BELMATT
HEALTHCARE TRAINING

MENTAL ILLNESS IN PRIMARY CARE

1

What is a mental illness?

It is when someone lacks the ability to manage day to day events and/or control their behavior so that basic physical and emotional needs are threatened or unmet.

2

These disorders can affect persons of any age, race, sex, religion, or income.

Mental illnesses are not the result of a personal weakness, lack of character, or poor upbringing.

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Why should I care?

- Because understanding of mental health issues brings awareness to the community and our surrounding environment.
- We will become a society that is accepting of others who do not fit our idea of a perfect population.

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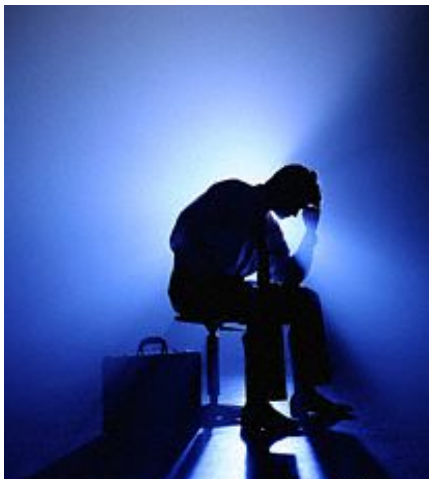
What is mental illness like?



Mental illness is a physical condition just like asthma or arthritis.

But still society believes that a person who is mentally ill needs to show more willpower -

to be able to pull themselves out it.

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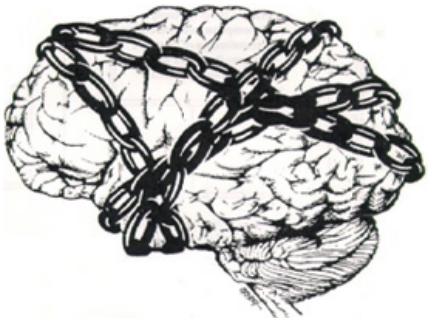
.....It is also like telling a person who has an amputated leg to run across the room.



But a person who has mental health issue has a "broken brain".

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Myths of Mental Illness

- Mental illness is caused by bad parenting.
  Fact: Most diagnosed individuals come from supportive homes.
- The mentally ill are violent and dangerous.
  Fact: Most are victims of violence.
- People with a mental disorder are not smart.
  Fact: Numerous studies have shown that many have average or above average intelligence.

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Mental Illnesses in our Community

- Depression
- Mania
- Schizophrenia

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CASE STUDY

86 yr old married woman

Been withdrawn and weepy for six weeks.
Eating very little & wishing she were dead

She appeared very dehydrated.

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Depression

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What is Depression?

Depression is a medical issue that affects a persons mood to be down, blue and/or fed up.

Depression is the most common mood disorder, affecting approximately 20 million people each year.

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Signs and Symptoms of Depression

- Fatigue or loss of energy
- Thoughts of death or suicide, including suicide attempts
- Feeling guilty, hopeless or worthless
- Difficulty concentrating, remembering or making decisions
- Persistent sad, anxious or empty mood
- Sleeping too much or too little; odd time of waking
- Reduced or increased appetite which results in weight gain or loss.
- Irritability or restlessness

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What factors causes depression?

There is no single cause of depression.

But here are some factors that may contribute to it's development:

- Psychological
- Biological
- Environment

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Evidence also suggests.

Scientists have also found evidence which makes some people with a genetic predisposition to major depression vulnerable to the disorder. However not everyone with a family history develops depression.

Some life event that may trigger episodes of depression:

- Death of a loved one
- Major loss or change
- Chronic stress
- Alcohol and drug abuse
- Heart disease and cancer
- medications

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How does depression work?

The way we respond to situations (with thoughts of hopelessness, anxiety, anger, etc.) effects the emotions we feel, which in turn, effects the chemicals that are released within our body.

And all emotional responses have a chemical consequence. Serotonin, a neurotransmitter (body chemical), is a major contributor in the depression cycle.

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Serotonin

When a person is depressed, their serotonin level is low, which causes several changes to the body:

1. Pain Threshold Lowered: A depressed person feels more pain from no apparent source. (back pain is very common amongst sufferers)

2. Sleep Disturbance: A depressed persons day runs on an average of 22 hours, not 24. And there are many spikes in temperature throughout the night which causes a person to wake many times, resulting in not getting any REM sleep.

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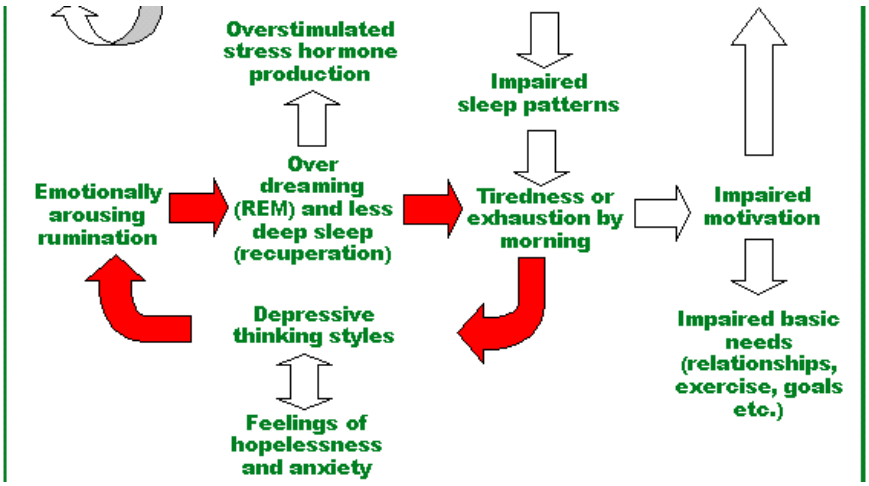
The Cycle of Depression



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How Can I Help A Person With Depression?

Be sensitive to their feelings, and validate those feelings.

Teach emotion-coping skills:

- Acknowledge and express emotions.
- Remind the person to challenge irrational thoughts and write them down in a journal.
- Teach that for every one negative thought they need to think of two positive thoughts.

Teach problem-solving skill:

- Help determine importance of problem while keeping down their stress and anxiety
- Break problem into small chunks
- Remind the person that it is ok to ask for help

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Assessing risk of suicide

- How do I assess the risk of suicide?
- Directly ask about suicidal thoughts and intent. Do not avoid the word 'suicide'.
  - Ask:
    - Do you ever feel that life is hopeless and not worth living?
    - Do you ever think about suicide?
    - Have you made any plans for ending your life?
    - Do you have the means for doing this available to you?
    - What has kept you from acting on these thoughts?
  - Follow up on 'not really' answers.

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Management

- **Manage suicide risk.** Options include:
  - Contacting the Crisis Resolution and Home Treatment (CRHT) team for an urgent assessment. Voluntary admission or compulsory admission may be required.
  - Reviewing a person frequently in primary care.
- **Manage any safeguarding concerns** for children or vulnerable adults in their care. Follow local safeguarding procedures if appropriate.
- **Manage any co-morbid condition associated with depression,** such as:
- **Alcohol or substance abuse —** treat the underlying drinking or substance problem; depressive symptoms frequently resolve following this. For more information,

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Mild or Subthreshold Depression

  - Provide information about the nature and course of depression.
  - Arrange follow up, normally within 2 weeks (consider contacting the person if they do not attend follow-up appointments).
- **For people with persistent subthreshold depressive symptoms or mild-to-moderate depression:**
  - Consider a psychological intervention. This is accessed by referral or self-referral to IAPT (Improving Access to Psychological Therapies). Following assessment, the following interventions may be offered:
    - One or more low-intensity psychological interventions or group-based cognitive behavioural therapy (CBT) for people who decline this intervention.
    - A group-based peer support programme, either alone or in combination with the above, for people with a chronic physical health problem.
  - Avoid the routine use of antidepressants, but consider this for people with:
    - A history of moderate or severe depression.
    - Subthreshold depressive symptoms that have persisted for a long period (typically at least 2 years).
    - Mild depression that is complicating the care of a chronic physical health problem.

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Moderate to Severe Depression

- offer an antidepressant*and* a high-intensity psychological intervention. Psychological interventions are accessed by referral or self-referral to IAPT. The type of intervention offered will depend on the severity of depression and the presence or absence of a chronic health problem.
- **For people starting an antidepressant:**
  - Consider suicide risk and toxicity in overdose.
  - Explain that symptoms of anxiety may initially worsen.
  - Explain that antidepressants take time to work.
  - Explain that antidepressants should be continued for at least 6 months following remission of symptoms, as this greatly reduces the risk of relapse.
- **Advise people with depression who may have an impaired ability to drive safely** due to suicidal thoughts, significant memory, concentration, or other problems, to inform the Driver and Vehicle Licensing Agency (DVLA). For the latest information from the DVLA regarding medical fitness to drive see www.gov.uk.
- **For people having difficulty sleeping**, offer sleep hygiene advice. For more information, see the section on Good sleep hygiene in the CKS topic on Insomnia.
- **Arrange follow up**to assess the response to treatment, the need for further management, and for any adverse effects or compliance issues associated with anti-depressants.
- **Provide information and advice** about depression and its treatment. Advise the person not to use St John's wort.

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Crisis Services

- Crisis resolution and home treatment (CRHT) teams usually include a psychiatrist, mental health nurses, social workers and support workers and are available 24 hours a day, seven days a week.
- The CRHT team assesses the person's needs, manages the risks of being at home, assists with self-help strategies, visits frequently, offers psychological and practical help, and administers medication.
- While there is insufficient evidence to clearly support their use in depression, the National Institute for Health and Clinical Excellence (NICE) advises that crisis teams may have a role for a small number of people with depression who require more intensive care.

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Compulsory Admission

- **If the person needs to be admitted to hospital,** every attempt should be made to persuade them to go voluntarily.
- **If admission is necessary but the person declines,** compulsory admission may be arranged under sections 2, 3, or 4 of the Mental Health Act.
- **The Mental Health Act allows compulsory admission** of people who:
  - Have a mental disorder of a nature and degree that warrants treatment in hospital, *and*
  - Need to be admitted in the interests of their own health or safety, or for the protection of other people.
- **Compulsory admission is arranged using the appropriate section of the Mental Health Act.**
  - **Section 2 allows compulsory admission for up to 28 days for assessment.**
  - **Section 3 allows compulsory admission for up to 6 months for treatment.**
    - Sections 2 and 3 require an application from an Approved Mental Health Professional (AMHP, formerly an Approved Social Worker), or, rarely, the person's nearest relative, and recommendations from two doctors; one of whom is section 12 approved (usually a psychiatrist) and one who has previous acquaintance with the individual (usually the person's GP if at all practicable).
    - Ideally, the person should be examined jointly by the two doctors with the AMHP also present. Where this is not possible, each doctor may carry out a separate examination. If the AMHP is not present, it is essential that at least one of the doctors discusses the person with the AMHP.

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Section 4

- **Section 4 is used in exceptional cases to permit compulsory admission for up to 72 hours** if there is urgent necessity, and undesirable delay would occur while trying to arrange admission under section 2.
  - It requires an application from an AMHP (or, rarely, the person's nearest relative) and just one medical recommendation, preferably from a doctor with previous acquaintance (usually the GP).
- **Section 136 may be used by police to take people from a public place to a place of safety** and enable examination by a registered medical practitioner and interview by an AMHP. The person's GP, if known, may be informed.

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Section 2

- For admission under section 2, where there is no obvious person to provide the second medical recommendation (for example because the person is not registered with a GP or is not known to local mental health services), another section 12-approved doctor is usually asked to assess the individual. However, in cases where this is not practicable, *any registered medical practitioner* may provide the second recommendation as long as they do not work in the same hospital as the doctor providing the first recommendation.
- Where the person has been compulsorily admitted under an emergency section 4, this section is usually converted to a section 2 (usually requiring further involvement of the GP).
- Guidance and forms for the most common sections of the Mental Health Act can be accessed from the Department of Health website, as well as details of amendments made in the Mental Health Act 2007[DH, 2007c].

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Follow Up

- **When should I review someone with depression?**
- **The review period should be determined by the risk of suicide and the need to assess the tolerability and effectiveness of any treatments started or changed.**
- **In general, for people not considered to be at an increased risk of suicide:**
  - Arrange an initial review:
    - Within 1 week for people less than 30 years of age who have been started on an antidepressant.
    - Within 2 weeks for other people.
  - Arrange subsequent reviews every 2–4 weeks for the first 3 months and if the response to treatment is good, longer review intervals can be considered.

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CASE STUDY

68 YR OLD SINGLE MALE

Picked up by police for stopping traffic & dressing in an untidy unkempt fashion

Brought to hospital where he claimed he was the King of Sweden and all cars & women were his.

Very cheerful & disinhibited, spoke very rapidly, felt he had limitless energy & wealth. Did not believe he was ill.

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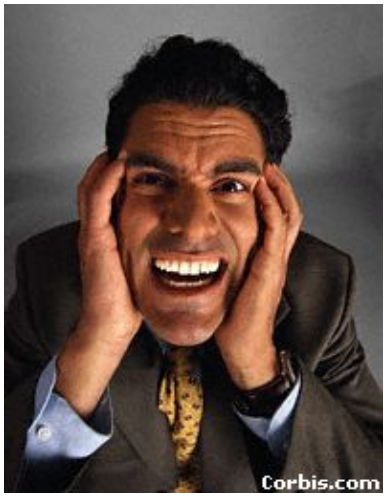

Mania

(bipolar disorder)

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Signs and Symptoms of Mania

- Increased physical and mental activity & energy
- Excessive irritability, aggressive behavior
- Decreased need for sleep; without experiencing fatigue
- Exaggerated optimism and self-confidence
- Racing speech and thoughts; flight of ideas
- Impulsiveness, poor judgment
- Reckless behavior: erratic driving, sexual indiscretions, spending sprees
- Grandiose delusions

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What is Mania?

Mania is part of a condition called bipolar disorder, also known as manic-depression.

Bipolar disorder usually causes a person's mood to alternate between symptoms of depression and mania, a heightened energetic state.

This mood disorder affects more than two million Americans.

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What Causes Mania?

- The neurotransmitters: Norepinephrine, dopamine, and serotonin, have been studied since the 1960s as factors in mania and depression.
- For example, during a manic episode, clients with bipolar disorder have a significantly higher Norepinephrine and epinephrine levels than a depressed or euthymic (normal mood) person.
- Norepinephrine and epinephrine are responsible for "fight or flight" responses.

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How Can I Help a Person Who is Manic?

- Use a firm and calm approach when communicating:
  "Lower your voice Don, or you will lose _____ privilege."
- Remain neutral; avoid power struggles and don't cast judgments.
- Firmly redirect energy into more appropriate and constructive behavior.
- Do not yell or sound threatening, the goal is to try to keep anxiety down in a person who exhibits mania.

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Refer all people with suspected bipolar disorder for a specialist mental health assessment.

  - Refer children younger than 14 years of age to Child and Adolescent Mental Health Services (CAMHS).
  - Refer young people aged 14 to 18 years to a specialist early intervention in psychosis service, or to a CAMHS team with expertise in the assessment and management of bipolar disorder, depending on local service provision.
- **Determine the urgency of any referral by assessing the risks of harm to the person and others.**
  - Refer for *urgent* assessment if the person presents with mania, severe depression, or if they are a danger to themselves or other people.

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While awaiting specialist assessment:

- Do not start antipsychotic medication unless on the advice from a consultant psychiatrist.
- Consider stopping antidepressant medication on specialist advice if mania develops.
- Advise the person to stop driving during the acute illness and that their insurance may not be valid if they continue to do so.

- For further information see the DVLA '*At a glance guide*'

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Treatment Options

- **For the treatment of mania, options include:**
  - A therapeutic trial of an oral antipsychotic (haloperidol, olanzapine, quetiapine, or risperidone).
  - If the first antipsychotic is not tolerated or not effective, a second antipsychotic (from one of the four antipsychotics listed above) is usually offered.
  - If a second-line antipsychotic is not effective, lithium may be added, or if this is not suitable, sodium valproate may be added instead.
- Antidepressant medication is usually stopped if the person develops mania while taking an antidepressant

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Adverse Effects

- **Antipsychotics can cause a wide range of adverse effects. The risk varies with the type of antipsychotic (first-generation or second-generation) and the individual drug. CKS recommends that people who may benefit from a dose reduction or switching drugs should be referred to specialist mental health services, or that advice should be sought.**
- **Adverse effects include** [Taylor et al, 2012; BNF 68, 2014] **:**
  - **Extrapyramidal symptoms** - more common with first-generation antipsychotics. They include:
- Dystonic reactions (abnormal movements of the face and body), and pseudoparkinsonism (tremor, bradykinesia, and rigidity)

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High Risk of Harm to self or Others

- arrange same-day specialist mental health assessment by the early intervention in psychosis service (if available). If:
  - This service is not available or cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team.
  - The person needs to be admitted to hospital, every attempt should be made to persuade them to go voluntarily.
  - Admission is necessary but the person declines, compulsory admission may be necessary under sections 2 or 4 of the Mental Health Act.
- **If the person is *not* judged to be at high risk of harm to themselves or others,** refer without delay, preferably to an early intervention in psychosis service (if available) or a specialist mental health service if not.
  - A consultant psychiatrist or a trained specialist with experience in at-risk mental states should carry out the assessment.
- **Do not start antipsychotic treatment drug while awaiting specialist assessment unless it is done under advice from a consultant psychiatrist.**

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CASE 3

- 78 YR OLD DIVORCED MAN
- Believed he was the head of a special organisation due to rule the world.
- He claimed to have been attacked by the MI5 using radio waves & had to protect himself by acquiring a gun & going into hiding. Brought to hospital after assaulting a member of public he thought was with MI5.
- He was very untidy, experienced auditory hallucinations of people scheming to kill him, and thought they could hear his thoughts & made him do things.
- He had a similar episode four years ago which had led to being admitted to a psychiatric unit but stopped taking medication on discharge.

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Schizophrenia

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What is Schizophrenia?

Schizophrenia is a chronic and severe brain disorder.

It is a disease that makes it difficult for a person to tell the difference between real and unreal experiences, to think logically, to have appropriate emotional responses to others, aspects of memory and to act appropriately in social situations.

The World Health Organization (WHO) has identified schizophrenia as one of the ten most debilitating diseases affecting all human beings.

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Symptoms of Schizophrenia

The severity of symptoms varies from one person to another, and typically symptoms will decline and then reappear.

Symptoms are divided into Positive and Negative symptoms.

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Positive Symptoms

Positive symptoms are characterized by abnormal thoughts, perceptions, language and behavior.

- Delusions: False beliefs/thoughts win no basis in reality
- Hallucinations: Disturbances of sensory perception (hearing, seeing or feeling things not there)
- Disorganized Thinking/Speech: Jumping from topic to topic, responding to questions with unrelated answers or speaking incoherently
- Disorganized Behavior:Problems in performing directed daily activities.
- Catatonic Behavior: Lowered environmental awareness, unresponsiveness, rigid posture, resistance to movement or instructions and inappropriate postures.

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Negative Symptoms

Negative symptoms are characterized by restrictions in range and intensity of emotional expression, communication, body language and interest in normal activities.

- Blunted (or flat) Affect: Decreased emotional expressiveness, unresponsive immobile facial appearance, reduced eye contact and body language.
- Alogia: Reduced speech. Responses are detached and speech is not fluid.
- Avolition: Lacking motivation, spontaneity, initiative. Sitting for lengthy periods or ceasing to participate in work or daily activities.
- Anhedonia: Lacking Pleasure or interest in activities that were once enjoyable.
- Attention Deficit: Difficulty in concentrating

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What Causes Schizophrenia?

There is no one cause to this complex and puzzling illness, but it is believed that some combination of genetic, biological (virus, bacteria, or an infection) and environmental factors play a major role.

There is currently no reliable way to predict whether a person will develop the disease.

John Nash, a famous Schizophrenic. His life story made into a film, *A Beautiful Mind.*

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What Occurs in the Brain of Someone with Schizophrenia?

Researchers believe an imbalance of neurotransmitters may cause the symptoms of schizophrenia. Two neurotransmitters that have most been implicated as abnormal in schizophrenia are dopamine and serotonin.

The ability to produce images have helped in identifying structural and functional differences in a schizophrenic brain versus a normal brain.

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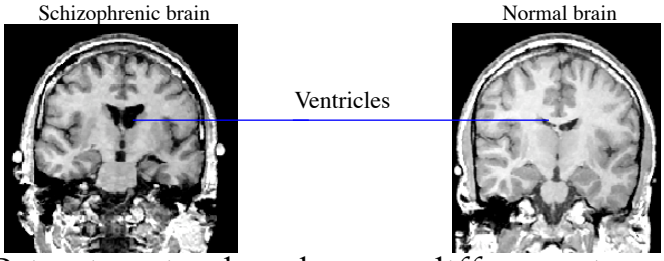
From The Looks of It



Brian imaging has shown a difference in:

- Enlargement of the ventricle
- Decrease in the hippocampus (controls emotional and working memory)
- Decrease in overall size
- Abnormal development of pre-frontal cortex (forehead region; controls information process, motivation, problem solving, decision making, and thinking speed)

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How Can I Help a Person With Schizophrenia

The following guidelines may be useful when talking to a person whose speech is confused and disorganized.

1. Do not pretend that you understand the persons words or meaning when you are confused
2. Tell the person that you are having difficulty understanding what they are trying to communicate
3. Place the difficulty of understanding upon yourself "I' m having trouble following what you are saying." not "You are not making any sense."
4. Tell the person what you do understand; reinforce clear communication.
5. Keep their anxiety down by: a calm voice and firm direction

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Antipsychotics

- Antipsychotics are available as oral preparations or depot injections. They are classified as first-generation antipsychotics (typical) and second-generation antipsychotics (atypical). For more information, see Table 1.
- Antipsychotics are thought to exert their effects by blocking dopamine-2 receptors in the brain; however, their exact mode of action is unknown. Antipsychotics also have significant effects on acetylcholine, histamine, norepinephrine, and serotonin pathways. They can cause extrapyramidal symptoms (EPS) and a wide range of other adverse effects.
- In general, second-generation antipsychotics are associated with fewer EPS than first-generation antipsychotics. However, second-generation antipsychotics are associated with several other important adverse effects, such as weight gain, glucose intolerance, and hyperprolactinaemia [National Collaborating Centre for Mental Health, 2014].
- Previous guidance issued by the National Institute for Health and Care Excellence (NICE) [NICE, 2002] recommended second-generation antipsychotics (for example olanzapine, risperidone, or quetiapine) in some situations as first-line treatment for schizophrenia because of their lower potential for EPS.
- NICE reviewed the evidence for the use of antipsychotics in psychosis and schizophrenia and concluded that choosing the most appropriate drug and formulation for the person is more important than the drug group (first or second generation) [National Collaborating Centre for Mental Health, 2014]. This was based on evidence from systematic reviews (particularly with regard to other adverse effects, such as metabolic disturbance) and evidence from effectiveness (pragmatic) trials [Lieberman et al, 2005; Jones et al, 2006].
- The only exception to this was clozapine, for which NICE found strong evidence to support its use in people who do not respond adequately to two other antipsychotics. Clozapine is always initiated and monitored in secondary care.

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CASE STUDY

- 86 yr old widow
- Been going out in the middle of the night for several months claiming to be going shopping and getting lost. Police had brought her back home on a number of occasions
- Did not have any recollection and had poor short-term memory but no other problems.

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Care Coordination

- Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care.
- Named professionals should:
- arrange an initial assessment of the person's needs, which should be face to face if possible
- provide information about available services and how to access them
- involve the person's family members or carers (as appropriate) in support and decision-making
- give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the Mental Capacity Act 2005
- ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate
- develop a care and support plan, and:
  - agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals
  - specify in the plan when and how often it will be reviewed
  - evaluate and record progress towards the objectives at each review
  - ensure it covers the management of any comorbidities
  - provide a copy of the plan to the person and their family members or carers (as appropriate).

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Pharmacological management of non-Alzheimer's dementia

- Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies.
- Only consider galantamine for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated.
- Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies[j].
- Consider memantine for people with dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated.
- Only consider AChE inhibitors[i] or memantine for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.
- Do not offer AChE inhibitors or memantine to people with frontotemporal dementia[i]
- Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.
- For guidance on pharmacological management of Parkinson's disease dementia, see Parkinson's disease dementia in the NICE guideline on Parkinson's disease.
- You must have the necessary skills and competence before initiating treatment.

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CASE STUDY

82 yr old widow

Recurring episodes of apprehension about future despite having supportive children.

Associated chest pains, palpitations, sweaty palms and trembling. Found it difficult to sleep.

Been repeatedly investigated by GP and physicians but no physical health problems identified.

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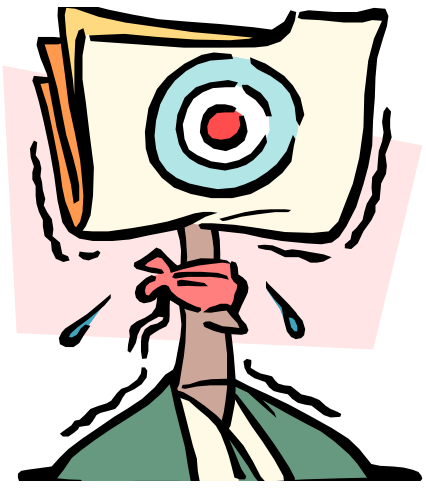
ANXIETY DISORDER



- Clinical Features: Irrational Apprehension, palpitations, increased sweating, somatic symptoms like chest & muscular pains, insomnia
- Rx: Cognitive behaviour therapy, Interpersonal therapy,
- Drugs: Cipramil, Prozac, Paroxetine, Setraline.
- Short-term use – diazepam or Lorazepam

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CASE STUDY

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- 68 yr old lady brought to the A&E dept.
  Took an overdose of paracetamol after husband died five weeks ago.
  Had no previous history of depression
  Has no living relatives and has chronic arthritis

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Deliberate self harm or attempted suicide

- **Initial Management:** 1) Obtain history & physical examination (carry out mental state examination). 2) Treat physical consequences of overdoses with antidotes, IV fluids and intensive care depending on severity
- **Intermediate / Long-term management**: If physically fit carry out a comprehensive risk assessment & rule out any underlying psychiatric disorder like depression & substance misuse
  Offer follow-up support & treatment where appropriate or refer to appropriate team

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CASE STUDY

- 46 yr old single mother of 3 teenage children of different fathers
- Parents separated when she was young
- Truanted as a child
- Several self harm attempts
- 14 yr old daughter pregnant & her partner has moved into their home smoking cannabis daily
- Came to GP surgery feeling low and suicidal

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Personality Disorder (Borderline PD)

- Long history of maladaptive pattern of behaviour
- Unstable relationships.
- Frequent self harm.
- Needs to be assessed for underlying psychiatric disorder like depression.
- Long term psychological, behavioural and social supportive care required.

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CASE STUDY

- 84 yr old unemployed man
- Drinks a bottle of whiskey daily
- Starts drinking first thing in the morning
- Suffers from recurring fits
- Several failed attempts to give up drinking
- Presents in GP surgery feeling depressed and seeking help

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Alcohol Dependency

- Long history of excessive alcohol use, with withdrawal symptoms
- Need to rule out other psychiatric and physical disorders – depression, liver disorders, delirium tremens, nutritional deficiencies etc
- May need admission for detoxification if wishes to stop and abstain (community detox possible)
- Treat underlying psychiatric and physical disorders

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CASE STUDY

- 63 yr old man witnessed the killing of wife and son in a road traffic accident
- Survived accident but had to have a below knee amputation
- Frequently has dreams and flashbacks about the accident
- Repeatedly startled at the slightest unexpected noise

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Post traumatic Stress Disorder

- Re-living of an acute stress often traumatic event leading to recurring anxiety
- Can be associated with depression
- Treatment can involve various psychological therapies like CBT, EMDR
- Medication: SSRI antidepressants, short term Anxiolytics

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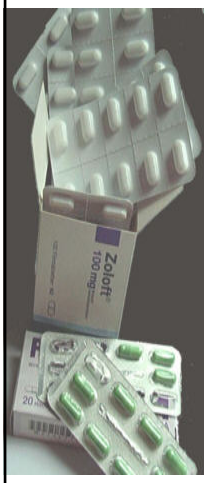
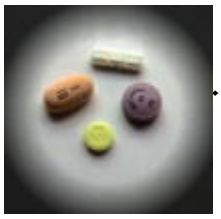
Treatment



With all of these illnesses, treatment, with the right combination of medications and/or therapy, can help stabilize the moods that interfere with a productive .



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Requiring psychiatric admission

- Suicide behaviour
- Homicidal state
- Self neglect
- Psychosocial crises

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Conclusion

Overall, mental health is an issue that effects everyone.

And hopefully, throughout the years, education will curve the sigma of these brain disorders so that hate, bias judgment and discrimination will be gone.

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