For field testing

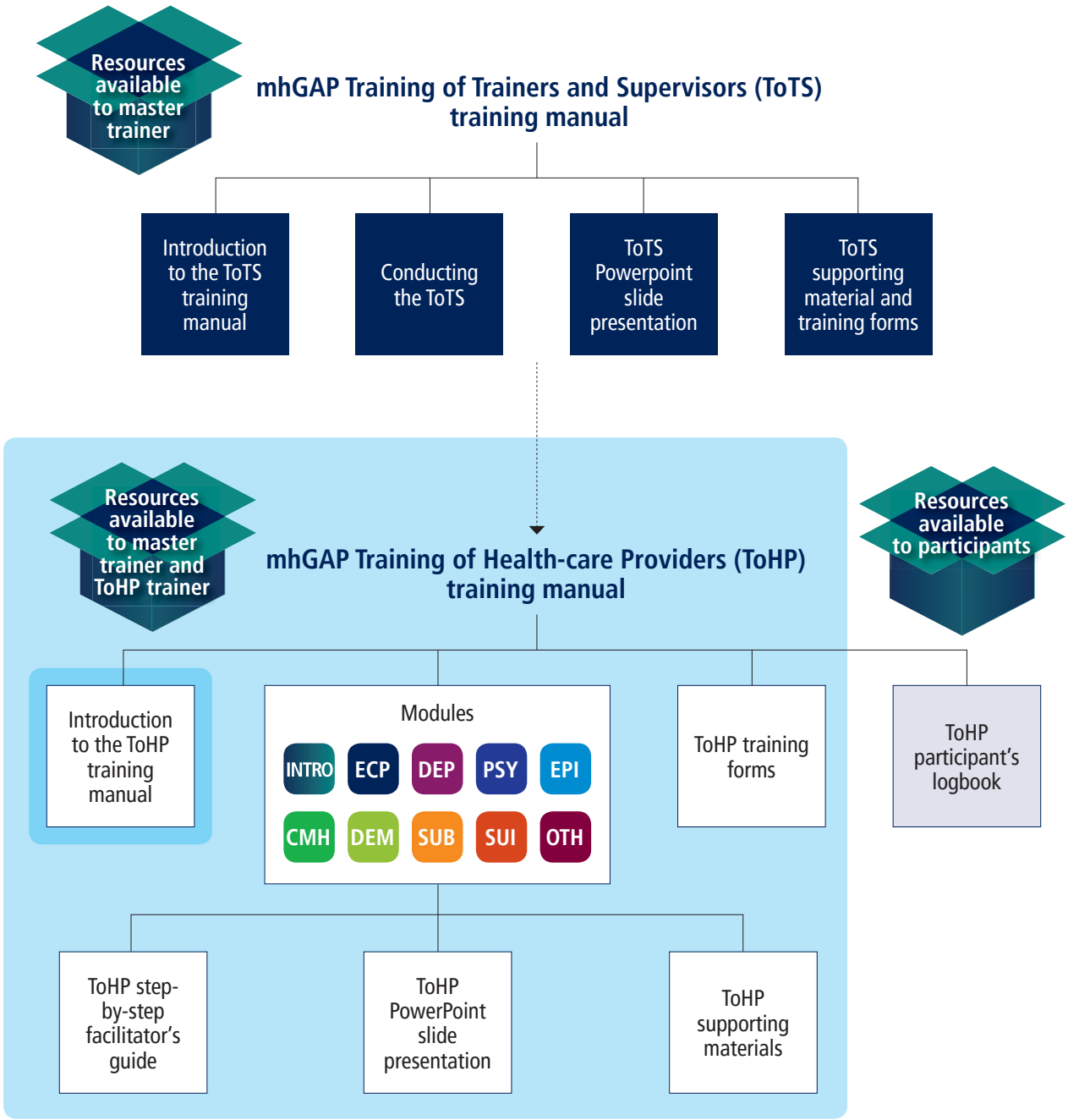
mhGAP Training of Health-care Providers (ToHP) training manual

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.

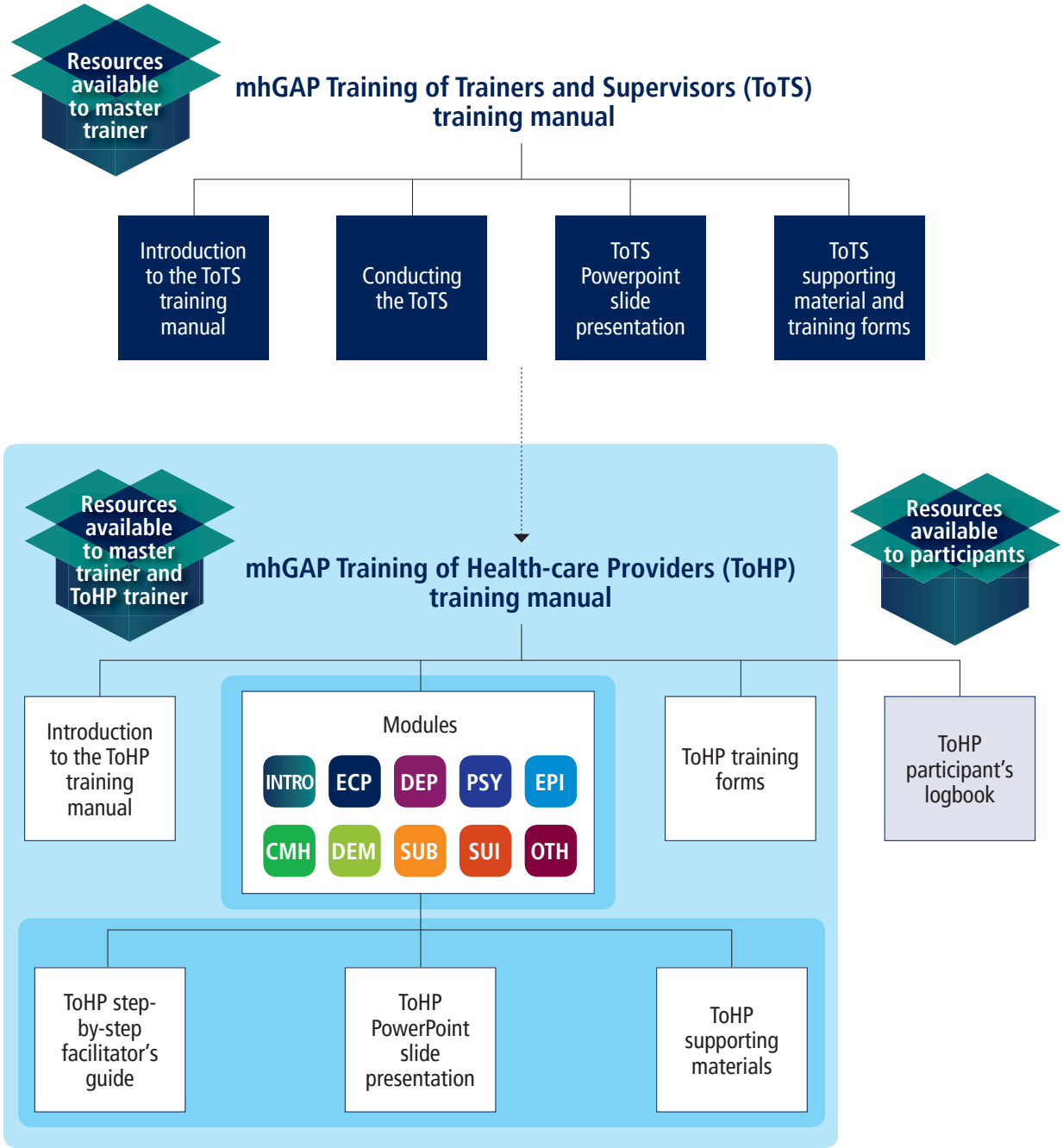
Instructions: The step-by-step facilitator's guides provide specific information on facilitator demonstrations, but general principles are:
- **Introduction:** Trainers should clarify the specific purpose of the demonstration.
- **Allocate roles:** Trainers work with another trainer or a participant 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.

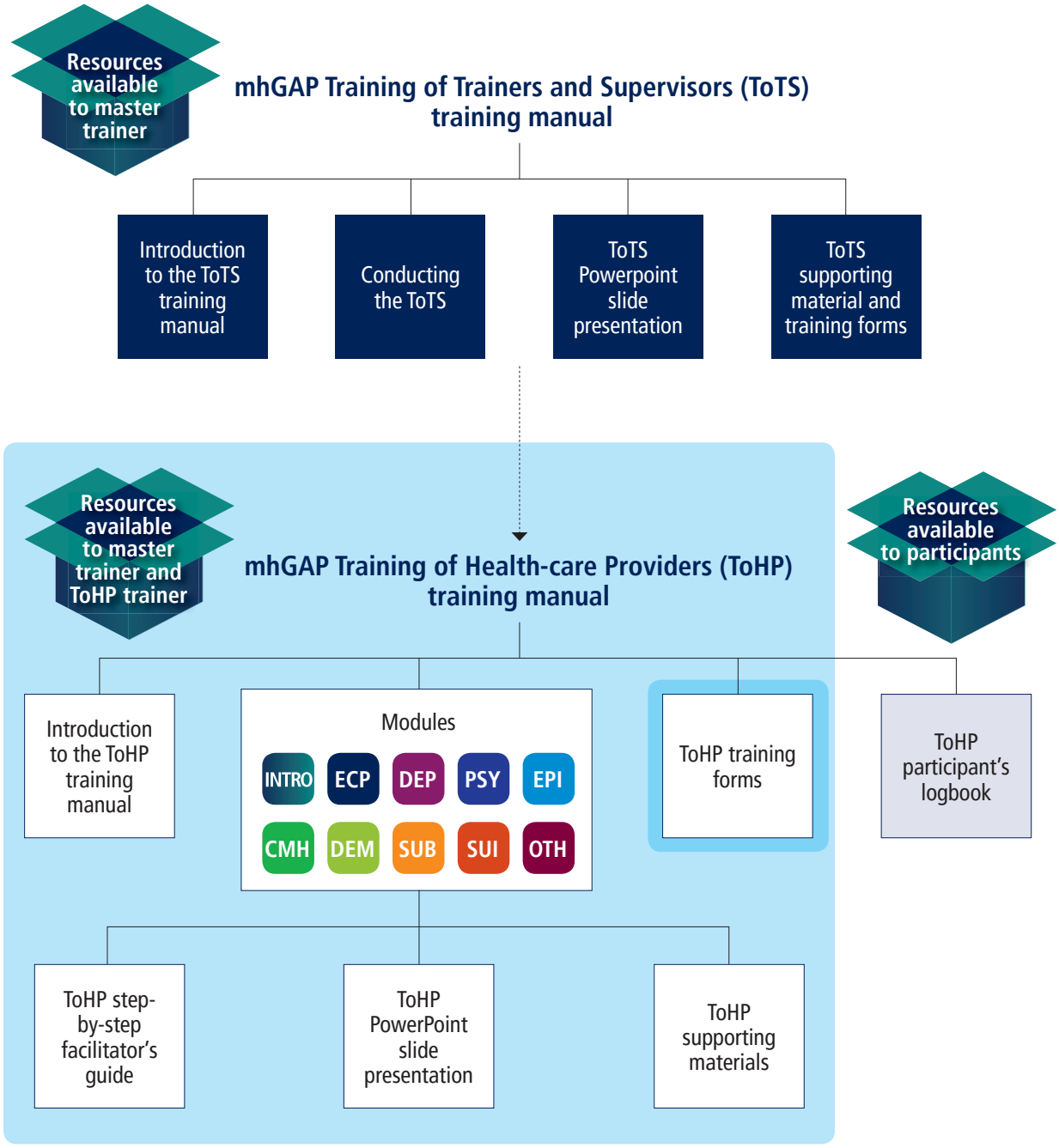
Competency assessment forms

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

World Health Organization

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

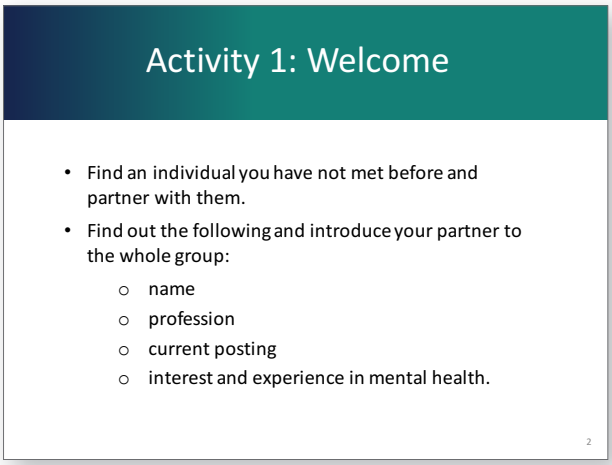
- The burden of mental, neurological and substance abuse (MNS) disorders is large with a wide treatment gap.
- Between 75–90% of people with MNS conditions do not get the treatment they require.
- The aim of the mhGAP is to enhance access to non-specialized treatment for people with MNS conditions.
- 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 Administer mhGAP ToHP pre-test	10 minutes 15 minutes	**Activity 1: Icebreaker** Run an icebreaker to welcome participants to the training and introduce participants to one another **Activity 2: ToHP pre-test** 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 Introduction to mhGAP Intervention Guide (mhGAP-IG) Introduction to mhGAP ToHP training methodology and what to expect from mhGAP ToHP training Collectively agree on the group training ground rules	30 minutes 15 minutes	Presentation on mhGAP Introduction to structure of mhGAP ToHP training **Activity 3: mhGAP ToHP training ground rules** Set ground rules for the mhGAP ToHP training
3. Introduction to common MNS conditions	Introduction to common MNS presentations	30 minutes	**Activity 4: Using the mhGAP-IG master chart** 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	**Brief discussion**
Total duration (without breaks) = 1 hours 45 minutes			

Step-by-step facilitator's guide

Session 1. Welcome

25 minutes



Activity 1: Icebreaker

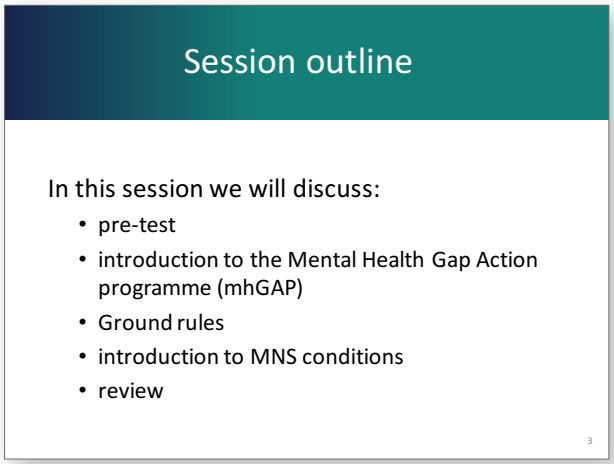
Choose whatever icebreaker you like, but make it interactive. Here are two examples you can use.

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.

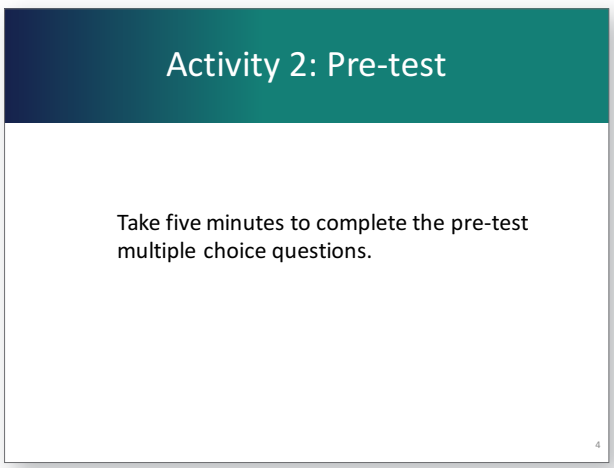
Icebreaker option 2
Duration: Five minutes to discuss with groups, approximately two minutes per presentation for each group.
Purpose: Helps team members develop an understanding of shared objectives and understand, in a non-confrontational way, how their views differ from others in the group.

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?).



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

Activity 2: Pre-test



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.

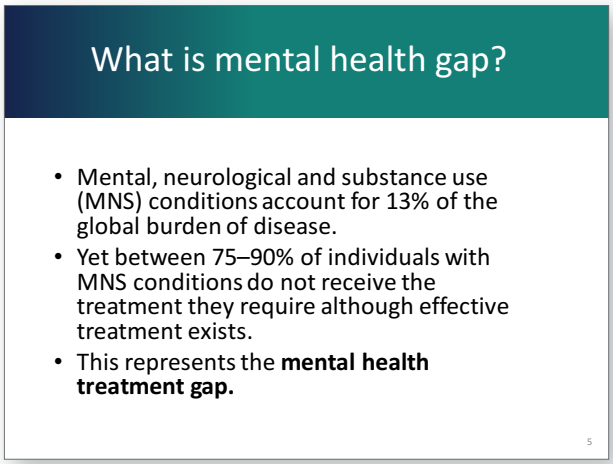
Give participants at least five minutes to complete the test.

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



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).

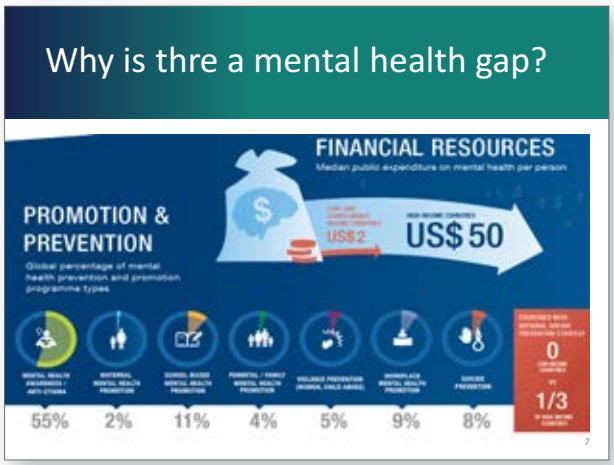
MNS conditions commonly co-occur with other chronic health conditions (e.g. HIV/AIDS, diabetes, cardiovascular disease), and, if untreated, worsen the outcome of these conditions. People with MNS conditions and their families are also challenged by stigma that further worsens their quality of life, affects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



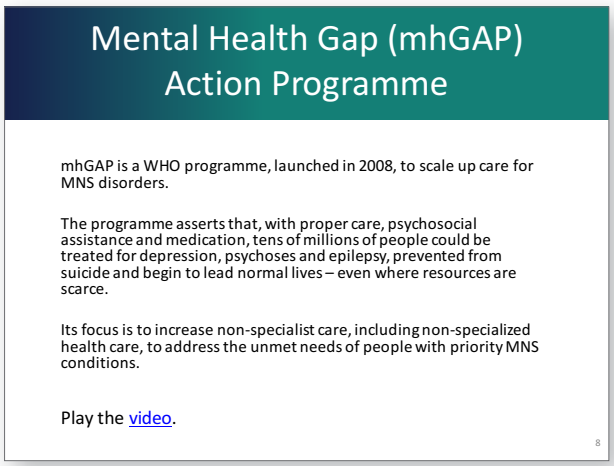
Explain that another reason for such a significant treatment gap is that financial resources for developing and maintaining MNS services in LMIC are extremely low.

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.



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.

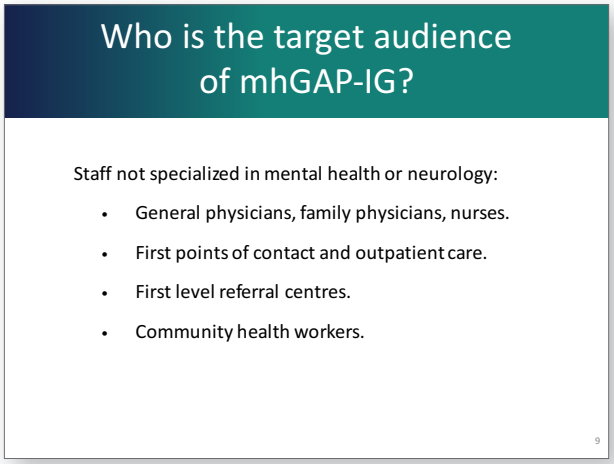
Increasing the number of health-care providers who can assess, manage and follow-up people with MNS conditions will reduce the mental health treatment gap.

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:

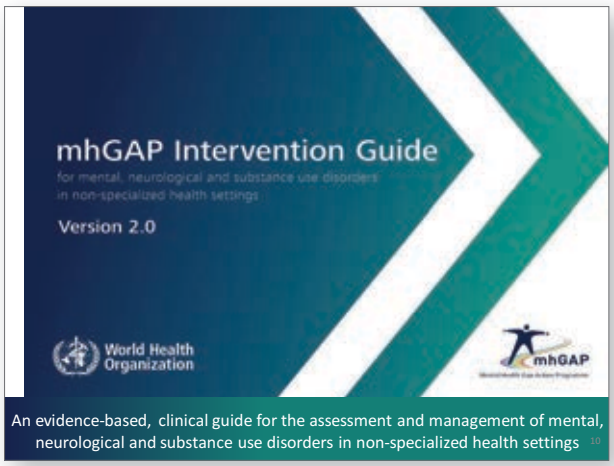
- **Overview of the video:** In LMIC, 75% of people do not get the mental health services they need. With costs as low as US$ 2 per person per year, and with proper care, assistance and medication, millions can be treated.
- A person with epilepsy reflects on changes brought about by an epilepsy treatment 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.



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.



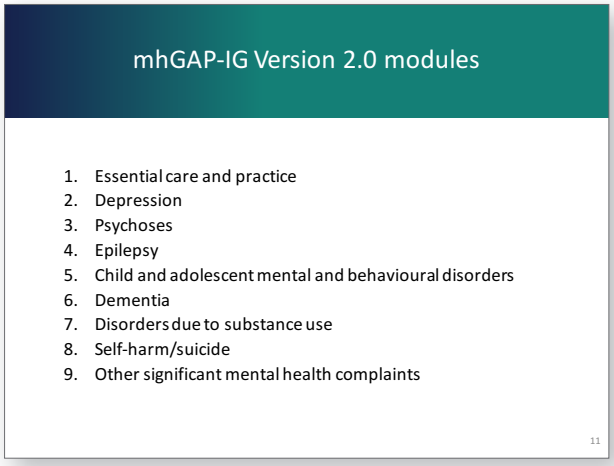
Introduce participants to Version 2.0 of the mhGAP-IG

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.

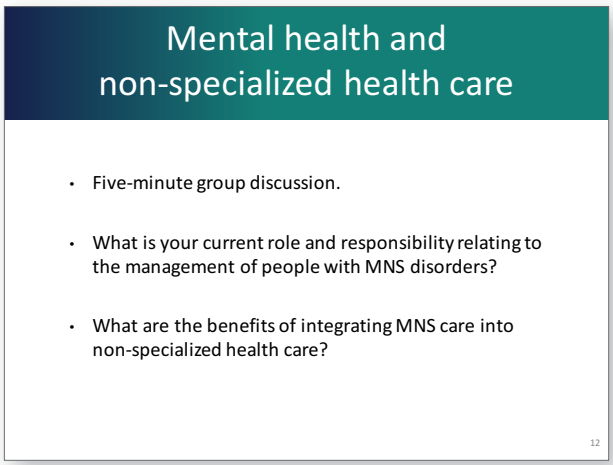
Explain mhGAP-IG

- 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.



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

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



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.

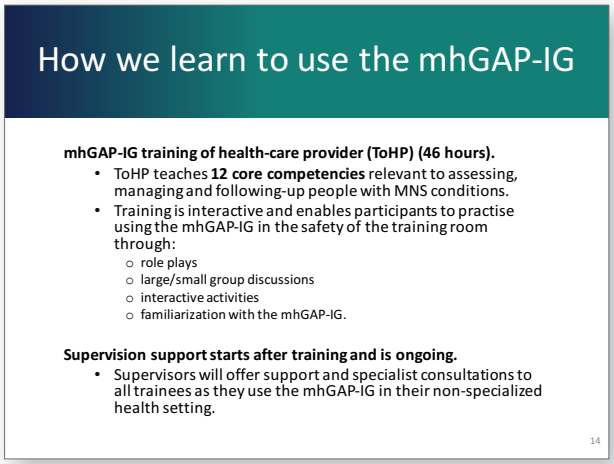
Encourage discussion.

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).



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.

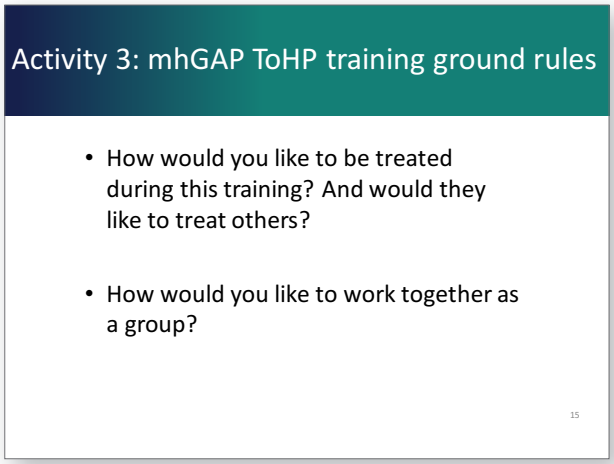
The more time spent using it, the more comfortable participants will feel with it.

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



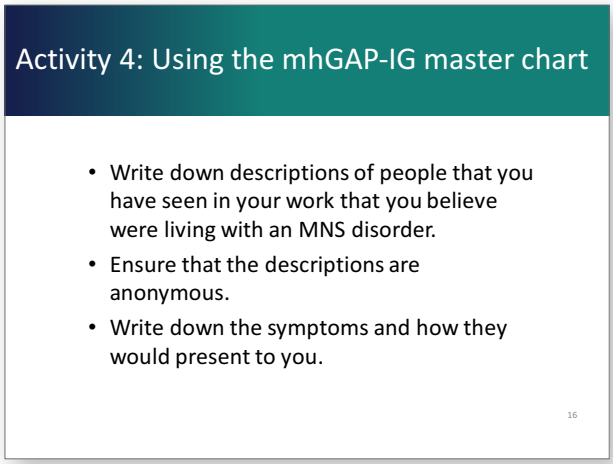
Duration: 15 minutes.

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

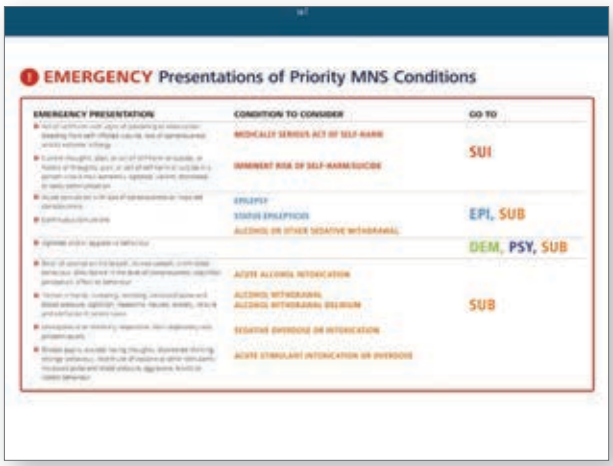
Activity 4: Using the mhGAP-IG master chart



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?



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.

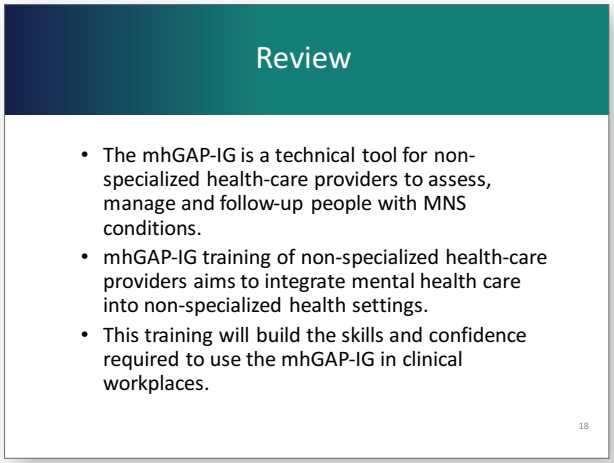
Have participants volunteer to read out loud the different emergency presentations.

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



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.

They 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 of concerns that the participants may have.

ECP

Essential care and practice

mhGAP training of health-care providers
Training manual

World Health Organization

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.

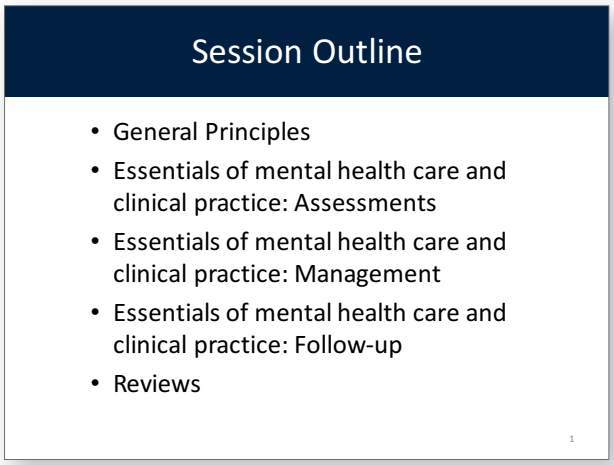
Session	Learning objectives	Duration	Training activities
1. General principles	Name the general principles of essential care and practice	15 minutes	**Introducing general principles of care** **Group discussion**
	Understand and practise using effective communication skills	15 minutes	**Activity 1: Facilitator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

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	**Activity 9: Follow-up** 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
Total duration (without breaks) = 5 hours 50 minutes			

Step-by-step facilitator's guide

Session 1. General principles

2 hours 20 minutes

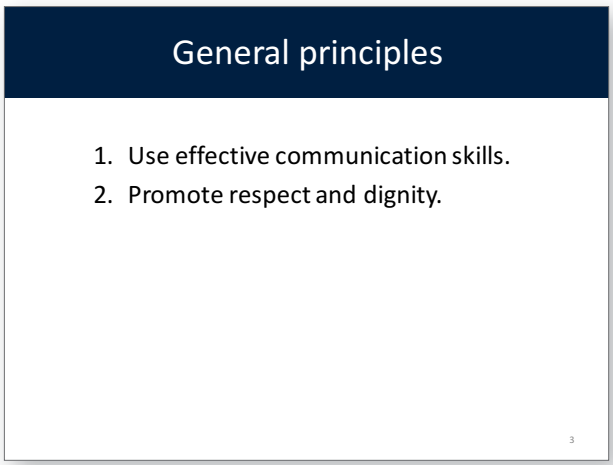


Begin the session by briefly listing the topics that will be covered.

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

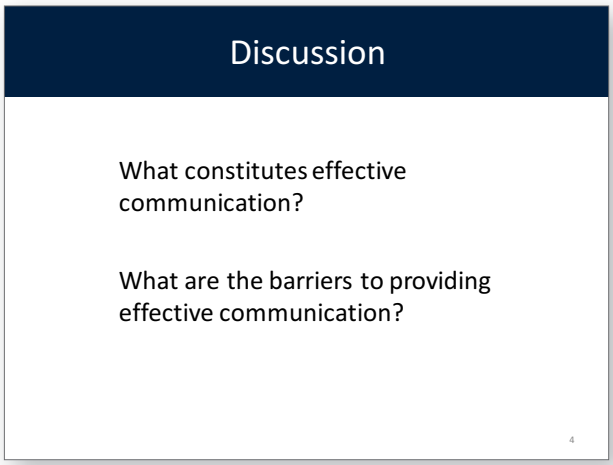
Write down the answers on a flip chart.

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



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.



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

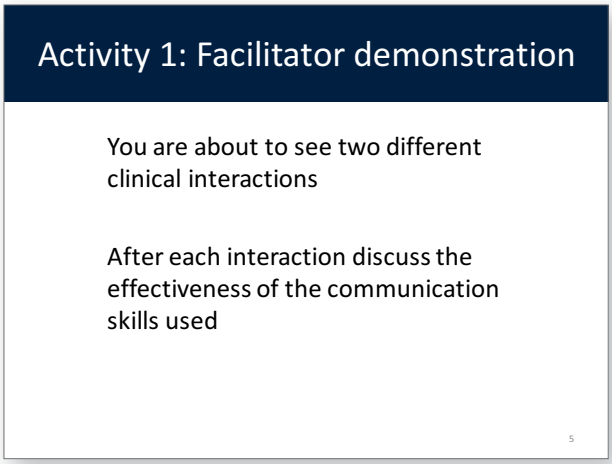
Note: If participants do not consider the role of body language in communication then prompt them to think about how body language affects communication.

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.

Activity 1: Facilitator demonstration: Good vs poor communication skills



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.

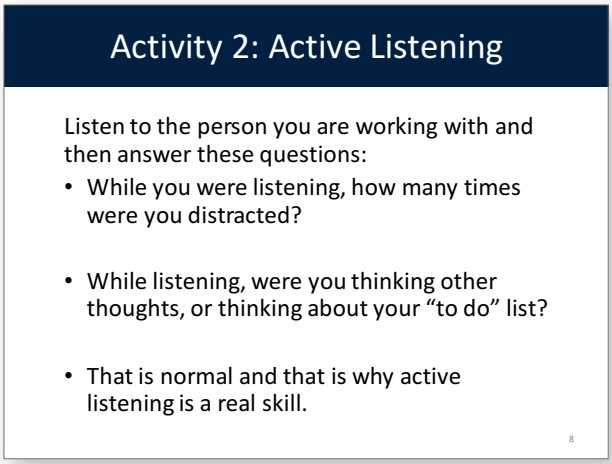
This trusting relationship between the health-care provider and the individual is essential, as it creates a comfortable environment where the person can share intimate or troubling thoughts, beliefs and emotions that underpin their symptoms.

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



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.

9

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

10

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.

11

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."

12

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."

13

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?"

14

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.

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".

15

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**.

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?

16

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.

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?"

18

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.

19

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..".

20

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."

21

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.

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."

22

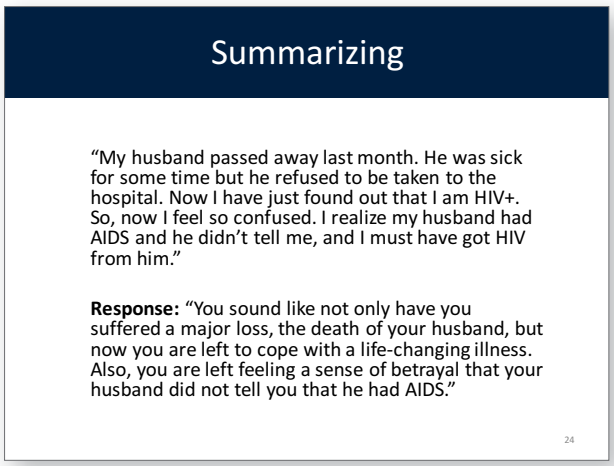
In this summary, the response identifies that the lady is "frustrated" about her husband's use of alcohol and is frustrated that it leads to arguments. It also recognizes that she feels unable to change this situation, which makes her feel hopeless about their future.

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."

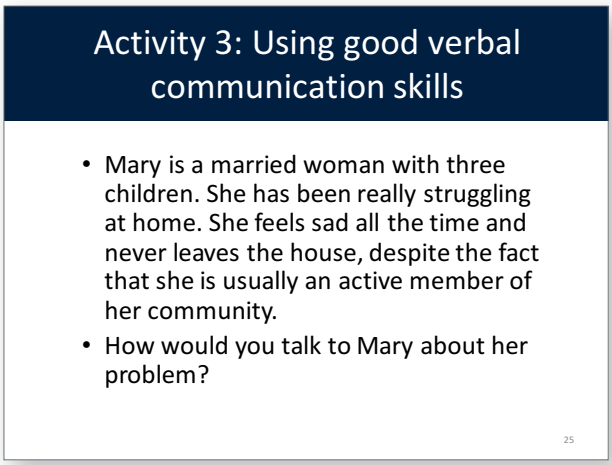
23

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.



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



Duration: 20 minutes.

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

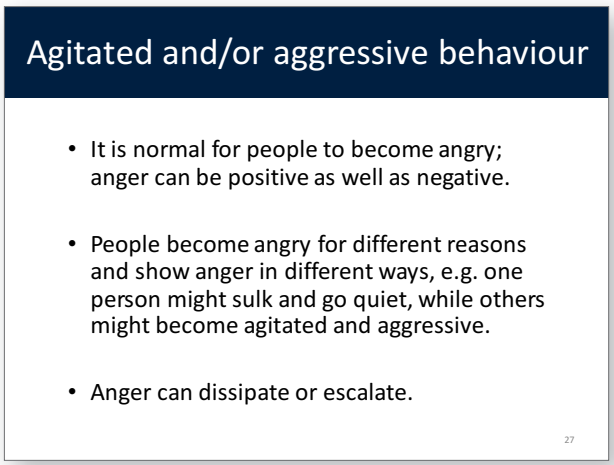
Situation: Mary is a married woman with three children. She has been really struggling at home. She feels sad all the time and never leaves the house, despite the fact that she is usually an active member of her community. How would you talk to Mary about her problem?

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?



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.

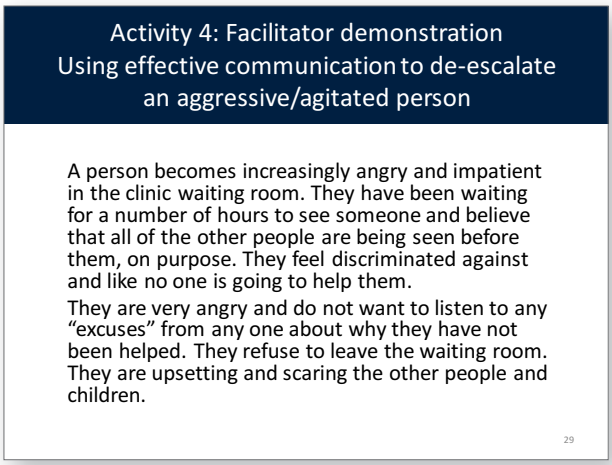
Direct participants to page 45 of mhGAP-IG Version 2.0.

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



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.

30

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.

31

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.

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.

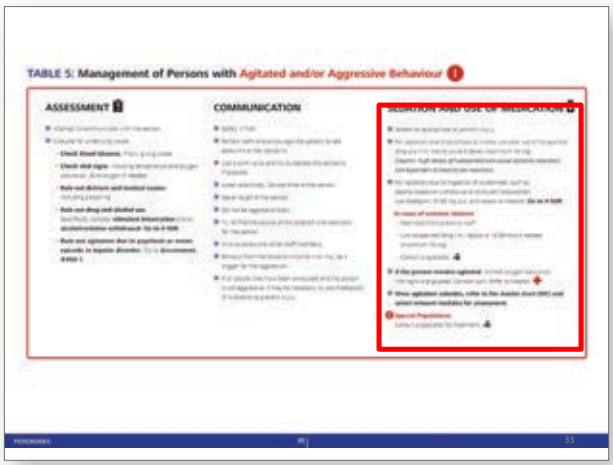
Do not be aggressive. Remaining calm is key to de-escalating agitation and aggression. By remaining calm, you can make the person feel safe. Focus on their anger and aggression rather than your own feelings.

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.



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.

34

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.

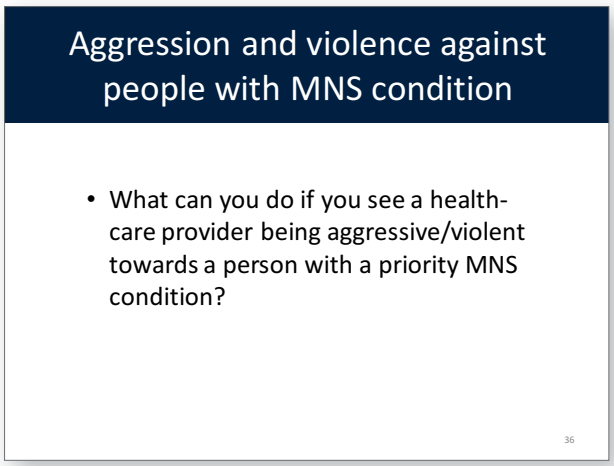
Aggression against adults and children with priority MNS conditions

- 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.

35

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.



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.

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?

38

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.

39

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.

40

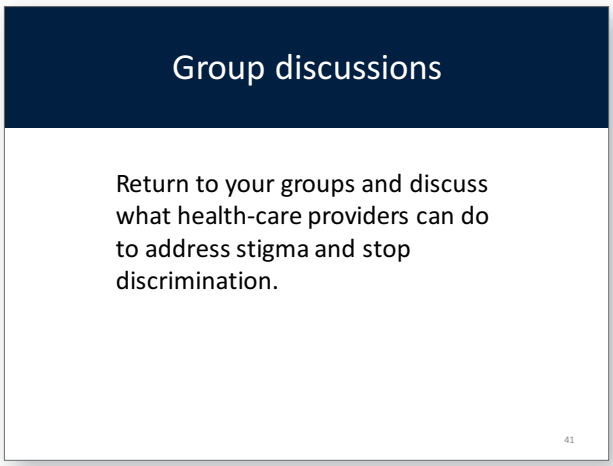
Explain that stigma can impact on your emotional state by affecting your sense of self and self-confidence.

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.



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.

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.

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.

Session 2. Essentials of mental health care and clinical practice: Assessments

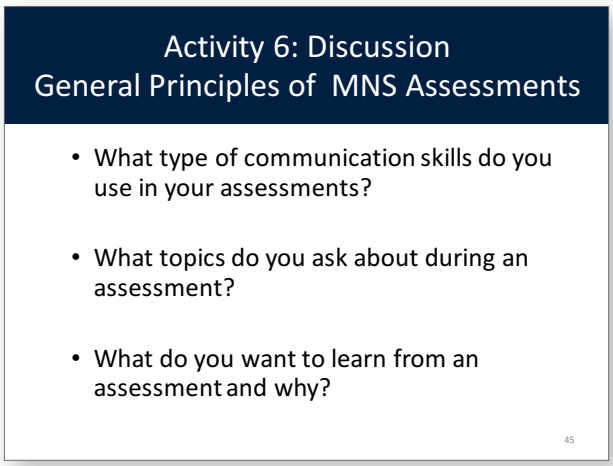
1 hours 10 minutes

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.

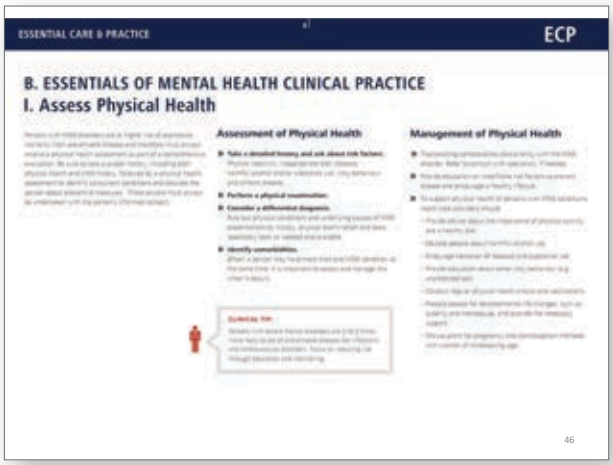
Instructions:
- Split the participants into groups.
- Ask each group to create a list explaining how they conduct a routine assessment in their clinic.
- Ask them to think about what type of questions and communication skills they use to conduct an assessment.
- What topics do they discuss with the person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



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).

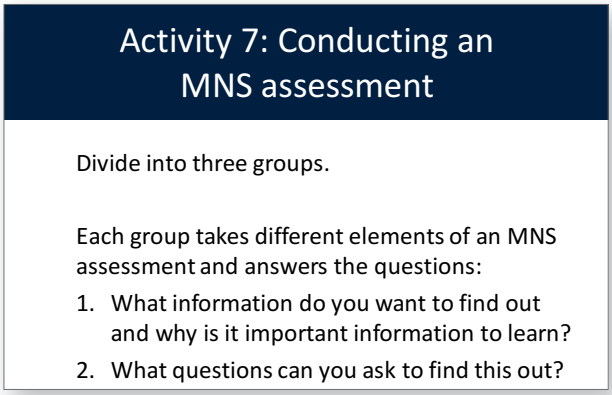
Therefore, when assessing a person with possible MNS conditions, always assess for physical health as well.

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



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?

49

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?

50

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?

51

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.

52

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?

53

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.

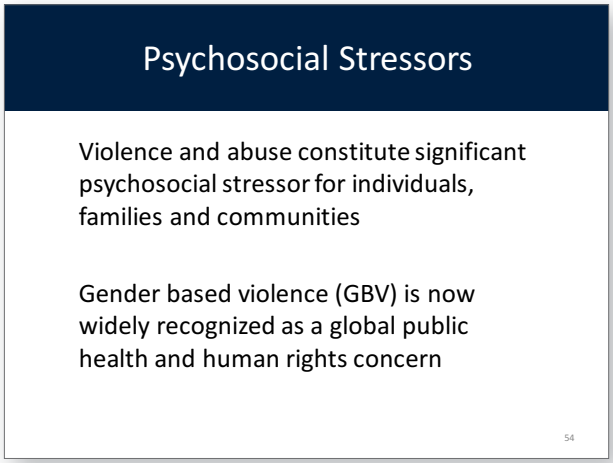
This should give you a holistic understanding of the person's life and current situation.

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.

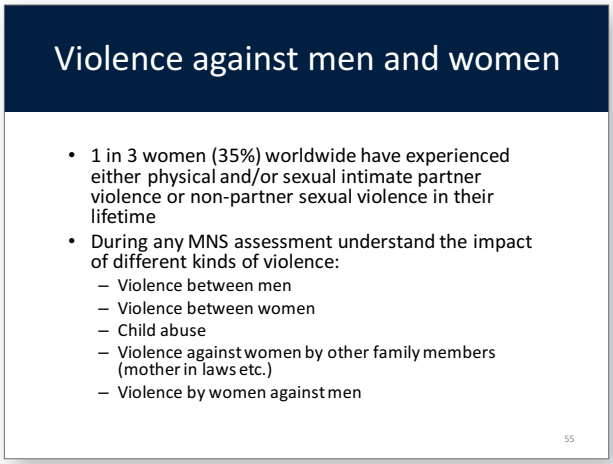


Explain that violence and abuse is a reality for many people and many families.

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.



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

56

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.

57

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

58

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.

59

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.

60

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.

LISTEN	Listen to the woman closely, with empathy, and without judging.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)
VALIDATE	Show her that you understand and believe her. Assure her that she is not to blame.
ENHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
SUPPORT	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

62

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

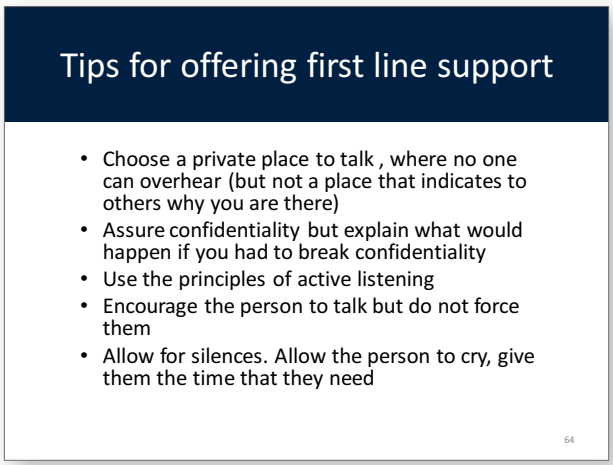
- Try to solve the persons problems
- Convince them/force them to leave a violent partner/family
- Convince/force them to go to the police
- Ask detailed questions that force them to relive painful events
- Ask them to analyze what has happened and why
- Pressure them to talk to you

63

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.



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

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).

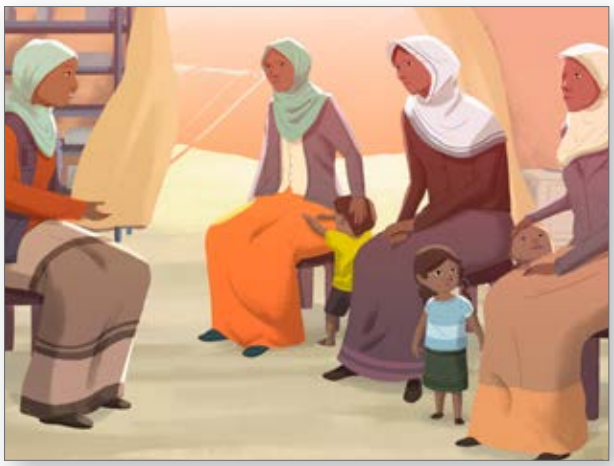
Make an **action plan** – list the steps, goals, actions behaviours needed to happen to achieve the goal (i.e. the person is going to meet friends who make them feel supported and cared for twice this week for at least 30 minutes each time.

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:

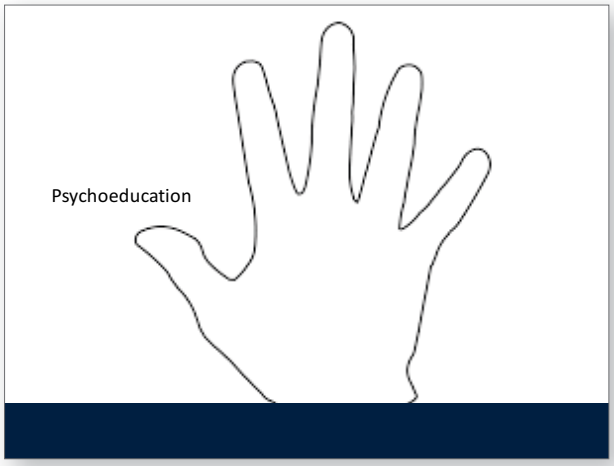
1. Psychosocial Interventions:
   - psychoeducation
   - reduce stress and strengthen social supports
   - promote functioning in daily activities.
2. Psychological interventions.
3. Pharmacological interventions.

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

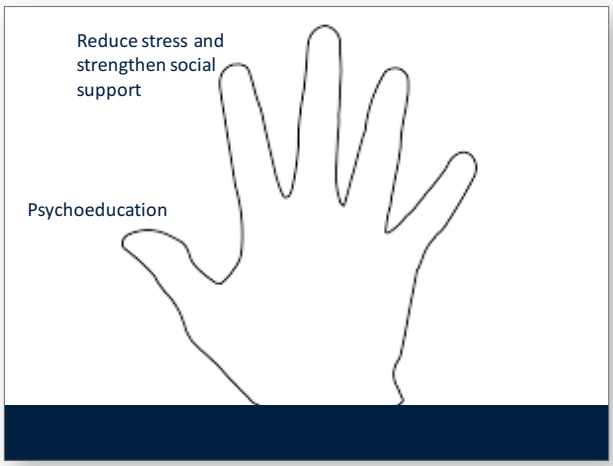
For now, we will look at the general principles behind different types of interventions.

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

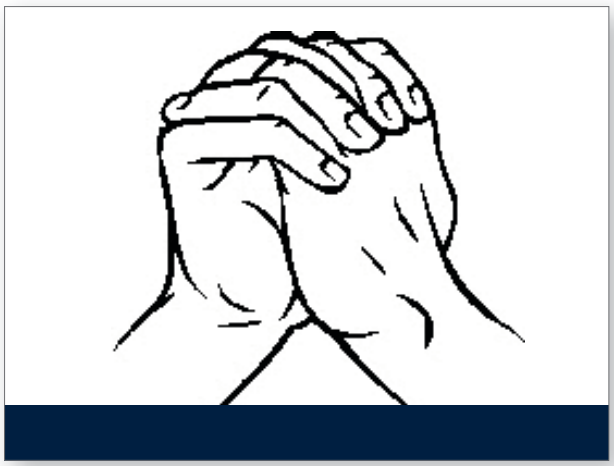
Raise your open hand to the participants.



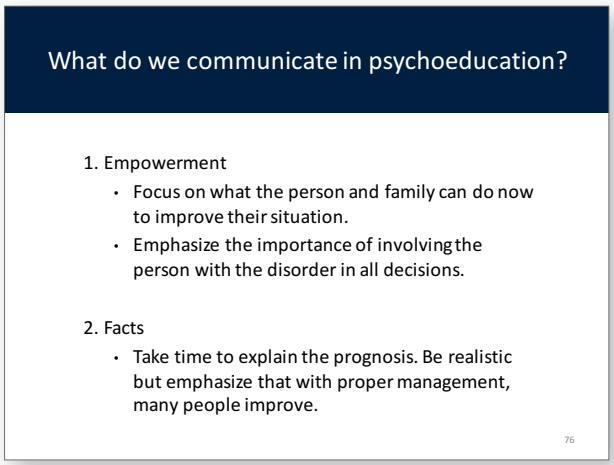
Explain that you can list the five interventions on your fingers to ensure that you always remember them.

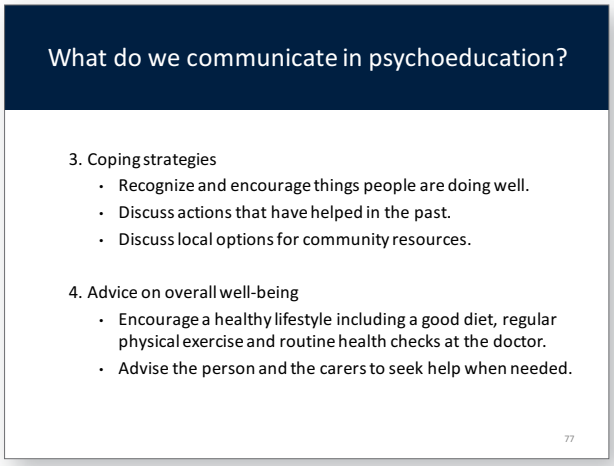


By placing **referral** in the palm of your hand you know that you always have the option to make a referral where a mental health specialist is available.



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.





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.

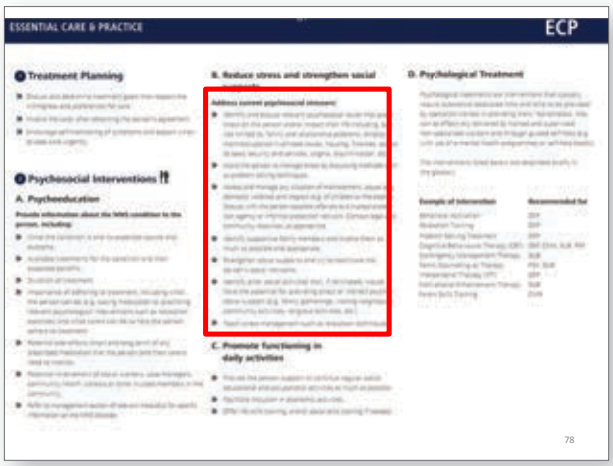
Moreover, literature on these topics may be confusing or otherwise difficult to comprehend.

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.

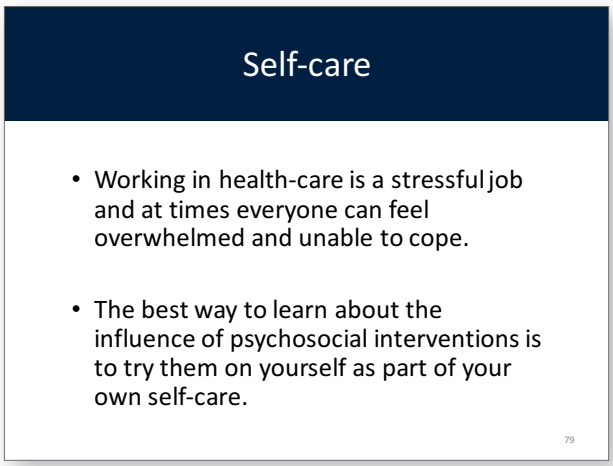
It can empower the person to take control of the condition.

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



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**.

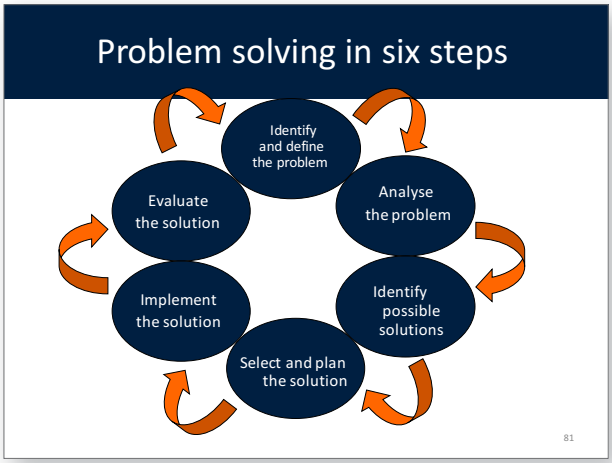


Working in health-care is a stressful job and at times everyone can feel overwhelmed and unable to cope.

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

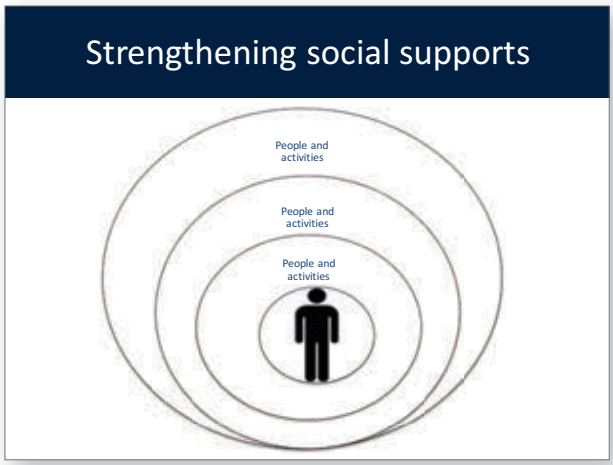
Duration: 20 minutes.

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?
Practical support (Who helps you in the house? Helps you with medication, etc.)		
Advice or information (Where do you go for advice and information?)		
Friendship (Who do you enjoy spending time with?)		
Emotional support (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

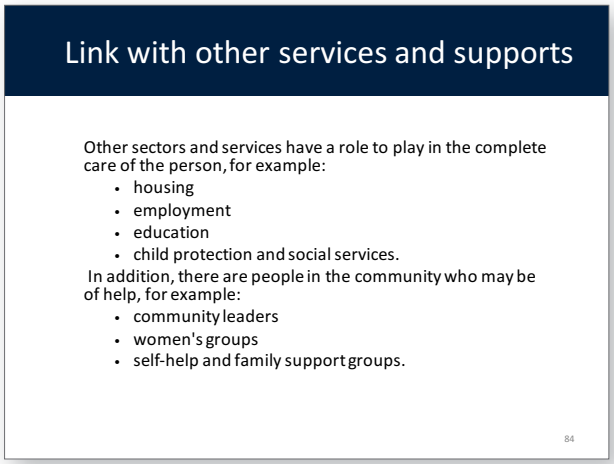
- Support the person to continue their regular social, educational, occupational activities as much as possible.
- Establish daily routines involving daily activities.
- Link the person with other appropriate services.

83

Promoting functioning in daily activities
Carrying out daily activities and tasks is very important for a person with a priority MNS condition.

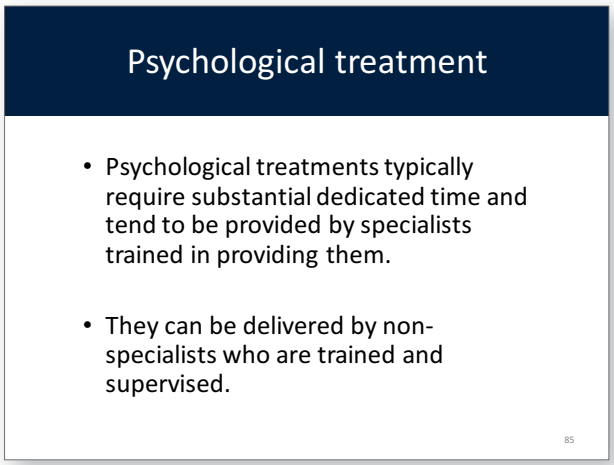
Routines may help people improve their mental well-being because they structure everyday life and give a sense of purpose. They ensure that a person eats and sleeps on a regular basis – important to maintaining well-being. Routines do not need to be complicated; even simple habits are useful. It could 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.



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
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.

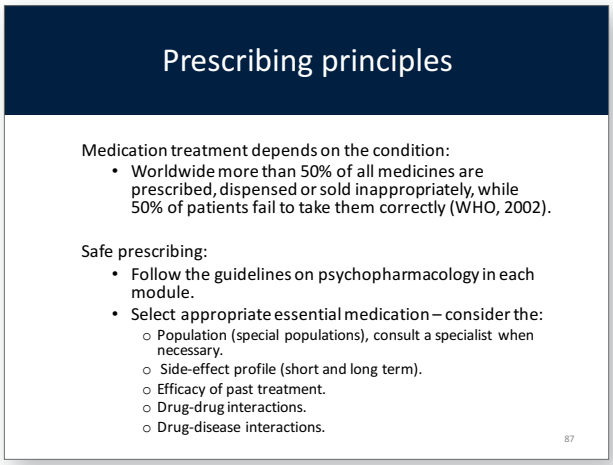
Trained health-care providers may not be available in each and every area, however, supervised health-care workers could effectively administer some psychological interventions through guided self- help and/or e-mental health programmes.

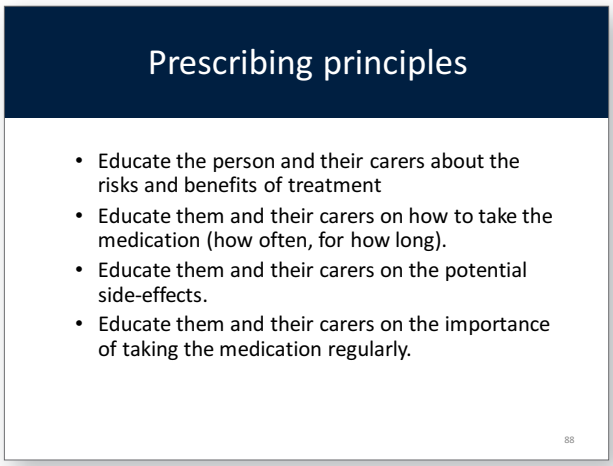
Pharmacological interventions
Explain that there are detailed guidelines on pharmacological interventions for specific MNS conditions in the corresponding modules, however, for now, describe the general principles of pharmacological interventions.

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.





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

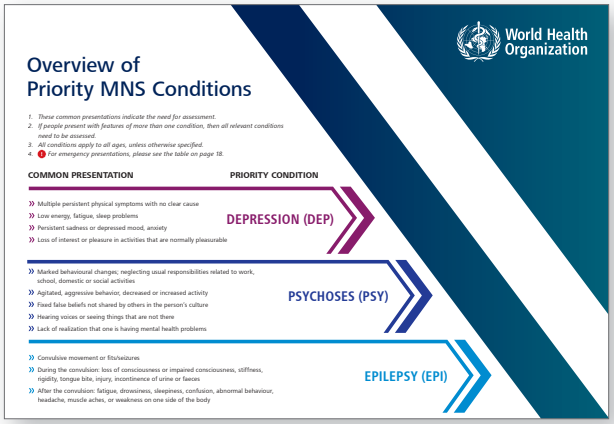
- What are the barriers to providing follow-up?
- What are possible solutions to those barriers?
- What can you do if you cannot provide follow up? How can you still help the person?

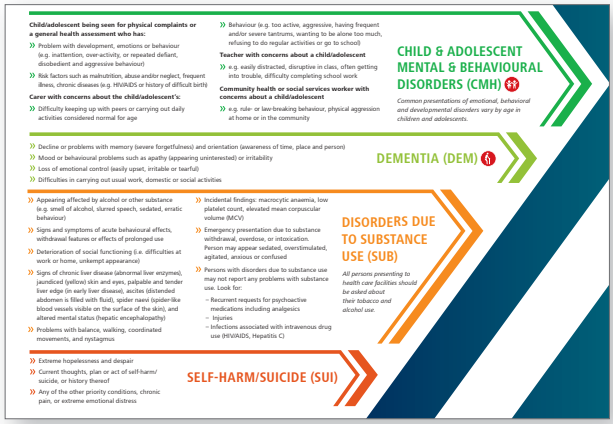
Duration: 20 minutes.

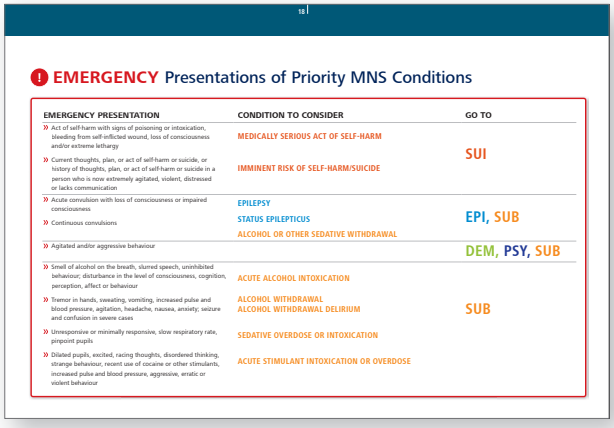
Purpose: Enable participants to discuss the barriers and identify solutions to providing follow-up in their clinical settings.

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.







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

ECP supporting material

- Treatment plan
- ECP Multiple choice questions

Supporting material available online at:
www.who.int/mental_health/mhgap/ecp_supporting_material.pdf

ECP

Essential care and practice

mhGAP training of health-care providers
Training manual

World Health Organization

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

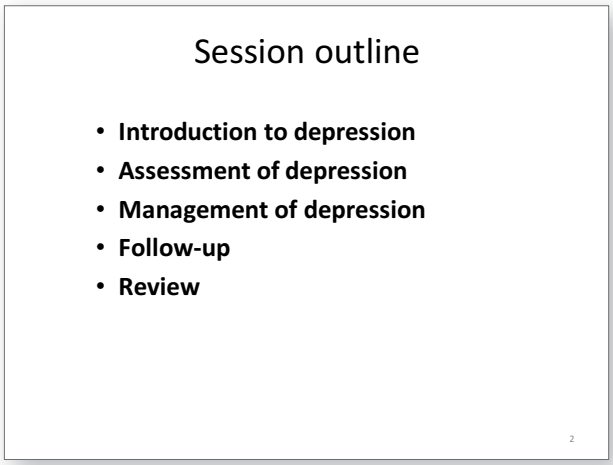
- Depression commonly presents with:
  - Multiple persistent physical conditions with no clear cause.
  - Low energy, fatigue and sleep problems.
  - Persistent sadness or depressed mood and anxiety.
  - Loss of interest in activities that are normal and pleasurable.
- Depression results from a combination 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	**Activity 1: Person's story followed by group discussion** Use the person's story to introduce depression **Presentation on depression** Use the person's story to illustrate the presentation on: • Symptoms of depression • Contributing factors to depression • How depression impacts on a person's life • Why it is a public health priority
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	**Activity 2: Video demonstration: Assessment** Use videos/demonstration role play to show an assessment and allow participants to note: • Principles of assessment (all aspects covered) • Effective communication skills (what and how this is done) **Activity 3: Role play: Assessment skills** 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	**Activity 4: Management of depression – which interventions?** Poster presentations and discussions on delivering management interventions **Activity 5: Video demonstration: Managing depression** Use video/demonstration role play to evaluate a management session discussing use of pharmacological and psychosocial interventions **Presentation and quiz on pharmacological interventions** **Activity 6: Role play: Psychosocial interventions** Feedback and reflection
4. Follow-up	Plan and perform follow-up for depression	30 minutes	**Activity 7: Video demonstration: Follow-up** Video with an improving patient at follow-up
5. Review		15 minutes	Multiple choice questions
Total duration (without breaks) = 4 hours 30 minutes			

Step-by-step facilitator's guide

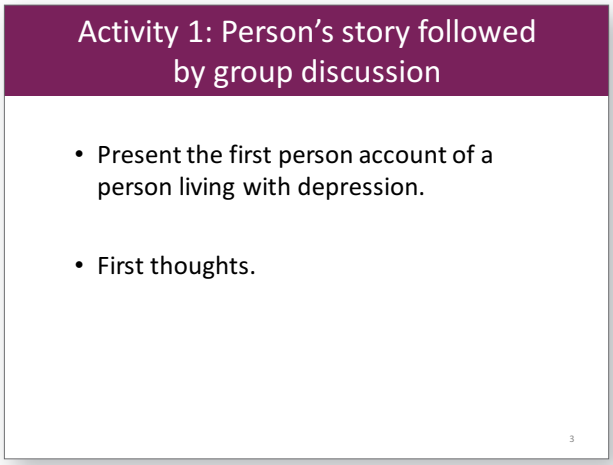
Session 1. Introduction to depression

50 minutes



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

Activity 1: Person's story followed by group discussion



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.

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.

Core symptoms of depression

- Persistent depressed mood.
- Markedly diminished interest in or pleasure from activities.

5

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.

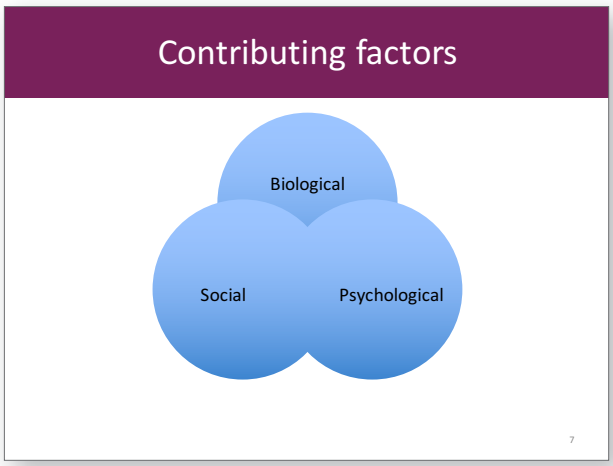
Encourage participants to think of any presentations and then show the next slide.

Common presentations of depression

- Multiple persistent physical symptoms with no clear cause
- Low energy
- Fatigue
- Sleep problems (sleeping too much or too little)
- Anxiety
- Significant change in appetite or weight (weight gain or loss)
- Beliefs of worthlessness
- Excessive guilt
- Indecisiveness
- Restlessness/agitation
- Hopelessness
- Suicidal thoughts and acts

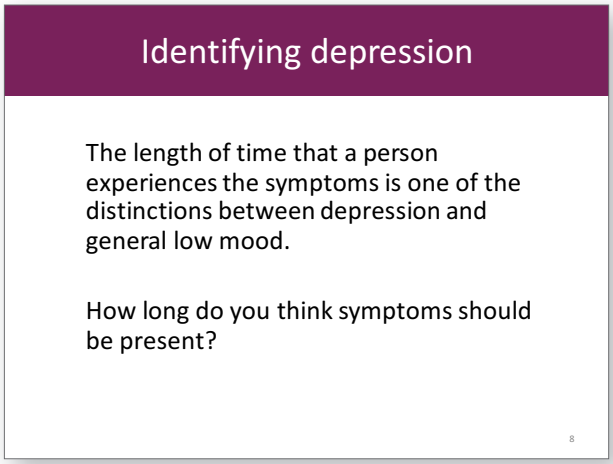
6

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.



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.

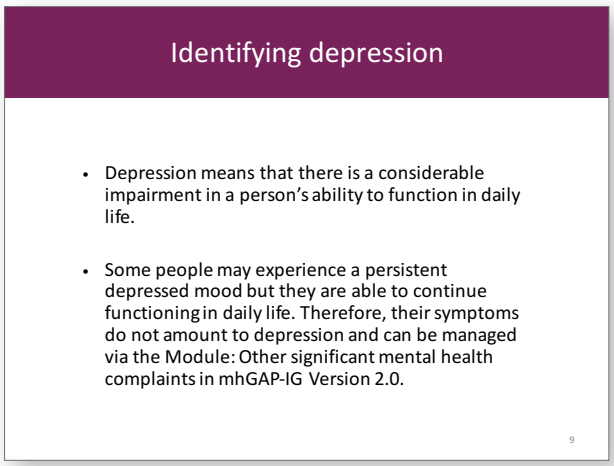


Identifying depression
Explain that differentiating between depression and low mood is an important skill. Low mood is normal and transient; many people can experience low mood from time to time. Depression lasts longer and has a profound impact on a person's ability to function in everyday life.

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.

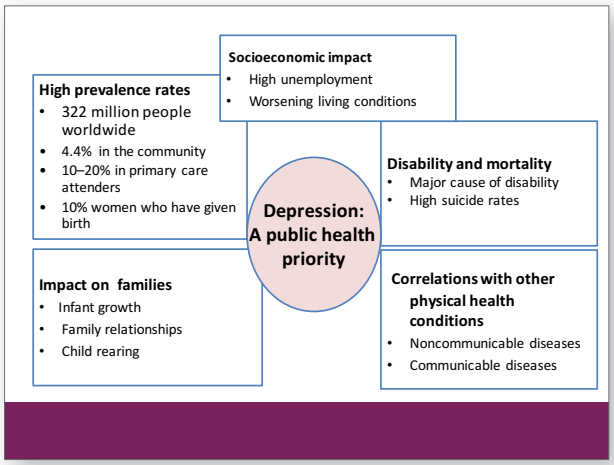
Explain that to identify depression, symptoms must be present for at **least two weeks**.



Identifying depression

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:

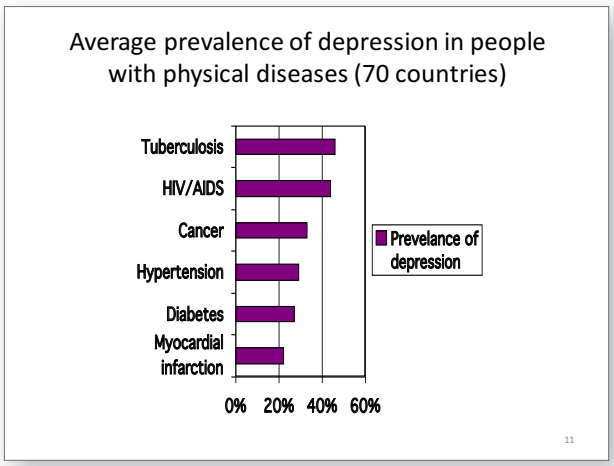
1. It is estimated that more than 322 million people worldwide suffer from depression, resulting in a prevalence rate of 4.4% in the general community and accounting for 10–20% of people who attend primary health-care clinics.

   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.

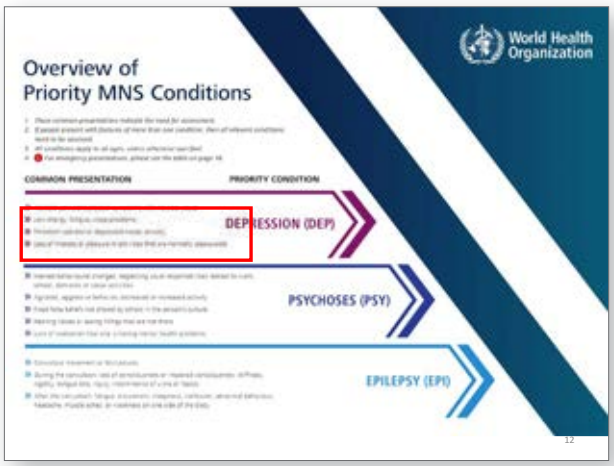


Explain that the relationship between depression and physical health is particularly important to focus on in non-specialized health settings.
Physical conditions can often manifest themselves first, and, if health-care providers only focus on the physical symptoms, the real cause of the problem may 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).

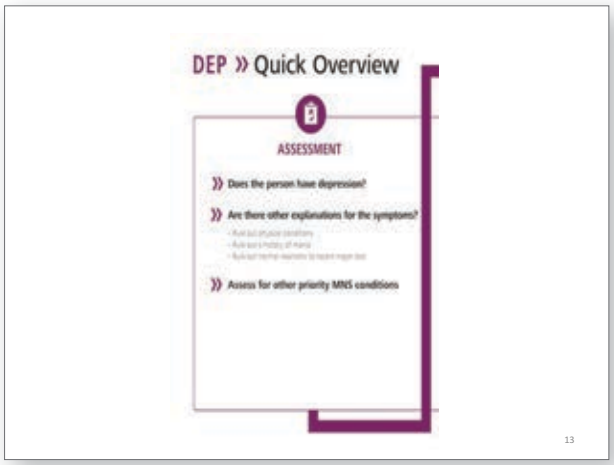
Review the common presentations.

Ask participants to think about how easy or hard it would be to identify depression in their practice.

Session 2. Assessment of depression

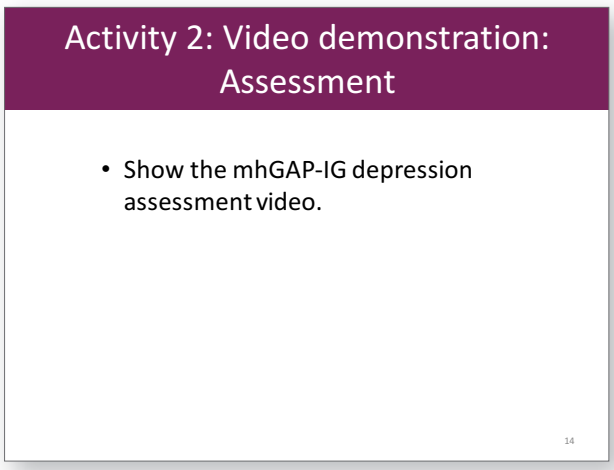
1 hour 10 minutes

Activity 2: Video demonstration: Assessment

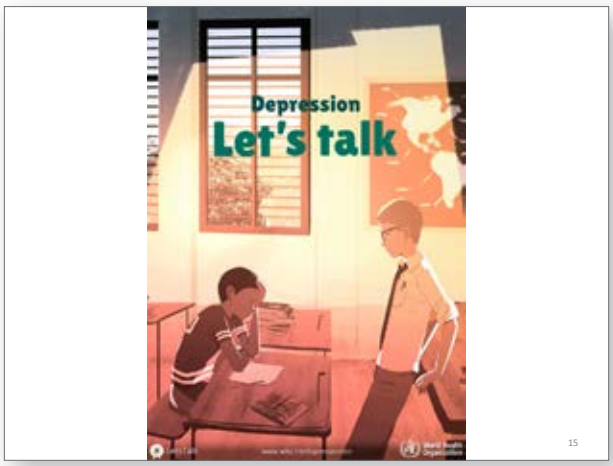


Instruct participants to turn to the assessment page in the mhGAP-IG Version 2.0 page 20.

Describe the principles of assessment for depression as on the slide.

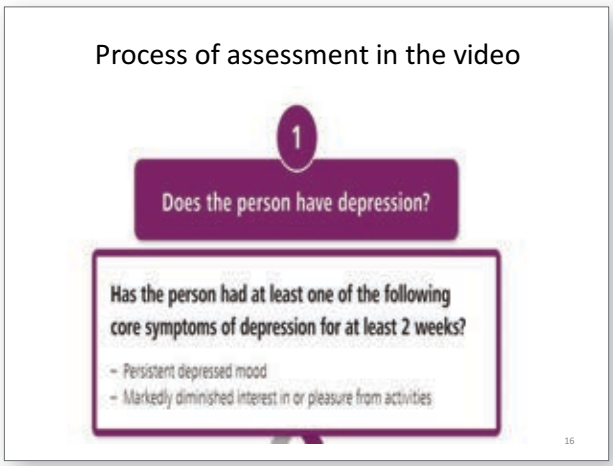


Explain to participants that you are going to show them a video of "Sarah" being assessed for depression (https://www.youtube.com/watch?v=hgNAySuIsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v). During the video, ask the participants to scan the depression assessment algorithm in the mhGAP-IG Version 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.

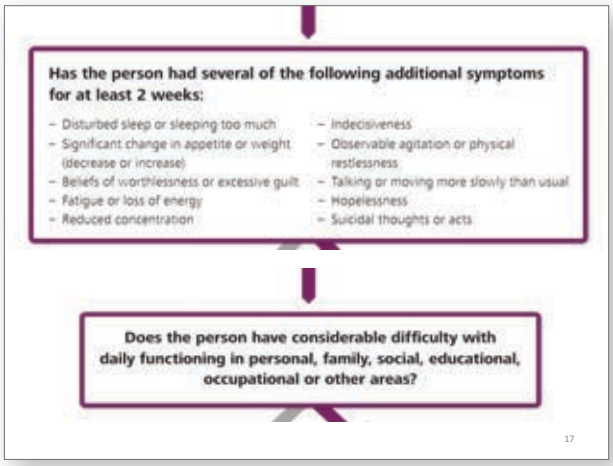


In plenary, use the mhGAP-IG algorithm to decide:

- 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?



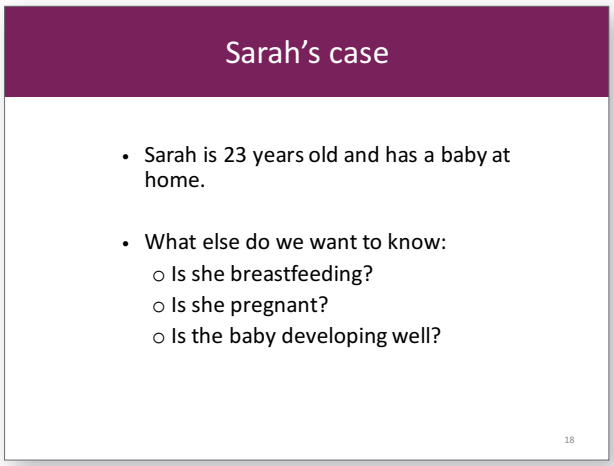
Ask the group if Sarah had any of the additional symptoms in the past two weeks?

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?

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?

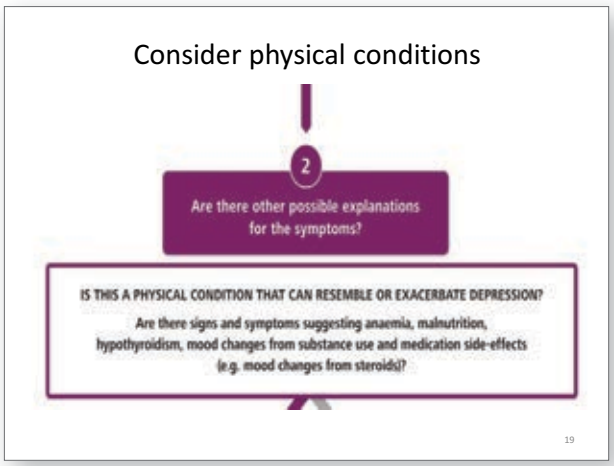
After receiving a few answers from the participants, reveal the answers on the slide and then explain that:

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?

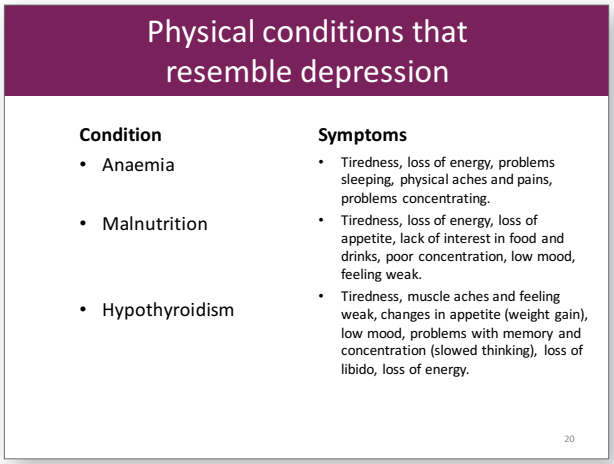
Explain that children and adolescents are considered a special population and to understand the presentation and management of depression in children and adolescents you need to go to the Module: Child and adolescent mental and behavioural disorders in the mhGAP-IG Version 2.0.



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?



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.

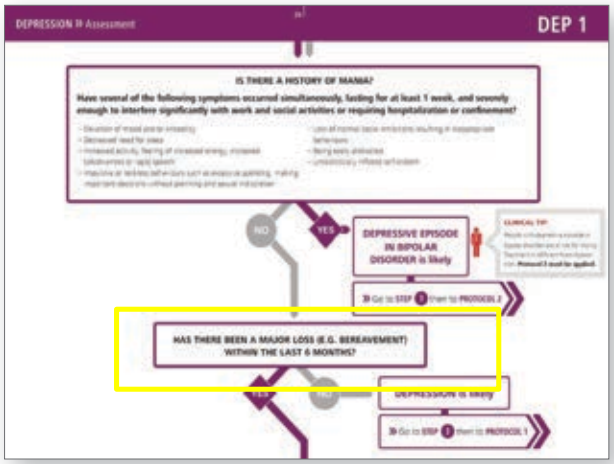
Explain that depression can be present as a part of bipolar disorder.

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.

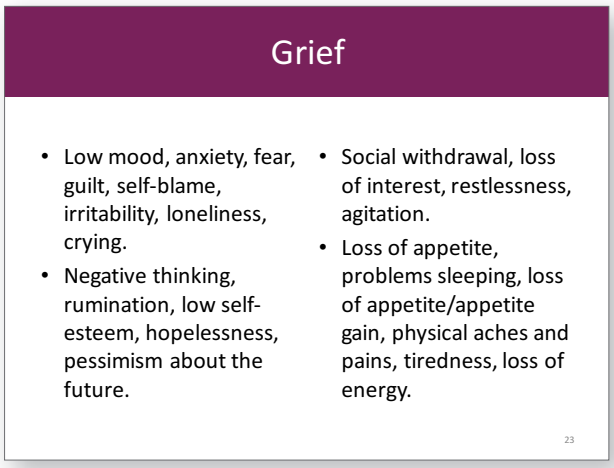
Ask if participants have taken care of someone with mania in the past. What are the symptoms?

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.

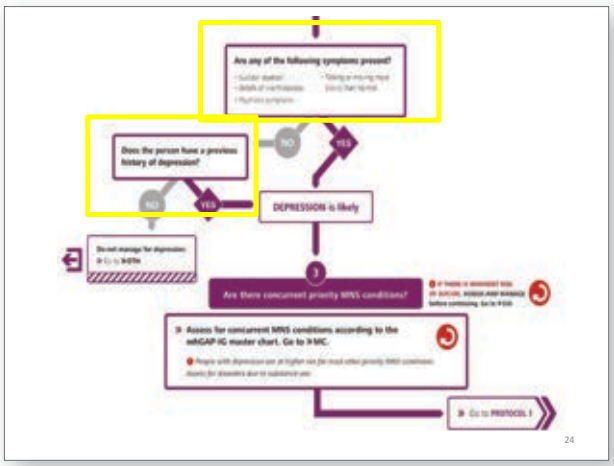


Depression and grief
Explain that grief is a normal reaction to loss. Many people who experience grief report feeling similar symptoms to depression.

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.

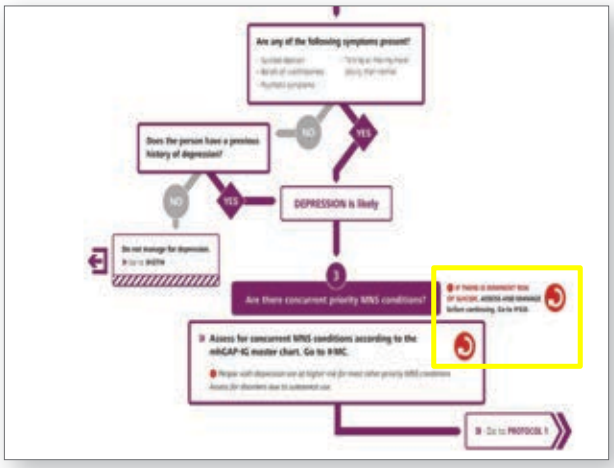
Sarah's case

- 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

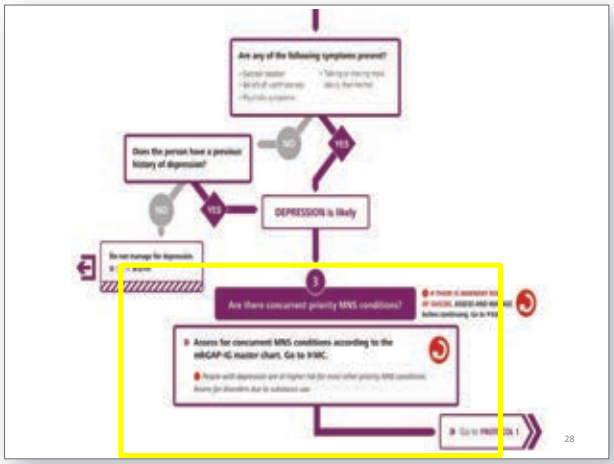
- Talking about self-harm/suicide is **ESSENTIAL.**
- Talking about self-harm/suicide **DOES NOT** increase the risk that the person will commit self-harm/suicide.
- If there is a risk of self-harm/suicide then **GO IMMEDIATELY TO MODULE: SELF-HARM/SUCIDE IN THE mhGAP-IG AND FOLLOW THE STEPS TO MANAGE 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?

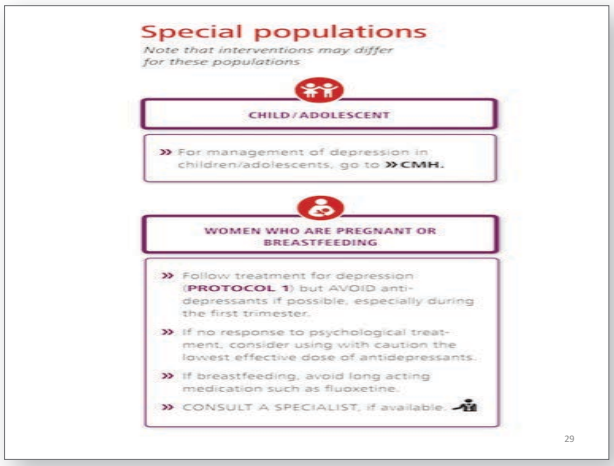


28

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.

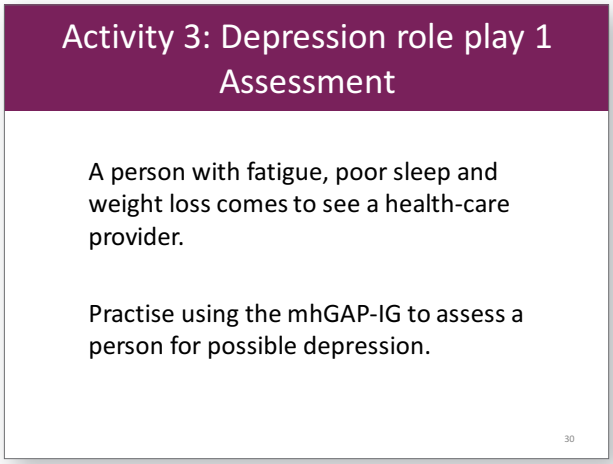


29

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



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.

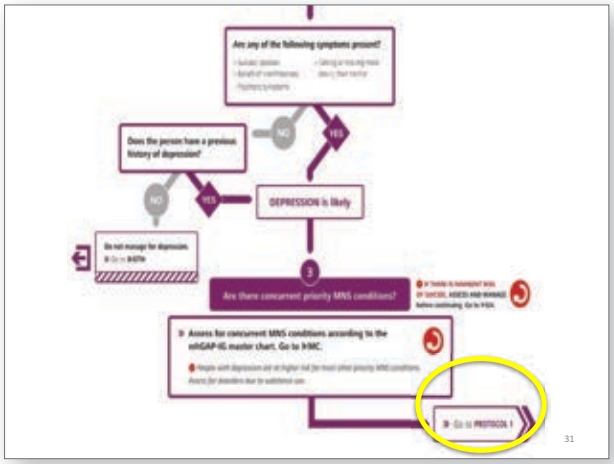
Purpose: This role play gives participants an opportunity to practise using the mhGAP-IG to assess for possible depression.

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

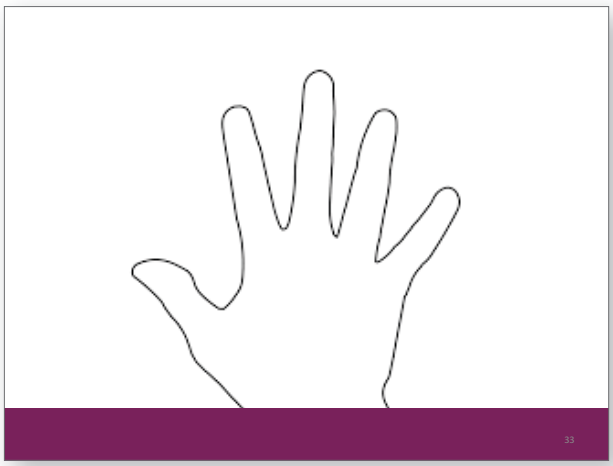
1 hour and 50 minutes



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.

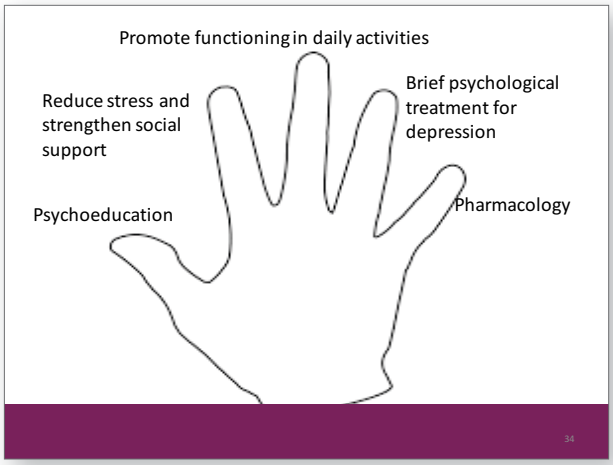


Remind participants how the management "hand" works (described when teaching the Module: Essential care and practice).

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.

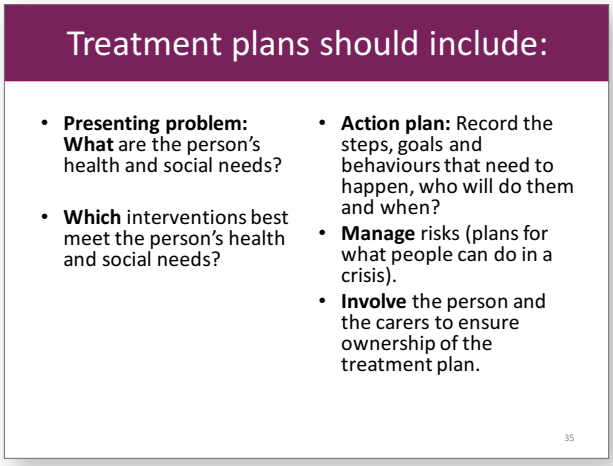
Give the participants a few minutes to suggest some interventions before moving on.



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.



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.

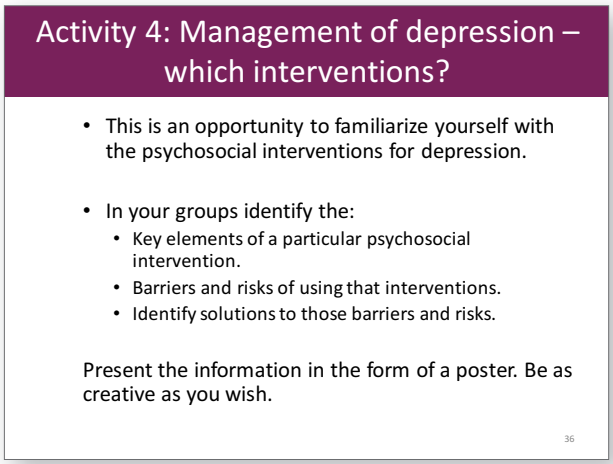
A treatment plan sets out:

- 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?



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.

37

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.

38

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.

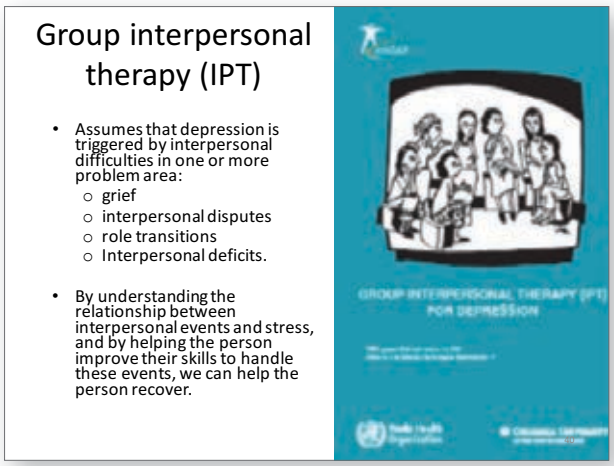
39

Explain that mhGAP-IG recommends **brief psychological treatments** as frontline treatments for depression.

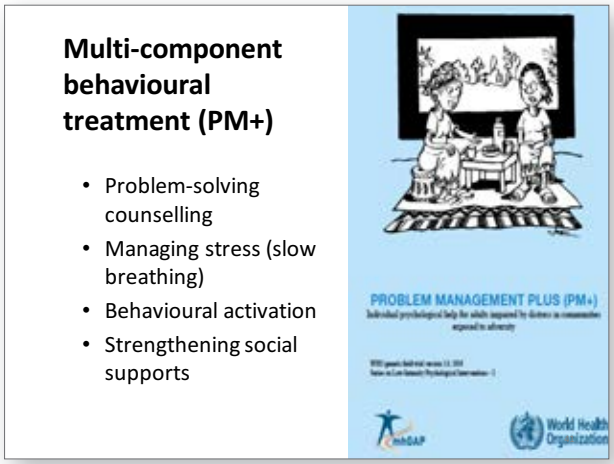
These interventions need to be delivered by trained individuals and the person should be supervised.

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.



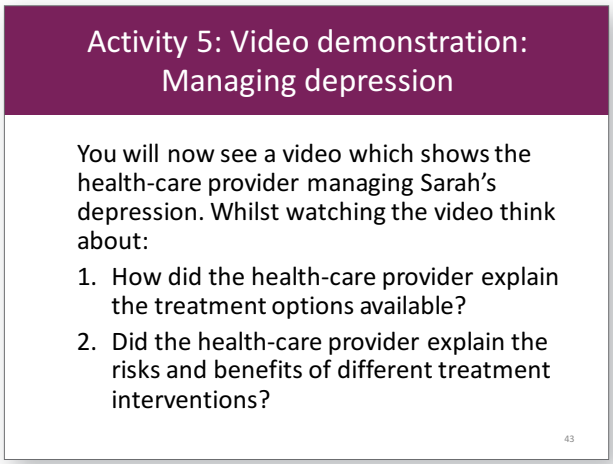
Using the points on the slide explain what **group interpersonal therapy** is.



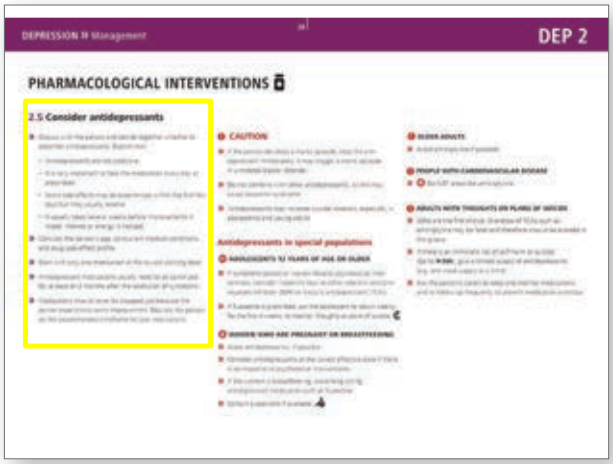
Explain that **problem management plus (PM+)** includes a variety of strategies, such as the principles of **behavioural activation** to have people schedule activities that they may have been avoiding in order to improve their mental well-being.

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



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.



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.


TABLE 1: Antidepressants

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)

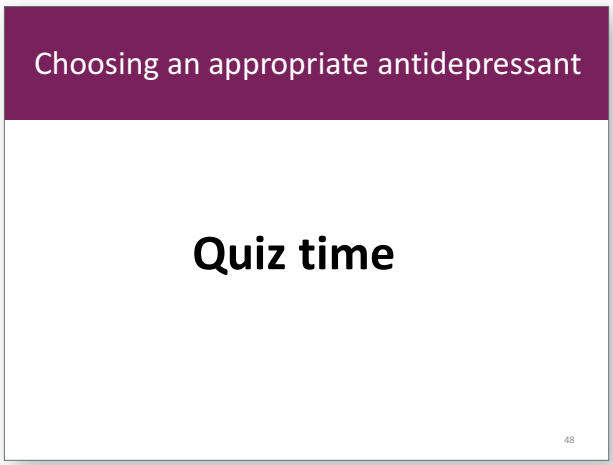
Avoid use in:

- 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.

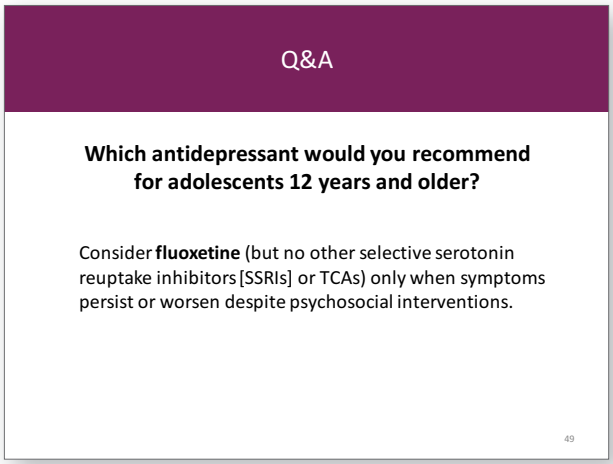
47

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.



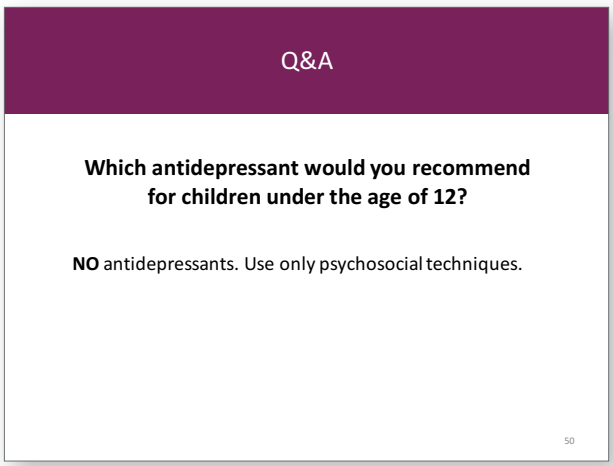
Direct participants to pages 28 and 29 in the mhGAP-IG and answer these questions:



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.



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.

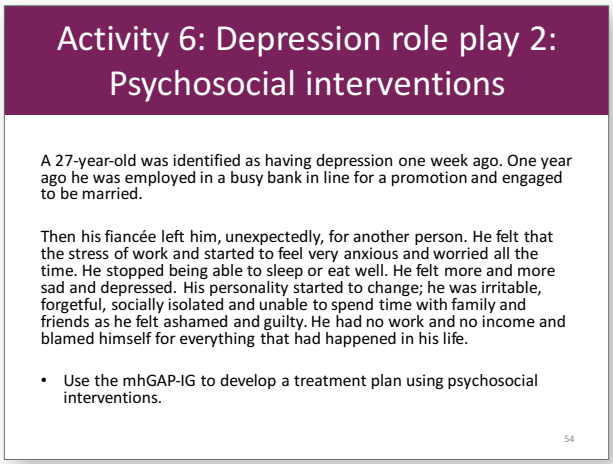
53

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



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.

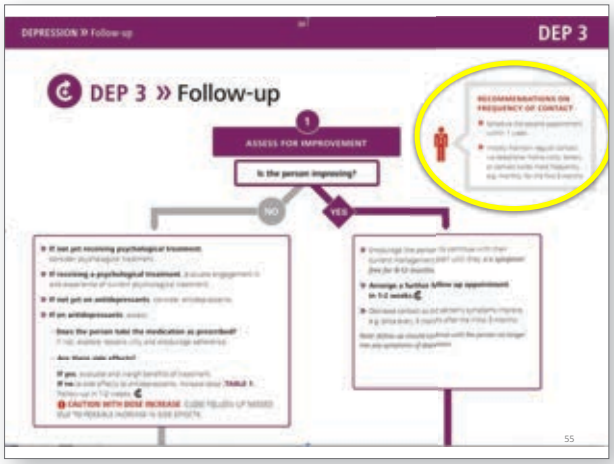
Situation:
- A 27-year-old was identified as having depression one week ago.
- One year ago he was employed in a busy bank and really enjoyed the job.
- He was in line for a promotion.
- He was in a relationship, engaged to be married and was really excited about the future.
- Then his fiancée left them, 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.

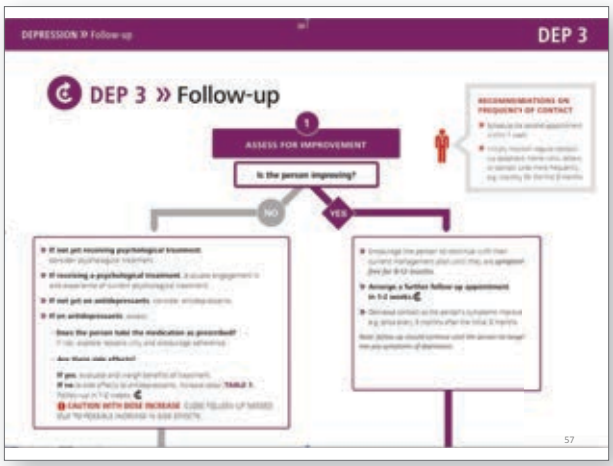
Possible presentations at follow-up

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 remining 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?

58

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.

59

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.

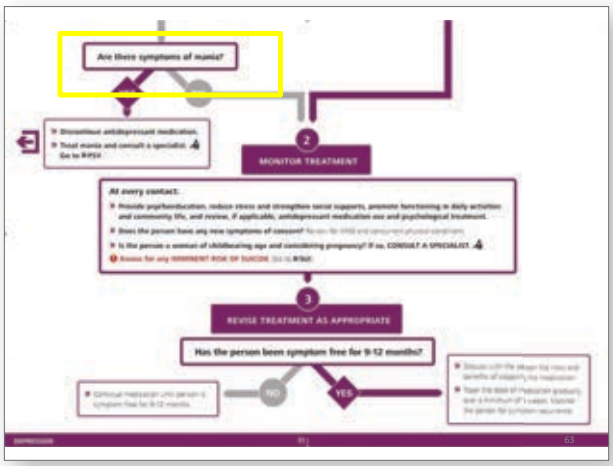
If the person chooses to stop taking medication after 9–12 months (a period of time that you would expect the medication to have been effective) then you must follow the steps explained on the slide.

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.

62

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

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

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=hgNAySuIsjY&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

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	Name common presentations of psychoses Promote respect and dignity for people with psychoses Understand that psychoses can be treated in non-specialized health settings	30 minutes 20 minutes	**Activity 1: Person's story followed by group discussion** • Use the person's story to introduce psychoses • Encourage participants to reflect on local understandings of psychoses **Presentation to supplement the story** Use the story as a basis for discussions on: • Common presentations of psychosis and bipolar disorder • How psychoses impact on a person's life • Human rights and psychoses • Why it is a public health priority and how can it be managed in non-specialized health settings **Activity 2: Case scenarios: Hallucinations and delusions**
2. Assessment of psychoses	Perform an assessment for psychoses Use effective communication skills when interacting with people with psychoses Assess and manage emergency presentations of psychoses Assess and manage physical health in psychoses	40 minutes 30 minutes	**Activity 3: Video demonstration: Assessment** Use video/demonstration role play to show an assessment and allow participants to note the principles of assessment (all aspects covered) **Activity 4: Role play: Assessment** Feedback and reflection
3. Management of psychoses	Provide psychosocial interventions to persons with psychoses and their carer Deliver pharmacological interventions as needed and appropriate in psychoses considering, special populations Refer to specialists and links with outside agencies as appropriate and available	30 minutes 20 minutes 25 minutes 35 minutes	**Activity 5: Video demonstration: Management** Use video/demonstration role play to evaluate a management session discussing use of pharmacological interventions and psychosocial interventions **Activity 6: Delivering psychoeducation** Enable participants to practise delivering key psychoeducation messages **Activity 7: Promoting functioning in daily activities** Give participants practical experience in understanding how important daily routines and functioning are to recovery **Discussion on psychosocial and pharmacological Interventions** • Use the mhGAP-IG to introduce participants to psychosocial and pharmacological interventions and how to deliver them • Use case scenarios as examples

Session	Learning objectives	Duration	Training activities
4. Follow-up	Plan and perform follow-up sessions for people with psychoses	5 minutes 30 minutes	**Discussion on the principles of follow-up** Use the mhGAP-IG to discuss follow-up for people with psychoses **Activity 8: Role play: Follow-up**
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. 2

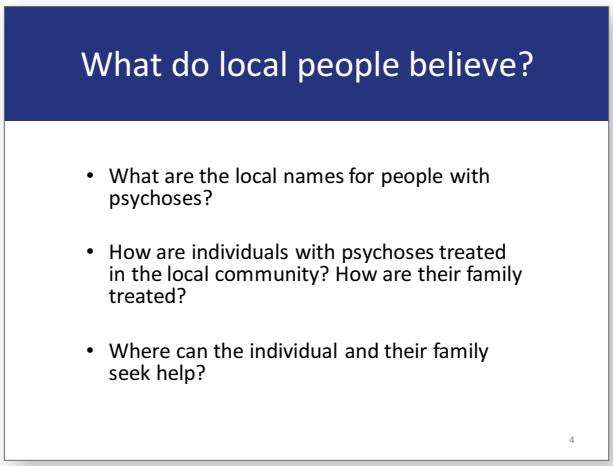
Begin the session by briefly listing the topics that will be covered.

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. 3

How to use the person's story

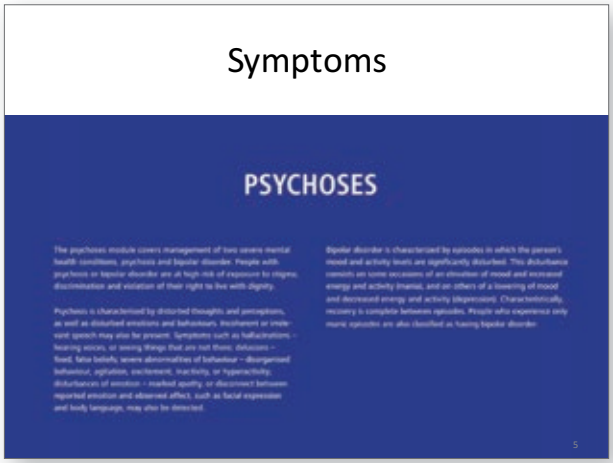
- Introduce the activity and ensure participants have access to pens and paper.
- Tell the story – be creative in how you tell the account to ensure the participants are engaged.
- First thoughts – give participants time to give their immediate reflections on the story. Give participants time to reflect on how living with psychoses can impact on a person's life.



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.

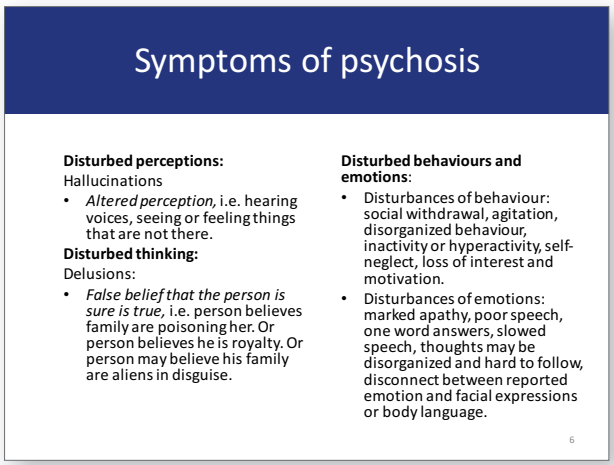
Note: In some countries there may not be an equivalent term for psychoses and participants will only know the term schizophrenia. In this case, you will need to communicate that psychoses is a syndrome that occurs in people with schizophrenia but also in other mental disorders.



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.

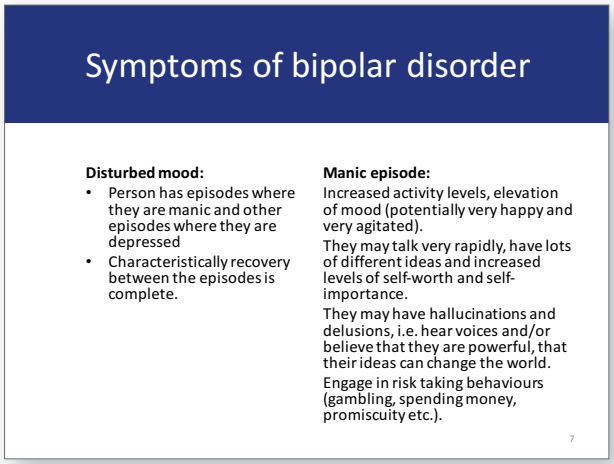


Symptoms of psychosis
Now take a look at the symptoms of psychosis in more detail. Explain that psychosis is characterized by **disturbed perceptions** (give examples of hallucinations) and **disturbed thinking** (give examples of delusions).

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.

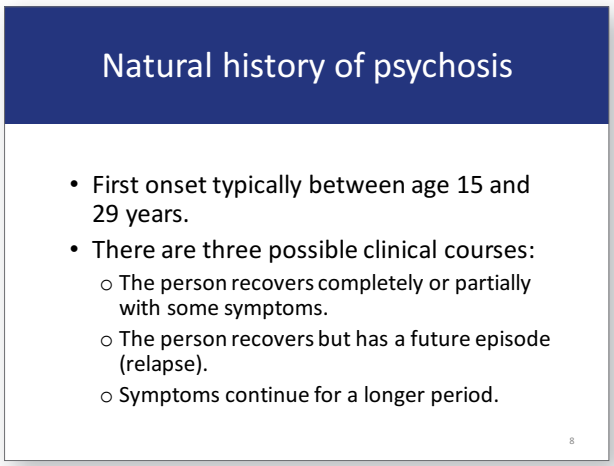
Quite often they do not interact with family and friends and become socially withdrawn preferring to spend time alone.

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
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.



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.

Explain that after the first episode the person can either recovery completely or partially (and never have another episode) or recover but have future episodes. Alternatively, symptoms continue for a longer period.

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.

9

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.

10

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.

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.

11

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, in human 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?

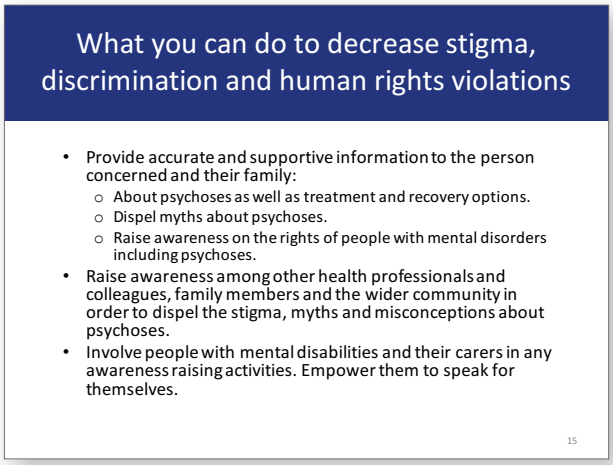
Ask participants to think what they can do to stop these human rights violations?

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.



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.

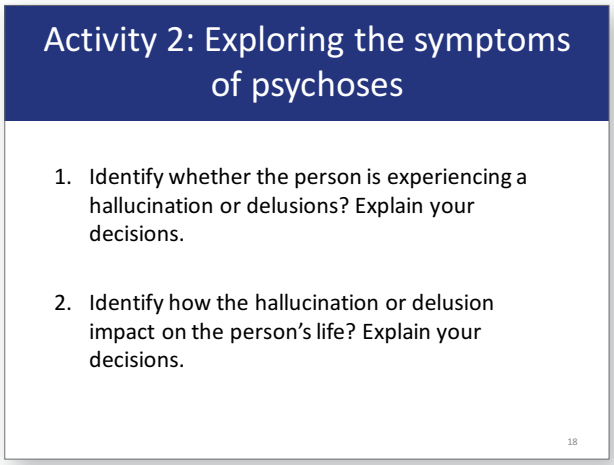
Emphasize that available treatment is effective and can be carried out in non-specialized health settings.

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



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

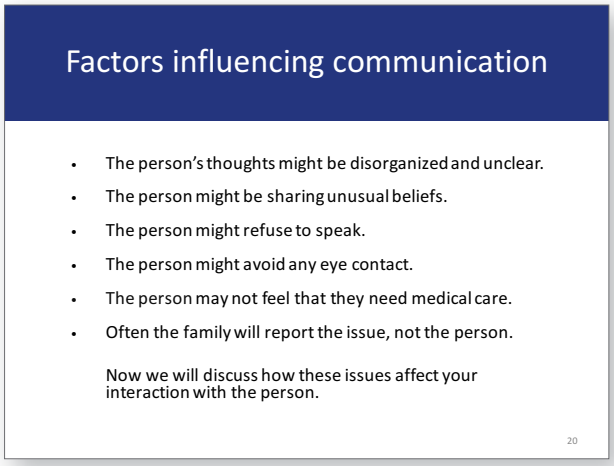
1 hour 10 minutes

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?



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

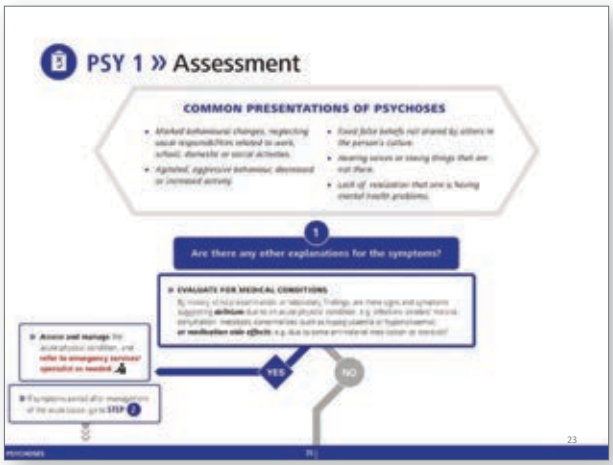
Show the mhGAP-IG psychoses assessment video.

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.

24

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:

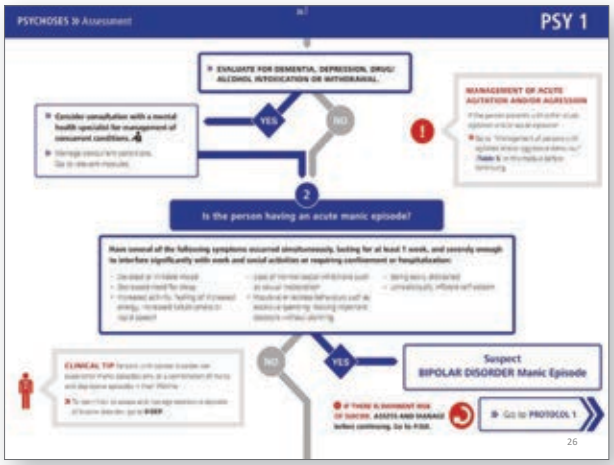
- Try to identify and manage underlying cause.
- Assess for dehydration and give fluid.
- Ensure that the person is safe and comfortable .
- Continue to reassess and monitor the person after initiating management.
- Refer the person to a specialist (e.g. neurologist, psychiatrist, or internal medicine 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.



26

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).

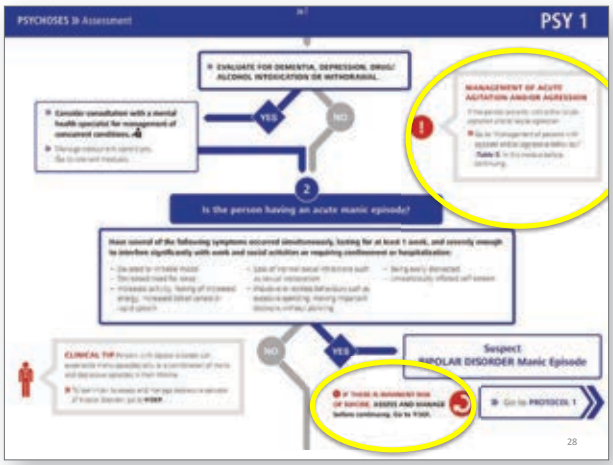
27

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.

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.

30

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.

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?

31

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.

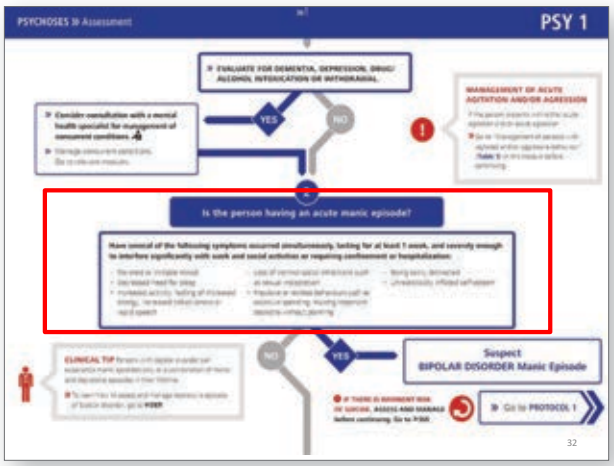
Use a calm voice and try and address any of her immediate concerns.

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.

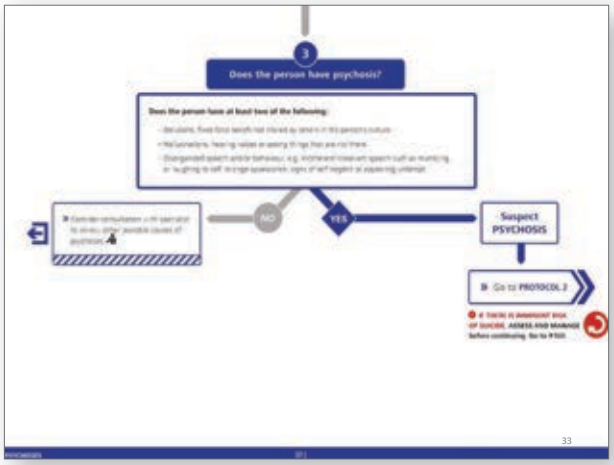
Involve the mother (if the young woman allows it) ask the mother why she thinks this is happening?

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?

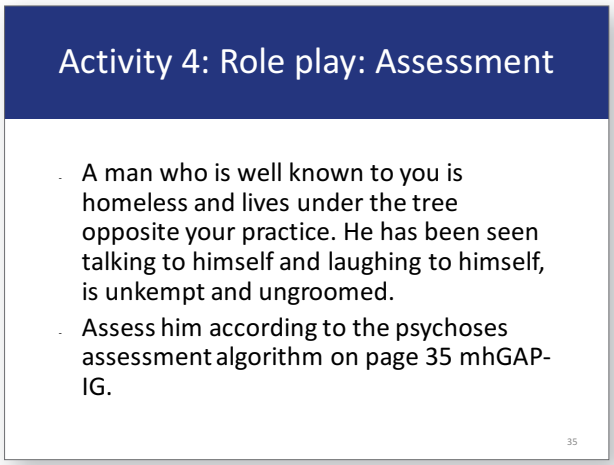
34

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



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.

Duration: 30 minutes.

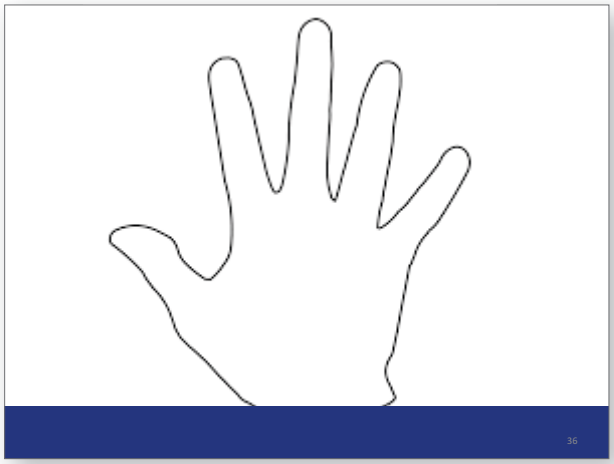
Purpose: This role play gives participants an opportunity to practise using the mhGAP-IG to assess for psychoses.

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.

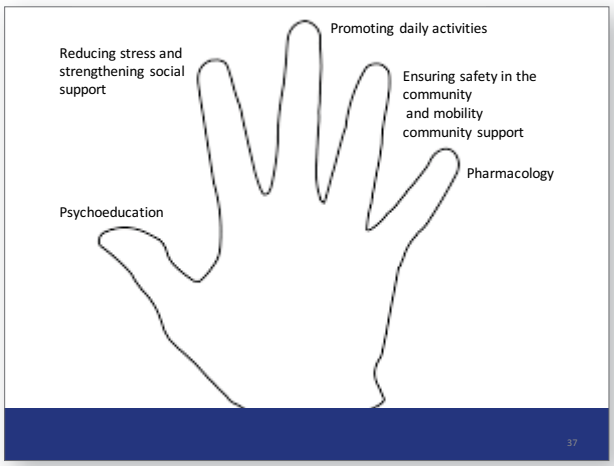
Instructions:
- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

Session 3.
Management of psychoses

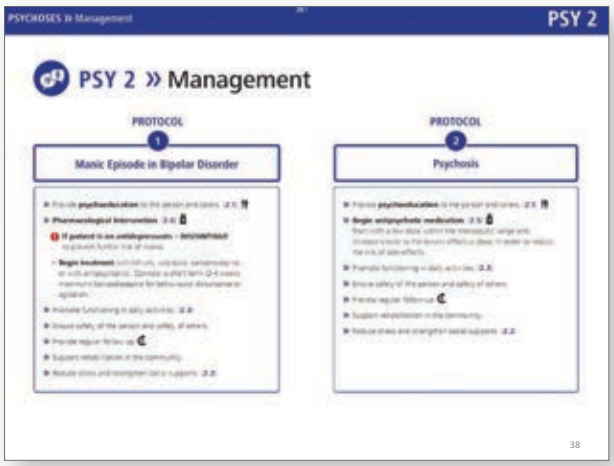
1 hours 50 minutes



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.

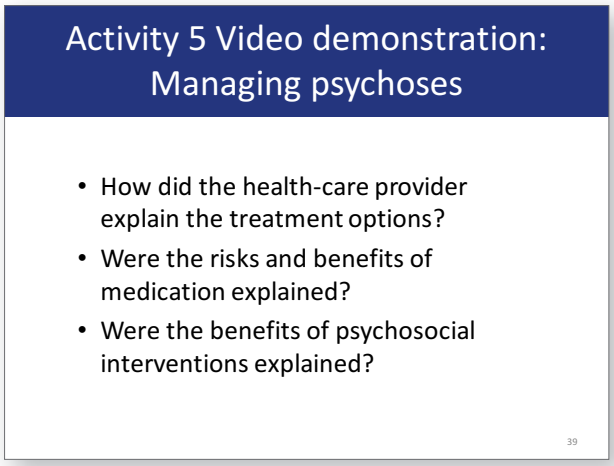


Direct participants to the management protocols on page 38 of the mhGAP-IG Version 2.0.

Choose volunteers to read them out loud.

Ask participants how confident they would feel using these management interventions.

Activity 5: Video demonstration: Management



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.

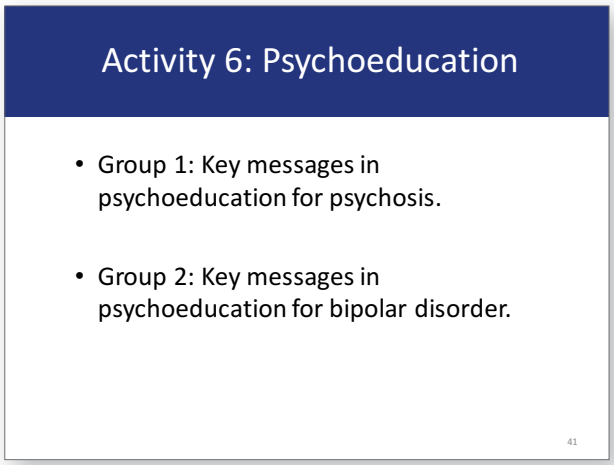
While watching ask participants to think about these questions:
- How the health-care provider explains the treatment options?
- Were the risks and benefits of medication explained?
- Were the benefits of psychosocial interventions explained?

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



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.

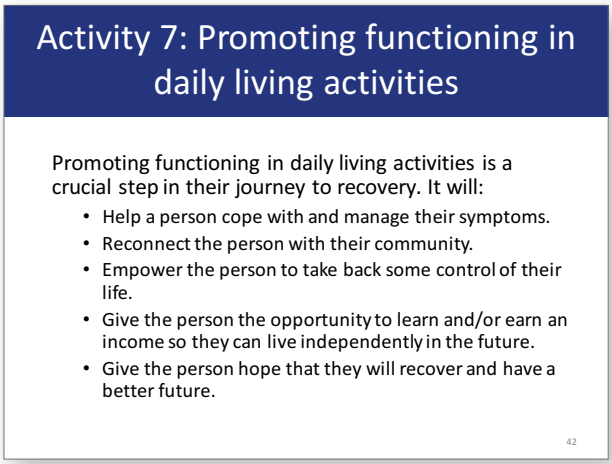
Instructions:
- Divide the participants quickly into two groups.
- Give each group paper, pens, flip chart paper, sticky notes etc.
- Give one group the topic: **Psychoeducation for psychosis**.
- Give the other group the topic: **Psychoeducation for bipolar disorder**.
- Give each group 10 minutes to 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



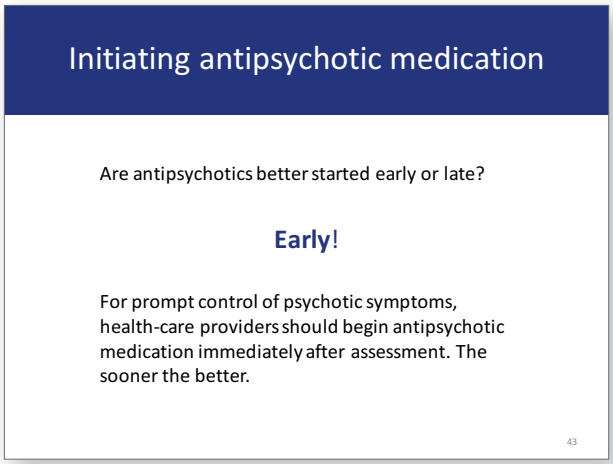
Duration: 25 minutes.

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.

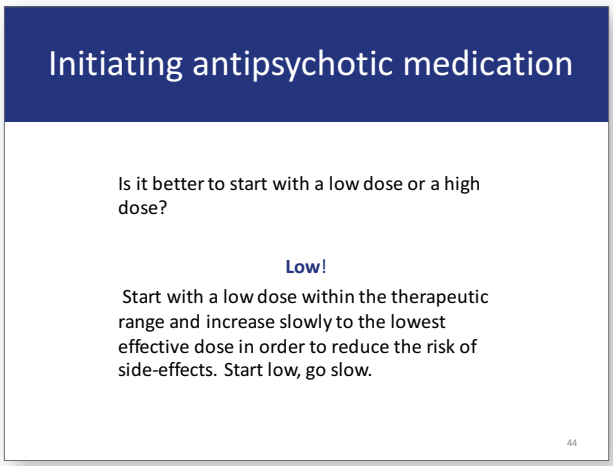
  - Negative effects of medication.
  - Loss of trust in the mental health system.
  - Loss of trust in the community and family.
  - Not being allowed to make decisions for yourself anymore.
  - Feeling that your opinion is not respected.
  - Negative attitudes from health-care providers.
  - Devaluing 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.



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.



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.

45

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!

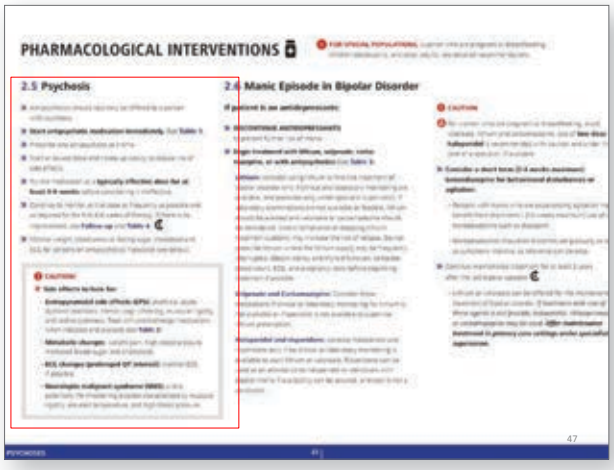
Try the first medication at an optimum dose for at least four to six weeks before considering it ineffective.

46

Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is **one**.

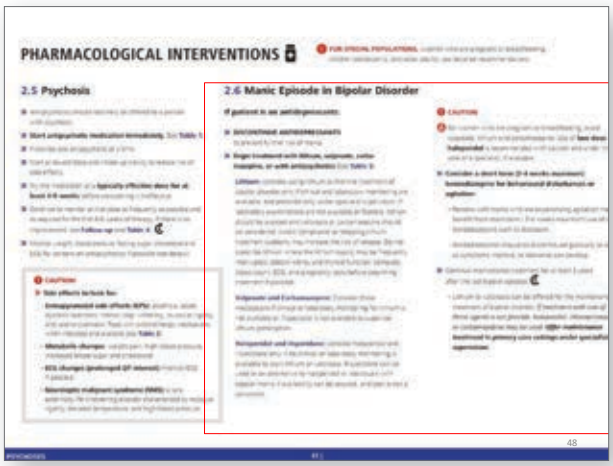
Try one medication and give it time to work before considering it ineffective.



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.



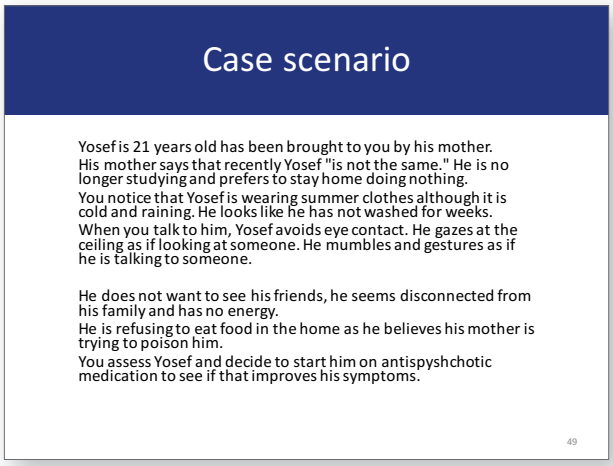
Direct participants' attention to the instructions in the mhGAP-IG for managing manic episodes with pharmacological interventions.

Ask participants:
Why a person with mania would be on antidepressants?

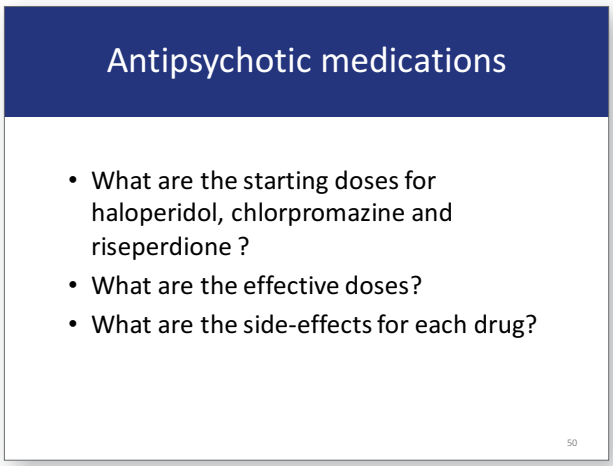
Remind them that people with bipolar disorders can experience episodes of mania and depression. In fact, remind them that often people with bipolar may experience more episodes of depression, therefore they may have already been prescribed an antidepressant.

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.



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.

51

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.

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?

53

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.

54

Introduce participants to the case study and ask them to use the mhGAP-IG to decide what management options are available to them.

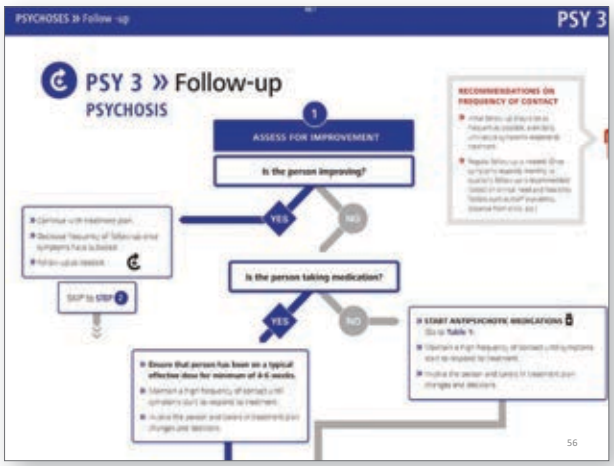
Ask them to refer to page 39 of the mhGAP-IG.

Special populations

- 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

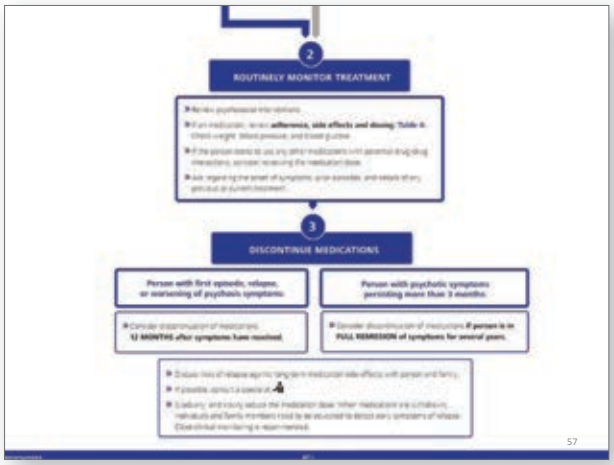
35 minutes



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.

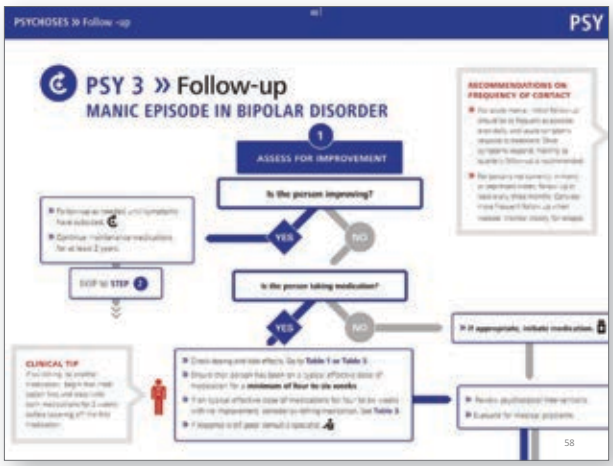
Reflect on how they might support a person to take their medication.



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?

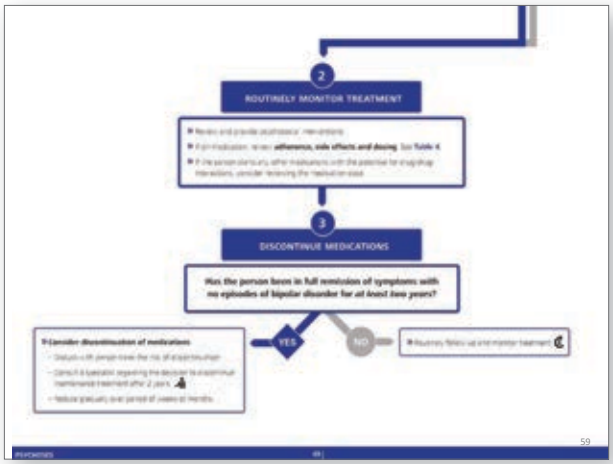
Clarify any concerns or questions they may have about step 3 and the discontinuation of medication.



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.

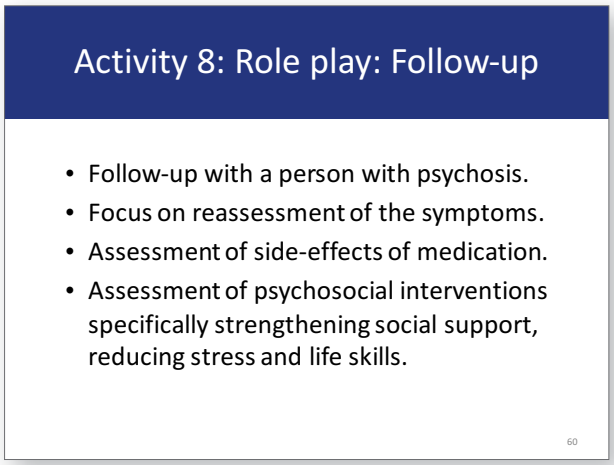
Clarify any queries or concerns the participants may have with these steps and outcomes.

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



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.

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

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=Ybn401R2gI4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5

Supporting material available online at:
www.who.int/mental_health/mhgap/psy_supporting_material.pdf

EPI

Epilepsy

mhGAP training of health-care providers
Training manual

World Health Organization

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	**Activity 1: Person's story followed by group discussion** Tell the person's story to introduce participants to what it feels like to live with epilepsy **Presentation on epilepsy** • Signs and symptoms of epilepsy • Causes of epilepsy • How epilepsy impacts a person's life • Why it is a public health priority
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	**Activity 2: Group discussion: Emergency presentations** **Activity 3: Video demonstration: Assessment** Use videos/demonstration role play to show an assessment and allow participants to note: • Principles of assessment (all aspects covered) • Effective communication skills (what and how this is done) **Activity 4: Role play: Assessment** 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 epilepsy **Activity 5: Role play: Management** Feedback and reflection
4. Follow-up	Plan and perform follow-up for epilepsy	10 minutes 30 minutes	Presentation on the principles of follow-up **Activity 6: Group discussion: How to reduce stigma and discrimination**
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.

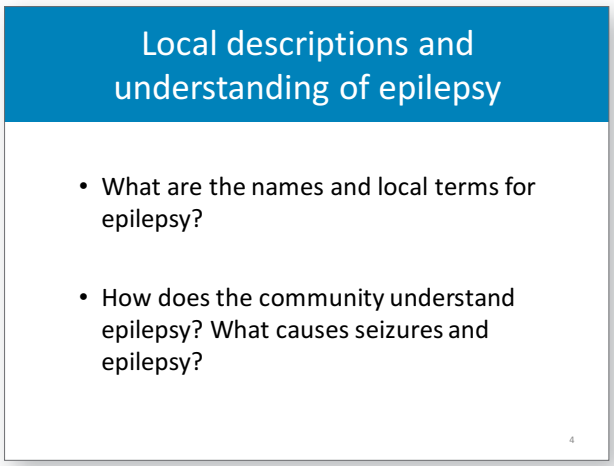
Begin the session by briefly listing the topics that will be covered.

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.

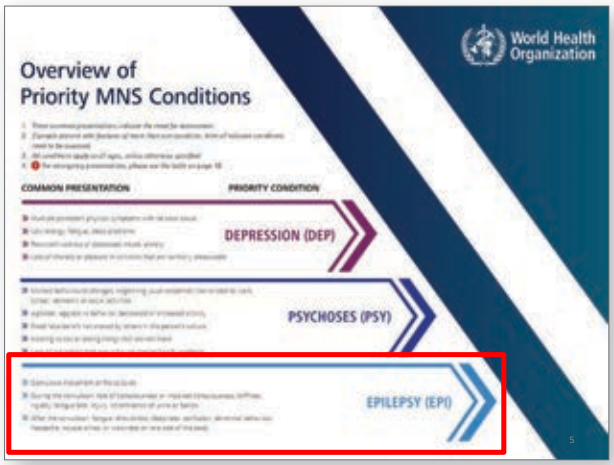
Using the person's story to:
- Introduce the activity and ensure participants have access to pens and paper.
- Tell the person's story – be creative in how you tell the story to ensure the participants are engaged.
- Immediate first thoughts – give participants time to give their immediate reflections 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?

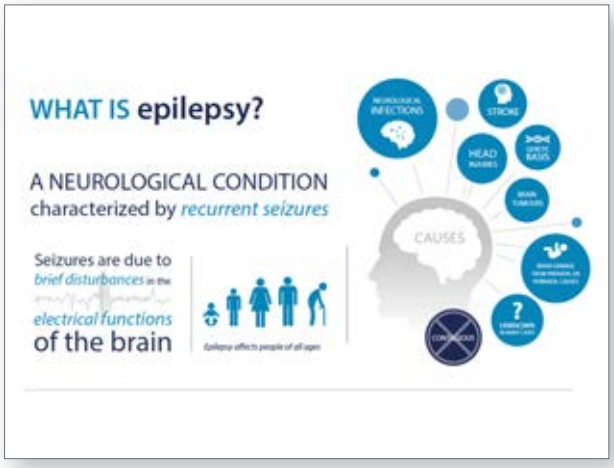


Write a list of local terms and descriptions for epilepsy and compare those with common presentations described in the mhGAP-IG.

(Maximum five minutes.)



Read through the common presentations of people with epilepsy.



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).

8

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.

9

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

During the seizure:

- Loss of awareness or consciousness.
- Convulsive movements (involuntary shaking of the body).
- Incontinence of urine or stool.
- Tongue-biting.
- Loss of vision, hearing and taste.

After the seizure:

- Low mood, anxiety, worry.
- Injuries sustained during seizures.
- Muscle aches.
- Tiredness/sleepiness.
- Abnormal behaviour.
- Confusion.
- Fatigue.
- Pains on one side of the body.

10

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.

11

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.

12

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.

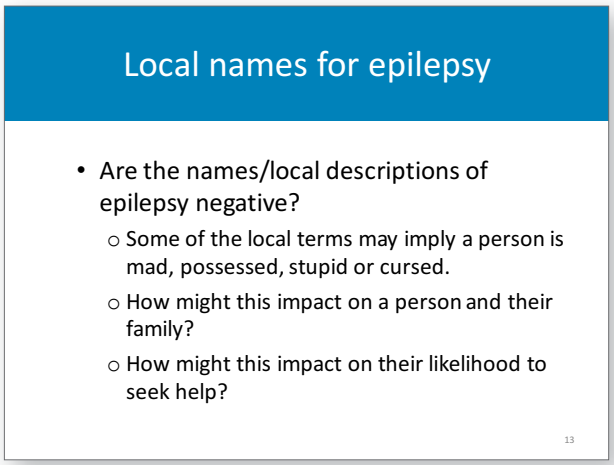
Antiepileptic medication is affordable – US$ 5 per year.

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.

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?

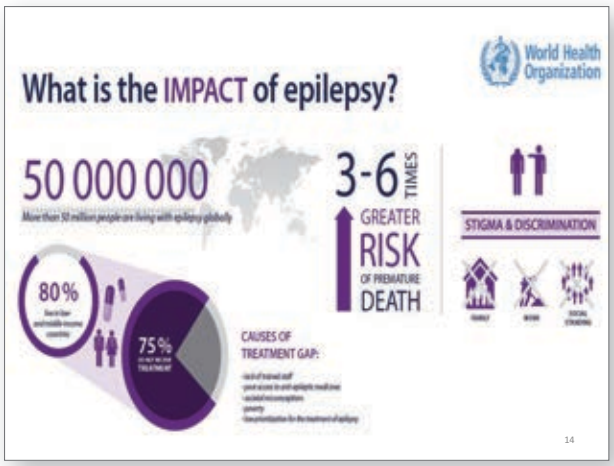
Explain that people living with epilepsy around the world are quite often stigmatized and discriminated against.

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

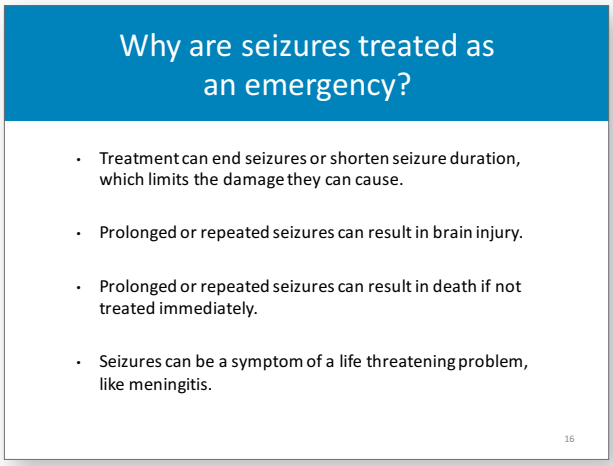
1 hour 40 minutes

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.

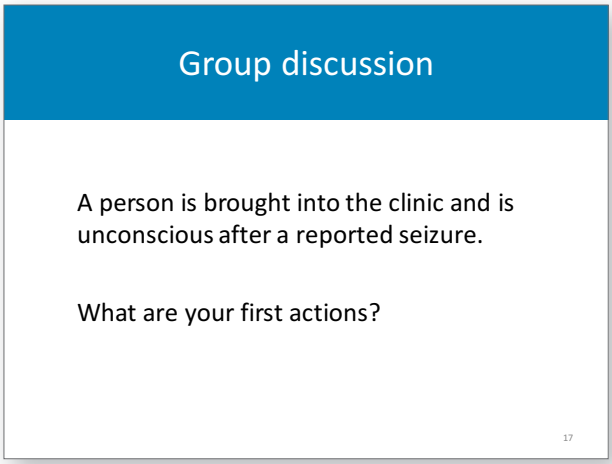
mhGAP-IG has an assessment algorithm for both and in this training we will start with how to manage seizures which present as emergencies.



Emphasize why managing seizures is an emergency.

Talk through the points on the slide.

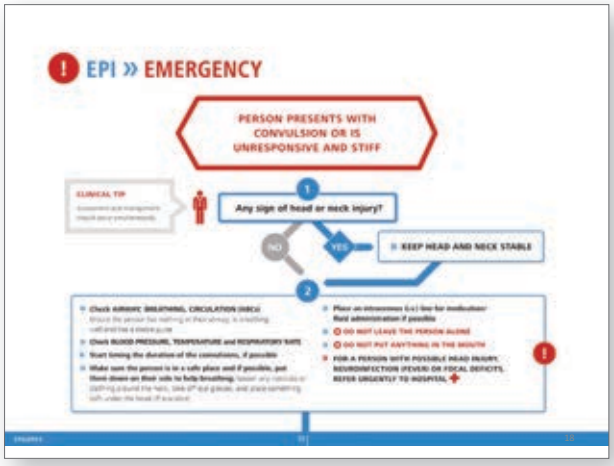
Activity 2: Group discussion: Emergency presentations



Duration: 10 minutes.

Purpose: To learn how much participants know about managing acute seizures.

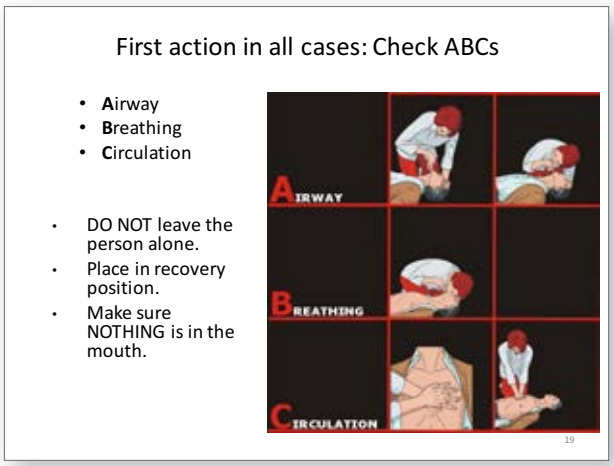
Instructions:
- Give individuals a few minutes to think individually about what they would do in this situation.
- Facilitate a group discussion and seek group consensus to create a comprehensive list of steps they would take to help the person.



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.

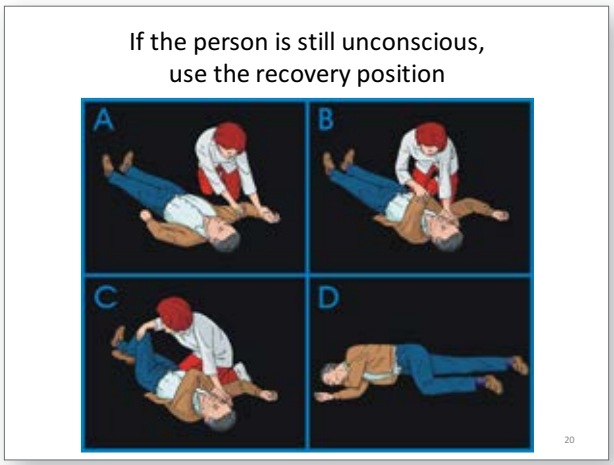
Ensuring the A, B, C (**a**irways, **b**reathing, **c**irculation) is crucial, even if they do not have a clear idea about the cause yet.



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.



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.

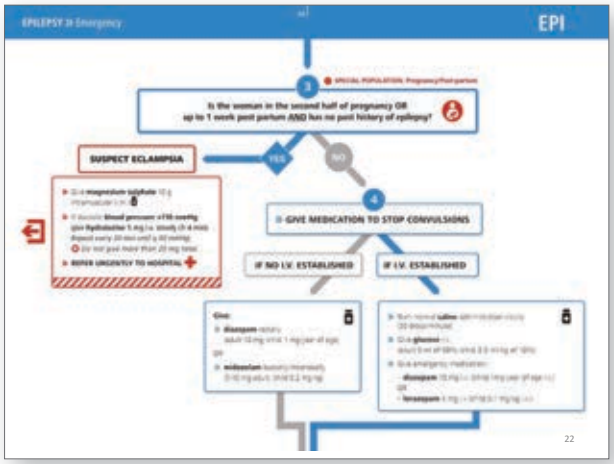
In particular, the respiratory rate should be counted. You may be using drugs that cause respiratory depression.

21

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.

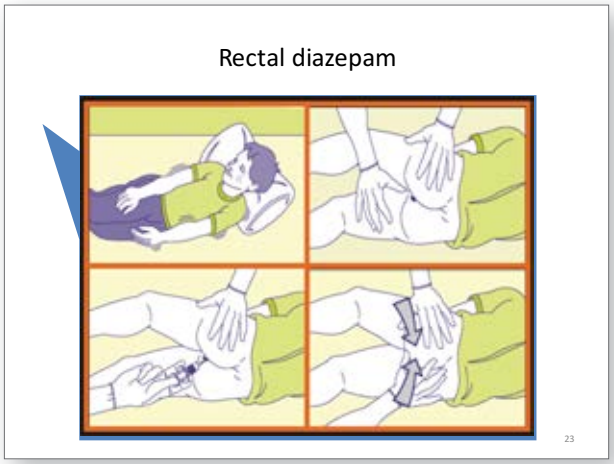
The condition poses a threat to the health of the mother and the baby.

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.

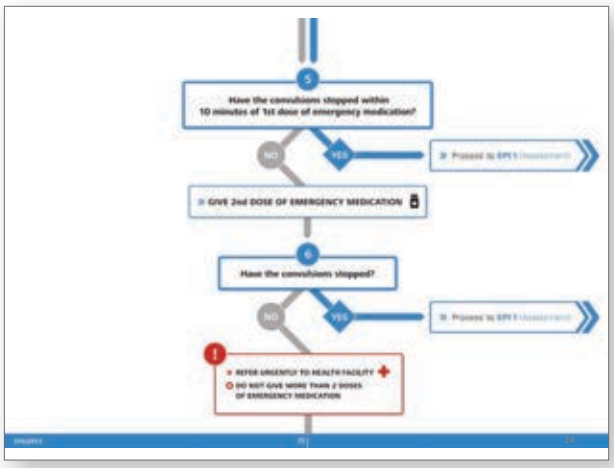


Explain how to give rectal diazepam. Mention to participants that they need to teach this to the carers of people with seizures for them to be able to do it at home.

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.

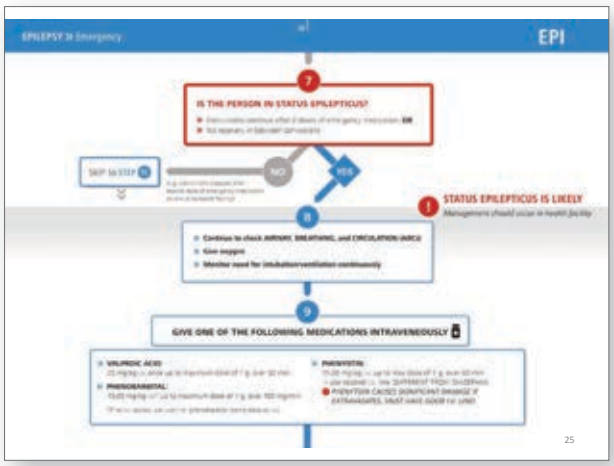
Ask participants what should they do if the convulsions have not stopped within 10 minutes of the first dose of medication?



Direct the participants to page 55 mhGAP-IG Version 2.0. Talk through steps 5 and 6.

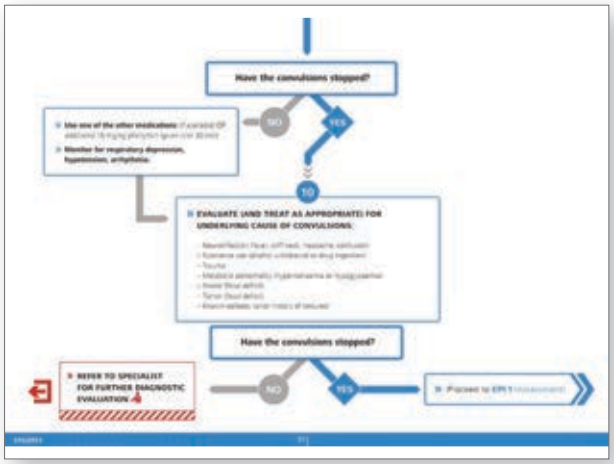
Explain that we will look at the management protocols in the next session but for now we will concentrate on the assessments.

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.



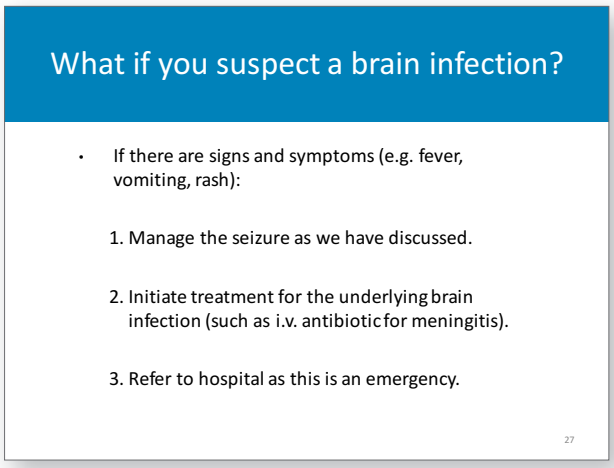
Once the convulsions have stopped, take step 10 (page 57 mhGAP-IG) – evaluate (and treat as appropriate) for underlying cause of convulsions.

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.



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.

28

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.

29

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.

30

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.

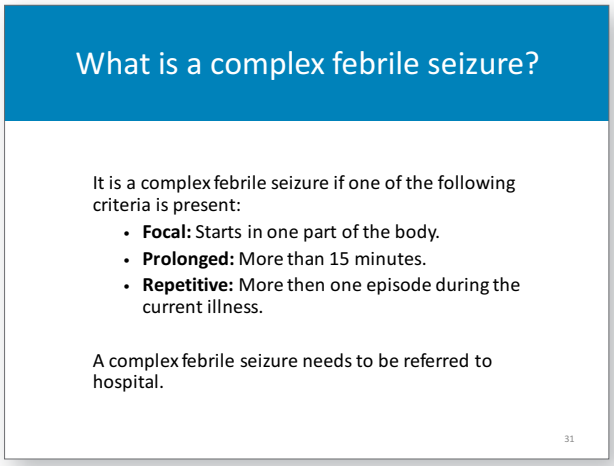
Ask the participants to explain the difference between febrile seizures and epilepsy.

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.

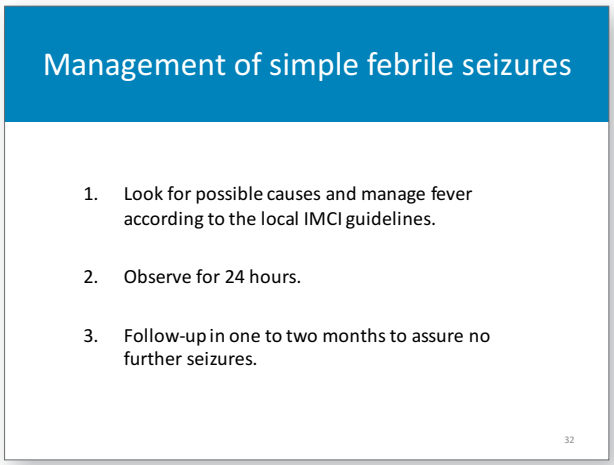
Clarify that it is important to rule out complex febrile seizures as these are at a higher risk of serious underlying pathology and generally need hospital admission, CT scan and lumbar puncture.



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**.



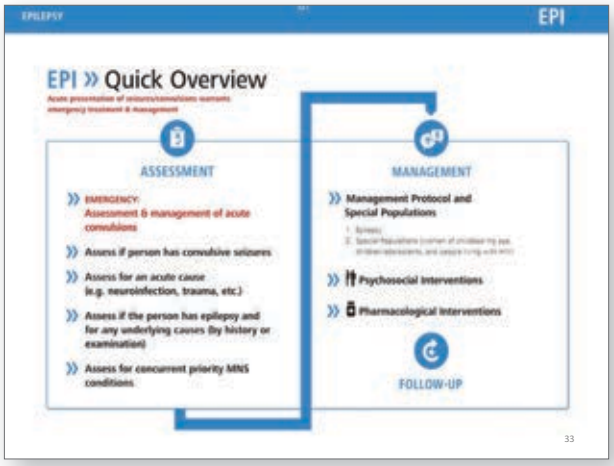
Talk through the points on the slide.

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



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

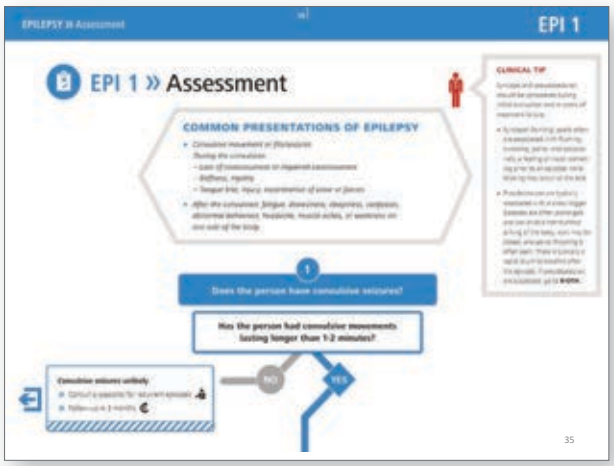
Activity 3: Video demonstration

- 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.

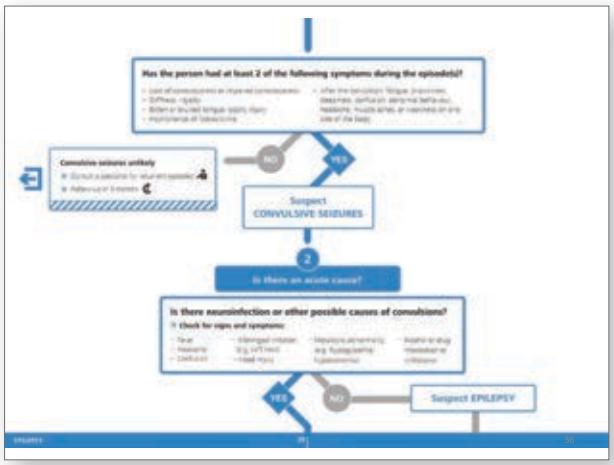
https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v.



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?

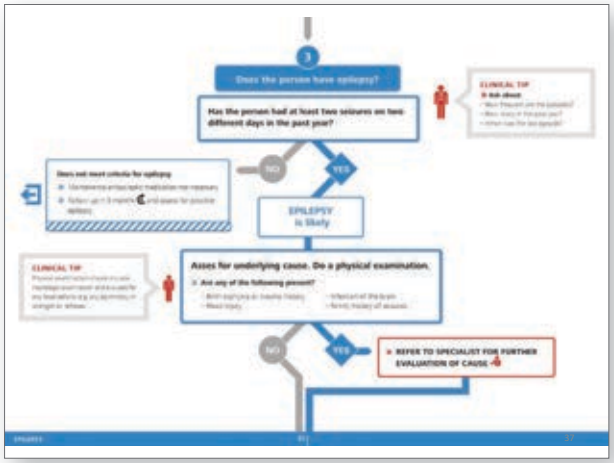
Seek group consensus.

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.

38

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.

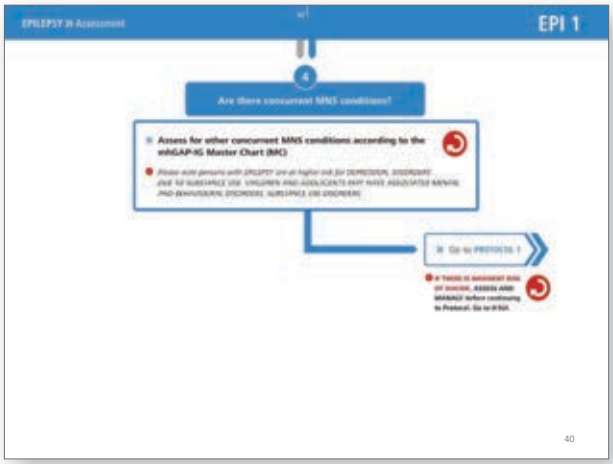
39

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.

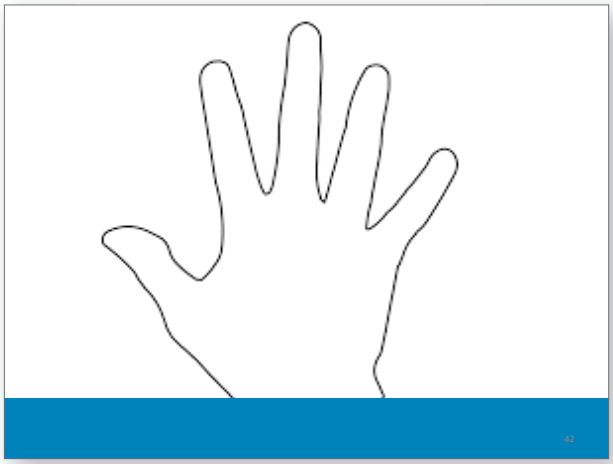
Purpose: This role play enables participants to practise conducting an assessment to establish if someone has epilepsy.

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.

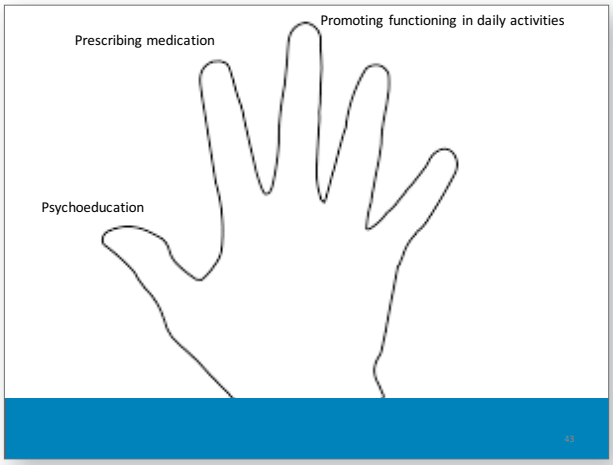
Instructions:
- Divide the participants into groups of four.
- Instruct one person to play the role of the health-care provider, one the person seeking help, one person the spouse and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

Session 3.
Management of epilepsy

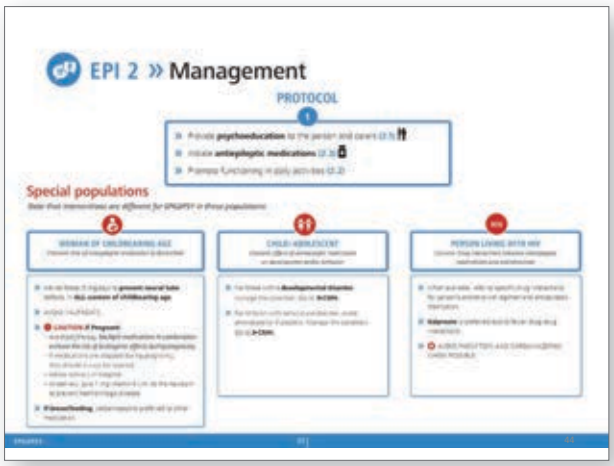
1 hour 15 minutes



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.

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

46

Emphasize that a seizure diary can be very helpful in managing epilepsy.

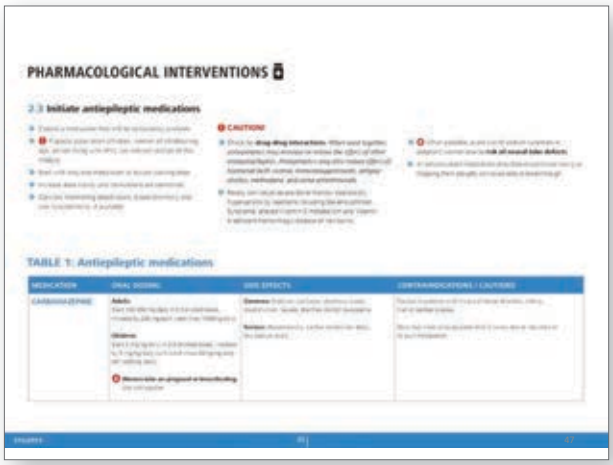
It is useful because it gives a clear idea about the person's problems and how they are progressing.

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.


PHARMACOLOGICAL INTERVENTIONS

2.3 Initiate antiepileptic medications

TABLE 1: Antiepileptic medications

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?

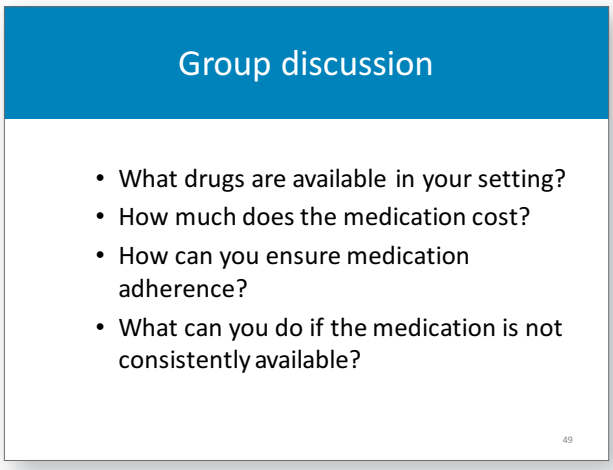
Point out the risks of prescribing medication to special populations.


EPI 2

TABLE 1: Antiepileptic medications (cont.)

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.

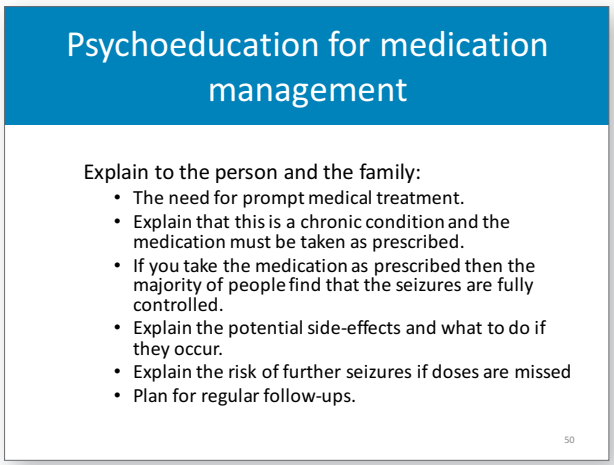

Group discussion

- 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?

49

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?

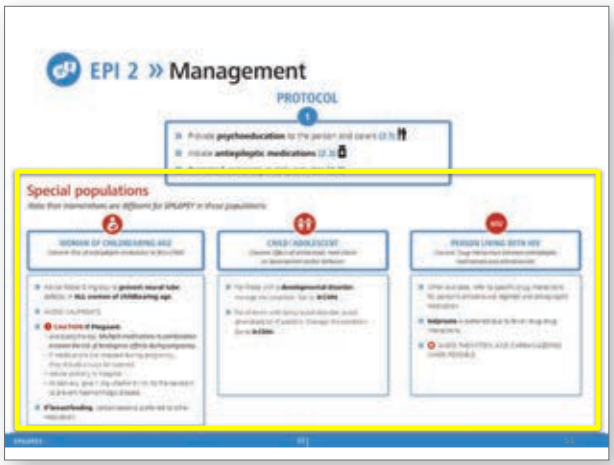


Psychoeducation for medication management

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.

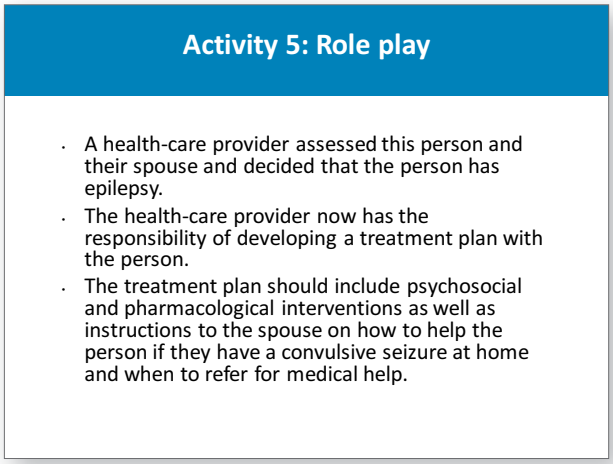


Ask participants to read through the management options for special populations.

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



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

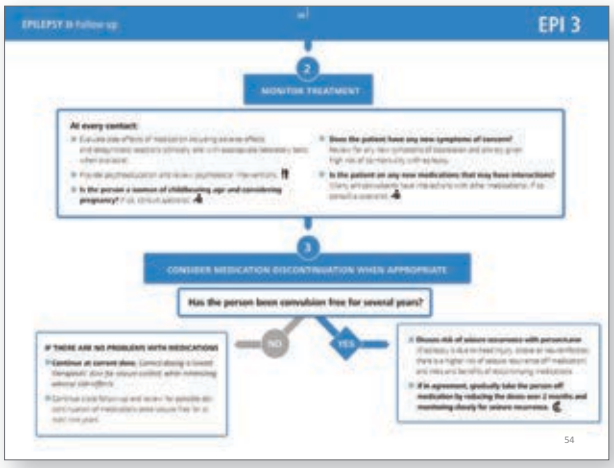
Highlight the recommendations on frequency of contact (page 67 mhGAP-IG Version 2.0) and explain that follow-up should occur every three to six months.

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.

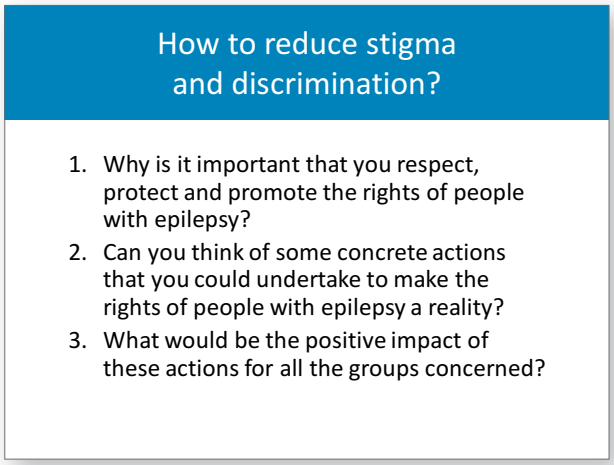


Describe what should be monitored at regular follow-ups.

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



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

EPI supporting material

- Person stories
- Role plays
- Multiple choice questions
- Video links

  Activity 3: mhGAP EPI module – assessment

  https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v

Supporting material available online at:
www.who.int/mental_health/mhgap/epi_supporting_material.pdf

Child and adolescent mental and behavioural disorders

mhGAP training of health-care providers
Training manual

CMH

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	**Activity 1: Person's story** Use a person's story to introduce common presentations of child and adolescent mental and behavioural disorders **Activity 2: Group work: Common presentations of developmental, behavioural and emotional disorders** How do they impact on the individual, family and society? Presentation on developmental, behavioural and emotional disorders **Activity 3: Group work: Developmental milestones**
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	**Understanding the assessment algorithm** Use the mhGAP-IG and PowerPoint presentation to explain the CMH assessment algorithm **Activity 4: Video demonstrations: Assessment** Use videos/demonstration role play to show an assessment and allow participants to follow it according to: mhGAP-IG assessment algorithm **Activity 5: Demonstration role play: Assessment (conduct disorder)** 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	**Management interventions for child and adolescent mental and behavioural disorders** **Activity 6: Role play: Psychosocial interventions** 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 **Role play: Follow-up** Following up with an adolescent with depression
5. Review		15 minutes	**Quiz**
Total duration (without breaks) = 5 hours 50 minutes			

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

2

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

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

3

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?

4

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.

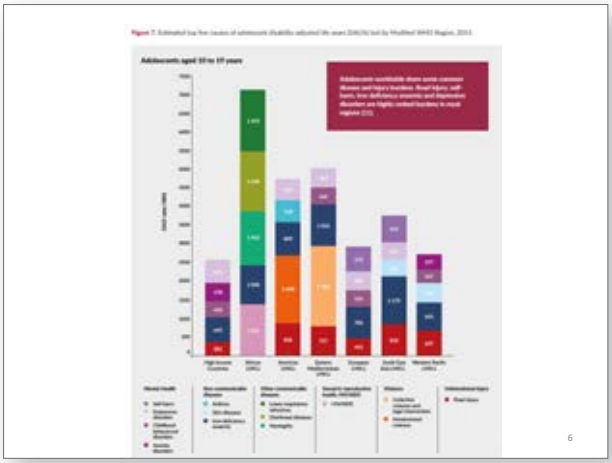


Figure 7 from the Global Accelerated Action for the Health of Adolescents (AA-HA!) shows the top five estimated causes of disability-adjusted life years (DALYs) lost for each modified WHO region, 2015.

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 through out life.

8

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.

9

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.

10

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.

11

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.

12

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.

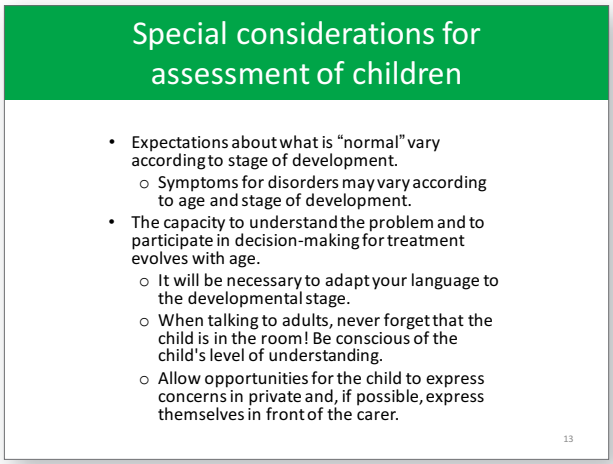
If the carer/adolescent has unrealistic expectations about management outcomes:

- 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.

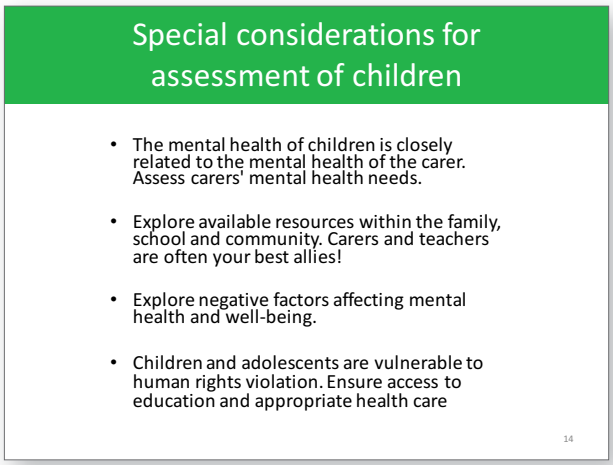
Child/adolescent is being neglected or abused:
- Explain to the carer that good care, adequate education and a positive environment are essential for the child/adolescent to learn, feel happy and behave well.
- Consult a specialist if the situation is severe or does not improve over time.
- Link the 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.



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.



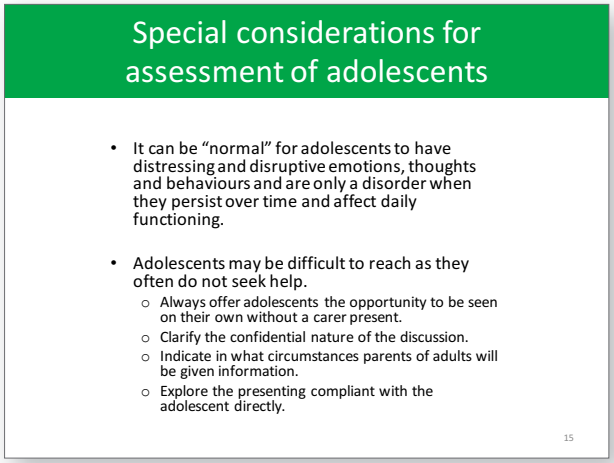
Read through the first point on the slide and explain that whenever we assess children's development and psychological well-being, we also need to assess:
- The carers' capacity to provide a caring environment.
- The availability of other people who can support the child and carers.

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.

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.

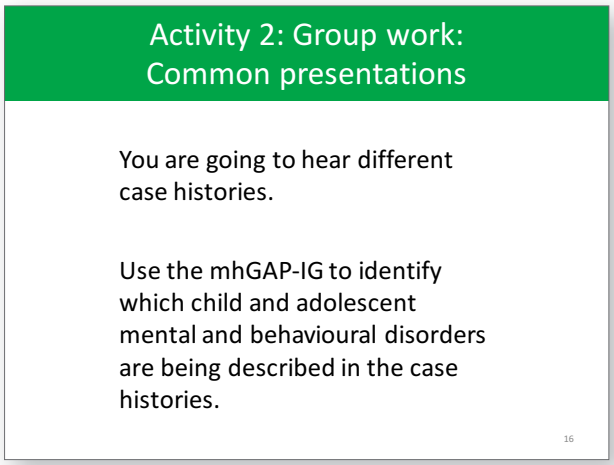


Explain that this slide introduces special considerations for the assessment of adolescents.

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



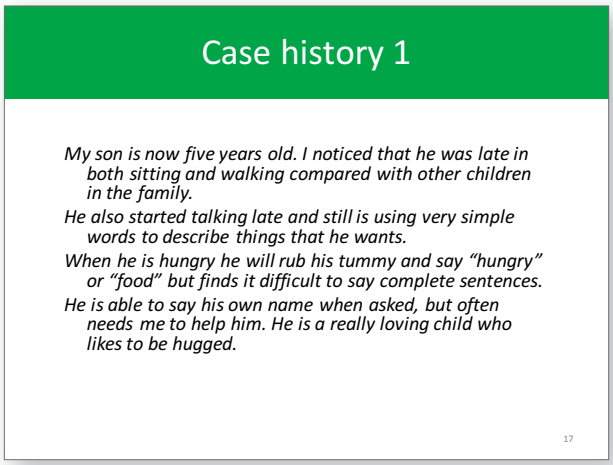
Duration: 30 minutes.

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.

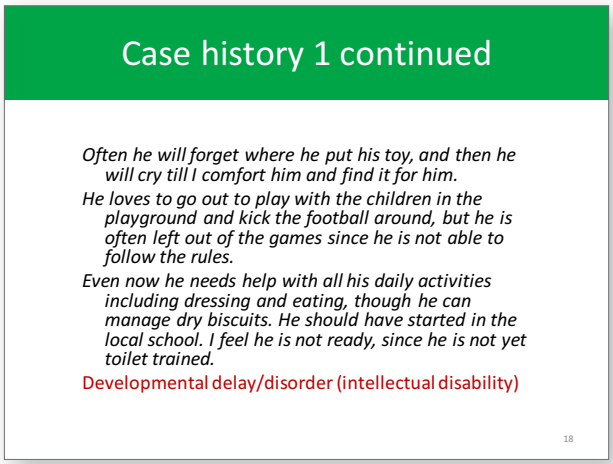
Instructions:

- 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).

- The answers are written in red on the slides.
- Do not reveal those answers until the participants have had a chance to identify and discuss the common presentations.



Read the case history out loud or ask a volunteer to read it.



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)

22

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)

23

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?

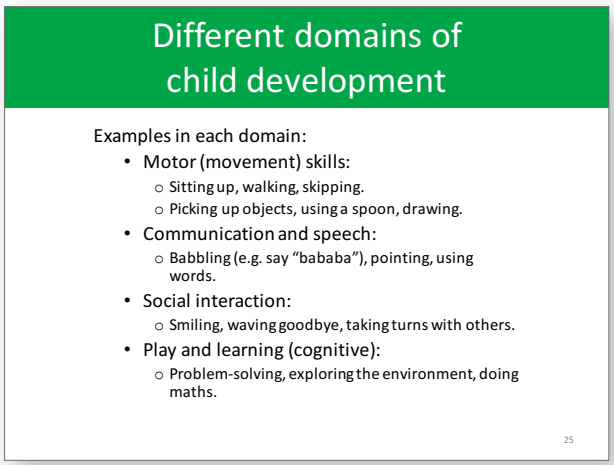
- The process of growing and acquiring new skills (i.e. walking and grasping objects, communicating, playing, interacting with others).
- It is a complex process, determined by the biological brain development, influenced in part by the quality of interactions with others (i.e. carers).
- Child development 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.

24

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.



Explain that these are the different domains of child development.

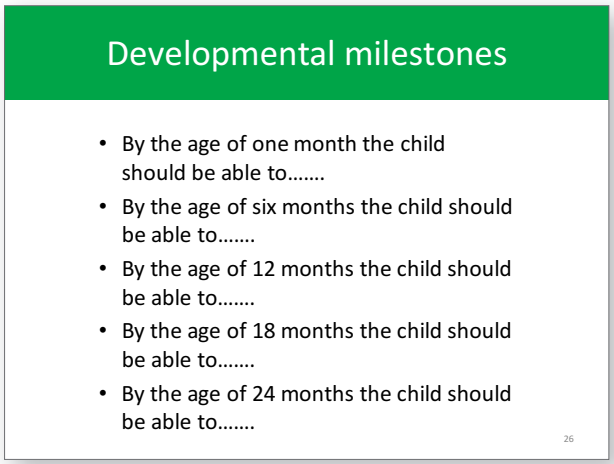
During childhood and adolescence these are the domains in which people grow, develop, acquire new skills and learn. All of which prepare them for adulthood.

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



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.

27

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.

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.

33

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.

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.

34

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.

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
- Consanguinous 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)

35

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.

Person's story

Hear what it is like to live with developmental disorders.

36

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.

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.

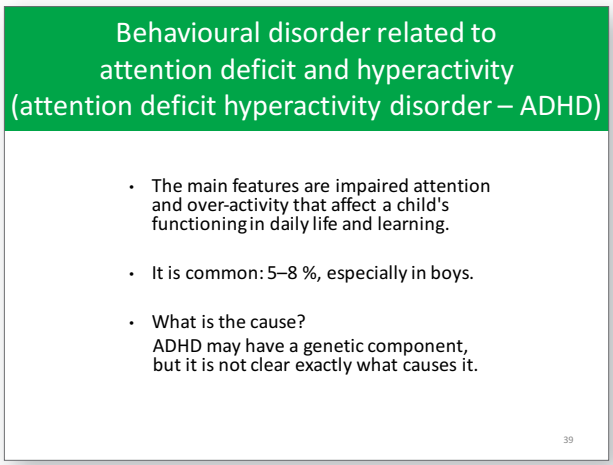
These problem behaviours can be defined as:

- **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

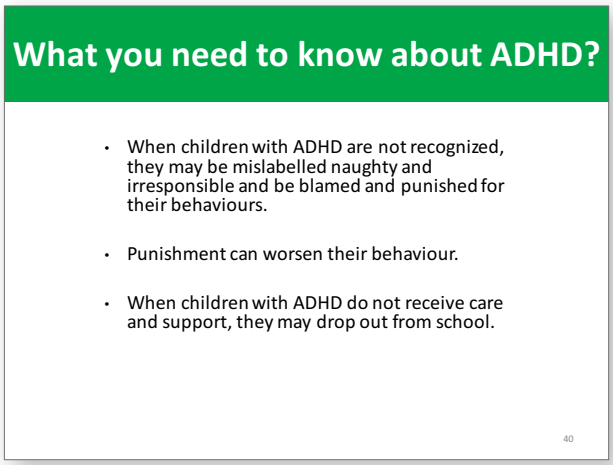
Explain that problem behaviours can be defined as:
- excessive over-activity
- excessive inattention
- excessive impulsivity
- repeated and continued behaviour that disturbs others
- sudden changes in behaviour or peer relations.

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).



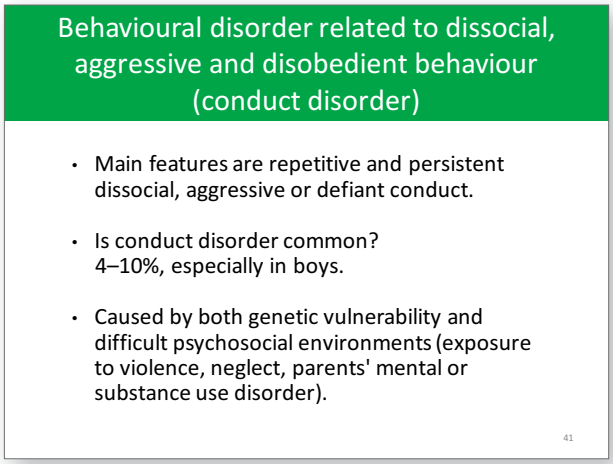
Explain that the behavioural disorder characterized by impaired attention and over activity is also called **attention deficit hyperactivity disorder** (or ADHD).

Talk through the points on the slide.



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.



Explain that the behavioural disorder characterized by dissocial, aggressive and disobedient behaviour is also called "conduct disorder".

Talk through the points on the slide.

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.

42

Emphasize again that early identification and support can change the course of a child/adolescent's entire life.

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:

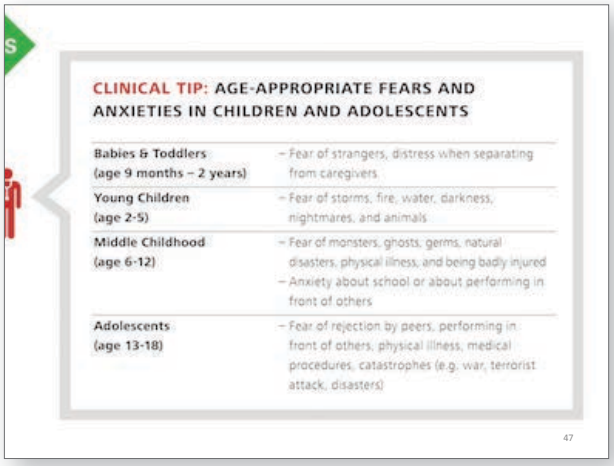
- Prolonged (intense emotions felt for prolonged period of time).
- Disabling: impedes the child/adolescents ability to function in everyday life.
- Distress: intensely feeling emotions such as sadness, fearfulness, anxiety and irritability.

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.



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.

48

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.

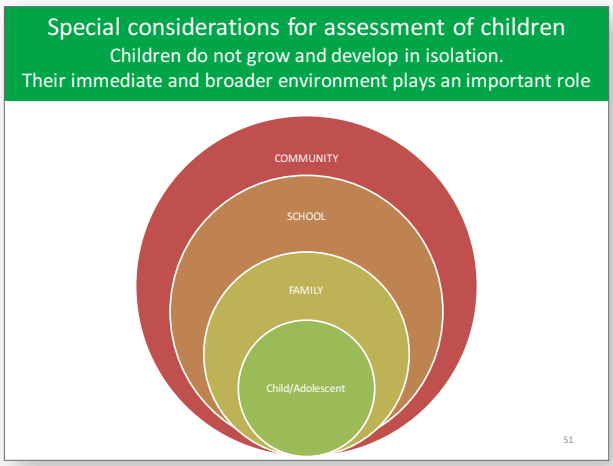
Since one month ago, his father reports that Omar has become withdrawn, preferring to stay at home rather than playing sports or visiting his friends, he has become irritable and quarrelsome with his siblings and cannot concentrate on his studies. He is worried about his forthcoming exams and does not 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.



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

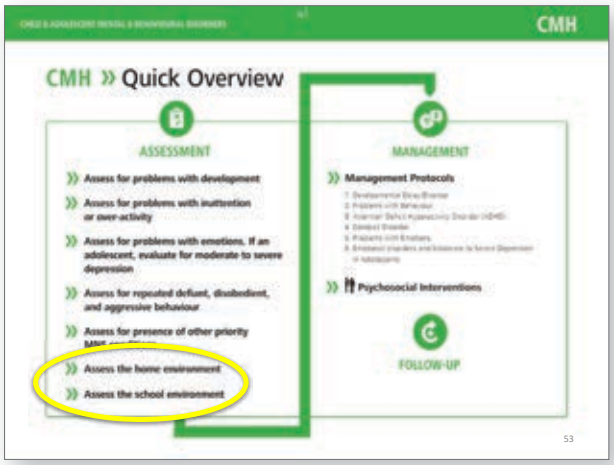
1 hour 50 minutes

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.

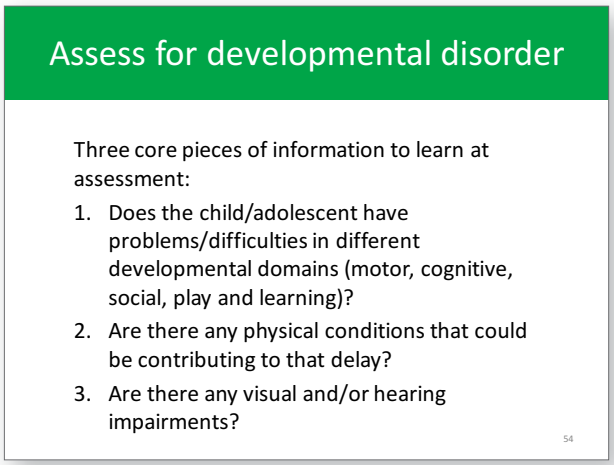


Explain to participants that this is particularly true for the assessment of the home environment and school environment.

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.



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.

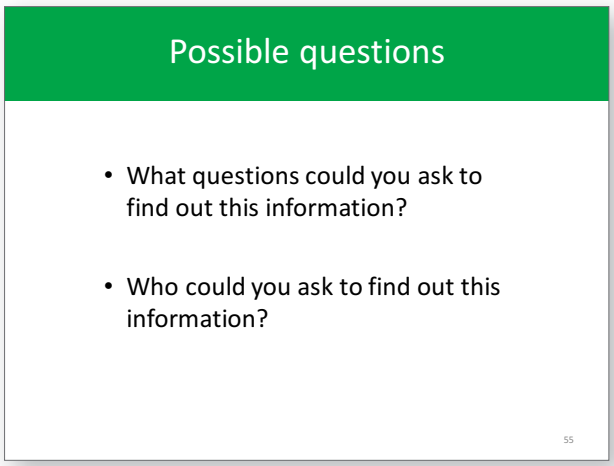
1. Does the child/adolescent have problems/difficulties in developmental domains? Remind participants what the developmental domains are (from the discussions at the beginning of the session).

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.

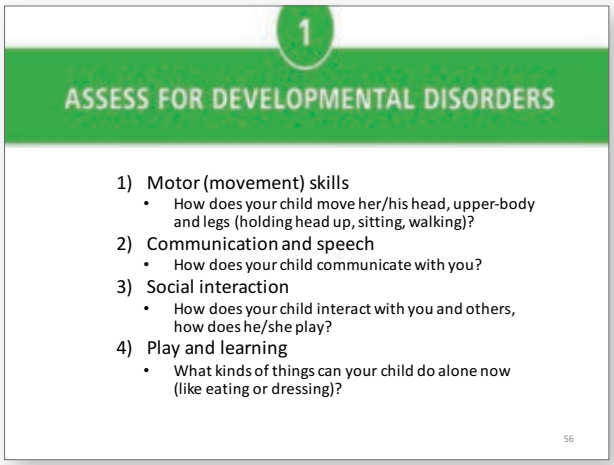
If the answers to **point 1** is **yes** then there are signs of developmental disorder and the participants should manage the disorder using the principles described in Protocol 1 (page 85).



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.



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?

58

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.

Assess for behavioural problems: Conduct disorder

1. Does the child/adolescent show repeated aggressive, disobedient or defiant behaviour?
2. Are those behaviours persistent, severe, and inappropriate:
   a. Present across multiple settings (home, school, social groups etc.)?
   b. Present for at least six months?
   c. Age appropriate (more severe than childishness or rebelliousness)?
   d. Severely impact on the child/adolescent's ability to function?

59

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

- What questions could you ask to find out this information?
- Who could you ask to find out this information?

60

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

- Do you find yourself arguing with your parents?
- Do you get irritated if your parents ask you to do something?
- Have you been feeling extremely angry and irritable recently?
- Are you having difficulties getting on with other people?

61

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?

62

Briefly talk through these examples of questions for the carer. Add them to the list produced by the participants.

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?

64

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

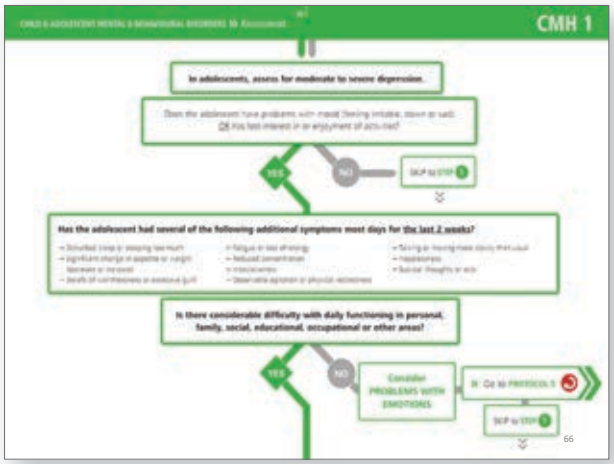
Hang those questions up on the wall in full view so that participants can use them when they are doing role plays.

Asking adolescents/carers about emotions

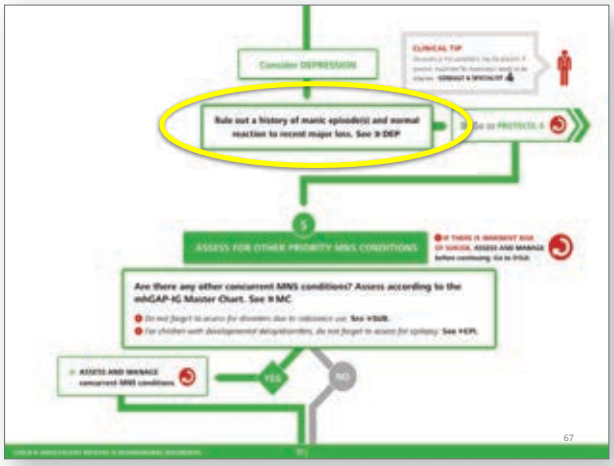
- Do they often feel irritable, sad, annoyed, down?
- Have they lost interest in activities they used to get enjoyment from?
- Do they have many worries or often seem worried?
- Do they have many fears and are they easily scared?
- Do they complain of headaches, stomach aches or sickness?
- Are they 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).

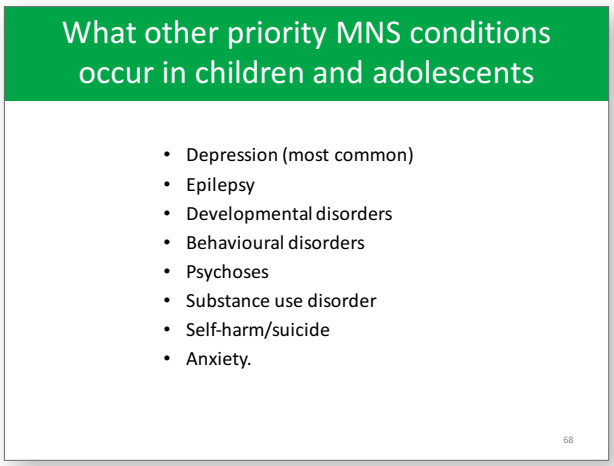


Highlight again that participants should always rule out a history of mania or manic episodes when assessing for depression. They should also explore if there has been a major loss in the past six months.

Although depression is common amongst adolescents it is important to also assess for other MNS conditions as well.

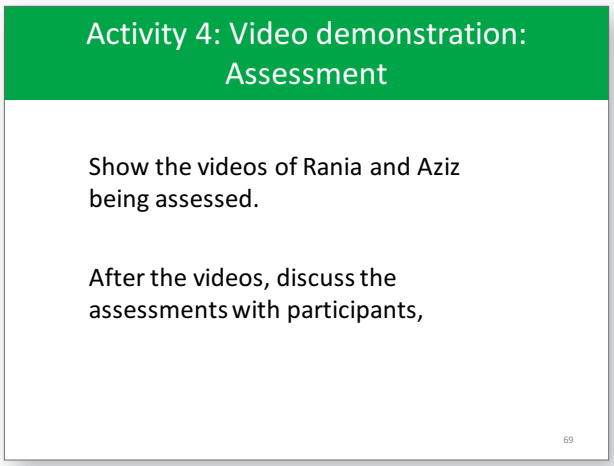
Ask participants what other priority MNS conditions they believe children and adolescents can experience?

Give them two or three minutes to answer before revealing the answers in the next slide.



Emphasize that most mhGAP priority disorders also occur in children and/or adolescents.

Activity 4: Video demonstration: Assessment

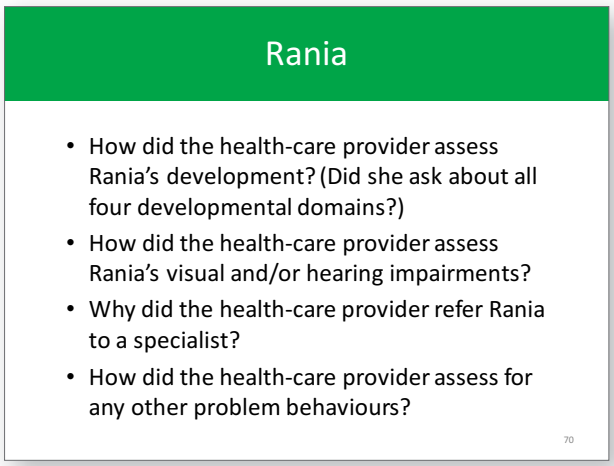


Duration: 20 minutes.

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=H6Nte7lxGlc&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.



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?

71

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?

72

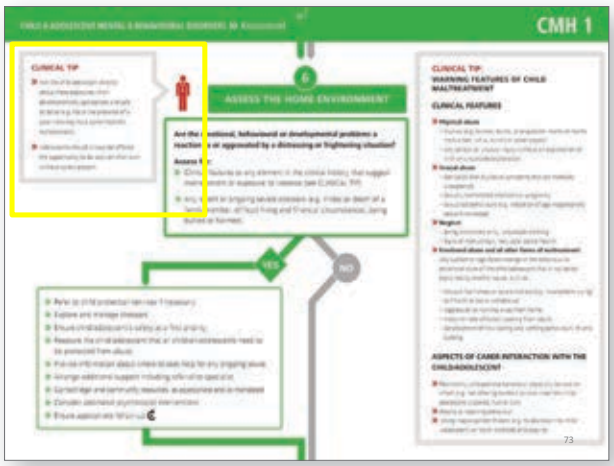
Talk through the points on the slide and explain that no matter whether you suspect developmental disorders, behavioural disorders or emotional disorders in a child/adolescent you should **always** conduct an assessment of the home and school environment.

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

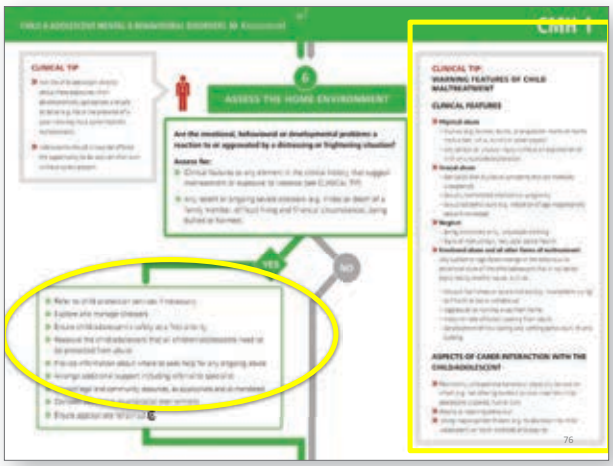
Talk through the different examples of questions that participants could use to ask the child/adolescent about their home environment.

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?

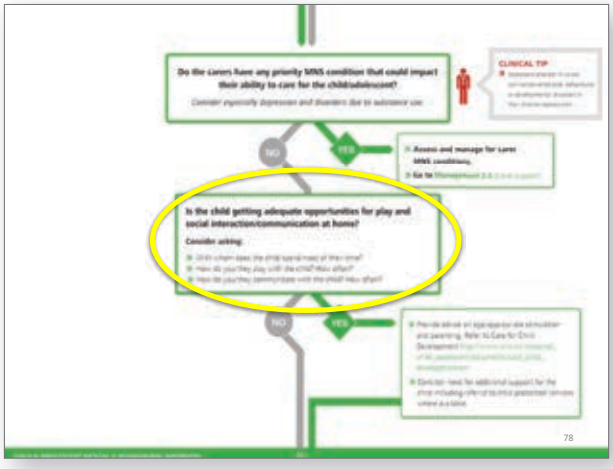
77

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.



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.

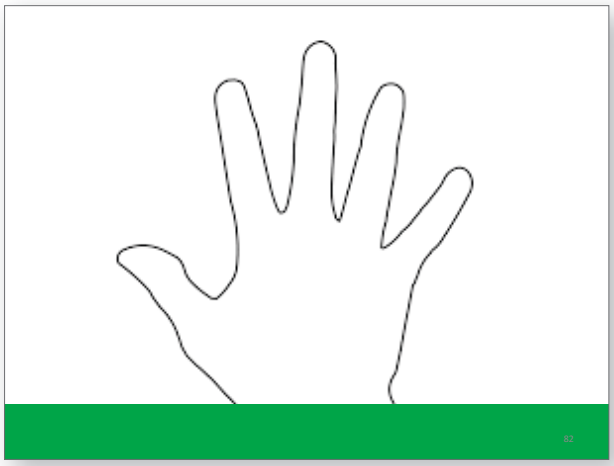
Instructions:
- The facilitator will play the role of the health-care provider.
- The co-facilitator (if there is no co-facilitator use a volunteer) will play the role of the mother.
- A volunteer participant will play the role of 13-year-old John.

- 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?

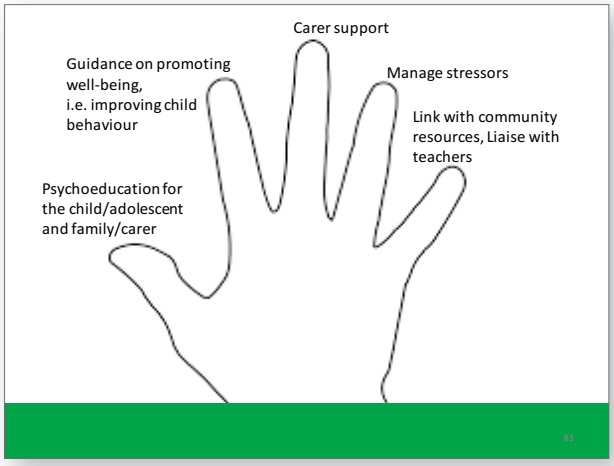
Note: Instead of a demonstration role play, you can use role play 4 (CMH supporting material) and allow them to practise assessing and managing an adolescent with conduct disorder.

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

Psychosocial interventions for treatment of behavioural disorders	Behavioural interventions for children and adolescents, and caregiver skills training.
Psychosocial interventions, treatment of emotional disorders	Psychological interventions, such as CBT, IPT for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers
Caregiver skills training for the management of developmental disorders	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.

84

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 breeched.

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.

87

See role play 2 (CMH supporting material).

Duration: 45 minutes.

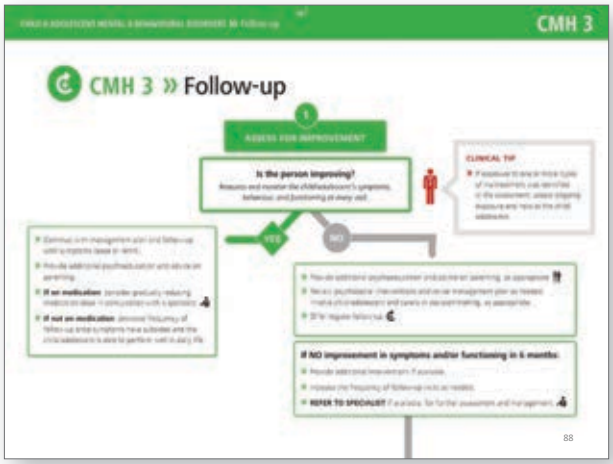
Purpose: To give participants the opportunity to read through, reflect on and practise using psychosocial interventions to care for a child and their carer.

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.

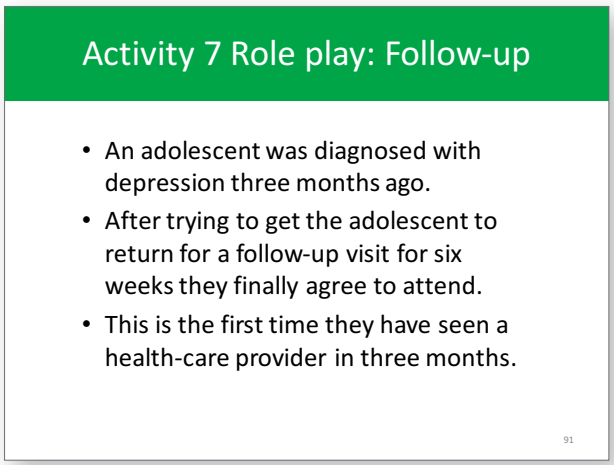
If a child/adolescent has been started on any pharmacological treatments, ensure that they are being monitored closely.

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



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

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=H6Nte7lxGIc&index=9&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v

Supporting material available online at:
www.who.int/mental_health/mhgap/cmh_supporting_material.pdf

Dementia

mhGAP training of health-care providers
Training manual

DEM

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

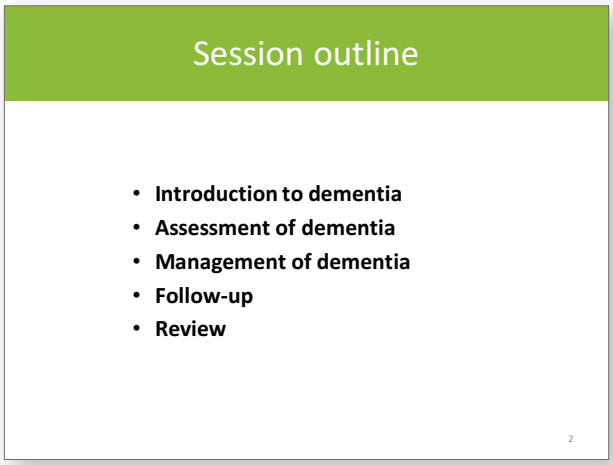
- Dementia is not a normal part of ageing.
- Dementia is usually progressive – it gets worse over time.
- Symptoms of depression and delirium in older adults can mimic symptoms of dementia, therefore, a thorough assessment and regular follow-up is essential.
- It is critical to assess the carer's stress 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	**Activity 1: Person's story** Tell the person's story to introduce participants to what it feels like to live with dementia **Presentation to supplement the person's story** Use the PowerPoint presentation to facilitate a structured discussion on: • Symptoms of dementia • Causes of dementia • How dementia impacts on a person's life • Why it is a public health priority
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	**Activity 2: Reflecting on caring for people with dementia** Give participants the opportunity to use the mhGAP-IG master chart to reflect on times they have cared for people with dementia **Activity 3: Video demonstration: Assessing for dementia** Use videos/demonstration role play to show an assessment and allow participants to note: • Principles of assessment (all aspects covered) • Effective communication skills (what and how this is done) **Activity 4: Role play: Assessment** 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	**Presentation on management interventions** **Activity 5: Case scenarios: Treatment planning** In three groups, participants practise developing a psychosocial treatment plan for a person with dementia and their carer Presentation on pharmacological interventions
4. Follow-up	Plan and perform follow-up	30 minutes	**Activity 6: Role play: Follow-up** 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

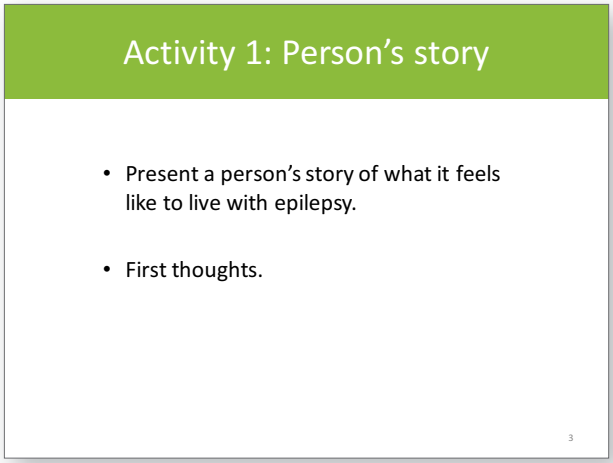
Session 1. Introduction to dementia

1 hour



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

Activity 1: Person's story



How to use the person's story:

- 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.
- First thoughts – give participants time to give their immediate reflections of the story. Have they cared for people with dementia in the past?

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.

5

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.

6

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

7

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 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.

8

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).

9

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.

10

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.

11

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 facilitates 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.

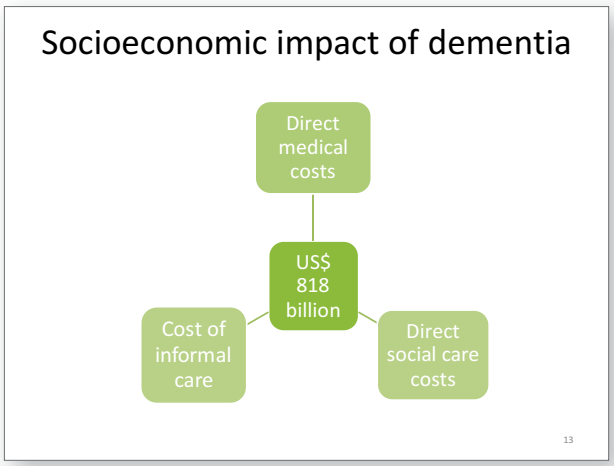
Physical, emotional and economic pressures can cause great stress to families and carers, which has far reaching impacts on the wider society and community.

Support for families of people with dementia is required from the health, social, financial and legal systems.

12

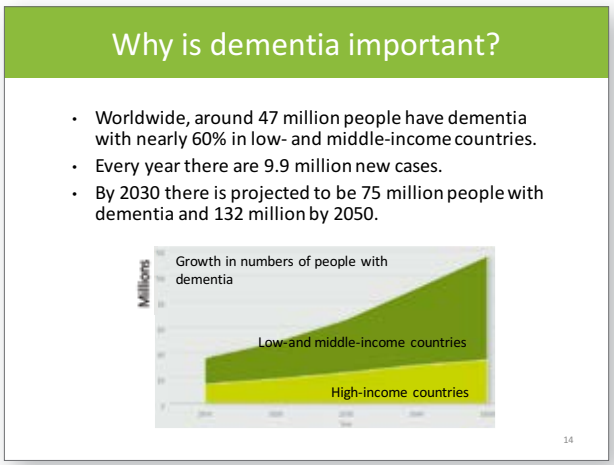
Impact on the carers

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.



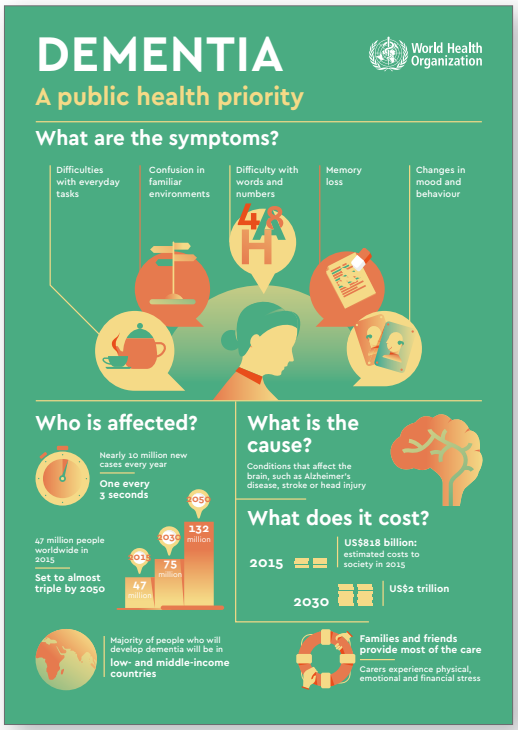
Explain that the socioeconomic impact of dementia is also overwhelming, including:
- direct medical costs
- direct social care costs
- costs of informal care (including carers having to take time off work etc.)

In 2015, the total global societal cost of dementia was estimated to be US$ 818 billion.



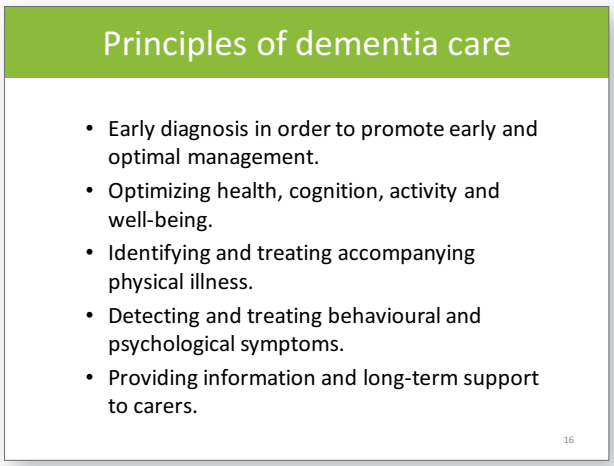
Dementia as a public health concern
Worldwide around 47 million people have dementia. Every year there are 9.9 million new cases.

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 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.



Talk through the points on the slide.

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.

18

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.
  - They way they express their emotions will change.
  - They may have hearing and visual problems as well.

19

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.

20

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)?

21

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

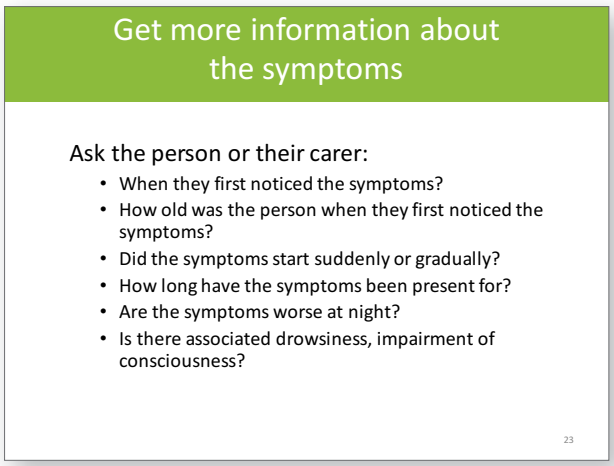
Ask the carer:

- 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 form what they used to do?

22

Ask the group to provide alternative, culturally appropriate, questions.

Make a note of their suggestions.



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.

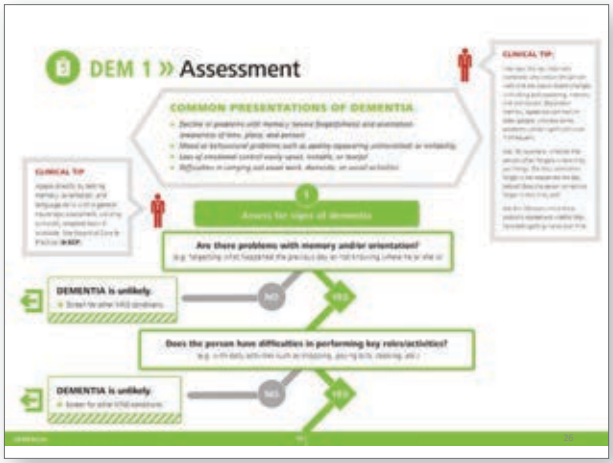
Re-emphasize that dementia is commonly misdiagnosed and therefore requires a thorough assessment.

Ask participants to reflect on why it is important to cover these steps in an assessment?

Activity 3: Video demonstration: Assessing for dementia

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:

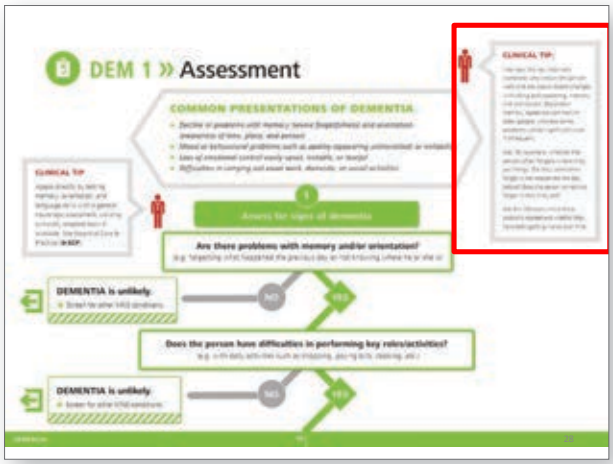
1. Tell them three words (e.g. boat, house, fish) and ask them to repeat after you.
2. Point to their elbow and ask, "What do we call this?"
3. Ask below questions:
   - What do you do with a hammer? *(Acceptable answer: "Drive a nail into something").*
   - Where is the local market/local store?
   - 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?"

27

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.



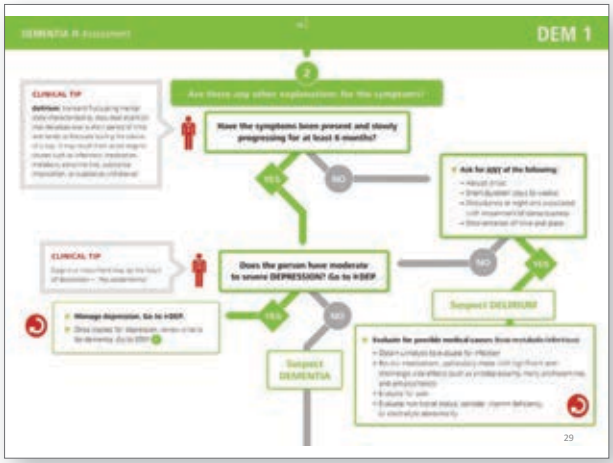
Start at the beginning of the assessment algorithm.

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).

30

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

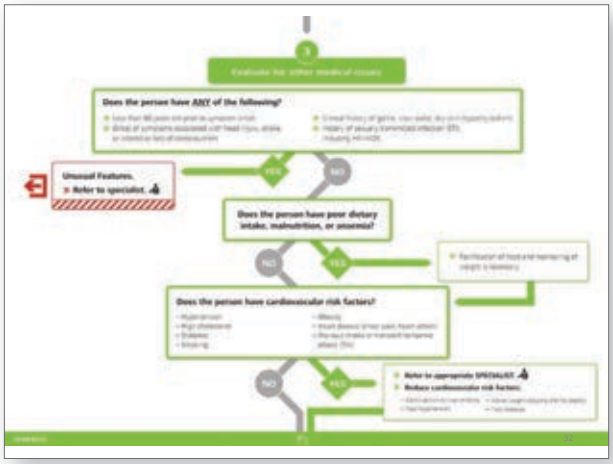
- In older people, depression can sometimes resemble dementia.
- Older people with depression can often be confused, irritable, lose interest and motivation, stop functioning well (be unkempt and neglect personal hygiene) and generally present in ways similar to dementia.
- If you suspect depression then go to the Module: Depression and manage the depression but the person should be re-assed for dementia 12 weeks later.

31

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?

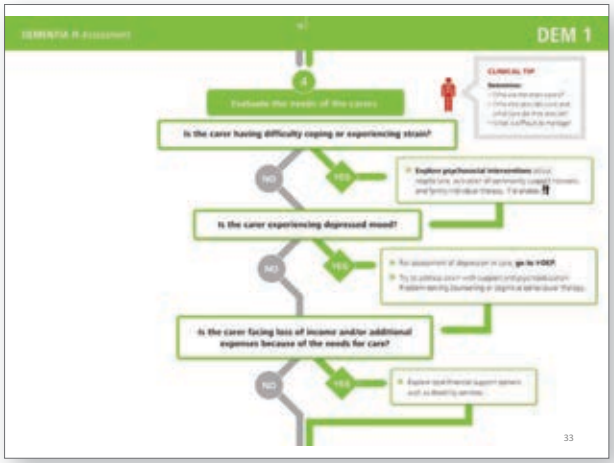
Instruct the participants to read through step 3 of the assessment for dementia.

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.

34

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

- Apathy
- Aggression
- Wandering
- Restlessness
- Eating problems
- Agitation
- Disinhibition
- Pacing
- Screaming
- Hallucinations
- Delusions
- Anxiety
- Uncontrollable emotional outbursts
- These are not usually present at the beginning of dementia

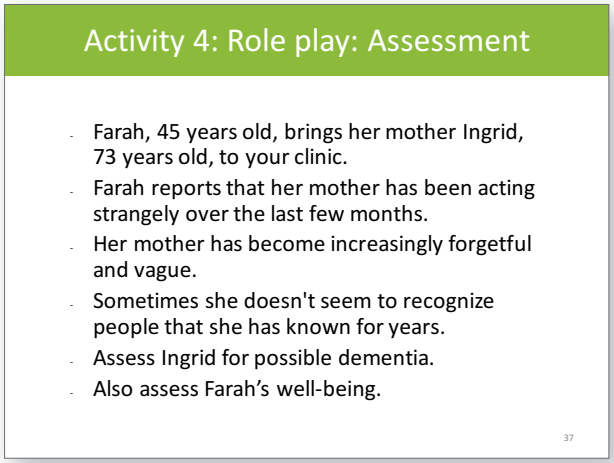
36

Work with the carers to help manage these behaviours and minimize any risks that the behaviour may cause.

Explain that in addition to the symptoms described in the mhGAP-IG, some people may experience apathy, eating problems, disinhibition, pacing and screaming.

Explain that these symptoms are usually seen in later stages of dementia.

Activity 4: Role play: Assessment



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.

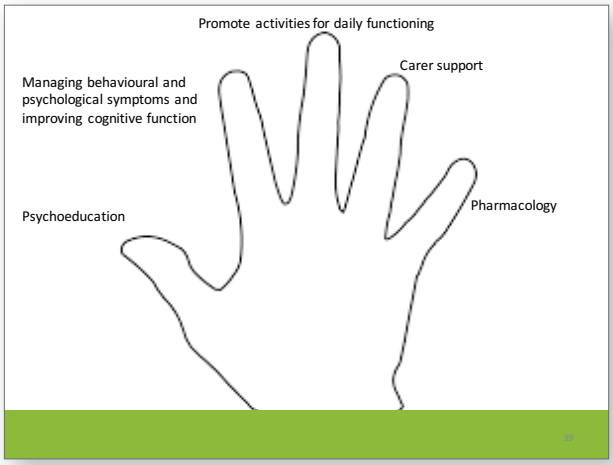
Situation:
- Farah, 45 years old, brings her mother Ingrid, 73 years old, to your clinic.
- Farah reports that her mother has been acting strangely over the last few months.
- Her mother has become increasingly forgetful and vague.
- Sometimes she doesn't seem to recognize people that she has known for 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.

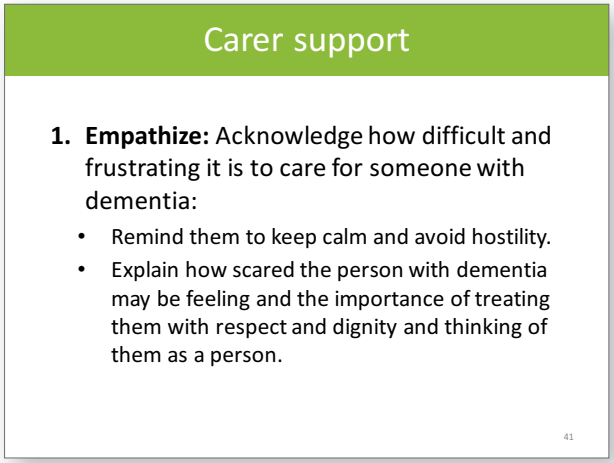
Management interventions should aim to enhance the person's independence as well as ensure that the carer's needs are supported.

Talk through the different protocols.

Emphasize the importance of delivering psychoeducation messages to the person and their carers.

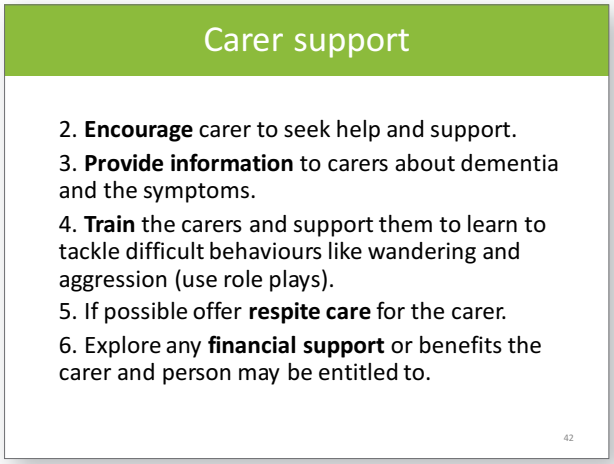
Psychoeducation: Explain the need to tailor and adapt the language when talking to the person with dementia so that they understand and are not overwhelmed.

Carer support: Ensure when delivering management interventions, to focus on the individual with dementia and the carer.



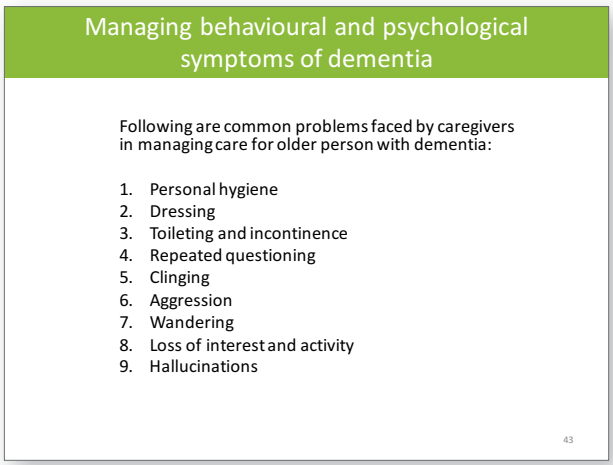
Explain that participants should find the time to see the carer alone.
Offer them support.

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.



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.



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.

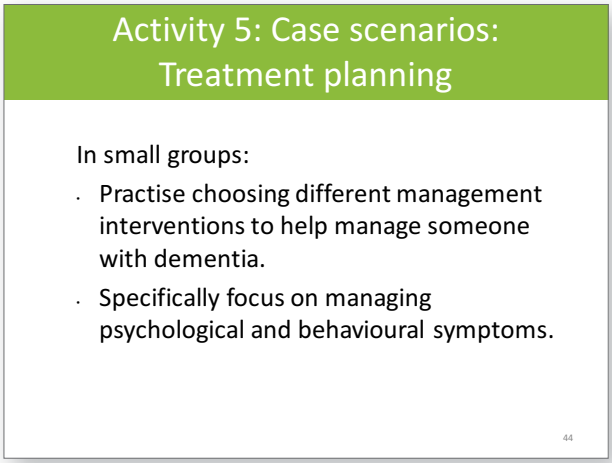
Not paying attention to personal hygiene, dressing, having problems toileting and with incontinence can be embarrassing and undignified for the person with dementia and very distressing for the carer. However, there are psychosocial strategies that can help support a person with dementia take back some 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.

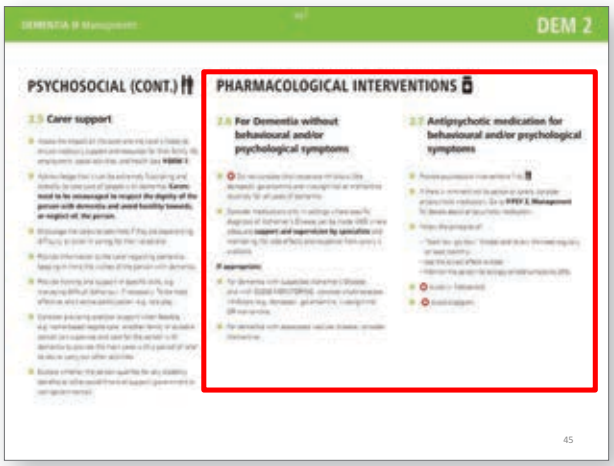
Activity 5: Case scenarios: Treatment planning



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.



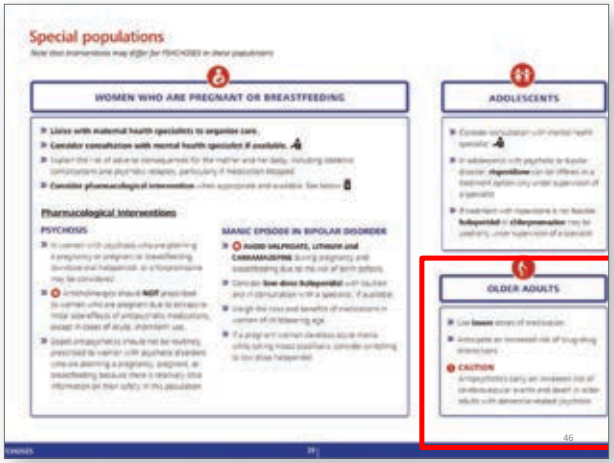
Pharmacological interventions
Emphasize that medication should **not** be routinely considered for all cases of dementia.

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.

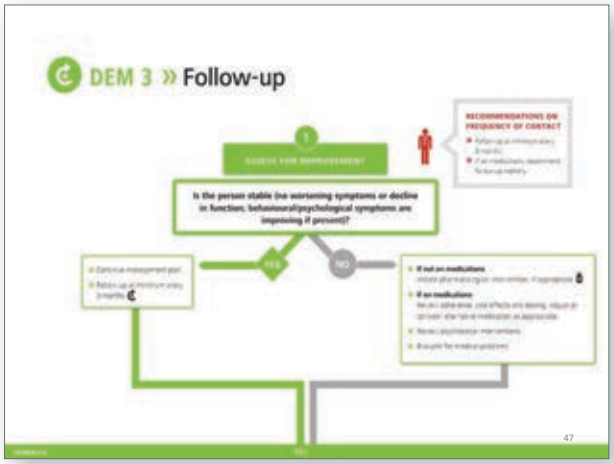


Explain that the behavioural and psychological symptoms can be very distressing for the person and the carer but that mhGAP recommends psychosocial interventions as the first-line treatment option, **not** pharmacological interventions.

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.

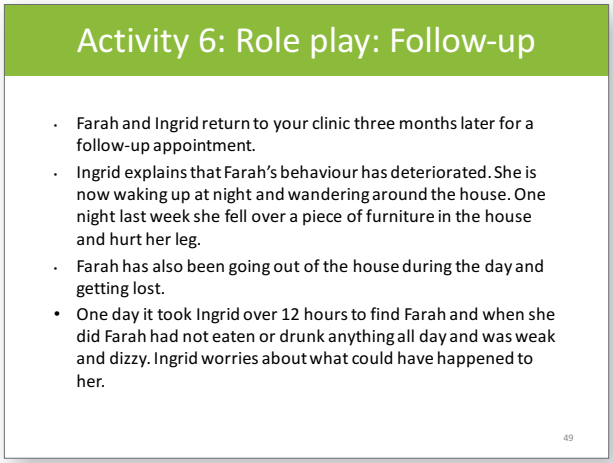
Have a different volunteer read out steps 2 and 3 of the follow-up algorithm.

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



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

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

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	Know the common presentations of disorders due to substance use Know the impact of disorders due to substance use of individuals and the family Understand the importance of managing substance use in primary health-care settings Promote respect and dignity for people with disorders due to substance use	30 minutes 20 minutes 60 minutes	**Activity 1: Group brainstorm: What substances?** Group brainstorm about different psychoactive substances **Activity 2: Person's story followed by group discussion** Use a person's story to introduce disorders due to substance use **Presentation to supplement person's story** Use the story as a basis for discussions on: • Common presentations of substance use • Impact of substance use on individuals and families • Why substance use is a public health priority • Role of primary health care
2. Assessment of disorders due to substance use	Perform an assessment for disorders due to substance use Assess and manage physical health in disorders due to substance use Use effective communication skills Refer to specialists and link with outside agencies for people with disorders due to alcohol use	40 minutes 30 minutes	**Activity 3: Video demonstration: Assessment** Use videos/demonstration role play to show an assessment and allow participants to discuss the principles of assessment, including when to refer **Activity 4: Role play: Assessing substance use** Feedback and reflection
3. Management 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	45 minutes 30 minutes 45 minutes	**Presentation on the principles of managing disorders due to substances** **Activity 5: Video demonstration: Motivational interviewing** **Activity 6: Role play: Motivational interviewing** Practise using motivational interviewing **Activity 7: Group work: Understanding the role of pharmacology in substance use disorders**
4. Follow-up	Plan and perform follow-up for people with disorders due to substance use	10 minutes	**Presentation on principles of follow-up**
5. Emergency presentations	Perform assessment and management of emergency presentations including when to refer	30 minutes	**Activity 8: Role play: Assessing and managing emergency presentations**
6. Review	Review the information and skills taught during the training	15 minutes	**Multiple choice questions and discussion**
Total duration (without breaks) = 5 hours 55 minutes			

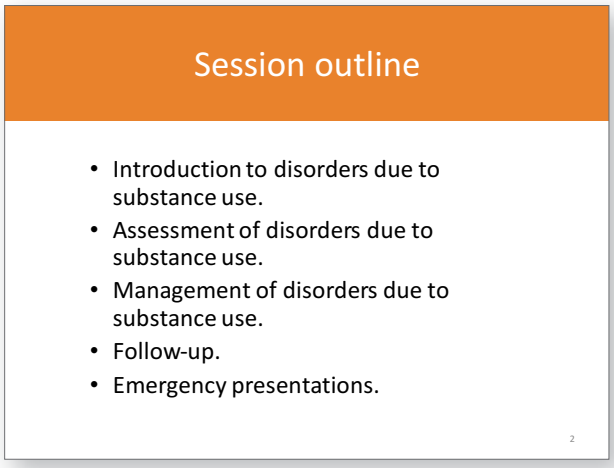
Step-by-step facilitator's guide

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



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

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?

3

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.

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 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.

© http://www.serenityranch.ca/blog/bid/79580/Benzodiazepines-are-they-safe-Serenity-Ranch

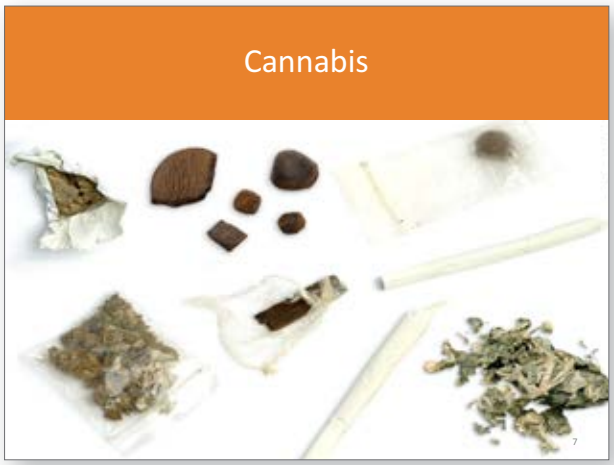
Benzodiazepines
Explain that this is an example image of what benzodiazepines may look like. However, there are many formulations that may not look like these.

Benzodiazepines are tranquillizers 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.



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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.

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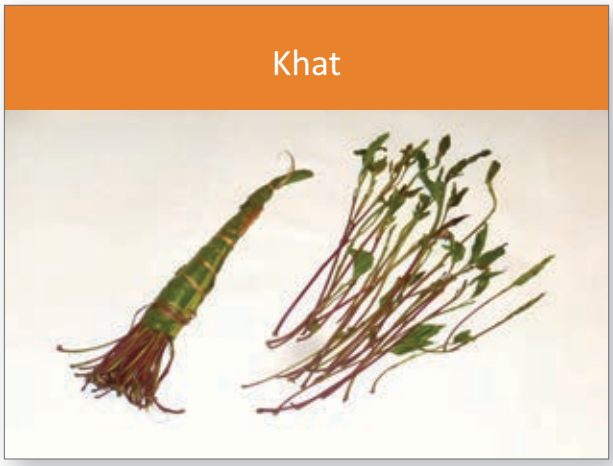
Stimulants
Stimulants include: amphetamines, cocaine, speed, crystal meth.

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.



© 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.

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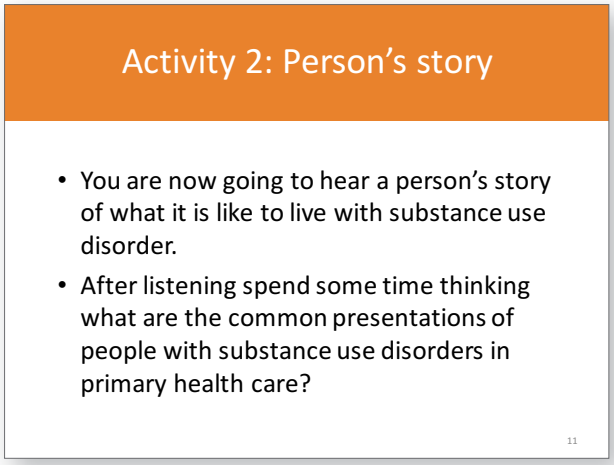
Tobacco
Explain that tobacco comes from the leaves of the tobacco plants and is mixed with other chemicals such as nicotine.

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.

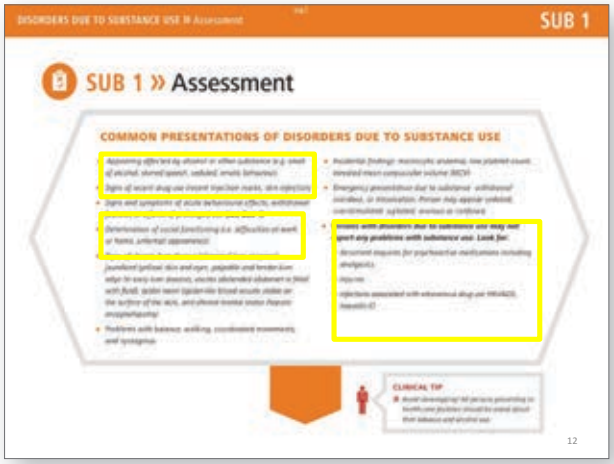
Activity 2: Person's story followed by group discussion



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.



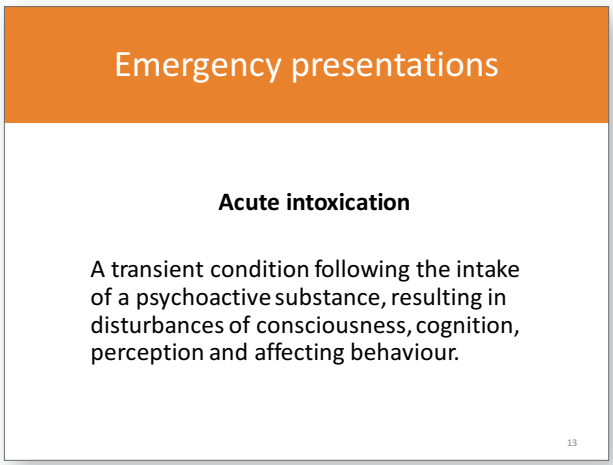
Direct participants to the common presentations described on page 114 mhGAP-IG Version 2.0 and in the master chart (disorders due to substance use).

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.

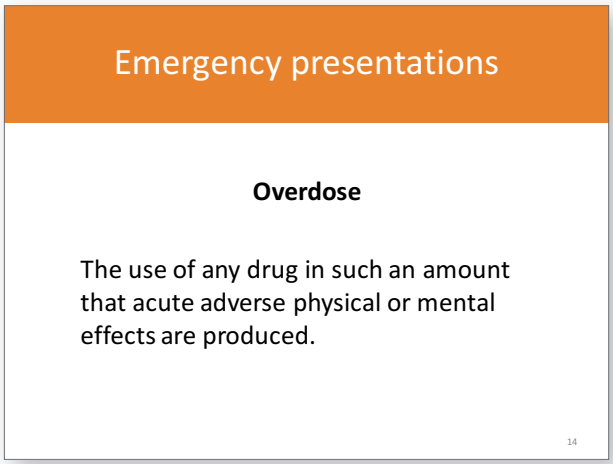
- People will present with physical health problems: liver disease, gastrointestinal problems, aches and pains.
- People will present with deterioration in their social functioning and often having many social problems – with work, school, in their studies, with their family and relationships.
- Often, 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 whist 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.



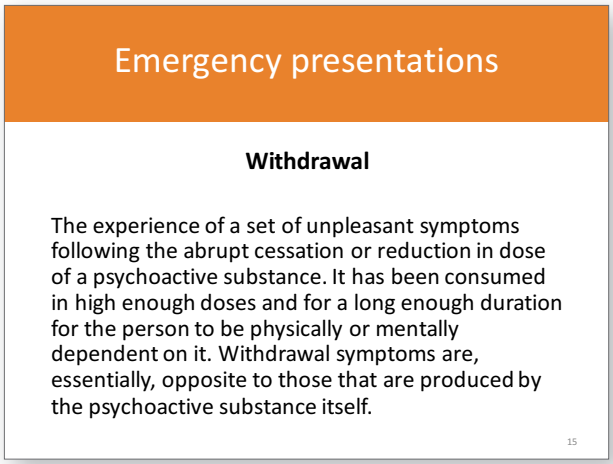
Explain that one emergency presentation is **acute intoxication**.

Ask participants for a definition of what we mean by acute intoxication before revealing the answer.



A second emergency presentation is **overdose**.

Ask participants for a definition of an overdose before revealing the answer.



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.

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.

16

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.

17

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 if often associated with social consequences, e.g. family or work problems.

18

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.

19

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.

20

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

- Intoxicating effects
- Toxic effects
- Immunosuppressant effects
- Teratogenic effects
- Accidents, injuries
- Liver fibrosis
- Brain injury
- Cancer
- Infections including HIV/AIDS and hepatitis C
- Hypertension/stroke
- Fetal alcohol syndrome
- Dependence/addiction
- Depression, psychosis

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

Familial breakdown
Problems/violence between spouses

Neglect of children
Leading to malnourishment, delayed development, abuse, violence

Poverty
Loss of income through missed employment, cost of substance use

Children

Familial breakdown
Parents fighting, disowning child

Loss of opportunities
Dropping out of school, employment, parents unable to work

Risk of criminal activity
Stealing from parents to pay for substances

22

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.

23

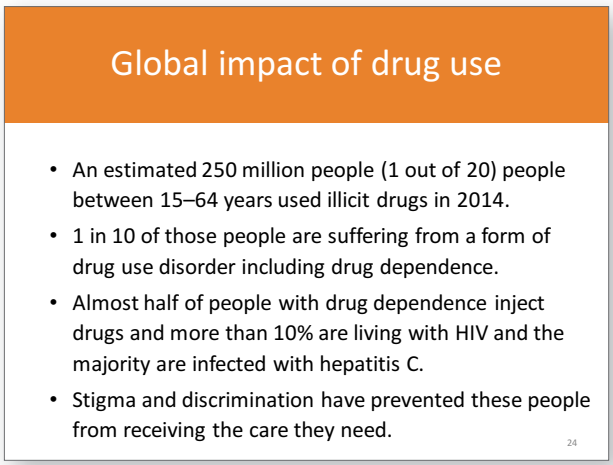
Talk through the statistics on the slide explaining that alcohol is widely used in many cultures. The harmful use of alcohol causes a large disease, social and economic burden in societies.

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.

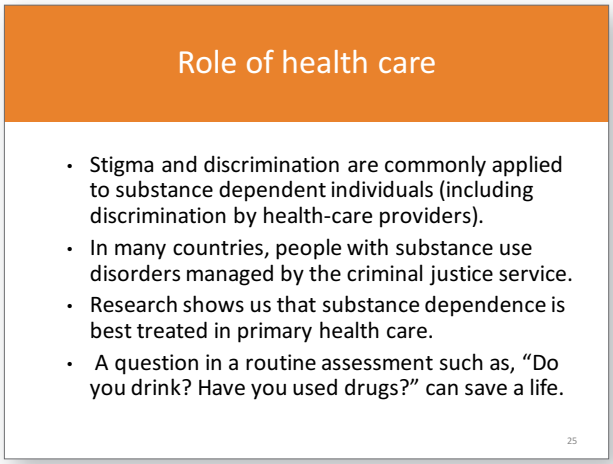
The level and severity of alcohol related harm is influenced by the quantity of alcohol available in a country, and, in some cases, the quality of that alcohol.



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 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.

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.

27

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.

Talk through the types of investigations that could be considered and why.

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 appoints to build trust.

29

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.

SUB

Activity 3: Video demonstration: Assessment

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.

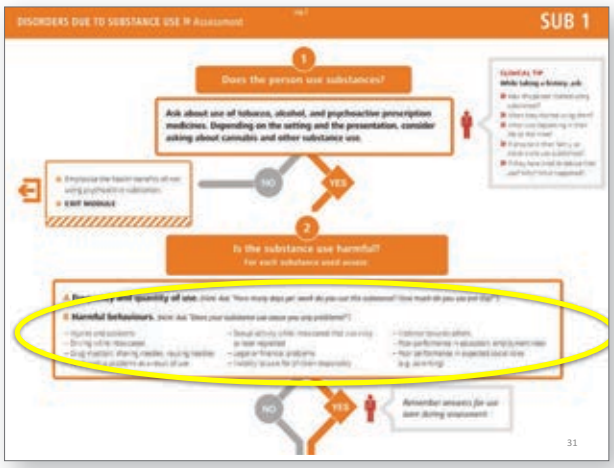
mhGAP SUB module (cannabis) assessment: https://www.youtube.com/watch?v=sccCxFfMGzk&index=13&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v.

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:

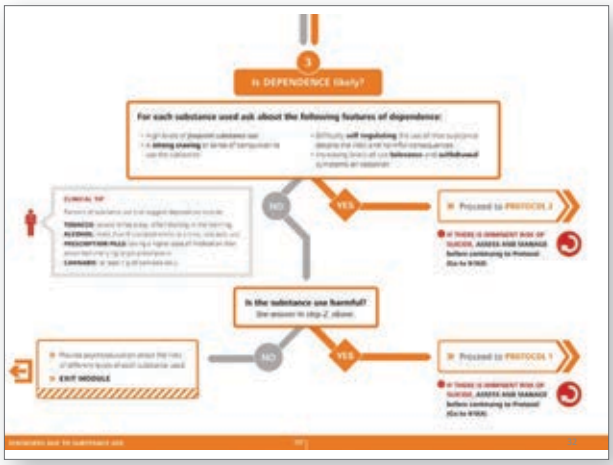
1. Discuss how the health-care provider established whether the person uses substances?

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**:
   a. How many days per week does the person use the substance? How much do you use per day?
   b. 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.



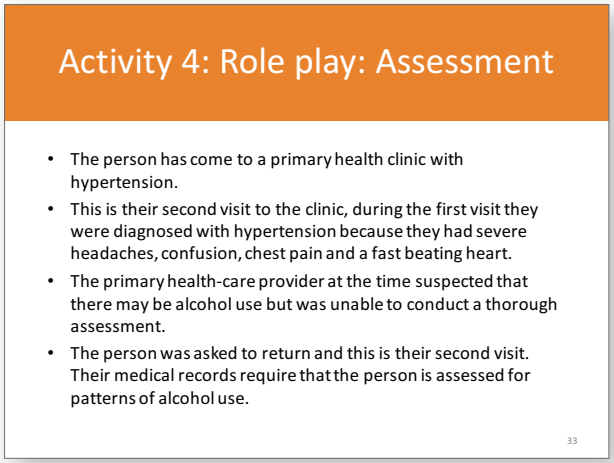
Once you have gathered this information the next step is to establish if dependence is likely.

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



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.

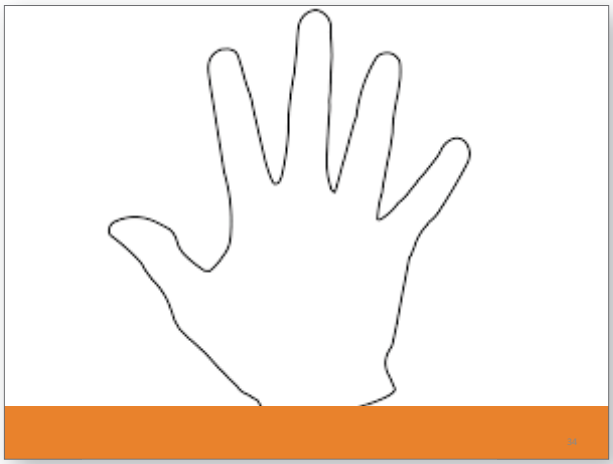
Situation:
The person has come to a primary health clinic with hypertension. This is their second visit to the clinic. During the first visit they were diagnosed with hypertension because they had severe headaches, confusion, chest pain and a fast beating heart. The primary health-care provider at the 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.

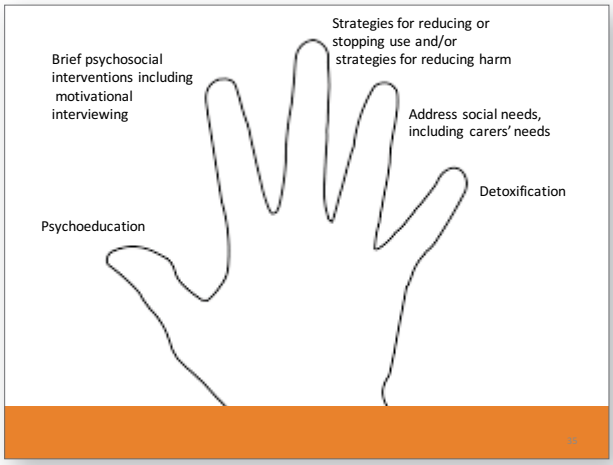
Note: The clinical scenario and notes below are only an example. In the supporting material there are other assessment role plays that involve someone being assessed for their drug use. Please use those if alcohol is not a problem substance in your country.

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?

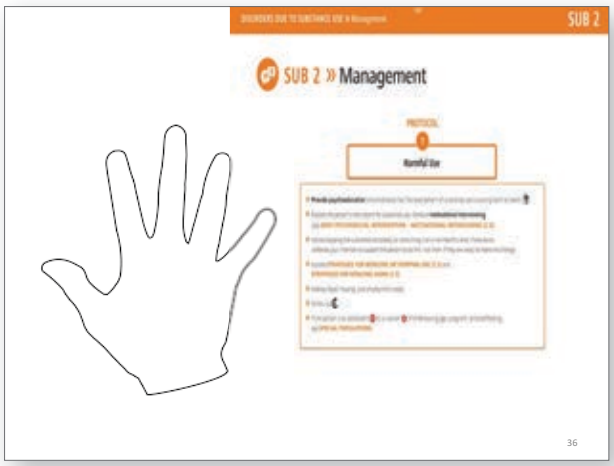


Explain the management options available and emphasize that the success of any intervention is dependent on how willing the person is to change and/or reduce and stop their consumption of substances.

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.



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.

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.

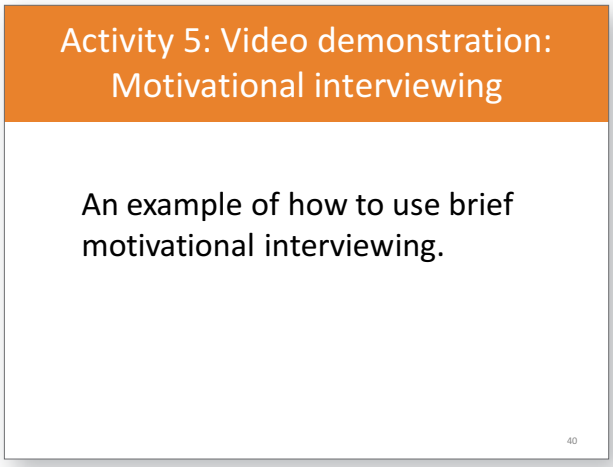
Give the participants time to read through the psychoeducation interventions and motivational interviewing (page 123).

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 believes 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



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

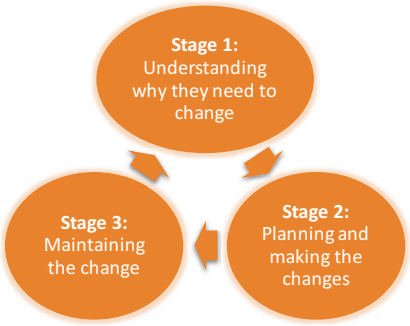
- The aim of motivational interviewing is to empower and motivate individuals to take responsibility and change their substance use behaviour.
- It can be used as a way of supporting and motivating people to travel through the different stages of change.

41

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



42

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.

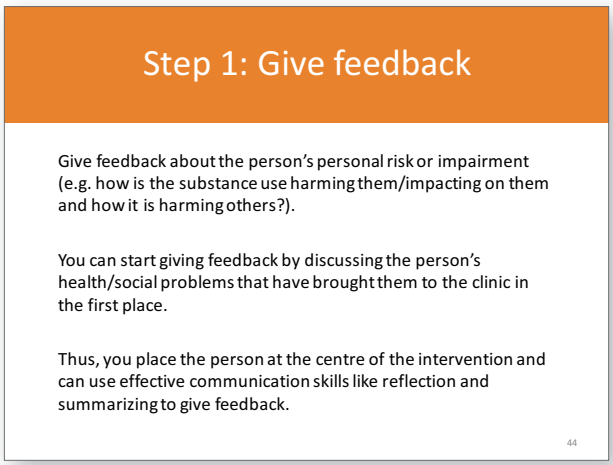
43

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.

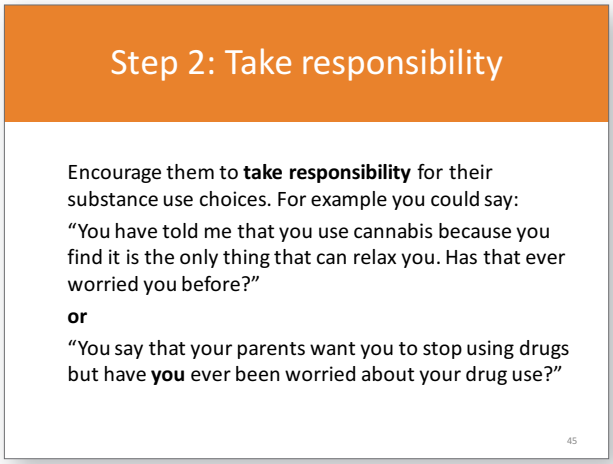


Step 1: Explain that initially the health-care provider will introduce the issue of substance use in the context of the person's health and well-being or in the context of the problem that brought them to the clinic in the first place.

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.

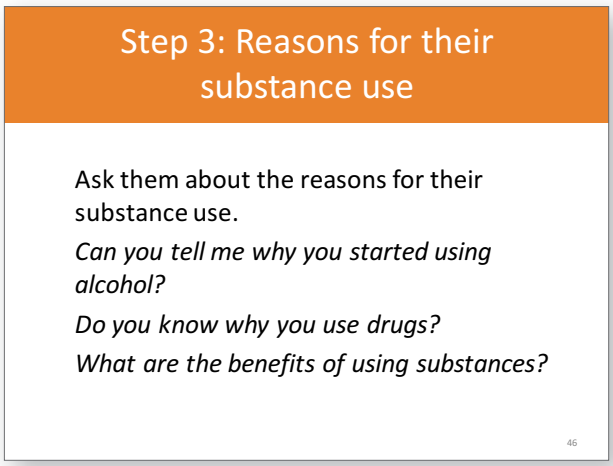


Step 2: Encourage the person to start taking responsibility for their substance use choices.

This includes their choice to engage with treatment or not.

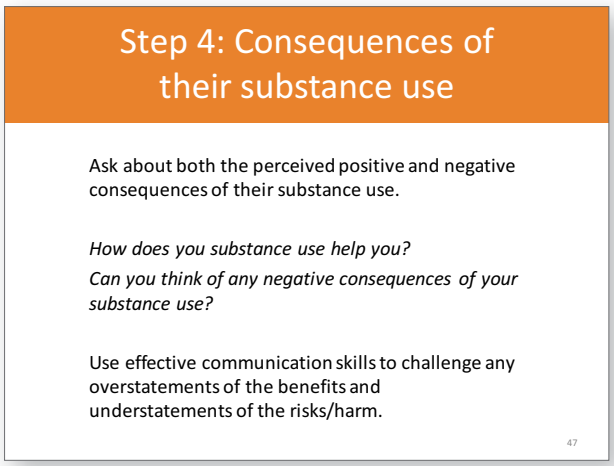
Taking responsibility is the first step in the person accepting that there is something in their life that they want to change.

Talk through the examples given on the slide.

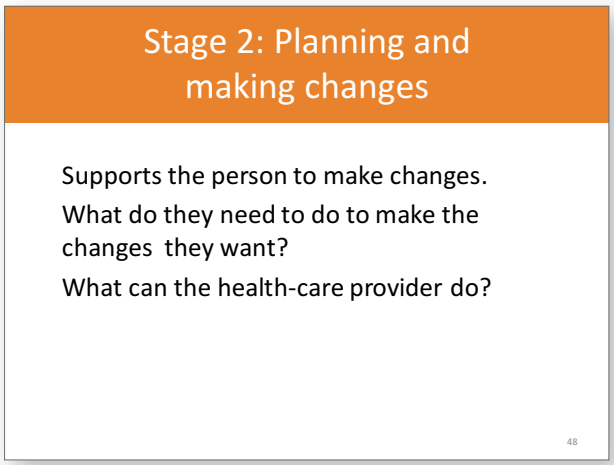


Step 3: If the person recognizes that they use substances as a response to other priority MNS conditions and or psychosocial stressors in their life, then continue to explore why they use substances in a response to those. What does the substance do? How does it help them? What are the perceived benefits of substance use?

Talk through the examples on the slide.



Step 4: 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.)?

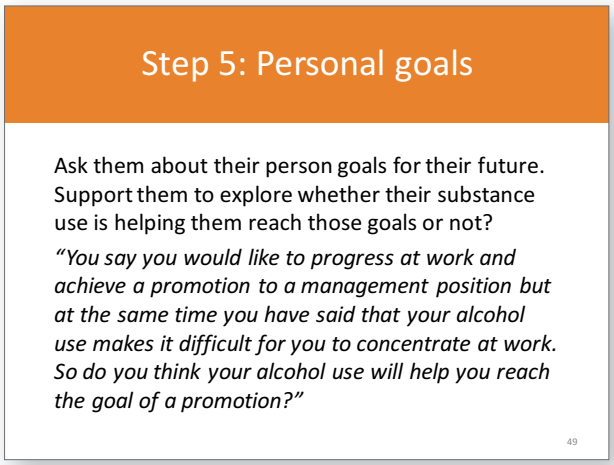


Stage 2
Explain that once the person has decided to make a change then we move to stage 2, which involves supporting the person to plan and to make the changes they need to.

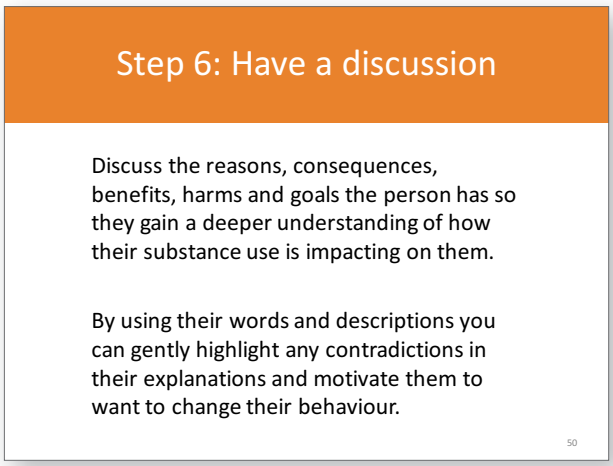
Help them set realistic goals and targets. Keep them motivated to make those changes.

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.

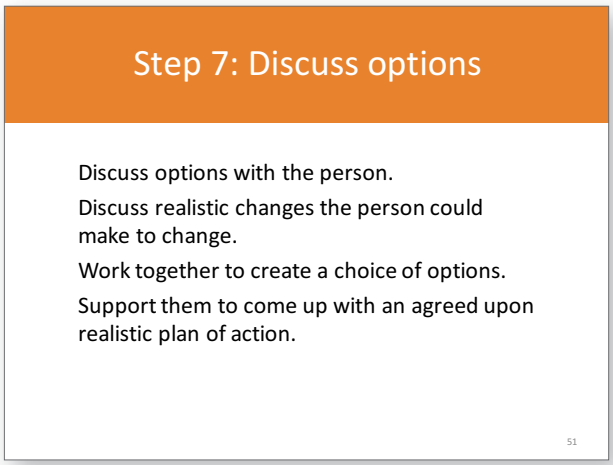


Step 5: Explain the points on the slide.



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.

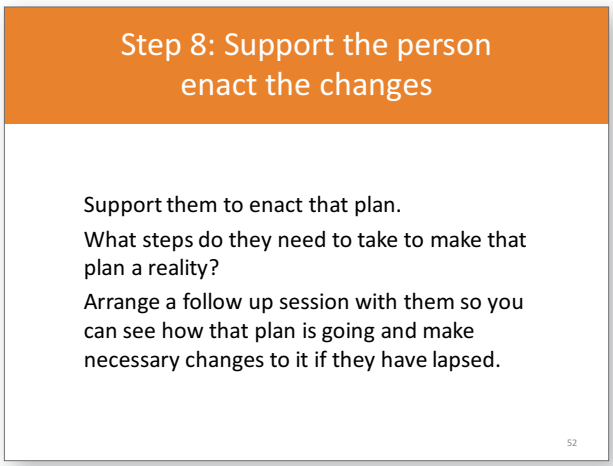
By using their words and their descriptions you can gently highlight any contradictions in their explanations and motivate them to want to change their behaviour.



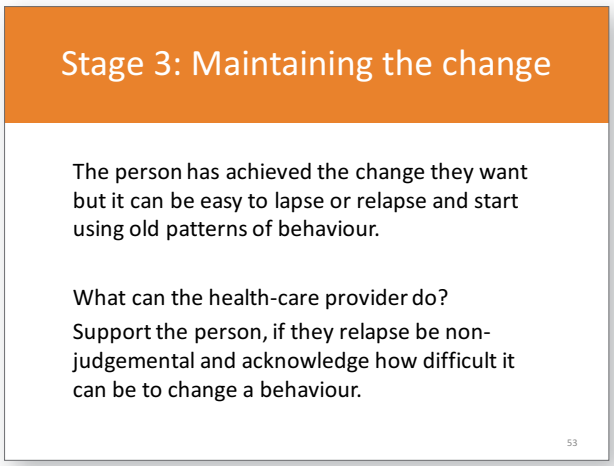
Step 7: If someone is very motivated and enthusiastic to change they can easily state that they are going to make some unrealistic changes. For example, a person with a dependence on alcohol explaining that they will just stop drinking for good the next day.

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.



Step 8: Explain the points on the slide.



Stage 3

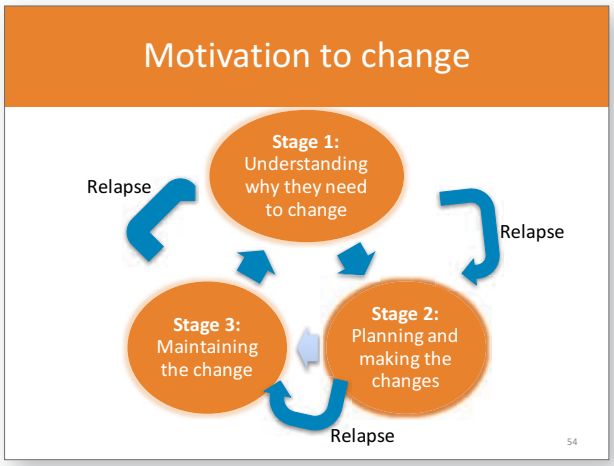
Explain that once the person has planned and implemented the changes they want, the final stage is maintaining the change.

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.

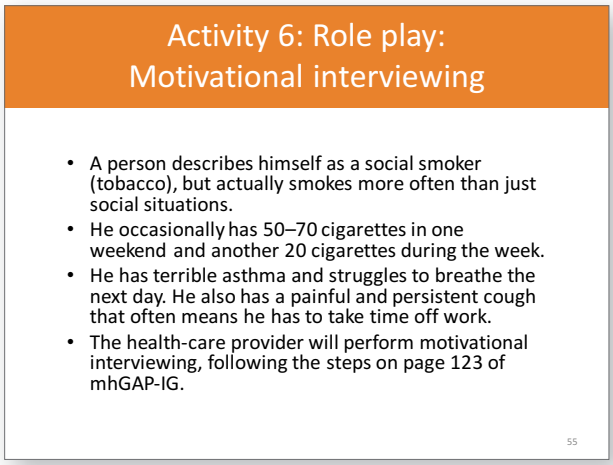


Describe again that relapse can happen at any stage, but if a person does fully relapse (i.e. they go back for a long period of time to their old behaviour and pattern of substance use) they will need to go back to stage 1 if they want to start making the changes again.

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



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.

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.

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.

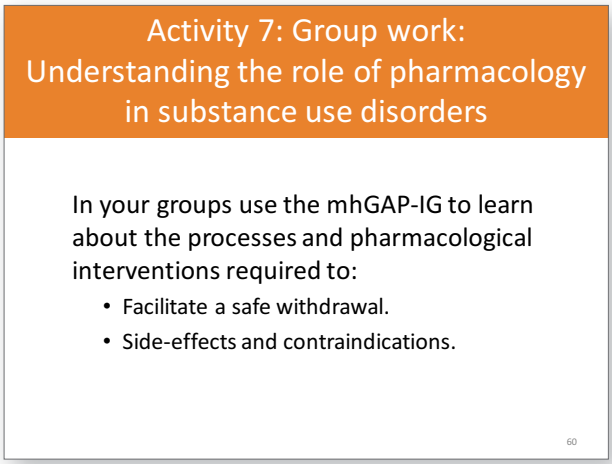
Assess the immediate needs of the family members including their health, mental health and social needs. If possible, try to meet those needs or link carers and families with other organizations that can meet those needs.

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



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.

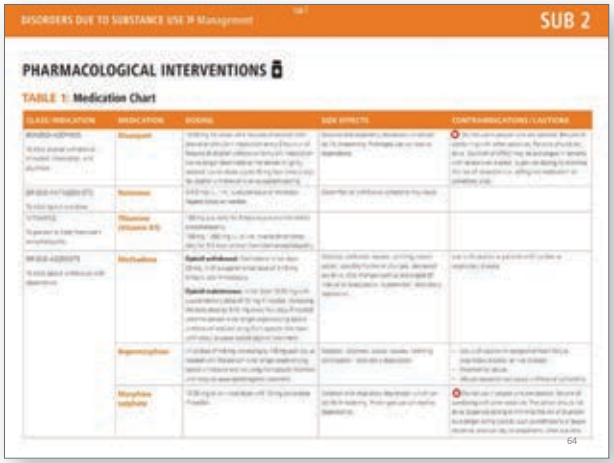
If necessary use these slides to talk through the different protocols and make sure that the participants understand how to support a planned withdrawal and which pharmacological interventions to use and when.

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.

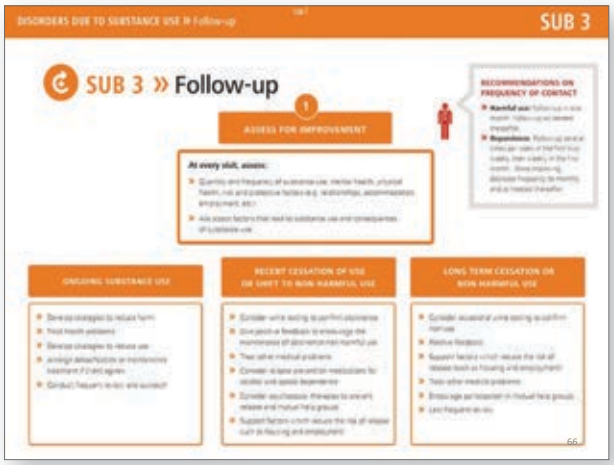
Emphasize the importance of understanding which medications should be used in which intervention.

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.

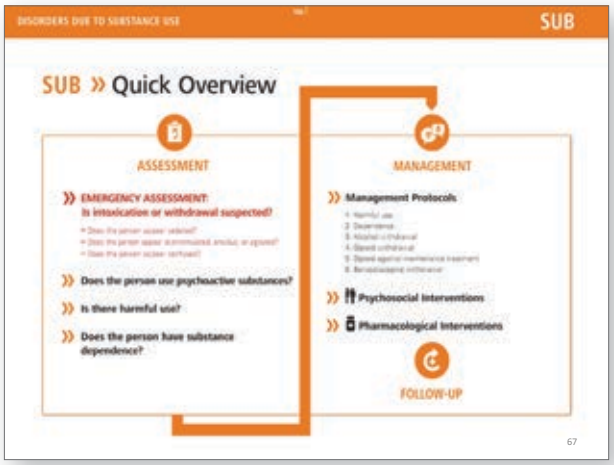
Changing a person's relationship with a substance requires a daily level of commitment and determination, as it can mean a person changing their normal behaviours. For example, someone may have decided not to mix with a certain social group. They may decide to avoid places, social occasions, activities 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

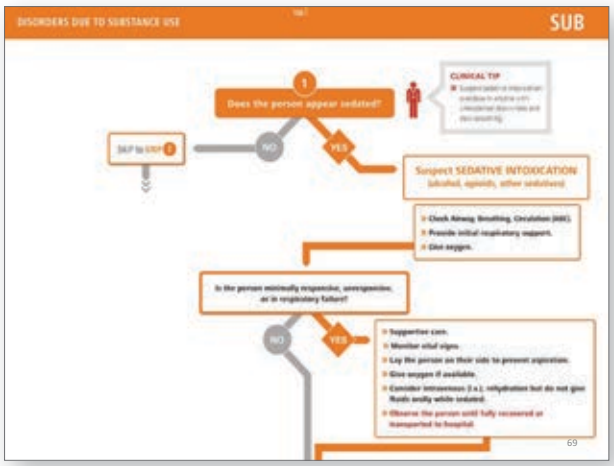


Explain that the principles of conducting an emergency presentation:

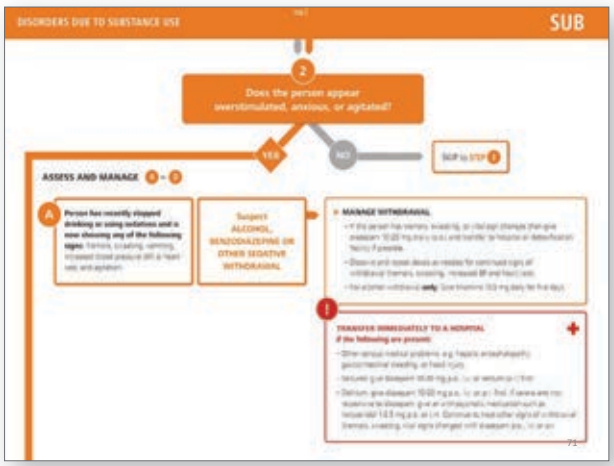
- Does the person appear sedated?
- Does the person appear overstimulated, anxious or agitated?
- Does the person appear confused?

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.



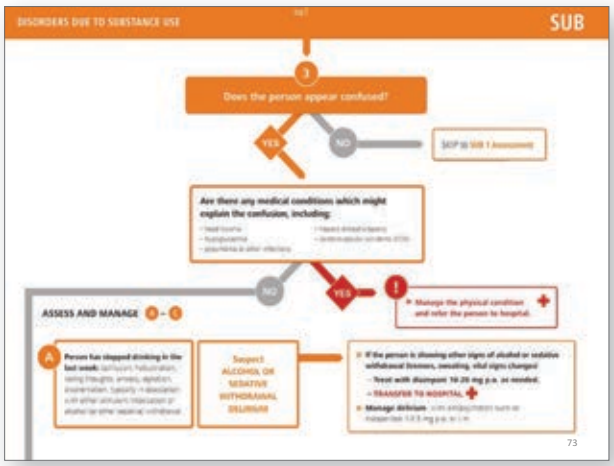
Does the person appear sedated?
Talk through the steps in the algorithm describing what to do if a person is sedated.



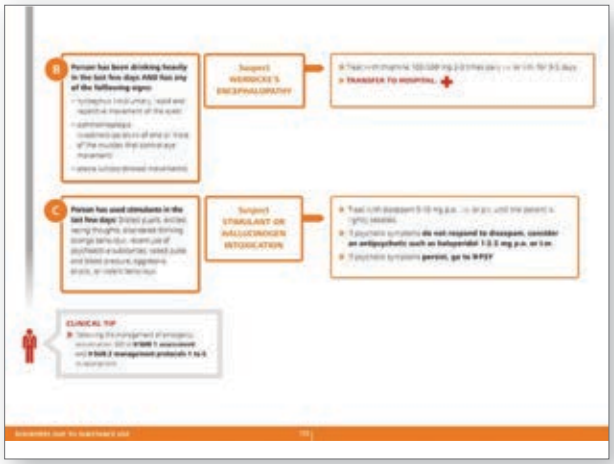
Does the person appear overstimulated, anxious or agitated?
Talk through the steps describing what to do to assess someone who presents in a state of overstimulation, anxiety or agitation.

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.

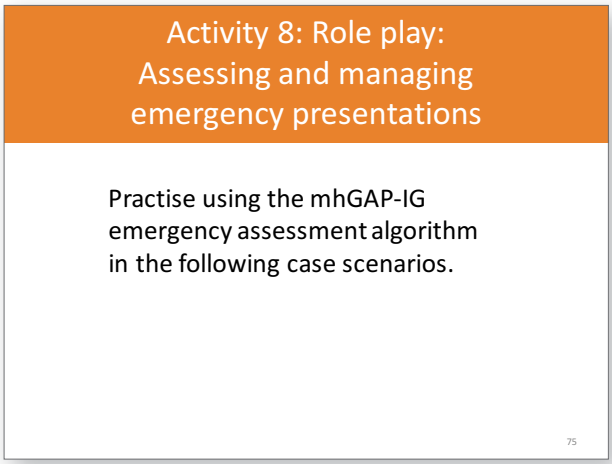
If the person has presented by themselves then ask if other people in the area know them.

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



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

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

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	Know the common presentations of self-harm/ suicide Promote respect and dignity for people with self-harm/ suicide	40 minutes	**Activity 1: Person stories followed by group discussion** Use the person stories to introduce self-harm/suicide **Presentation to supplement first person accounts discussion** Use the person stories as a basis for discussions on: • Common presentations of self-harm/ suicide • Risk factors • Why it is important to learn how to manage self-harm/suicide in non-specialized health settings
2. Assessment of self-harm/suicide	Know the principles of assessment of self-harm/ suicide Perform assessments for self-harm/suicide Assess and manage co-morbid physical health in self-harm/ suicide Assess and manage emergency presentations of self-harm/suicide Refer to specialists and links to outside agencies for self-harm/suicide, as appropriate	40 minutes 30 minutes	**Activity 2: Video demonstration: Assessment** 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 **Activity 3: Role play: Assessment** How to assess someone for self-harm/suicide
3. Management of self- harm/ suicide	Know the management principles of self-harm/suicide Provide psychosocial interventions to a person with self-harm/suicide	30 minutes 30 minutes	**Presentation on psychosocial interventions and brief group discussion** **Activity 4: Role play: Management interventions**
4. Follow-up	Offer follow-up for self-harm/ suicide, as appropriate	40 minutes	**Activity 5: Role play: Follow-up**
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.

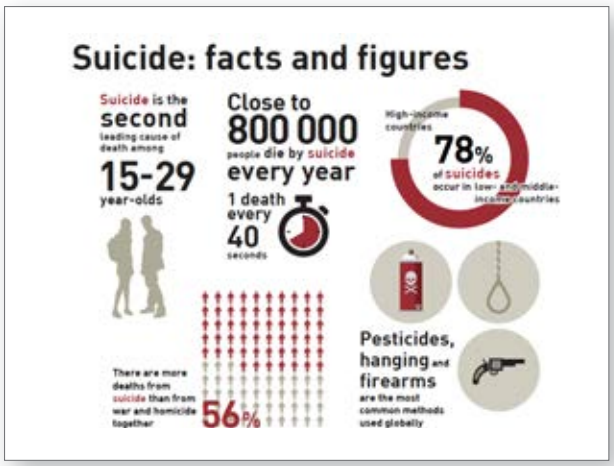
Activity 1: Person stories followed by group discussion

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.

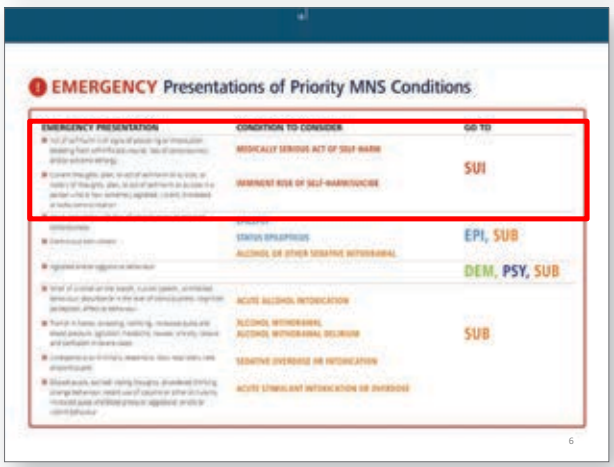
Some 78% of global suicides occurred in low- and middle-income countries in 2015.

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:

1. As an emergency presentation of self-harm/suicide.
2. 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.

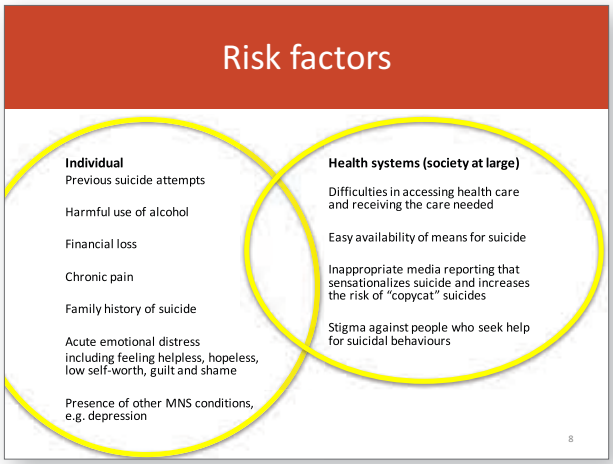
Assessing someone with thoughts, plans or acts of self-harm/suicide requires that you explore:
- any plans
- risk factors
- protective factors.

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.)

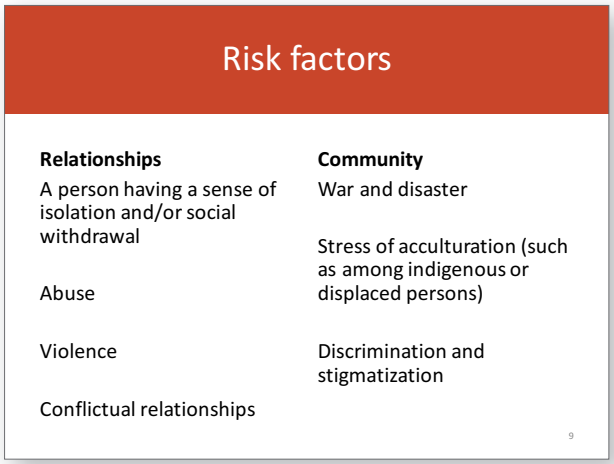
Ask the group to reflect on why these may be risk factors.

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?

SUI

- 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.)

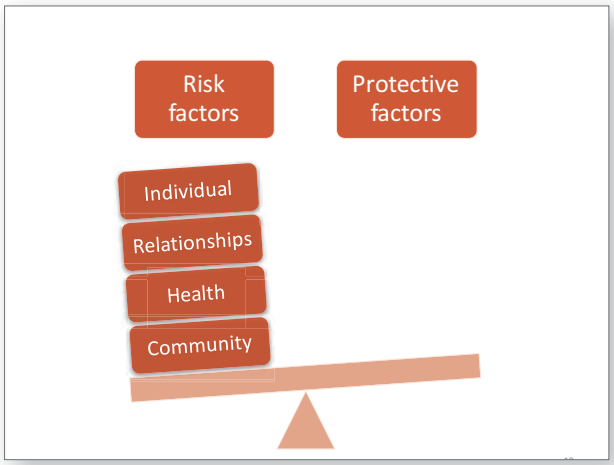


Explain that relationship problems are a risk factor for self-harm/suicide including:
- a sense of isolation
- abuse
- violence
- fights/conflicts.

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.

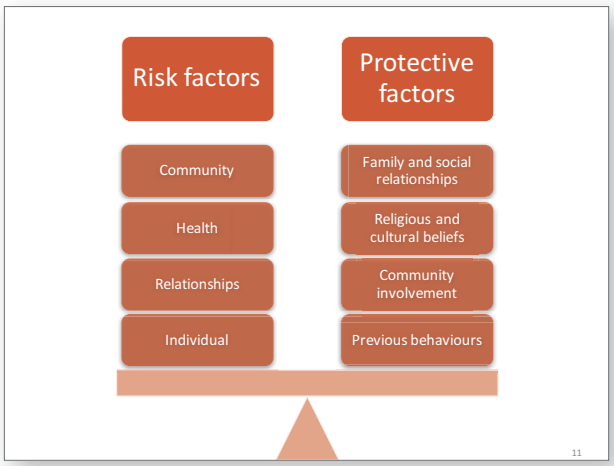


Explain that if risk factors increase, the risk of self-harm/suicide increases.

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

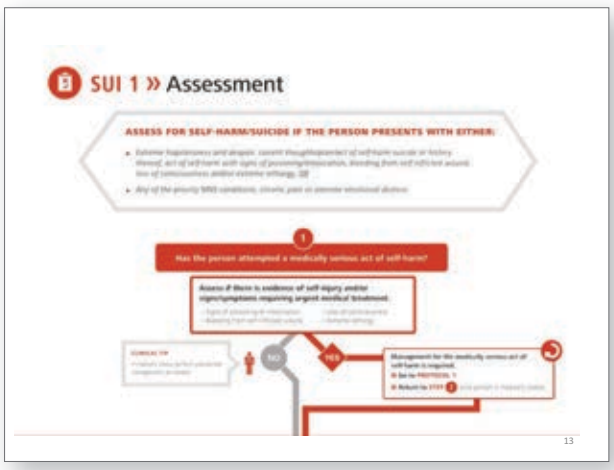
Activity 2: Video demonstration: Assessment

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=4gKIeWfGIEI&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.

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.

15

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).

16

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.

17

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.

18

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.

19

Talk through the minimum set of skills and resources as described on the slide.

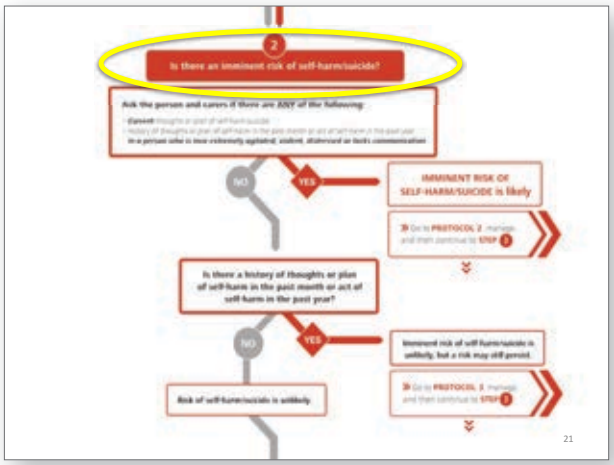
Stress that if the health-care facility/ provider does not have ALL FOUR of these resources, then the person should be transferred to a facility with these minimum resources immediately.

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.

20

Stress the importance of avoiding the actions displayed in the slide.



21

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?*

22

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.

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?

23

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?

24

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

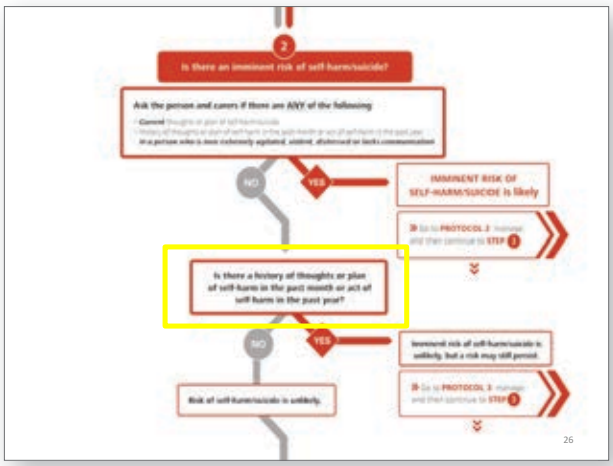
- What are some of the aspects of your life that make it worth living?
- How have you coped before when you were under similar stress?
- What has helped you in the past?
- Who can you turn to for help? Who will listen to you? Who do you feel supported by?
- What changes in your circumstances will change your mind about killing yourself?

25

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.

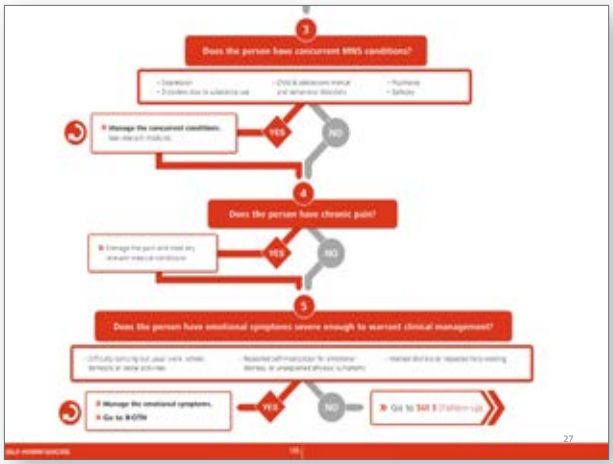
Continue with the assessment algorithm.



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?

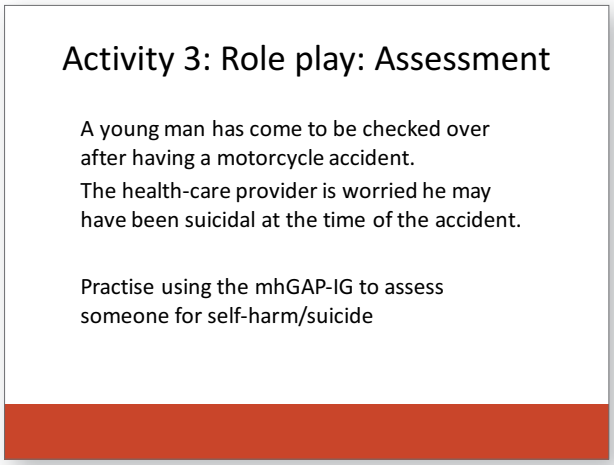


Emphasize that while assessing for suicide, it is essential to assess for:

- 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



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.

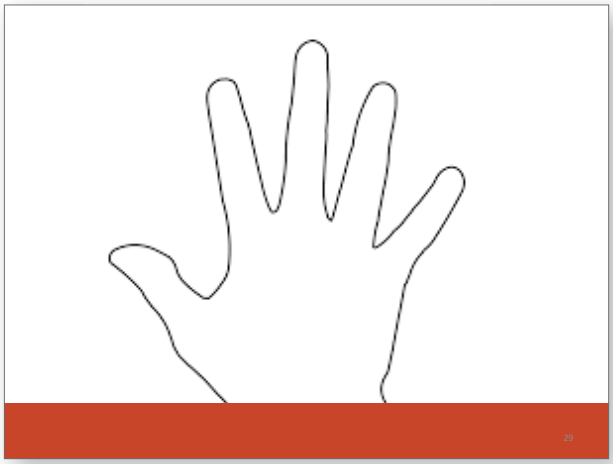
Purpose: This role play gives participants an opportunity to practise using the mhGAP-IG to assess for possible self-harm/suicide.

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.

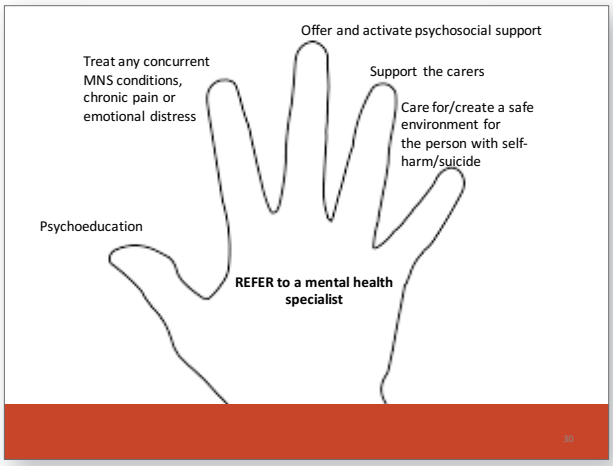
Instructions:
- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the 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.

31

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.

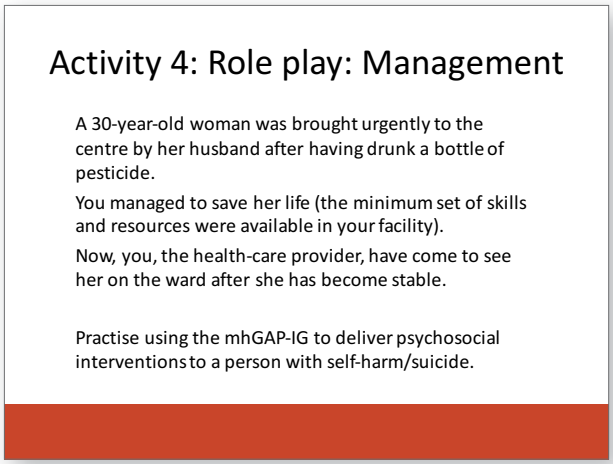
Remind participants to involve carers, where possible, in the assessment and management of the person with self-harm/ suicide.

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



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.

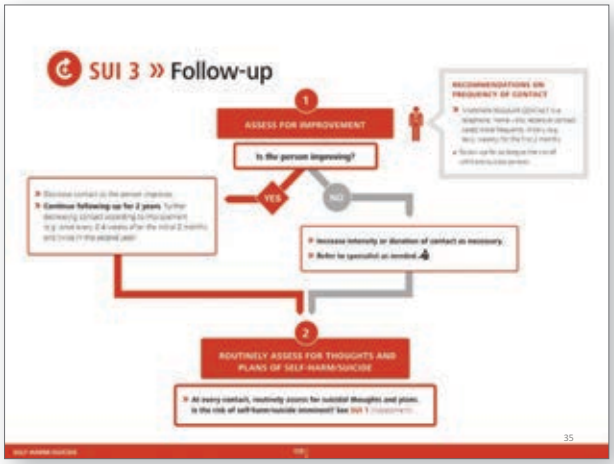
Purpose: This role play gives participants an opportunity to practise using the mhGAP-IG to manage self-harm/suicide with psychosocial interventions.

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

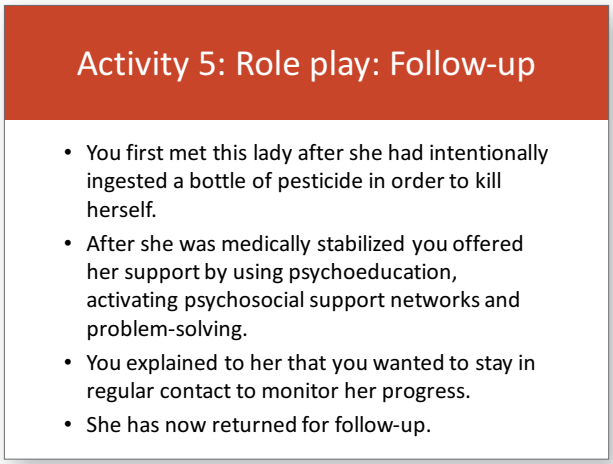
A 25-year-old woman sees you in a clinic. She is very upset and tearful. She explains that she is scared because she is fighting with her mother all the time, who demands that she gets married to a man that she does not love.

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



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

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=4gKIeWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v

Supporting material available online at:
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

OTH

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

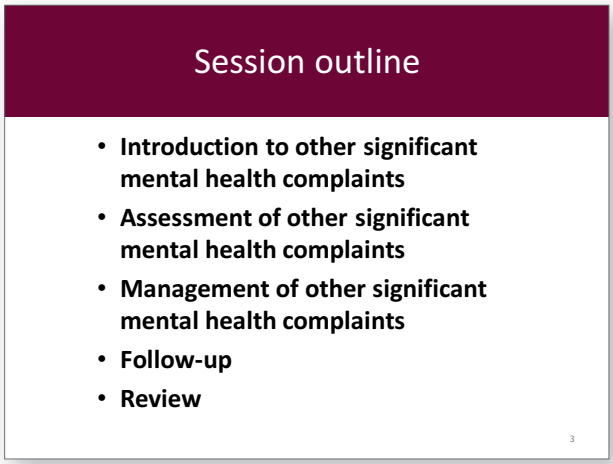
- Common presentations of other significant mental health complaints include: depressed mood, irritability, anxiety, stress, extreme tiredness, unexplained physical complaints.
- Other significant mental health complaints are frequently seen in non-specialized health settings, but are often treated inappropriately, 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 complains, 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	**Presentation on other significant mental health complaints** Use case studies to present common presentations of depression symptoms not amounting to depression, stress/PTSD, grief and medically unexplained symptoms **Reflection** 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 **Activity 1: Discussion: What is violence?** Reflect on types of violence. **Activity 2: Discussion: Stressors through the life course** 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 manages physical health in other significant mental health complaints	10 minutes 20 minutes 30 minutes	**Activity 3: Communication skills: Dos and don'ts** How to communicate with people with other significant mental health complaints **Activity 4: Video demonstration: Assessment** Use videos/demonstration role play to show an assessment and allow participants to note the principles of assessment (all aspects covered) **Activity 5: Role play: Assessment after exposure to extreme stressors**
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	**Presentation on management of other significant mental health complaints** **Activity 6: Addressing psychosocial stressors** Enable participants to practise using a brief problem solving strategy **Activity 7: Relaxation and stress management** Either in plenary or small groups practise different breathing and relaxation techniques **Activity 8: Role play: Assessment and management** Feedback and reflection
4. Follow-up	Plan and perform follow up for other significant mental health complaints	10 minutes	**Brief presentation and brainstorm on follow-up principles and activities**
5. Review		15 minutes	**Multiple choice questions and discussion**
Total duration (without breaks) = 4 hours 30 minutes			

Session 1.
Introduction to other significant mental health complaints

1 hour 35 minutes

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.



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.

4

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.

5

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.

6

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.

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?

7

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
  - Behavoiural 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)

8

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.

9

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

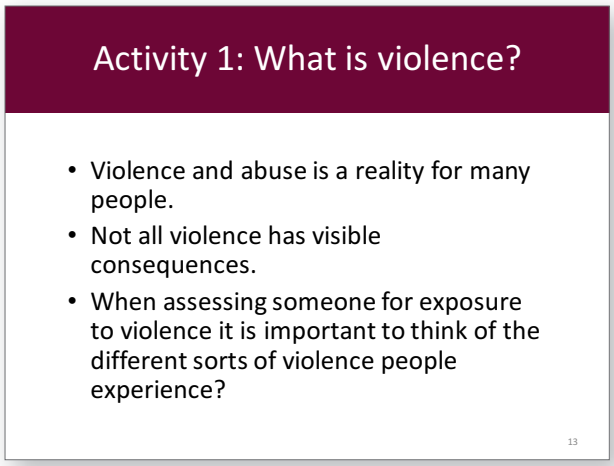
- Serious accidents
- Physical and sexual violence
- Humanitarian disasters (war, epidemics, earthquakes)
- Forced displacement
- Loss of loved one
- Major losses (including loss of identity/income/job/role/country/ family etc.)

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?

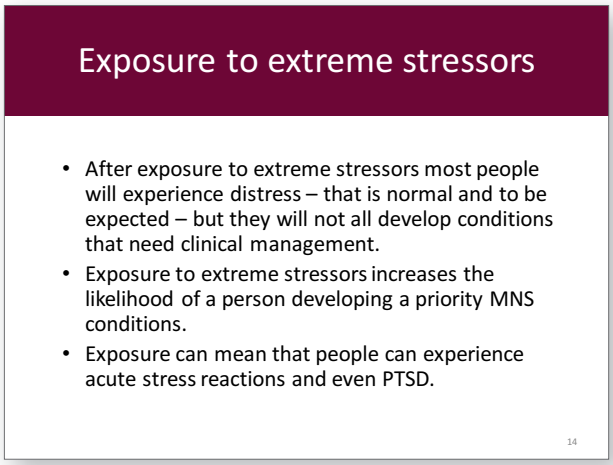


Duration: 15 minutes.

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.



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.

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.
  - Jumpiness 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.

17

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 my have been experiencing PTSD?
- How did they present to you?
- How did you care for them? Did it help?

18

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.

19

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.

20

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).

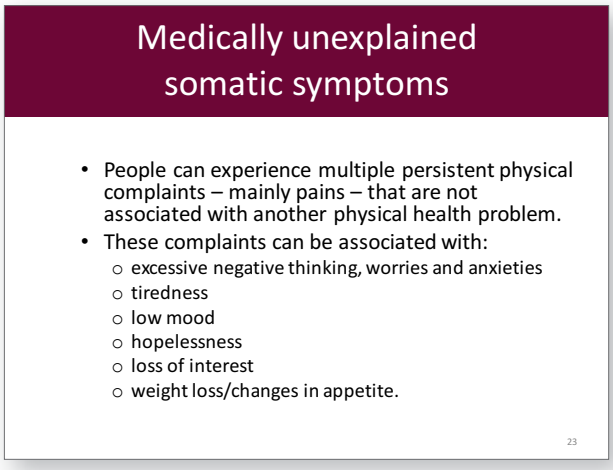
Activity 2: Discussion: Stressors through the life course

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?



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 of and trying to find out what is wrong with him.

24

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

25

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.

27

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.

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.

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

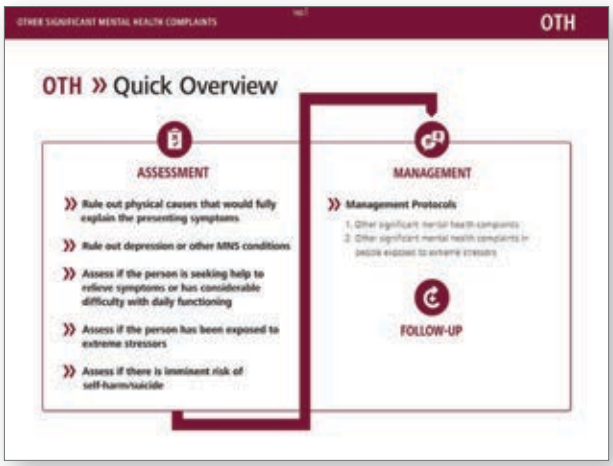
How to communicate with people with other significant mental health complaints.

Do the activity before showing the answers on the slide.

Duration: 10 minutes maximum.

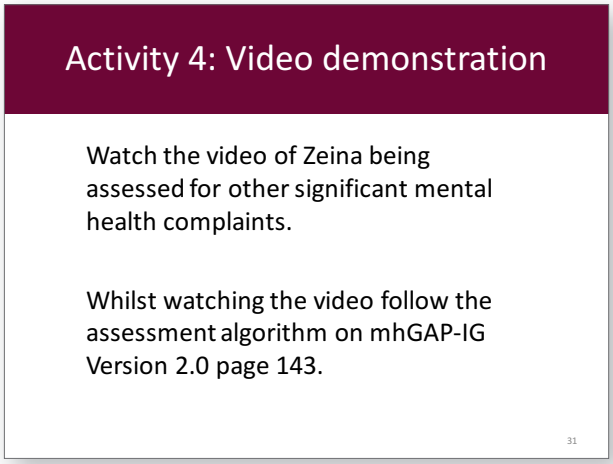
Materials: Flip chart and markers.

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.



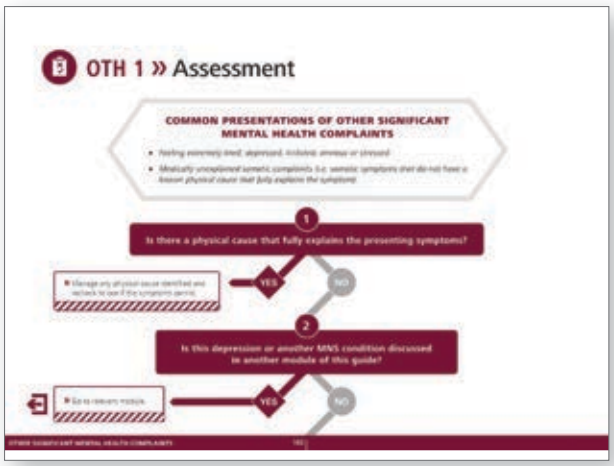
Describe the principles of assessing someone for other significant mental health complaints as on the left side of the slide.

Activity 4: Video demonstration: Assessment



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.

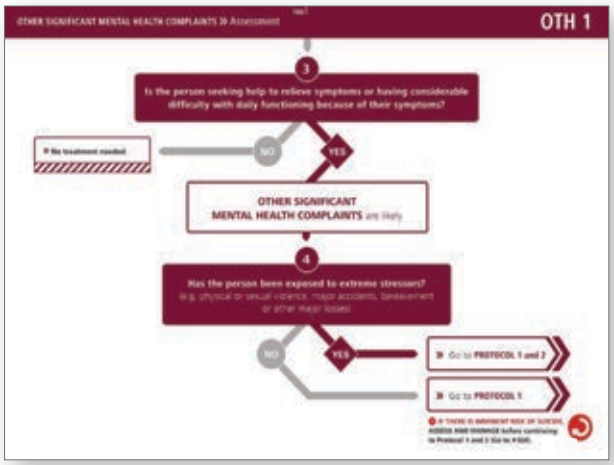


The **first step** is to assess if there is a physical cause that fully explains the presenting symptoms. Ask the participants how the health-care provider explored if there is a physical cause that fully explained Zeina's presenting symptoms?

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?

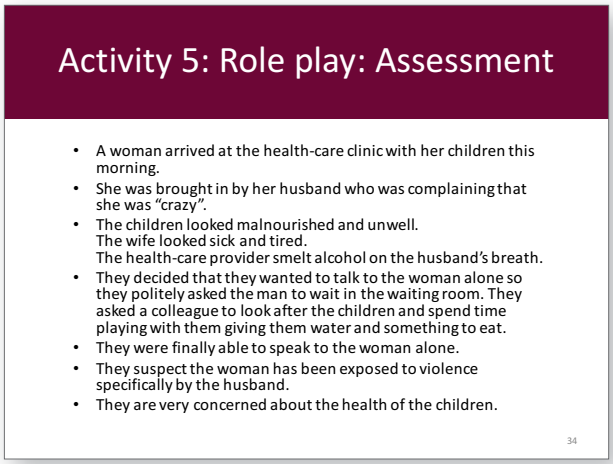
Explain that participants could ask:
- How are these symptoms impacting on your ability to carry out your daily tasks?
- Are you still able to cook, visit with friends, work, etc?

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



Duration: 30 minutes.

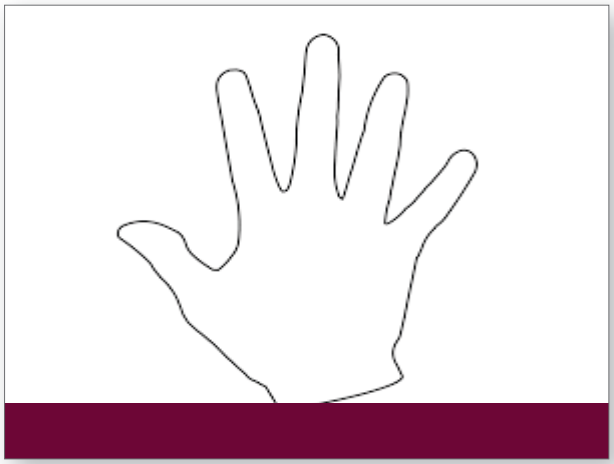
Purpose: To enable the participants to practise using the mhgAP-IG to assess and manage people with other significant mental health complaints.

Instructions:

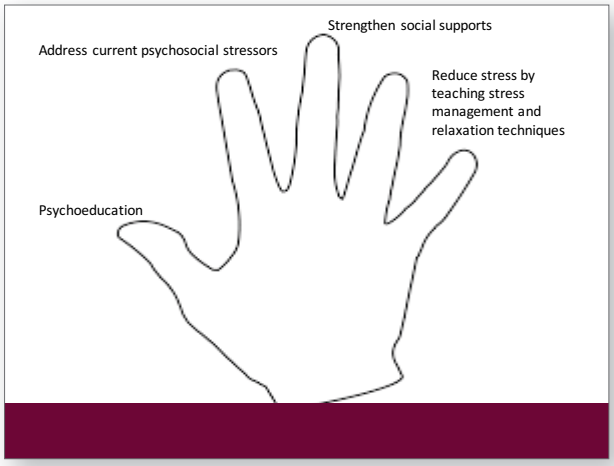
- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.
- Distribute the role play instructions to each person depending on their role.
- Distribute the LIVES intervention (Listen, Inquire, Validate, 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.

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.

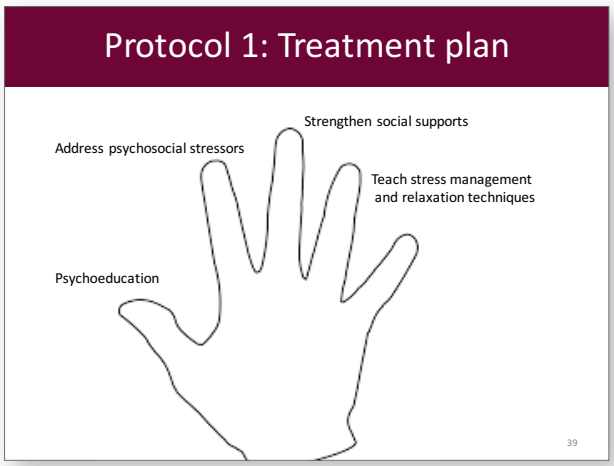
Emphasize that some self-medication can lead to dependency (e.g. certain painkillers, benzodiazepines) or cause harm to the person through worsening of symptoms or side-effects.

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.

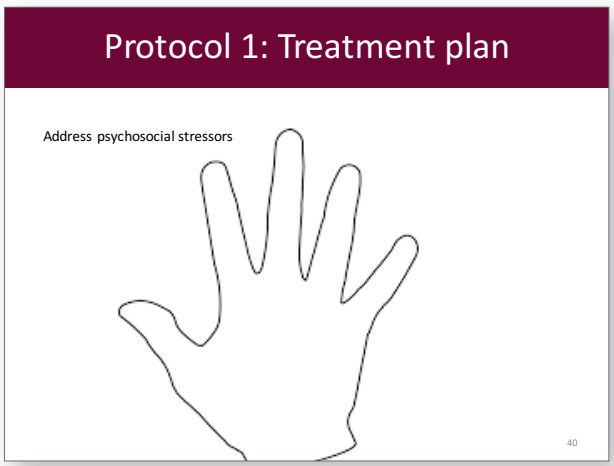
Explain that there is a growing body of evidence to show that psychosocial interventions are more effective than medications in managing other significant mental health complaints.



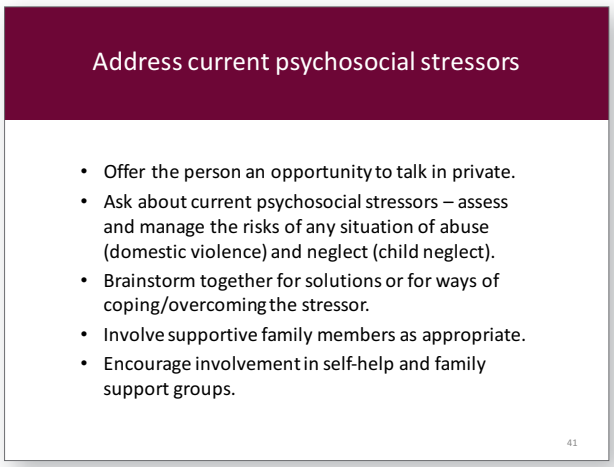
Direct participants to read through the mhGAP-IG Version 2.0 Protocol 1 (page 145) as you discuss the possible interventions. Remind participants **not** to prescribe medications and **not** to prescribe unnecessary vitamin injections and placebos.

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.



Direct participants to read through the mhGAP-IG Version 2.0 Protocol 1 (page 145) as you discuss the possible interventions.



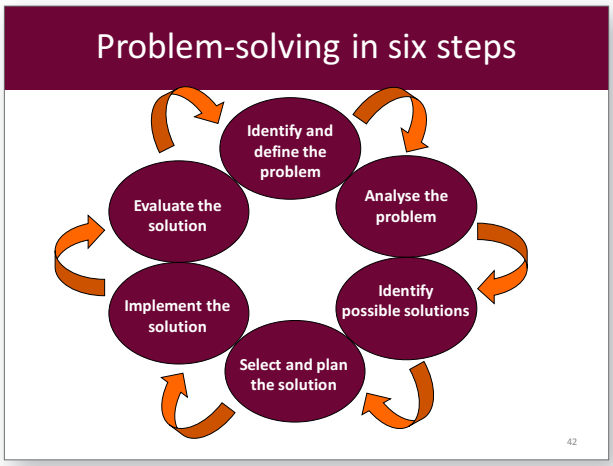
Talk through the points on the slide.

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).

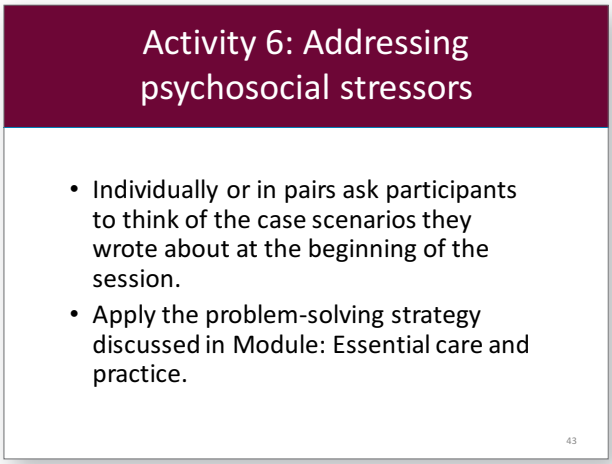
Ask the group if there are trustworthy, accessible services or protection mechanisms for child abuse and neglect.



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

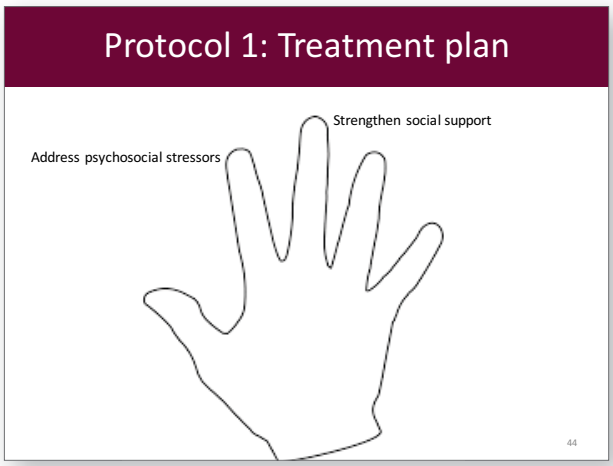


Duration: 45 minutes.

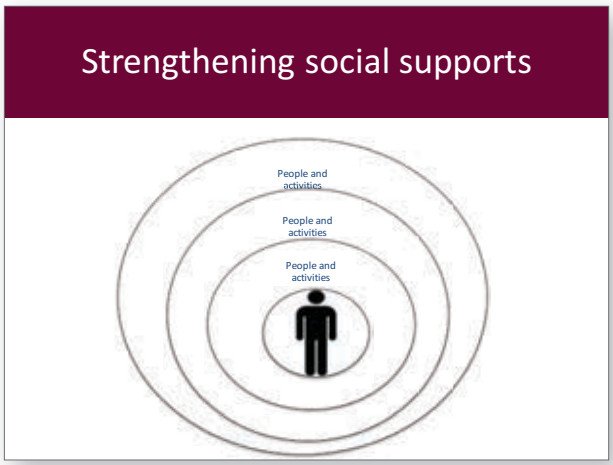
Purpose: To enable participants to practise using the problem-solving technique to address psychosocial stressors.

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.



Alongside addressing current psychosocial stressors, it is important to help the person strengthen social supports.



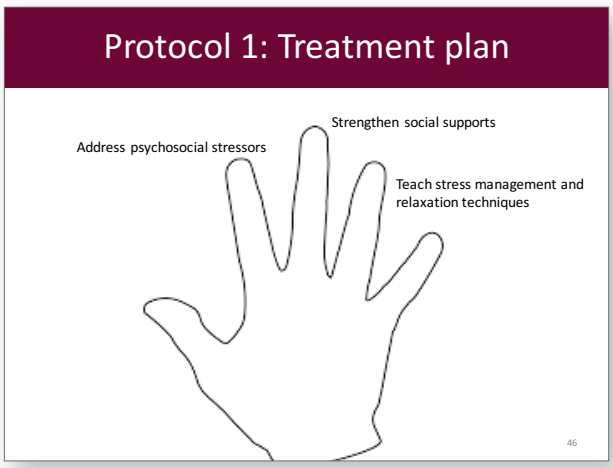
Remind participants of the strengthening social supports activity from the Module: Essential care and practice.

This is an example of a 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).

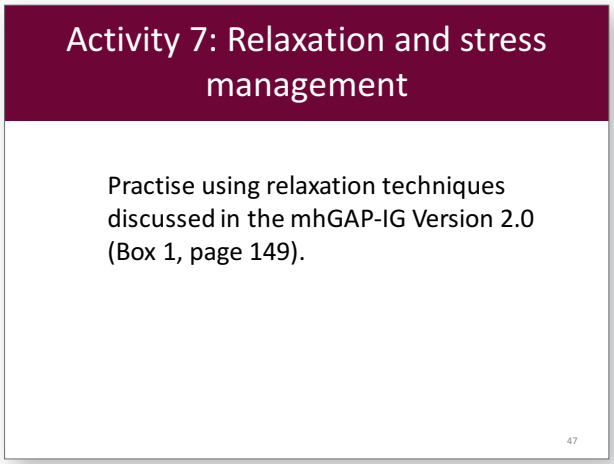
Ask participants to explain a brief activity they could use to support a person increase their social supports?

Remind them of the technique they practised in the Module: Essential care and practice.



Alongside addressing current psychosocial stressors and strengthening social supports, it is important to teach individuals stress management and relaxation techniques.

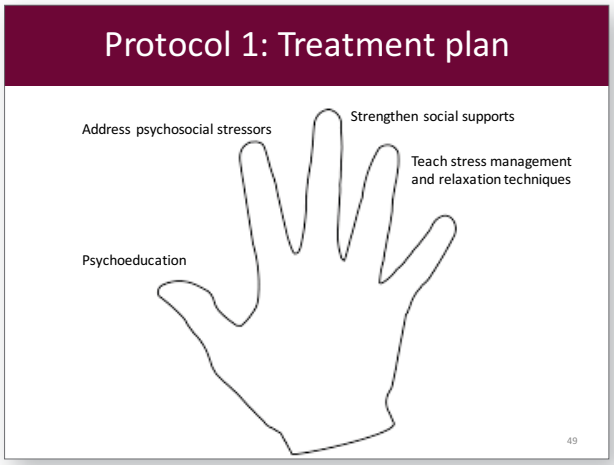
Activity 7: Relaxation and stress management



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.



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?

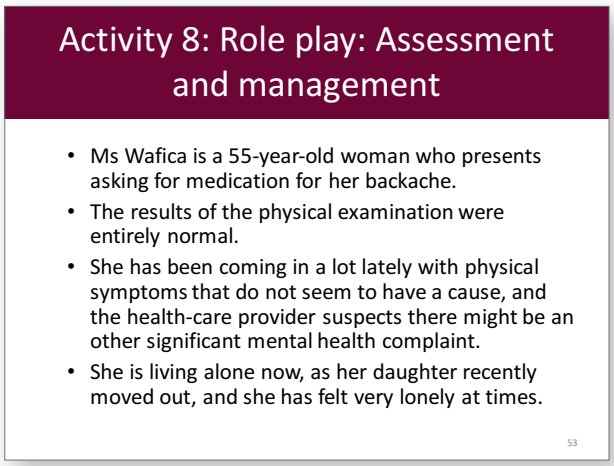
How could they make it culturally appropriate?

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



Duration: 30 minutes.

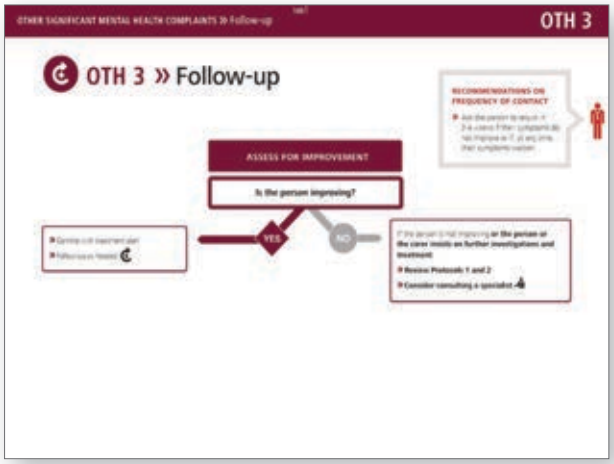
Purpose: To practise performing assessment and management for other significant mental health complaints specifically.

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.

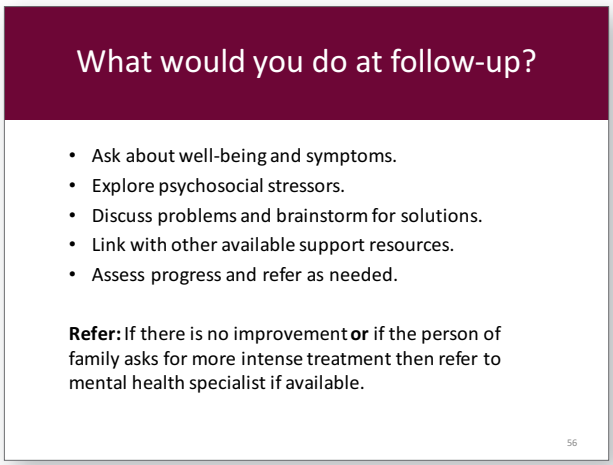
55

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.



Ask for ideas from the participants about what to do at follow-up before revealing the answer.

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

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

ToHP training forms

mhGAP training of health-care providers
Training manual

World Health Organization

Contents

Training needs assessment form

Training needs assessment

Location of training:	Contact person:

Please identify which of the following sources were used to complete this form:

- ☐ WHO/UN sources of information
- ☐ National sources of information
- ☐ Other published literature
- ☐ Review of adverse events
- ☐ Audit reviews
- ☐ Review of hospital admissions data
- ☐ Discussion with management
- ☐ Discussion with staff
- ☐ Discussion with patients
- ☐ Other: . . . . . .

Target population

Which MNS conditions should be managed in non- specialized health settings? (as per national level protocols and guidelines or discussions with stake holders):

- ☐ 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

Local Resources

Which medications are available in this area?

- ☐ Acamprosate
- ☐ Amitriptyline*
- ☐ Benzhexol
- ☐ Biperiden*
- ☐ Buprenorphine
- ☐ Carbamazepine*
- ☐ Chlorpromazine*
- ☐ Cholinesterase inhibitors
- ☐ Clonidine
- ☐ Diazepam*
- ☐ Disulfram
- ☐ Fluoxetine*
- ☐ Fluphenazine*
- ☐ Haloperidol*
- ☐ Lithium*
- ☐ Lofexidine
- ☐ Methadone*
- ☐ Methylphenidate
- ☐ Midazolam*
- ☐ Morphine*
- ☐ Naloxone*
- ☐ Naltrexone
- ☐ Oxazepam
- ☐ Phenobarbitol*
- ☐ Phenytoin*
- ☐ Risperidone*
- ☐ Sodium Valproate*
- ☐ Thiamine*
- ☐ . . . . . .

* WHO Essential Medicines List 2017

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:

- ☐ 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
- ☐ 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
2. = D
3. = D
4. = B
5. = D
6. = D
7. = C
8. = D
9. = C
10. = D
11. = D
12. = A
13. = B
14. = D
15. = A
16. = A
17. = C
18. = C
19. = A
20. = C
21. = B
22. A = ii
B = iii
C = iv

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
2. = B
3. = C
4. = A
5. = D
6. = B
7. = C
8. = D
9. A = i
   B = v
   C = vi
10. A = ii
    B = iii
    C = iv

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
1. Promote respect and dignity			
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			
2. Know common presentations			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
3. Know assessment principles			
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			
4. Know management principles			
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			
5. Use effective communication skills			
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			
6. Perform assessment			
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			
7. Assess and manage physical conditions			
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			

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
8. Assess and manage emergency presentations			
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			
9. Provide psychosocial interventions			
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)			
10. Deliver pharmacological interventions as needed and appropriate			
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			
11. Plan and perform follow-up			
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			
12. Refer to specialist and link with outside agencies			
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): . . . . . .

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

Please rate the following:	Poor	Average	Excellent	Additional comments
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	
Overall quality of this module	1	2	3	

What was best about this module?

What did you learn from this module that you anticipate using again?

What would you suggest to improve this training module?

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				
Please rate the following:	**Poor**	**Average**	**Excellent**	**Additional comments**
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	
Overall quality of this module	1	2	3	

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

What would you suggest to improve this training module?

ToHP participant's logbook

mhGAP training of health-care providers
Training manual

World Health Organization

Contents

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
Clinical resource forms	
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.
Supervision forms	
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
Clinical resource forms						
Local referral points – clinicians	✓					
Local referral points – services	✓					
Treatment plan			✓	✓	✓	✓
Supervision forms						
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			
Psychiatrist/s			
Name	Services offered	Address	Contact details
Mental health nurse/clinician/s			
Name	Services offered	Address	Contact details
Neurologist/s			
Name	Services offered	Address	Contact details
Drug and alcohol clinician/s			
Name	Services offered	Address	Contact details
Other			
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:

Presenting problem

Brief summary of the reason the person is seeking help

Written treatment plan

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 commending 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.

Supervision techniques	Intervention
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:

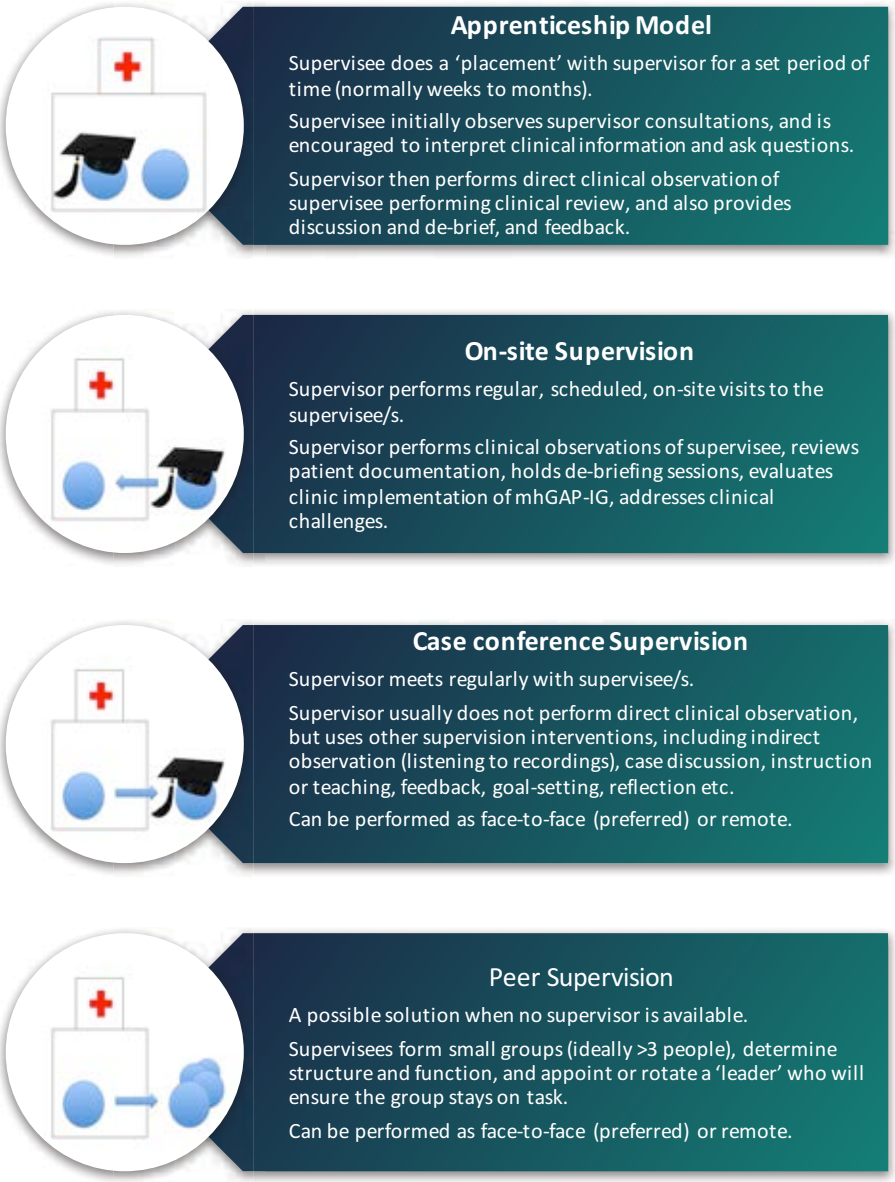
- Be punctual for supervision.
- Adhere to the structure and agenda.
- Be prepared to discuss at least one or two cases you have seen recently, ideally one which has been challenging in some way. Complete and bring the difficult case report form to your supervision.
- Contribute to feedback and discussion 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
Who?		
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.	
What?		
3.	What model of supervision will you use? Apprenticeship/on-site/case conference/peer.	
When?		
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.	
Where?		
8.	Where will your supervision occur? Will it rotate or be in the same place? Will it be face-to-face or remote?	
How?		
9.	At or before your first session, decide on how the group will function: • Determine an agenda. • Determine which forms you will use, and when. • 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). • Determine who will keep records and be the primary contact person.	
10.	At or before your first session, decide on the "ground rules". • What is everyone's responsibility in regard to attendance and participation? • Should everyone prepare a case for every session, or will it rotate? • How will feedback and discussion occur in a constructive and respectful manner?	
11.	Consider what supervision methods and skills you will use (see Table 3). • Generally, start with direct observation, indirect observation or case discussion. • This is likely to prompt other interventions, such as encouragement, guidance, problem-solving, reinforcement, reflection etc. • Plan for other interventions such as formulating, rehearsal of skills and specific skills training.	
12.	How will you evaluate supervision and know that it is working? • Look for opportunities to bring in an outside expert to evaluate. • Discuss progress and what is working and not working at least six-monthly as a group. • Other methods of evaluation or documentation may be required by your local area.	

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
1. Promote respect and dignity			
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			
2. Know common presentations			
Know common presentations of priority MNS conditions			
Know other symptoms that may present as part of priority MNS conditions			
3. Know assessment principles			
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			
4. Know management principles			
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			
5. Use effective communication skills			
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			
6. Perform assessment			
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			
7. Assess and manage physical conditions			
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			

Competency assessment (Only use competencies which apply to task)	Needs work	Achieved	N/A
8. Assess and manage emergency presentations			
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			
9. Provide psychosocial interventions			
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)			
10. Deliver pharmacological interventions as needed and appropriate			
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			
11. Plan and perform follow-up			
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			
12. Refer to specialist and link with outside agencies			
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:

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

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
2. = B
3. = C
4. = A
5. = D
6. = B
7. = C
8. = D
9. A = i
   B = v
   C = vi
10. A = ii
    B = iii
    C = iv

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