol.
  - D The person can be settled down when they are agitated by reducing the amount of food they are given.

## PSY multiple choice answers

- |        |        |        |        |        |        |        |        |        |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 1. = A | 2. = B | 3. = B | 4. = D | 5. = B | 6. = D | 7. = D | 8. = C | 9. = A |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|

# Epilepsy

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# EPI supporting material

- Person stories
- Role plays
- Multiple choice questions
- Video links

## Activity 3: mhGAP EPI module – assessment

<https://www.youtube.com/watch?v=RUIRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

## EPI person stories

This is a personal story describing what it feels like to live with epilepsy. This story should last between three to five minutes maximum. The story can be adapted as required to fit the context and setting of the training.

EPI

You can choose to read out the story in a creative and engaging manner. Or, where available, you can show videos of the person story by downloading the video.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who have lived with epilepsy and would like to share their experiences, then ask them to share their story with you. Ask them to describe to you how it feels to live with epilepsy and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

### Person story 1

When I was six years old, I started getting these attacks. My family and I did not understand what was happening to me. When I was walking around the city the attacks would come. If I sat and did nothing they would still come. It felt like there was nothing I could do to control them or stop them.

It was really tough for me. As I started to go to school these attacks would still come, and when they happened in school the other children grew more and more scared of me and started to avoid me. None of the kids wanted to sit next to me in the classroom. In fact they would all move their chairs and tables as far away from me as possible. They thought that they would catch the illness by touching me. People avoided me for so long that I started to believe that I was bad and contagious as well.

(continued)

### Person story 1 (continued)

I grew up a very lonely child and never really understood what was happening to me. I tried to help my mother and sisters do the chores in the household, but because of these attacks there were so many things I could not be trusted to do. I couldn't be trusted to cook because of the fire and I never felt free in my own home.

When I had an attack in the streets and I was on my own, I was so vulnerable anyone could have done anything to me, taken me anywhere. I was often found after an attack uncovered or having soiled myself and everyone would know my shame. I was so embarrassed and was afraid to leave the house on my own.

My father would always protect me but my mother was ashamed of me and would get very angry with me. She and my aunts would say that because of the epilepsy I would never be able to get married or have children. I believed that no man would want to marry me and I would often sit down and have a conversation with myself and say, "What kind of life am I going to have?" Some days I would feel so sad that I could not force myself to get out of bed.

After my father, my protector, died, I did meet a nice man and I married him. I was surprised when I became pregnant and I started to understand that what my mother and aunts had told me growing up was wrong. I was nervous about having children and I questioned how well I would be able to look after my babies. I wondered if I would drop them and hurt them if I had an attack. During pregnancy, the attacks were more frequent so I asked for help. I learned about the attacks and understood more about the condition. Now I have two daughters and they know that I have epilepsy and they know that it is not contagious. They have learned my triggers and understand when I am about to have an attack, and when that happens, they help me. They often remind me to take my medication and I am so proud when I hear them educating other children about epilepsy.

It is still hard and my attacks are worse when I am tired and stressed but in general I am able to manage them. The medication has helped a lot and once I got used to taking it regularly it just feels normal now.

I don't feel embarrassed about my epilepsy anymore and I feel sorry for ignorant people who do not take the time to understand me or the condition. As my girls grow up I will start to think about finding a job, but all I can do is take it one day at a time.

Adapted from WHO: Treating and defeating epilepsy in Ghana  
<https://www.youtube.com/watch?v=gFxnbNO02ok>

## EPI role plays

Note: Role plays 3, 4 and 5 are additional to those supplied for the activities – as an option for those wanting to change the role play scenarios and help participants develop different skills.

### Role play 1: Assessment

**Purpose:** This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

**Duration:** 25 minutes.

**Situation: PERSON SEEKING HELP**

- You did not want to come and seek help.
- You believe that you fainted because you have been feeling very tired recently.
- You do not remember fainting and you do not know how long you fainted for, but your spouse has told you that you were shaking for one minute and unresponsive for five minutes.
- This has happened before, about six months earlier, but you were on your own.
- Again, you do not remember how it happened but you do remember waking up and feeling very stiff and achy.
- You do not have a fever, headache, or any symptoms of a neuroinfection. You do drink alcohol, but not very much. You have never used drugs.
- After you fainted you felt very tired and sleepy. Your muscles were aching and you felt weak.
- You do not have a family history of seizures, your birth was normal and you have not had a head injury or suffered any physical trauma.
- You do not have any concurrent MNS conditions.

**Instructions:**

Let your spouse start the conversation.

## Role play 1: Assessment

**Purpose:** This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

**Duration:** 25 minutes.

**Situation: CARER SEEKING HELP**

- You saw your spouse collapse in the garden. You rushed over and watched her shaking on the floor for about one minute.
- You were scared and did not know what to do.
- After the shaking stopped your spouse was unresponsive for five minutes even though you were shouting loudly in her ear.
- You noticed that your spouse had been incontinent of urine during the event.
- You asked your spouse to seek help but she would not.
- You noticed how drowsy your spouse was after the event and it took her some time to recover to normal.
- You are very worried that there is something seriously wrong with her.

**Instructions:**

You are to start the conversation by talking about how worried you are.

## Role play 1: Assessment

**Purpose:** This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

**Duration:** 25 minutes.

**Situation: HEALTH-CARE PROVIDER**

- A person comes to a non-specialized health setting for the first time after they had a fainting spell the week before.
- The person comes with their spouse.
- Conduct an assessment using the mhGAP-IG page 58 to establish whether the person has epilepsy.
- Use effective communication skills with the person and their spouse to establish:
  - Was the seizure convulsive?
  - Did the seizure have an acute cause?
  - Does the person have epilepsy?
  - Are there concurrent MNS conditions?

**Instructions:**

- The carer seeking help will start the conversation.
- You are to conduct an assessment and then explain your findings.

## Role play 1: Assessment

**Purpose:** This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

**Duration:** 25 minutes.

**Situation: OBSERVER**

- A person comes to a non-specialized health setting for the first time after they had a fainting spell the week before.
- The person comes with their spouse.
- The health-care provider conducts an assessment using the algorithm on page 58 of the mhGAP-IG.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' interview
- 5–10 minutes for feedback and small-group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
6. Assesses and manages physical condition

Grade the level of competency the health-care provider achieves.

## Role play 2: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: PERSON SEEKING HELP**

- A health-care provider assessed you and your spouse and decided that you have epilepsy.
- React in a way you think people would upon learning they had epilepsy (including showing any shock, fear, judgement and stigma, resistance, questioning the skills of the health-care provider etc.).
- Listen to the psychoeducation delivered by the health-care provider and ask any questions you may have.
- Ask the health-care provider what you can do to get better. Work with the health-care provider to help you manage the condition.

**Instructions:**

The health-care provider will start the conversation.

## Role play 2: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: CARER SEEKING HELP**

- A health-care provider assessed your spouse and decided they have epilepsy.
- Ask any questions you believe a spouse may have upon hearing that their spouse had a diagnosis of epilepsy (including showing any shock, fear, judgement or stigma).

**Instructions:**

The health-care provider will start the conversation.

## Role play 2: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You have just assessed this person and their spouse and diagnosed them with epilepsy.
- You now have the responsibility to develop a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to the spouse on how to help the person if they have a convulsive seizure at home, and when to refer for medical help.

**Instructions:**

- Start by explaining the results of the assessment and explaining that the person has a condition called epilepsy.
- Ensure that you give appropriate psychoeducation to the person with epilepsy and their spouse.
- Explain that you would like to start the person on antiepileptic medication
- Describe the medication, possible risks and benefits, dosage etc.
- Create a care plan with the person using strategies to promote functioning in daily activities and community life.

## Role play 2: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- A health-care provider assessed this person and their spouse and decided that the person has epilepsy.
- The health-care provider now has the responsibility to develop a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to the spouse on how to help the person if they have a convulsive seizure at home, and when to refer for medical help.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small-group discussion.

Please assess the following competencies:

8. Provides psychosocial intervention
9. Delivers pharmacological intervention

Grade the level of competency the health-care provider achieves.

Ensure that the health-care provider discusses ways to promote the person's functioning in daily activities. Ensure the health-care provider mentions risks of driving, cooking on an open fire, swimming alone, excessive use of alcohol etc.

## Role play 3: Emergency management

**Purpose:** To enable participants to practise emergency assessment and management of epilepsy.

**Duration:** 30 minutes.

### Situation: PERSON SEEKING HELP

- You are Nikolaj, a 17-year-old boy.
- In the past, you have had “episodes” where you felt strange and noticed a funny smell, then blacked out. When you wake up you have been incontinent of urine.
- People have told you that during these episodes you shake. You often wake up feeling confused and sore.
- It happened at school two years ago and you were told not to come back so that you did not make the other children sick. You have not been back since. Your family has put you to work making things to sell in their shop instead.
- You are otherwise well.
- Today, you felt the strange feeling and funny smell coming on, and your mother has taken you to the health clinic which is nearby.

### Instructions:

- You will start the conversation by saying that you do not feel well and you want to lie down.
- When you lie down on the floor you will “pass out” and then start shaking.
- You black out for a long period. You may stop shaking intermittently but then you start again.
- You only wake up once the health-care provider has stated that they are going to give you an anticonvulsant intravenously. When you wake up you are still quite confused.

## Role play 3: Emergency management

**Purpose:** To enable participants to practise emergency assessment and management of epilepsy.

**Duration:** 30 minutes.

**Situation: CARER SEEKING HELP**

- You are Siti, 44-year-old mother to Nikolaj.
- Nikolaj has had these funny episodes for a few years now.
- The episodes are frightening – he will pass out, then start shaking, be incontinent of urine, and then be confused for a while afterwards.
- He had to leave school a few years ago, which made you very sad. You are also worried that he will never get a wife because of these episodes.
- People have told you different things – that maybe he is possessed, or that you will “catch” the same condition and start having the episodes too.
- Today he has told you he thinks one of the episodes is coming on. You have taken Nikolaj to the health clinic.
- You have explained to the health-care provider what has happened in the past.

**Instructions:**

- You accompany Nikolaj and assist. When he starts to become more unwell you become very upset.
- Once the emergency is over, the health-care provider may ask you some questions about Nikolaj’s health. You should answer in the negative or say that you do not know, and that he is fine apart from these episodes.

## Role play 3: Emergency management

**Purpose:** To enable participants to practise emergency assessment and management of epilepsy.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are a local health-care provider in a small community.
- A lady called Siti and her son Nikolaj rush in.
- Nikolaj looks unwell.
- Siti tells you she is worried he is going to have another episode. The episodes sound to you like epilepsy – she describes that he falls down, starts shaking and becomes incontinent. He is often confused when he wakes up.

**Instructions:**

- Nikolaj will start the conversation.
- Perform emergency assessment and management of Nikolaj for suspected epilepsy as per page 57 of mhGAP-IG Version 2.0.
- You will get extra information on physical assessment as you proceed through the role play.
- If a medication or other invasive treatment is needed, say verbally what you would like to give.

## Role play 3: Emergency management

**Purpose:** To enable participants to practise emergency assessment and management of epilepsy.

**Duration:** 30 minutes.

### Situation: **OBSERVER**

- Nikolaj is a 17-year-old boy who seems to have a history of seizures.
- His mother, Siti, has run to the health-care provider as Nikolaj feels a seizure coming on.
- The health-care provider will perform emergency assessment and management of Nikolaj for suspected epilepsy.

### Instructions:

- You will need to provide the following extra information to the health-care provider as they proceed through the examination.
- If they check ABCs, report that Nikolaj has nothing in their airway, is breathing fine and has a stable pulse.
- If they check vital signs, tell them the following (on every occasion):
  - BP 148/102
  - Pulse 127
  - O<sub>2</sub> saturation 96%
  - Temp. 36.4 degrees
  - RR 10.

Nikolaj is in status epilepticus so will not wake up until intravenous anticonvulsants are administered. The role play should end once the health-care provider assesses evaluates for an underlying cause of the convulsions, as per page 57 of mhGAP-IG Version 2.0.

Please keep to time:

- 3 minutes reading
- 10–15 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

7. Assesses and manages emergency presentation

Grade the level of competency the health-care provider achieves.

## Role play 4: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: PERSON SEEKING HELP**

- You are Nikolaj, a 17-year-old boy.
- An hour ago, you had a witnessed seizure, and the health-care provider has now diagnosed you with epilepsy.
- You still feel quite groggy and out of it, but you are interested to know what epilepsy means and what the treatment will be. You are particularly interested to know if this means you can go back to school.

**Instructions:**

- Let the health-care provider start the conversation.
- You ask a few questions on anything you are not sure about.

## Role play 4: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: CARER SEEKING HELP**

- You are Siti, 44-year-old mother to Nikolaj.
- He has just had another seizure, which the health-care provider has told you is "epilepsy". You do not know what this means but you are worried.
- Nikolaj has had a few episodes before and you have had to pull him out of school. You are worried he will never get married. People have told you he might be possessed.
- The health-care provider is about to tell you what the treatment will be.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 4: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care provider working in a local clinic.
- You have just witnessed Nikolaj, a 17-year-old boy, have a seizure after being brought in by his mother, Siti.
- You have diagnosed epilepsy.
- You learn that Nikolaj has been taken out of school because of previous seizures, and that Siti has been very worried about him. Neither of them knows what epilepsy is.
- You now have the responsibility to develop a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to Siti on how to help Nikolaj if he has a convulsive seizure at home.

**Instructions:**

- You are to start the conversation.
- Start by explaining the results of the assessment and explaining that Nikolaj has a condition called epilepsy.
- Ensure that you give appropriate psychoeducation to Nikolaj and Siti.
- Explain that you would like to start the person on antiepileptic medication.
- Describe the medication, possible risks and benefits, dosage etc.
- Create a care plan with Nikolaj and Siti using strategies to promote functioning in daily activities and community life.

## Role play 4: Management

**Purpose:** To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- The health-care provider has just assessed and managed Nikolaj, a 17-year-old boy who has had a seizure.
- The health-care provider has diagnosed him with epilepsy.
- The health-care provider will now need to develop a treatment plan, including psychosocial and pharmacological interventions, as well as instructions to Siti on how to help Nikolaj if he has a convulsive seizure at home, and appropriate psychoeducation.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
8. Provides psychosocial intervention
9. Delivers pharmacological intervention

Grade the level of competency the health-care provider achieves.

Ensure that the health-care provider discusses ways to promote the person's functioning in daily activities, particularly encouraging Nikolaj to return to school and giving reassurance that he can live a normal life. Ensure the health-care provider mentions the risks of driving, cooking on an open fire, swimming alone, excessive use of alcohol etc.

## Role play 5: Follow-up

**Purpose:** To enable participants to practise performing follow-up for a person with epilepsy.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are Nikolaj, a 17-year-old boy who was diagnosed with epilepsy.
- It is now six months later, and you are attending for a follow-up review with the health-care provider.
- You started taking the medication the health-care provider gave you after the witnessed seizure, and it seemed to work well – you had no more seizures and managed to go back to school, which you are very happy about.
- You have had no more seizures since then.

**Instructions:**

Let the health-care provider start the conversation.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** As per above, but you are having terrible side-effects with the medication. You feel sleepy and unsteady on your feet, and you have fallen over and also fallen asleep at school.

**Option 2:** You actually stopped the medication two weeks ago as your mother wanted to save some money to pay for your schooling. Since then, you have had two seizures, but you have not told anyone as you are worried you will not be able to go to school.

## Role play 5: Follow-up

**Purpose:** To enable participants to practise performing follow-up for a person with epilepsy.

**Duration:** 30 minutes.

**Situation: CARER SEEKING HELP**

- You are Siti, 44-year-old mother to 17-year-old Nikolaj.
- Six months ago Nikolaj was diagnosed with epilepsy by the health-care provider.
- He has been taking medication since then and the seizures have stopped.
- He has returned to school.
- You are attending for follow-up.

**Instructions:**

Let the health-care provider start the conversation.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** As per above, but Nikolaj is having terrible side-effects with the medication. You often notice he is sleepy and unsteady on his feet. He has fallen over and fallen asleep when he should be helping you around the house.

**Option 2:** Two weeks ago, you asked Nikolaj to stop the medication. Now that he is back at school there is less money in the house, and you thought that because he has been so well and not had any seizures that he must be cured and no longer needed the medication.

## Role play 5: Follow-up

**Purpose:** To enable participants to practise performing follow-up for a person with epilepsy.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are about to review Nikolaj, a 17-year-old boy, with his mother, Siti.
- You diagnosed Nikolaj with epilepsy six months ago after you witnessed him having a seizure.
- They have returned for follow-up.

**Instructions:**

- Turn to page 67 of mhGAP-IG Version 2.0 and perform follow-up for Nikolaj.
- You are to start the conversation.

---

**Extended version (only read this if instructed by facilitator)**

An extended version option is available for this role-play. Even if instructed to complete this, continue to perform follow-up using page 67 of your mhGAP-IG Version 2.0.

## Role play 5: Follow-up

**Purpose:** To enable participants to practise performing follow-up for a person with epilepsy.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- Nikolaj is a 17-year-old boy, accompanied by his mother, 44-year-old Siti.
- Nikolaj was diagnosed with epilepsy by this health-care provider six months ago after a witnessed seizure.
- He was commenced on medication and has been seizure-free since then.
- Nikolaj and his mother are attending for follow-up.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
10. Plans and performs follow-up

Grade the level of competency the health-care provider achieves.

---

**Extended version (only read this if instructed by facilitator)**

**Option 1:** As per above, Nikolaj is having terrible side-effects with the medication. He feels sleepy and unsteady on his feet, has fallen over and also fallen asleep at school.

**Option 2:** Nikolaj actually stopped the medication two weeks ago as Siti wanted to save some money to pay for his schooling. She thought he must be cured as he has not had any seizures. Since then, Nikolaj has had two seizures, but has not told anyone as he is worried he will not be able to go to school.

# EPI multiple choice questions

- 
1. Which of the following is a common presentation of epilepsy? Choose the best answer:
    - A Delayed developmental milestones.
    - B Slow respiratory rate and pinpoint pupils.
    - C Tremor in hands, sweating and vomiting.
    - D Convulsive movements or fits.
  
  2. Which of the following is a common presentation of epilepsy? Choose the best answer:
    - A Loss of consciousness, stiffness/rigidity, tongue-biting and urinary incontinence.
    - B Marked behavioural changes and neglecting usual responsibilities.
    - C Bleeding from a self-inflicted wound.
    - D Smell of alcohol on breath, slurred speech and uninhibited behaviour.
  
  3. Which of the following statements concerning epilepsy is correct? Choose the best answer:
    - A Epilepsy is a communicable disorder of the brain.
    - B Epilepsy is a sign of spirit possession.
    - C Epilepsy is always genetic in cause.
    - D Epilepsy is one of the most common neurological disorders.
  
  4. Which of the following statements concerning epilepsy is correct? Choose the best answer:
    - A Epilepsy can often cause people to be dangerous to others.
    - B Epilepsy does not occur in children or adolescents.
    - C Epilepsy can be well-controlled in the majority of people with proper treatment.
    - D Epilepsy does not present as an emergency situation and does not always require medication.
  
  5. Which of the following is a common cluster of symptoms in epilepsy? Choose the best answer:
    - A Eclampsia and fever, followed by head injury.
    - B Signs of poisoning and self-harm, followed by loss of consciousness.
    - C Loss of consciousness and tongue-biting, followed by confusion.
    - D Nausea and headache, followed by increased pulse.
  
  6. Which of the following is a common cluster of symptoms in epilepsy after a seizure? Choose the best answer:
    - A Drowsiness, confusion, abnormal behaviour.
    - B Extreme hopelessness and despair, thoughts of self-harm or suicide.
    - C Excessive crying, clinging to a carer, sleeping and eating difficulties.
    - D Dilated pupils, abdominal cramps, diarrhoea.

7. Which of the following is an important step in the emergency treatment of someone with epilepsy having a convulsion? Choose the best answer:
- A Use a calm voice when talking with the patient and listen carefully.
  - B Check airway, breathing and circulation.
  - C Give intramuscular or subcutaneous naloxone.
  - D Give thiamine injection.
- 
8. Which of the following is the best combination treatment for epilepsy? Choose the best answer:
- A Seeing a traditional healer and taking herbal products as advised by them.
  - B Pharmacological interventions and herbal products.
  - C Psychosocial interventions and antiepileptic medication.
  - D Psychosocial interventions and magnesium sulphate.
- 
9. Which of the following might you say to a carer of someone with epilepsy? Choose the best answer:
- A Epilepsy is contagious – they should be careful of touching the person when they are having a seizure.
  - B When the person is having a seizure they should try and restrain them.
  - C The person only needs medication if they feel that a seizure is imminent.
  - D Epilepsy is the recurrent tendency for convulsions.
- 
10. Which of the following requires emergency medical treatment? Choose the best answer:
- A When someone starts to feel that a seizure is imminent.
  - B If the seizure lasts for more than one minute.
  - C If the seizure lasts for more than five minutes.
  - D If the person is drowsy once the seizure is over.

## EPI multiple choice answers

- |        |        |        |        |        |         |        |        |        |        |
|--------|--------|--------|--------|--------|---------|--------|--------|--------|--------|
| 1. = D | 5. = C | 9. = D | 2. = A | 6. = A | 10. = C | 3. = D | 7. = B | 8. = C | 4. = C |
|--------|--------|--------|--------|--------|---------|--------|--------|--------|--------|



# Child and adolescent mental and behavioural disorders

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# CMH supporting material

- Person stories
- Developmental milestones
- Role plays
- Demonstration role play: Conduct disorder
- Multiple choice questions
- Video links

Activity 4: mhGAP CMH module – assessment (developmental disorders)

<https://www.youtube.com/watch?v=GKSTkyv3wAM&index=8&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

Activity 4: mhGAP CMH module – assessment (behavioural disorders)

<https://www.youtube.com/watch?v=H6Nte7lxGlc&index=9&list=PLU4ieskOli8GicaEnDwesQ6-yaGxhes5v>

## CMH person stories

CMH

These are a collection of personal stories describing what it feels like to live with child and adolescent mental and behavioural disorders. Each story should last between three to five minutes. The stories can be adapted as required to fit the context and setting of the training.

You can choose to read out the stories in a creative and engaging manner. Or, where available, you can show videos of the person's story by downloading the videos attached to this document.

If suitable, seek permission to use a person's story from the local area. If there are carers of children/adolescents with mental and behavioural disorders that you know well and would like to share their experiences then ask them to share their story with you. Ask them to describe to you how it feels to be the carer to a child/adolescent with mental and behavioural disorders and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

## Person story 1: Developmental disorder

I am the mother of three wonderful children: Jacob, Faith and Abigail. Jacob is my oldest. I remember the day I first realized that there was something different about Jacob. He was three years old and playing in the park with some other children but unlike the other children, he still could not talk. I assumed it was my fault and told myself that I must be doing something wrong but I did not understand what I was doing wrong.

I would dread waking Jacob up in the mornings as he would throw huge tantrums and it was almost impossible to get him dressed. Watching Jacob throw a tantrum was very stressful he would cry for hours and hours. I was always worried that the neighbours would hear him and would think that I was hurting him. Some of the neighbours and people in the community believed that children who cannot speak or act strangely are possessed or evil. I knew that others blamed me and believed that I must be cursed or have done something wrong to have a child with a problem.

I had no one to talk to as I was so ashamed. I would speak to my husband but we would often disagree and fight as we were both tired and stressed. I found it difficult to sleep or eat and would often just cry. My husband really did not want to accept that there might be something wrong with his first-born son. I felt like he blamed me as well. As time went on Jacob would get more and more stressed as he could not express himself and I did not understand him.

When I had my daughter, and watched her grow I could see the difference between her and Jacob and it broke my heart. I spent many years thinking so much about Jacob and what his problems would mean for him and our family.

By the time my third child arrived I had spent time with a very caring nurse who helped me learn that the most important thing I could do for Jacob was to love him, accept him for who he is and try my best to encourage and help him; I did not need to fix him.

Jacob was always a very affectionate child and would often love to give and receive cuddles, in between tantrums. He always loved to watch me cook in the kitchen. It was hard for him to stop and watch me for long as he would get distracted and need to start moving but when that happened I would get him to help me pour water into the pots. He really enjoyed doing that.

Jacob is now seven years old, he is still very active and struggles to concentrate but things are improving. I have been encouraging Jacob to use gestures and words by responding whenever I notice him communicating. We started with basic words and gestures but have moved on. I have been supporting him so that he can do more to help me in the kitchen. I learned how to break activities down into very small steps to help him understand what he needs to do. Then I would teach him the skill one small step at a time and provide him with lots of encouragement. I think learning to do small steps on his own makes him feel very proud of himself.

We still have a long way to go but things are so much better than they were in the early days. Jacob and his sisters love to play together and I have learned not to blame myself but to be proud of my loving and caring son.

Adapted from: Caregiver stories from WHO Parent Skills Training package for caregivers of children with developmental delay/disorders (available on request).

## Person story 2: Living with intellectual disability

I was six years old. It was September and the long, hot summer had come to an end. When I got to school, I knew something was not quite right. I was returning to the same classroom and the same teacher but there were none of the same students. I was in kindergarten again. My parents told me that my birth date was in the wrong month which meant I could not go into primary school and would have to repeat kindergarten. At the time, I accepted this explanation.

It was not until the following year in grade one that I had any idea that the excuse my parents used for repeating kindergarten was a white lie. I did not know that the real reason was because I could only count to ten while my classmates were counting to 100; I could not tie my shoes while classmate were tying them for me and I could not write my first name.

I have vivid memories of my parents meeting my primary school teacher to discuss my school difficulties. After being sent out of the room fully aware of the topic of conversation, I was mad! How dare you, I thought, have a conversation about me without including me! My attempts to eavesdrop failed, but I did not need to hear what they were saying. I knew exactly what they were talking about – me and my unfinished maths book! I had tried to hide the fact that I could not cope with maths and had hidden the maths book in my desk.

Soon I was faced with one of the most traumatic experiences of my childhood. I found myself with my mother at an interview with a scary doctor who seemed to have no rapport with children. I was commanded to answer her questions. She frightened me and I instantly took a dislike to her. I shut up like a clam and was totally uncooperative. I remember my mother arguing with her so evidently things did not go well. Many years later, I discovered this scary doctor was a very eminent child psychiatrist at a major children's hospital!

The next thing that happened to me was that I was moved into a special education class. I wondered what was so special about me? I was just a normal kid who wanted to fit in, do well in school, and make my parents proud of me, but somehow my inability to do maths seemed to make me "special". So, the "special" kid went into a "special" class with seven other "special" kids, with other "special" problems. I felt different and abnormal.

I remained in the special education class for two years. During this time, I was slowly reintegrated back into the mainstream class. My academic reintegration went fairly smoothly, but my social re-integration was a disaster. On my first day, I went to class wanting to make friends, but I really did not know how. My poor social skills made it difficult for me to relate to people. I had trouble understanding humour, keeping up with conversations, and using and understanding body language. As a result, children did not want to play with me. The memories I have of my early school years are of isolation, loneliness and of the many recesses where I sat alone on the school steps. When I set out to find a friend the kids ran away from me. One well meaning, but misguided, teacher took pity on me sitting by myself and decided to assign me a "friend". News of this assigned friend got around the school and I was told, "You're such a loser, you had to be assigned a friend." Throughout my primary school years, I experienced this kind of social rejection, over and over again. This was the part of my intellectual disability nobody understood.

(continued)

## Person story 2: Living with intellectual disability (continued)

### The story moves forward ... to secondary school

To help with my intellectual disabilities in maths, science and French, I would spend one period a day in the school learning centre, often called the "romper room"! Maths and French were compulsory in grade nine and I had a lot of difficulty with these credits, but coping socially weighed much more heavily on my mind. I dreaded group work because I was always the last one to be picked to join a group. I was really very unhappy in high school. I felt totally isolated, and soon became depressed. I was labelled as being mentally ill and passed from one psychiatrist to another. Many interpretations were made to explain my problem. I was told I had a depressive mental illness and was put on medication. I was told I was too dependent on my parents which I have since learned is very common with intellectual disabilities.

With hindsight, I know all my pain could have been prevented. To know the cause of my problem would have enabled me to cope with it. It was the not knowing that left me in the dark.

I am not sure quite when I discovered I had an intellectual disability. I think I always knew, but could not put a label to it. One day I found myself at an intellectual disability association. Here I read some of the literature on the topic and here I found a revelation. As I filled out an intellectual disabilities checklist, I was amazed to find how much of the list applied to me. I was also amazed to learn that many of the symptoms had to do with social skills.

To be able to label my problem as an intellectual disability was the beginning of my recovery. I had a reason for being as I am. I was not mentally sick, retarded or stupid. As I continued to explore this subject, I found out how many famous people have intellectual disabilities, and as I was able to speak to others on this topic. Finally, I decided to come out of the closet altogether! I decided that much more was to be gained by shouting out my intellectual disability to make others aware of it, though it takes us longer to learn and learning is more difficult, those of us with intellectual disabilities get there in the end and can be successful, productive members of society.

Adapted from: <http://www.ldpride.net/yourhost.htm>

## Person story 3: Living with conduct disorder

A nine-year-old girl named Sybil has been in five different grade schools because of antisocial behaviour. Since the age of six, she has frequently initiated physical fights using broken bottles and bricks. In the past year, to the horror of her neighbours, Sybil stole several of their cats, doused them in gasoline and set them on fire. When asked why, she stated that she thought it was "funny" and that she likes "watching what they (the cats) do when they are on fire." Most recently, she threatened to kill her second-grade teacher for preventing her from attending recess. Her family is no longer able to control her violent outbursts and has brought her to a psychiatric inpatient facility, Prentiss Hospital, in a major urban area. This is Sybil's third such hospitalization.

When Sybil is first admitted to Prentiss, Timothy, a fourth-year medical student planning to pursue a psychiatry residency, is asked to interview her family. Sybil was brought to the hospital by her paternal grandmother and her father, who is wheelchair-bound. He has been in and out of jail for drug-related offenses since Sybil's birth and is agitated throughout the interview. Sybil's grandmother tells the story of Sybil's life. At three months of age, she was removed from her mother's custody because of neglect and has only seen her mother twice since then. She seemed to be doing OK until the age of six (records show she has a normal IQ and was doing well in school), but between the ages of six and seven she became increasingly aggressive and exhibited sexually inappropriate behaviour. Sybil's performance in school deteriorated rapidly, and she currently has domestic violence charges pending against her in court for hitting her cousin in the face with a brick. Her family appeared relieved but also concerned when they left Sybil at Prentiss Hospital that day, no longer able to cope with a problem they did not fully understand.

During her weeks-long stay at Prentiss, Sybil exhausts the staff with her violent outbursts and obsessive need for attention. Day after day, Tim sits down to talk with her and feels that he is getting nowhere. She won't look him in the eye. Her answers to his questions are one-word responses, non sequiturs or deliberate provocation. "When I get out of here I am going to buy me some weed and some new jeans and go with my boyfriend." Or "I like to be mean more than I like to be nice." Weeks pass without stable emotional contacts; Sybil is no longer in touch with her family because phone calls home produced more volatility than calm or reassurance. Sybil herself has lost interest in her family. Early in her hospitalization, Sybil's psychiatrist prescribed a mood stabilizer and an antipsychotic medication, which are mildly effective in controlling her behaviour. The drugs cause a blunted affect and are sedating.

Tim begins to worry that they are losing Sybil and that Sybil is becoming lost to herself. Her tenuous ability to hold on to relationships is being pushed to the brink, and he wonders if the staff shouldn't be more insistent on family connections; isn't some family connection, however difficult, better than none?

Adapted from: <http://journalofethics.ama-assn.org/2006/10/ccas3-0610.html>

## Person story 4: Living with depression in adolescence

My son is 16. He is a beautiful, empathic, popular, funny, smart, athletic young man. However, his depression and anxiety is less than beautiful. In fact, it is ugly, and mean, and at times relentless. Some months ago, my beautiful son, decided that he had had enough of the silent, constant emotional pain that came with feeling less than he felt he should be. Ironically his suicidal thoughts snuck up after a football match where he had scored three goals – and led his team to victory.

I guess I can forgive myself now for assuming that he might have been feeling positive, feeling that for once he was enough. How wrong we were. After the match, my son went into his room, and shut the door. He missed dinner, which was not unusual, however his increasing level of agitation was something I had never witnessed before. My child was restless, angry, and sullen. The pain and desperation in his eyes was something that I will never forget. It was vastly distressing to watch at the time, and even now, as I write, I feel immense sadness.

As the behaviours escalated, we began to realise that our child needed immediate assistance from a health professional. As I sat with our beautiful boy, talking calmly and quietly, my husband went into another room and called a psychiatrist. Our son spoke also with the psychiatrist, who confirmed with us that his depression had really "kicked in".

Will had recently been prescribed medication, and his psychiatrist told us that for this particular crisis, we should increase it to a level where he might feel sedation or calm. We thought about the logistics of driving our son to the hospital, but we were not sure that one of us alone could get him there safely, we have other younger children that we couldn't leave at home, nor did we want to bring them and expose them to the distressing behaviour of their brother. We removed all his electronic devices with internet access, and hid anything that we thought he could use to harm himself.

That night as I continued to talk quietly to him; I reassured him that if the pain got too bad we always have options, we could take him to hospital, or we could organize an emergency "at home assessment". I told him the story of how we had loved him even before he was born, and that we loved him now, more than he could ever imagine. Fortunately, he fell asleep as we talked, and I lay on the floor at the end of his bed until sunrise.

Will continues to see a therapist, and although he still has some rough patches, he is getting better each day. I think as parents, we are forever altered by the experience; we practise self-care, and are learning to be kind on ourselves, and our parenting limitations and abilities.

Adapted from: <https://www.beyondblue.org.au/connect-with-others/personal-stories/story/caroline>

# Developmental milestones

By the age of one month the child should be able to ...  
By the age of six months the child should be able to ...  
By the age of 12 months the child should be able to ...  
By the age of 18 months the child should be able to ...  
By the age of 24 months the child should be able to ...

**By the age of ONE MONTH a child should be able to:**

- Bring both hands towards her or his mouth
- Turn towards familiar voices and sounds
- Suckle the breast

**By the age of SIX MONTHS a child should be able to:**

- Reach for dangling objects
- Sit with support
- Smile

**By the age of 12 MONTHS a child should be able to:**

- Crawl on hands and knees and pull up to stand
- Try to imitate words and sounds and respond to simple requests
- Enjoy playing and clapping
- Pick things up with thumb and one finger

**By the age of TWO YEARS a child should be able to:**

- Walk, climb and run
- Point to objects or pictures when they are named (e.g. nose, eyes)
- Scribble if given a pencil or crayon
- Imitate the behaviour of others
- Make sentences of two or three words
- Learn to defecate in an appropriate place (18 months)

**By the age of THREE YEARS a child should be able to:**

- Walk, run, climb, kick and jump easily
- Say own name and age
- Use make-believe objects in play
- Feed herself or himself

**By the age of FIVE YEARS a child should be able to:**

- Speak in sentences and use many different words
- Play with other children
- Dress without help
- Answer simple questions
- Count five to 10 objects

# CMH role plays

Note: Role plays 1, 3 and 4 are additional to those supplied for the activities – for those wanting to extend training.

## Role play 1: Assessment

**Purpose:** To assess a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are Aziz, a six-year-old boy.
- Your mother has taken you to the health-care provider after your teacher said something to her.
- You are always getting into trouble at school, but it is not your fault.
- You cannot sit still, you are always distracted and you like to keep moving.
- You often have a “sore tummy” or your “head hurts”, particularly when it is the morning and you have to go to school.
- You often refuse to go to school and spend a lot of time alone.

**Instructions:**

- You do not say anything unless asked specifically by the health-care provider.
- You fidget and keep moving around in your chair, sometimes you want to get up to look at something, or play with things in the room. This is quite disruptive.
- If the health-care provider does a physical examination you should respond normally, i.e. you do not have any trouble hearing or seeing.

## Role play 1: Assessment

**Purpose:** To assess a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

### Situation: CARER SEEKING HELP

- You are Fatima, mother to Aziz (six years old).
- You have decided to bring him to the health centre because he often complains about a headache and stomach ache in the morning and refuses to go to school. He is failing to make expected weight gains.
- His teacher also expressed some concerns about Aziz's behaviour and suggested that you take him to the doctor. Aziz is constantly moving, and not able to sit calmly for more than a few minutes.
- In class, he keeps changing his position or playing with objects on his desk.
- He is not able to focus on an assignment for more than a few minutes and often forgets to do the homework.
- He spends a lot of time alone.
- You are very worried about him and very stressed.
- You have five other children who are all well-behaved and you get frustrated with Aziz that he is like this.
- Your husband sometimes gives Aziz a smack when he cannot sit still and is disruptive at home.
- As far as you know, Aziz's health is otherwise ok.

### Instructions:

Let the health-care provider start the conversation.

## Role play 1: Assessment

**Purpose:** To assess a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

### Situation: HEALTH-CARE PROVIDER

- You are meeting with Fatima and her son Aziz, who is six years old.
- Fatima is very worried about Aziz because he is complaining of feeling unwell and refusing to go to school.
- The teacher also has some concerns, which Fatima will tell you about.

### Instructions:

- You are to start the conversation.
- Perform an assessment for a child and adolescent mental and behavioural disorder, starting on page 72 of your mhGAP-IG.
- Make sure you do a full assessment and assess for all disorders, as there may be more than one.
- At the end, make sure you tell Fatima what you think is going on with Aziz.

## Role play 1: Assessment

**Purpose:** To assess a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- Aziz is six years old. His mother, Fatima, has brought him to the health centre because he often complains about a headache and stomach ache in the morning and refuses to go to school. He is losing weight.
- The mother reports that Aziz's teacher has also expressed some concerns about Aziz's behaviour and suggested that she take him to see a health-care provider.
- Aziz is constantly moving, and not able to sit calmly for more than a few minutes. In class, he keeps changing position or playing with objects on his desk. He is not able to focus on an assignment for more than a few minutes and often forgets to do the homework. He spends a lot of time alone.

**Instructions:**

- The health-care provider will perform an assessment for a child and adolescent mental and behavioural disorder, starting on page 72 of your mhGAP-IG.
- They will need to do a full assessment and assess for all disorders, as there may be more than one.
- If they perform a physical examination, you can report that all the findings they ask for are normal.

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion..

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment

And grade the level of competency the health-care provider achieves.

## Role play 2: Psychosocial intervention

**Purpose:** To provide psychosocial interventions for a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are Aziz, a six-year-old boy.
- Your mother has taken you to the health-care provider after your teacher said something to her.
- You are always getting into trouble at school, but it is not your fault.
- You cannot sit still, you are always distracted and you like to keep moving.
- You often have a “sore tummy” or your “head hurts”, particularly when it is the morning and you have to go to school.
- You often refuse to go to school and spend a lot of time alone.
- The health-care provider has just told your mother that you have “ADHD and maybe an emotional disorder”.
- You do not know what this means but you listen to what the health-care provider says.

**Instructions:**

- You do not say anything unless asked specifically by the health-care provider.
- You fidget and keep moving around in your chair, sometimes you want to get up to look at something, or play with things in the room.

## Role play 2: Psychosocial intervention

**Purpose:** To provide psychosocial interventions for a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: CARER SEEKING HELP**

- You are Fatima, mother to Aziz (six years old).
- You have decided to bring him to the health centre because he often complains about a headache and stomach ache in the morning and refuses to go to school. He is failing to make expected weight gains.
- His teacher also expressed some concerns about Aziz's behaviour and suggested that you take him to the doctor. Aziz is constantly moving, and not able to sit calmly for more than a few minutes.
- In class, he keeps changing his position or playing with objects on his desk.
- He is not able to focus on an assignment for more than a few minutes and often forgets to do the homework.
- He spends a lot of time alone.
- You are very worried about him and very stressed.
- You have five other children who are all well-behaved and you get frustrated with Aziz that he is like this.
- Your husband sometimes gives Aziz a smack when he cannot sit still and is disruptive at home.
- As far as you know, Aziz's health is otherwise ok.
- The health-care provider has just told you Aziz has "ADHD and maybe an emotional disorder". You do not know what this means so you are keen to hear what the management is.

**Instructions:**

You are concerned that your son has been diagnosed with a mental and behavioural disorder so you ask lots of questions, including whether he should still go to school or if he will get married.

## Role play 2: Psychosocial intervention

**Purpose:** To provide psychosocial interventions for a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are meeting with Fatima and her son Aziz, who is six years old.
- Fatima is very worried about Aziz because he is complaining of feeling unwell and refusing to go to school.
- The teacher also has some concerns, including that he is constantly moving, not able to sit calmly, and plays with objects on his desk. He is not able to focus on his assignments and often forgets to do the homework.
- He spends a lot of time alone.
- You have just diagnosed Aziz with ADHD, and think he may have an emotional disorder as well.

**Instructions:**

- You do not need to perform an assessment for Aziz.
- Please proceed to page 85 of your mhGAP-IG to begin providing psychosocial management for Aziz and his mother Fatima.
- Make sure you give general and specific recommendations for both conditions.

## Role play 2: Psychosocial intervention

**Purpose:** To provide psychosocial interventions for a child and their carer for a child and adolescent mental and behavioural disorder.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- Aziz is six years old. His mother, Fatima, has brought him to the health centre because he often complains about a headache and stomach ache in the morning and refuses to go to school. He is failing to make expected weight gains.
- The mother reports that Aziz's teacher has also expressed some concerns, that Aziz is constantly moving, and not able to sit calmly for more than a few minutes. In class, he keeps changing position or playing with objects on his desk. He is not able to focus on an assignment for more than a few minutes and often forgets to do the homework. He spends a lot of time alone.
- The health-care provider has just identified him as having ADHD, and suspects a likely emotional disorder as well. They will now provide psychosocial management.

**Instructions:**

- The health-care provider does not need to perform an assessment for Aziz.
- They should proceed to page 85 of mhGAP-IG to begin providing psychosocial management for Aziz and his mother Fatima.
- They should give general and specific recommendations for both conditions.
- If they perform a physical examination, you can report that all the findings they ask for are normal.

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion..

Please assess the following competencies:

4. Uses effective communication skills
7. Provides psychosocial interventions

And grade the level of competency the health-care provider achieves.

## Role play 3: Assessment and management

**Purpose:** To practise assessment of a child, and provide management for a child and adolescent mental and behavioural disorder.

**Duration:** 40 minutes.

### Situation: PERSON SEEKING HELP

- You are Nisha, a four-year-old girl.
- You have a developmental disorder.
- You do not talk, but grunt occasionally.
- You just look around the room but do not make specific eye contact.
- You grunt if there is a loud noise.
- You do not really react to what is happening in the room.
- You have a limp in your walk, you need your mother's help to walk properly.
- You do not misbehave.

### Instructions:

Let the health-care provider start the conversation and examine you as needed.

## Role play 3: Assessment and management

**Purpose:** To practise assessment of a child, and provide management for a child and adolescent mental and behavioural disorder.

**Duration:** 40 minutes.

### Situation: CARER SEEKING HELP

- You are Daria, mother to Nisha, a four-year-old girl.
- You are worried about Nisha as she does not seem to be making the same progress as her older brothers.
- She only started to sit up at one year old, and could only walk from three years old. She still walks with a limp and needs your support.
- She still does not talk or communicate, but grunts occasionally if she is uncomfortable.
- She does not make proper eye contact but often just stares around the room.
- She is meant to start school soon but you cannot see how she will manage.
- She does not dress or toilet herself without help.
- She does smile occasionally and likes to be hugged or sung to, but you only volunteer this information if asked specifically.
- She is not a lot of trouble, but because she does not interact you often just leave her in a cot all day so you can get on with the housework.
- You do not like to leave the house with her as you do not want people to talk about her. For the same reason, you do not want to send her to school either.
- You have heard that sometimes children like this are put in care homes and your husband has asked you to ask about this.

### Instructions:

- Let the health-care provider start the conversation.
- However, you should ask a lot of questions and get quite upset when talking about Nisha.

## Role play 3: Assessment and management

**Purpose:** To practise assessment of a child, and provide management for a child and adolescent mental and behavioural disorder.

**Duration:** 40 minutes.

### Situation: **HEALTH-CARE PROVIDER**

- You are a health-care provider, and Daria is a mother who has just brought in her daughter, Nisha.
- You can see that Nisha appears to not be talking or making eye contact.
- You know that Daria is worried that Nisha has not walked and talked at the same time that her brothers did.

### Instructions:

- You are to start the conversation.
- Turn to page 72 of your mhGAP-IG and perform an assessment of Nisha and her mother. Ensure you include a physical examination.
- After this, tell Daria what you think is going on and provide a psychosocial intervention.

## Role play 3: Assessment and management

**Purpose:** To practise assessment of a child, and provide management for a child and adolescent mental and behavioural disorder.

**Duration:** 40 minutes.

### Situation: **OBSERVER**

- Nisha is a four-year-old girl who has been brought in by her mother.
- She is not talking.
- She sat up and walked at a later age than other children.
- She cannot care for herself.
- She is often left in a cot for long periods of the day.
- She does not misbehave or cause trouble, and smiles occasionally.

### Instructions:

- The health-care provider will need to perform an assessment and then provide psychosocial interventions.
- You will need to provide the following extra information to the health-care provider as they proceed through the examination:
  - Does not follow moving object with eyes.
  - Hearing is fine.
  - Nisha is showing signs of malnutrition – very thin, signs of anaemia (pale conjunctiva), dehydrated with dry mucosa.

Please keep to time:

- 3 minutes reading
- 20–25 minutes' consultation
- 10 minutes for feedback and small group discussion..

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
7. Provides psychosocial interventions

And grade the level of competency the health-care provider achieves.

## Role play 4: Assessment and management

**Purpose:** To assess and manage an adolescent presenting with a behavioural disorder.

**Duration:** 40 minutes.

### Situation: PERSON SEEKING HELP

- You are John, a 13-year-old boy.
- Your father has made you see the health-care provider and you are angry about this.
- You do not think there is anything wrong with you.
- You do get in trouble a lot at school but you do not care, you hate school.
- You think your classmates are idiots and often get into fights with them.
- You were recently in trouble for harming a cat.
- You now do not bother going to school if you can avoid it.
- This has caused lots of arguments at home, it was made worse when your parents found out you stole money from them. You think they are unfair.

### Instructions:

- You do not care about this interview, you act angry and do not really give helpful answers.
- You sit with your arms crossed and stare at the floor the whole time.

## Role play 4: Assessment and management

**Purpose:** To assess and manage an adolescent presenting with a behavioural disorder.

**Duration:** 40 minutes.

### Situation: CARER SEEKING HELP

- You are father to John, a 13-year-old boy who you have taken to see the health-care provider due to your concerns about his behaviour.
- John has been skipping lessons over the past few months and has stolen quite a large amount of money from home.
- The teachers have recently punished him for maltreating a cat, and for aggressive behaviour towards classmates. They also report that he is very impulsive and difficult to manage.
- You are getting fed up with his behaviour. You are not afraid to tell the health-care provider that you "give him a good whack" whenever he gets him trouble.
- You do not spend much time with him anymore because you are angry with his behaviour.
- You are thinking of "kicking him out of home" if this continues.

### Instructions:

Let the health-care provider start the conversation.

## Role play 4: Assessment and management

**Purpose:** To assess and manage an adolescent presenting with a behavioural disorder.

**Duration:** 40 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are about to interview John and his father.
- John's father has brought him in as he is concerned about his behaviour, and there have been some issues at school as well.

**Instructions:**

- Perform an assessment of John and his father, starting on page 72 of the mhGAP-IG.
- Once the assessment is complete, tell John and his father what you think is going on.
- Then, starting at page 85 of your mhGAP-IG, provide a psychosocial intervention to John and his father.

## Role play 4: Assessment and management

**Purpose:** To assess and manage an adolescent presenting with a behavioural disorder.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- John, is a 13-year-old boy who has been taken to see the health-care provider by his father due to concerns about his behaviour.
- John has been skipping lessons over the past few months and has stolen quite a large amount of money from home.
- The teachers have recently punished him for maltreating a cat, and for aggressive behaviour towards classmates. They also report that he is very impulsive and difficult to manage.

**Instructions:**

- The health-care provider will need to perform both an assessment and provide a psychosocial intervention for John and his father.
- If they perform a physical examination, you can report that all the findings they ask for are normal.

Please keep to time:

- 3 minutes reading
- 20–25 minutes' consultation
- 10 minutes for feedback and small group discussion..

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
7. Provides psychosocial interventions

And grade the level of competency the health-care provider achieves.

## Role play 5: Follow-up

**Purpose:** To give participants the opportunity to practise developing the skills necessary to deliver a follow-up assessment to an adolescent with depression.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You were identified as having depression three months ago.
- You have not been seen by the health-care provider for three months as you do not want to attend. They have been calling you for six weeks to come in for a follow-up visit to which you finally agree.
- Since your last meeting with the health-care provider things have been getting more difficult.
- You are continuing to fight with your family, especially your father. You are finding it harder and harder to talk to your mother as you feel she is not listening to you.
- You are feeling very sad and you cry almost every day.
- You are not attending school as you do not have the energy and you worry that you will be in trouble with your teachers for not having completed your study.
- You have not had any thoughts of self-harm/suicide but you have felt hopeless about your future.

**Instructions:**

- You are very quiet and withdrawn.
- Let the health-care provider start the conversation.

## Role play 5: Follow-up

**Purpose:** To give participants the opportunity to practise developing the skills necessary to deliver a follow-up assessment to an adolescent with depression.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- An adolescent was identified as having depression three months ago.
- After trying to get the young person to come for a visit for over six weeks they finally agree.
- They have not been seen by a health-care provider for three months.

**Instructions:**

- You are to start the conversation.
- Carry out a routine follow-up assessment on the adolescent to see if their symptoms have improved or not.
- Assess if the adolescent is experiencing any new problems or symptoms related to their depression.
- Be particularly aware of assessing the adolescent for suicidal thoughts.
- Possible questions to ask:
  - *"Have you ever felt so bad that you have had thoughts of being dead or killing yourself?"*
  - *"Some people hurt themselves by hitting, cutting, burning or other ways to try to cope with uncomfortable or painful feelings. Is this something you have done?"*
- **Remember that asking about self-harm/suicide does NOT provoke acts of self-harm/suicide. It often reduces anxiety associated with these thoughts or acts and helps the person feel understood.**
- Explore the psychosocial stressors at home, in their relationships, at school and for any exposure to maltreatment.
- Explore with the adolescent whether medication would be beneficial.

## Role play 5: Follow-up

**Purpose:** To give participants the opportunity to practise developing the skills necessary to deliver a follow-up assessment to an adolescent with depression.

**Duration:** 30 minutes.

### Situation: **OBSERVER**

- The adolescent was identified as having depression three months ago.
- After chasing the young person for over six weeks they finally agree to come for a follow-up visit.
- They have not been seen by a health-care provider for six weeks.
- Things have been more difficult for the adolescent since the last appointment they are not getting any better.

### Instructions:

- The health-care provider will carry out a routine follow-up assessment on the adolescent to see if their symptoms have improved or not.
- They should:
  - Carry out a routine follow-up assessment on the adolescent to see if their symptoms have improved or not
  - Assess if the adolescent is experiencing any new problems or symptoms related to their depression.
  - Be particularly aware of assessing the adolescent for suicidal thoughts.
  - Explore the psychosocial stressors at home, in their relationships, at school and for any exposure to maltreatment.
  - Explore with the adolescent whether medication would be beneficial.

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion..

Please assess the following competencies:

4. Uses effective communication skills
5. Plans and performs follow-up

And grade the level of competency the health-care provider achieves.

# Demonstration role play: Conduct disorder

Perform the case demonstration (with other two facilitators) in plenary according to the script. It will take about 10 minutes.

## SETTING: HEALTH CENTER

NURSE RUTH, a middle-aged woman wearing a white gown welcomes SENAIT, a young married woman that she already knows, and greets SENAIT's 13-year-old son, JOHN. She invites SENAIT and JOHN into the room and asks them to take a seat.

NURSE RUTH

*So, please tell me why you are here today.*

SENAIT

*Well, his teachers told me that John has been fighting a lot with the other children at school and skipping his lessons.*

JOHN (sitting quietly looking away from Nurse RUTH and his mother)

SENAIT (visibly upset)

*He does not listen to me anymore, and when I talk to him, he is angry very easily. My mother and father- in- law have told me that he is being disrespectful. I thought that this was only at home, but his teachers told me that he does not listen to them either.*

NURSE RUTH (to John)

*John, what do you think about your mother is saying?*

JOHN (still looking away)

*I don't know.*

SENAIT

*He also has new possessions (to John). John, where did you get the money for those things?*

JOHN

*I already told you, my friends gave it to me.*

SENAIT

*He always blames things on his friends.*

NURSE RUTH

*How often does he get into fights at school and how long has this been going on for?*

SENAIT

*His teacher told me that recently, the fights are almost every week and it seems like it has been getting worse over the past year. He was doing very well in school and now he barely makes passing marks. He is very smart but he has become careless and lazy.*

NURSE RUTH

*It is good that you recognize that he is smart. But right now, you both seem very frustrated with what is happening. Is there anything that happened at home or at school when all of these things started happening?*

**SENAIT**

*No, not that I can think of.*

**NURSE RUTH**

*And overall, John has been healthy? Does he have any medical problems?*

**SENAIT**

*No, he is very healthy.*

**NURSE RUTH**

*I can see that you both are frustrated, and I would like to be able to help you. Would it be possible for you to wait a few moments outside the room so that I may speak with John alone?*

**SENAIT**

*Yes, that would be fine. (Senait steps outside the room)*

**NURSE RUTH**

*John, your mother has told me some things but I would like to hear your side of the story. I want to let you know that I have asked your mother to step outside so that we may talk in confidence.*

**JOHN (now looking at Nurse RUTH)**

*Things are not as bad as she said. I just don't like the people in my school, so I started spending time with some older kids.*

**NURSE RUTH (looking at the John)**

*Tell me more about your new friends. What do you enjoy about spending time with them?*

**JOHN**

*Are you going to tell my mother?*

**NURSE RUTH**

*Like I said before, I will not share what you tell me now with anybody else.*

**JOHN**

*Well, my new friends are more fun. We play pranks on other people, sometimes they steal things, but it doesn't hurt anyone.*

**NURSE RUTH**

*I see. And what do you think would happen if you did get caught?*

**JOHN**

*My mother has asked me but I just deny it or walk away from her. I know it makes her upset but like I said it doesn't hurt anyone.*

**NURSE RUTH**

*It seems that your mother is hurt then. Does your father ask you about it as well?*

**JOHN**

*No, he spends most of his time at work and did not notice it.*

NURSE RUTH

*I see. Tell me, what other things do you do for recreation?*

JOHN

*I play football and listen to music.*

NURSE RUTH

*That's great, do you still enjoy those things?*

JOHN (smiling)

*I still play football every weekend and my whole family has always enjoyed music.*

NURSE RUTH

*That sounds like something that you can still enjoy together. Can you tell me a little more about how school is going?*

JOHN

*I used to be a good student, I'm smart, you know? But I've been skipping lessons to be with friends, and so my marks are not so good anymore.*

NURSE RUTH

*I can tell you are a smart person. You have a lot to say and I appreciate that you are being honest with me. It seems that your friends are very important to you but they sometimes get you into trouble.*

JOHN

*I guess that is true.*

NURSE RUTH

*Do any of your friends use drugs or alcohol?*

John

*Some of them steal beer from the store or their house but I've never seen any of them using any drugs.*

NURSE RUTH

*And how about you, have you ever tried alcohol or drugs?*

JOHN

*No way! I've seen my friends drunk and I don't want to look like that. Whenever they start drinking I just leave.*

NURSE RUTH

*You are very smart to get away from that situation. Drugs and alcohol can really cause a lot of problems and lead you to make poor choices.*

JOHN

*I know, that's why I don't do those things.*

NURSE RUTH

*So, John, what would you like to have happen after this visit? Your mother expressed some of her concerns and it seems that you don't share the same concerns.*

JOHN

*I don't think things are that bad and I don't think that I really need to come back here. I know that I need to just go to school. My grades will improve.*

NURSE RUTH

*I see that you know what things need to change, and attending school is one thing that would help. Another thing that would help is to stop fighting at school, do you agree?*

JOHN

*Yes. I will try.*

NURSE RUTH

*Even though you don't feel like you need to come back, I think it is important, so how about I give you some options and then we can have your mom come in and all come to an agreement about what happens next?*

JOHN

*Okay, fine.*

NURSE RUTH

*Let us start with those two goals and plan to meet again in one month. If you miss school again, then I will see you again in two weeks.*

JOHN

*Okay, but I'm not going to miss school anymore.*

NURSE RUTH

*Very good then. John, I really appreciate your honesty and will also be honest with you. You are a very smart person and am proud of you that you have managed to stay away from drugs and alcohol. Is there anything else that you would like to tell me before we ask your mother to come back into the room?*

JOHN

*No.*

NURSE RUTH

*Okay, can you ask your mother to come back in?*

JOHN (stands up to get his mother)

SENAIT (sits down)

NURSE RUTH (to Senait)

*Thank you for waiting outside. (to John) John, would you like to tell your mother what the plan will be?*

JOHN

*Okay. I'm not planning to skip lessons anymore. And, I won't get into fights anymore either.*

SENAIT

*Really? I don't believe it. And what am I supposed to do if he does miss school or if the teachers notify me that he has been in another fight?*

NURSE RUTH

*Well, John was the one who came up with these goals and so we should give him a chance to meet them. Let us plan to meet again in one month. If things are not going well and John is missing school or is in another fight, please come back in two weeks. With your permission, may I speak with John's teacher? I would like to make sure that John has an opportunity to improve his grades and also understand what concerns the school may have. The school can also offer support and may have resources so that John can meet his goals.*

SENAIT and JOHN

*That's fine.*

NURSE RUTH

*Do you have any other questions or concerns? We know that things may not change immediately but we can all work together improve the situation.*

SENAIT and JOHN

*No.*

NURSE RUTH

*Then that's it for today. Just to summarize for all of us, we all agree that attending school and avoiding fighting is the goal right now. We each have a task to do. Senait, you will encourage John to meet his goals and be positive about the behaviours he wants to change. John, your goal is to attend school and avoiding fighting. We will meet again in one month to see how things are going and during that time I will contact the school to see if there are any other areas that need to be addressed. If things are not going as planned, then we will meet in two weeks instead.*

JOHN

*Ok, I can do that.*

SENAIT

*Thanks very much for your help.*

NURSE RUTH

*You're welcome. See you soon.*

# CMH multiple choice questions

- 
1. Which of the following is the best description of a child developmental disorder? Choose only one answer:
    - A Child developmental disorders have a relapsing and remitting course.
    - B Child developmental disorders are always associated with abuse and neglect.
    - C Child developmental disorders category includes attention deficit hyperactivity disorder and conduct disorder.
    - D Child developmental disorders involve impaired or delayed functions related to central nervous system maturation.
  2. Which of the following is the best description of a child and adolescent behavioural disorder? Choose only one answer:
    - A Behavioural disorders involve impaired or delayed functions related to central nervous system maturation.
    - B Behavioural disorders category includes attention deficit hyperactivity disorder and conduct disorder.
    - C Behavioural disorders are characterized by increased levels of somatic symptoms.
    - D Behavioural disorders can include extreme shyness and clinging to a carer.
  3. Which of the following is the best description of a child and adolescent emotional disorder? Choose only one answer:
    - A Child and adolescent emotional disorders are very uncommon.
    - B Child and adolescent emotional disorders category includes autism spectrum disorder and intellectual disability.
    - C Child and adolescent emotional disorders often overlap with other developmental and behavioural disorders.
    - D Child and adolescent emotional disorders category includes attention deficit hyperactivity disorder and conduct disorder.
  4. Which of the following cluster of symptoms is most likely to represent a child and adolescent mental and behavioural disorder? Choose the best answer:
    - A Chronic HIV infection, but otherwise well-cared for.
    - B Failure to thrive, delay in reading and writing, poor school performance.
    - C Untreated thyroid condition in a child.
    - D Fever and convulsions in a child with infection.
  5. Which of the following cluster of symptoms is most likely to represent a child and adolescent mental and behavioural disorder? Choose the best answer:
    - A Excessive running around, absent-mindedness, repeated behaviour that disturbs others.
    - B Uncontrolled pain from an ear infection.
    - C Untreated malnutrition due to famine.
    - D A very active toddler, but no different to his older brother and not causing the family any distress.

- 
6. Which of the following cluster of symptoms is most likely to represent a child and adolescent mental and behavioural disorder? Choose the best answer:
- A Visual and hearing impairment.
  - B Decline in memory and loss of orientation.
  - C Excessive crying and clinging, refusal to go to school, problems with mood.
  - D Convulsive seizure due to metabolic abnormality.
- 
7. Which of the following statements regarding child and adolescent mental and behavioural disorders is correct? Choose the best answer:
- A Child and adolescent mental and behavioural disorders rarely overlap with each other.
  - B Child and adolescent mental and behavioural disorders often have a relapsing and remitting course.
  - C Child and adolescent mental and behavioural disorders should be assessed independently of the home and school environments.
  - D Child and adolescent mental and behavioural disorders often present with concerns from the carer, teacher or community health worker.
- 
8. Which of the following statements regarding assessment for child and adolescent mental and behavioural disorders is correct? Choose the best answer:
- A You only need to assess the child or adolescent in the domain (i.e. motor, cognitive, social, communication and adaptive) which seems most relevant.
  - B You only need to assess for symptoms of one disorder as the conditions rarely overlap.
  - C You do not need to assess for other priority MNS conditions as the child or adolescent is too young.
  - D You should always assess the home and school environment of the child or adolescent.
- 
9. Which of the following situations with a child or adolescent would require urgent action? Choose the best answer:
- A A child discloses to you that they are being sexually abused.
  - B A parent discloses to you that their child was born with HIV and is currently receiving treatment.
  - C A child has considerable difficulty with daily functioning.
  - D A child shows disobedient or defiant behaviour.
- 
10. Which of the following is good advice for any child and adolescent mental and behavioural disorder? Choose the best answer:
- A The carer can use threats or physical punishment if a child has problematic behaviour.
  - B The carer should remove the child from mainstream school as soon as possible.
  - C The carer can use other aids such as television or computer games instead of spending time with the child.
  - D The carer should give loving attention to the child every day and look for opportunities to spend time with them.

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11. Which of the following is the best first-line treatment for child and adolescent developmental disorder? Choose only one answer:

- A Psychosocial intervention.
  - B Pharmacological treatment.
  - C Referral to specialist.
  - D Referral to outside agency.
- 

12. Which of the following actions can help protect the rights of the child and adolescent with a mental or behavioural disorder? Choose the best answer:

- A Encouraging institutionalization where it is available for the child.
  - B Encouraging the child to leave school early and remain in the house, as they are unlikely to learn anything.
  - C Encouraging the child to participate in family and community life.
  - D Encouraging criticism and punishment for any inappropriate behaviour.
- 

13. Which of the following should be given as advice to an adolescent with a mental or behavioural disorder? Choose the best answer:

- A They should avoid community and other social activities as much as possible.
- B They should avoid the use of drugs, alcohol and nicotine.
- C They should avoid school if it makes them anxious.
- D They should avoid being physically active for more than 30 minutes each day.

## CMH multiple choice answers

1. = D	6. = C	11. = A	5. = A	10. = D
2. = B	7. = D	12. = C	4. = B	9. = A
3. = C	8. = D	13. = B		

# Dementia

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# DEM supporting material

- Person stories
- Role plays
- Case scenarios
- Treatment planning handouts
- Treatment planning suggestions
- Multiple choice questions
- Video link

## Activity 3: mhGAP DEM module – assessment

<https://www.youtube.com/watch?v=f09nwqF1OJE&index=11&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

## DEM person stories

These are two personal stories describing what it feels like to live with dementia. Each story should last between three to five minutes maximum. The stories can be adapted as required to fit the context and setting of the training.

You can choose to read out the stories in a creative and engaging manner. Or, where available, you can show videos of the person stories by downloading the videos.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who are living with dementia and would like to share their experiences, then ask them to share their story with you. Ask them to describe to you how it feels to live with dementia and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

## Person story 1: My disappearing world...

My name is Kate. I am married and have two sons who are 21 and 22. I was born in 1958 in a small country hospital and grew up in a farming community. My first career was nursing, specializing in operating theatres. I then changed careers and became a chef. Finally, I worked in health-care sales.

In 2008, I was working full time, studying for a double degree, caring for our school-age children and running our home with my husband. Then, I was diagnosed with dementia, a debilitating and terminal illness that is trying to steal the very essence of who I am. Losing my legs and arms or my sight or hearing might be better than this hideous disease. I cried, almost nonstop, for about three weeks. I used to think "if only someone would tell me it is depression or some bizarre mental illness... anything other than dementia". It feels as if my soul is being sucked out, little by little, as my world slowly disappears.

It started with headaches followed by symptoms of dyslexia. I would try and read books but the letters would move themselves on the page and appear scrambled with lost meaning. I am terrified at the idea of losing my independence and having to go into institutional care. My life has changed in ways that are challenging to understand and difficult to live with. The feeling that my life is slipping away from me is almost tangible and I do sometimes feel cheated. I fear that I will never get to know my grandchildren. Speaking and thinking is more difficult, the search for words, the meaning of words, numbers and equations, now a major challenge. It is harder to process information, to know how to act and to respond, how to behave appropriately and to know what to do in normal everyday situations. I am disappearing. My mind is filling up with hallucinations of wild cats and strangers. These things feel real for a moment and terrifying for days afterwards as I feel the madness creeping into my soul. I am hearing things that are not there, becoming fixated on things, and adopting strange behaviours. I spend my days getting lost and I feel as if I am drowning.

It is no longer possible to be sure of what I will do or how I will behave, reducing my desire and enthusiasm to go out to socialize or to do simple things. It feels humiliating and demoralizing to show my symptoms, and I am often very fatigued as I spend a large amount of energy hiding them. Sadly, because of this many people do not believe I have dementia.

I fear the doctors and nurses will be too slow to help as my world disappears.

<https://www.fightdementia.org.au/about-dementia/resources/stories/my-disappearing-world>

## Person story 1: Dementia

My mother was diagnosed with Alzheimer's disease two years ago, aged 60, and there is barely any aspect of her life that has been unaffected by her diagnosis. She had to retire earlier than she would have otherwise and has not been able to enjoy retirement to the fullest, as she so deserved. Mum's communication has also been affected by the dementia. She often has things she wants to tell us because she still has interests and notices the things going on around her, but the words regularly escape her, leaving her scared, sad and frustrated.

Sadly, some of mum's friends do not call/visit anymore as they are too daunted by the diagnosis – even though mum is still very much herself minus the same ability to express herself. Unfortunately, they proved Mum right in her earlier reluctance to share her diagnosis as she feared people would immediately treat her differently if they did know. My father is having to learn skills that he has not had to master previously, such as cooking. At the same time he's aware that he needs to tread carefully and ensure he's not taking tasks from mum before she is ready to give them up, as this can upset her. This is one of the crueler parts of Alzheimer's; that the person living with the condition is totally aware of the fact that they are losing their capacity to perform even the most menial task. These are just a few of the things mum deals with daily, along with the terrifying knowledge of what lays ahead.

Mum has expressed to me that her greatest fear is being in a care facility and being quite aware, but not having the ability to speak and express herself. I believe this is one of the most important messages we need to get out to the wider community. Although people with dementia may not be able to properly communicate, they often still understand a lot of what's going on around them. They deserve respect, compassion, dignity and at least the same standard of care as someone fully comprehending and expressive. Most people reading this would know about these symptoms and struggles, as they have been touched in some way by dementia. The general public, however, knows very little about the realities of the disease because it is frightening and this is what I strongly believe needs to change. We must educate people about all forms of dementia.

People need to know that the person with dementia they encounter may seem incapable of comprehending because they are unable to express themselves, but that they may be quite aware of what is happening. My father, siblings, nephews, my children and I have lost some part of our precious mother and grandmother already, and remain heartbroken and scared about the future. Two things are certain for me though. Firstly, we will all be with mum every step of this path she walks, with love, compassion and admiration for how she faces it. Secondly, I personally will do whatever I can to raise awareness about the realities of living with Alzheimer's so that people with the condition may be better understood and treated in future. If you meet someone out in the community that you suspect has some form of dementia, PLEASE treat them with respect, kindness, patience, understanding and care.

<https://www.fightdementia.org.au/about-dementia/resources/stories/vanessa>

## Role play 1: Assessment

**Purpose:** To assess a person for dementia and their carer.

**Duration:** 30 minutes total or less.

**Situation: CARER SEEKING HELP**

- You are Farah, a 45-year-old lady.
- You have brought your mother Ingrid, 73 year old, to see the health-care provider.
- You report that your mother has been acting strangely over the last few months.
- Your mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people she has known for years.
- You also are very concerned about the future.
- Your father died last year and your mother seems to have slowly deteriorated since then.
- Your mother has had a lot of trouble remembering to do things.
- She usually doesn't remember how she got there.
- Her memory problems started gradually and have got worse.
- You are experiencing three main problems in organizing care for your mother: problems with hygiene and bathing; problems with using the toilet, in particular incontinence of urine; and problems with repeated questioning.
- You have symptoms of fatigue and drowsiness over the last month.
- The fatigue seems to be there all the time.
- The fatigue and drowsiness are making it difficult to work and spend time with family.
- You are otherwise well.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 1: Assessment

**Purpose:** To assess a person for dementia and their carer.

**Duration:** 30 minutes total or less.

### Situation: PERSON SEEKING HELP

- You are Ingrid, a 73-year-old lady.
- Your 43-year-old daughter, Farah, has brought you to see a health-care provider as she is worried about you.
- You have been feeling very frustrated lately as you have been struggling to complete tasks that you have been doing for years like cooking and cleaning.
- You also are frustrated because you are struggling to think of the words you need when you need them.
- You are very frustrated because you don't know why this is happening and you are scared.
- Sometimes your head feels like there is "concrete" in it and you just can't think or remember things – it feels slow and confused.
- You miss your husband and have been feeling very sad about losing him.
- You are scared because you have been getting lost when you go out on your own and you are confused by people who come up and greet you but you don't know who they are.
- You do not want to burden your daughter with this and you know that you already are.
- You are aware that she has to get on with her own life and you do not want her to spend too much time looking after you.
- You want to stay independent but you struggle to do things on your own and that scares and frustrates you.

### Instructions:

Let the health-care provider start the conversation.

## Role play 1: Assessment

**Purpose:** To assess a person for dementia and their carer.

**Duration:** 30 minutes total or less.

**Situation: HEALTH-CARE PROVIDER**

- Farah, 45 years old, brings her mother Ingrid, 73 years old, to your clinic.
- Farah reports that her mother has been acting strangely over the last few months.
- Her mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people that she has known for years.
- Assess Ingrid for possible dementia.
- And assess Farah's well-being.

**Instructions:**

- You are to start the conversation.
- At the end, you are to explain to Farah and Ingrid the diagnosis.

## Role play 1: Assessment

**Purpose:** To assess a person for dementia and their carer.

**Duration:** 30 minutes total or less.

**Situation: OBSERVER**

- Farah, 45 years old, brings her mother Ingrid, 73 years old, to the clinic.
- Farah reports that her mother has been acting strangely over the last few months.
- Her mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people that she has known for years.
- The health-care provider needs to assess Ingrid for possible dementia, and assess Farah's well-being.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
8. Performs assessment

And grade the level of competency the health-care provider achieves.

## Role play 2: Follow-up

**Purpose:** To manage a person, with their carer, for dementia.

**Duration:** 30 minutes total.

### Situation: CARER SEEKING HELP

- You are Farah, a 45-year-old lady. You have returned to see the health-care provider with your mother, Ingrid, a 73-year-old lady.
- At the last review, the health-care provider diagnosed your mother with dementia.
- You explain that Ingrid's behaviour has deteriorated. She is now waking up at night and wandering around the house. One night last week she fell over a piece of furniture in the house and hurt her leg.
- Ingrid has also been going out of the house during the day and getting lost.
- One day it took you over 12 hours to find Ingrid and when you did Ingrid had not eaten or drunk anything all day and was weak and dizzy. You worry about what could have happened to her.
- You are exhausted. You are still not sleeping because your mother has been waking and wandering around the house for the last two weeks.
- You are spending your days trying to look after your mother but she is getting very aggressive and quite often leaves the house without telling you where she is going.
- The day you lost her you were so worried and scared and now you do not feel like you can leave her alone at all.
- You think that your mother is more depressed than she was before as she seems more sad and less interested in doing any normal activities. She is showing no interest in cooking or eating and is losing a lot of weight.

### Instructions:

Let the health-care provider start the conversation.

## Role play 2: Follow-up

**Purpose:** To manage a person, with their carer, for dementia.

**Duration:** 30 minutes total.

### Situation: PERSON SEEKING HELP

- You are Ingrid, a 73-year-old lady. Your 45-year-old daughter, Farah, has brought you to see a health-care provider but you are not sure why.
- You are very confused and find it difficult to understand what the health-care provider is saying to you.
- You just want to go home and you ask Farah to take you home repeatedly.

### Instructions:

Let the health-care provider start the conversation.

## Role play 2: Follow-up

**Purpose:** To manage a person, with their carer, for dementia.

**Duration:** 30 minutes total.

**Situation: HEALTH-CARE PROVIDER**

- Farah and Ingrid return to your clinic three months later for a follow-up appointment.
- Farah is a 45-year-old lady, and Ingrid is her 73-year-old mother. You have previously diagnosed Ingrid with dementia and advised on management.
- Farah explains that Ingrid's behaviour has deteriorated. She is now waking up at night and wandering around the house. One night last week she fell over a piece of furniture in the house and hurt her leg.
- Ingrid has also been going out of the house during the day and getting lost.
- One day it took Farah over 12 hours to find Ingrid and when she did Ingrid had not eaten or drunk anything all day and was weak and dizzy. Farah worries about what could have happened to her.
- You need to perform follow-up and decide on appropriate management.

**Instructions:**

You should start the conversation.

## Role play 2: Follow-up

**Purpose:** To manage a person, with their carer, for dementia.

**Duration:** 30 minutes total.

### Situation: **OBSERVER**

- Farah and Ingrid return to the clinic three months later for a follow-up appointment.
- Farah is a 45-year-old lady, and Ingrid is her 73-year-old mother. The health-care provider has previously diagnosed Ingrid with dementia and advised on management.
- Farah explains that Ingrid's behaviour has deteriorated. She is now waking up at night and wandering around the house. One night last week she fell over a piece of furniture in the house and hurt her leg.
- Ingrid has also been going out of the house during the day and getting lost.
- One day it took Farah over 12 hours to find Ingrid and when she did Ingrid had not eaten or drunk anything all day and was weak and dizzy. Farah worries about what could have happened to her.
- The health-care provider needs to perform follow-up and decide on appropriate management.

### Instructions:

Please keep to time:

- 3 minutes reading
- 10–15 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
10. Plans and performs follow-up
11. Refers to specialist and links with other services

And grade the level of competency the health-care provider achieves.

## DEM case scenarios and handouts

Case scenario, treatment planning handouts and suggestions from *Helping carers to care: Training modules* (Alzheimer's Disease International, 10/66 Dementia Research Group, 2009).

Give out the case scenarios and treatment planning handouts.

Give out the treatment planning suggestions after 10 minutes of discussion.

### Case scenario 1: Treatment planning

Sara is 75 years old and has been showing signs of dementia for the last five years. The main problem experienced by the family at the moment is that she gets very angry and aggressive. Her aggression generally happens in two main contexts: when her daughter encourages her to take a bath; and at night when she tends to get up from her bed and wander around the house (occasionally she leaves the house as well), when her daughter tries to get her back into bed and/or back into the house Sara screams that she has to find her babies and refuses to let her daughter touch her or accompany her back into the house. At times she has become violent hitting her daughter with her walking stick and other household items.

### Case scenario 2: Treatment planning

Jin is a 76-year-old man with Alzheimer's disease. He has been slowly deteriorating over the past six years. Initially, he had trouble finding the right words and would lose things. His 69-year-old wife, Wendy, took him to see the health-care provider five years ago and he was told he had dementia.

For the last year Jin has appeared very apathetic and withdrawn. He sits in the chair or lies in bed and needs to be prompted to go to the toilet, wash, eat and drink. He scarcely speaks and it is very hard to engage him in a conversation. He seems to have lost interest in life. He used to enjoy playing board games with a group of friends but he says that he cannot remember the rules and does not want to see his friends as he does not trust them anymore.

## Case scenario 3: Treatment planning

Marium is a 61-year-old lady with likely vascular dementia after a stroke two years ago. Since the stroke, she has shown significant changes in her behaviour. She used to be very independent but now does not like to be left alone. She becomes very distressed, cries and screams inconsolably if her husband leaves her – even for five minutes. If her husband leaves she follows him out of the house and can wander around the town looking for him. Her husband is struggling as he still needs to work in order to earn money but is missing days of work because Marium does not allow him to leave her.

When they are at home together Marium often spends hours asking the same questions repeatedly such as, "Are the kids in school? I have to go and get the kids into school" or "Have we got the shopping? I must go to the market". He tries to answer her but she keeps asking the same questions. It is driving him crazy.

## Case scenario 4: Treatment planning

Jon is 88 years old. He was widowed six years ago and identified as having dementia five years ago. He lives with his eldest son, his daughter-in-law and three grandchildren. In the past six months he has been seeing and hearing things (including his dead wife) that no one else in the family sees or hears. He often talks to her and encourages his grandchildren to speak to her. This is distressing for his son and grandchildren.

He also explains that he often feels insects crawling over his skin. He tries to show his family but they do not see anything. The insects scare him and he can become quite aggressive.

## Treatment planning handout 1: Personal hygiene

The amount of help a person with dementia needs in personal care varies. A person with dementia will be able to care for themselves in the early stages of the disease, but may gradually begin to neglect themselves and will eventually need total help.

Dressing and bathing are personal activities. We each have our own individual ways of doing things. Some people change their clothes twice a day, some every other day – each of us is quite set in our habits. If a family member has to help, they may overlook these personal habits and cause the person some stress. Taking a bath by oneself is a sign of independence, and it is a private activity, so suddenly if someone has to help the person to bathe and change clothes it can be very upsetting.

People with dementia can become abusive and uncooperative, unaware that the carer is only trying to keep them clean. Look for ways to simplify the number of decisions involved in bathing and dressing without taking away their independence.

## Treatment planning handout 2: Dressing

People with dementia often forget how to dress and may not recognize the need to change their clothes. Sometimes people may appear in public with inappropriate clothing or no clothing. The person may be unaware that they are not properly dressed, they may not realize that this may be very shocking for others. So be patient if the person is not properly dressed. Being angry will make them feel more confused and scared.

## Treatment planning handout 3: Toileting and incontinence

The person with dementia may lose the ability to recognize when to go to the toilet, where the toilet is or what to do when in the toilet. People with dementia can become incontinent of urine and faeces. The two are separate problems but one can occur without the other.

Medical problems can cause incontinence, so if this problem occurs for the first time, you should check with the doctor straight away. There may be a bladder infection, diabetes or a problem with medication that can be corrected.

People sometimes suggest that you should give the person with dementia fewer drinks to reduce incontinence. However, be careful. Particularly in hot weather, an older person can get dehydrated (dry out) very quickly, and this can make them seriously ill. Both too little and too much fluid can be bad.

People use different terms for passing urine (pee, piss, take a leak, going to toilet etc.). Due to difficulty with language the person may be unable to say that they need to go to the toilet and use the wrong words.

Regularly taking the person to the toilet can avoid a lot of embarrassment for the person and family.

## Treatment planning handout 4: Repeated questioning

A person with dementia may quickly forget what they asked even before we answer. So, they repeatedly ask the same question. This can be frustrating and exhausting for family members. If they are repeatedly asking the same question it may be that they are worried about something else. If family members can correctly guess and provide reassurance the questioning might stop.

## Treatment planning handout 5: Clinging

The person with dementia can become very dependent on the carer or family member, become clingy and feel anxious if they are apart from the person. This can be quite difficult for the family member as they will find it difficult to get on with their life. Also, the person can become very restless or frightened if the carer disappears. The trusted carer becomes the only security for the patient.

It is vital to try to sort out this problem. No carer, however devoted, can afford to spend 24 hours a day, seven days a week, in constant care. You need time to yourself, to rest, to recharge your batteries, and to return to your caring role refreshed and as energetic as before.

## Treatment planning handout 6: Aggression

Aggression may or may not be a problem. Generally, this is a symptom that appears rather late in the course of the dementia, when the person with dementia may have deteriorated in many ways. It is, of course, very disturbing to the family. Aggression can have several causes.

1. The person with dementia may be in pain or discomfort. They may, for example turn out to have a fractured leg that has not been noticed. They should, therefore, always be checked over by a doctor.
2. People with dementia sometimes falsely believe that, for example, someone has been stealing their possessions. They genuinely believe this to be true, and so understandably can become aggressive.
3. People with advanced dementia may no longer recognize family members. They may think that you are someone else who is threatening them in some way. Again, understandably this can lead them to be aggressive.
4. Aggression is often caused by extreme anxiety. Try to work out what is making them so anxious.
5. Sometimes aggression is simply a result of severe brain damage to parts of the brain that control aggressive behaviour. Always remember, whatever the cause, it isn't the fault of the person with dementia. It is a result of the illness.

## Treatment planning handout 7: Wandering

The person with dementia can leave the house and may not know how to get back. This can be a major problem for the family, as they have to go in search for them. It becomes all the more difficult if it happens at night.

Wandering can also occur if the person with dementia goes out during the day, forgets what they had gone out to do and then gets lost, confused, distressed and unable to get home.

Wandering can occur with the carer or family members, for example if the person with dementia gets lost while out, especially in busy places like a market.

## Treatment planning handout 8: Loss of interest and activity

For many carers, as the disease progresses, one of the most distressing things is the sense that the person with dementia has withdrawn from their family and the world. They communicate less and less, and can seem to take little interest in what goes on around them. It is very important to recognize that the person with dementia cannot help this change. They are not being lazy, or difficult. It is just part of the illness. However, as with other aspects of the illness, there are things that you can do that may make a difference.

### Are they depressed?

- Many people with dementia get depressed. They may appear sad, anxious or tearful. They may talk in a despairing way. Often, they lose interest in things, and sometimes stop eating and drinking.
- This is not surprising. When people with dementia are aware of their limitations, this can be very frustrating and upsetting. Also, they can misunderstand what is going on around them, and this will be bewildering and frightening.
- As many as half of all people with dementia may have some degree of depression.
- If you suspect depression use the DEP module in the mhGAP-IG to assess and manage:
  - Ensure that you maintain open communication with the person.
  - If you think the person has depression then refer them to a mental health specialist where available.

## Treatment planning handout 9: Hallucinations

When a person with Alzheimer's or another dementia hallucinates they may see, hear, smell, taste or feel something that isn't there. Some hallucinations may be frightening while others may involve ordinary visions of people, situations or objects from the past.

Hallucinations are false perceptions of objects or events involving the senses. These false perceptions are caused by changes within the brain that result from Alzheimer's, usually in the later stages of the disease. The person may see the face of a former friend in a curtain or see insects crawling on their hand. In other cases, a person may hear someone talking and may even engage in conversation with the imagined person.

Alzheimer's and other types of dementia are not the only causes of hallucinations so ensure that you assess for other MNS conditions and physical health such as:

- psychoses
- depression
- substance use
- physical problems, such as kidney or bladder infections, dehydration, intense pain or alcohol or drug abuse
- eyesight or hearing problems
- medications.

## Treatment planning suggestions 1: Personal hygiene

- Try to know how they like to take a bath (type of soap, warm or cold water, time of the day etc.).
- While bathing, allow them to do as much they can for themselves – pouring water, applying soap, drying.
- If they are used to pouring water, do the same, do not suddenly expose them to a shower.
- If they refuse to bathe, try again a little later, when their mood has changed.
- If they feel shy, keep their body covered during bathing.
- It will be better to encourage them to sit while giving a bath as it will cut down on their scope to make sudden movements, and reduce the risk of falling.

## Treatment planning suggestions 2: Dressing

- Consider comfort and convenience as well as dignity. Too many layers of clothes can be difficult and confusing to put on correctly. Ensure the person is warm enough in cold weather but loose fitting clothes are generally easier to put on, and more comfortable, particularly in hot weather.
- It may be very difficult for people with dementia to manage zippers. It may be easier to wear skirts or trousers held up by elastic. Clothes can be altered and fitted with zippers instead of buttons.
- It can be difficult to manage buttons too, so a local tailor can convert the buttons into Velcro, which will be very easy to use both for the person with dementia and their carer.
- Too many choices can be confusing. Try to select clothes for the person and lay them out the night before, so that they can find them easily when they need to dress in the morning.

## Treatment planning suggestions 3: Toileting and incontinence

- Make a schedule and assist the person in going to the toilet regularly – ask them regularly if they need to go to the toilet.
- Label the toilet door using bright colours and large letters.
- Easily removable clothing will help them not to pass urine in their pants.
- Always seat them in a chair from which they can get up easily.
- Cut down on drinks before bedtime.
- Provide a commode by the bedside so that they can avoid searching for the toilet in the night.

## Treatment planning suggestions 4: Repeated questioning

- Repeated questioning, or calling out, is often a sign of anxiety and insecurity. If appropriate offer them reassurances, give them a hug and tell them how much you care for them.
- Don't keep answering the question over and over if this seems to be getting you nowhere. This will only make you impatient and the person will pick up on your frustration and become more anxious.
- Try to distract the person offering something else to see, hear or to do.
- Talk about the person's favourite topics.
- You could try writing down the answer to commonly asked questions and refer to it when the person starts questioning.

## Treatment planning suggestions 5: Clinging

- As far as possible, try to involve other trusted people as regular carers, so that the person with dementia can identify with at least two people. When one person wants to take time off the other can care for the person with dementia.
- It is better to use a few regular carers rather than many. As many different people will appear as strangers to the person with dementia.
- When you have to take time away, first do it for a short time and slowly increase it, rather than start by being away for long hours.
- If you can arrange for other family members to take over at home for a while, try to take a short break. Go to visit your friends, or go out to do something enjoyable. Don't feel bad about this. You will feel better for it, and the person with dementia will be better off with you refreshed rather than tired and irritable. Remember, it is good for them as well as for you!

## Treatment planning suggestions 6: Aggression

- Keep calm and try not to show fear.
- Try to find out what provoked such anger. Think back and see if there is a pattern of some kind. Try to avoid such situations in future.
- At all costs, do not become aggressive yourself. If you are losing your temper, remove yourself from the person with dementia until you cool down.
- Do not physically push, pull or restrain the person, unless it is necessary to do so for their own safety.
- If all other measures fail, your doctor may be able to help with medication to calm down the person if they become violent often.

## Treatment planning suggestions 7: Wandering

- Do not use physical restraints.
- Try using warning signs on key exit points in your house which say "no exit" "wet paint" or "danger".
- Try to place physical obstacles close to the exit points which make it difficult for them to leave through a door.
- If you have a yard or garden then make sure they can spend enough time in that area to enjoy the benefits of being outside and reduce any urges to leave the house. Provide objects of interest for the person to look at touch and feel and encourage them to remain in this area and reduce any urges to wander off.
- As a last resort, if all else fails, then lock the front door.
- Keep an identification card with your address and telephone number in the person's pocket so that other people can help the person.
- Embroider their address in all their dresses and clothes so that other people can help.
- If the person gets lost, inform the police and give them a recent photograph.
- While taking the person out always hold hands, offer them reassurances and encourage them to stay close to you.
- When you find the person try not to get angry. Remember this behaviour is part of the condition. Just take their hand and lead them back. (This will avoid a lot of embarrassment for both of you.)

## Treatment planning suggestions 8: Loss of interest and activity

### Maintain communication

- Make sure the person can see and hear properly (e.g. spectacles may no longer be of the right prescription, or a hearing aid may not be working properly). This will mean that the person can continue to communicate with the world around them.
- Make sure you have their attention before speaking.
- Speak clearly, slowly, face to face and at eye level.
- Show love and warmth through hugs, if this is comfortable for the person.
- Pay attention to their body language – people whose language is impaired communicate through non-verbal means.
- Be aware of your own body language.
- Find out what combination of verbal cues or prompts, guidance and demonstration are needed to communicate effectively with them.

### Keep up activities and interests

- Planned activities can enhance a person's sense of dignity and self-worth by giving purpose and meaning to life.
- Remember, however, that because dementia advances, their likes, dislikes and abilities will change over time. There is no point in trying to encourage the person with dementia to do something that doesn't interest them, or that overwhelms their abilities. You will need to try different things.
- A person who was once a homemaker, gardener, trade person or business executive may gain satisfaction and reassurance from using some ability related to their job. Often some of these abilities are retained even when the person appears to forget so much else.
- In the later stages of the illness, consider how you may stimulate each of the senses in simple, interesting, but reassuring ways:
  - **Hearing:** music, a radio programme, reading a book or poem out loud, singing.
  - **Touch:** interesting objects that can be squeezed or bent or are covered in soft material (make sure that they cannot come to any harm with them!).
  - **Sight:** bright colours, painting, clearly labelled pictures of relatives, old photographs.
  - **Smell:** involve them in cooking, familiar smells of food and spices (remember again to keep things safe at all times!), perfumes.

## Treatment planning suggestions 9: Hallucinations

- When responding to hallucinations, be cautious. First, assess the situation and determine whether the hallucination is a problem for the person or for you. Is the hallucination upsetting? Is it leading the person to do something dangerous? Is the sight of an unfamiliar face causing the person to become frightened? If so, react calmly and quickly with reassuring words and a comforting touch. Do not argue with the person about what they are seeing or hearing.
- Respond in a calm, supportive manner. You may want to respond with, "Don't worry. I am here. I will protect you. I will take care of you".
- Gentle patting may turn the person's attention toward you and reduce the hallucination.
- Acknowledge the feelings behind the hallucination and try to find out what the hallucination means to the individual. You might want to say, "It sounds as if you are worried or I know this is frightening for you".

### Use distractions

- Suggest a walk or move to another room. Frightening hallucinations often subside in well-lit areas where other people are present.
- Try to turn the person's attention to music, conversation or activities you enjoy together.

### Modify the environment

- Check for sounds that might be misinterpreted, such as noise from a television or an air conditioner.
- Look for lighting that casts shadows, reflections or distortions on the surfaces of floors, walls and furniture. Turn on lights to reduce shadows.
- Cover mirrors with a cloth or remove them if the person thinks that they are looking at a stranger.

# DEM multiple choice questions

1. Which of the following is a common presentation of dementia? Choose the best answer:

- A Low mood and loss of enjoyment in usual activities.
- B Fixed false beliefs and hearing voices.
- C Excessive hyperactivity and inattention.
- D Decline or problems with memory and orientation.

2. Which of the following is a common presentation of dementia? Choose the best answer:

- A Severe forgetfulness and difficulties in carrying out usual work, domestic or social activities.
- B Drowsiness and weakness down one side of the body.
- C Fluctuating mental state characterized by disturbed attention that develops over a short period of time.
- D Low mood in the context of major loss or bereavement.

3. Which of the following is the best description of dementia? Choose only one answer:

- A Dementia is a communicable disease of the brain that can be contagious.
- B Dementia is most common in those aged 40–50 years old, and rare after this age.
- C Dementia is a chronic and progressive syndrome due to changes in the brain.
- D Dementia is rarely noticed by anyone other than the person who has it.

4. Which of the following is the best description of dementia? Choose only one answer:

- A Dementia can have a large impact on the person, their carer, family and society at large.
- B Dementia can be cured through pharmacological interventions.
- C Dementia does not interfere with activities of daily living, such as washing, dressing, eating, personal hygiene and toilet activities.
- D Dementia is a normal part of ageing.

5. Which of the following is a common cluster of symptoms in dementia? Choose the best answer:

- A Minimally responsive, slow respiratory rate and pinpoint pupils.
- B Problems with orientation, mood and emotional control.
- C Failure to thrive, poor motor tone, delay in reading and writing.
- D Elevated mood, decreased need for sleep, increased activity.

6. Which of the following is a common cluster of symptoms in dementia? Choose the best answer:

- A Excessive over-activity and inattention.
- B Excessive crying, clinging to a carer and extreme shyness.
- C Abrupt onset and disturbed level of consciousness.
- D Decline of memory with mood or behavioural problems.

- 
7. Which of the following statements best describes treatment options in dementia? Choose only one answer:
- A All people with dementia should have access to pharmacological interventions, regardless of specialist availability.
  - B Pharmacological interventions, if started early enough, can cure dementia.
  - C With early recognition and support, the lives of people with dementia and their carers can be significantly improved.
  - D Psychosocial interventions for dementia should only be provided by a specialist, due to their complexity.
- 
8. Which of the following might you do first for a carer of someone with dementia? Choose the best answer:
- A Provide them with antipsychotic medication to administer to the person if their behaviour is unmanageable.
  - B Provide them with details of specialists, to see if the person can be started on medication.
  - C Assess their needs, including whether they are coping or becoming depressed.
  - D Refer them to a social worker who can assess whether they are experiencing financial hardship.
- 
9. Which of the following is the best first-line treatment for someone with dementia? Choose the best answer:
- A Pharmacological interventions.
  - B Psychosocial interventions.
  - C Antipsychotic medication.
  - D Referring to a specialist.
- 
10. Which of the following are components of psychosocial intervention in dementia? Choose the best answer:
- A Interpersonal therapy in combination with cognitive behavioural therapy.
  - B Promoting independence and support for the person with dementia, including ways to improve cognitive functioning.
  - C Cholinesterase inhibitors, in combination with antipsychotics if there are behavioural and/or psychological symptoms.
  - D Reducing physical activity, changing their usual routine and leaving things exactly as they are in the house.
- 
11. Which of the following might you tell a carer of someone with dementia? Choose the best answer:
- A The person with dementia will only get worse so you should not bother trying to help them.
  - B A lot can be done to make the person with dementia more comfortable and to make providing support less stressful.
  - C Taking the person to new and unfamiliar places can help stimulate their memory.
  - D The person with dementia should avoid physical and recreational activities to help preserve their health.

## DEM multiple choice answers

- |        |        |         |        |        |         |
|--------|--------|---------|--------|--------|---------|
| 1. = D | 5. = B | 9. = B  | 4. = A | 8. = C |         |
| 2. = A | 6. = D | 10. = B | 3. = C | 7. = C | 11. = B |

# **Disorders due to substance use**

**mhGAP Training of Health-care Providers  
Training manual  
Supporting material**



# SUB supporting material

- Person stories
- Role plays
- Emergency presentations role plays
- Multiple choice questions
- Video links

## Activity 3: mhGAP SUB module (alcohol) assessment

<https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=15>

## Activity 3: mhGAP SUB module (cannabis) assessment

<https://www.youtube.com/watch?v=sccCxFfMGzk&index=13&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

## Activity 5: mhGAP SUB module (cannabis) management

<https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

# SUB person stories

These are a collection of personal stories describing what it feels like to live with substance use disorder. Each story should last between three to five minutes. The stories can be adapted as required to fit the context and setting of the training.

You can choose to read out the stories in a creative and engaging manner. Or, where available, you can show videos of a person's story by downloading the videos.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who have lived with disorders due to substance use and would like to share their experiences then ask them to share their story with you. Ask them to describe to you how it feels to live with a disorder due to substance use and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

## Person story 1: Street drugs

Nyaope, also known as whoonga, is a very addictive, dangerous and destructive street drug. It is a mixture of heroin and cannabis and has become increasingly popular since 2010.

I remember my first smoke on that Saturday with a friend over a few drinks. I remember how good it felt; better than alcohol, the feeling of being in control of the world. I was "hooked" from the first puff. The satisfaction only lasted a few minutes and already I wanted more in my body, having a small amount of money on me, I bought a fix and went on using it all night.

I am an experimental person and that is exactly what got me addicted, I had no challenges in my life which I can blame for the addiction. My life, after that one smoke, changed for ever because all I cared about was feeding the addiction and nothing else. The drug was easily available as I bought it from a dealer on my street, who was surprised by my frequent visits.

I wanted nothing but the feeling of being intoxicated by the drug. I lost interest in everything else, neglected my daughter, family and chores. I would just wake up in the morning to go look for money for a fix.

I started stealing as a result, at home, car break-ins, shops in town and even house robberies. I would steal money from tills, clothes or any item that could be sold fast for cash.

My family noticed my addiction due to the physical changes that addicts undergo: weight loss (I went from a size 38 to 28), sudden dark pigmentation of skin, not eating and taking less care of themselves.

My family were devastated, especially because I had a child, but they however continued to support me to stop using the drug.

Withdrawal symptoms are worse than labour pains. Trust me, I know.

I could not sleep for four days, sweating, having stomach cramps, throwing up, a runny stomach and paralysed by the lack of drugs in my body. I was admitted to hospital for two weeks which ended my misery and I got proper treatment under supervision which helped me a lot.

Adapted from: <http://mobserver.co.za/20119/sesys-story/>

## Person story 2: Alcohol

When I was drinking at age 32 I didn't look too bad – at least on the outside. I had a lovely wife and two kids, we owned a house and I drove a nice car. But on the inside I was a complete mess. I could not hold down a job and even getting casual work was increasingly difficult.

The house and car I had were expensive and kept me in debt. My wife had to work two jobs for us to survive.

My biggest problems were inside my head: self-hatred, acute self-consciousness, fear, shame and continuous dread of impending calamity. I could not get rid of the feeling that everything was going to fall apart all the time.

The alcohol used to stop me worrying about these things. If I had any worries or negative thoughts about myself I would drink and magically all the thoughts and worries would disappear.

But after years of using this magic – it stopped. Alcohol no longer made everything better. Instead it brought no relief from the pain and fear I was feeling. The magic door had closed and I had to live with the pain.

When I first started drinking – in my teens and early twenties – it was all so wonderful.

Although I was a pretty ordinary person, not a lot of confidence but reasonably clever and friendly, when I found alcohol it gave me boundless confidence. I became loud, funny, and interesting and found everything and everyone enjoyable.

For several years this was my experience of drinking – I would drink feel confident and have fun – the only problems were the occasional hangovers the next morning.

However, in that time I had become dependent on alcohol this was evident when I started needing it to get me to sleep at night. If I didn't have a drink last thing at night it was difficult to sleep. I would toss and turn and feel terribly uncomfortable. A little drink always worked its magic.

The next problem to occur was the shakes. This started as just a slight tremor in the mornings. But then someone noticed it and said, "Wow you must have been drinking last night." I was terribly embarrassed by the remark and from then on tried hard to stop my hands shaking. The trouble is, the harder you try to stop them shaking, the worse they shake. If I had to sign something in front of people, my hands would go completely out of control and I couldn't even hold the pen. By age 26 this had become a serious impediment to normal life. It was really scary.

I remember one time I went to work and a colleague needed me to sign a receipt urgently. As soon as I walked in the door she shoved the receipt and a pen under my nose and asked me to sign it. I quickly made an excuse, "I have to make an urgent phone call first," and went upstairs to my office. Every now and then she'd call out, "Can you sign it now?" I made some fake phone calls and tried to sound busy. I paced up and down in a state of absolute panic.

(continued)

## Person story 2: Alcohol (continued)

That was about five or six years before I finally allowed the thought that alcohol was the real problem come fully into my consciousness. During that time the fear of shaking became one of the main obsessions in my life. First thing on waking I would start thinking of who might ask me to sign my name or hand me a cup of tea. I had to plan every part of my day around when I could have a drink and mix with people safely. It wasn't long before I concluded that the only sensible thing to get drunk first thing in the morning and then it didn't matter when someone asked me to sign things. If I was drunk all day everyday my hands were always steady and I could complete any task.

So I entered that stage where there was no part of my life that wasn't affected by alcohol. I spiralled further and further into misery and fear to the point where alcohol dulled the panic but not the pain and shame. I remember the last party I went to as a drunk. I sat in a corner acutely self-conscious and uptight. I felt everyone was looking at me.

Eventually I let one of those friends help me. I visited my doctor and attended Alcoholics Anonymous and it took me well over a year to stop drinking. I have been sober for 20 years now and I now longer have any desire to drink.

I used to hate the idea of stopping drinking because it seemed all the fun in life would disappear. But it was the misery that disappeared. Laughter, fun and joy came back into my life. I enjoyed the thrill of doing scary things stone-cold sober. I experienced the contentment that I belong in the world. I'm a valued person who brings value to others.

Adapted from: Alcoholics Anonymous Australia (2017). *He had to learn the first step*. Retrieved from <http://www.aa.org.au/new-to-aa/personal-stories-first-step.php>

## Person story 3: Alcohol – Samwell's story

Back in high school, I always distanced myself from the other students. I was a hard worker, with my eyes firmly fixed on the prize. I wanted to be chief executive office of a big company in the city, and to achieve that, I knew I had to work hard.

But when I was about to complete high school, things took an unexpected turn. I started associating with some students who had lost focus in life and were indulging in alcohol. Ironically, they were the most popular group. Although I had never wanted to be like them before suddenly I felt like something was missing from my life, or I was missing out on something and I wanted to be more like them.

They received all the attention from the girls and appeared to shine when they went out in public. I wanted to feel important and be just like them – so I joined them. Their leader was a boy called Martin.

Martin effectively inducted me into the world of alcohol. My life took a turn that crushed my dreams, my life, my family and my friends.

I failed to get onto my dream university course, a bachelor of commerce, and accounting, because I did my last school exam paper, Accounts Paper II, while still extremely drunk.

Actually, I would have missed the exam, had it not been for the intervention of one close friend Festus, who ensured that I spent the night before the exam in school. Aware of my predisposition to drink, he had made a point of searching for me in all the bars and clubs near school and when he found me in one of these bars he insisted I stay with him and try and sober up.

Those days the Mututho laws had not been enacted, so bars were open all day. Festus was kind enough to hire a taxi to take us back to school, but it was 2am before I finally laid my head on my pillow.

Five hours of sleep did nothing to reduce my drunkenness, and neither did the 30-minute cold shower. I staggered into the exam room, sat at my desk and waited for the invigilator to distribute the exam paper. I was actually wavering between sleep and wakefulness. I did not even hear the invigilator giving instructions, and it was the student sitting behind me who woke me up and advised me to go and wash my face. On seeing my state, the kind invigilator further advised that I take a 30-minute power nap before taking the exam. This I did; in fact, I extended it to an hour. It was a fellow candidate who came to wake me up with an hour remaining, and my mind less foggy. I tackled only two 10-mark questions out of the required five. My accounts teacher was confident that I would score a straight A, going by my past records. However, I disappointed him, thanks to my love of alcohol. A love that made me miss out achieving the grades I needed to get onto my dream course.

Nevertheless, I got admitted to Egerton University in Njoro, Nakuru County. In Njoro, several factors, as if in a grand conspiracy, connived to create an ideal environment for my nascent alcoholism. I was taking a BSc in agricultural business management degree course, or Agribus, as we preferred to call it.

The campus' remoteness from "civilization" ensured that I was far away from the prying eyes of my kith and kin, guaranteeing me "utmost freedom of alcoholic expression" and maximum staggering distance.

I got a loan from the Higher Education Loans Board without my parents' knowledge, which I used to boost my drinking kitty.

I don't remember attending morning lectures or going to the library during my brief stay at the university.

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### Person story 3: Alcohol – Samwell's story (continued)

Meanwhile, my drinking increased to the point where I had more alcoholic hours than credit hours, which inevitably made me miss crucial assignments and term papers. As a rule in all universities, missing a certain number of classes and not doing assignments automatically lead to discontinuation. And that is how I bid my university education goodbye.

In 2001, a year after being kicked out of university, life started getting difficult. Luckily, my parents never lost hope in me and continued helping me.

Over time, I got numerous jobs but I could not hold down any for more than three months because of my drinking. In fact, I have never held down a job long enough to qualify for annual leave.

I once got a job interview with a leading airline for the position of cabin crew. I had all that was required for the job, and all I had to do was show up for the interview. However, a friend whom I had not seen in a while came to my place as I was preparing to go for the interview. He had a quarter bottle of gin, which he asked me to take to steel my nerves. And being the fool that I was, I swallowed his bait, thinking the gin would boost my confidence during the interview. However, I took one swig too many, which we ended up topping up with several quarters. That is how my journey to face the panel ended.

I had great luck getting jobs, which was evenly matched by the frequency of losing them. For some reason, I just couldn't wait to be sacked but took it upon myself to walk out.

One case, which I remember to date, happened when I was working in a casino in the city centre. I remember staggering to the manager's office and giving him a management 101 tutorial while on alcoholic auto pilot.

My mother, Edah, has always been a guiding light in my life. In psychology, she is what I have learnt here in rehab is known as an "enabler". With her love and care, she unwittingly makes me more of an alcoholic.

My being her only son only makes this relationship even worse with regard to my drinking. It's a Catch-22 situation in which showing love and concern only fanned the embers of alcoholism.

She has taken me to hospital numerous times, she has been given grim prognoses, ranging from pyloric ulcers to pneumonia. She has shouldered the emotional pain that accompanies alcoholics.

I would say it was largely for her sake that I decided to go into rehab. I went there after sleeping at a Mama Pima's (chang'aa den) for three days, of course without food or a bath. I was brought here by Pastor Patrick Kiema.

The bishop a man of matchless modesty and refinement, listened to my story with deep interest, then, without even seeking my consent, said a lengthy prayer after which he asked me whether I was willing to give my life to Christ.

Here in rehabilitation, I am living as a new creature, with the fruits of the Holy Spirit slowly blossoming in me.

Shortened from: Samwell Born Maina (2015). Kenya: Learn from my story and steer clear of the path of self-ruin. *Daily Nation*. Retrieved from <http://allafrica.com/stories/201507071618.html>

## SUB person stories

Note: Role plays 3, 4, 5 and 6 are additional to those supplied for the activities – for those wanting to extend training.

### Role play 1: Assessment

**Purpose:** To enable participants to practise using the mhGAP-IG algorithm to assess a person use of alcohol.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- This is your second visit to the clinic. During the first you were diagnosed with hypertension after presenting with severe headaches, confusion, chest pain and a fast beating heart.
- You were asked to return and this is your second visit.
- You need to drink daily up to 10 to 12 drinks.
- If you stop drinking for six hours, you start shaking and craving alcohol.
- You are not working and take your spouse's money to buy alcohol.
- You admit that you drink alcohol but you minimize the amount and you do not think it is a problem.
- You have no other mhGAP priority condition.
- You used to drink after work, but you lost your job when the factory was closed and now you are drinking all day.
- You say you never get drunk.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 1: Assessment

**Purpose:** To enable participants to practise using the mhGAP-IG algorithm to assess a person use of alcohol.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- The person has come to a primary health clinic with hypertension.
- This is their second visit to the clinic. During the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart.
- The primary health-care provider at the time suspected that there may be alcohol use but was unable to conduct a thorough assessment.
- The person was asked to return and this is their second visit. Their medical records require that the person is assessed for patterns of alcohol use.
- This is your first time of meeting the person.

**Instructions:**

Perform an assessment for a disorder of substance use starting on page 116 of your mhGAP-IG Version 2.0.

## Role play 1: Assessment

**Purpose:** To enable participants to practise using the mhGAP-IG algorithm to assess a person use of alcohol.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- The person has come to a primary health clinic with hypertension.
- This is their second visit to the clinic. During the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart.
- The primary health-care provider at the time suspected that there may be alcohol use but was unable to conduct a thorough assessment.
- The person was asked to return and this is their second visit. Their medical records require that the person is assessed for patterns of alcohol use.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' consultation
- 5–10 minutes for feedback and small-group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment

And grade the level of competency the health-care provider achieves.

## Role play 2: Psychosocial intervention

**Purpose:** To enable the participants to practise using the principles of motivational interviewing.

**Duration:** 40 minutes.

**Situation: PERSON SEEKING HELP**

- You describe yourself as a social smoker as in the past you have gone a month without smoking anything. But, in reality, you normally smoke most weeks and every weekend.
- You occasionally have 50–70 cigarettes in one weekend and another 20 cigarettes during the week.
- You say you only smoke at social occasions as it relaxes you but in the past few years you have also started to smoke during the week on your own.
- You have found that tobacco is the only way you can relax at the moment.
- If you do not smoke you find that you are very tense and irritable.
- In the past year, your asthma has deteriorated and you are finding it harder and harder to breathe.
- You cannot walk 100 metres without stopping to catch your breath.
- You have developed a cough which is very painful and leaves you feeling weak and debilitated.
- You are missing more and more days off work because of this cough and you are worried that you will lose your job.

**Instructions:**

Let the health-care provider start the conversation.

As the health-care provider assesses your levels of motivation to change you have these pointers:

• **Taking responsibility:**

- You are worried about your smoking and you would like to stop all together.
- You are worried because you have noticed that your breathing and asthma are getting worse all the time and that scares you. You are also worried because your cough is getting worse and causes you a lot of pain.

• **Reasons why you use tobacco:**

- You started when you were an adolescent partly because of peer pressure and partly because you are an anxious person and you found it a lot easier to be in social situations if you had a cigarette in your hand.

• **Consequences of your tobacco use**

**The negatives:**

- Your asthma has deteriorated.
- You have developed a painful cough.
- You have lost your overall fitness and find it difficult to walk 100 metres without becoming out of breath.
- You are losing money because cigarettes are becoming more expensive.
- You are in trouble with work as you are having to take time off work to seek help over your asthma and cough.

**The positives:**

- You are an active person and the cigarettes seem to calm you down this is especially true in social situations.
- You find it easier to talk to people and socialise when you smoke this important for you as you have a job that requires that you do a lot of socializing.

• **Personal goals:**

- You want to start doing more exercise and get fitter as you are worried about your overall health. Your own father died of lung disease when he was young and you do want the same thing.
- You want to learn how to manage your anxiety in different ways.
- You want to give up smoking but you have a couple of stressful life events coming up which you think you need cigarettes to cope with them.

## Role play 2: Psychosocial intervention

**Purpose:** To enable the participants to practise using the principles of motivational interviewing.

**Duration:** 40 minutes.

**Situation: HEALTH-CARE PROVIDER**

- A person describes himself as a social smoker (tobacco), but actually smokes more often than just social situations.
- He occasionally has 50–70 cigarettes in one weekend and another 20 cigarettes during the week.
- He has terrible asthma and struggles to breathe the next day. He also has a painful and persistent cough that often means he has to take time off work.

**Instructions:**

You do not need to repeat an assessment.

Explore with Mr Sana his motivation to change his smoking following the steps on page 123 of the mhGAP-IG Version 2.0, using the eight steps of motivational interviewing:

1. Start by giving him feedback from the initial assessment (that his smoking is causing the deterioration in his health and will continue to do so).
2. Encourage him to take responsibility by asking if he is worried about his smoking.
3. Discuss the reasons why he smokes.
4. Discuss the consequences of his smoking (positive and negative).
5. Discuss his personal goals.
6. Have a discussion to summarize what he has told you.
7. Discuss options.
8. Support the changes he chooses to enact.

## Role play 2: Psychosocial intervention

**Purpose:** To enable the participants to practise using the principles of motivational interviewing.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- A person describes himself as a social smoker (tobacco), but actually smokes more often than just social situations.
- He occasionally has 50–70 cigarettes in one weekend and another 20 cigarettes during the week.
- He has terrible asthma and struggles to breathe the next day. He also has a painful and persistent cough that often means he has to take time off work.
- The health-care provider will perform motivational interviewing following the steps on page 123 of mhGAP-IG Version 2.0.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 20–25 minutes' consultation
- 5–10 minutes for feedback and small-group discussion.

Please use the following competency assessment forms:

4. Uses effective communication skills
8. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

## Role play 3: Psychosocial intervention

**Purpose:** To enable the participants to observe, reflect and then practise using the principles of motivational interviewing.

**Duration:** 50 minutes.

### Situation: PERSON SEEKING HELP

- You are Mr Sana.
- You describe yourself as a social drinker, as you often go two to three weeks without drinking anything. You usually only drink at weekend parties.
- You occasionally have seven to nine drinks in one night.
- You are worried about your alcohol use as you are having more and more nights when you cannot remember how you got home and that scares you. Explain that on those nights you do not have any memory of what happened from the early evening until the next morning.
- Your wife has told you that you often come home and fight with her. You have woken up with cuts and bruises on your body and you are worried about what you have done.
- You use alcohol because you are socially quite anxious and alcohol helps you to relax. When you drink you are able to talk to people more easily and you feel more confident.
- The positive aspect of your alcohol use is that you feel more confident, you find it easier to talk to people, you feel happier in the short term.
- The negative effects are that you are often told that when you drink you are quite argumentative and often fight with people that you do talk to. The hangover you have the next day and over the weekend is awful. In fact, it takes you until mid-week to feel well again.

### Instructions:

Let the health-care provider start the conversation.

## Role play 3: Psychosocial intervention

**Purpose:** To enable the participants to observe, reflect and then practise using the principles of motivational interviewing.

**Duration:** 50 minutes.

**Situation: HEALTH-CARE PROVIDER**

- Mr Sana describes himself as a social drinker.
- He often goes for two to three weeks without drinking anything.
- He only usually drinks at weekend parties.
- He occasionally has seven to nine drinks in one night.
- Sometimes he cannot remember how he got home.
- Talk to him about this situation and provide advice.

**Instructions:**

- You do not need to repeat an assessment.
- Explore with Mr Sana his motivation to change his drinking following the steps on page 123 of the mhGAP-IG Version 2.0.
- Use these questions as a basis for your motivational interview:
  - Have you ever thought about why you use the substance?
  - What are the consequences of your alcohol use: What does alcohol do for you? How does it help you? Does it cause you any problems?
  - Has alcohol ever caused you harm? Can you see it causing you harm in the future?
  - How do you see yourself in the future? What would you like to be doing?
  - Does your alcohol use stop you from achieving those goals? If so how?
  - What is most important to you in your life at the moment?

## Role play 3: Psychosocial intervention

**Purpose:** To enable the participants to observe, reflect and then practise using the principles of motivational interviewing.

**Duration:** 50 minutes.

**Situation: OBSERVER**

- Mr Sana describes himself as a social drinker.
- He often goes for two to three weeks without drinking anything.
- He only usually drinks at weekend parties.
- He occasionally has seven to nine drinks in one night.
- Sometimes he cannot remember how he got home.

**Instructions:**

The health-care provider will perform motivational interviewing with Mr Sana following the steps on page 123 of mhGAP-IG Version 2.0.

Initially, the facilitator will play the role of the health-care provider and then ask the participants to reflect on what they have seen:

- What went well?
- What did they like about the intervention?

Afterwards, please keep to time:

- 3 minutes reading
- 10–15 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please use the following competency assessment forms:

- 4. Uses effective communication skills
- 7. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

## Role play 4: Follow-up and psychosocial intervention

**Purpose:** To practise working with a person to develop strategies to reduce and stop alcohol use.

**Duration:** 20 minutes.

**Situation: PERSON SEEKING HELP**

- You are Mr Sana.
- You describe yourself as a social drinker, as you often go two to three weeks without drinking anything. You usually only drink at weekend parties.
- You occasionally have seven to nine drinks in one night.
- During your last meeting, the health-care provider performed motivational interviewing.
- After your last meeting with the health-care provider you are very motivated to stop using alcohol as you are worried that if you continue as you are you are going to develop a dependency.
- You do not know how you are going to stop as you are currently living through a very stressful situation and at the moment you are using alcohol to cope with that stress.
- You are really unsure how you would cope in social situations without alcohol as you quite often find that the only way you can talk to people is if you have some alcohol.
- Your wife is very supportive and she really wants you to stop so she would act as protective factor.
- Your job and work has been suffering because of your drinking and so you are worried that you might lose your job. If you did lose your job that would be a stress and would be a risk factor.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 4: Follow-up and psychosocial intervention

**Purpose:** To practise working with a person to develop strategies to reduce and stop alcohol use.

**Duration:** 20 minutes.

**Situation: HEALTH-CARE PROVIDER**

- Mr Sana describes himself as a social drinker.
- He often goes for two to three weeks without drinking anything. He only usually drinks at weekend parties.
- He occasionally has seven to nine drinks in one night.
- Sometimes he cannot remember how he got home.
- On your last meeting, you provided motivational interviewing.
- Today, Mr Sana has returned for a follow-up visit.
- He explained that after thinking about his alcohol use he has decided that it is best if he stops using alcohol.

**Instructions:**

- Mr Sana is very motivated to change his use of alcohol.
- Perform a follow-up appointment.
- Discuss with Mr Sana how he plans to stop using alcohol.
- Support Mr Sana to identify risk factors that might stop him from stopping his alcohol use.
- Support Mr Sana to identify any protective factors that may help him stop using alcohol.
- Create a list with Mr Sana of strategies he can use to stop using alcohol.

## Role play 4: Follow-up and psychosocial intervention

**Purpose:** To practise working with a person to develop strategies to reduce and stop alcohol use.

**Duration:** 20 minutes.

**Situation: OBSERVER**

- Mr Sana describes himself as a social drinker.
- He often goes for two to three weeks without drinking anything.
- He only usually drinks at weekend parties.
- He occasionally has seven to nine drinks in one night.
- Sometimes he cannot remember how he got home.
- On the last meeting, the health-care provider provided motivational interviewing.
- Today, Mr Sana has returned for a follow-up visit.
- He explained that after thinking about his alcohol use he has decided that it is best if he stops using alcohol.
- The health-care provider will perform follow-up and work with him to develop strategies to reduce and stop his use.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please use the following competency assessment forms:

- 4. Uses effective communication skills
- 9. Provides psychosocial intervention
- 10. Plans and performs follow-up

And grade the level of competency the health-care provider achieves.

## Role play 5: Assessment and psychosocial intervention

**Purpose:** To enable the participants to practise assessing and managing a person with problematic khat use.

**Duration:** 45 minutes.

### Situation: PERSON SEEKING HELP

- You are Yasser, a 37-year-old male who works in the marketplace.
- You chew a lot of khat, generally two bundles each day. It is easy to get in the marketplace, and you will always have one after lunch and then often go to a khat session in the evening. Sometimes if you are tired you may even have one in the morning.
- You love chewing khat. It makes you as if all your problems have gone away. It gives you energy to get through the day. You love the social aspect as well.
- Unfortunately, though you are starting to experience some troubles with khat.
- You are being seen at this clinic for trouble with your liver and gut. You are often constipated, have little appetite and do not eat much. Your mouth is very dry.
- You also find that you feel quite depleted after chewing, but often cannot sleep due to insomnia. You will often be irritable after chewing, and if you go more than a day without it you become quite depressed.
- Last year, after you chewed more khat than usual, you experienced psychosis, where you could hear people mention your name and you felt worried for your safety. You had to stay in hospital for six days. You try to avoid more than two bundles a day now. Your wife is very angry with your khat use. She says that you never do anything around the house after you have been chewing, and is angry that you are always going off to khat sessions with your friends. You are worried she might leave you.

### Instructions:

- Let the health-care provider start the conversation.
- After they have performed assessment they will provide a psychosocial intervention.

## Role play 5: Assessment and psychosocial intervention

**Purpose:** To enable the participants to practise assessing and managing a person with problematic khat use.

**Duration:** 45 minutes.

**Situation: HEALTH-CARE PROVIDER**

- Yasser is a 37-year-old man who has come for treatment at your clinic for weight loss, constipation and no appetite. He has poor liver function tests.
- When assessing his physical health, he told you that he chews a lot of khat.
- Your notes show that he was treated for psychosis last year which was suspected to be khat-induced.

**Instructions:**

- Perform an assessment for a disorder of substance use starting on page 116 of your mhGAP-IG Version 2.0, and explain to Yasser what you think is going on.
- After the assessment, explore with Yasser his motivation to change his chewing following the steps on page 123 of the mhGAP-IG, using the eight steps of motivational interviewing:
  - Start by giving him feedback from the initial assessment (that his chewing is causing the deterioration in his health and will continue to do so).
  - Encourage him to take responsibility by asking if he is worried about his chewing.
  - Discuss the reasons why he chews.
  - Discuss the consequences of his chewing (positive and negative).
  - Discuss his personal goals.
  - Have a discussion to summarize what he has told you.
  - Discuss options.
  - Support the changes he chooses to enact.

## Role play 5: Assessment and psychosocial intervention

**Purpose:** To enable the participants to practise assessing and managing a person with problematic khat use.

**Duration:** 45 minutes.

**Situation: OBSERVER**

- Yasser is a 37-year-old man who has come for treatment at the clinic for weight loss, constipation and no appetite. He has poor liver function tests.
- When assessing his physical health, he told the health-care provider that he chews a lot of khat.
- He was also treated for psychosis last year which was suspected to be khat-induced.
- The health-care provider will perform an assessment for a disorder of substance use, then provide a psychosocial intervention.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 30–35 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please use the following competency assessment forms:

4. Uses effective communication skills
5. Performs assessment
8. Provide psychosocial intervention

And grade the level of competency the health-care provider achieves.

## Role play 6: Assessment

**Purpose:** To enable the participants to practise assessing a person with problematic cannabis use.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are Alejandro, a 28-year-old man.
- You have attended the clinic on your mother's insistence. She thinks that you have a problem with smoking too much cannabis.
- You smoke every day, about 15–20 cones each day.
- You like the feeling of being "stoned". Sometimes your friends will come by and smoke with you. You all have a laugh and sit around smoking cigarettes, of which you will often smoke 20–30 a day. You do not take any other drugs or alcohol.
- You have a job in the mornings driving a truck for about five hours. You have no interest in working more.
- Your mother is threatening to have you leave the home if you do not stop smoking.
- You do not want to stop, but you are worried about this because currently most of your income goes on cannabis.
- You also have a cough which you dislike.
- You have noticed that sometimes if you smoke too much you get quite paranoid, worry that your friends do not like you and are plotting against you, but mostly you just feel relaxed.

**Instructions:**

- You have just smoked and are currently "stoned". Slouch in your chair and give slow responses.
- Otherwise, let the health-care provider lead the interview.

## Role play 6: Assessment

**Purpose:** To enable the participants to practise assessing a person with problematic cannabis use.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care provider at a local clinic.
- You are about to meet Alejandro, a 28-year-old still living with his mother.
- His mother has made the appointment as she is concerned that he is smoking too much cannabis.

**Instructions:**

- You are to start the conversation.
- Perform an assessment for disorders due to substance use, starting on page 116 of your mhGAP-IG Version 2.0.

## Role play 6: Assessment

**Purpose:** To enable the participants to practise assessing a person with problematic cannabis use.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- The health-care provider is about to meet Alejandro, a 28-year-old attending the clinic.
- His mother has made the appointment as she is worried that he is smoking too much cannabis.
- Alejandro smokes about 15–20 cones each day. He also smokes about 20–30 cigarettes but takes no other drugs or alcohol.
- He enjoys smoking and finds it quite social.
- His mother is threatening to throw him out of the house if he does not stop.
- He spends most of his money on cannabis.
- He also has a cough and occasionally experiences marijuana.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 15–20 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please use the following competency assessment forms:

4. Uses effective communication skills
5. Performs assessment

And grade the level of competency the health-care provider achieves.

# SUB emergency presentations role plays

## Emergency presentations role play 1: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

**Situation: PERSON SEEKING HELP**

- You are Koya, a 28-year-old mother of three children.
- You became addicted to heroin after you started dealing it for your boyfriend to bring in some extra money.
- Now you inject it daily otherwise you start to feel terrible, with anxiety and stomach cramps.
- You tried to do a sudden cessation last week in the hospital, which costs you a month's pay that you had been saving. Unfortunately, you felt so bad when you stopped that yesterday, when you were back at home, you gave in and decided to start using again.
- You used an amount larger than you normally would.
- You became drowsy and your breathing slowed down.
- Your boyfriend became worried and has taken you to the hospital, but he has left as he was worried he would get in trouble with the police if they know that you use.
- You are suffering an opioid overdose.
- You are slumped in the chair, very drowsy. You are barely able to respond.

**Instructions:**

- You will say very little in this role play, maybe mumble a few words. Your eyes are closed and your breathing is slow.
- If you get injected with naloxone you will wake-up quite quickly and start asking where you are and what happened.

## Emergency presentations role play 1: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are working in a community clinic.
- You do not normally treat emergencies, but as the nearest hospital is over an hour away you have some supplies on hand just in case.
- Today, you have been called into the waiting room by a nurse.
- There is a lady slumped in the chair, eyes closed and barely breathing. She is heavily sedated.

**Instructions:**

- Perform emergency assessment and management of this lady for a disorder of substance use.
- You will get extra information on physical assessment as you proceed through the role play.
- At the end, you should tell the person seeking help what has happened and what your ongoing emergency management will be.

## Emergency presentations role play 1: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

**Situation: OBSERVER**

- The health-care provider works in a community clinic where they have some supplies to treat emergencies just in case.
- They have been asked to see a lady slumped in the chair, eyes closed and barely breathing. She is heavily sedated.
- She has taken an opioid overdose
- The health-care provider will perform emergency assessment and management of this lady for a disorder of substance use.

**Instructions:**

- You will need to provide the following extra information to the health-care provider as they proceed through the examination:
- If they check vital signs, tell them the following:
  - Pulse 50
  - Blood pressure 90/63
  - Respiratory rate 8 breaths/minute
  - O<sub>2</sub> saturation 92%.
- If they check pupils, tell them the following:
  - Pinpoint pupils.
- At the end, the health-care provider needs to tell the person seeking help what has happened and what the ongoing emergency management will be.

Please keep to time:

- 3 minutes reading
- 5 minutes' consultation
- 5–10 minutes for feedback and small-group discussion.

Please use the following competency assessment forms:

7. Assesses and manages emergency presentations of priority MNS conditions

And grade the level of competency the health-care provider achieves.

## Emergency presentations role play 2: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

### **Situation: PERSON SEEKING HELP**

- You are Kofi, a 53-year-old living in a small town.
- You have been a heavy drinker for some time – you enjoy the local “home brew”, which you buy from your neighbour, a mother of five who makes it to bring in extra income for the family.
- You have been drinking every day since you were a teenager. You normally drink two to three bottles each day.
- Two months ago, you started experiencing a terrible pain in your stomach. You have not been to see a doctor yet, but you think the pain is worse when you drink. You have decided to try to stop drinking to see if the pain goes away.
- Your last drink was yesterday morning.
- You have been feeling quite unwell since then.
- You are anxious and sweating. You cannot keep still.
- Your hands have started to shake.
- You think you can see things crawling on the ground in the corner of your eyes.
- You have attended the local clinic for assistance as you are quite frightened.

### **Instructions:**

- You do not say much, but move around constantly, looking at different things in the room, and you have a tremor in your arms.
- Allow the health-care provider to start the conversation.

---

### **Extended version (only read this if instructed by facilitator)**

Your presentation is as above, but you have a more pronounced delirium. In particular, you are disorientated to date and time, and appear more confused or unsure about any questions. The hallucinations are more pronounced, distracting and distressing, and you are more agitated.

## Emergency presentations role play 2: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- You are a health-care provider working in a small town.
- Kofi is a 53-year-old who has come to see you.
- He appears very anxious.

**Instructions:**

- Perform emergency assessment and management of this man for a disorder of substance use.
- You will get extra information on physical assessment as you proceed through the role play.
- At the end, you should tell the person seeking help what has happened and what your ongoing emergency management will be.

---

**Extended version (only read this if instructed by facilitator)**

An extended version option is available for this role play. Even if instructed to complete this, continue to perform assessment for a disorder of substance use.

## Emergency presentations role play 2: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

### **Situation: OBSERVER**

- Kofi is a 53-year-old who has come to see the health-care provider of a small town.
- He is a heavy drinker who has stopped suddenly due to health concerns.
- He appears very anxious.
- The health-care provider will perform emergency assessment of this man for a disorder of substance use.

### **Instructions:**

- You will need to provide the following extra information to the health-care provider as they proceed through the examination:
- If they check vital signs, tell them the following:
  - Skin is clammy and they are observed to be shaking. Pupils are normal.
  - Pulse is 110
  - Blood pressure is 184/123.
- At the end, the health-care provider needs to tell the person seeking help what has happened and what the ongoing emergency management will be.

Please keep to time:

- 3 minutes reading
- 5 minutes' consultation
- 5–10 minutes for feedback and small group discussion.

Please use the following competency assessment forms:

6. Assesses and manages physical condition of priority MNS conditions
7. Assesses and manages emergency presentations of priority MNS conditions

And grade the level of competency the health-care provider achieves.

---

### **Extended version (only read this if instructed by facilitator)**

The presentation is as above, but Kofi has a more pronounced delirium. In particular, he is disorientated to date and time, and appears more confused and unsure about any questions. The hallucinations are more pronounced, distracting and distressing, and he is more agitated.

## Emergency presentations role play 3: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

### Situation: PERSON SEEKING HELP

- You are Prasert, a 31-year-old man.
- You started using methamphetamines about six months ago with your friends.
- You initially started by smoking, but now you have started injecting.
- You find that you need more and more to get the same “hit”.
- Over the last week you have not been feeling well.
- You have had some more methamphetamine two hours ago to try and feel better.
- You are quite paranoid and think that your drug dealer is after you because you owe him money.
- You have gone to the local clinic because you think it will be a “safe place”.
- You feel agitated and anxious and you cannot sit still. You have lots of jerky movements.
- You pick at your skin a lot.
- You talk very fast.

### Instructions:

- You talk a lot, move and look around, pick at your skin. You are very anxious.
- You start talking before the health-care provider, telling them everything that has been happening.

---

### Extended version (only read this if instructed by facilitator)

After a few minutes of talking with the health-care provider you become very agitated that they are not listening to your worries about your drug dealer. You start yelling at them, stand up and gesture wildly. You ask the health-care provider if you they can hear the drug dealer in the room next door, and you go and check. You become more and more agitated to the point that you might hit someone.

## Emergency presentations role play 3: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- Prasert has been brought into your clinic.
- He is a 31-year-old who is very agitated.

**Instructions:**

- Perform emergency assessment and management of this man for a disorder of substance use.
- You will get extra information on physical assessment as you proceed through the role play.
- At the end, you should tell the person seeking help what has happened and what your ongoing emergency management will be.

---

### Extended version (only read this if instructed by facilitator)

If there is an extended version, you will get new information from the person seeking help towards the end of the interview.

You may need to revise your assessment and use a different module based on this new information.

## Emergency presentations role play 3: Assessment and management

**Purpose:** To assess and manage an emergency presentation of a disorder of substance use.

**Duration:** 15 minutes or less.

### Situation: **OBSERVER**

- Prasert has been brought into the clinic.
- He is a 31-year-old who is very agitated.
- He has been using methamphetamine for six months, both smoking and intravenously.
- He has signs of methamphetamine and is very agitated.
- The health-care provider will perform emergency assessment for a disorder of substance use.

### Instructions:

- You will need to provide the following extra information to the health-care provider as they proceed through the examination:
- If they check vital signs, tell them the following:
  - Dilated pupils
  - Pulse 124
  - Blood pressure 148/105.
- At the end, the health-care provider needs to tell the person seeking help what has happened and what the ongoing emergency management will be.

Please keep to time:

- 3 minutes reading
- 5 minutes' consultation
- 5–10 minutes for feedback and small-group discussion.

Please use the following competency assessment forms:

### 7. Assesses and manages emergency presentations of priority MNS conditions

And grade the level of competency the health-care provider achieves.

---

### Extended version (only read this if instructed by facilitator)

After a few minutes, it will become clear that Prasert is suffering from agitation and aggression as part of a methamphetamine-induced psychosis. The health-care provider will need to use the Table from Management of Persons with Agitated and/or Aggressive Behaviour to continue assessment [mhGAP-IG page 45].

## SUB multiple choice questions

---

1. Which of the following is considered an emergency presentation of a disorder due to substance use? Choose the best answer:

- A Mania.
  - B Depression.
  - C Anaemia.
  - D Overdose.
- 

2. Which of the following is considered an emergency presentation of a disorder due to substance use? Choose the best answer:

- A Tremor in hands, sweating, increasing pulse and other symptoms of alcohol withdrawal.
  - B Macrocytic anaemia, low platelet count, chronic liver disease and other symptoms of prolonged use of alcohol.
  - C Low energy, persistent sadness, suicidal thoughts and other symptoms of depression.
  - D Elevated mood, increased activity, unrealistically inflated self-esteem.
- 

3. Which of the following is considered an emergency presentation of a disorder due to substance use? Choose the best answer:

- A Sexual activity whilst intoxicated that was later regretted.
  - B Intravenous drug use of stimulants or opioids.
  - C Aggressive or violent behaviour whilst intoxicated with stimulants.
  - D Relationship problems as a result of substance use.
- 

4. Which of the following is considered a psychoactive substance? Choose the best answer:

- A Magnesium sulphate.
  - B Normal saline.
  - C Cannabis.
  - D Pesticides.
- 

5. Which of the following statements best describes withdrawal? Choose only one answer:

- A A transient condition following the intake of psychoactive substances.
- B A set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance.
- C A set of unpleasant symptoms including fixed false beliefs, aggressive behaviour and deterioration in functioning.
- D A chronic and progressive syndrome due to changes in the brain.

---

6. Which of the following best describes symptoms of substance dependence? Choose only one answer:

- A Sedation, unresponsiveness, pinpoint pupils following use.
  - B Current thoughts of suicide, bleeding from self-inflicted wound and extreme lethargy.
  - C Strong cravings, loss of control over substance use, withdrawal state upon cessation of use.
  - D Intravenous drug use once per month, but violent towards others when does use.
- 

7. Which of the following illnesses should you screen for in people who inject opioids? Choose the best answer:

- A HIV and hepatitis.
  - B Wernicke's encephalopathy.
  - C Epilepsy.
  - D Thyroid disease.
- 

8. Which of the following is a good approach to take when talking with someone who has a disorder of substance use? Choose the best one:

- A Express surprise when they tell you how much they use, as it may shock them into stopping.
  - B Explain to them that they are bringing great shame to their family, so they should try and stop.
  - C Communicate to them that it is possible to stop, and be non-judgemental in your approach.
  - D Encourage them to go frequently to places or situations where they use, so they can learn to stop the cravings.
- 

9. Which of the following is part of a psychosocial intervention for disorders due to substance use? Choose the best answer:

- A Maintain adequate hydration.
  - B Give naloxone if signs of overdose.
  - C Referral to a specialist.
  - D Mutual help groups.
- 

10. Which of the following is a strategy to prevent harm from drug use and related conditions? Choose the best answer:

- A Advise not to drive if intoxicated.
- B Do not ensure condom availability, as it may encourage risky sexual activity.
- C Advise to reuse needles so they have more money for food.
- D Do not screen for tuberculosis.

11. Which of the following is an element of motivational interviewing? Choose the best answer:

- A Causing shame and embarrassment for the person.
- B Asking the person the reasons for their substance use.
- C Blaming by other people in their lives as a cause of their substance use.
- D Ensuring hepatitis A vaccination.

12. For which of the following psychoactive substances might you or a specialist consider substitution therapy? Choose the best answer:

- A Alcohol.
- B Opioids.
- C Cannabis.
- D 3,4-methylenedioxymethamphetamine (MDMA).

## SUB multiple choice answers

- |        |        |        |        |        |         |        |        |         |        |        |         |
|--------|--------|--------|--------|--------|---------|--------|--------|---------|--------|--------|---------|
| 1. = D | 5. = B | 9. = D | 2. = A | 6. = C | 10. = A | 3. = C | 7. = A | 11. = B | 4. = C | 8. = C | 12. = B |
|--------|--------|--------|--------|--------|---------|--------|--------|---------|--------|--------|---------|

# **Self-harm/suicide**

**mhGAP Training of Health-care Providers  
Training manual  
Supporting material**



# SUI supporting material

- Person stories
- Role plays
- Multiple choice questions
- Video link

Activity 2: mhGAP SUI module – assessment and management

<https://www.youtube.com/watch?v=4gKleWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

## SUI person stories

These are a collection of personal stories describing what it feels like to live with self-harm/suicide. Each story should last between three to five minutes maximum. The stories can be adapted as required to fit the context and setting of the training.

You can choose to read out the stories in a creative and engaging manner. Or, where available, you can show videos of the person stories by downloading the videos attached to this document.

If suitable, seek permission to use a person's story from the local area. If there are service users that you know well who have lived with self-harm/suicide and would like to share their experiences, then ask them to share their story with you. Ask them to describe to you how it feels to live with self-harm/suicide and how it has impacted on their life. You can write this down and use their story, with their consent, to teach other participants.

## Person story 1: Depression and self-harm/suicide

I'm Della, I live in a different town from my family, I work full time and I have to get through all my daily chores alone, ploughing through the darkness of depression. It's hard, really hard. Depression doesn't care if I have to get up early and work a nine-hour shift. Depression doesn't care if I need to get into town to do some basic shopping. Depression doesn't care if I've made arrangements with friends. I can be perfectly happy one day and wake up the next day with dark sadness and suicidal thoughts. There is no warning and there's no way to stop it.

Having been living with depression for years I take daily medication, I attend regular appointments with my primary health-care doctor and I have counselling, but none of that can stop depression. The hardest part for me to handle is how it affects my work. I love my job and the routine of going to work every day. Being surrounded by the staff who are loving and supportive is the best feeling, but when depression is hovering I can't deal with work; all I want to do is sit and cry and feel sorry for myself. I need a routine to keep myself focused. If my routine changes it can take me long time to adjust and I know it will have an impact on my mental well-being. When depression visits me, I struggle to work. I don't eat well. I self-harm and I have thoughts about ending my life.

It's a scary place, and although I have the support of friends and family, I tend to push them away. I don't know why. Maybe it's the thoughts I have and the shame I feel that I can't control my own mind. I'll be honest, I've lost friends. I've nearly lost family in the past when my mental illness got the better of me and I tried to end my life. None of that matters now. I'm just coming out of a depressive episode, and, as hard as it was, I'm still learning about my mental health and so are my family and friends. I'm blessed to have the ones who have stuck by my side.

I'm tired of hiding my thoughts and hiding my self-harm. If I'm in a low point I want to be able to tell everyone close so they know I'm not just being miserable, unsociable or boring but because I'm dying inside. I used to hide my mental illness. I hid it from my ex-boyfriend for a long time, too long. I was ashamed and I honestly thought I couldn't be loved. I hated myself. I still do at times, so why would anyone chose to love me? It wasn't until things got particularly bad that he found out. I guess it's thanks to him I'm so open about it now. He was amazing and supportive and for once I didn't feel alone. I had someone by my side who was listening to me and didn't judge me.

## Person story 2: A person with thoughts of suicide

I've struggled with depression as long as I can remember in my adult life. It has followed me everywhere I've gone, like a big heavy black gate dragging behind me. Up until 18, I was fine, but that's when I started hiding away from people – it's when my alcoholism started and it's at that point I started to just not feel comfortable around people.

Sixteen and a half years later, I'm still fighting the same fight, day in, day out. It's led me to severe alcohol addictions, losing friends and a suicide attempt. After all that, do I feel better? Well, not yet. I still struggle to explain this, and I struggle to let family and friends in. Sometimes my working day feels like it's two days' long; I limp through that and then I struggle with being on my own – fighting my mind, fighting anxiety, fighting alcohol dependencies and just... fighting to simply stay alive.

I hate it. Suicide is a normal thought for me and it's one I suppress, at least once a week, but often more. I've never seen myself getting past the age of 35... my 35th birthday is four months away. The nearer it gets the more hope I have that once I get through it this will all stop. But I have to be honest – I cannot guarantee that I will get through it at all. I just can't see myself living past 35 – it all goes black.

In part, I've accepted that this is going to be a life-long battle. As painful as it is to admit, I have to accept that this is going to be a part of me. I've never been in a serious relationship, partly because I don't have any confidence in myself, but mainly because I just don't know how I would explain this to a significant other. I go days, sometimes weeks, without talking to anyone. It's not personal; it's just that that's what I've got to do when this is at its worst. At its absolute worst, it takes every bit of strength within me to look after myself, to shower, brush my teeth etc. Despite all I experience, I still cannot talk to anyone about this without breaking down in tears. I want to be surrounded by my friends and family, but at the same time I don't want to be anywhere near anyone. I hate it. I hate just how much it takes me away from being me. It's the hardest thing to explain to people.

When I'm feeling suicidal, this is when I find it the hardest to engage with anyone – friends, family. It's hard enough talking to people when my depression hits its peak but when suicidal thoughts start to swirl, I close off. I just can't bring myself to say it.

I've always found it hard to speak to people – I just don't want them worrying. At my lowest I write and write and write as I find this is the most therapeutic way for me to deal with everything that I have to deal with. I don't feel awkward or as if I'm burdening people, which is something I feel as if I'm doing when I ask people if I can talk. It's not always easy but I wish we could all have more confidence to just... tell people exactly how we're feeling. If we could just talk about what goes on, hopefully this would make people struggling more comfortable with just... telling people what is wrong so that they can get the support that they need.

I guess the advice I would give to others going through it is no matter how dark it gets, there's always a light at the end of that dank, dark, spider-infested tunnel that you walk through. By talking about what's happening we move closer to the end of that tunnel. We need to create a society where talking about this is normal, so that people feel able to reach out towards that light.

Adapted from: <https://www.time-to-change.org.uk/blog/we-need-talk-about-male-suicide>

## Person story 3: Impact of suicide

My mother took her own life when I was five years old. She left behind a husband and two daughters. I remember my dad telling me that Mummy had gone to sleep and that she hadn't woken up. As I got older I couldn't understand why no one spoke of her death or why friends and family rarely spoke of her. As a child, I remember not understanding why my mother wasn't there, and wondering what could be so bad for her family not to speak of her. I remember comparing my loss to a girl in my school class who had lost her mum to cancer and thinking that our losses were somehow different. As I got older I became more aware that there was something that wasn't being spoken about, something I didn't fully understand.

No one ever made a conscious decision to keep her death a secret, but it wasn't until I was older that I learned the truth about my mum's death. As a teenager and adult I have struggled with my own mental health, I have struggled to cope and come to terms with a loss I didn't fully understand, and to mourn someone I didn't even remember. I have spent a long time being angry at her, not understanding how she could have left us. I have struggled to talk about her death to others – I wrongly interpreted people's discomfort around the word "suicide" as a sign I shouldn't say anything. I would tell people that she had died when I was little and I would quickly change the subject, underplaying the loss as much as possible because I thought that that was the right thing to do.

Talking helped me come to terms with it. My own recovery journey has taught me that by not talking about your experiences, you are depriving yourself of support. By keeping suicide a secret, it feeds the idea that the person who has died did something shameful. Talking about suicide helps the people left behind normalize their experience. By being able to talk about my mum's death, I have found community and support. Instead of feeling alone in my grief and anger, I found a shared experience with others.

By talking about suicide, it helps to reduce the stigma for families, but also encourages those who have thought about or attempted suicide to seek support. By talking about suicide, it helps remind people that it is not a choice; it is the darkest of times where all rational thinking is gone, combined with overwhelming pain and unbearable hopelessness.

Adapted from: <https://www.time-to-change.org.uk/blog/lets-talk-about-suicide>

## SUI role plays

Note: Role play 4 is additional to those supplied for the activities – for those wanting to extend training.

### Examples of questions to use when caring for someone with self-harm/suicide

Give copies of these example questions to participants before role playing activities. During the role plays, encourage participants to use these questions as well as to adapt them to fit their local context.

#### Initiating a conversation about self-harm/suicide

Explore the person's negative feelings first and then ask if they have any plans or thoughts about self-harm/suicide:

*I can see that you are going through a very difficult time. In your situation many people feel like life is not worth it. Have you ever felt this way before?*

If the answer is YES, then continue to explore these negative feelings:

*What are some of the aspects in your life that make it not worth living?*

*What are some of the aspects in your life that make it worth living?*

*Have you every wished to end your own life?*

*Have you ever thought about harming yourself?*

If the answer is YES, ask:

*How would you do that? Have you thought about how you would harm yourself?*

*Have you thought about how you would kill yourself?*

*Have you told anyone else about these ideas?*

Now employ some direct questioning to really understand how imminent the risk of self-harm/suicide is:

*What thoughts specifically have you been having?*

*How long have you been having these thoughts?*

*How intense have they been? How frequent? How long have they lasted?*

*Have these thoughts increased at all recently?*

*Do you have a plan for how you would die or kill yourself?*

*What is it? Where would you carry this out? When would you carry it out?*

*Do you have the means to carry out this plan?*

*How easy is it for you to get hold of the gun/ropes/pesticide etc. (means)...?*

*To what means do you already have access? What steps do you need to take to access the means?*

*Have you made any attempts already? If yes – what happened?*

After you have asked questions about a person's negative feelings and thoughts/plans of self-harm/suicide, balance this by exploring and asking about positive elements in their life and possible protective factors:

*What are some of the aspects of your life that make it worth living?*

*What would help you to feel or think more positively, optimistically or hopefully about your future?*

*How have you coped before when you were under similar stress?*

*What has helped you in the past?*

*Who can you turn to for help? Who will listen to you? Who do you feel supported by?*

*What changes in your circumstances will change your mind about killing yourself?*

*What would make it more (or less) likely that you would try and take your own life?*

*If you began to have thoughts of harming or killing yourself, what would you do to prevent them?*

## Role play 1: Assessment

**Purpose:** To practise using the mhGAP-IG to carry out an assessment for self-harm/suicide.

**Duration:** 30 minutes.

### Situation: PERSON SEEKING HELP

- It is important to remember that you will not want to talk about ideas of suicide right away. Do your best to play this role naturally. You have never met this health-care worker before.
- You don't think you have any major injuries, but you thought you should get checked out.
- You were riding along and hit the curb because you were not paying attention.
- You know you shouldn't have gotten on your motorcycle because you were very upset at the time.
- You are extremely upset about your results in an exam.
- You are concerned that you will never get a decent job and that your family will be disappointed.
- You have been able to sleep or eat since you found out about the exam.
- You feel like it would be easier to die than face the shame for you and your family.
- You have thoughts about getting back on your bike and driving off the bridge.

**Possible protective factors:** Your family is a protective factor as you are close to them and feel supported by them.

### Instructions:

Allow the health-care provider to start the conversation.

## Role play 1: Assessment

**Purpose:** To practise using the mhGAP-IG to carry out an assessment for self-harm/suicide.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- A young man has come to be checked out after having a motorcycle accident.
- You are worried he may have been suicidal at the time of the accident.

**Instructions:**

- You will start the conversation.
- You should not start the conversation by asking about self-harm/suicide bluntly.
- You should try to find an appropriate sequence in the conversation to ask about self-harm/suicide.
- You should initiate the conversation by using open-ended questions about how the young man is feeling.
- Once the dialogue has started, use the mhGAP-IG to carry out a thorough assessment.

## Role play 1: Assessment

**Purpose:** To practise using the mhGAP-IG to carry out an assessment for self-harm/suicide.

**Duration:** 30 minutes.

**Situation: OBSERVER**

A young man has come to be checked out after having a motorcycle accident. The health-care provider is worried he may have been suicidal at the time of the accident.

The health-care provider will need to start the conversation, but not be blunt about asking about self-harm/suicide. Instead they should use open-ended questions and find an appropriate sequence in the conversation to ask about self-harm/suicide, and use the mhGAP-IG to carry out a thorough assessment.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
7. Assesses and manages emergency presentation

Grade the level of competency the health-care provider achieves.

## Role play 2: Management

**Purpose:** This role play gives participants an opportunity to practise discussing psychosocial management interventions.

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are a 30-year-old woman who was brought urgently to the health-care centre by your husband having drunk a bottle of pesticide.
- The health-care provider managed to save your life, and you are now on the ward and stable.
- You should act very sad and quiet. Do not look the health-care worker in the eyes.
- You have post-natal depression, but you have no other priority condition.
- You do not have chronic pain.
- You have been feeling worse and worse since your baby was born less than one month ago.
- The baby cries all the time and you can't sleep at all. You don't know what to do.
- You have been feeling down and irritable. You have no desire to hold your baby. All you want to do is stay in bed and sleep.
- You say you feel "tired all the time". You have no appetite and have little interest in normal activities.
- You have been thinking about killing yourself for the last two weeks.
- You don't see the point of living life anymore.
- For the past week, you have been thinking about hanging yourself or drinking the cleaning supplies in the house.

**Possible protective factors:**

- You trust your husband and have a very strong relationship with him. You love him very much.
- You have a strong group of friends but you have not seen them in a while as you are busy with the baby.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 2: Management

**Purpose:** This role play gives participants an opportunity to practise discussing psychosocial management interventions.

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- A 30-year-old woman was brought urgently to the centre by her husband after having drunk a bottle of pesticide.
- You managed to save her life (the minimum set of skills and resources were available in your facility).
- Now you have come to see her on the ward as she is stable.
- She has been unhappy for two weeks. Her husband has already told you that she had her first child less than a month ago.
- You have assessed her and diagnosed her with post-natal depression but no other MNS condition and no chronic pain.
- You last saw her yesterday for an assessment and these were your findings:
  - She has been feeling worse and worse since her baby was born.
  - The baby cries all the time and she can't sleep at all. She doesn't know what to do.
  - She has been feeling down and irritable. She has no desire to hold her baby. All she wants to do is stay in bed and sleep.
  - She says she is "tired all the time". She has no appetite and has little interest in normal activities.
  - She has been thinking about killing herself for the last two weeks.
  - She doesn't see the point of living life anymore.
  - For the past week, she has been thinking about hanging herself or drinking the cleaning supplies in the house.

**Instructions:**

- You have decided to use the psychosocial interventions described in the management of self-harm/suicide (page 138 mhGAP-IG Version 2.0).
- You are to start the conversation.

## Role play 2: Management

**Purpose:** This role play gives participants an opportunity to practise discussing psychosocial management interventions.

**Duration:** 30 minutes.

### Situation: **OBSERVER**

- A 30-year-old woman was brought urgently to the centre by her husband after having drunk a bottle of pesticide.
- The health-care provider managed to save her life (the minimum set of skills and resources were available in their facility), and has now come to see her on the ward as she is stable.
- She has been unhappy for two weeks. Her husband has already told the health-care provider that she had her first child less than a month ago.
- The health-care provider has assessed her and diagnosed her with post-natal depression but no other MNS condition and no chronic pain.
- The health-care provider last saw her yesterday for an assessment and these were their findings:
  - She has been feeling worse and worse since her baby was born.
  - The baby cries all the time and she can't sleep at all. She doesn't know what to do.
  - She has been feeling down and irritable. She has no desire to hold her baby. All she wants to do is stay in bed and sleep.
  - She says she is "tired all the time". She has no appetite and has little interest in normal activities.
  - She has been thinking about killing herself for the last two weeks.
  - She doesn't see the point of living life anymore.
  - For the past week, she has been thinking about hanging herself or drinking the cleaning supplies in the house.

### Instructions:

The health-care provider has decided to use the psychosocial interventions described in the management of self-harm/suicide (page 138 mhGAP-IG Version 2.0).

Please keep to time:

- 3 minutes reading
- 10 minutes' interview
- 5–10 minutes for feedback and small group discussion..

Please assess the following competencies:

- 4. Uses effective communication skills
- 7. Provides psychosocial interventions

Grade the level of competency the health-care provider achieves.

## Role play 3: Follow-up

**Purpose:** To practise how to work with different clients at follow-up, including a client whose symptoms are remaining the same.

**Duration:** 30 minutes.

### Situation: PERSON SEEKING HELP

- Since you left the hospital you have been feeling the same.
- Through lessons you learned at a psychoeducation session, you have talked to your husband and he has started to help you care for the baby more and as a result you are getting more sleep.
- However, you still feel tired all the time.
- You are still unable to find the time to visit friends although you do think that would be helpful.
- You continue to have thoughts about taking your own life but they are less intense than they were before.
- You still do not see a point in living as you do not feel you are doing a good job as a mother and so no one would miss you.

### Instructions:

You are to let the health-care provider start the conversation.

## Role play 3: Follow-up

**Purpose:** To practise how to work with different clients at follow-up, including a client whose symptoms are remaining the same.

**Duration:** 30 minutes.

### Situation: HEALTH-CARE PROVIDER

- You first met this lady after she had intentionally ingested a bottle of pesticide in order to kill herself.
- After she was medically stabilized you offered her support by using psychoeducation, activating psychosocial support networks and problem-solving.
- You explained to her that you wanted to stay in regular contact with her to monitor her progress.
- She has now re-attended for follow-up.

### Instructions:

- Use page 139 of your mhGAP-IG Version 2.0 to guide follow-up with this lady.
- You are to start the conversation.

## Role play 3: Follow-up

**Purpose:** To practise how to work with different clients at follow-up, including a client whose symptoms are remaining the same.

**Duration:** 30 minutes.

**Situation: OBSERVER**

- The health-care provider first met this lady after she had intentionally ingested a bottle of pesticide in order to kill herself.
- After she was medically stabilized the health-care provider offered her support by using psychoeducation, activating psychosocial support networks and problem-solving.
- She has now re-attended for follow-up, but has not improved.
- The health-care provider will now use page 139 of mhGAP-IG Version 2.0 to guide follow-up with this lady.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 10–15 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
10. Plans and performs follow-up
11. Refers to specialist and links with outside agencies

Grade the level of competency the health-care provider achieves.

Role play 4 is a supplementary role play for extending training.

## Role play 4: Assessment and management

**Purpose:** To practise assessing and managing a person after an episode of self-harm.

**Duration:** 30 minutes or less.

**Situation: PERSON SEEKING HELP**

- You are an 18-year-old woman called Anika. You still live with your parents and you are accompanied by your father.
- You have presented to the health-care centre as you made cuts to your arms after an argument with your father. The cuts have been sown up.
- You have had a lot of stress lately. You have been arguing with your parents as you have started a friendship with a man of whom your parents disapprove.
- You are not depressed, you still enjoy all your usual activities, you are just frustrated with the situation at home. You feel there is no solution.
- You have cut yourself before when you were frustrated.
- You don't want to die, you just want your parents to listen to you.
- You do not want to stay in hospital. If you feel that you are getting enough support then you will agree not to harm yourself anymore.
- If you are asked for more information, answer in the negative.

**Instructions:**

- You should act as though you are still angry with your father.
- Let the health-care provider start the conversation.

## Role play 4: Assessment and management

**Purpose:** To practise assessing and managing a person after an episode of self-harm.

**Duration:** 40 minutes or less.

**Situation: CARER SEEKING HELP**

- You are the father of Anika, who is 18 years old, and who lives with you.
- She has recently started a friendship with a man of whom you disapprove. You do not want Anika to keep seeing him.
- Today, she cut herself to her wrists after an argument about this. She has done this before, after an argument.
- The cuts have been sown up.
- You are worried about her but do not know how to resolve the situation, you are not going to back down about your concerns, but other than that you are keen to help her in any way possible. You do not want her to stay in hospital.

**Instructions:**

- You are firm but loving with Anika, who is still angry with you.
- You should let the health-care provider start the conversation.

## Role play 4: Assessment and management

**Purpose:** To practise assessing and managing a person after an episode of self-harm.

**Duration:** 40 minutes or less.

**Situation: HEALTH-CARE PROVIDER**

- Anika is an 18-year-old woman who has come to see you with her father after making self-inflicted lacerations to her arm. The cuts have been sown up.
- You know a bit about the family, and know that Anika has recently started a friendship with a man of whom the family disapproves. You suspect that they had a fight about this, which prompted Anika to harm herself.
- You do not have facilities to admit Anika to hospital, and neither she nor her father want that anyway.

**Instructions:**

- Perform an assessment of Anika from page 133 of your mhGAP-IG Version 2.0.
- Once you have performed an assessment, move on to management of Anika, starting on page 136 of mhGAP-IG Version 2.0.

## Role play 4: Assessment and management

**Purpose:** To practise assessing and managing a person after an episode of self-harm.

**Duration:** 40 minutes or less.

### Situation: **OBSERVER**

- Anika is an 18-year-old woman who has come to see the health-care provider with her father after making self-inflicted lacerations to her arm. The cuts have been sown up.
- Anika has recently started a friendship with a man of whom the family disapproves. She and her father had an argument, after which she cut herself out of frustration.
- There are no facilities to admit Anika to hospital, and neither she nor her father want that anyway.
- She has harmed herself before when she felt frustrated.
- The father cares for her very much, but will not change his mind about her friendship with this man. However, he is keen to support her in other ways.
- She is not depressed and not suicidal. If she is given enough support she will be unlikely to harm herself again.
- The health-care provider will perform an assessment of Anika from page 133 of your mhGAP-IG Version 2.0. Once they have performed an assessment, they will move on to management of Anika, starting on page 136 of mhGAP-IG Version 2.0.

### Instructions:

Please keep to time:

- 5 minutes reading
- 15–20 minutes' interview
- 10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
7. Assesses and manages emergency presentation
8. Provides psychosocial interventions

Grade the level of competency the health-care provider achieves.

## SUI multiple choice questions

1. Which of the following best describes a presentation of self-harm/suicide? Choose only one answer:
  - A Multiple persistent physical symptoms with no clear cause.
  - B Low energy, fatigue, sleep problems.
  - C Extreme hopelessness and despair, current thoughts of injuring self.
  - D Loss of interest or pleasure in activities that are normally pleasurable.

---

2. Which of the following conditions are most likely to be seen in someone with self-harm/suicide? Choose the best answer:
  - A Any priority MNS condition, chronic pain or extreme distress.
  - B Anaemia, malnutrition, or hypothyroidism.
  - C HIV, hepatitis or tuberculosis.
  - D Head or neck injury, eclampsia or febrile convulsions.

---

3. In which of the following conditions should you ask someone directly whether they are experiencing self-harm/suicide? Choose the best answer:
  - A Thyroid disease.
  - B Any MNS condition.
  - C Tuberculosis.
  - D Never – it is better not to ask about self-harm in case it provokes self-harm acts.

---

4. Which of the following should occur first in the emergency management of self-harm/suicide? Choose the best answer:
  - A Medical treatment of injury or poisoning.
  - B Problem-solving therapy.
  - C Psychoeducation to the carer.
  - D Continuing follow-up for two years.

---

5. Which of the following should occur first in the management of self-harm/suicide? Choose the best answer:
  - A Provide emotional support to carers and family members of person.
  - B Prescribe medication for any concurrent MNS conditions.
  - C Place the person in a secure and supportive environment at a health facility.
  - D Maintain regular contact for the first two months.

---

6. Which of the following intervention/s are the best for self-harm/suicide? Choose only one answer:
  - A Antidepressants and motivational interviewing
  - B Interventions to improve cognitive functioning.
  - C Do not leave alone and mobilize social supports.
  - D Opioid agonist maintenance treatment for chronic pain.

- 
7. Which of the following should you tell the carer of someone who has had an episode of self-harm or a suicide attempt? Choose the best answer:
- A Medication will be made available so that they can keep the person sedated.
  - B Restrict the person's contact with family, friends and other concerned individuals in case it is too overwhelming.
  - C Remove access to any means of self-harm and try and provide extra supervision for the person.
  - D Forced vomiting is an emergency treatment option if they suspect any self-harm or suicide.
- 
8. Which of the following is part of a psychosocial intervention for someone with self-harm/suicide? Choose the best answer:
- A Sedation and use of medication such as haloperidol.
  - B Motivational interviewing and substitution therapy.
  - C Use materials such as newspapers or the TV to orient people to current events.
  - D Problem-solving and optimizing social supports.

## SUI multiple choice answers

- 1. = C      4. = A      7. = C
- 2. = A      5. = C      8. = D
- 3. = B      6. = C

# Other significant mental health complaints

mhGAP Training of Health-care Providers  
Training manual  
Supporting material



# OTH supporting material

- Role plays
- LIVES intervention
- Case scenarios
- Alternative relaxation exercises
- Multiple choice questions
- Video link

Activity 4: mhGAP OTH module – assessment, management and follow-up

<https://www.youtube.com/watch?v=t6EP24FTzn8&index=17&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v>

# OTH role plays

Note: Role plays 3 and 4 are additional for supplementary activities.

## Role play 1: Assessment

**Purpose:** To practise performing assessment and management in exposure to extreme stressor (violence).

**Duration:** 30 minutes.

**Situation: PERSON SEEKING HELP**

- You are a 35-year-old woman with three children ages 10, 7 and 5.
- You have been married to your husband for 12 years and the first four of those years were happy.
- However, your husband lost his job and his parents died all within quick succession eight years ago and that is when he started using alcohol and drugs to cope.
- He would beat you when he was really drunk. The beatings are always on your body and never on your face that way no one else can see the bruises. He has broken your ribs several times. He has almost broken your back on one occasion. He also beats your children and ritually humiliates them. When he beats your children, you throw yourself in front of him to have him beat you and save your children.
- You work but he takes all the money and spends it on alcohol and drugs. There is never enough money for food.
- You and your children are malnourished
- Your children are sick and withdrawn. They do not play any more and are afraid of their father. They do not want to stay in the house and repeatedly ask you to leave. You are very worried for your children especially as your husband humiliates them regularly.
- Your husband's father was an important person in your community before he died and as a result you cannot go to any one for help as you fear that will bring shame on your father-in-law's memory and your husband.
- You want to leave but you are too scared and do not think it is possible.

**Instructions:**

Let the health-care provider ask you about your experiences of violence. This is the first time you have ever talked to anyone about it and you are very scared of what will happen to you.

## Role play 1: Assessment

**Purpose:** To practise performing assessment and management in exposure to extreme stressor (violence).

**Duration:** 30 minutes.

**Situation: HEALTH-CARE PROVIDER**

- A woman arrived at your clinic with her children this morning.
- She was brought in by her husband who was complaining that she was “crazy”.
- The children looked malnourished and unwell.
- The wife looked sick and tired.
- You smelt alcohol on the husband’s breath
- You decided that you wanted to talk to the woman alone so you politely asked the man to wait in the waiting room. You asked a colleague to look after the children and spend time playing with them giving them water and something to eat.
- You were finally able to speak to the woman alone.
- You suspect intimate partner violence, specifically the husband against the wife.
- You are very concerned about the health of the children.

**Instructions:**

- You start the conversation.
- Use open questions to raise the issue of violence and probe gently. Find out how it is impacting on the woman and the children. Using the LIVES intervention (see OTH supporting material), listen, enquire about needs and validate what she tells you.
- Depending on her specific needs, create a safety plan with the woman.
- Identify what further support she needs and refer her/provide her information where to go (do not give flyers/documents for her to take with her if it is not safe to do so).

## Role play 1: Assessment

**Purpose:** To practise performing assessment and management in exposure to extreme stressor (violence).

**Duration:** 30 minutes.

### Situation: **OBSERVER**

- A woman arrived at the health-care clinic with her children this morning.
- She was brought in by her husband who was complaining that she was "crazy"
- The children looked malnourished and unwell.
- The wife looked sick and tired.
- The health-care provider smelt alcohol on the husband's breath.
- They decided that they wanted to talk to the woman alone so they politely asked the man to wait in the waiting room. They asked a colleague to look after the children and spend time playing with them giving them water and something to eat.
- They were finally able to speak to the woman alone.
- They suspect the woman has been exposed to violence specifically by the husband.
- They are very concerned about the health of the children.

### Instructions:

Please keep to time:

- 3 minutes reading
- 20–25 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
8. Provides psychosocial intervention

Please watch for how the health-care provider uses the LIVES approach and specifically the safety planning during the interview.

## Role play 2: Assessment and management

**Purpose:** Participants will gain understanding of assessment and management of a person with a medically unexplained somatic complaint.

**Duration:** 40 minutes.

### Situation: PERSON SEEKING HELP

- You are Ms Wafica. You do not have any medical history or any other priority condition.
- You not been feeling sad and you are not depressed. You have never had ideas of self-harm or suicide.
- You work as a secretary. The aches and pains make it difficult to concentrate, but you go to work every day.
- You have been coming a lot to the centre recently with different symptoms.
- It all started two months ago when your only daughter got married and moved out, but you do not see the two as connected.
- Now, you live alone.
- You have felt very lonely at times.
- Today you have come in for backache.
- You insist that there is something physically wrong with you, and you request a lot of medical tests from the health-care provider.
- You insist that you need medication.

### Instructions:

- Let the health-care provider start the conversation.
- You are insistent on tests and medication until you feel that the health-care provider has convinced you otherwise.

## Role play 2: Assessment and management

**Purpose:** Participants will gain understanding of assessment and management of a person with a medically unexplained somatic complaint.

**Duration:** 40 minutes.

### Situation: HEALTH-CARE PROVIDER

- Ms Wafica is a 55-year-old woman who presents asking for medication for her backache.
- The results of your physical examination were entirely normal.
- You know she has been coming in a lot lately with physical symptoms that do not seem to have a cause.
- You suspect there might be an other significant mental health complaint.

### Instructions:

- Perform an assessment, starting on page 148 of mhGAP-IG Version 2.0.
- You should begin the conversation by asking Ms Wafica more about her pain.
- Once complete, you should explain to Ms Wafica what you think is happening and provide psychosocial intervention.

## Role play 2: Assessment and management

**Purpose:** Participants will gain understanding of assessment and management of a person with a medically unexplained somatic complaint.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- Ms Wafica is a 55-year-old woman who presents asking for medication for her backache.
- The results of the physical examination were entirely normal.
- She has been coming in a lot lately with physical symptoms that do not seem to have a cause, and the health-care provider suspects there might be an other significant mental health complaint.
- She is now she is living alone as her daughter recently moved out, and she has felt very lonely at times.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 20–25 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
8. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

## Role play 3: Assessment and management

**Purpose:** To practise performing assessment and management in stress.

**Duration:** 40 minutes.

**Situation: PERSON SEEKING HELP**

- You are Vladimir, a 51-year-old man.
- You are married with four children.
- Four months ago at work, 15 people lost their jobs. Since then, there are fewer people so there is much more work to do. Additionally, you and everyone else are now worried that more people will lose their jobs, and that you might be next.
- You think about this a lot.
- You worry that you will not be able to provide for your family.
- You spend so much time worrying that you cannot sleep at night.
- Lately you feel unwell all the time, particularly very tired.
- You are often irritable with your wife and children, which upsets you greatly.
- You have been a smoker for a long time, and lately you are smoking much more than you used to.
- You are not sad or suicidal – you would never dream of killing yourself.
- Your wife has told you to stop yelling at the children and told you to see a health-care provider otherwise she might leave you.
- You would like to sleep better and ask for some medication for this.

**Instructions:**

Let the health-care provider start the conversation.

## Role play 3: Assessment and management

**Purpose:** To practise performing assessment and management in stress.

**Duration:** 40 minutes.

**Situation: HEALTH-CARE PROVIDER**

- You are about to see Vladimir, a 51-year-old man who is not feeling well.
- You have seen him in the past for chest infections as he is quite a heavy smoker.
- Today, he is come in to see you as he is feeling “unwell”.

**Instructions:**

- Perform an assessment for other significant mental health complaints, starting on page 143.
- Once complete, tell Vladimir what you think is happening and provide psychosocial intervention. This should include relaxation training.

## Role play 3: Assessment and management

**Purpose:** To practise performing assessment and management in stress.

**Duration:** 40 minutes.

### **Situation: OBSERVER**

- Vladimir is a 51-year-old man who is not feeling well.
- A number of people have recently lost their jobs at his work. This has created extra stress but he is also worried he will lose his job.
- He is irritable with his family, tired and not sleeping properly.
- He is not sad or suicidal.
- His wife has told him to stop yelling at the children and told him to see a health-care provider otherwise she might leave him.
- He would like to sleep better and ask for some medication for this.
- The health-care provider will perform an assessment and then a psychosocial intervention for an other significant mental health complaint, including relaxation training.

### **Instructions:**

Please keep to time:

- 3 minutes reading
- 20–25 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
8. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

## Role play 4: Assessment and management

**Purpose:** To practise assessment and management of a person experiencing post-traumatic stress disorder.

**Duration:** 40 minutes.

### Situation: PERSON SEEKING HELP

- You are Magui, a 29-year-old mother of three children who has been displaced from your home by civil war.
- The war has been brutal. Many women and children have not been allowed to escape, but were captured and harmed.
- There have been attacks on hospitals, convoys of women and children, and international workers.
- You were lucky to escape with your children but you do not know where your husband is, as you were separated as you fled.
- You travelled for two weeks by foot with your children to find somewhere safe. That was four months ago.
- Now that you are in safe accommodation you are finding things incredibly difficult.
- You often wake at night, screaming. You wake up your children and the other residents. You have nightmares about the attacks.
- Sometimes during the day you have very vivid memories of when a bomb went off in a marketplace. You were not injured, but people near you were. When you have these memories you feel as though you are transported back, you can hear the screams and smell the blood.
- You feel constantly on edge, any loud noise will make you jump.
- You avoid the marketplace now, which makes it difficult to get food for your children.
- You have come to see the health-care provider to get help.

### Instructions:

- Let the health-care provider start the conversation.
- You are on edge and startle easily to any noise during the interview.

## Role play 4: Assessment and management

**Purpose:** To practise assessment and management of a person experiencing post-traumatic stress disorder.

**Duration:** 40 minutes.

### Situation: HEALTH-CARE PROVIDER

- You are a health-care provider working in a clinic which services a large refugee population, as a nearby province has been affected by brutal civil war.
- You are about to see Magui, a mother of three children.
- You know that Magui is a refugee herself and suspect that she may have post-traumatic stress disorder.

### Instructions:

- Perform an assessment for an other significant mental health complaint, starting on page 143 of your mhGAP-IG.
- After the assessment, explain to Magui what you think is happening.
- Then, proceed to perform management as required.

## Role play 4: Assessment and management

**Purpose:** To practise assessment and management of a person experiencing post-traumatic stress disorder.

**Duration:** 40 minutes.

**Situation: OBSERVER**

- The health-care provider works in a clinic which services a large refugee population, as a nearby province has been affected by brutal civil war.
- They are about to see Magui, a mother of three children.
- Magui is a refugee herself and the health-care provider suspects that she may have post-traumatic stress disorder.
- The health-care provider will perform the assessment starting on page 143 of themhGAP-IG, then will proceed to appropriate management.

**Instructions:**

Please keep to time:

- 3 minutes reading
- 20–25 minutes' interview
- 5–10 minutes for feedback and small group discussion.

Please assess the following competencies:

4. Uses effective communication skills
5. Performs assessment
8. Provides psychosocial intervention

And grade the level of competency the health-care provider achieves.

# LIVES intervention

**First-line support involves 5 simple tasks.** It responds to both emotional and practical needs at the same time, The letters in the word "LIVES" can remind you of the 5 tasks that protect women's lives.

<b>L</b> isten	Listen to the woman closely, with empathy, and without judgement.
<b>I</b> nquire about needs and concerns	Assess and respond to her various needs and concerns – emotional, physical, social and practical (e.g. childcare).
<b>V</b> alidate	Show her that you understand and believe her. Assure her that she is not to blame.
<b>E</b> nhance safety	Discuss a plan to protect herself from further harm if violence occurs again.
<b>S</b> upport	Support her by helping her connect to information, services and social support.

## First-line support care for emotional needs

First-line support may be the most important care that you can provide, and it may be all that she needs.

First-line support is care for emotional and practical needs. Its goals include:

- Identifying her needs and concerns
- listening and validating her concerns and experiences
- helping her to feel connected to others, calm and hopeful
- empowering her to feel able to help herself and to ask for help
- exploring what her options are
- respecting her wishes
- helping her to find social, physical and emotional support
- enhancing safety.

Remember: When you help her deal with her practical needs, it helps with her emotional needs.

When you help with her emotional needs, you strengthen her ability to deal with practical needs.

You do not need to:

- solve her problems
- convince her to leave a violent relationship
- convince her to go to any other services, such as police or the courts
- ask detailed questions that force her to relive painful events
- ask her to analyse what happened or why
- pressure her to tell you her feelings and reactions to an event

These actions could do more harm than good.

### Tips for managing the conversation

- Choose a private place to talk, where no one can overhear (but not a place that indicates to others why you are there).
- Assure her that you will not repeat what she says to anyone else and you will not mention that she was there to anyone who doesn't need to know. If you are required to report her situation, explain what you must report and to whom.
- First, encourage her to talk and show that you are listening.
- Encourage her to continue talking if she wishes, but do not force her to talk. ("Do you want to say more about that?")
- Allow silences. If she cries, give her time to recover.

**Remember: Always respect her wishes.**

# OTH: Case scenarios: Psychosocial interventions

## Symptoms of depression not amounting to depression

A 69-year-old woman presents with physical aches and pains all over her body, frequent headaches and low mood. She states that she has been crying a lot recently because of the pains. She says she feels lonely as her family and grandchildren have moved to a different city. She is staying active and spend times with friends. She is able to cook and attend to her daily chores but she has low motivation for trying anything new, she feels sad and in pain.

## Stress

A 45-year-old man attends primary health-care clinic with stomach aches. He describes the pain as so bad that when it comes on he has problems catching his breath. He has had to take a lot of time off work because of his stomach aches and as a result he has fallen behind in his work. He is the main breadwinner in the family but feels very anxious as he has a demanding boss and so much work to catch up on he does not know where to start. He is struggling to sleep at night as he is always thinking about what he has to do.

## Post-traumatic stress disorder

A 23-year-old woman presents to the primary health-care provider with racing heart and problems breathing. After spending some time listening to her, the health-care provider learns that she was raped one year ago at a party. She has flashback memories of that attack and nightmares that stop her from sleeping. She avoids spending time with people as she feels frightened by them. If she is in social situations she feels very jumpy and uncomfortable and always seek to leave early. She is exhausted.

## Bereavement

A 22-year-old girl attended primary health-care clinic complaining of aches and pains all over her body. She explained that she is socially isolated and does not want to see people as they just make her very angry and she finds them unhelpful. She feels sad all the time. After some time, she explains that her father died four months ago. She was close to her father and misses him and is angry and does not understand how people can carry on as normal.

## Medically unexplained somatic symptoms

A 35-year-old man presents with a pain in the middle of his body, problems breathing, dizziness and nausea when he bends forward. He says that he has been experiencing these problems for approximately four years and has seen countless doctors and specialists. He had to leave his job as a mechanic because he could no longer bend forward. He says the severity of the symptoms have stayed the same over the four years but he has become increasingly frustrated and tired of living with them of and trying to find out what is wrong with him.

# Alternative relaxation exercises

## Basic relaxation and mindfulness strategies: Participatory demonstration (30 minutes)

- Breathing and relaxation exercises are great tool for soothing the nervous system.
- They can help relieve the tension that builds in the body and mind from difficult life experiences, and can help alleviate feelings of stress, depression, anxiety, anger and grief.
- They can help us feel calmer, steadier and more balanced.
- We call many of these activities **mindfulness practices**, because they help us to become **more mindful of the present moment**, and less caught up in distractions and stress.

### Demonstration 1: Abdominal breathing (or belly breathing) (five minutes)

- Often when we are stressed, our breathing becomes shallow, high in our chests, and we forget to breathe deeply into our bellies.
- Abdominal breathing is very calming and centring, and helps us to draw nurturing oxygen deep into our lungs.

#### Instructions for the group:

- Bring your hands to your lower belly with your two middle fingers touching.
- Relax your shoulders.
- Take a long, deep, gentle **inhale**, sending the breath all the way down to your belly, so your stomach expands (keep your shoulders relaxed). You should find that your middle fingers naturally part slightly as the belly expands with the breath.
- **Exhale** slowly, feeling how the belly naturally draws inwards as the breath exits the body and the middle fingers slide to touch again.
- Do this abdominal breathing a minimum of 10 times (inhale/exhale).
- **With children** you can explain that when they inhale they are blowing up their tummy softly like a balloon, and when they exhale, the air is going slowly out of the balloon again.

### Demonstration 2: The wave of light (five minutes)

- This exercise combines breath, movement and visualization.

#### Instructions for the group:

- Find a comfortable standing position.
- Relax your shoulders. Ground your feet evenly.
- Feel the length in your spine, from your tailbone to the top of your head.
- Place your left foot forward, grounding the feet again.
- Inhale: float your hands forwards and over your head. Imagine you are drawing a wave of bright light above your head.
- Exhale: move your hands downwards, past the shoulders, as if you are showering yourself with a wave of soothing cool light.
- Keep this flowing for at least ten breaths. With each inhale imagine drawing that wave of beautiful, healing light above you. With each exhale, imagine that cool, shining light flowing down over you, taking your tightness and troubles away.
- Repeat on the other side, with the right foot forward. Breathe in the shower of light. Exhale and let go of any negativity within you. Feel the flow of light cleansing and renewing you.

### **Demonstration 3: Loving kindness (a short exercise for children) (five minutes)**

#### **Instructions for the group:**

- Close your eyes and think of someone you really love.
- Imagine that person is standing in front of you – really picture them there.
- What do they look like? Picture their eyes, and their smile. Perhaps they have a pleasant familiar smell.
- Now put your arms around yourself and imagine that person is giving you a big hug, sending you love and strength.
- Hug them back, sending that love back to them.

### **Demonstration 4: Using hands to release stress and build calm (five minutes)**

#### **Instructions for the group:**

- Make a fist with your hand.
- Take an inhale and imagine you are squeezing all your worries and stress into your fist,
- Hold your breath. Squeeze those hands really tight!
- Then exhale deeply, and release your fingers – letting the stress and worries go.
- Now, with one hand, take hold of a finger on the opposite hand.
- Squeeze the finger softly and inhale, saying in your head, “I am calm”.
- As you exhale, relax the squeeze and say, “I am peaceful, I am kind”.
- Variation: These words are an example. You can substitute many others, such as, “I am loved, I am perfect just as I am, I am clever, I am strong”, etc.

### **Demonstration 5: My special place (a guided meditation script) (10 minutes)**

#### **Instructions for the group:**

- Sit or lie down in a comfortable position.
- Close your eyes.
- Relax all the muscles in your body.
- Take several deep breaths, breathing in through your nose and out through your mouth.
- Inhale all the way to your belly. Exhale, feel your chest soften.
- Keep breathing slowly and softly. Gentle long inhales then gentle long exhales.
- Listen and follow the story in your mind.

#### **Facilitator to read this script, slowly and in a calm voice:**

Think about a place that makes you feel safe, calm and happy. This could be a beach, a forest, a place in your house/a loved one's house. It could be near the ocean, or a river or lake, or up in the mountains. It can be a real place that you know, or an imaginary place you would like to visit. Wherever it is, this is a place where you feel completely safe, calm and contented. It is a place where you can be completely yourself, where you feel free, where you feel happy and at ease.

Continue to breathe in slowly, and breathe out slowly.

Imagine you are standing in that place that makes you feel safe, calm and happy. What does it look like? What do you see? Is it sunny? Or cool? What colours do you see? Imagine yourself walking around, as you notice things. Is there any water, or trees? Is there grass? Or sand? What colour is the sky? What else do you see? Are there flowers? Perhaps you see animals or people?

Now focus on the sounds of this place. What can you hear? Can you hear the wind? Do you hear water? Maybe there is the sound of birdsong. Perhaps you can hear music, or children playing. If you are walking, what does the ground sound like as you walk on it?

Now start to think about the lovely smells in this happy place. What fragrances are entering your nostrils? Perhaps the scent of a flower, or your favourite food cooking somewhere. Breathe in deeply and enjoy those good smells.

And now, start to focus on how it feels to be here. Check into your body. How does your skin feel – can you feel the breeze on your skin? Do you feel warm or cool? What do you feel inside? Maybe some warmth, or a smile.

You may like to keep walking, or you may like find somewhere comfortable to lie down in this place now; you choose – it's your space and you can do anything you want here, you can be yourself. Just continuing to enjoy how it feels to be here, calm, relaxed, safe and happy, surrounded by these beautiful sights, sounds, smells and sensations.

**Leave a silence of at least two minutes, before continuing:**

This is a place you can always come back to, which is always there, inside your heart. You can visit whenever you want. Now, very gradually, begin to notice your breathing again – the gentle rhythm of inhales and exhales. Notice the feeling of the air on your skin. Very softly begin to wiggle your fingers and toes. Inhale and take a big stretch. Exhale deeply. When you are ready, open your eyes.

**Variation:** For young children, this kind of concentration might be difficult. In cases such as this, you can "tell a story" instead, so that you create the safe space for them as part of your story. For example: "Imagine that you are standing on a white sandy beach. It's early in the morning, and everything is quiet. The sun is rising slowly and you can feel the warm light on your face and your body. You are feeling happy and peaceful. The sand beneath your bare feet is soft and warm. A light breeze strokes your face. The sky is blue and open, and birds are flying and singing above. This place is safe and you can relax here".

# OTH multiple choice questions

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1. Which of the following could be a presentation of an other significant mental health complaint? Choose the best answer:
  - A Somatic symptoms, examination and blood tests reveal presence of HIV.
  - B Anxiety and agitation, following sudden cessation of alcohol.
  - C Tired and stressed, medically unexplained somatic symptoms.
  - D Irritated and stressed, history-taking reveals a manic episode.

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2. Which of the following conditions would exclude an other significant mental health complaint? Choose the best answer:
  - A Depression.
  - B Self-harm/suicide.
  - C Physical violence.
  - D Bereavement.

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3. Which of the following cluster of symptoms fits best with an other significant mental health complaint? Choose the best answer:
  - A Fixed false beliefs and lack of realization that one is having mental health problems.
  - B Elevated mood and loss of normal social inhibitions.
  - C Anxiety and agitation after stimulant use.
  - D Feeling depressed after an extreme stressor.

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4. Which of the following cluster of symptoms fits best with an other significant mental health complaint? Choose the best answer:
  - A Fatigue and confusion after a seizure.
  - B Failure to thrive and poor motor tone.
  - C Medically unexplained somatic symptoms.
  - D Delirium associated with cerebral malaria.

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5. Which of the following is important in the management of other significant mental health complaints? Choose the best answer:
  - A Prescribing anti-anxiety and/or antidepressant medication.
  - B Give a vitamin injection.
  - C Repeat multiple laboratory investigations.
  - D Reduce stress and strengthen social supports.

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6. Which of the following might you tell someone who has medically unexplained somatic complaints, where you have identified an other significant mental health complaint? Choose the best answer:
  - A The symptoms are all in their head, and they need to 'snap out of it' and stop wasting your time.
  - B All laboratory investigations should be repeated in three months.
  - C You understand that the symptoms are not imaginary, and ask what their explanation is.
  - D If there are any incomplete investigations they should be hopeful that that will find the answer.

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7. Which of the following is part of a psychosocial intervention where the person seeking help witnessed the death of a loved one to violence? Choose the best answer:
- A They should talk about the incident as much as possible, even if they do not want to.
  - B It is normal to grieve for any major loss, in many different ways, and in most cases grief will diminish over time.
  - C Avoid discussing any mourning process, such as culturally appropriate ceremonies/rituals, as it may upset them further.
  - D Refer to a specialist within one week of the incident if they are still experiencing symptoms.
- 
8. Which of the following steps, in the correct order, are involved in performing relaxation training? Choose the best answer:
- A Explain what you will be doing, start relaxation exercise and demonstrate breathing, focus on breathing technique, then encourage self-practice.
  - B Encourage self-practice before explaining or demonstrating, then focus on breathing technique.
  - C Start relaxation exercise and focus on breathing, then explain what you have done at the end of the exercise.
  - D Discuss traumatic event, then focus on breathing technique, then encourage self-practice.

## OTH multiple choice answers

- |        |        |        |        |        |        |        |        |
|--------|--------|--------|--------|--------|--------|--------|--------|
| 1. = C | 2. = A | 3. = D | 4. = C | 5. = D | 6. = C | 7. = B | 8. = A |
|--------|--------|--------|--------|--------|--------|--------|--------|



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