Mental Health Care
An Introductory Manual For Training General Health Personnel
About BasicNeeds: www.basicneeds.org
BasicNeeds is an international mental health organization, which works to bring about lasting change in the lives of people affected by mental illness and epilepsy. BasicNeeds has developed a community based approach to mental health called the Mental Health and Development Model (MHD). This model introduces affordable community mental health care into low- and middle-income countries through five separate but interlinked modules: capacity building, community mental health, livelihoods, research and management.

Usage of This Manual
We are keen to hear about your experiences using the manual - both positive and negative.

It is the authors’ intention that this training manual be made widely and freely available for use and adaptation by other facilitators in a range of settings. If you are using this manual to guide your own training, we ask that you give due acknowledgement to the source during the course of your training programme.

For further comments or enquiries about this manual please contact: Shoba Raja at shoba.raja@basicneeds.org

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Abbreviations

LMIC - Low- and Middle-Income Countries
PHC - Primary Health Care
MNS - Mental, Neurological and Substance Use Disorders
WHO - World Health Organization
MH - Mental Health
BN - BasicNeeds
IQ - Intelligence Quotient
CHW - Community Health Worker
ADHD - Attention Deficit Hyperactivity Disorder
MMSE - Mini Mental State Examination
mhGAP – IG - mental health gap intervention guidelines
I founded BasicNeeds in 1999/2000 to transform the lives of people living with mental illness and epilepsy in the world’s poorest communities. There are far too many people living with epilepsy and mental illness without any kind of attention or treatment. I want to change this, and therefore our programmes aim to work with as many people as possible. An important aspect of our programmes and a factor that allows us to work with so many people is our Model of Mental Health and Development, which I first conceived whilst founding BasicNeeds. This model is composed of five modules, one of which is community mental health, and this manual is part of the resources for executing that module.

When facilitating community mental health, it is so important to work with existing government health infrastructure, so as to ensure that the work being done has long lasting effect and will be incorporated into the general health care system. Often the people we work with live in remote areas far away from the nearest psychiatric hospitals, and the doctors and nurses at the local health centres have little training or experience in working with people with mental illness or epilepsy. BasicNeeds has conducted many training programmes for community health staff around the world, and over the last ten years acquired a lot of hands-on experience in training. I am very pleased to see those experiences brought together and further embellished by drawing from other rich resources such as the WHO mhGAP intervention guidelines. I know that it will be a great addition to our existing manual intended for training community health workers which is currently being field tested. We also intend to field test this manual and evaluate it in the next two to three years.

I am grateful to Shoba Raja and Erla Magnusdottir for putting together this manual, and everyone who was involved, including all the peer reviewers, who generously took time out to review the manual. We are planning to use this primarily in health settings in the low- and middle-income countries where we currently work, but obviously would be delighted if other organizations or individuals also find it useful.

Chris Underhill
January 2012
Introduction

1. **Introduction**

Neuropsychiatry disorders account for 14% of the global burden of disease (Prince et al., 2007). In practice this burden is more pronounced in low- and middle-income countries (LMICs) where limited resources are allocated to mental health services. A study by the World Mental Health Survey revealed that between 76.3 and 85.4% of people with mental illness or epilepsy in LMICs received no treatment in the 12 months prior to interview (Demyttenaere et al., 2004). With scarce resources, millions of people who have no access to mental health services are living in a world of isolation, fear, abuse and neglect.

A community based approach to treating mental disorders is now widely recognized as the appropriate way forward in both high income and LMICs. It is viewed as a multidimensional intervention process that can effectively meet a community’s need for appropriate mental health services. Holistic care can be provided locally and coordinated by health professionals and local organizations. Users and carers are considered partners. In effect, community based care means that power is shifted from the institutions to the community.

A key component of community based care is the integration of mental health services into primary health care (PHC). In LMICs with large mental health service gaps and limited numbers of psychiatrists and psychiatric nurses there needs to be more flexibility in service provision through effective integration into PHC. Studies have shown that general practitioners can effectively deliver most mental health services if they receive appropriate training and support (Patel et al., 2007).

Several manuals, guidelines and material are available that have contributed to developing ideas for integrated mental health services, as well as training for this purpose. Resources which BasicNeeds has substantially drawn upon in designing this manual are listed in the box here below.

   

   
   Available from: http://www.who.int/mental_health/mhgap_final_english.pdf

   
Importantly in designing this manual, BasicNeeds draws upon ten years of hands-on work of operating large mental health field programmes in nine LMICs in Asia and Africa. Working in partnership with government and key stakeholders, BasicNeeds has gained significant experience and expertise in training and capacity building of general health personnel for providing mental health services. This training manual has been designed with the objective of equipping general health personnel to close the mental health “service gap” in their own setting.

2.0 About the Manual

Settings:

- Low- and middle-income countries
- District level health centre, and primary health facilities
- Mainly government health centres, but also if applicable private health centres.

Who are the Participants?

Those undergoing the training will be general health personnel. It could include government PHC personnel such as general doctors, nurses, pharmacists and/or their counterparts in private health settings.

*Note: BasicNeeds has a separate training manual for Community Health Workers.

Who is the Facilitator?

We recommend two facilitators, a lead facilitator and co-facilitator. The success of the training will be determined by two important factors:

1) Training skills of the lead facilitator
2) Training methodology used

This is because the training is interactive and requires the facilitator to be creative, energetic and responsive to the participant group. It is not necessary for both facilitators to be mental health specialists, but it is strongly recommended that at least one should be or have significant experience working in mental health. The specialist could be the co-facilitator. Regardless of who the lead facilitator is, it is crucial that the lead facilitator is foremost an experienced trainer.

3. Aim and Objectives

The overall aim of this training manual is to successfully build capacities of general health personnel to provide mental health services. By conclusion of this training, participants should be able to:

- Assess whether people who come into their health facility are experiencing symptoms of mental disorders.
- Decide upon appropriate treatment and know when it is necessary to refer to a specialist.
Manage mental health conditions utilizing both pharmacological and non pharmacological interventions (as appropriate).

Refer people when they need specialized care to appropriate services.

Increase their understanding of mental, neurological and substance disorders, and be able to further use existing resources (e.g. manuals and guidelines) when required.

4. Structure

The manual is divided into these main sections;

I. Introduction to Ideas and Topics
II. Common Conditions
III. Facilitation of Overall Learning
IV. Material for Participants
V. Appendix

Each part is divided into sessions; the sessions are further divided into tasks.

Each session has its aim stated clearly at the start and generally consists of (1) presentations that are given by the facilitator, (2) handouts for participants and (3) activities that involve the whole group.

It is recommended that all facilitators cover Part I and III. For Part II, each condition has been designed as a stand-alone piece, which allows the facilitator to decide which conditions are the most relevant and select accordingly. For e.g. in some settings alcohol and substance use disorders may be uncommon and therefore the facilitator could decide not to cover those conditions in the training. Time constraint can also be an issue in which case the facilitator can select what she/he perceives as the most pressing conditions in that particular setting.

The training manual is designed for maximum flexibility, so that it can be easily adapted for different contexts.

At the end of the manual there is a section called Material for Participants. It includes all materials that the participant will require, such as case studies, handouts, medication charts etc. It is recommended to print out one copy of this section for each participant, which they can take away if they wish to.

The Appendix includes all material that the facilitator will need in order to conduct the training. While using the manual the facilitator will find, running throughout, helpful references to appropriate appendices for particular tasks.

Getting Organized for the Training (Information for the Facilitator)

Budget: Ensure that you have a clear and appropriate budget, e.g. conference hall rent, travel cost, per diem, tea and lunch etc.

Choose a Venue: It is important to find an appropriate venue for the training. We recommend a spacious room that has light furniture that is easy to move if required, allowing easy movement of participants and group activities.
Number of Participants: Recommended number of participants is 25 - 30. With too few participants, some activities may be more restricted, likewise with too many it will become difficult to manage the group.

Know your Participant Group Beforehand: It is important to know who the participants are that you will be training, e.g. are they doctors, nurses, their previous experiences working with mental health care (if any)?

Make a Decision: Customize your training schedule in accordance with the location of the training. For e.g. what the greatest need in that setting is and who the participants are could determine what conditions will be chosen. Make a decision on what and how many sessions you will be covering.

Review Material: Prior to commencing the training it is essential that the facilitators carefully review each session he/she plans to cover, including going over the case studies and other materials and adapting them appropriately to the local setting and culture (e.g. changing names).

Prepare Clear Instructions: It is important to have clear instructions prepared for each activity. Otherwise precious time may be lost if participants are unclear or confused about the activity to be undertaken. It may be helpful to write down instructions beforehand.

Translation: If required you will need to allow sufficient time to plan for appropriate translation of the materials. It is important to think this through carefully and if required consult appropriately about how best to translate terms that may not have equivalent terminology in the local language, e.g. depression, psychosis, dementia.

2 Facilitators: If there are 2 facilitators, it is important to plan who does what for every session. It may be helpful to write down instructions.

Seating Arrangement: Unless otherwise specified, it is advisable to arrange the seating in a circular or U configuration, as this allows for more open discussion and easy transition into group work.

Other: Facilitators may supply notepads and pens for the participants to take their own notes.

6. Tips for Trainers

- Avoid too simple explanations, or too technical terms. Avoid using abbreviations and acronyms that participants may not be familiar with.
- Remember that the participants are experts in their own setting; therefore ask them not to hesitate to inform the facilitator if any of the information is not appropriate for their setting. Also ensure that they feel comfortable to bring up any issue at any point.
- Encourage participants to share relevant experiences with the group. Emphasize that you hope that the participants will learn equally from each other as from the training itself.
- Encourage lively discussions by asking open-ended questions, e.g. “Can you tell me about...?”
- Invite participants to answer each other’s questions by asking, “Does anyone have an answer to that question?”
7. Evaluating the training

Be sure to evaluate the training by asking the participants for feedback with suggestions to further improve future training programmes. Session 20 will help you with this.

Have a Questions and Comments box in the room. At the end of each training day ask participants to place written comments and questions in the Questions and Comments box. Use the comments that have been received during the final evaluation.

The distribution of personalized Certificates of Attendance at the completion of the training is usually appreciated.

8. Including representation of people who have experienced a mental disorder

The training will be enhanced if you are able to include the perspective of people who have been Users of mental health services. Therefore providing an opportunity for a person who has experienced a mental disorder to contribute to the training by telling his/her own story is recommended. Support groups for mental health service Users and their families may have been formed, and contact with such organizations can facilitate inclusion of the user perspective. The person can share his/her experience of mental illness, of mental health services, and of the factors that supported and hindered recovery.

This will require careful advance planning and must be included in an appropriate session.

#### Sessions – Part I

<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Page</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>15</td>
<td>40 minutes</td>
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<tr>
<td>2</td>
<td>Mental Health Knowledge</td>
<td>18</td>
<td>40 minutes</td>
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<tr>
<td>3</td>
<td>Recognizing Mental Disorders</td>
<td>22</td>
<td>40 minutes</td>
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<tr>
<td>4</td>
<td>Overview of Commonly Seen Conditions</td>
<td>26</td>
<td>60 minutes</td>
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<tr>
<td>5</td>
<td>The Context of Mental Health</td>
<td>28</td>
<td>30 minutes</td>
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#### Sessions – Part II

<table>
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<th>Session</th>
<th>Title</th>
<th>Page</th>
<th>Duration</th>
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<tbody>
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<td>6</td>
<td>Introduction to Moderate / Severe Depression</td>
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<td>90 minutes</td>
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<td>7</td>
<td>Introduction to Psychosis</td>
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<td>90 minutes</td>
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<td>8</td>
<td>Introduction to Bipolar Disorder</td>
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<td>90 minutes</td>
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<td>9</td>
<td>Introduction to Epilepsy</td>
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<td>90 minutes</td>
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<td>10</td>
<td>Introduction to Children and Mental Health</td>
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<td>90 minutes</td>
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<td>11</td>
<td>Introduction to Dementia</td>
<td>71</td>
<td>90 minutes</td>
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<td>12</td>
<td>Introduction to Alcohol and Drug Disorders</td>
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<td>90 minutes</td>
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<tr>
<td>13</td>
<td>Introduction to Self-Harm / Suicide</td>
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<td>90 minutes</td>
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<td>14</td>
<td>Concurrent Conditions</td>
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<tr>
<td>15</td>
<td>Carers</td>
<td>90</td>
<td>30 minutes</td>
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<td>16</td>
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<td>17</td>
<td>Interviewing Skills</td>
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<td>18</td>
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<td>19</td>
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<td>20</td>
<td>Participatory Evaluation</td>
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<td>60 minutes</td>
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#### Example of a Schedule (first two days have been filled in as an example)

<table>
<thead>
<tr>
<th>Day 1</th>
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<tbody>
<tr>
<td>09:00 – 09:40 Introduction</td>
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<tr>
<td>09:40 – 10:20 Mental Health Knowledge</td>
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<tr>
<td>10:20 – 11:00 Recognizing Mental Disorders</td>
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<tr>
<td>11:00 – 11:30 Tea break</td>
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<tr>
<td>11:30 – 12:30 Overview of Commonly Seen Conditions</td>
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<tr>
<td>12:30 – 13:00 Context of Mental Health</td>
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<tr>
<td>13:00 – 14:00 Lunch</td>
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<tr>
<td>14:00– 14:30 Revision Quiz - Part I</td>
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<tr>
<td>14:30– 16:00 Moderate / Severe Depression</td>
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## Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>09:00 – 09:30</td>
<td>Answer Questions from Day 1</td>
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<td>09:30 – 11:00</td>
<td>Psychosis</td>
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<tr>
<td>11:00 – 11:30</td>
<td>Tea break</td>
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<tr>
<td>11:30 – 12:30</td>
<td>Bipolar Disorder</td>
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<tr>
<td>12:30 – 13:30</td>
<td>Lunch</td>
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<tr>
<td>13:30 – 15:00</td>
<td>Epilepsy</td>
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<tr>
<td>15:00 – 15:30</td>
<td>Tea break</td>
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<tr>
<td>15:30 – 16:30</td>
<td>Revision Quiz Part II &amp; III</td>
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## Day 3

<table>
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<th>Time</th>
<th>Activity</th>
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## Day 4

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<th>Time</th>
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**Blank Schedule - To be tailored by the facilitator**

## Day 1

<table>
<thead>
<tr>
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10. Useful background information for the facilitator

   Available from: http://www.who.int/mental_health/mhgap_final_english.pdf


   Available from: http://books.google.co.in/books

5. Mental Health Programme in Egypt. Diagnostic and Management Guide for Mental Disorders in Primary Care, Geneva: World Health Organization;


7. BasicNeeds: Essential Skills for Mental Health Care; 2010
Glossary

**Antidepressants**: A class of medicines used to treat depression.

**Antipsychotics**: A class of medicines used to treat psychosis.

**Carer**: A person who takes care of a person with mental illness or epilepsy for daily chores and support in the recovery process.

**Concurrent Conditions**: More than one condition prevailing at one time.

**Mood Stabilizers**: A class of medicines used to treat bipolar disorder.

**Non Pharmacological Treatment**: Treatment that involves means other than through medication.

**Pharmacological Treatment**: Treatment by prescribing medication.

**Psycho Education**: Refers to the education offered to people who live with MNS disorders and their families or carers. The goal is for people to be able to cope better with their illness through increased understanding of their condition.

**Self-harm**: A broader term referring to intentional self-inflicted poisoning or injury, which may or may not have a fatal intent or outcome.

**Special Olympics**: Is the world’s largest sports organization for children and adults with intellectual disabilities. Participants include 3.1 million athletes in 175 countries.

**Specialist**: A person who has experience working with MNS disorders (e.g. psychiatrist, psychiatric nurse, counsellor, mental health or substance abuse social worker).

**Young Carer**: A child or young person (<18 years) who takes care of a person with mental illness or epilepsy for daily chores and support in the recovery process.

*Note

- Throughout the manual the terms mental illness / mental disorders and MNS are used interchangeably.
- If quotation marks are used, they are direct quotes from other resources (e.g. the mhGAP - IG ).
Mental Health Care: An Introductory Manual For Training General Health Personnel

Training Part 1

BasicNeeds BasicRights
Task 1 - Introduction (15 minutes)
Directions: Step 1:
Greet the class and introduce yourself to them.

Step 2
Give a training timetable (See Appendix 1 for a blank timetable to be designed by the facilitator) and provide a brief outline of the programme and the topics you will be covering. Introduce the questions and comments box (See Introduction, pg 5), but also encourage participants to ask questions at any point during the training.

Task 2 - Introduce your fellow participant (15 minutes)
Directions: Step 1
Hand out the illustrated cards found in Appendix A (each picture has been split in two). Each person gets one half of a picture. Instruct participants to find the person with the other half of their illustrated card.
Step 2
Participants then introduce themselves to their partners and share three pieces of information about themselves.

- Their name and where they are from.
- One positive thing about themselves OR one of their favourite roles as a health professional.
- Their expectations from this training.

Allow five minutes for discussion in pairs, then participants should introduce their partner to the rest of the group and mention what their partner hopes to gain by participating in the training. The facilitator writes the participants’ expectations of the training on a large piece of paper and sticks it up on the wall of the training room.

Task 3 - Aim and Objectives (10 minutes)
Directions
State the overall aim and objectives of the training.

Aim and Objectives
The overall aim of this training manual is to allow the facilitator to successfully build capacities of general health personnel to provide mental health services. By conclusion of this training, participants should be able to:

- **Assess** whether people who come into their health facility are experiencing symptoms of mental disorders.
- **Decide** upon appropriate treatment and know when it is necessary to refer to a specialist.
- **Manage** conditions utilizing both pharmacological and psychosocial interventions (as appropriate).
- **Refer** people when they need specialized care to appropriate services, if possible.
- **Increase their understanding** of mental, neurological and substance disorders, and be able to further use existing resources (e.g. manuals and guidelines) when required.
SESSION 2

Mental Health Knowledge

*Session Aim*: To assess participants’ prior understanding of mental, neurological and substance disorders (MNS).

*Session Tasks*: 1. To assess participants’ prior knowledge through a pre-quiz. 2. To encourage participants to think about how they would define mental health.

*Session Duration*: 40 minutes

*Materials*: True or False Quiz (Appendix B), Visual Aids for presentation (Appendix F), pencils.

**Task 1 - True or False Quiz (20 minutes)**

**Directions: Step 1 (15 minutes)**
Ask participants to complete a short True or False quiz. Emphasize that they are not expected to know all the correct answers at this stage. If the facilitator has prior knowledge that the participants have not had much exposure to mental health, ask them to complete only part I of the quiz.

**Step 2 (5 minutes)**
Once participants have completed the quiz, reveal answers (see Appendix). Ask participants to score their own quiz.

Note that even if participants score 100%, it does not mean that they know how to put the knowledge into practice, and therefore will still benefit from going through the various activities.
**Task 2 - Define Mental Health (20 minutes)**

**Directions: Step 1 (10 minutes)**
Ask participants to write down their definition of mental health. Once completed, ask participants to stick their definition up on the wall. Suggest that they revisit their definition at the end of the training course and see if their definition of mental health has changed from their original one.

**Step 2 (10 minutes)**
Give a definition of mental health using information provided in the Information for Facilitator box below.

The facilitator then sticks the Visual Aids found in Appendix F on the wall in the centre of the definitions that participants wrote earlier.

---

**Information for Facilitator**

Mental health is defined by the World Health Organization as a state of well-being in which the individual:

- Realises his or her own abilities;
- Can cope with the normal stresses of life;
- Can work productively fully; and
- Is able to make a contribution to his or her community.
- A healthy person has a healthy mind and is able to think clearly;
- Solve problems in life;
- Work productively;
- Enjoy good relationships with other people;
- Feel spiritually at ease; and
- Make a contribution to the community.

Mental health is vital for individuals, families and communities, and is more than just the absence of mental disorder.

To be a healthy person we need to have both mental and physical health, and these are related to each other.

Mental health provides individuals with the energy for active living, achieving goals and interacting with people in a fair and respectful way.
Mental health is vital for individuals, families and communities, and is more than just the absence of mental disorder.

HEALTHY BODY + HEALTHY MIND = HEALTHY INDIVIDUAL

To be a healthy person we need to have both mental and physical health, and these are related to each other.
Mental health provides individuals with the energy for active living, achieving goals and interacting with people in a fair and respectful way.

**Session 2 References**

1. BasicNeeds: An Introduction to Mental Health, Facilitator’s Manual for Training Community Health Workers in India
# Recognizing Mental Disorders

<table>
<thead>
<tr>
<th>Session Aim</th>
<th>To introduce common symptoms of MNS disorders.</th>
</tr>
</thead>
</table>
| Session Tasks | 1. Presentation on type of symptoms commonly associated with mental disorders.  
3. Identifying type of symptoms in case studies.  
4. Group Discussion. |
| Session Duration | 40 minutes |
| Materials | Paper and marker pens, black/white board and ‘symptoms of mental disorders cards’ (found in Appendix C), Case Studies A and B (Appendix E), Visual Aids for presentation and game (Appendix F). |

## Task 1 - Presentation (10 minutes)

**Directions:**

Give a short presentation on the information provided in the Information for Facilitator box below. As the facilitator introduces each type of symptom (e.g. physical, feeling), bring out the visual aid that corresponds to the symptom category and hang it up somewhere visible in the room. These will then be used during the next exercise.

## Information for Facilitator

Mental disorders are largely diagnosed by interviewing the patient and carers about presentation of symptoms. The symptoms of mental disorders can be divided into these five categories.

- **Physical symptoms** are those that involve the physical functioning of the body, e.g. aches and pains, weakness, tiredness, sleep disturbance and increased or decreased appetite.

- **Feeling symptoms** are those that involve our emotions or feelings, e.g. sadness, fear and worry.

- **Thinking symptoms** are those that affect the way a person thinks, e.g. problems in understanding, concentrating, memory, and judgment (decision-making). Thinking about ending your life (suicide) or thinking that someone else is going to harm you are examples of thinking symptoms.

- **Behavioural symptoms** are those that affect the way people act or what they do. Behaviours are what we actually see others doing, e.g. being aggressive, increased or decreased talking, withdrawal from family and friends, self-harm, e.g. cutting the skin and attempting suicide.
Perception symptoms are those that involve the person perceiving or experiencing things that are not actually real (although they seem very real to the person experiencing them). For e.g. the person may be hearing voices or seeing things that are actually not present.

Some of the symptoms associated with mental disorders, such as feelings of sadness and worrying a lot, affect everybody from time to time. These symptoms only become a mental disorder when they are excessive and prevent the person from leading a normal life.

Other symptoms such as hearing voices are commonly symptoms of mental disorders. The different types of symptoms are closely related to each other, e.g. hearing voices saying that others are going to harm you can lead to aggression due to fear.

Experiencing the symptoms of mental disorders does not mean the individual is weak or lazy, possessed by supernatural forces, or losing his/her mind.

---

**Task 2 - Symptoms of Mental Disorders Cards (10 minutes)**

**Directions:**
Ask each participant to randomly select one card from the pile of ‘symptoms of mental disorders cards’ (found in Appendix C). The symptom group headings (physical, feeling, thinking, behaving, perceiving) should already be up on the wall from the presentation given earlier. Ask the participants to stand next to the symptom group that best reflects the type of symptom depicted on the card they are holding. The facilitator can demonstrate this activity by selecting a symptom card and moving to stand in the area of the room with the related heading, e.g. if the card says “tiredness” stand in the physical symptom area of the room. If participants place their symptoms in the incorrect symptom group, e.g. a person with the sadness symptom card stands next to the thinking symptom label ask the person to draw a humour card (found in Appendix D). The card will instruct the participant a “penalty,” e.g. sing a song, tell a joke etc.

It is an energizing activity as it allows participants to move from their seats. Ask participants to stay in their groups for the next activity.

**Task 3 - Case Studies (10 minutes)**

**Directions: Step 1**
Ask participants to look at Case Study A and B. Ask each group to:

- Identify and list all the symptoms in the case studied and split them into “symptom categories” (e.g. physical, feeling).

**Case Study A**

Mike is a 25 year old student who, many months ago, started locking himself in his room. Mike used to be a good student but failed his last exams. His mother says that he often spends hours staring into space. Sometimes he mutters to himself as if he were talking to an imaginary person. He was forced to come to the clinic by his parents. At first he refused to talk to the nurse. After a while he admitted that he believed that his parents and neighbours were plotting to kill him and that the devil was interfering with his mind. He said he could hear his neighbours talk about him and say nasty things outside his door. He felt as if he had been possessed, but did not see why he should come to the clinic since he was not ill.
Case Study B

Rita is a 58 year old woman whose husband died last year. Her children are all grown up and have left the village for better employment opportunities in a big city. She started experiencing poor sleep and loss of appetite soon after her husband died. The symptoms worsened when her children left the village. She experiences headaches, backaches, stomach aches and other physical discomforts, which have led her to consult the local clinic many times. There she was told she was well, but was prescribed sleeping tablets and vitamins. She felt better immediately, particularly because her sleep improved. However within two weeks her sleep has got worse again. She went back to the clinic and was given more sleeping pills and injections. This has been going on for months, and now she can no longer sleep without the sleeping pills.

Step 2: After 10 minutes, ask two volunteers (one for each case study) to report back to the rest of the group the symptoms their group identified.

Note to Facilitator

Mike is experiencing the following symptoms:

Thinking symptoms – believing that his parents and neighbours are plotting to kill him and that the devil is interfering with his mind.

Behavioural symptoms – locking himself in his room, failing exams, staring into space, talking to himself.

Perceptual – hearing voices.

And possibly also emotional symptoms such as fear.
Note to Facilitator

Rita is experiencing the following symptoms:

**Physical symptoms** – poor sleep, multiple unexplained physical complaints, loss of appetite.

**Emotional symptoms** – sadness and grief.

**Behavioural symptoms** – frequent consultations at the local clinic.

Task 4 - Group Discussion (10 minutes)

Directions:

Lead a brief group discussion using the following points:

- How difficult was it to identify the symptoms of the mental disorder?
- How would experiencing these symptoms affect the individual’s life and that of their family?

Session 3 References

1. BasicNeeds: An Introduction to Mental Health, Facilitator’s Manual for Training Community Health Workers in India
Overview of Common Conditions

**Session Aim**: To introduce symptoms of commonly seen mental health conditions.

**Session Tasks**: See directions below.

**Session Duration**: 60 minutes

**Materials**: Visual Aids (Appendix F)

**Directions**
There are different means by which this activity can be delivered. This may depend upon available resources in a particular setting. See below different variations and combinations (options A - D); choose options that are most appropriate for your setting.

This is a key introduction to what is later to come in the training; therefore it is very important that it is well presented.

**Tasks (60 minutes)**
Choose either option A or B presented here below, each session will take 30 minutes.

Option A: (30 minutes) - Participants give Examples from their Setting

**Directions: Step 1**
Ask participants (one at a time) to give examples of people who came into their health centre, or that they have encountered elsewhere who they think may have been experiencing a MNS disorder (without identifying people by name). Ask the participants to describe the symptoms that they observed.

Listen carefully to the description of symptoms being described by participants, and if they match the symptoms of a particular condition planned to be covered during this training, write the name of the condition on a large sheet of paper and hang it up on the wall.

**Step 2**
Summarize the symptoms that have been described by the participant and place a visual aid (Appendix F) next to the name of the condition. Note that at times it might be necessary for the facilitator to elaborate or add information, e.g. “It sounds like the person was experiencing symptoms of decreased energy. If the person has been experiencing reduced energy and diminished activities for at least 2 weeks the person may be suffering from moderate / severe depression.”

Repeat these two steps for as many examples as are given by participants. Encourage all participants to participate in this activity. Even though they find it difficult to provide examples, ask them to comment or ask a question.
*Note
Some examples provided may include conditions that will not be covered during the training. If that is the case, provide basic information on the condition but explain that it will not be covered during the training. Do not write the name of the condition down on the large sheet of paper.

Step 3
Provide information on the remaining conditions that have not been described by participants. This may be done by reading out case studies (Appendix E) or by providing examples from your own experiences.

At the end of this task, a large sheet of paper should be hanging on the wall with names of all the conditions that will be covered during the training, accompanied by a visual aid for each one.

**Option B (30 minutes) - Theatre Directions: Step 1**

A locally hired theatre group depicts symptoms of conditions to be covered during the training through gestures, movements, sounds and actions.

*Note
This requires careful planning beforehand, ensure that the theatre group depicts accurately the conditions, that they are respectful to people with mental health problems (i.e. no derogatory gestures) and that they understand in detail what you are trying to achieve.

Step 2:
At the end of each act, write down the name of the condition being described through theatre on a large sheet of paper. Next to the name of each condition place a visual aid (Appendix).

Choose either option C or D presented here below, each session will take 30 minutes.

**Option C: (30 minutes) - Life Story**

**Directions: Step 1**

A person who has experienced a mental disorder shares her/his story with participants. The person can share his/her experience of mental illness, of mental health services, and of the factors that supported and/or hindered recovery.

*Note
It will be important for the facilitator to discuss with the person who will be sharing his/her story beforehand, and agree upon the content and the allocated time of the talk.

Step 2
Allow participants to ask questions to the person who has kindly shared their story.

**Option D: (30 minutes) - Facilitator reads out a Life Story**

**Directions: Step 1**

The facilitator reads out a life story of a person with a mental illness.

Read the story in first person, avoid using a monotonous voice, but rather bring the story to life with, for e.g., quotes describing experiences and interventions, interactions the person has had etc.

Step 2
Encourage participants to ask questions about the life story and summarize important points.
SESSION

The Context of Mental Health

Session Aim: To get participants to think about important contextual factors when helping a person with MNS disorders.

Session Task: Interactive presentation.

Session Duration: 30 minutes

Materials: Black/white board for presentation.

Task 1 - Presentation (30 minutes)

Directions:
Facilitator leads an interactive presentation, see box below.

Information for Facilitator

There are important contextual factors to consider when working with a person who has a MNS disorder, such as:

A. Culture
B. Poverty
C. Gender
D. Discrimination

A. Culture and Mental Health
The way mental health is perceived may differ between different countries.

Step 1:
Explain to participants that each handout given out during Part II of the training has a blank section, where participants can add information that is relevant to their own setting. Emphasise that not all information that is included in this manual may be relevant to how things are perceived in their setting, or cultural information may be missing that would be important to include in the manual. See example here below:
B. Poverty and Mental Health
People living in poverty are more likely to experience mental disorders due to the stresses associated with being poor, and mental disorders are likely to worsen poverty, so that it becomes a cycle that is difficult to break.

Step 1:
Invite participants to comment on the information presented and give examples from their own experience about how poverty can contribute to mental disorders.

Step 2:
Invite participants to discuss ways in which communities can help break the cycle of poverty and mental disorders.

Examples that may be given:
- Effective treatment for mental disorders.
- Employment opportunities including income generation schemes and micro-credit schemes.
- Access to education.

C. Gender and Mental Health
How does gender relate to mental health?
Step 1
Ask participants to brainstorm some ideas about how gender might affect mental health for men and women differently. Ask one or two volunteers to write these ideas on the black/white board as you go along.

Examples may include:
- In some cultures men do not discuss their problems with friends and find solutions as much as women.
- In some cultures it is more acceptable for men to drink alcohol, leading to more problems - drinking in men and more stigma for women who have a drinking problem.
- Domestic violence and rape can place great stress on the life of a woman.
Women's income is often lower than that of men, and they have less control over household finances.

Women may not be able to independently access treatment unless there is agreement from senior members (whether male or female) of the household.

A woman cannot receive needed health services because norms in her community prevent her from travelling alone to a clinic.

Families may be more reluctant to spend money on treatment for women compared to men.

D. Stigma and Discrimination

Directions: Ask participants the questions below (1 - 4). Together discuss explanations and solutions; use the sample answers for support.

1. Why is there stigma and discrimination in relation to MNS disorders?

Sample Answers:

- People with mental disorders are sometimes stigmatized and discriminated against because they think and behave differently.

- Not knowing the facts about mental disorders sometimes makes people afraid of those who are suffering from a mental disorder.
2. How do stigma and discrimination affect a person with a mental disorder?

Sample Answers:

- A person suffering from a mental disorder may be rejected by friends, relatives, neighbours and employers.
- A person who is rejected may then feel more lonely and unhappy and this will make recovery even more difficult.
- Stigma also affects the family and caretakers of a person with a mental disorder and may lead to isolation and humiliation.
- Stigma can cause delays in seeking treatment for a family member with a mental disorder.

3. How can stigma and discrimination be reduced?

Sample Answers:

- People with mental disorders should be seen as active and valuable members of the community.
- Openly talk about mental disorders in the community to help people understand that a person with a mental disorder is a fellow human being and is entitled to be valued as such.
- Provide accurate information to family members and community groups on what causes mental disorders, how common they are, and that they can be treated.

4. How should one counter negative stereotypes and misconceptions surrounding mental disorders?

Sample Answers:

Educating people about the following points:

- Mental disorders are a bit like an illness of the mind.
- Having a mental disorder is not a character weakness or a result of being deliberately lazy or difficult.
- Mental disorders are not the result of curses, black magic or evil spirits.
- Anyone can suffer from a mental disorder.
- People with a mental disorder often need help to recover.
- A person with a mental disorder can hold a job and get married.
- Most people with mental disorders are not violent.
- Provide support and treatment for people suffering from mental disorders so that they can meaningfully participate in community life.
- The community can help reduce stigma and discrimination by having laws that ensure all people are treated fairly and given respect.
- A community that respects and protects basic civil, political, economic, social and cultural rights is essential for promoting mental health and reducing stigma and discrimination.
Mental Health Care: An Introductory Manual For Training General Health Personnel

Training Part 2

BasicNeeds
BasicRights
Part II is divided into 10 sessions. Different conditions will be introduced in each session, and each session ranges between 30 - 90 minutes. This section of the training is where the facilitator will select what sessions are appropriate for a specific setting. **It is important to plan ahead of time what sessions will be covered during the training.**

<table>
<thead>
<tr>
<th>Sessions – Part II</th>
<th>Condition</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Introduction to Moderate / Severe Depression</td>
<td>90 minutes</td>
</tr>
<tr>
<td>7</td>
<td>Introduction to Psychosis</td>
<td>90 minutes</td>
</tr>
<tr>
<td>8</td>
<td>Introduction to Bipolar Disorder</td>
<td>90 minutes</td>
</tr>
<tr>
<td>9</td>
<td>Introduction to Epilepsy</td>
<td>90 minutes</td>
</tr>
<tr>
<td>10</td>
<td>Introduction to Children and Mental Health</td>
<td>90 minutes</td>
</tr>
<tr>
<td>11</td>
<td>Introduction to Dementia</td>
<td>90 minutes</td>
</tr>
<tr>
<td>12</td>
<td>Introduction to Alcohol and Drug Disorders</td>
<td>90 minutes</td>
</tr>
<tr>
<td>13</td>
<td>Introduction to Self-Harm/Suicide</td>
<td>90 minutes</td>
</tr>
<tr>
<td>14</td>
<td>Introduction to Concurrent Conditions</td>
<td>60 minutes</td>
</tr>
<tr>
<td>15</td>
<td>Carers</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

In Appendix B find a **Revision Quiz** for Training Part II. It is recommended to do one - two sections from the quiz at the end of each training day in Part II. Allocate thirty minutes to one hour for this as you plan your schedule.
Introduction to Moderate/Severe Depression

Session Aim: To introduce symptoms of moderate/severe depression and how to appropriately manage them.

Session Tasks:
1. Presentation by facilitator + handout I
2. Group Exercise using case studies
3. Group Discussion

Session Duration: 90 minutes

Materials: Case Study C and D (Appendix E), Black/white board, Service Charts (Material for Participants).

Task 1 - Presentation (30 minutes)
Directions: Step 1

Give a short presentation on the information provided in the Information for Facilitator box below.

Information for Facilitator

What is Depression?
Everyone will experience feeling sad at some point. However, moderate - severe depression should be considered if the person has difficulties carrying out his/her usual work, school, domestic or social activities due to symptoms of depression.

A person suffering from moderate - severe depression “experiences depressed mood, loss of interest and enjoyment and reduced energy leading to diminished activity for at least 2 weeks. Many people with depression also suffer from anxiety symptoms and medically unexplained somatic symptoms.”

Anyone can experience depression. However some groups may be at a higher risk for developing depression, e.g. women have a higher risk of depression than men. Those who have had a stroke, or those with physical ailments will be at greater risk of experiencing depression.

Although significant life changes (e.g. disaster, death of a loved one) are risk factors for depression they should be distinguished from depression, at least do not consider antidepressants as first line response.

Common Symptoms/Diagnosis
Use the following questions to assess risk of moderate - severe depression

1. For the last two weeks have you felt sad? Most of the day, almost every day? For children and adolescents it may present itself as irritability.

2. During the last two weeks have you had little interest or pleasure in activities that before were pleasurable?
3. During the last two weeks have you experienced decreased energy and find yourself easily tired?

If YES to two or three questions, moderate – severe depression is a possibility. But before making a decision look for:

**Other Common Symptoms of Depression**

Has the person had at least three other symptoms of depression?

- Difficulty in concentrating
- Thoughts that she/he is not as good as others (low self-esteem)
- Guilty feelings
- Hopelessness about the future
- Ideas of self-harm or suicide
- Disturbed sleep
- Poor appetite

If there are other symptoms of depression present and if the person has difficulties in carrying out usual work, school, domestic or social activities, then manage the case as moderate / severe depression.

**Differential Diagnosis:** Depression may be confused with other medical conditions, for e.g. weight loss and fatigue can be associated with diabetes, cancer, thyroid disease. The use of certain medicines can also cause depressive symptoms. Remember to always rule out other possibilities before confirming diagnosis.
Note that it is possible that the person has both depression and another condition. For e.g. people may try to treat their symptoms using alcohol or drugs because they make them feel better in the short-term, but often in the long run creating a cycle that becomes hard to break (See Session 14). In the case of multiple conditions, all conditions need to be treated.

**Treatment /Management**

**Non Pharmacological Treatment**

**Psycho Education**

- Emphasize that depression is very common and that treatment is available and usually very helpful (though treatment usually takes time to be effective).
- Encourage the person to engage in activities that they found pleasurable before, even if those activities do not seem appealing at present.
- Advocate the importance of getting regular sleep, and encourage regular exercise.
- Emphasize the benefits of engaging in regular social activities.
- Stress the importance of recognizing thoughts of *suicide and seek help if those thoughts are recognized.*

*Note - Suicide Risk* (Session 13 will be on self-harm/suicide)

People suffering from moderate - severe depression are at higher risk of suicide. Closely monitor the person and ask about thoughts or plans of suicide/self-harm. It is important to realise that asking about suicide does not put ideas into people’s head. In contrast it can be a relief to the person to have a chance to discuss their feelings and thoughts.

**Involve supportive family members and friends**

The support of loving family members and friends can facilitate recovery (See Session 15 on Carers for more information).

**Address Social Stressors**

Give the person an opportunity to talk openly. Ask about what is going on in his/her life:

- Family difficulties
- Relationship difficulties
- Financial stress
- Employment related stress
- Negative behaviour from neighbours, colleagues, community
- Other

Is violence, abuse or neglect (of children and the elderly) suspected? If so, are there any community supports or services in place that you can refer to?

**Problem Solving**

Help the person to find ways of problem solving. This may be done by identifying small manageable tasks at a time.
The aim of problem solving is not to solve people's problems for them, rather it is to help them solve their own problems. Steps in problem solving include:

- Identify the problem/s through a process of discussion.
- Explore the problem/s and how it/they relate to any symptoms such as excessive fear and worry. Sometimes it is useful to draw a picture of the problem to help understand it.
- Select one problem only (select a problem that has an achievable solution) and a goal for overcoming this particular problem.
- Brainstorm possible solutions together, and once an appropriate and achievable solution is agreed upon, help the person make a plan for carrying out the solution - one step at a time.
- Encourage the person to try out the solution and review the outcome. Did it help?

Reactive Social Networks

- Ask the person about prior social activities, identify positive activities that if reinitiated would provide support (e.g. family gatherings, sports, religious activities, community activities).
- Build the person's confidence and encourage them to engage in social activities as far as possible.

Pharmacological

Antidepressants are commonly used to treat depression. Consider if medication is necessary. Symptoms should have lasted for at least two weeks and be seriously affecting the person's day to day life, prior to prescribing antidepressants.

There are two main types of antidepressants.

- Tricyclic antidepressants - TCAs (Amitriptyline)
- Serotonin Booster* - SSRIs (Fluoxetine)

According to the WHO, essential medicines for depressive disorders are: Amitriptyline and Fluoxetine


Considerations when prescribing Antidepressants:

- SSRIs* are the first choice for people who have suicidal thoughts or thoughts of harming themselves.
- To avoid overdose in a person at risk of self-harm, prescribe only one week of antidepressants at a time.
- All antidepressants are similarly effective in treatment of acute depressive symptoms but they differ in terms of side effects.
- Antidepressants take three to four weeks to act and it is very important that you take them every day.
- Treatment must be continued for at least nine to twelve months to avoid relapse.
- Antidepressants only work if they are given in the right dose.
- TCAs can cause drowsiness, tell patients to avoid alcohol.
- Side effects are often short-lived. Encourage patients to continue medication if they do experience side effects.
Avoid TCAs in older people and people with cardiovascular disease.

SSRIs cause fewer side effects but may be more expensive.

Follow UP

- Provide regular follow up (e.g. in person at the clinic, by phone, or through community health workers).
- Re-evaluate the person for improvement (e.g. after 4 weeks).

Did you Know?

- Abraham Lincoln: The revered sixteenth President of the United States suffered from severe and incapacitating depression that occasionally led to thoughts of suicide, as documented in numerous biographies by Carl Sandburg. (National Alliance on Mental Health, http://www.nami.org/template.cfm?section=Helpline)

- Mahatma Gandhi was believed to suffer from depression in his last years of life. (http://www.lib.virginia.edu/area-studies/SouthAsia/gandhi.html)

- Depression is twice as common in women compared to men. (http://www.who.int/mental_health/prevention/genderwomen/en/)

- In a study conducted by the Asian Psychological Association, Asian Americans had a lower rate of depression than white Americans. Do you think this is because the rate of depression is really lower in the Asian American population, or that reporting is different between the two populations? http://www.apa.org/monitor/feb06/health.aspx

Step 2:
Handout I summarizes information given in presentation.

Task 2 - Group Activity (30 minutes)
Directions: Step 1 (20 minutes)
Split the participants into four groups. Ask participants to read Case Studies C and D carefully, and then to design flow charts as to how they would access/decide/manage the condition. An example of a flow chart is given here below.
The case study may give limited information; ask participants to make notes of all questions they would further want to ask. For the sake of this exercise manage the condition you think is most likely.

**Step 2 (10 minutes)**

Ask one member from each group to present their flow chart to the rest of the group. See notes below for facilitator.

### Information for Facilitator - Case Study C

Lucy is likely experiencing postnatal depression; it is very common during pregnancy or up to one year after the child is born.

**Flow Chart**

**Assess:** Lucy is experiencing the following symptoms:

- Decreased energy or easily fatigued
- Reduced concentration and attention
- Reduced self-esteem and confidence
- Disturbed sleep
- Difficulties carrying out usual work
Decide: Symptoms suggest depression and since Lucy has recently had a child, very likely postnatal depression. However, one should also assess for concurrent conditions or other explanations.

Examples of further questions the health provider may want to ask Lucy:

- How long have the symptoms lasted?
- Ask about thoughts of self-harm/suicide.
- Rule out other medical explanations.
- Does Lucy have depression with psychotic features (delusions, hallucinations)? If so suspect postpartum psychosis - consult a specialist. (Note that psychosis will be covered in Session 7).
- Ask about prior episodes of manic symptoms. (Bipolar disorder will be in Session 8). Concurrent conditions: Consider possible alcohol use disorder, other medical illnesses.

Manage as moderate / severe depression. (Consult a specialist before prescribing antidepressants as the mother is likely breast feeding).

Closely Follow Up

Information for Facilitator - Case Study D

Anny is suffering from moderate - severe depression. You should pay special attention to her contemplation of suicide. (Note that suicide/self-harm will be gone over in Session 13).

Assess: Symptoms include:

- Tired all the time
- Loss of interest in activities that used to be enjoyable (e.g. food, reading, children)
- Low self-esteem
- Feeling guilty
- Somatic symptoms, e.g. headache
- Contemplating suicide
- Difficulties in carrying out usual work, school, domestic or social activities

Decide: Symptoms suggest moderate / severe depression.

Ask Anny about:

- Current thoughts or plans to commit suicide or self-harm
- Access to means of self-harm

Rule out any other underlying medical cause. Recent loss of loved one/major life change?

Note that asking about self-harm/suicide does not provoke one to act. However, try to establish a relationship with the person before asking questions about self-harm.

Manage: For depression, see above or handout. Prescribe antidepressant. Note that SSRIs are first line of treatment for people with thoughts of self-harm/suicide.

Closely Follow Up
Task 3 - Group Discussion and Role Play (30 minutes)

Directions: Step 1 (20 minutes)
Facilitator leads a group discussion.

- Ask participants to discuss how depression is perceived in their setting.
- Do they routinely screen people for depression? (Discuss how they can use the 3 questions introduced during the presentation for screening purposes - see Step 2 below).
- Who would they screen, who do they perceive being at high risk?
- Ask participants if there are any services or protocols in place if any of the following is suspected: maltreatment, abuse, e.g. domestic violence, neglect (of children and older people). Introduce the service charts (See Material for Participants) that can be filled out by participants throughout the course, give participants a few minutes to start filling out these charts.

Step 2 (10 minutes)
Ask participants to work with a neighbour. One participant will act as the health personnel and the second participant as a person who has come to the clinic. The health personnel practices by asking screening questions for depression (e.g. For the last two weeks have you felt sad? Most of the day? Almost every day?)

- It is not always easy to ask these questions, therefore practicing how to introduce the questions is important in order to feel comfortable doing so.

The facilitator does a short demonstration and then asks participants to come up with a script themselves. They can use the script below, or case studies from Task 1 for support.

<table>
<thead>
<tr>
<th>Health Personnel: Hello Rita, what can I do for you today?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rita:</strong> I am still not sleeping, my stomach aches, I have no appetite, and my back is aching.</td>
</tr>
<tr>
<td><strong>Health Personnel:</strong> I am sorry to hear, Rita, that you are still not feeling well. We did a lot of tests last time when you were here which came out negative. Let’s see if we can figure out what is bothering you. Tell me, Rita, have you felt sad for the last two weeks?</td>
</tr>
<tr>
<td><strong>Rita:</strong> Yes, I have.</td>
</tr>
<tr>
<td><strong>Health Personnel:</strong> When you say sad, is it most of the day? Every day?</td>
</tr>
<tr>
<td><strong>Rita:</strong> I feel down most of the time.</td>
</tr>
<tr>
<td><strong>Health Personnel:</strong> Are you doing activities that you did before, like the women’s group that you used to attend, have you been going to the meetings?</td>
</tr>
<tr>
<td><strong>Rita:</strong> No, I have not been going for the last month, I do not even write to my own children.</td>
</tr>
<tr>
<td><strong>Health Personnel:</strong> Why do you think you are not doing activities that you enjoyed before?</td>
</tr>
<tr>
<td><strong>Rita:</strong> I feel very tired all the time, just the thought of going seems overwhelming.</td>
</tr>
</tbody>
</table>
Step 3:
Ask two pairs of participants to demonstrate their script to the rest of the group.

Context Specific Notes (Facilitator’s Notes)

Session 5 References

1. Mental Health Programme in Egypt: Diagnostic and Management Guide for Mental Disorders in Primary Care
2. WHO, Pharmacological treatment of mental disorders in primary health care
3. Patel, Where there is no Psychiatrist
4. WHO, mhGAP - IG
Introduction to Psychosis (Including Schizophrenia)

Session Aim: To introduce symptoms of psychosis and how to appropriately manage them.

Session Tasks:
1. Presentation by facilitator + handout II
2. Participants read a case study.
3. Facilitator(s) use scripts to demonstrate communication techniques.
4. Participants answer the questions of a concerned mother.

Session Duration: 90 minutes

Materials:
- Black/white board for presentation
- Role Play Script 1 and 2 (Appendix G)
- Case Study E (Appendix E)

Session 6: Task 1 - Presentation (30 minutes)
Directions: Step 1
Presentation by facilitator, see Information for Facilitator box.

Information for Facilitator

What is Psychosis?
Psychosis is characterized by delusions (false beliefs), hallucinations (false sensory perceptions not shared by others) and loss of contact with reality, narrowed range of emotions and often bizarre behaviours. Psychosis can also lead to difficulties with social interactions and, depending on severity, difficulties with carrying out daily activities. Although psychotic symptoms can be associated with a range of medical conditions (e.g. physical trauma, temporal lobe epilepsy, dementia, neurological and endocrine disease, metabolic abnormalities and substance abuse disorders), they are most commonly associated with schizophrenia and schizophrenia related disorders and will be the primary focus of this session.

Both men and women are affected equally by schizophrenia, though onset is believed to be later in women. Symptoms may develop rapidly over several weeks or more slowly over several months.

Common Symptoms of Psychosis
- Delusions - False beliefs, e.g. thinking others are trying to harm him/her, or believing that his/her mind is being controlled by others. * (Refer section below).
- Hallucinations - False perceptions - seeing, smelling or tasting things that are not there, and most commonly hearing voices that are not there. * (Refer section below).
Strange behaviours, e.g. talking to himself/herself.

Poor concentration and inability to think clearly.

Lack of motivation to do things or over activity.

Inappropriate emotions, e.g. laughing at something sad.

Loss of social skills and social withdrawal.

Restlessness, walking up and down.

Poor personal hygiene.

Saying things that do not make sense to others.

Sometimes aggression/agitation.

Neglect of usual responsibilities related to work, school or domestic activities.

*About False Beliefs/Unusual Beliefs:

Unusual beliefs that are obviously false are called delusions.

These false beliefs cannot be altered through reason.

The false belief is very real to the person who is experiencing it.

Examples include a person thinking:
1. Others are talking about them, trying to hurt them, plotting to harm them or interfering with their thoughts.
2. That they have great wealth, talent, power, influence and beauty.
3. That they are incredibly ugly and their appearance disgusts others.
4. They are dead, dying or no longer exist

*About False Perceptions/Hearing Voices:

- The person hearing voices may be quite frightened because the voices are very real to him/her.
- People who hear voices can appear to be talking to themselves, but they are actually answering the voices.
- Occasionally the voices may instruct the person to inflict self-harm or harm others.
- The person hearing voices may also be very suspicious of others and have unusual beliefs, e.g. believing that people are spying on them.
- The person who is hearing voices may not be taking good care of themselves.

**Diagnosing Psychosis**

If multiple symptoms (see above) are present, psychosis is a possibility. **If feasible, refer to a specialist for all first episodes to confirm the diagnosis and for advice regarding appropriate treatment.**

**Differential Diagnosis** that can cause psychotic symptoms:

- Alcohol or drug induced symptoms.
- Alcohol or drug withdrawal symptoms
- Medical conditions (e.g. delirium due to cerebral malaria, sepsis, head injury).
Suspect **chronic psychosis** if symptoms persist for more than 3 months.

**Bipolar disorder** if symptoms of mania exist, for e.g. elevated mood. Will be covered during Session 8.

**Depression** (depressive psychosis), if depressive delusions are prominent.

### Initial Response

**How to help a person who you suspect to be experiencing symptoms of psychosis**

1. Assess the risk of suicide and harm to self or others.
   - Try to determine if there is any risk of self-harm or any threat of harm to others.
   - A person who is hearing voices may be frightened and suspicious and needs to be approached in a very non-threatening way.
   - If the person is suicidal seek help.
   - If the person threatens violence to others try to restore calm and safety

2. Listen without judgment.
   - Speak calmly, clearly and in short sentences.
   - Introduce yourself and let him/her know that you want to help.
   - Don’t be critical of the person.
   - Avoid confrontation and arguments.
   - Don’t tell him/her that there are no voices or that his/her beliefs are wrong.
   - Don’t pretend that you can hear the voices or agree with false beliefs.

3. Give reassurance and information.
   - Try to talk to the person when he/she is calm and thinking clearly.
   - Be honest and try to win the person’s trust.
   - Do not make promises you cannot keep and do not lie to the person.

4. Encourage the person and reassure him/her that you can help.
   - Refer to a specialist if needed/available.

### Treatment

Different forms/stages of psychosis need different management. Therefore before putting together a treatment plan, one needs to take into consideration whether it is acute or chronic psychosis, depression / manic psychosis. (For the latter, refer to Session 7). Here below are general treatment guidelines that can be adapted appropriately to meet different needs.

#### Non Pharmacological Treatment

Provide education to the person and families. Emphasize: (1) that with treatment the person’s condition will likely improve significantly; (2) the importance of continuing social, educational and occupational activities; (3) the importance of taking medicine regularly; (4) the importance of maintaining a healthy lifestyle (exercise, maintaining personal hygiene, avoiding alcohol); (5) the **right of the person to be involved in every decision that concerns his or her treatment**.

**Explain to his/her family** (1) that hearing voices is a symptom of psychosis and that he/she may firmly believe things that are untrue, (2) that the person with psychosis will often refuse that they are ill, (3) that it is important to recognize relapses or worsening symptoms, (4) that it is important to include the person in family and social gatherings , (5) that in general, it is better for the person to live with family or community members in a supportive environment outside hospital settings.
See Session 15 for more information on carers.

**Pharmacological Treatment**

Antipsychotic medication is used to treat psychosis. Medication should be started immediately after diagnosis has been made. (If possible consult with a specialist to confirm diagnosis, and discuss treatment plan).

The following antipsychotic drugs are on the WHO list of Essential Medicines:
- Chlorpromazine (Injection/Oral)
- Fluphenazine (Injection)
- Haloperidol (Injection/Oral)

**Things to Consider when Prescribing Antipsychotic drugs**
- Prescribe one antipsychotic medication at a time - “Start low - go slow.” (Part III of this training manual will go over medication and include a chart with recommended dosages).
- Try medication at optimum dose for at least 4 - 6 weeks before considering it ineffective.
- Side effects may be reduced by reducing the dose slightly.
- Oral haloperidol or chlorpromazine should be offered routinely to a person with psychosis.
- Only consider intramuscular long lasting treatment (injection) if adherence is poor.
- For acute psychosis, continue antipsychotic treatment for 12 months after recovery.
- For people with chronic psychosis, consider stopping treatment if the person has been stable for several years, weighing the increased risk of relapse following discontinuation of medication.

**Follow Up**
- Regular follow up is required.
- Initial follow up should be frequent (even daily) until acute symptoms begin to respond to treatment.
- After the person starts to respond to treatment, monthly to quarterly follow up is advised, or based on individual need and feasibility (e.g. staff availability, distance from clinic).
- During follow up visits, assess for; (1) symptoms, (2) side effects of medications, (3) adherence, (4) concurrent medical conditions, (5) need for non pharmacological interventions at each stage.

*Note - Non adherence is common and therefore involvement of carers is important during such times. (Session 15)*

**Did You Know?**
- After recovering from schizophrenia John Nash won the Nobel Prize in 1994 for Economics. Mental health experts say that while Nash’s life is undeniably remarkable, his gradual recovery from schizophrenia is not.
  http://www.depression-guide.com/john-nash-schizophrenia.htm

Media often hypes the relationship between mental illness and violence, and particularly in relation to psychosis. In fact people with mental illness are much more likely to be the VICTIMS of violence.
than the perpetrators. It is important to remember that most violent crimes are not committed by persons with psychosis, and most persons with psychosis do not commit violent crimes. Substance abuse significantly raises the rate of violence in people with psychosis but also in people who do not have any mental illness.

http://www.healthyplace.com/thought-disorders/nimh/are-people-with-schizophrenia-likely-to-be-violent/menu-id-1154/

**Step 2**
Handout II summarises information given in presentation.

**Task 2 - Case Study (15 minutes)**
**Directions:** Ask participants to read Case Study E and work with a partner. First carefully read the case study and then answer the questions below.

- What is likely causing Sara's strange behaviour?
- Think about how you (the health professional) would communicate with Sara and her mother. This will lead into the next step of the activity, so just briefly discuss with a partner what you think is important to remember in order to communicate effectively with the person suffering from psychosis and their family.

**Task 3 - Role Play (20 minutes)**
**Directions:** Use Role Play Script 1 (Appendix G). The aim of this exercise is to show that the type of response can make a difference to the person with a mental disorder. Some can make the situation better and some will make it worse. The role play requires two facilitators and should take about 5 minutes.

- Ask the participants to watch the actions of the person responding to Sara.
- Ask participants to watch how Sara responds.
- After the role play ask the group to discuss how the person responding to Sara behaved and what happened to Sara.

Now role play using Role Play Script 2. This role play also requires two facilitators and should take about 5 minutes.

- Ask the participants to note the actions of the person responding to Sara.
- Ask participants to note how he/she responds.
- After the role play ask the group to discuss how the person responding to Sara behaved and what happened to Sara.
- Ask participants which seemed to be the most helpful way of responding to Sara and why.

**Task 4 -Questions (25 minutes)**
**Directions:** Ask participants to imagine that after consultation with Sara and her mother, you have consulted with a specialist who has confirmed your diagnosis of psychosis. These are some of the questions that Sara's mother has. Divide participants into small groups and ask them to try to answer her questions.
a) Will the symptoms ever completely go away?
b) What has caused her condition? I have thought it was witchcraft for years.
c) Will I be able to take Sara with me to family gatherings, because now people worry that she will hurt others or herself?
d) How do I know if the medication is effective when no other remedies from the traditional healer seemed to work?
e) What are some of the side effects of the medication?
f) Will she be able to stop taking the medication once the symptoms have gone away?
g) Will Sara be able to work again?
h) Do you think it is better for Sara to go to a hospital to live while she gets better?
i) If she has children will they also get the illness?
j) Should she avoid marrying?
k) If she refuses the medication, should I hide it in her food?

When finished each group is asked to read out one of their answers. Ask other groups to comment if their answers differ significantly.

Information for Facilitator

Examples of answers: Important to note that there is often more than one correct answer.

a) It can vary greatly. In most cases symptoms improve after initiating treatment. It is important to keep managing treatment and to find out what can be done to help Sara.

b) The cause of schizophrenia is not completely understood, although it is not caused by witchcraft. Experts say that it is a combination of genetic and environmental factors that may cause schizophrenia.

c) Yes, it is important to include Sara in family and other social gatherings. People with psychosis are often discriminated against, but should enjoy the same rights as all people. Explain to your family that her condition was not due to witchcraft but as a result of a medical condition that she is now receiving treatment for.

d) See if Sara’s symptoms improve. Do the voices disappear or fade? Is she able to return to doing tasks she was doing before? It is important to remember that it takes time for the medication to be effective, therefore try the medication and dose for at least 4 - 6 weeks before considering it ineffective.

e) These are some reported side effects, for e.g. some medications make you drowsy, dizzy. There is muscular rigidity or difficulty in urinating. Tardive dyskinesia (involuntary muscular movements) can be a long-term side effect of some antipsychotic medications. Neuroleptic malignant syndrome is another symptom, very rare and potentially life-threatening, with muscular rigidity, elevated temperature and blood pressure.
f) For acute psychosis, treatment should be continued for at least 12 months after signs of improvement.

g) It is important for Sara to be meaningfully occupied. Work can also help her recovery, as she will gain confidence. To be meaningfully occupied can be doing household chores; you can start with simple tasks and build up from there.

h) In general it is better for the person to live with family or community members in a supportive environment outside hospital setting. Long-term hospitalization should be avoided, except in special cases.

i) Some women worry about passing the illness on to their children, since genetics are one of the known risk factors of developing schizophrenia; however, there are many women who have had healthy children. If Sara decides later on to have children she should discuss it with her doctor, it might be important to change her medicines or lower the dosages while she is pregnant.

j) Sara can get married, she should be encouraged to live a normal life as far as possible.

k) Try to get consent from Sara, as a last option you may consider hiding medicines in her food. You might want to discuss this with her when she is feeling well. Ask her in advance to give you consent to do this.
SESSION 8

Introduction to Bipolar Disorder

Session Aim: To enable participants to recognize symptoms of bipolar disorder and manage appropriately.

Session Tasks:
1. Presentation + handout III
2. Role Play - Design a Script
3. Recap Activity

Session Duration: 90 minutes

Materials: Black/white board for presentation, Case Study F (Appendix E)
Role Play 3 (Appendix G)

Session 7 - Task 1 (30 minutes)
Directions: Step 1
Presentation by facilitator, see Information for Facilitator box.
**Information for Facilitator**

**What is Bipolar Disorder?**

A person with bipolar disorder experiences extreme mood swings from:

- Depression - Low mood, decreased energy and activity
- Mania - Increased energy and activity
- Normal - Commonly recovery is complete between episodes.

People who experience only manic episodes are also classified as having bipolar disorder. In severe cases, patients may have hallucinations (hearing voices or seeing visions) or delusions during periods of mania or depression.

The onset of manic symptoms can be very gradual, with weeks or even months before the disorder becomes fully recognizable.

**Common Symptoms/Diagnosis**

**Depression:** Symptoms similar to that of depression (see Session 6).

**Mania:**

- A very happy mood or irritability
- Increased activity and excitement, unable to be still and relax
- Unrealistic plans or ideas
- Spending a lot of money
- Not sleeping
- Rapid talking
- Inflated self-esteem
- Increased sexual energy or inappropriate sexual behaviour
- Limited understanding that he/she is behaving in an unusual way.

If other medical conditions have been ruled out, and multiple symptoms exist that have lasted for at least 1 week and are significantly interfering with the person’s day to day life, mania is likely.

**Differential Diagnosis:** Make sure that no other physical illness or substance abuse disorders are causing the manic symptoms.

Both men and women can be affected, usually in early adulthood.

**Treatment**

1. **Non Pharmacological Treatment**

**Psycho Education:** Explain what bipolar disorder is to the person and their family.

**Monitor Mood:** Such as through keeping a daily mood log.
**General Coping Plan:** Regular work or school schedule that avoids sleep deprivation. Seek advice on major decisions (particularly finances).

**Prevent Relapses:** Come back if symptoms return. A person in the manic state might not want to seek care, therefore it is important for carers to be part of relapse prevention (Session 15).

**Build Relations:** It is important for the health professional to build the trust of the person with bipolar disorder. This might also improve treatment adherence.

**Resume positive social activities,** such as hobbies, exercise, social networks.

**2. Pharmacological Treatment**

If the person is in a state of mania, consider using one of these mood stabilizers (see below), or antipsychotic medication may be used for quicker results in the case of acute mania. *Consult a specialist if possible.*

- Lithium carbonate
- Sodium valproate
- Carbamazepine

Discontinue any use of antidepressants if the person is in the manic state.

**Things to Consider:**

- None of these drugs should be given to pregnant women.

If a person in a manic state is feeling agitation, consider short-term use of a benzodiazepine such as diazepam.

- Lithium must not be used if there are no facilities for testing blood levels of the drug.

- Treatment should be regularly monitored every 3 - 6 weeks.

- If a person has known prior episodes of mania but now has depression, do not prescribe antidepressants alone - they are less likely to induce mania if prescribed with mood stabilizers or antipsychotic therapy. Consult a specialist if available.

- Continue medication at least for 2 years after an episode. Many patients will need treatment for longer.

**Follow Up**

- **Regular follow up is very important.** People in manic state often are unable to see the need for treatment and may stop taking their medicines, therefore the relapse rate is very high.

- In order to prevent relapses it is crucial to involve supportive family members or carers.

- At each follow up, assess (1) symptoms, (2) side-effects of medications, (3) adherence and (4) success of non pharmacological interventions.

- A person with mania should be evaluated as frequently as possible (e.g. in person at the clinic, by phoning the person with mania or/and their carer, or through home visits by CHWs). The evaluation should be more frequent until the manic episode is over.
Did you know?

*Note

The facilitator is advised to do research beforehand on public figures from their country to include with this list.

The following people are believed to have suffered from bipolar disorder.

Author **Virginia Woolf** who wrote To the Lighthouse and Orlando experienced the mood swings of bipolar disorder characterized by feverish periods of writing and weeks immersed in gloom.

Composer **Ludwig van Beethoven**, the famous opera singer **Gaetano Donizetti**, the artist **Vincent Van Gogh** are other people who had bipolar disorder.

*Note

It is often believed that there is some link between bipolar disorder and creativity. However this link should not be over romanticized; both Woolf and Van Gogh committed suicide. A person who is suffering or suspected to suffer from bipolar disorder should always seek treatment.

Step 2: Handout III summarizes information given in presentation.

**Task 2 - Design a Script (45 minutes)**

**Directions: Step 1 (15 minutes)**

Ask participants to work in pairs for this activity. The participants will decide who will act as the doctor and who will be the husband of Manik (See script below, or Role Play 3 - Appendix G).

Read carefully the script between Manik’s husband and the doctor. As one will notice, the script is incomplete, therefore it is the participants’ role to improvise and complete the script.

The facilitator should walk around and observe how the different groups are progressing with the activity. If anyone is struggling, help them, the box for facilitator has some useful suggestions.

The purpose of this activity is to demonstrate how important it is for health professionals to build relationships with the person suffering from bipolar disorder and his/her family/carer. This is true for all mental illnesses, perhaps particularly for bipolar disorder because the relapse rate is very high and the person in the manic state may often refuse that he/she is ill. This exercise helps the participant think of how to tackle such situations.

**Role Play 3**

**Scene:** Manik’s husband calls the health clinic. He is very distressed.

**Manik’s husband:** My wife Manik is a 31 year old woman. She has started behaving in an unusual manner. She is sleeping much less than usual and is constantly on the move. Manik has stopped looking after the house and our children as efficiently as before. She is talking much more than normal and often says things that are unreal and grand, such as that she can heal other people and that she comes from a very wealthy family, even though I’m a farmer. She has also been spending all our money on things we cannot afford. I tried to bring her to the clinic but she becomes angry and irritable.

**Health Professional:** Participants to improvise
Information for Facilitator
Examples of questions that the health professional may ask:

1. How long have the symptoms lasted?
2. Ask about past experiences. Has this occurred before? Has Manik experienced symptoms of depression? (Explain symptoms of depression).
3. Any concurrent conditions, alcohol or drug use?
4. Do you believe that Manik is contemplating self-harm?
5. Discuss ways of getting Manik and her husband to come to the clinic. If not possible can you go and see them at home?
6. Ask about particular stresses or pressures that Manik might have been under.
7. Explain that it is important to speak calmly to Manik. She is likely suffering from a mental illness, what she is feeling may seem very real to her. Therefore do not get angry at her for not telling the truth. Explain that you believe that they can help her at the health centre. Try to convince her to come in for a consultation.

Examples of questions that Manik’s husband may ask:

1. Why is she behaving like this?
2. Is there a cure, do you think you can help her?
3. How do I stop her from spending all our money? I get really angry at her, also for saying things that are untrue.
4. Will the medication alleviate her symptoms?
5. What else can I do to help her?

Step 2
Ask participants to continue with Role Play 4. Ask them to switch so that whoever played Manik’s husband in step 1, becomes the doctor. As in the previous step, the script is incomplete, therefore it is the participants’ role to improvise and complete the script.

Again the facilitator should walk around and observe how the different groups are progressing with the activity. If anyone is struggling, help them, the box for facilitator has some useful suggestions.

Role Play 4
Scene: This scene takes place four weeks later. During her last visit, Manik was prescribed medication, as well as given advice on how to manage her illness. Manik has come to the clinic for a follow up visit.
**Health Professional:** Hello Manik, nice to see you again. How have you been feeling lately?

**Manik:** Ever since I have started taking drugs from the hospital, I am doing well, only that I feel dizzy and tired, especially when I take the drugs. I have stopped taking the medicine for about two weeks now. Look, the drugs are making me very fat. I don’t hear voices any more, I do settle in one place instead of walking aimlessly down streets.

**Health Professional:** Participants improvise

**Manik:** Participants improvise

**Health Professional:** Participants improvise

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**Information for Facilitator**
Manik’s comments reflect an attitude towards medication that is common for people with bipolar disorder (as other mental illnesses). Manik says the drugs make her feel dizzy and tired. She has stopped taking her medications, which can lead to relapse.

The person acting as the health professional should steer the conversation to address the importance of taking medication regularly. Get more feedback from Manik about side effects, it might be important to change the dosage. Involve Manik’s husband in follow up procedures and re-emphasize to him how important it is for Manik to take her medication regularly.

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**Step 3 (15 minutes)**
When participants have completed the role play as described in Step 1 and 2 ask a few pairs of participants to perform their script to the rest of the group. Together discuss what is important to consider when treating a person suffering from bipolar disorder. The facilitator writes down key suggestions on the black and white board.

**Task 3 - Recap (15 minutes)**
To conclude this session, ask participants to work in pairs. In pairs come up with five things they can recollect from this session. The facilitator then asks each pair to share one recollection with the rest of the group.

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**Context Specific Notes**

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**Session 7 References**
1. BasicNeeds: An Introduction to Mental Health, Facilitator’s Manual for Training Community Health Workers in India
2. Mental Health Programme in Egypt: Diagnostic and Management Guide for Mental Disorders in Primary Care
3. WHO mhGAP- IG
Session Aim: Introduce participants to epilepsy recognition and management.

Session Tasks:
1. Presentation + Handout IV
2. Group Activity - Role Play
3. Recap Activity

Session Duration: 90 minutes

Materials: Black/white board, 5 printed copies of mhGAP - IG, Role Play Scripts 3-5 (Appendix G).

Task 1 - Presentation (30 minutes)
Directions: Step 1
Presentation by facilitator, see Information for Facilitator box.
Information for Facilitator

What is Epilepsy?

*Note

Epilepsy is NOT a mental illness, but rather a neurological condition. This training manual includes mental, neurological and substance disorders although sometimes we may speak generally of mental illness when really referring to MNS disorders.

“Epilepsy is a chronic condition, characterized by recurrent unprovoked seizures.”

There are two main forms of epilepsy:

Non Convulsive: “Has features such as change in awareness, behaviour, emotions or senses (such as taste, smell, vision or hearing) similar to mental health conditions, so may be confused with them.”

Convulsive: “Has features such as sudden muscle contraction, causing the person to fall and lie rigidly, followed by the muscles alternating between relaxation and rigidity, with or without loss of bowel or bladder control. This type is associated with greater stigma and higher morbidity and mortality.”

This session focuses on convulsive epilepsy.

What Causes Epilepsy?

“It has several causes; it may be genetic or may occur in people who have a past history of birth trauma, brain infections or head injury. In some cases, no specific cause can be identified. Seizures are caused by abnormal discharges in the brain and can be of different forms; people with epilepsy can have more than one type of seizure.”

Acute Seizure Management

*Note – refer to mhGAP - IG for acute seizure management.

- Check airway, breathing and circulation.
- Protect person from injury: make sure they are in a safe place away from fire or other things that might injure them.
- DO NOT leave the person alone. Seek help if possible.
- Put the person on their side to prevent aspiration.
- DO NOT put anything in the mouth.

Is the person unconscious or convulsing?

Measure: Blood pressure, temperature and respiratory rate.

Look for: (1) Signs of serious head and spine trauma, (2) Pupils: dilated or pinpoint? Not equal? Not reactive to light? (3) Signs of meningitis, (4) Focal deficits.

Ask about:

- If unconscious, ask accompanying person, “Has there been a recent convulsion?”
- Duration of impaired consciousness / convulsion.
- Number of convulsions.
- History of head trauma or neck injury.
- Other medical problems, medications or poisons (e.g. organophosphate poisoning), substance use such as stimulant intoxication, benzodiazepine or alcohol withdrawal (Session 12).
- A history of epilepsy.

**If Convulsing:**
- Insert an intravenous (i.v.) line and give fluids slowly (30 drops / minute).
- Give glucose i.v. (5 ml of 50 % glucose in adults; 2 - 5 ml / kg of 10 % glucose in children).
- Give diazepam i.v. (10 mg) slowly (Child: 1 mg / year of age) or lorazepam i.v. 4 mg (0.1 mg / kg), if available.
- Give diazepam rectally (same dose as above) if i.v. line is difficult to establish.
- **DO NOT** give intramuscular (i.m.) diazepam. If convulsion does not stop after 10 minutes of first dose of diazepam, give second dose of diazepam or lorazepam (same dose as first) and REFER PERSON URGENTLY TO HOSPITAL.
- **DO NOT** give more than two doses of diazepam.

**If in second half of pregnancy or up to 1 week postpartum AND no past history of epilepsy, suspect eclampsia.**
- Give magnesium sulfate 10 g i.m.: Give 5 g (10 ml of 50 % solution) i.m. deep in upper outer quadrant of each buttock with 1 ml of 2 % lignocaine in the same syringe.
- If diastolic blood pressure is > 110 mmHg, give hydralazine 5 mg i.v. slowly (3 - 4 minutes). If i.v. is not possible, give i.m. If diastolic blood pressure remains > 90 mmHg, repeat the dose at 30 minute intervals until diastolic blood pressure is around 90 mmHg. Do not give more than 20 mg in total.

REFER PERSON URGENTLY TO HOSPITAL and follow local guidelines for management of pregnancy, childbirth and postpartum care.

**Symptoms/Diagnosing Epilepsy**
Epilepsy symptoms may vary greatly between different individuals; but are usually characterized by a **convulsive seizure**. If a person experiences at least two seizures in one month, one can suspect epilepsy.

Some people experience some sort of **Warning Aura** just before they have a seizure. Could include changes in sensations, headache, anxiety and mood change (often unique to each individual).

**Ask about:**
- Loss of impaired consciousness
- Stiffness, rigidity lasting longer than 1 - 2 minutes
- Convulsive movements lasting longer than 1 -2 minutes
- Tongue bite or self-injury
- Loss of control of urine and/or faeces
- After seizures: Fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches
If convulsive movements present and at least 2 other criteria, consider epilepsy, but first rule out other acute causes.

**Differential Diagnosis**
- Head or neck injury
- Neuroinfection (meningitis/encephalitis)
- Substance abuse
- Alcohol withdrawal
- Cerebral malaria
- Hypoclycaemia or hyponatraemia

If head or neck injury, or neuroinfection suspected, manage convulsions as above (acute seizure management). *Head or neck injury: DO NOT move neck because of possible cervical spine injury.* Log-roll person when moving.

**REFER PERSON URGENTLY TO HOSPITAL**

**Epilepsy - Treatment/Management**

**Pharmacological**

**Antiepileptic drugs:** Phenobarbital, phenytoin, carbamazepine or valproate based on availability.

**Things to Consider**

* Initiate with only one antiepileptic drug at a time, initiate with the lowest dosage and slowly build up until seizure control has been obtained. (More details about recommended dosages will be given in Part III of this training).

* The correct dosage is the smallest one at which complete seizure control is achieved without adverse effects.

* Only consider stopping treatment if no seizures have been detected for up to two years. In some cases, long term antiepileptic therapy may be required.

* Pregnant women and anticonvulsants: Avoid valproate in pregnant women, avoid polytherapy in pregnant women, advise delivery in a hospital. At delivery, give 1 mg vitamin K i.m. to the newborn to prevent haemorrhagic disease of the newborn.

**Non Pharmacological Education**

Explain that although epilepsy is a chronic condition, seizures can be fully managed in 75% of individuals, after which they can live without medication for the rest of their lives.

There are often misconceptions about epilepsy, such as that it is a contagious disease, or that it is caused by witchcraft or evil spirits. It is important to correct any such ideas and emphasize that people with epilepsy can lead normal lives, they can have families and work in most jobs (with exception of perhaps near heavy machinery, or involving driving).
However, people with epilepsy might want to make lifestyle changes by ensuring that they:

- Receive regular sleep
- Eat regularly
- Limit alcohol intake
- Avoid extreme exercise
- Avoid swimming alone
- Avoid situations that might lead to sudden excitement or stress

**Things to remember when an individual is having a seizure:**

- Lay the person on their side, with head turned to the side to help keep the airway open, and prevent aspirating secretions and vomit.
- Make sure the person is breathing properly.
- Do not put anything in the person's mouth.
- Do not try to restrain the person having a seizure.
- Stay with the person until the seizures are over.
- If the person feels the seizures coming, ask them to lie down somewhere safe to protect themselves from falling.
- Epilepsy usually starts before the age of 30. If someone is having a first seizure and is over the age of 30, the person may suffer from a serious brain or medical disorder.

**Follow Up**

- Ask and look for symptoms, response, side effects and adherence.
- The side effects could be because of high dose of the antiepileptic drug, or these could be idiosyncratic effects such as allergic reactions, bone marrow depression, or hepatic failure.
- For more details of individual antiepileptic drugs, see *Part III*
- If there are dose-determined adverse effects, decrease the dose of the medication. In case of idiosyncratic reactions, stop the antiepileptic drug the person is on and switch to any of the other antiepileptic drugs.
- If response is poor (less than 50% reduction in frequency of seizures) despite good adherence, increase to maximum tolerated dose.
- If response still poor, try monotherapy with another drug. Start the second drug and build up to an adequate or maximum-tolerated dose and only then taper slowly off the first drug.
- If seizures are very infrequent and higher doses of medications produce side-effects, less than complete seizure freedom may be the goal.
- If seizures continue after attempts with two monotherapies, review diagnosis (including co-morbidity), treatment adherence and, if necessary, consult a specialist for further assessment and treatment.
- If there are adverse effects or response is poor, follow up monthly.
Continue to meet every 3 months if seizures are well under control.

*Note
As noted above epilepsy is not a mental illness, but rather a neurological condition. However, in some settings epilepsy has many common features with mental illnesses. For instance, many cultures perceive epilepsy as being caused by supernatural forces such as witchcraft, similar to misconceptions about some forms of mental illnesses. Epilepsy can cause great stress to the person experiencing the symptoms and his/her family. Therefore pay close attention to the mental health needs of people with epilepsy and their families.

**Did you know?**

*Note – Include people in this list from your own setting/country.

(http://www.ninds.nih.gov/disorders/epilepsy/detail_epilepsy.htm#166123109)

The following famous people are believed to have had epilepsy: the Russian writer Dostoyevsky, the philosopher Socrates, the military general Napoleon, as well as the inventor of dynamite, Alfred Nobel, who established the Nobel Prize. Several Olympic medallists have had epilepsy.

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**Step 2:** Handout IV summarizes information given in presentation.

**Task 2 - Role Play (40 minutes)**

**Directions: Step 1 (20 minutes)**

Ask participants to break into groups of three, each group is assigned either Script 4, 5, or 6. Note that multiple groups can use one script. Ask each group to decide who will be which persona in the role play. Each persona in the script is given clear instructions. The one assigned the role of doctor has to determine what is causing the unknown seizures. Ask participants acting as doctors to refer to the WHO mhGAP - IG for this exercise.

The facilitator should walk around and observe and give feedback to participants as they are preparing their script.

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**Note to Facilitator**

The objective of the exercise is that participants have to use the information they have given during the presentation, and use materials such as the mhGAP - IG.

Here below find notes on each script.

In **Script 3** - John was suffering from epilepsy, but before coming to that conclusion did the participant acting as the doctor rule out all other possible explanations for the seizures?

In **Script 4** - Rasheda was suffering from epilepsy. Did the participant acting as the doctor provide both pharmacological and non pharmacological interventions? Did he/she emphasize that people with epilepsy can live normal lives, and that Rasheda should go to school like normal children her age?

In **Script 5** - Eugene has been suffering from epilepsy for eight years. He has continuously been starting and stopping antiepileptic drugs. Did the participant acting as the doctor stress the importance of taking the drugs continuously as prescribed? If the drugs are taken correctly and if Eugene has had no seizures in two years, he could perhaps stop taking the drugs altogether.
**Step 2 (20 minutes)**
When participants have completed the role play as described in Step 3 ask three groups to present their act to the rest of the group.

**Task 3 - Recap (15 minutes)**
To conclude this session, ask participants to work in pairs. In pairs come up with five things they can recollect from this session. The facilitator then asks each pair to share one recollection with the rest of the group.

**Context Specific Notes**
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**Session 9 References**
1. WHO, mhGAP - IG
2. Patel, Where there is no Psychiatrist
Session Aim: To introduce common mental health conditions of children/ young adults.

Session Tasks:
1. Presentation by facilitator (A. Development Disorders, B. Behavioural Disorders, C. Young Carers) + Handout V
2. Group Discussion
3. Case Study

Session Duration: 90 minutes

Material:
Black/white board for presentation, Handout V, Case Study F (Appendix E), Information Sheets (Material for Participants)

Task 1 - Presentation (45 minutes)
Directions: Step 1
Give a short presentation on the information provided in the Information for Facilitator box below.
Information for Facilitator

Children and Mental Health

Like adults, children can also experience mental health problems. It is important to remember that each age group, social group, gender, will have different needs.

In relation to children and mental health, it may be advisable to refer to a child mental health specialist (if feasible). However, as a doctor or a nurse at the primary health care level, it is important to be aware of signs and be able to support the child and the family as appropriate. Here below is basic information on common mental health conditions experienced by children.

A. Development Disorders

Developmental disorder is a broad term that includes disorders such as intellectual disabilities (or *mental retardation) and autism. Development disorders usually do not fluctuate as is common with mental disorders, but rather are constant. Although development disorders originate during childhood they tend to persist throughout the person's life.

*Note that the term mental retardation is not advisable to use because it has been associated with stigma. However, because it is a term that is still the most widely recognized it has been used here above.

(1) Intellectual Disability

Intellectual disability is characterized by limitations across multiple development areas, lower intellectual functioning, difficulties carrying out practical skills and impaired social skills. Lower Intelligence Quotient (IQ) makes it more challenging to adjust to the daily demands of life. However, it is important to remember that limitations in individuals often coexist with strengths, and that a person's level of life functioning will improve if appropriate support is in place.

(2) Pervasive Development Disorders (Autism)

Autism is characterized by impaired social skills, communication and language difficulties, and a narrow range of interests and activities that are unique to the individual and carried out repetitively. Autism is usually recognized in infancy or early childhood. Often, though not always, there is some level of intellectual disability.

Causes of Development Disorders

There can be multiple causes of development disorders:

- Problems that have developed during pregnancy. For e.g. if the mother consumes excessive alcohol, or if the mother has certain types of infections. In some parts of the world if the mother has low levels of iodine or salt, the child may be born with a condition of low thyroid hormone function.

- Problems during childbirth, e.g. birth long before expected birth date.

- Conditions during the first year of life, including infections of the brain, severe and prolonged jaundice, uncontrolled convulsions, accidents and severe malnutrition.

- Not looking after the child, including abuse and emotional neglect.

- Genetic conditions such as Down's Syndrome. A child with Down's Syndrome often has slanting eyes, low ears, a short neck and a single prominent crease across the palms.

Symptoms/Presentation

These disorders usually originate during childhood. They involve impairment or delay in
development, for e.g. in walking, talking, understanding instructions. See chart below for milestones in development.

<table>
<thead>
<tr>
<th>Milestone *</th>
<th>Common Age to Achieve Milestone</th>
<th>Suspect Development Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds to name/voice</td>
<td>01 - 03 months</td>
<td>4th month</td>
</tr>
<tr>
<td>Smiles at others</td>
<td>01 - 04 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Holds head steady</td>
<td>02 - 06 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Sits without support</td>
<td>05 - 10 months</td>
<td>12th month</td>
</tr>
<tr>
<td>Stands without support</td>
<td>09 - 14 months</td>
<td>18th month</td>
</tr>
<tr>
<td>Talks in 2-3 word sentences</td>
<td>16 - 30 months</td>
<td>3rd year</td>
</tr>
<tr>
<td>Eats/drinks by self</td>
<td>02 - 03 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Can tell own name</td>
<td>02 - 03 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Is toilet trained</td>
<td>03 - 04 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Avoids simple hazards</td>
<td>03 - 04 years</td>
<td>4th year</td>
</tr>
</tbody>
</table>

**Things to Consider**

- Local validation of this chart’s milestones may differ between different settings; one can use the chart for guidance but should not base diagnosis on it alone.

- Children suffering from autism may be quite normal in terms of development of movements, but may mainly have problems with speech and communication.

- It is important to also examine the child’s vision, hearing, or any other sensory problems before diagnosing the child with a development disorder, for e.g. a child with hearing deficit will not be able to talk at the age mentioned above.

- In the older children assess how they are doing in school. How do they compare to their peers?

**Management**

If you are confident that the child has a development disorder, determine severity by assessing how much the child can do.

- If the child’s condition is mild, most likely they will be able to go to a normal school, and given the right support will be able to live independently. People with mild development disorders are more aware of their situation and may therefore be more prone to mental illnesses. Always remember to include the person and never speak as if they are not in the room.

- If the child has a moderate mental disorder they will most likely need to go to a special school (if available) or receive extra support at school. They may need help with daily activities. Most will not be able to have a regular job, although sheltered employment may be possible.

- Children with severe development disorders will need constant caring.

Regardless of the severity, it can be important to have a regular schedule. Break activities into smaller components. Give rewards for achievements regardless of how small they are. Never ignore the child, love them and care for them, and spend time with them.

*If the cause of the condition is low thyroid function or repeated convulsions, assess whether it is possible if the child also has associated epilepsy. Refer to a specialist, if possible, as intervention can...
help prevent further disability.

B. Behavioural Disorders
“Behavioural disorders include disorders such as hyperkinetic disorder or attention deficit hyperactivity disorder (ADHD) or other behavioural disorders. Behavioural symptoms of varying levels of severity are very common in the population.”

How to Diagnose Behavioural Disorders/Symptoms
Is the child experiencing multiple symptoms listed here below?

- Inattention
- Premature breaking off from tasks
- Leaving tasks unfinished
- Frequent changing from activity to activity
- Hyperkinesis:
  - Over-activity (excessive for the context or situation)
  - Difficulty sitting still
  - Excessive talking or noisiness
  - Fidgeting or wriggling
- Age of onset and persistence in different settings: They may have trouble with parents, teachers, siblings, peers, or in all domains of function. If the problems are only in one domain consider causes specific to that domain.

Only if:

- Severe symptoms are present and persist in multiple settings,
- Exceed those of other children of the same age and intelligence level,
- Started before age 6,
- Lasted at least 6 months,
- Caused significant disruption in child functioning,
- All other explanations have been ruled out (other medical conditions, hyperthyroidism, depression or alcohol use)

should ADHD be considered.

Treatment: Try non pharmacological interventions and only when ALL of them have failed consider prescribing methylphenidate (Ritalin) if available in your setting. Consult a specialist.

Advice for parents
*Note - Some of the recommendations below are more suited to developed countries and may be difficult for parents to put into practice in settings where there are already so many demands on the family to just survive the next day. However, the recommendations can be used for general guidance and adapted to local settings if fitting. Encourage participants to make suggestions that would be appropriate for their setting.
- Give the child more help to remain calm and attentive at home and school.
- Avoid punishment, the child is not purposely behaving in this manner.
- When a child behaves badly, do not scold or hit him. You are giving the wrong kind of attention to the child and the behaviour will only get worse. Instead try time out.
- Give praise and reward when the child behaves in the right manner.
- Do not give too many commands at the same time because the child will not follow what you are expecting of him. For e.g. do not say, “Have a bath and finish your studies.” Instead, break this up into two commands; after the child has finished the first activity give praise and ask him to do the second.
- Reduce stimulation to the child, for e.g. give him one toy at a time.
- Keep a pride file on the child’s achievements; you can file drawings, certificates and other mementoes of the child’s abilities.
- Be specific about what you want the child to do. For e.g. instead of telling a child who is about to eat, “Be a good boy now,” you could say, “Please finish your food before you leave the table.”
- Regular sport or physical activity is a useful way of allowing the child to release excess energy.
- Establish a regular routine for the child. Do not leave things for the child to decide. Put a time chart up on the wall so that the child knows what is to be done during the day.
- Listen to the child’s feelings and thoughts. Many children with ADHD feel misunderstood and unhappy. Show the child that you know why he is having difficulties and that you want to help him get more in control of his life.
- Avoid taking him to crowded places like markets and weddings. If you do take him, be prepared to come back home if supervising him becomes difficult.
- Plan activities beforehand so as not to be surprised and upset by his behaviour.

**Other Behavioural Disorders**

Examples of other behavioural disorders may include activities such as: excessive levels of fighting or bullying; cruelty to animals or other people; fire-setting; severe destructiveness to property; stealing; repeated lying and running away from school or home. Judgments concerning the presence of other behavioural disorders should take into account the child or adolescent’s developmental level and duration of problem behaviours (at least 6 months).

**C. Young Carers**

Children in poor communities are used to taking on their fair share of the household workload. Responsibilities may include taking care of a parent, sibling or relative with a mental illness. These responsibilities can develop into heavy burdens for the child/young adult, and if they fail to receive any form of support, they may be at risk themselves to develop mental health problems.

“I didn’t pass my primary school examinations because I had to spend most of the time caring for my father and often missed school,” says Yohane, 16 years, a young carer of a mentally ill person.

Yohane is among thousands of young carers of people with mental illness in Tanzania who takes on the practical and emotional caring responsibility of his father who is suffering from schizophrenia.
Identifying Young Carers
The young carer is often identified when they bring their mentally ill relative to the clinic. As a health personnel if you identify a young carer, provide support to that child. See below a few suggestions as to how you can help lighten the burden of the young carer.

How to Help
- Inform the young carer about mental illness and caring skills. If community health workers (CHWs) are common in your setting, arrange a CHW to visit regularly the person with mental illness and the young carer.
- Support the young carer to get access to means of developing their survival skills through life skills training, education and practical livelihood opportunities.
- Put a young carer in touch with other children/young adults in similar situations. Allow them to share their experiences and provide one another with advice and support.
- Attend to the psychological needs of young carers during visits to the clinic.

Did you know?
Do you know where the last Summer Special Olympics were held?
Answer: 2011. They were held in Athens, Greece.

Share the story below, or substitute with a context specific example.

One Athlete’s Journey
Alcino Pereira from East Timor is an example of how one athlete’s journey to the World Games can open doors for others, even in a place of conflict. East Timor is a war-torn nation that has been struggling for more than 30 years to gain independence from Indonesia. In all this devastation, people with intellectual disabilities are often abandoned and forgotten. Pereira, 38, an orphan whose father was killed in an uprising, has never had access to health care, and he is unable to speak. He walks with a limp and has limited motion in one arm, but he loves to run. Every day he runs across his home town of Dili in worn-out sneakers, earning him the nickname, “the running man.”

In 2007, “the running man” was East Timor’s first Special Olympics athlete to compete at the World Games, making him famous in his home country. The people of East Timor, including the Prime Minister and the Bishop, rallied in support of his trip to Shanghai, China, site of the Games. Though Pereira did not win his race, he brought spectators to their feet. When he returned to East Timor, he became the face of a public awareness campaign aimed at helping more citizens with intellectual disabilities in his country.
Step 2: Handout V summarizes information given in presentation.

**Task 2 - Group Discussion (25 minutes)**

**Directions:**
- Ask participants to think about how people with development disorders/behavioural disorders are perceived in their setting.
- Ask participants to share examples with the whole group.
- Discuss services that are in place. Are there special schools? Sheltered employment? Services for young carers (e.g. self-help groups)?

Give participants time to fill out relevant sections on the information sheets - Services in your Area (Material for Participants).

**Task 3 - Case Study (20 minutes)**

**Directions: Step 1**

Ask participants to work in pairs and read Case Study F.

Instruct participants to come up with a plan for Amil. How would you go about teaching him to eat himself? Also, think of simple tasks around the kitchen he can help with. Break activities into simple tasks. Think of rewards for him.

*Amil is a 14 year old boy who has a moderate development disorder. Amil is a very likable boy, he is very affectionate, sometimes inappropriately affectionate, which makes other children afraid of him. He is often made fun of by the other children. Although he is 14, he struggles doing tasks that children half his age are able to do. For instance, he has trouble eating by himself, he often creates a mess and makes sounds. As a result the other children make fun of him.*

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal *</th>
<th>Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn to greet someone</td>
<td></td>
</tr>
<tr>
<td>Say goodbye</td>
<td></td>
</tr>
<tr>
<td>Share toys</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* Repeat an activity for at least two weeks before moving to the next one.

**Step 2:** Ask each pair to share their ideas with the rest of the group.

**Context Specific Notes**

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**Session 10 References**

1. Patel, Where there is no Psychiatrist
2. WHO, mhGAP - IG
3. http://www.aaidd.org/content_100.cfm?navID=21
4. BasicNeedsTanzania, Young Carers’ Programme, We Care
Introduction to Dementia

Session Aim: Participants learn to recognize signs of dementia and manage appropriately.

Session Tasks:
1. Presentation
2. Memory Test
3. Resources for the Elderly
4. Role Play - caring for a person with dementia

Session Duration: 90 minutes

Material: Black/white board for presentation

Task 1 - Presentation (30 minutes)
Directions: Step 1
Give a short presentation on the information provided in the Information for Facilitator box below.
Information for Facilitator

What is Dementia?

Dementia is a disease where the brain gradually degenerates; the most common form of dementia is Alzheimer's Disease and hence will be the focus of this session. Other forms of dementia include; medical conditions such as Parkinson's Disease, Huntington's Disease, strokes that disrupt oxygen flow, poor nutrition (e.g. vitamin deficiency in LMICs), drug and alcohol related dementia, injuries to the brain, infection or illness that affects the central nervous system such as HIV, and creutzfeldt - Jakob Disease. Some causes of dementia are treatable, and further degeneration can be prevented if identified early.

It is important to note that dementia is not part of normal aging. Although it is more common in older people, at times it may be difficult to distinguish between normal aging and symptoms of dementia.

<table>
<thead>
<tr>
<th>Typical Aging:</th>
<th>Symptoms of Dementia:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complains about memory loss but can provide examples of forgetfulness.</td>
<td>May complain of memory loss if asked; unable to recall specific instances.</td>
</tr>
<tr>
<td>Occasionally searches for words.</td>
<td>Frequent word-finding pauses, substitutions.</td>
</tr>
<tr>
<td>May have to pause to remember directions, but doesn’t get lost in familiar places.</td>
<td>Gets lost in familiar places and takes excessive time to return home.</td>
</tr>
<tr>
<td>Remembers recent important events; conversations are not impaired.</td>
<td>Notable decline in memory for recent events and ability to converse.</td>
</tr>
<tr>
<td>Interpersonal social skills are at the same level as they’ve always been.</td>
<td>Loss of interest in social activities; may behave in socially inappropriate ways.</td>
</tr>
</tbody>
</table>

Symptoms/ Presentation

Symptoms include forgetfulness, personality change and impaired intellectual functions. These changes will impact everyday living such as washing, dressing, eating, personal hygiene, independence and relationships. See below descriptions of different stages of dementia and symptoms that may be present at each stage.

Stages of Dementia

**Early stage:** The person may appear confused and forgetful about recent events. Concentration and making decisions become more difficult. The person may lose interest in usual activities. Early stages of dementia may easily be confused with normal aging.

**Middle stage:** Confusion, memory loss and mood changes become more apparent. Behavioural problems such as aggression manifest. The person may wander out of the house, sleep may become disturbed and the person can no longer with ease look after herself/himself. Simple everyday tasks such as dressing may become challenging. The person may have difficulty with talking and following everyday conversations.

**Late stage:** The person no longer recognizes relatives or friends. Loss of weight, seizures and incontinence of urine and stool may occur. It is almost impossible to have any sensible conversation with the person. The person appears confused all the time. Death usually follows soon, often through pneumonia or other infections.
**Diagnosis**

Neuroimaging is often not available in developing countries. Therefore use more feasible diagnostic methods such as:

- Simple memory tests - The mini mental state examination (MMSE) has been translated into many languages (but may not be appropriate for all settings). Cultural differences may impact memory tests, so it is advisable to check in your setting if there are guidelines or protocols in place for diagnosing dementia.

- Interviews with person and their close relatives or caregiver. Keep in mind that some people with dementia and their carers may not be aware of symptoms or are simply in denial, therefore diagnosis can be challenging and has to be handled with care. You may also want to know the “usual activities” for older people in your area and for this particular family. Explore whether there have been any recent progressive changes. Does the person make errors or take longer to carry out tasks, perform them?

Sample questions for an interview with a key informant. Ask about (1) Recent changes in thinking and reasoning (2) Memory and orientation (3) Ask, for e.g. whether the person often forgets where they put things (4) Do they sometimes forget what happened the day before? (5) Does the person sometimes forget where they are? (6) Ask the informant when these problems started and whether they have been getting worse over time (6) Are there any time periods, lasting days, weeks or longer, when thinking and memory are completely back to normal?

**Differential Diagnosis**

Depression and dementia are both common forms of mental illnesses experienced by the elderly. The two disorders are interlinked; research has found depression to be a risk factor for dementia. However, symptoms of depression may also present similarly to that of dementia. If dementia is suspected, also screen for depression since that can be easily treated.

**How to Treat Someone with Dementia**

Although there is no cure for dementia in many cases, particularly looking at Alzheimer's Disease, there is much that can be done for the person and family. Here below are a few suggestions:

- Establish a routine and keep tasks simple.
- If possible let the person be independent. For e.g. many can feed themselves, even if they are slow and unsteady.
- Never forget that the person has dignity. Do not talk negatively about her/him in their presence.
- Avoid confrontation and arguments.
- Speak slowly, clearly and minimize background noise. If the person has not understood, try to rephrase using simpler words and shorter sentences.
- Show love and affection whenever possible. A hug is worth a hundred pills.
- Laugh with the person (never at her/him).
- Listen to her/him and encourage sharing problems.

**Practical Everyday Tips**

- Provide regular orientation information, signs in the house, for e.g. bathroom, kitchen etc.
Use materials such as newspapers, radio or TV programmes and family albums to promote communication, to orient them to modern events, to stimulate memories.

Make adjustments to living conditions - avoid clutter.

Make sure the person's eyeglasses are correct.

Set up a regular toilet routine.

Use clothing that can be easily removed (and put back on).

Limit drinks at bedtime.

Keep a vessel for urine during the nights

**Tips for Eating**

- Use finger foods.
- Cut up food into small, bite size pieces.
- Do not serve food too hot.
- Remind the person how to eat.
- If the person has difficulties swallowing refer to a specialist.
- Mix the food and serve it in a ready-to-eat form.

**Anger**

- Do not argue back, keep your calm.
- Try to comfort, hold hands firmly and talk gently.
- Distract the person by drawing attention to something in the room.
- Try to find out what made the person angry and try to avoid this in future.

**Wandering away from home.**

- Use an identification bracelet or necklace.
- Keep the doors of the house locked.
- When the person is found do not show anger.

**Things to Consider**

**Family/Caregivers:** It is very difficult for close family members and caregivers to see their loved relative with dementia. Attend to the family/caregiver, assess for strain, burden, depression and provide support as needed. Are there support groups in place? If unattended, caregivers are vulnerable themselves to develop a mental illness. (See Session 15 for more information on carers).

**Neglect:** A person with dementia needs love and caring. If you suspect that they are being neglected, what actions can you take?

**Did you Know?**

- It is estimated that by 2040, 71% of 81.1 million dementia cases will be in the developing world (Kalaria et al., 2008).
Studies have shown that several species of medicinal plants have activities in vitro or in vivo which have shown therapeutic properties in relation to dementia. For e.g. blueberries, club moss, garlic, ginseng, green tea, pomegranate, and rhubarb (Kalaria et al., 2008).

Step 2:
Handout VI summarizes information given in presentation.

Task 2 - Memory Test (30 minutes)
Directions: Step 1
Ask participants to work in pairs for this exercise. Choose a diagnostic memory test to introduce to participants. If there is a test that is commonly used in your setting, see if you can obtain a copy of that test. The advantage would be that it will already be culturally and linguistically appropriate.

Step 2:
Decide who will act as the interviewer and who will be the interviewee. Follow directions from the test that you are using. Switch so that each participant has an opportunity to be an interviewer and interviewee.

Task 3 - Resources for the Elderly (15 minutes)
Directions: Give participants 10 minutes to fill out the relevant section of the chart, Services in Your Area.

Task 4 - Role Play (15 minutes)
Directions: Step 1 (10 minutes)
The person who is living with dementia must be shown dignity through all stages of the illness. It is difficult to imagine what the person is going through. The purpose of this task is therefore for participants to try to relate more to what it is like being dependent on others in order to carry out simple everyday tasks, such as eating. Ask participants to take turns feeding each other. This is a good exercise to break up the training day. If possible schedule it around tea time.

Step 2 (5 minutes)
Discuss how participants felt being fed. What worked well? For e.g. did they feel more comfortable with smaller bites? Or if the person feeding them communicated regularly with them.

Context Specific Notes

Session 11 References
1. Patel, Where there is no Psychiatrist
2. WHO, mhGAP - IG
4. Kalaria et al., 2008
SESSION

12

Introduction to Alcohol and Substance Use Disorders

**Session Aim**: Recognizing and managing appropriately alcohol and substance use disorders.

**Session Tasks**

1. Presentation I by facilitator + Handout
2. Activity involving case study
3. Presentation II by facilitator + Handout
4. Group Discussion

**Session Duration**: 90 minutes

**Material**

Material: Black/white board, Flow Chart (Appendix H), Case Study H (Appendix E), WHO ASSIT Guide

**Task 1 - Presentation I (20 minutes)**

**Directions: Step 1**

Give a short presentation on the information provided in the Information for Facilitator box below.
Information For Facilitator

What is an Alcohol Use Disorder?
Using alcohol does not in itself mean that a person has a disorder. Use of alcohol becomes a disorder when:

- It leads to problems at work, home or in the community
- It causes damage to health
- The person becomes physically and psychologically dependent on alcohol.

*Note that harmful use of alcohol can contribute to the development of a mental disorder, or can occur as a result of a mental disorder.

Why do people use too much alcohol?
- Many people start using alcohol because it creates increased feelings of pleasure and decreased feelings of distress.
- Problems arise when people use alcohol as a way of coping with difficulties or stress caused by things like relationship conflicts or financial worries.
- Once people start using alcohol regularly they can/may develop a physical and psychological need to continue, this is called dependence or addiction.

Dependence can cause:
- Mental health problems such as depression, hallucinations and memory loss.
- Physical health problems such as confusion and blackouts, liver failure, heart failure, bleeding in the stomach, sleep problems, and sexual impotence.
- Greater risk of accidents and falls, violence and aggression.
- Social problems such as being unable to work, study or participate in everyday life, getting into fights and conflicts with the law.
- Financial problems and poverty due to the cost of alcohol and inability to work because of the mental problem.

How to recognize alcohol dependence
- A person with alcohol dependence may want to drink alcohol at unusual times like as soon as he/she wakes up.
- The person may show signs of poor personal hygiene.
- The person may be unable to meet routine obligations.

For severe withdrawal symptoms,

Look for:
- Tremor in hands
- Sweating
- Vomiting
- Increased pulse and blood pressure
- Agitation

**Ask about:**
- Headache, nausea, anxiety
- Note - Seizures and confusion may occur in severe cases.

**How to help a person engaging in harmful use of alcohol:**
1. Assess the risk of suicide or harm to self or others.
   - Urgent medical help may be required if the person is suffering from
     - intoxication or overdose of alcohol,
     - severe withdrawal reaction,
     - serious infection or injuries from alcohol use.
2. Listen without judgment.
   - Do not be critical of the person.
   - Stopping alcohol use is not easy for those who are dependent.
3. Give reassurance and information.
   - Harmful use of alcohol is a common problem.
   - Often other problems such as depression or anxiety underlie an alcohol problem and there are effective treatments for the underlying problems.

There are three stages to overcoming an alcohol problem:
1. Admitting there is a problem.
2. Stopping or reducing the harmful use of alcohol.
3. Remaining sober.

**Step 2:** Handout VII summarizes information given in presentation.

**Task 2 - Case Study (30 minutes)**

**Directions: Step 1 (20 minutes)**
Divide the participants into smaller groups. Ask each group to identify one member of the group who will make notes to feed back to the whole group. It could be helpful to do a flow chart: (1) Assess, (2) Decide, (3) Manage. Each group is given a copy of Case Study H and after reading the case study they discuss the following:
- What type of disorder is the person in the case study experiencing?
- What factors could contribute to this disorder?
- What actions can you take to help this person?
Case Study H
Amar is a 44 year old man who has been ill with a number of physical complaints over the past several months. His main complaints are that his sleep is not good, that he often feels like vomiting in the morning, and that he is generally not feeling well. Amar has recently been to see the doctor for severe burning pain in the stomach area, and he was prescribed medication for a stomach ulcer. Today he is sweating profusely and his hands are shaking. When you ask him how he is feeling he sits down and starts to cry. He admits that he is sick because he has been drinking increasing amounts of alcohol in the previous few months as a way of coping with stress in the family. However, now the drinking itself has become a problem and he cannot pass even a few hours without having a drink.

Step 2 (10 minutes)
Ask the small groups to share the results of their discussion with the whole group. Write the participants’ suggested actions on the black/white board.

Task 3 - Presentation II (30 minutes)
Directions: Step 1
Presentation by facilitator from box below.

What are Drug Use Disorders?
Conditions resulting from different patterns of drug use include:
- Acute sedative overdose (e.g. alcohol, valium).
- Acute stimulant intoxication or overdose.
- Harmful or hazardous drug use.
- Cannabis dependence.
- Opioid dependence (e.g. heroin).
- Stimulant dependence (Cocaine, Ecstasy, amphetamine).
- Benzodiazepine dependence and their corresponding withdrawal states.
- Culturally-relevant substances, e.g. khat (amphetamine-like substance).

Harmful use of drugs is a pattern of drug consumption that is causing damage to health. The damage may be physical (as in cases of infections related to drug use) or mental (e.g. episodes of depressive disorder) and is often associated with damage to social functioning (e.g. family problems, legal problems or work-related problems).

Drug dependence
“Drug dependence is a cluster of physiological, behavioural and cognitive phenomena in which drug use takes on a much higher priority for a given individual than other behaviours that once had greater value. The drug withdrawal state refers to a group of symptoms occurring upon cessation of a drug after its prolonged daily use.”
Task 4 - Group Discussion (15 minutes)
Attitudes to drug disorders vary greatly between different cultures. Lead a group discussion on what services are available in your community for people suffering from drug use disorders. See below for ideas of discussion topics.

Information for Facilitator
Questions to stimulate conversation among participants:

- Is drug use common in your setting?
- Are drug screening tests available?
- Do you screen drug users for HIV/STIs?
- Are there needle exchange programmes in place?
- Is substitution therapy available for treating withdrawal symptoms such as methadone maintenance treatment?
- Are there support groups for people suffering from drug disorders?

Introduce the WHO – ASSIT Guidelines.

Context Specific Notes

Session 11 References
1. Patel, Where there is no Psychiatrist
2. WHO, mhGAP - IG
3. WHO, ASSIT Guidelines
SESSION 13

Self Harm / Suicide

Session Aim: To introduce participants to responding to someone who is suspected of having or previously having had thoughts of self-harm.

Session Tasks:
1. Presentation by facilitator + Handout
2. Activity involving Case Study
3. Theatre production

Session Duration: 90 minutes

Material: Black/white board for presentation, Handout, Case Study I (Appendix E)

*Note
Some information from this session is directly extracted from the WHO mhGAP – IG.

Session 12: Task 1 - Presentation (30 minutes)
Directions: Part 1
Facilitator gives presentation from box below.
**Information for Facilitator**

**Suicide** is the act of deliberately killing oneself.

**Self-harm** is a broader term referring to intentional self-inflicted poisoning or injury, which may or may not have a fatal intent or outcome.

If a person over the age of 10 years has experienced any of the following they are at risk of self-harm, suicide.

1. Any of the conditions covered in session above
2. Chronic pain (illnesses that cause continuous pain can cause the person experiencing the pain to feel suicidal)
3. Acute emotional distress
   - Unhappy relationships
   - Poverty and economic difficulties
   - Losing a loved one
   - Not having friends with whom to share problems and feelings.
   - Teenagers may become suicidal if they are experiencing problems at school or having severe difficulty communicating with their parents.
   - Other

**Ask about thoughts or plans of self-harm in the last month, and acts of self-harm within the past year.**

“Asking about self-harm does NOT provoke acts of self-harm. It often reduces anxiety associated with thoughts or acts of self-harm and helps the person feel understood. However, try to establish a relationship with the person before asking questions about self-harm. Ask the person to explain their reasons for harming themselves.”

How to respond to a person who has deliberately harmed themselves, or attempted suicide.

**Immediate Response**

- If the person has already harmed himself/herself (e.g. swallowed poison, a wound is bleeding, there is loss of consciousness), emergency medical treatment is required.

If pesticide use is common in your setting refer to the document below:

http://www.who.int/mental_health/prevention/suicide/pesticides_intoxication.pdf

- If medical hospitalization is needed, monitor the person closely to prevent suicide.

**Questions for the family:**

- Ask the family questions. What happened? Was it a dangerous attempt?
- Has it happened before? People with a history of suicide attempts are more likely to try to repeat it.
- Is there a history of mental illness or a serious physical illness?
- Other explanations.
Questions for individual who attempted suicide:

- What happened? Do you want to end your life? Why?
- Did you have a plan? For how long were you planning this? (Attempts that have been carefully planned are more serious).
- How do you feel now? Many are relieved that the attempt was not successful. If they are not relieved, more likely to try again.
- Have you been feeling depressed? (Refer to Session 6).
- Do you feel you drink too much alcohol or take drugs? (Refer to Session 12).
- Have you experienced violence at home? (Enquire carefully about the situation at home).
- What reasons are there for you to continue living? This is important in order to try to think of the good things in life.

How to respond if a person has been brought into the health centre who might be at risk of self-harm/suicide:

Ask person and carer about:

(*Note - It is important to involve the carer(s). However the person should also be interviewed alone by the health personnel).

- Current thoughts or plan to commit suicide/self-harm.
- History of thoughts or plan of self-harm in the past month or act of self-harm in the past year.
- Access to means of self-harm.

How to respond if after assessment the person is believed to be at risk of self-harm/suicide:

- Remove access to all dangerous items such as knives and poison (or advise close relatives/friends to do so).
- Create a secure and supportive environment.
- Ensure the person is not left alone. Enlist help from a named staff member or family member to ensure safety.

*Attend to the person (see advice below).
- Consult with a specialist (if possible).
- *Attend to the person.
- Listen non-judgmentally, do not give advice or contradict the person.
- Let the person know that you and others care about him/her.
- Help the person to think positively about their situation and explore reasons and ways to stay alive.
- Focus on the person’s positive strengths by getting them to talk of how earlier problems have been resolved.
- Help the person to identify their negative thoughts and how they make them feel. For e.g. “I will
always feel miserable, nothing will change in my life." Suggest some positive ways of looking at the same situation. For e.g. “These feelings are temporary, I feel this way because I am not well, and talking to the health worker, taking my medicine (if appropriate) and trying to solve my problems will make me feel better.”

- Encourage the person to frequently challenge negative thoughts in this way.

**If no imminent risk of self-harm/suicide, but there is a history of thoughts or plan of self-harm in the past month, or act of self-harm in the past year,**

**How to Respond:**

- Monitor the person closely.
- Mobilise family, friends and other concerned individuals or other available community resources (e.g. women’s groups, self-help groups) to support the individual during imminent risk period.
- Advise person and carer(s) to restrict access to means of self-harm (e.g. pesticides, medication) while the individual has thoughts, plans or commits acts of self-harm.
- Involve the family. If there is conflict or violence in the family you may need to suggest alternative support networks such as women’s groups, friends or a religious leader.
- Inform carers and other family members that asking about suicide will often reduce the anxiety surrounding the feeling, the person may feel relieved and better understood.
- Carers of people at risk of self-harm often experience severe stress. Provide emotional support to relatives/carers if they need.
- Inform carers that even though they may feel frustrated with the person, it is suggested to avoid hostility or set questions for the family.

**Follow Up**

- Anyone at risk of self-harm/suicide should be closely monitored. Provide regular contact (via telephone, through CHW visits, letters). More frequently initially (e.g. weekly for the initial 2 months) and less frequently as the person improves (e.g. once in 2 - 4 weeks thereafter). Consider maintaining more intensive or longer contact if necessary.
- Follow up for as long as suicide risk persists. At every contact, routinely assess suicide thoughts and plans.

**Did you Know?**

In China suicide is the fifth leading cause of death. The burden can vary between different countries, but suicide often claims more lives than people realize.
**Task 2 - Case Study (30 minutes)**

**Directions: Step 1 (10 minutes)**
Ask participants to get into groups of five. First, read Case Study I and together discuss possible explanations for why Ahanti is feeling sad and hopeless and thinking about suicide.

**Step 2 (10 minutes)**
Ask each group in turn to call out an explanation about why Ahanti is sad until all suggestions have been voiced. In their same groups, next ask participants to think of as many ways as possible of helpfully responding to Ahanti.

**Step 3 (10 minutes)**
Ask participants for the last part of this task to work in pairs. Imagine that Ahanti is coming one week later for a follow up visit. One participant will act as the health personnel and the second participant as Ahanti. The health personnel practices asking questions regarding self-harm/suicide (e.g. “For the past week have you had thoughts of ending your life?” “Can you tell me about those thoughts?”)

- It is not always easy to ask these questions, therefore practicing how to introduce the questions is important in order to feel comfortable doing so.

**Task 3 - Theatre Production (30 minutes)**

**Directions: Step 1 (20 minutes)**
In the same groups as above, ask participants to use the case study above as an inspiration and come up with a theatre production. It could be a song, short play, or a dance.

Ask the participants to think of the activity as a communication medium to reach people in their community who might be in need of help. Explain that often people who are contemplating suicide feel alone and isolated. They might not be aware that they can ask for help, or that there are others who might be experiencing what they are experiencing.

**Step 4 (10 minutes)**
At the end ask each group to perform whatever they have come up with.

Ask participants if suicide is common in their setting. If so, encourage participants to develop this activity further. For e.g. it would be ideal to use community health workers or volunteers to perform a local theatre production, to draw attention to the matter.

**Context Specific Notes**

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**Session 11 References**

1. Patel, Where there is no Psychiatrist
2. WHO, mhGAP - IG
Session Aim: To give an example of a case study that may involve management of multiple conditions.

Session Tasks:
1. Presentation by facilitator
2. Activity involving a case study

Session Duration: 60 minutes

Purpose:
Material: Black/white board, Case Study J

Task 1 - Presentation (20 minutes)
Directions: Short presentation by facilitator

Information for Facilitator

Concurrent Conditions
It is important to remember that multiple conditions can prevail at one time. For e.g. even though you have identified a likely condition causing the symptoms, never forget to assess possible concurrent conditions.

Here are a few suggestions to keep in mind.

- **Assess for threat of self-harm/suicide for all conditions that have been covered during this training.**
- Always ask about drug or alcohol use.
- Never jump to conclusions, rule out all other possible explanations. For e.g. in the case of epilepsy, just because someone has had a seizure does not automatically mean epilepsy. Or just because someone has had a hallucination does not automatically indicate psychosis.
- In all people who suffer from serious illnesses assess for depression.
- Important to consult a specialist prior to prescribing multiple types of medication.
Task 2 - Case Study Activity (40 minutes)

Directions: Step 1
Divide participants into small groups (3 - 4). Read out the first handout in a series of handouts to be distributed. Together each group has to manage and decide upon a treatment plan for Amar.

*Note

Limited information is given in the handouts. However, each group has the opportunity to ask Amar (“facilitator”) three more questions after each handout is given.

Step 2:
The facilitator walks around to the different groups after each handout has been distributed and provides each group with answers to their three questions. See below for sample questions and answers. However, in some cases the facilitator might have to come up with answers if they are not included here below.

Step 3:
Allow ten minutes in between handouts. Get feedback from the different groups, discuss together how you would manage Amar’s condition.

Handout 1:
Amar presents himself at the clinic. He has been ill with a number of physical complaints over the past several months. His main complaint is that his sleep is not good and he is generally not feeling well.

You do a physical examination but are unable to find any physical explanation for his ailments. You ask him about his mental state, and he admits to experiencing some stress lately, because a lot has been going on in the family.

How do you respond?

Information for Facilitator - Sample Questions and Answers
Q. How long have you been feeling unwell?
   A. About a month.

Q. Can you tell me more about the family difficulties you have had, and how that is causing you stress?
   A. It was a bad harvest, so I have to find a part time job, my youngest son has been very ill, and my wife is pregnant again. I guess a combination of these factors is worrying me. Although I doubt that is the reason for my illness.

Q. For how long have you had difficulties sleeping?
   A. Also for about a month. I only fall asleep in the morning, and then if I sleep during the day my family gets upset with me.

Q. Amar, do you feel sad? Most of the day? Almost every day? How does it compare to before?
   A. Yes, I am sad because things in my life are not going well. It is difficult to be happy. Before I was sometimes sad, but now I am always sad.

Q. Can you tell me about some of the things you enjoyed before? Are you doing those things/activities?
Handout 2

Two months have passed now. Amar comes back to the clinic. He looks shabby and unwell. He has severe burning in his stomach area. You notice that he is sweating profusely and his hands are shaking.

You ask him questions and he starts crying and admits that he has been feeling very sad and stressed about his family. In order to cope with the stress he started drinking, now the drinking has become the problem.

How do you respond?

Information for Facilitator - Sample Questions and Answers

Q. Amar, how long have you been having alcohol withdrawal symptoms?
A. I have been drinking more than usual for the last three months, but these symptoms started about six weeks ago. Now I need to drink as soon as I wake up, otherwise I feel unwell.

Q. Can you tell me more about your symptoms? Do you feel nauseous, have a headache etc.?
A. Yes, both, and as you can see my hands are shaking.

Q. Tell me more about what is going on in your family. Did the problem solving activity that we did last time help you?
A. Yes it did, in the beginning, but then things got more out of control and I was unable to cope.

Q: Amar, I worry about you. Do you ever have thoughts of self-harm or suicide? It can be common to have such thoughts if you are experiencing extreme stress and feel that you cannot cope. It is important that you know that you can freely express your thoughts and feelings here. I can help you.
A: Sometimes when I am very drunk, I have such thoughts, but otherwise not.

Handout 3

Five months have passed. You have scheduled an appointment with Amar. He has not shown up for his previous appointments and you keep on having to reschedule them. You manage to talk to his wife and convince her to accompany him to the appointment.

You ask Amar if he is still consuming alcohol, or having withdrawal symptoms. Amar says that he has reduced the alcohol intake; his wife confirms that is true. However, he still lacks energy, he finds it difficult getting out of bed, and he refuses to do activities that he found enjoyable before.

How do you respond?
**Information for Facilitator - Sample Questions and Answers**

Q. Amar, have you been taking the medication that I prescribed last time?

A: Yes, I have, and it helped me reduce my alcohol intake. I was starting to feel a lot better but then I stopped taking it altogether. I have recently started taking it again but only half the amount that you suggested so that it lasts longer.

Q: It worries me that your wife tells me that you still refuse to do activities you enjoy. Last time we discussed that you should sing every day, even if just one song. Have you been doing this?

A: I feel very exhausted, I have no desire to play music any more.

Q: Amar, you told me once that you sometimes thought about why you should continue living, and that when you were very drunk you sometimes contemplated harming yourself. Have you had any such thoughts recently?

A: No, I have not, since I have not been drinking as much. It goes against my religion, and even if I feel very sad I know that I must continue to live to support my family.

**Handout 4**

Eight weeks later, another visit by Amar. His condition seems to have improved and he is adhering to his treatment plan. He is feeling low though, and says that he has been fired from his part time job. He missed out a lot during his illness and this causes him stress.

How do you respond?
Session Aim: To emphasize the importance of attending to carers

Session Tasks:
1. Presentation by Facilitator + Questions
2. Group Discussion

Session Duration: 30 minutes

Task 1 - Presentation and Questions (15 minutes)
Directions: Step 1
Facilitator gives presentation from box below.
Helping families/carer(s) cope with mental disorder.

- Families/carer(s) often provide most of the support and care for a person with a mental disorder living in the community.
- Families/carer(s) play a big role in the lives of the person they are caring for, for e.g. they are often responsible for making sure that treatment plans are adhered to. They are also often the ones who notify the health professional if symptoms worsen. It is very important for health personnel to have a good relationship with the families/carer(s) of people with mental disorders.
- Families/carers often do not understand the symptoms of mental illness, and therefore need information about the problems that the person they are caring for is experiencing.
- It is important to remember that living and caring for someone who suffers from a mental disorder can be very stressful and it is important that families receive help and support.
- Without help in managing their own stress, carers may unintentionally behave in a way that creates more stress for the person with the mental disorder, which will have a negative effect on his/her health.

Step 2
Use the following questions to generate discussion about the information presented above.

- What might be stressful for families/carers about having a family member with a mental disorder?
- Why is it important that the family understand the mental disorder that their family member or person they are caring for is experiencing?
- What type of problems might occur if the family does not have help to manage their own stress?
- Ask participants if anyone can think of an example of something a family might do with good intention that could cause more stress for the person with a mental disorder.

Task 2 - Case Study (15 minutes)

Step 1
Ask participants to divide into groups of 4 - 5 people. Ask each group to identify a member of the group who will:

- Read the case study provided (Case Study I).
- Make notes of the discussions to feed back to the whole group.

Hand out copies of Case Study I to each group and ask the groups to read it and suggest how they would support this family.

Case Study

Six months ago the doctor started Ramesh on some medication for his odd behaviour. He has now stopped talking to himself and is less frightened and agitated. However, he complains of feeling tired all the time, he sleeps for long periods of the day and does not take good care of his appearance and hygiene. When his father returns from work he often finds Ramesh still in bed at 4 o’clock in the afternoon. The father is very angry because his wife did not get Ramesh up to do some chores around the home. Ramesh’s mother says that she
did not want to disturb Ramesh because “he is ill and he needs his sleep.” His father says that Ramesh should change his behaviour and start taking more responsibility and help out more in the home.

Step 2

After 10 minutes ask each group to share their suggestions with the larger group, summarise the discussion by writing these important actions for supporting the family of a person with a mental disorder on the black/white board.

- Help the family find ways of reducing their own stress.
- Help the family find ways to support the person with the mental disorder and let them know that recovery takes time.
- Provide information on support groups if available.
- Encourage the family to maintain some of their own interests and not devote their life exclusively to the person with the mental disorder.
Directions: Step 1
Start each new training day with one - two sections of the quiz. The quiz is split into six different sections (see below). Each section should take approximately 30 minutes to complete. The facilitator can choose to omit or create new questions in place of others, if the topic was not covered in the training.

Directions: Step 2
Divide participants into Quiz Teams (4 - 5 in each team).

Ask each group to come up with a name for their Quiz Team. Assign one person in the group to write down all answers for the group. The facilitator acts as a quiz master and reads out one question at a time, following guidelines given in Appendix B. Give participants a brief overview on the format of the quiz:

Category 1: General Knowledge regarding Mental Health

Category 2: Common Disorders, Part A
(Questions on Depression, Psychosis, Bipolar Disorder and Epilepsy)

Category 3: Make a Poster
Participants are given 20 minutes to design an information poster. The objective of the poster should be to raise awareness in the general community of mental illness and encourage people to seek help.

Category 4: Common Disorders, Part B
(Questions on Behavioural Disorders, Dementia, Alcohol and Drug Disorders)

Category 5: Participants get a Cartoon Series - they have to design a script from the cartoons and perform it to the rest of the group.

Category 6: Supervision and Knowing when to Refer

Step 3
Give a reward to all members of the team with the highest score.

Time: 3 hours (to be split up into four 30 minute sessions, or as appropriate).
Purpose: To review information that has been covered.
Material: Quiz questions and instructions for facilitator (Appendix B).
Mental Health Care:
An Introductory Manual For Training
General Health Personnel

Training
Part
3

BasicNeeds
BasicRights
Task 1 - Presentation (30 minutes)

Directions

Step 1

Presentation by facilitator from box below.
Information for Facilitator

Emphasize that it is often good to liaise with a specialist when prescribing medication, particularly if they have never done so before. Then with time they will gain experience and confidence. However, even though they will not be the ones directly prescribing the medication, it is important to be familiar with them, because they might be the ones monitoring the patient and following up any side effects.

Knowing when to prescribe medication

Medication is not always needed; sometimes people expect medication when they see a doctor. They consider it a waste of time if they are not prescribed medication. Never prescribe medication just because the person expects medication. However, it is equally important to know when to prescribe medication. General health staff are often afraid of psychiatric medicines. Psychiatric drugs are just as safe as other medication if they are prescribed correctly.

These conditions (which have been covered in this training) generally will always benefit from medication:

- Psychosis
- Bipolar Disorder
- Severe - Moderate Depression, particularly when condition has lasted more than a month and is seriously affecting the person’s day to day life.
- Epilepsy

Steps in using medicines

- Identify the type of mental illness.
- Decide if medication is necessary and choose specific medication.
- Consider costs and availability of medicine in your setting when choosing medication.
- Remember that the decision to prescribe medication should not replace non pharmacological interventions.
- Patients should be informed about possible side effects.
- Be aware of all other substances taken by the person, both medical and non medical (e.g. alcohol).
- Start with a low dosage and gradually increase to limit side effects.
- Monitor side effects.
- Never exceed the maximum dosage.
- Regularly review the person’s health.
- Before prescribing, check to see whether they are a special group, e.g. pregnant woman, child/adolescent.

What if the person does not improve?

If you have prescribed medication but the person’s condition does not improve, consider the following explanations:

Poor Compliance: Is the person taking the correct dosage? Often when people start to feel better they stop taking medication.
Not enough medication: This is especially true of antidepressants which are often prescribed in too small quantities.

Medicines not taken for long enough: Often it takes time for medication to become effective, the person may be impatient and conclude that it is ineffective.

Wrong diagnosis: Reconsider diagnosis only if you believe that the patient has been taking the full recommended dose for at least one month.

Task 2 - Review Medicines (10 minutes)
Directions
Ask participants to refer to their medication chart (Material for Participants) for a list of common mental, neurological and substance use disorder medication. Ask participants to tick which ones they have in their clinic. The handout leaves a space for names to be placed in local languages.

*Note
This chart should only be used for general guidance, please check carefully what drugs and dosages are recommended in your clinical setting.

Task 2 - Role Play (30 minutes)
Directions: Step 1
Split participants into two groups, those in group 1 will act as health professionals, participants in group 2 will act as people seeking treatment.

Participants in group 1 (health professionals) are asked to find a seat in the room; each health professional should be given a selection of empty medication bottles (if available). They should also have their answer sheet (see Appendix L) in front of them and any available reference material (medication chart, mhGAP - IG).

Step 2
Now ask participants in group 2 to draw a card with information on their condition (see box below). They then go around and find a person in group 1, describing to him/her the symptoms that correspond to the condition they have been given. Also say what number your role play is so that the person acting as the health professional can keep an accurate record on their answer sheet. Allow participants to switch six times, so that each health professional is able to decide what to prescribe to each person (1 - 7 below). Switch them, so that those with the role play of health professionals become people seeking treatment and vice versa.

1. You are a pregnant woman who has been diagnosed with bipolar disorder.
2. You are suffering from psychosis, you were given a starting dose of Haloperidol 1.5 - 3 mg, it has now been 6 weeks, you feel like it might have some minor effects but not enough.
3. You have recently given birth and are experiencing postpartum depression.
4. You are a 25 year old healthy male; you have just been diagnosed with bipolar disorder. You are not taking any other substances, neither medical nor non medical.
5. You are a 14 year old boy who has just been diagnosed with epilepsy.
Step 3
At the end of this exercise, come together as a group. The facilitator emphasizes that the objective of this exercise is for participants to familiarize themselves with common drugs to treat mental illnesses. Ask people what they prescribed each person (1 - 7). See information box for facilitator below.

Information for Facilitator
1. You are a pregnant woman who has been diagnosed with bipolar disorder.
   Always consult a specialist before prescribing medicine to a pregnant woman.

2. You are suffering from psychosis. You were given a starting dose of Haloperidol 1.5 - 3 mg, it has now been 6 weeks, you feel like it might have some minor effects but not enough.
   Consider increasing the dosage. According to WHO recommendations therapeutic dosage starts at 4 -10 mg/day/orally.

3. You have recently given birth and are experiencing postpartum depression, symptoms have lasted for over a month.
   Ask if the mother is breast feeding, consult a specialist.

4. You are a 25 year old healthy male; you have just been diagnosed with bipolar disorder. You are currently in the manic state. You are not taking any other substances, neither medical nor non medical.
   Prescribe a mood stabilizer, remember to avoid prescribing lithium if no laboratory testing is available in your setting.

5. You are a 14 year old boy who has just been diagnosed with epilepsy.
   Prescribe an antiepileptic drug according to availability in your setting.

6. You are a 27 year old man who has severe alcohol withdrawal symptoms.

7. You are a 50 year old woman. For one week you have been feeling very sad, you no longer want to do things that you found enjoyable before. Your husband has recently passed away.
   Do not prescribe antidepressants as first means of intervention, but rather provide psychosocial interventions.

Session 16 References
1. WHO, Pharmacological treatment of mental disorders in primary health care
2. Patel, Where there is no Psychiatrist
Session 17

Interviewing Skills

Session Aim: For participants to practice interviewing skills.

*Note - If possible bring in an extra facilitator to lead this session, they should have substantial interviewing experience and be able to demonstrate interviewing skills/techniques.

Session Tasks:
1. Presentation
2. Interviewing demonstration
3. Activity involving Interview Skills Cards
4. Practicing problem solving and listening techniques

Session Duration: 70 minutes

Material: Interview Skills Cards (found in Appendix H)

Task 1 - Presentation (10 minutes)
Directions: Give a presentation based on the Information for Presentation box below.
**Information for Presentation**

**Why are Interview Skills Important?**

*Diagnosis:*

Mental health differs from many other medical conditions, in that diagnosis is often almost entirely based on interviews with the person and his/her family. Often the person will deny that they have a problem. In order to make the person feel at ease and gather important information, interview skills/techniques become crucial.

*Build Rapport:*

Medication is only one form of treatment. Only when medication is used in combination with other forms of interventions will best results be obtained. Throughout the training we have mentioned forms of non-pharmacological interventions (e.g. education for person and his/her family, reactivating social networks, problem solving).

In order to effectively deliver these interventions, the health professional has to build rapport with the person and his/her family, which will be done through interviews and counselling. The health centre might be very busy, and the time that you have to spend with each individual may be limited. These are certainly challenges, but try to the best of your ability to give time to interview the person and carer.

Remember that those 10 minutes you spend interviewing become very important in order to understand how to help the person suffering from a mental illness, as well as to prevent relapses.

*Who will you Interview?*

Person and close family members or carers. It is important to always include the person who has a mental illness in discussions about their treatment and future. It is common for doctors and family to forget to include the person in important decision making.

**Basic Interviewing Skills**

- **Active Listening** - Allow the person to do most of the talking.
- **Attending Behaviour** - Being aware of your own body language (e.g. maintain eye contact). Also pay attention to the person’s body language and tone of voice.
- **Open-ended questions** encourage the person to talk freely and provide lots of information, e.g. “Could you tell me something about…?” The opposite of close-ended questions (e.g. “Are you tired?”)
- Probing questions can be used if answers are very brief and you would like more information, e.g. “Can you tell me a little bit more about that?”
- **Reflecting Feelings** - Uses other skills such as observation and summarizing. It helps the person to recognize the feelings associated with events. This skill involves reflecting back the feeling content of what is being said to the person, e.g. “It sounds like you’re feeling very frightened just now,” or reflecting back to a past situation, “That must have made you feel quite angry.”
- **Non-Judgmental** - Ask questions in a neutral non-judgmental way and be sensitive to the person’s emotions.
- **Trustworthy** - Assure person of confidentiality.
- Encourage person to seek support from family and friends.
Task 2 - Demonstration (10 minutes)

Directions
Either the facilitator (or if available the interviewing trainer) will demonstrate interviewing skills. Ask one of the participants to volunteer for the purpose of this demonstration.

Task 3 - Interviewing Skills Cards (20 minutes)

Directions: Step 1 (10 minutes)
Cut up the (translated) interviewing skills cards and put them in a container before the participants arrive.

Arrange the participants in pairs and ask each pair to select one card from the container (these include Active Listening, Open-ended Questions, Probing Questions, Reflecting Feelings, Attending Behaviour, Encouragement).

Ask each pair of participants to develop a very brief role play that demonstrates that particular skill in action. They can ask the facilitator for clarification of the skill if they do not fully understand how to implement it in practice.

Step 2: (10 minutes)
Ask each pair to firstly describe the interviewing skill on their card to the rest of the group, and then act out the role play.

If there is time, this process can be repeated to consolidate the learning.

Task 4 - Problem Solving (30 minutes)

Directions: Step 1
Ask participants to remain in their pairs to practice further interviewing skills. In pairs, participants listen to each other’s everyday problems and identify one that has a potential solution and that they are willing to talk about. One member of the pair acts as interviewer and helps the other person to think about their problem, find a solution, and come up with a plan to carry out the solution.

The facilitator should try and observe participants during this exercise and provide feedback to each pair engaged in the exercise. Allow 10 -15 minutes for this exercise and then ask the pairs to swap roles and repeat the exercise for a further 10 -15 minutes.

Step 2:
Then ask the participants to re-form the larger group to discuss:

- The strategies they used as an interviewer to talk to the other person.
- The strategies they used as a person with a problem to overcome the problem (but they don’t have to mention the problem itself).

Session 17 References

1. BasicNeeds: An Introduction to Mental Health, Facilitator’s Manual for Training Community Health Workers in India
SESSION 18

Ongoing Supervision and Knowing when to Refer

Session Aim: For participants to recognize how supervision can be effective and when it is necessary to refer to a specialist.

Session Tasks:
1. Presentation
2. Action plan for supervision and referral
3. Examples of when supervision/referral would be advisable

Session Duration: 30 minutes

Purpose: Material: Black/white board for presentation

Task 1 - Presentation (15 minutes)
Directions: Presentation by facilitator from box below.
**Information for Facilitator**

*Note* - During this training we have covered a lot of information in a short time period. Just because we have covered a subject during this training does not mean that you will be ready to manage all scenarios on your own. Having ongoing supervision and knowing when to refer is crucial at all times.

Supervision can have different meanings in different settings. For e.g. a psychiatrist could come and visit the clinic weekly or monthly. Or if your health centre is located far away from the nearest specialist, with modern technology, supervision can be carried out through mobile phones, and where possible computers.

Note that the person who acts as your supervisor may also be the person you refer to, or it could be a different person.

Close supervision is recommended for at least 1 - 2 years and later could be slowly tapered off with some form of supervision for 3 - 4 yrs or indefinitely; this will however depend upon previous experience and exposure during this time period.

**Will you be Prescribing Psychiatric Drugs?**
What are the regulations in your setting regarding prescription of psychiatric drugs? Even if you will be the one prescribing medication, it is important to have a supervisor whom you can consult with.

**Referral**
Here are some examples when it is strongly advised to refer to a specialist, if feasible.

- Person has thoughts of suicide or self-harm, or made an attempt.
- Person is violent.
- Person with abnormal behaviour and evidence of physical illness such as head injury or high fever.
- Person who may no longer be managed at home.
- Person who has adverse side effects from psychiatric drugs.
- Person who is not responding to treatment.
- The person belongs to a special group (pregnant, child, adolescent, breastfeeding etc.).
- Person confined at home or elsewhere.

Keep in mind when referring a patient to include as much information as possible. Consider writing a referral letter or follow whatever protocols are in place.

**What to Include in a Referral Letter**
When making a referral include as much information as possible:

- The patient’s name, hospital number (if available), date of birth, address and telephone number, national number
- The presenting complaint
- The reason for referral
- Past psychiatric history
- Background
BasicNeeds’ Mental Health and Development Programme in Nepal is being implemented by local partner LEADS since April 2010. The programme operates in the remote mountainous districts of Baglung and Myagdi in the Western Region. Sparsely populated and poorly connected, distances here are still measured in the number of days it takes to walk. A BN - LEADS baseline study in mid-2010 showed a complete lack of mental health services and no trained personnel in the districts. The nearest mental health service was at the psychiatric department of the regional hospital in Pokhara town, which is 50 kilometres away with no reliable public transport.

Six field consultations held between August and December by LEADS brought 184 Users to the programme who were directed to attend mental health camps that were to be coordinated by LEADS in coordination with Dr. Lumeshor and his small team from the psychiatric department of the regional hospital. In preparation for the camps LEADS organised for 65 health post staff to be trained in mental health. Six mental health camps (3 in Baglung and 3 in Myagdi) were held between July and December. The camps were held at the district hospitals. At the camps Users were registered and their baseline data was recorded. They were examined by the psychiatrist and the pharmacy staff distributed the prescribed medicines. A month’s medicine was given to most Users.

The rapidly increasing number of Users at the camps and the psychiatrist’s inability to keep up the pace of demand from their base at the regional hospital posed a challenge to sustaining the quality and efficiency of the services provided. LEADS was compelled to introduce follow-up clinics to be held at the health posts and district hospitals where Users could come for follow-up checks and advice. The trained health personnel would attend to them. A meeting was called with both district authorities and all practicalities were discussed in detail. The district authorities granted permission and officially recorded this in the minutes of the meeting.

For the first time rural health facilities and district hospitals in both districts began to run mental health follow-up clinics. Being newly trained, the health personnel clearly needed further on-the-job coaching and supervision. For this LEADS provided a mobile recharge card for NPR 200 per month to each health facility in-charge (head) and district focal person. Dr. Lumeshor was given a mobile phone with a sim card to receive calls on the days when the follow-up clinics were held. Since calls received are free of charge the psychiatrist does not need to be reimbursed. As they see patients the trained health workers use their mobile phones to call Dr. Lumeshor and report overall status, if there are any side effects or any complications. Based on their dialogue with him and his advice the health workers are beginning to: assess recovery, adjust medicine dosage or stop certain medicines, provide supportive therapy and make an immediate referral if required.

**Having Supervision**

As you begin to diagnose and treat individuals with mental, neurological and substance disorders it
Task 2 - Action Plan (15 minutes)

Directions
Ask participants to take a minute to think if there is a specialist that they know of who could act as their supervisor. It could be a person working in a psychiatric hospital near-by. Although, remember that even if the hospital or the person is far away, with modern technology such as mobile phones, they could have a direct link with a psychiatric hospital.

Give participants 10 - 15 minutes to write down a plan of action as to how they will go about referrals and seeking a specialist’s advice. It could be that there are in place existing protocols. If so what are they? If there are no protocols, write down a suggested plan. Ask participants to further brainstorm on this and discuss with their colleagues.

Task 3- Examples of when referral/supervision is required

Directions: Step 1
Ask participants to work in groups of 3 - 4. See below a list of different scenarios. Ask them to discuss each situation and discuss actions they would take. For e.g. Do they (i) Perceive it as a case that they could treat themselves? (ii) Need supervision? (iii) Or would it be advisable to refer to a specialist?

Person who comes to see you is a:

- Pregnant woman who has been diagnosed with bipolar disorder.
- Returning patient suffering from psychosis who was given a starting dose of Haloperidol 1.5 - 3 mg. It has now been 6 weeks, the person feels the medicine has had some minor effects but not enough.
- Woman who has recently given birth and is experiencing postpartum depression, symptoms have lasted for over a month.
- 40 year old healthy male who has been diagnosed with bipolar disorder. He has symptoms of mania, currently in the manic state. He is not taking any other substances, neither medical nor non medical.
- 14 year old boy who has just been diagnosed with epilepsy.
- 27 year old man who has severe alcohol withdrawal symptoms.
- 50 year old woman. For two weeks she has been feeling very sad, no longer wants to do things that she found enjoyable before. Her husband has recently passed away.

Step 2:
Come together in one group and discuss what decisions were made about each case and the reasons behind those decisions.

Session 18 References

1. BasicNeeds, Nepal
2. WHO, Mental Health Programme in Egypt. Diagnostic and Management Guide for Mental Disorders in Primary Care
Directions: Step 1
Participants have now completed the training course. Explain that the purpose of this activity is to brainstorm and identify what steps need to be taken next in order to facilitate the process by which participants will be able to apply their knowledge.

Divide participants into small groups (3 - 4 people per group). One person in each group will be asked to volunteer to provide information on his/her health setting to be used for the purpose of this exercise. If there are participants from the same health centre, it may be beneficial for them to work together, since the exercise provides an opportunity to explore how mental health service provision can be introduced or expanded in their particular setting. Give each group 3 large sheets of paper or poster sheets.
Step 1 (10 minutes)
Ask the participant whose health setting is being used to describe it to the rest of the group. It is important for the other participants to understand the setting thoroughly in order to be able to carry on with this exercise. Include as much information as possible. Start with more general information, for example, number of doctors, nurses, pharmacists. Average number of people that come to the clinic per day. In total how many people does the health centre serve? What services are currently provided, e.g. TB, malaria etc.? Do they work with other hospitals in the area? Management structure? Then identify what services, if any, are in place for mental, neurological and substance use disorders. The participants should neatly place all the information on one of the large sheets of paper. Explain that at the end of the exercise each group will make a short presentation.

Step 1 - Example:
Population in catchment area: 50,000
# of doctors: 1 full time / 1 part time
# of nurses: 1 full time
# of pharmacists: 1 full time
Average number of patients per day: 40
Main services provided: Malaria, TB, pneumonia
MNS services: Treat patients with epilepsy, for other MNS disorders usually refer to psychiatric hospital in city
Pharmacological stock: Some stock of Phenobarbital; other drugs not available
MNS patients in last 3 months: 2: Epilepsy – 1; Psychosis - 1

Step 2 (20 minutes)
Ask each group to come up with a list of the most pressing mental health needs in their setting. In a column next to it, list how these needs are addressed at the moment. In a third column, identify gaps in service provision that could be addressed. Again ask participants to place all the information on a large sheet of paper.

Step 2 - Example

<table>
<thead>
<tr>
<th>MNS Needs</th>
<th>How are needs addressed?</th>
<th>Gaps in Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy in children</td>
<td>Parents often bring children to see traditional healers, see doctors as a last option.</td>
<td>Irregular supply of antiepileptic drugs; it means that seizures often return and people lose faith in the medicine.</td>
</tr>
<tr>
<td>Suicide among rural women</td>
<td>Not being addressed at the moment.</td>
<td>Support networks for women, training for doctors in how to respond to pesticide consumption.</td>
</tr>
<tr>
<td>People with serious mental illnesses</td>
<td>They are referred to the nearest psychiatric hospital.</td>
<td>Often people will not have money to go to the hospital.</td>
</tr>
</tbody>
</table>
**Step 3 (20 minutes)**

Ask participants to look at the list that they constructed in Step 2. In particular ask them to look at the last column, where gaps in service provision were identified. Ask them to think about how they could potentially improve gaps that they identified in service provision. Participants will be asked to think of ways in which they can improve service provision for one of the gaps identified. This could involve having a clear protocol in place for supervision and referral. (It may be useful to think back to Activity 18).

Ask participants to draw up a budget, timeframe for the intervention and any other logistics.

Ask participants to think of any weaknesses in their intervention. Do a SWOT diagram. A method used to weigh the Strengths, Weaknesses, Opportunities and Threats of an intervention.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
</tbody>
</table>

For e.g. a weakness could be that it is time consuming to treat patients and to consult with a specialist. However, it could be an opportunity to help people who need caring.

**Step 3 - Example**

Improve service provision for people suffering from serious mental illnesses.

What is happening now? Patients are being referred to the nearest psychiatric hospital, but will not go because it is too expensive or far away.

**Intervention:** Provide services directly at the community health centre.

What needs to happen for this to be possible?

**Process**
SWOT diagram:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>People will not have to travel long distances to health centre</td>
<td>Health centre is already understaffed</td>
</tr>
<tr>
<td></td>
<td>No money to order new drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>People that receive treatment will be able to return to the workforce and contribute to overall economy</td>
<td>Health staff will be too busy, it could result in a decline in other programmes (e.g. TB, malaria interventions)</td>
</tr>
</tbody>
</table>

Timeframe

<table>
<thead>
<tr>
<th>Task</th>
<th>Jan - Feb</th>
<th>Feb - Mar</th>
<th>Mar - Apr</th>
<th>Apr - June</th>
<th>July - Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact potential supervisor</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with supervisor</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set up mobile phone used for supervision</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Order medication stock</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased staff time</td>
<td>?</td>
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</table>

Budget:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Medication</td>
<td>?</td>
</tr>
<tr>
<td>Mobile phone bill</td>
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<tr>
<td>Total</td>
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Step 4:
Ask participants to come up with a list of challenges associated with this intervention (these can be taken from the SWOT diagram). Next ask them to think of ways those challenges can be overcome.

Step 4: Example

<table>
<thead>
<tr>
<th>Challenges</th>
<th>How challenges can be overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre under-staffed</td>
<td>Train community health workers</td>
</tr>
<tr>
<td></td>
<td>Is it possible to hire a part time nurse? Or would it be possible for the part time doctor to become full time?</td>
</tr>
<tr>
<td>Cost of ordering new drugs, increased staff wages, extra staff, training</td>
<td>Is it possible to apply for an increase in funding? NGOs in your area willing to support the project</td>
</tr>
</tbody>
</table>

Step 5
To conclude this session, each group will present their intervention to the rest of the class. Other groups and facilitators will question the person presenting on any gaps in their design. This way the whole group can discuss together how this proposal could be turned into reality.
Session 19: Participatory Evaluation

Time: 1 hour

Purpose: To allow participants time to brainstorm the highs and lows of the training programme and to communicate their ideas to the facilitator.

Materials: Large pieces of paper and marker pens.

Directions: Step 1
What have we learnt? Ask the participants to revisit their definition of mental health from the beginning of the training and think of something they have learnt that they are willing to share with the larger group, i.e. what new knowledge or understanding do they have now that they did not have at the beginning of the training? Allow 3 minutes for this reflection, and then ask each of them to share their particular learning with the rest of the group, one by one. Each person should only speak for approximately one minute.
NB: One of the facilitators can lead this session and the other can make notes based on the participants’ comments. These notes will create a record for the purpose of course evaluation.

**Step 2 - Brainstorming the highs and lows**
Divide the participants into three groups and provide each group with large sheets of paper and pens. Ask each group to spend 10 minutes brainstorming the highs and lows of the training programme. ‘Highs’ can include overall comments about the structure, content and coordination of the course, any new learning, and any sessions or teaching strategies they particularly enjoyed. ‘Lows’ can include sessions they did not enjoy and concepts they found difficult to understand. Then ask the participants to spend an additional 5 minutes prioritizing their ideas so that they finish with 5 priority highs and 5 priority lows for their group. Ask each group to identify a member of the group who will write the 5 priority highs and 5 priority lows on the paper provided.

**Step 3 - Creating the final list**
Ask each group in turn to call out their list of 5 highs and 5 lows and write the ideas on the white/black board under the two headings ‘highs’ and ‘lows’. Combine similar ideas from different groups so that the final list reflects all three groups. Ask the group if they have any suggestions on how to improve the programme. This forms another record for the course evaluation and contains information that can be used to inform the development and implementation of subsequent trainings.

**Step 4 - Question Box**
Participants are asked at the end of each training day to provide comments and questions. The comments should be included in the final evaluation.

**Step 4 - Presentation of Certificates of Attendance**
A small presentation ceremony that acknowledges participants’ efforts by presenting them with Certificates of Attendance is a pleasant way to end the course, especially if it is coupled with chai and sweets, or other locally available produce.
References


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Assessment Quiz

Session 2 – Task 1

Assessment Quiz - Blank Quiz

Fold over answers and unfold upon completion of Part I of the quiz.

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<td>F</td>
<td>8</td>
<td>F</td>
<td>9</td>
<td>T</td>
<td>10</td>
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Fold over

Part I - General

1. Mental disorders are common - about one in five adults experiences a mental disorder at some stage in their life.

2. Mental disorders cannot affect children or young people.

3. You can usually tell by looking carefully at a person whether they are experiencing a mental illness.

4. While seizures, epilepsy and intellectual disability (mental retardation) are all disorders that affect the brain, these are usually not classified as mental disorders.

5. Mental disorders are NOT the result of possession by evil spirits, curses, astrological influences, character weakness, laziness, karma or black magic.

6. Mental illness can be caused by a combination of factors including: stressful life events, biological factors, individual psychological factors, e.g. poor self-esteem, negative thinking, adverse life experiences during childhood, e.g. abuse, neglect, death of parents or other traumatic experiences.

7. Mental disorders are always long-term conditions that can never be fully cured.

8. When a mental disorder is suspected, have the person admitted to a psychiatric hospital immediately.

9. When a family member has a mental disorder, that family is often socially and economically disadvantaged.

10. A holistic model of promoting mental health may include addressing the physical, social, psychological and economic needs of a person and their family.
Answers to Part II
Fold over answers and ask participants to unfold upon completion of Part II of the quiz.

<table>
<thead>
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<th>1 - T</th>
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<th>3 - T</th>
<th>4 - F</th>
<th>5 - T</th>
<th>6 - F</th>
<th>7 - F</th>
<th>8 - T</th>
<th>9 - F</th>
<th>10 - T</th>
</tr>
</thead>
</table>

Fold over

Part II - Symptoms and Treatment of Mental Disorders

1. These are examples of symptoms of acute psychosis: incoherent or irrelevant speech, delusions and hallucinations.

2. Fluoxetine is a type of antidepressant.

3. A person with bipolar disorder often experiences extreme mood swings, from a low mood to increased energy and activity.

4. Usually no medication is required to treat bipolar disorder.

5. 75% of all epileptic seizures can be managed by antiepileptic drugs.

6. In managing mental disorders with proper medication there is no need for other interventions.

7. Dementia is part of normal aging.

8. Severe alcohol withdrawal symptoms may include seizures and confusion.

9. Asking a person if they have thoughts of suicide may provoke the person to act on those ideas, and therefore those questions should be avoided.

10. If a person presents unexplained medical symptoms, and all tests have been negative, consider if the person is suffering from a mental disorder.
Case Studies

*Note that the case studies are taken either from Vikram Patel's book, Where there is no Psychiatrist, or from BasicNeeds.

Case study A
Mike is a 25 year old student who, many months ago, started locking himself in his room. Mike used to be a good student but failed his last exams. His mother says that he often spends hours staring into space. Sometimes he mutters to himself as if he were talking to an imaginary person. He was forced to come to the clinic by his parents. At first he refused to talk to the nurse. After a while he admitted that he believed that his parents and neighbours were plotting to kill him and that the devil was interfering with his mind. He said he could hear his neighbours talk about him and say nasty things outside his door. He felt as if he had been possessed, but did not see why he should come to the clinic since he was not ill.

Case study B
Rita is a 58 year old woman whose husband died last year. Her children are all grown up and have left the village for better employment opportunities in a big city. She started experiencing poor sleep and loss of appetite soon after her husband died. The symptoms worsened when her children left the village. She experiences headaches, backaches, stomach aches and other physical discomforts, which have led her to consult the local clinic many times. There she was told she was well, but was prescribed sleeping tablets and vitamins. She felt better immediately, particularly because her sleep improved. However within two weeks her sleep has got worse again. She went back to the clinic and was given more sleeping pills and injections. This has been going on for months, and now she can no longer sleep without the sleeping pills.

Case study C
Lucy was 23 when she had her first baby. During the first few days after the baby was born, she had been feeling tearful and mixed up. The midwife reassured her that she was only passing through a brief phase of emotional distress, as experienced by mothers. She suggested that Lucy and her husband spend a lot of time together and care for the baby and said that her mood would improve. As expected, Lucy felt better within a couple of days. Everything seemed fine for the next month or so. Then, quite gradually, Lucy began to feel tired and weak. Her sleep became disturbed. She would wake up early in the morning, even though she felt tired. Her mind was filled with negative thoughts about herself, and to her fright, about her baby. She began to lose interest in her home responsibilities. Lucy's husband was becoming very irritated with what he saw as her lazy and uncaring behaviour.

Case Study D
Anny is 43 years old. Her symptoms started very gradually, but before she knew it she had lost all interest in life. Even her children and family did not make her happy. She felt tired all the time. She could not sleep and used to wake up at 2 or 3 in the morning and then just toss and turn. She lost her taste for food and lost weight. She even lost interest in reading because she could not concentrate. Her head ached. Anny
felt lousy about herself and worried that she was a burden on the family and so on. The worst thing was that she felt embarrassed about the way she felt and could not tell anyone. Her mother-in-law used to complain that Anny had become lazy. Once Anny contemplated suicide. That is when she spoke to her husband who has brought her into your clinic. That was two months after the symptoms first started.

**Case Study E**
Sara is a 28 year old woman from Uganda. Seven years ago she started behaving strangely. It started only a few months after she got married. She started by talking to herself and fearing that people were following her wanting to kill her. Her newly wed husband sent her to her parents’ house.

One day while in the garden she started screaming that people wanted to slaughter her. To protect herself from these “evil people” Sara disappeared from home for a week. She was found in a village nearby, where she had another attack and muddled the names of her grandparents. A person in that village happened to recognize her grandfather’s name and reunited her with the family.

Sara's family searched for a cure for their daughter. They visited multiple traditional healers exhausting their resources but were determined not to give up. The search for treatment came to an abrupt end when her father died five years later. Her mother, caring for five other children as well, could not afford to spend any more money on herbal treatments for her daughter. She cultivated the little land they had, but even that was difficult for her to manage since much of her time was spent caring for Sara.

Sara's situation continued to deteriorate. She began to strip and run nude in the village, laughing unnecessarily and eating garbage. Her mother, feeling helpless, bought shackles and clipped her feet together every time she noticed Sara was about to run away. She explained that she felt it was the only way she could protect her, because she worried about her safety if she ran away.

**Case Study F**
Amil is a 14 year old boy who has a mild/moderate development disorder. Amil is a very sweet boy; he is very affectionate, sometimes inappropriately affectionate which makes other children afraid of him. He is often made fun of by the other children. Although he is 14, he struggles doing tasks that children half his age are able to do.

**Case Study G**
Amar is a 44 year old man who has been ill with a number of physical complaints over the past several months. His main complaints are that his sleep is not good, that he often feels like vomiting in the morning, and that he is generally not feeling well. Amar has recently been to see the doctor for severe burning pain in the stomach area, and he was prescribed medication for a stomach ulcer. Today he is sweating profusely and his hands are shaking. When you ask him how he is feeling he sits down and starts to cry. He admits that he is sick because he has been drinking increasing amounts of alcohol in the previous few months as a way of coping with stress in the family. However, now the drinking itself has become a problem and he cannot pass even a few hours without having a drink.

**Case Study H**
Ahanti is a 25 year old woman who is married and has one daughter and one son. She has gradually lost all interest in life. Even her children and family don’t make her happy. She feels tired all the time and has lost her taste for food; she cannot sleep at night and has lost weight. Ahanti feels like she is a burden on the family. She feels embarrassed about her situation and cannot tell anyone. Her mother-in-law complains that she has become lazy and her husband is frustrated with her and keeps yelling at her and hit-
ting her. Now Ahanti feels like ending her life. She is so scared by these feelings that she has come to talk to the doctor.

Case Study I
Six months ago the doctor started Ramesh on some medication for his odd behaviour. He has now stopped talking to himself and is less frightened and agitated. However, he complains of feeling tired all the time, he sleeps for long periods of the day, and does not take good care of his appearance and hygiene. When his father returns from work he often finds Ramesh still in bed at 4 o’clock in the afternoon. The father is very angry because his wife did not get Ramesh up to do some chores around the home. Ramesh’s mother says that she did not want to disturb Ramesh because “he is ill and he needs his sleep.” His father says that Ramesh should change his behaviour and start taking more responsibility and help out more in the home.
1. Moderate/Severe Depression
2. Psychosis
3. Bipolar Disorder
4. Epilepsy
5. Development Disorder
6. Dementia
7. Alcohol Disorders
Symptoms of Moderate - Severe Depression

For at least 2 weeks, have you been experiencing at least 2 of the following symptoms?

- Low or sad mood
- Loss of interest or pleasure
- Decreased energy/Easily fatigued

During the last 2 weeks have you had at least 3 other features of depression?

- Reduced Concentration /Attention
- Reduced self-esteem
- Ideas of guilt or unworthiness
- Ideas or acts of self-harm/suicide
- Disturbed sleep
- Bleak view about future
- Diminished appetite
1. Basic Psychosocial Support
Psycho Education:

Depression is common, probably a lot more common than you think.

Engage in activities that you found pleasurable before: Get Regular Sleep; Involve supportive family members and friends in treatment.


Reactivate social networks

2. If symptoms have lasted at least 2 weeks and are seriously affecting the person’s life (e.g. person has difficulty carrying out usual work or activities), then moderate-severe depression is likely. Consider not only basic psychosocial support but also antidepressants or referral for psychotherapy.

<table>
<thead>
<tr>
<th>Common Antidepressants</th>
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<tbody>
<tr>
<td>Amitriptyline</td>
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<tr>
<td>Fluoxetine</td>
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</table>

Things to Consider:

- Antidepressants take three to four weeks to act.
- Treatment must be continued for at least nine to twelve months to avoid relapse.
- May cause drowsiness, avoid with alcohol.
- Side effects are often short-lived.
Common Symptoms of Psychosis

- Social withdrawal and neglect related to work, school, domestic or social activities
- Beliefs that thoughts are being broadcasted from one’s mind
- Incoherent or irrelevant speech
- Delusions
- Hallucinations
- Agitation
- Withdrawal/Disorganized

If multiple symptoms are present, psychosis is likely. But first...

Rule out psychotic symptoms due to:
- Alcohol
- Cerebral Malaria
- Infection
- Head Injury
1. Non Pharmacological Interventions

Psycho Education:
With treatment your condition will likely improve significantly. Exercise; Maintain Personal Hygiene; Avoid Alcohol.

Remember that you have the right to be involved in all decisions that concern you.

Information for Carers/Family
- Hearing voices is a symptom of psychosis; he/she may firmly believe things that are untrue.
- The person suffering from psychosis will often refuse that they are ill.
- It is important to recognize relapsing and worsening symptoms.
- It is important to include the person in family and social gatherings.

2. Pharmacological Interventions

It is important to start taking medication immediately after diagnosis has been confirmed.

<table>
<thead>
<tr>
<th>Common Antipsychotics</th>
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<tbody>
<tr>
<td>Chlorpromazine (Injection/Oral)</td>
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<tr>
<td>Haloperidol (Injection/Oral)</td>
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<tr>
<td>Fluphenazine (injectible)</td>
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</table>

Things to Consider:
- Try medication for 4 - 6 weeks before considering it ineffective.
- Only consider long lasting injectable antipsychotic if treatment adherence is a problem.
- Side effects can often be reduced by reducing the dose slightly.
- Continue medication at least for 1 year (many patients will need treatment for much longer).
Have you experienced EXTREME mood swings? Going from (i) Depression: See Handout I (ii) Normal: Recovery is common between episodes, to (iii) Mania? (See Below)

**Symptoms of Mania:**
- Feeling very happy or irritable
- Increased activity, restlessness, excitement
- Increased talkativeness
- Loss of normal social inhibitions
- Decreased need for sleep
- Inflated self-esteem
- Distractibility
- Elevated sexual energy or sexual indiscretions
- In very severe cases delusions
- Hallucinations

If the person has multiple symptoms lasting for at least 1 week severe enough to interfere with work or social activities, mania is likely.
1. Non Pharmacological Interventions

Psycho Education:

Bipolar disorder is a common mental health condition that involves extreme mood swings. The strategies given below can help you or your loved one cope with bipolar disorder:

- Monitor your mood: For e.g. keeping a daily mood log.
- Plan regular work or a schedule that avoids sleep deprivation.
- Seek advice on major decisions such as finances.
- Prevent relapses. If you or a family member recognizes relapses seek care immediately.
- Resume positive activities: Hobbies, Exercise, Socialize.

2. Pharmacological Interventions

### Common Mood Stabilizers

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>Lithium Carbonate</td>
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<tr>
<td>Sodium Valproate</td>
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<tr>
<td>Carbamazepine</td>
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</tbody>
</table>

### Acute Episode

- Consider antipsychotics (intramuscular only if oral treatment is not feasible).
- For person in manic state experiencing agitation consider benzodiazepines

### Things to Consider

- Only consider Lithium if clinical and laboratory monitoring available
- Treatment should be regularly monitored every 3 – 6 weeks
- If no improvement is seen after 6 weeks – consult a specialist
- Antidepressants (especially tricyclics) should not be prescribed alone – they are less likely to induce mania if prescribed with mood stabilizers or antipsychotic therapy
- Continue medication at least for 2 years after an episode (many patients will need treatment for longer)
- Lowering prescription dosage may reduce adverse effects
Symptoms of Epilepsy

Symptoms of epilepsy vary greatly between different people and type of seizure, age of person etc.

During Seizures:

Loss of impaired consciousness.
Stiffness, rigidity lasting longer than 1 - 2 minutes.
Convulsive movements lasting longer than 1 - 2 minutes.
Tongue bite or self-injury.
Loss of control of urine and/or faeces.

After Seizures:

Fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches

If person has had at least 2 convulsive seizures in the last year on 2 different days, and 2 other criteria (during seizure/after seizure), it could be due to epilepsy.

If seizures last for over 30 minutes or occur with such frequency that person does not recover between episodes, consider Status Epilepticus.

But rule out other medical conditions:

Head or neck injury
Neuroinfection (meningitis/encephalitis)
Substance abuse
Alcohol withdrawal
Cerebral malaria
Hypoclycaemia or hyponatraemia
1. Non Pharmacological Interventions

Psycho Education:

Although epilepsy is a chronic condition, seizures can be fully managed in 75% of all individuals. People with epilepsy can and should live normal lives. Remember that epilepsy is NOT contagious. Keep a simple seizure diary.

2. Pharmacological Interventions

<table>
<thead>
<tr>
<th>Common Antiepileptic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenobarbital</td>
</tr>
<tr>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Sodium Valproate</td>
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<tr>
<td>Phenytoin</td>
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</tbody>
</table>

**Things to Consider:**

- Treatment is started with one antiepileptic drug at a time.
- The lowest dosage is given and slowly increased until seizure control has been obtained.
- The correct dose is the lowest dose that controls seizures without adverse side effects.
- There is often a delay between starting treatment and observed effect, therefore don’t immediately conclude that treatment is ineffective.
- If response is poor despite good adherence, the dosage may be increased.
- Medication is only stopped if no seizures have taken place for up to two years.

3. Helping a Person who is having a Seizure

Lay the person on their side, head turned to the side to keep airway open.

Make sure the person is breathing properly.

Do NOT put anything in the person’s mouth.

Stay with the person until the seizures are over.

If the person feels the seizure coming, ask them to lie down somewhere safe.
Symptoms of Development Disorders

Delays in Development

<table>
<thead>
<tr>
<th>Milestone *</th>
<th>Common age to achieve milestone</th>
<th>Suspect mental retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds to name/voice</td>
<td>1 - 3 months</td>
<td>4th month</td>
</tr>
<tr>
<td>Smiles at others</td>
<td>1 - 4 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Holds head steady</td>
<td>2 - 6 months</td>
<td>6th month</td>
</tr>
<tr>
<td>Sits without support</td>
<td>5 - 10 months</td>
<td>12th month</td>
</tr>
<tr>
<td>Stands without support</td>
<td>9-14 months</td>
<td>18th month</td>
</tr>
<tr>
<td>Talks in 2-3 word sentences</td>
<td>16 - 30 months</td>
<td>3rd year</td>
</tr>
<tr>
<td>Eats/drinks by self</td>
<td>2 - 3 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Can tell own name</td>
<td>2 - 3 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Is toilet trained</td>
<td>3 - 4 years</td>
<td>4th year</td>
</tr>
<tr>
<td>Avoids simple hazards</td>
<td>3 - 4 years</td>
<td>4th year</td>
</tr>
</tbody>
</table>

*For autism, delays will mainly be noticed with speech, communication, difficulties expressing needs. Examine: Vision, Hearing, Other sensory functions before confirming diagnosis.
Management / Development Disorders

Assessment and Management
Consider if delay in development is a result of:

- Nutritional deficiency/iodine deficiency. If yes → manage nutritional problem.
- Non stimulating environment/mother with depression. If yes → manage appropriately.

Psycho Education:

- Care for and accept the child with development disorder.
- Learn what makes your child happy and what situations are stressful.

Understand that people with development disorders often find new situations difficult. Therefore keep a regular schedule (eating, playing, learning and sleeping). Break tasks into smaller, more manageable steps. Reward good behaviour. Teach everyday life skills and personal hygiene. Encourage education if possible - or if available identify special schools.

Consider employment or if possible Sheltered Employment. Identify local resources available to people with disabilities and their families. Tend to carers and family.
Symptoms of Dementia:
A person suffering from dementia may have problems with: Memory orientation; Performing key roles and activities.

Diagnosis:
A) A Simple Memory Test
B) Interview family member or person who knows the person well. Ask if:
(i) Symptoms persisted for at least 6 months, (ii) are progressive in nature and (iii) impede social function. If yes to all, consider dementia.

But first rule out other medical conditions:
Goitre, slow pulse, dry skin or hypothyroidism?
*Assess for depression, common in dementia.
*Risk of self-harm.

Sexually transmitted infection (STI) or HIV? Cardiovascular disease?

Poor dietary intake, malnutrition, anaemia?

Other physical problems related to eyesight, hearing, bladder and bowel etc.

If onset is abrupt and short delirium is likely, consult a specialist.

If unusual features are present, consult a specialist.

Onset before the age of 60 years.

Clinical hypothyroidism

Cardiovascular disease

History of previous STI or HIV

History of head injury or stroke
Management / Dementia

Psycho Education for person and family

Although there is no cure there is much that can be done for the person and family.

- Use newspapers, radio, family albums to stimulate memory.
- Speak clearly and minimize background noise.
- Make adjustments to living conditions - avoid clutter.
- Put up signs in the house, e.g. bathroom, kitchen etc.
- Identify events that may trigger problems and try to avoid those events.
- Encourage person to do activities they enjoy, for e.g. listening to music.

Pharmacological Intervention

Consider antipsychotic medication only after a trial of psychosocial interventions:

<table>
<thead>
<tr>
<th>Atypical antipsychotic medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
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</table>

You may consider these medications if symptoms persist and there is imminent risk of harm.
Alcohol Disorders

Alcohol Disorders:
Alcohol usage becomes a problem if usage....

- Leads to problems at work or home
- Causes damage to health
- The person becomes physically and psychologically dependent on alcohol

Recognizing Alcohol Dependence
If 3 or more features are present suspect alcohol dependence

- Difficulties in controlling alcohol use
- A strong desire or sense of compulsion to take alcohol
- Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses
- A physiological withdrawal state when alcohol use has ceased or been reduced
- Alcohol use persisting despite clear evidence of harmful consequences
- Neglect of alternative pleasures or interests because of alcohol use

*Note - Harmful use of alcohol can contribute to the development of a mental disorder and can occur as a result of a mental disorder.
Management / Alcohol Disorders

Management of Alcohol Withdrawal Symptoms

- Not having alcohol at home
- Avoid going to places where people use alcohol
- Self-help groups, if available
- Ask support from family and friends
- Address housing and employment needs

Pharmacological:

- Consider administering diazepam (dosage depends on each individual) in a hospital setting - can be given more frequently/hourly
- Administer thiamine 100 mg/day orally for 5 days (or longer if required) to prevent the development of thiamine-deficiency syndromes such as Wernicke's Encephalopathy
- Ensure adequate fluid intake
Flow Chart

Assess
What symptoms are present?

Decide
Have you ruled out other conditions?

Treatment
Role Play 1 - Unhelpful response
Doctor: Good morning Sara, how are you feeling?
Sara: Appears distracted and doesn’t answer.
Doctor: (louder) Sara, I said, how are you feeling today?
Sara: I feel frightened; he's trying to harm me again.
Doctor: Who is trying to harm you Sara? I don't see anyone.
Sara: Looks fearful and says, you know who it is, everyone knows who it is, and he's just told me so.
Doctor: (appearing irritated) Sara, I don't have a clue what you are talking about. Who told you they are going to harm you? I can't hear anyone. Stop talking like this. People will think you are mad.
Sara: Begins to look distressed.
Sara: Of course, you know what I am talking about. You can hear him, everyone can hear him, they must be able to, he is shouting so loud.
Doctor: (shouting) I have had it with you, Sara, and your stupidity. You pretend to hear voices and you say they are trying to harm you when anyone can see that nobody is trying to harm you. Just stop being silly and pull yourself together.
Sara: Becomes distressed and begins to cry and gets up and leaves.
End of role play.

Role Play 2 - Helpful response
Doctor: Good morning Sara, how are you feeling?
Sara: Appears distracted and doesn’t answer.
Doctor: (speaking softly) Sara, you appear to be a little distracted. Are you feeling ok?
Sara: I feel frightened; he's trying to harm me again.
Doctor: (again speaking softly) Who is trying to harm you Sara?
Sara: Looks fearful and says, you know who it is, everyone knows who it is, and he's just told me so.
Doctor: Sara, are you hearing the voices of someone other than me talking to you at the moment? Sara looks puzzled.
Sara: Yes I am, and he is threatening to kill me. Can’t you hear him?
Doctor: No Sara, I can't hear the voice, but I do believe that you can hear it and it sounds as though the things that the voice is saying to you are very frightening.

Sara: Yes they are frightening. I try to tell myself that he can't hurt me but sometimes the voice is so loud I feel certain that he is going to get me.

Doctor: That must be very distressing Sara, you know it isn’t uncommon for people to hear voices when there is nobody there talking to them.

Sara: Isn’t it? I thought I was the only one who heard voices like this.

Doctor: No Sara, I have met lots of people who have heard voices like yours and many of them have been able to learn ways of making the voices less distressing.

Sara: I wish I could stop this voice from bothering me. Can you help me do that?

Doctor: I can’t promise that I can make the voices stop completely, but I can help you cope with the voices to make them less distressing. Would you like me to tell you more about how we might be able to do this?

Sara: Appears less tense and more hopeful.

Sara: Yes, I’d like you to tell me more about that.

End of role play.

Role Play 3
Scene: Manik's husband, calls the health clinic, he is very distressed.

Manik's husband: My wife Manik is a 31 year old woman. She has started behaving in an unusual manner. She is sleeping much less than usual and is constantly on the move. Manik has stopped looking after the house and our children as efficiently as before. She is talking much more than normal and often says things that are unreal and grand, such as that she can heal other people and that she comes from a very wealthy family (even though I'm a farmer). She has also been spending all our money on things we cannot afford. I tried to bring her to the clinic but she becomes angry and irritable.

Health Professional: Improvise

Manik's husband: Improvise

Health Professional: Improvise

Manik's husband: Improvise

Role play 4
Doctor

Who you are: You are a doctor at the local clinic.

Context: You have been called out to the market located outside your clinic. You find a nine year old boy, John, who is convulsing; his mother is attending to him anxiously. Shortly after you arrive at the scene the convulsions stop, but John is confused and startled.

Your Role: You have to determine what is causing John's seizures. Ask John and his mother questions; use the mhGAP - IG manual for guidance.
John

Who you are: You are a nine year old boy who has just gone to the market with his mother when suddenly you have a seizure. As this scene takes place, you have just recovered from the seizure; you are frazzled, a doctor and your mother are standing over you.

Context: The seizures started happening about one year ago. You do not know why they happen, otherwise you feel fine most of the time. Most of the time they happen at night and no one except for your family notices. Your family has been worried, your mom took you to see multiple healers in the village. “I’m still hoping that if we provide more offerings to the healer the seizures might stop. It is difficult because the family does not have a lot of money and I know the healer asks for a lot. Last month it happened at school, people are saying it is linked with witchcraft. I am really hoping it will never happen at school again; otherwise I might have to stay at home until the healer can make it better.”

Your Role: The doctor will likely ask you a series of questions; you are feeling confused and dizzy. At first act shy, you are afraid to say too much because you are embarrassed and would rather not that everyone around in the market knows that it has been happening repeatedly. As the doctor reassures you that it is ok for you to talk to him/her slowly give some information (see context above).

Mother

Who you are: You are the mother of a nine year old boy John. You have taken him to the Sunday market to do some shopping when he suddenly has a seizure. This scene takes place right as the seizures are stopping. Someone has called a doctor who is now standing over John examining him.

Context: You have been so worried about John and these strange behaviours. People say witchcraft, you do not know what to believe, but you worry if this does not stop it could ruin the reputation of the family. You have suggested seeing a doctor but your mother-in-law refuses to spend money on the doctor, she thinks the healer is the best option. You feel like the family blames you, you feel guilty. You are unable to sleep and feel constantly tired; you lack motivation in caring for your other children. You no longer want to do things that you found enjoyable before such as going with your friends to the market.

Your Script: You are shy at first to answer the doctor’s questions. However, you are also hopeful that he may be able to help, so you try to answer some of his questions. These are some examples of the questions he/she may ask and answers you may give.

Has John experienced seizures like this before? Yes.

How long do they typically last? Usually less than ten minutes.

Has he complained about any other physical symptoms? No.

No fever, stiff neck? No.

When did the seizures first start? First seizure was one year ago.

How often does he get the seizures? At least every month.

Role Play 5

Doctor

Who you are: You are a doctor at the local clinic.

Context: A mother and her daughter have just entered your clinic. They have been referred to come see
you by a community health worker.

**Your Script:** You have to diagnose and treat Rashida's illness. Ask Rashida and her mother questions; use the mhGAP - IG manual for guidance.

**Rashida**

**Who you are:** You are Rashida, an eight year old girl, who has come with her mother to see the doctor. You have seen multiple traditional healers for your mysterious illness in the past, although this is the first time you see a modern doctor. You hope that this doctor can cure your illness and that you can go to school like normal children.

**Rashida/ Context:** I feel a bitter taste in my mouth, then I start shaking and fall down.

Other times, I feel like I am being whipped with a cane and then I fall to the ground. Although I fall I am usually conscious of whatever happens around me.

People tease me, they say if I fart and they smell the flatulence, they will be infected with my sickness. So they do not come near me. They even mock me, saying I am possessed by evil spirits. Even when children who are younger than me pass provocative comments about me, I dare not touch them because they will always call in their elder siblings to beat me up.

**Your Script:** The doctor will ask you a series of questions, answer to the best of your ability, using information given in the context. If information is not provided improvise.

**Who you are:** You are the mother of Rashida who has been suffering from a mysterious illness for the past four years. You have taken Rashida to see a specialist. When the scene takes place you have just entered the doctor’s office.

**Rashida’s mother/Context:**

Rashida’s condition started while she was living with her grandmother. She used to exhibit signs of dizziness and this later developed into convulsive episodes. We sent her to a traditional healer for treatment and the healer confirmed that Rashida’s illness was convulsion. He requested ten Ghana Cedis (GBP£ 5.20) and a red cock to make herbal preparations for Rashida, but this did not stop the illness. We went to another traditional healer called Afa Rahimu. He requested twenty Ghana Cedis, (that is about GBP£ 10.07) and a bottle of perfume in order to treat our child. After his treatment, Rashida was still experiencing fits, so we sent her to another healer a neighbour recommended to us. This healer also asked for ten Ghana Cedis (about GBP£5.20) and a white goat. The last traditional healer we went to requested us for ten Ghana Cedis and a black hen, but there was still no change in Rashida’s condition. So we decided to stop visiting healers and to wait on God.

I faced a lot of stigma in the neighbourhood. I even quarrelled with some neighbours and friends because of derogatory remarks they made about me. Some of my friends do not want their children to play with Rashida. Some people even think that Rashida should be taken away from the community. We have not enrolled Rashida in school, considering how people behave towards her at home, she is likely to suffer the same rejection at school. It is best for her to stay outside school till she gets stabilized.

**Your Script:** Try to answer the doctor’s questions to the best of your ability. Use information given in the context and improvise when needed.
Role Play 6

Who you are: You are a doctor at the local clinic.

Context: A boy and his father have just entered your clinic.

Your Script: You have to manage Eugene's condition. Ask about his medical history since he has suffered from the condition for a long time. Come up with a treatment plan.

Who you are: You are Eugene, 16 years old. You have had unexplained seizures since you were eight years old.

Eugene/Context:

I first started experiencing symptoms of my illness when I was eight years old. I used to wake up in the middle of the night, talking, shouting and making noise in the dark. My mother and grandmother prepared herbal concoctions for me to drink. My symptoms stopped but this was only temporary.

The stable condition did not last for long. I relapsed and this time it was very bad. My mother decided to send me to my father in Accra. This time I could not do anything on my own. I would wake up in the middle of the night, to me hitting my head.

I was taken to Accra's psychiatric hospital where they did some scans. The scans did not reveal the cause of my illness, but they still gave me some drugs to take. The drugs improved my condition, but I still had seizures. My father took me to some traditional healer who had a good reputation. The healer gave me a bottle of Frytol cooking oil to be drunk in the evening and morning. I stopped taking the drugs I had received at the psychiatric hospital and concentrated on the cooking oil. However my symptoms became worse again, I also developed diarrhoea. I finally realized that it was not doing anything, so I started taking the medication from Accra. My parents, still looking for a complete cure, then took me to a pastor who prescribed some herbal remedies. Again I stopped taking the hospital medicine. My illness became much worse at that point. I realized that the medication from the hospital helped. When taking them I would only experience the seizures at night, so no one in the community knew of my condition. I could go on with my everyday life. For instance, I had completed a technical school course in electronics. I was ready to start work, the problem was that I ran out of medication and started experiencing seizures all the time. It was starting to affect my ability to get a job, no one would hire a person who they worried was possessed by evil spirits. My parents had spent all their resources on the various healers. The hospital is also so far away, so just getting there costs a lot of money on top of the cost of the medication. I am really hoping that I can get a job to pay for my medication but I need my seizures to stop first.

Your Script: Try to answer the doctor’s questions to the best of your ability. Use information given in the context and improvise when needed.

Who you are: You are the father of a 16 year old boy, Eugene. Your boy has been suffering from seizures for the last 8 years. As the scene takes place you have just entered the doctor's office.

Context: You and Eugene's mother live separately. Eugene used to live with his mother but she could not manage his illness. She had tried everything, so she thought that as the father I might be able to help. Eugene came and lived with me when he was 10 years old. At that stage his condition was very severe. He was not able to do anything on his own. He would wake up everyone in the house at night with his screaming. A neighbour suggested going to see a doctor at the psychiatric hospital. We went to the hospital, which was far away and expensive. I had to take time off from work, which also meant
that I lost salary for that day. The medication they gave Eugene at the hospital improved his condition, but the illness did not go away completely. I was determined not to give up, I asked around and was recommended a very powerful healer. The healer prescribed remedies. Even though expensive I had more faith in his remedies than in the hospital's. Eugene's condition seemed to get worse, and he went back to the hospital tablets. We tried some other healers, but in the meantime he would go back to the hospital drugs. One day Eugene came up to me and told me that his drugs from the hospital were almost finished. I suggested he have only a fraction of a tablet at a time. However his condition continued to get worse. Now he is starting to have fits in the middle of the day, people are already talking that he is possessed by evil spirits. I have come to the local clinic as a last resource, I hope they are able to help and that they will not charge too much.
### Medication Chart

*Note

This chart should only be used for general guidance, please check carefully what drugs and dosages are recommended in your clinical setting.

(Patel, Table 11, WHO List of Essential Medicines)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Local name and Cost</th>
<th>Special Use</th>
<th>Dosage</th>
<th>Common Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Depression</td>
<td>Healthy Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
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</tbody>
</table>

**Starting dose**
Start with 20 mg/day orally unless adolescents, elderly, medically ill (then 10mg).

**Therapeutic dose**
20 - 40 mg/day orally. Further increase to 60 mg daily if no improvement seen. Note that each dose increase should only happen after 4 – 6 weeks.

- Serious side effects (these are rare):
  - marked / prolonged akathisia
  - bleeding abnormalities in those who regularly use aspirin and other non steroidal anti-inflammatory drugs.

- **Common side effects**
  (Most side effects diminish after a few days; none are permanent).
  - Restlessness, nervousness, insomnia, anorexia and other gastrointestinal disturbances, headache, sexual dysfunction.

- **Cautions**
  - Risk of inducing mania in people with bipolar disorder.
<table>
<thead>
<tr>
<th>Antipsychotics</th>
<th>Psychosis</th>
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</thead>
<tbody>
<tr>
<td><strong>Amitriptyline</strong></td>
<td>Healthy Adults</td>
</tr>
<tr>
<td><em>Note – DO NOT prescribe for adolescents.</em></td>
<td><strong>Starting Dose</strong> Initiate treatment with 50 mg at bedtime.</td>
</tr>
<tr>
<td><strong>Maintenance Dose</strong> Increase by 25 to 50 mg every 1 - 2 weeks, aiming for 100 - 150 mg by 4 - 6 weeks depending on response and tolerability. If no response in 4 - 6 weeks or partial response in 6 weeks, increase dose gradually (maximum dose 200 mg) in divided doses (or a single dose at night).</td>
<td><strong>Serious side-effects</strong> (these are rare) » Cardiac arrhythmia. <strong>Common side-effects</strong> (Most side effects diminish after a few days; none are permanent). » Orthostatic hypotension (fall risk), dry mouth, constipation, difficulty urinating, dizziness, blurred vision and sedation. <strong>Cautions</strong> » Risk of switch to mania, especially in people with bipolar disorder; » Impaired ability to perform certain skilled tasks (e.g. driving) - take precautions until accustomed to medication; » Risk of self-harm (lethal in overdose); » Less effective and more severe sedation if given to regular alcohol users.</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td><strong>Psychosis</strong></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Healthy Adults</td>
</tr>
<tr>
<td><em>Note - Helps sleep and is useful given at night for people with psychosis and sleep problems. Chlorpromazine shouldn’t be given for sleep problems unless the person also has psychosis.</em></td>
<td><strong>Starting Dose</strong> Start with 75 mg</td>
</tr>
<tr>
<td><strong>Maintenance Dose</strong> 75 - 300 mg/day</td>
<td><strong>Stiffness, dryness of mouth, restlessness, drowsiness, dizziness, weight gain, sudden jerky movements, Sedation Photosensitivity (for CPZ only)</strong></td>
</tr>
<tr>
<td>Fluphenazine*</td>
<td>Given as deep intramuscular injections for long-term treatment of schizophrenia</td>
</tr>
<tr>
<td>Drug</td>
<td>Use</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td><strong>Haloperidol</strong></td>
<td>Useful for severe agitation and is less sedative.</td>
</tr>
</tbody>
</table>

**Mood Stabilizers**

<table>
<thead>
<tr>
<th>Mood Stabilizer</th>
<th>Bipolar Disorder</th>
<th>Starting Dose</th>
<th>Maintenance Dose</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lithium Carbonate</strong></td>
<td>For control of manic depressive disorder; avoid if serum levels cannot be obtained or when the person is taking diuretics.</td>
<td><strong>Starting Dose</strong> 300 mg/day orally, increase every 5 - 7 days depending on plasma levels.</td>
<td><strong>Maintenance dose</strong> Plasma level of 0.6-1.0 mEq/L. Typical dose 600 - 1200mg per day.</td>
<td>Nausea, diarrhoea, weight gain, increased thirst, interactions with non-steroidal anti-inflammatory drugs. Note that lithium can be very dangerous if taken in excess.</td>
</tr>
<tr>
<td><strong>Carbamazepine</strong></td>
<td>Same as lithium</td>
<td><strong>Starting dose</strong> 200 mg/day orally.</td>
<td><strong>Maintenance dose</strong> 400 - 600 mg/day orally.</td>
<td>Serious side effects: Rash and drop in white blood cell count. Nausea, drowsiness, diarrhoea, weight gain, tremor, jaundice, liver failure, pancreatitis. <strong>Contra-indicated in pregnancy due to teratogenicity.</strong></td>
</tr>
<tr>
<td><strong>Sodium Valproate</strong></td>
<td>Same as lithium.</td>
<td><strong>Starting Dose</strong> 500 mg/day orally.</td>
<td><strong>Maintenance dose</strong> 1000 - 2000 mg/day.</td>
<td>Nausea, difficulty walking, constipation, sedation, serious allergic reactions, hyponatraemia. Note that a sudden fall in blood count can occur. Contra-indicated in pregnancy due to teratogenicity.</td>
</tr>
</tbody>
</table>

**Substance Disorders**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Managing Opioid Withdrawal</th>
<th>Initial Dose</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methadone</strong></td>
<td>Managing opioid withdrawal</td>
<td>Initial dose of 15 - 20 mg, increasing if necessary to 30 mg per day, and then tapering off over 3 to 10 days. Care should be taken particularly if the person is prescribed other sedative drugs.</td>
<td></td>
</tr>
<tr>
<td><strong>Buprenorphine</strong></td>
<td>Managing opioid withdrawal</td>
<td><strong>Day 1:</strong> 100 mg (intramuscular), <strong>Day 2:</strong> 100 mg (intramuscular), <strong>Day 3:</strong> 100 mg (intramuscular), <strong>Day 4:</strong> 50 mg (orally), <strong>Day 5:</strong> 50 mg (orally), <strong>Day 6:</strong> 50 mg (orally), <strong>Day 7:</strong> 50 mg (orally)</td>
<td></td>
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<tr>
<td><strong>Clonidine</strong></td>
<td><strong>Managing opioid withdrawal</strong></td>
<td><strong>Dose range of 0.1 - 0.15 mg 3 times daily (according to body weight). Symptomatic treatment should be given, e.g. treat nausea with antiemetics, pain with simple analgesics, and insomnia with light sedatives. Monitor blood pressure closely.</strong></td>
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<tr>
<td><strong>Alcohol Use</strong></td>
<td><strong>Diazepam</strong></td>
<td><strong>Initial dose of up to 40 mg daily (i.e., 10 mg four times daily or 20 mg twice daily) for 3 - 7 days. In people with impaired hepatic metabolism (e.g. liver failure, elderly) use a single low dose initially (5 - 10 mg) and determine the duration of action of this dose before prescribing further doses.</strong></td>
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<tr>
<td><strong>Vitamin B1</strong></td>
<td><strong>Administer thiamine 100 mg / day orally for 5 days (or longer if required).</strong></td>
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<tr>
<td><strong>Epilepsy</strong></td>
<td><strong>Phenobarbitone</strong></td>
<td><strong>For all types of epilepsy in adults. Epilepsy in children.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Starting dose</strong></td>
<td><strong>Start with 60mg per day for 2 weeks.</strong></td>
<td><strong>Starting dose</strong></td>
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<tr>
<td><strong>Maintenance dose</strong></td>
<td><strong>Increase to 120mg if poor response. If still seizures persist then increase to 180mg / day.</strong></td>
<td><strong>Maintenance dose</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Starting dose</strong></td>
<td><strong>For children, start with 2mg/kg for 2 weeks.</strong></td>
<td><strong>Maintenance dose</strong></td>
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<tr>
<td><strong>Maintenance dose</strong></td>
<td><strong>Increase to 3mg/kg if needed, and thereafter up to a maximum of 6mg / kg.</strong></td>
<td><strong>Dose-determined:</strong></td>
<td></td>
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<tr>
<td><strong>Phenytoin</strong></td>
<td><strong>For all types of epilepsy in adults. For epilepsy in children</strong></td>
<td><strong>Dose-related: drowsiness, ataxia and slurred speech, motor twitching and mental confusion, coarseening of facial features, gum hyperplasia and hirsutism (uncommon); idiosyncratic: anaemia and other haematological abnormalities, hypersensitivity reactions including skin rash, hepatitis.</strong></td>
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<tr>
<td><strong>Starting Dose</strong></td>
<td><strong>150 - 200 mg/ day</strong></td>
<td><strong>Starting Dose</strong></td>
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<tr>
<td><strong>Maintenance dose</strong></td>
<td><strong>200-400 mg/day</strong></td>
<td><strong>Maintenance dose</strong></td>
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<tr>
<td><strong>Starting Dose</strong></td>
<td><strong>3 - 4 mg/kg/day</strong></td>
<td><strong>(maximum 300 mg daily)</strong></td>
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<tr>
<td>Drug</td>
<td>Usage in Adults</td>
<td>Usage in Children</td>
<td>Dosage Details</td>
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<tr>
<td>Sodium Valproate</td>
<td>For all types of epilepsy</td>
<td>For epilepsy</td>
<td>Start with 400 mg/day; increase over 2 weeks to a maximum of 2000 mg a day.</td>
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<td></td>
<td><strong>Starting dose</strong></td>
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<td><strong>Maintenance dose</strong></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>For all types of epilepsy</td>
<td>For epilepsy</td>
<td><strong>Starting dose</strong></td>
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<td><strong>Maintenance dose</strong></td>
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Services in Your Area

(Patel, Where there is no Psychiatrist, pg 244 - 247)

**Services for Children**
May include children’s homes, juvenile homes, child telephone helplines, child abuse agencies, organizations working with street children, child protection agencies, agencies working on children’s issues such as Save the Children, special schools for children with development disorders.

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<tr>
<th>Name of Contact Person</th>
<th>Services Offered</th>
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**Resources for the Elderly**
These may include: residential home for the elderly; government agencies providing welfare and financial assistance to elders; local chapters on Alzheimer’s Disease International, HelpAge and other agencies specifically working on issues that affect elderly people.

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**Resources for Drug and Alcohol Problems**
These may include local chapters of Alcoholics Anonymous and other agencies working with drinking problems; agencies working with the families of persons with dependence problems; health facilities specializing in drug and alcohol dependence.

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<th>Name of Contact Person</th>
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Resources for Women
These may include women's organizations; family violence units in the police and other government agencies; lawyers, social workers and counsellors sensitive to women's violence issues; residential shelters for women; women's health clinics.

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<th>Name of Contact Person</th>
<th>Services Offered</th>
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Resources for Families of Persons with a Mental Illness
These may include support groups and organizations working with the families of those who suffer from any type of mental illness, or more specifically, mental retardation, dementias in older people, drinking and drug problems, and severe mental disorders.

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<tr>
<th>Name of Contact Person</th>
<th>Services Offered</th>
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Mental Health Professionals
These may include psychiatrists, psychologists and other mental health professionals. In particular, record information on the nearest psychiatric hospital facility and emergency clinic to which very sick people can be referred.

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<th>Name of Contact Person</th>
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Livelihood Opportunities - Government Schemes
Session 17

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Mental Health Care: An Introductory Manual For Training General Health Personnel
Session 1: Task 1 - Blank Timetable

<table>
<thead>
<tr>
<th>Day 1</th>
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Session 1: Task 1 - Illustrated Instruction Cards
This introductory activity requires about 10 or 12 illustrations (assuming there will be 20 participants). Each illustration is cut in half (or can be drawn as two separate halves). Each participant receives half a picture and has to find the person who has the other half of that picture to form a pair. Each person introduces himself/herself to their other half as described in the activity. The pictures can be very simple, for example, pictures of animals, a sad face, a happy face or other pictures that are relevant to that particular setting. The idea of the picture is just a way of bringing two participants together.
Session 2 - Task 1
Assessment Quiz - Solutions and Explanations for Facilitator
Part I - General

Answers and Explanations – Note that the explanations are mainly for the facilitator, the facilitator should not spend time going over the quiz.

1. Mental disorders are common - about one in five adults experiences a mental disorder at some stage in their life. T

2. Mental disorders cannot affect children or young people. F
   Mental disorders can affect both men and women, and can affect people from different age groups including the young and the elderly.

3. You can usually tell by looking carefully at a person whether they are experiencing a mental illness. F
   Most people suffering from a mental disorder look the same as everyone else. It’s not always possible to tell that someone is experiencing a mental disorder just by looking at the person.

4. While seizures, epilepsy and intellectual disability (mental retardation) are all disorders that affect the brain, these are usually not classified as mental disorders. T
   However, stress that for this training we will also cover these disorders; explain why the WHO might include these conditions together, for example, both are conditions of the brain and people suffering from them are often both vulnerable to stigma and human rights violations.

5. Mental disorders are NOT the result of possession by evil spirits, curses, astrological influences, character weakness, laziness, karma or black magic. T

6. Mental illness can be caused by a combination of factors including: stressful life events, biological factors, individual psychological factors, e.g. poor self-esteem, negative thinking, adverse life experiences during childhood, e.g. abuse, neglect, death of parents or other traumatic experiences. T

7. Mental disorders are always long-term conditions that can never be fully cured. F
   A mental disorder can be a brief episode or it may be a long-term condition. The severity of mental illness can greatly vary, some people following treatment will be able to completely recover, others may go through cycles.
8. When a mental disorder is suspected have the person admitted to a psychiatric hospital immediately. F

Institutionalized care should be avoided if possible, very rarely is it necessary to admit a patient for a long time stay at a hospital.

9. When a family member has a mental disorder, that family is often socially and economically disadvantaged. T

10. A holistic model of promoting mental health may include addressing the physical, social, psychological and economic needs of a person and their family. T

Part II - Symptoms and Treatment of Mental Disorders

1. These are examples of symptoms of acute psychosis: incoherent or irrelevant speech, delusions and hallucinations. T

2. Fluoxetine is a type of antidepressant. T

3. A person with bipolar disorder often experiences extreme mood swings, from a low mood to increased energy and activity. T

4. Usually no medication is required to treat bipolar disorder. F

Medication is usually required and is continued at least 2 years after the last bipolar episode.

5. 75% of all epileptic seizures can be managed by antiepileptic drugs. T

6. In managing mental disorders with proper medication there is no need for other interventions. F

Studies repeatedly show that best results are obtained when medication is used in combination with other psychosocial interventions such as education, counselling etc.

7. Dementia is part of normal aging. F

Dementia is not part of normal aging. It can occur at any age, although more common in older people.

8. Severe alcohol withdrawal symptoms may include seizures and confusion. T

9. Asking a person if they have thoughts of suicide may provoke the person to act on those ideas, and therefore those questions should be avoided. F

Asking about suicide does NOT provoke acts of self-harm.

10. If a person presents unexplained medical symptoms, and all tests have been negative, consider if the person is suffering from a mental disorder. T
Part II - Revision Quiz - Instructions for Facilitator

Category 1 (General Information)
1. Mental disorders are a common problem. True or False? (1 point)
2. Who is the most likely to develop a mental disorder? (1 point)
3. Hearing voices is an example of what type of symptom the person has. (E.g. physical/ feeling/ thinking/ behaviour/ imagining). (1 point)
4. Sleep disturbance is an example of what type of symptom the person has. (For e.g. physical/ feeling/ thinking/ behaviour/ imagining). (1 point)
5. Mental disorders only exist when symptoms are excessive and prevent the person from leading a normal life. True or False? (1 point)

Category 2 (Depression, Psychosis, Bipolar Disorder and Epilepsy)
6. Name two symptoms of depression. (1 point for each correct symptom)
7. Name the category of drugs used to treat severe depression. (1 point). Name one such drug. (1 point)
8. Name three symptoms of psychosis. (1 point for each correct symptom)
9. What characterizes bipolar disorder? (2 points)
10. A person who only experiences mania, but not depression has bipolar disorder. True or False? (1 point)
11. Name two possible causes of epilepsy. (1 point for each correct answer)
12. What is status Epilepticus? (1 point)

13. Clue Question
A bell will be placed in the middle of the room; it should ideally be equidistant from the different teams. Ask each group to assign one runner.

Give three clues as to what condition you are describing. 1st clue (3 points), 2nd clue (2 points), 3rd clue (1 point). The team first to the bell has the right to answer. If the team answers incorrectly the other teams have a chance to answer.

Clue 1
Pharmacological treatment of this disorder should be continued for at least 12 months after full remission. The drug chlorpromazine is commonly used to treat this condition.

Clue 2
The disorder affects men and women equally, although onset of symptoms happens later in women. People with this condition are at high risk of exposure to human rights violations.
Clue 3
Common symptoms include incoherent or irrelevant speech, delusions and hallucinations.

Instructions for Quiz Master – Once round I of the quiz has been completed, ask groups to switch with another team, go over the answers together, put the total score up on the right hand of the answer sheet. Move on to the next round.

Category 3: (Design a Poster)
Instructions for Quiz Master: Give out large sheets of papers, coloured markers, paint, whatever may be available. Allow 20 minutes for each group to design an information poster based on information that has been covered in this training. The objective of making the poster should be to disseminate information to the general public, in order for them to recognize signs of mental illness/epilepsy and present to the clinic.

Instructions for Quiz Master: Once all posters are finished, collect them. Ask groups to give scores from 1 - 5, scoring all posters except for their own, collect the scoring sheets and add up and record on the right hand side of the answer sheet. Move on to the next category.

Category 4: (Development Disorders, Behavioural Disorders, Dementia, Alcohol and Drug Disorders)
*Note - even if you did not cover all these conditions you can still attempt to answer these questions, as all participants should have received a general overview of all conditions. However, if very pressed for time, consider skipping this category.

1. Development disorders, an umbrella term covering disorders such as.... (name two). (1 point for each correctly identified)
2. Attention deficit hyperactivity disorder or ADHD is a type of behavioural disorder. True or False? (1 point)
3. John is 13, he used to have no problems in school. But for the last three months he is having trouble paying attention in class, he often leaves tasks unfinished, and has difficulties with sitting still. Suspect ADHD. True or False? (1 point)
4. Dementia is part of normal aging. True or False? (1 point)
5. Name a drug used for severe alcohol withdrawal. (1 point)
6. List three ways alcohol can be harmful to one’s health. (1 point for each correctly identified)
7. Injecting drug users are at higher risk of developing HIV and other STIs than the general public. True or False? (1 point)
8. How can opioid withdrawal be treated? (1 point)
9. Clue Question
Clue 1 (3 points)
This condition is an illness of the brain that tends to get worse over time.

Clue 2 (2 points)
Depression is common in this condition, there is no cure although much can be done to help and support the family.

Clue 3 (1 point)
Symptoms of this condition include problems with memory, orientation, speech and language, difficulties performing key roles and activities.
Instructions for Quiz Master: Hand out a cartoon series to each group. The group performs a script from the cartoons. Like when scoring the information posters, once everyone has presented their script, ask the groups to anonymously give points from 1 - 5 to all groups except for their own. Collect the score sheets and add up the points and record on right hand side of master score sheet.

Category 6 (Supervision/Referral)

1) Give seven examples when it would be strongly advised to refer. (1 point for each correct answer)

2) Read Case Study I, write a referral note.
Symptom Cards

Self-blame

Talking to himself/herself

Hearing voices
Fear

Sadness

Sleep disturbance
Muscle tension

Stomach pains

Heart pounding
Feeling hopeless

Mood swings

Lack of energy
Increased or decreased talking

Attempting suicide

Thinking about suicide
Poor concentration

Seeing things not really there

Poor judgement
Believing others are going to harm you

Aggression

Withdrawing from friends and family
Cut up the humour cards and ask participants to pick one.

- Tell a joke or sing a song
- Ask the group to guess what you are doing, or acting out. (You are washing laundry)
- Clap your hands five times
- Ask the group to guess what you are drawing. (You should draw a farmer)
- Tell the group about a memorable incident during your working career
- You choose someone else to sing a song
Case Studies

*Note that the case studies are taken either from Vikram Patel's book, Where there is no Psychiatrist, or from BasicNeeds.

Case Study A
Mike is a 25 year old student who, many months ago, started locking himself in his room. Mike used to be a good student but failed his last exams. His mother says that he often spends hours staring into space. Sometimes he mutters to himself as if he were talking to an imaginary person. He was forced to come to the clinic by his parents. At first he refused to talk to the nurse. After a while he admitted that he believed that his parents and neighbours were plotting to kill him and that the devil was interfering with his mind. He said he could hear his neighbours talk about him and say nasty things outside his door. He felt as if he had been possessed, but did not see why he should come to the clinic since he was not ill.

Case study B
Rita is a 58 year old woman whose husband died last year. Her children are all grown up and have left the village for better employment opportunities in a big city. She started experiencing poor sleep and loss of appetite soon after her husband died. The symptoms worsened when her children left the village. She experiences headaches, backaches, stomach aches and other physical discomforts, which have led her to consult the local clinic many times. There she was told she was well, but was prescribed sleeping tablets and vitamins. She felt better immediately, particularly because her sleep improved. However within two weeks her sleep has got worse again. She went back to the clinic and was given more sleeping pills and injections. This has been going on for months, and now she can no longer sleep without the sleeping pills.

Case study C
Lucy was 23 when she had her first baby. During the first few days after the baby was born, she had been feeling tearful and mixed up. The midwife reassured her that she was only passing through a brief phase of emotional distress, as experienced by mothers. She suggested that Lucy and her husband spend a lot of time together and care for the baby and said that her mood would improve. As expected, Lucy felt better within a couple of days. Everything seemed fine for the next month or so. Then, quite gradually, Lucy began to feel tired and weak. Her sleep became disturbed. She would wake up early in the morning, even though she felt tired. Her mind was filled with negative thoughts about herself, and, to her fright, about her baby. She began to lose interest in her home responsibilities. Lucy’s husband was becoming very irritated with what he saw as her lazy and uncaring behaviour.

Case Study D
Anny is 43 years old. Her symptoms started very gradually, but before she knew it she had lost all interest in life. Even her children and family did not make her happy. She felt tired all the time. She could not sleep, and used to wake up at 2 or 3 in the morning and then just toss and turn. She lost her taste for food and lost weight. She even lost interest in reading because she could not concentrate. Her head ached. Anny
felt lousy about herself and worried that she was a burden on the family and so on. The worst thing was that she felt embarrassed about the way she felt and could not tell anyone. Her mother-in-law used to complain that Anny had become lazy. Once Anny contemplated suicide; that is when she spoke to her husband who has brought her to your clinic. That was two months after the symptoms first started.

**Case Study E**

Sara is a 28 year old woman from Uganda. Seven years ago she started behaving strangely. It started only a few months after she got married, she started by talking to herself and fearing that people were following her wanting to kill her. Her newly wed husband sent her to her parents’ house.

One day while in the garden she started screaming that people wanted to slaughter her. To protect herself from these “evil people” Sara disappeared from home for a week. She was found in a village nearby, where she had another attack and muddled the names of her grandparents. A person in that village happened to recognize her grandfather’s name and reunited her with the family.

Sara’s family searched for a cure for their daughter, they visited multiple traditional healers exhausting their resources but were determined not to give up. The search for treatment came to an abrupt end when her father died five years later. Her mother, caring for five other children as well, could not afford to spend any more money on herbal treatments for her daughter. She cultivated the little land they had, but even that was difficult for her to manage since much of her time was spent caring for Sara.

Sara’s situation continued to deteriorate. She began to strip and run nude in the village, laughing unnecessarily and eating garbage. Her mother, feeling helpless, bought shackles and clipped her feet together every time she noticed she was about to run away. She explained that she felt it was the only way she could protect her, because she worried about Sara’s safety if she ran away.

**Case Study F**

Amil is a 14 year old boy who has a mild/moderate development disorder. Amil is a very sweet boy; he is very affectionate, sometimes inappropriately affectionate, which makes other children afraid of him. He is often made fun of by the other children. Although he is 14, he struggles doing tasks that children half his age are able to do.

**Case Study G**

Amar is a 44 year old man who has been ill with a number of physical complaints over the past several months. His main complaints are that his sleep is not good, that he often feels like vomiting in the morning, and that he is generally not feeling well. Amar has recently been to see the doctor for severe burning pain in the stomach area, and he was prescribed medication for a stomach ulcer. Today he is sweating profusely and his hands are shaking. When you ask him how he is feeling he sits down and starts to cry. He admits that he is sick because he has been drinking increasing amounts of alcohol in the previous few months as a way of coping with stress in the family. However, now the drinking itself has become a problem and he cannot pass even a few hours without having a drink.

**Case Study H**

Ahanti is a 25 year old woman who is married and has one daughter and one son. She has gradually lost all interest in life. Even her children and family don’t make her happy. She feels tired all the time and has lost her taste for food; she cannot sleep at night and has lost weight. Ahanti feels like she is a burden on the family. She feels embarrassed about her situation and cannot tell anyone. Her mother-in-law complains that she has become lazy and her husband is frustrated with her and keeps yelling at her and hitting her. Now Ahanti feels like ending her life, she is so scared by these feelings that she has come
to talk to the doctor.

Case Study I
Six months ago the doctor started Ramesh on some medication for his odd behaviour. He has now stopped talking to himself and is less frightened and agitated. However, he complains of feeling tired all the time, he sleeps for long periods of the day, and does not take good care of his appearance and hygiene. When his father returns from work he often finds Ramesh still in bed at 4 o'clock in the afternoon. The father is very angry because his wife did not get Ramesh up to do some chores around the home. Ramesh's mother says that she did not want to disturb Ramesh because “he is ill and he needs his sleep.” His father says that Ramesh should change his behaviour and start taking more responsibility and help out more in the home.
Session 2: Task 2 - Defining Mental Health

Cut up the visual aids here below and place them in the centre of the definitions that participants wrote and should be sticking on the wall.
HEALTHY BODY + HEALTHY MIND = HEALTHY INDIVIDUAL
Mental health provides individuals with the energy for active living, achieving goals and interacting with people in a fair and respectful way.
Session 3: Task 1 - Symptom Categories

Physical Symptoms

Feeling Symptoms
Perception Symptoms
Session 4

Depression

Psychosis

Self Harm/ Suicide

Children and Mental Health
Role Play / Scripts

Role Play 1 - Unhelpful response
Doctor: Good morning Sara, how are you feeling?
Sara: Appears distracted and doesn't answer.
Doctor: (louder) Sara, I said how are you feeling today?
Sara: I feel frightened; he's trying to harm me again.
Doctor: Who is trying to harm you Sara? I don't see anyone.
Sara: Looks fearful and says, you know who it is, everyone knows who it is, and he's just told me so.
Doctor: (appearing irritated) Sara, I don't have a clue what you are talking about. Who told you they are going to harm you? I can't hear anyone. Stop talking like this. People will think you are mad.
Sara: Begins to look distressed.
Sara: Of course you know what I am talking about. You can hear him, everyone can hear him, they must be able to, he is shouting so loud.
Doctor: (shouting) I have had it with you Sara, and your stupidity, you pretend to hear voices and you say they are trying to harm you when anyone can see that nobody is trying to harm you. Just stop being silly and pull yourself together.
Sara: Becomes distressed and begins to cry and gets up and leaves.
End of role play.

Role Play 2 - Helpful response
Doctor: Good morning, Sara, how are you feeling?
Sara appears distracted and doesn't answer.
Doctor: (speaking softly) Sara, you appear to be a little distracted. Are you feeling ok?
Sara: I feel frightened; he's trying to harm me again.
Doctor: (again speaking softly) Who is trying to harm you, Sara?
Sara looks fearful and says, you know who it is, everyone knows who it is, and he's just told me so.
Doctor: Sara, are you hearing the voices of someone other than me talking to you at the moment? Sara looks puzzled.
Sara: Yes I am, and he is threatening to kill me. Can't you hear him?
Doctor: No Sara, I can’t hear the voice but I do believe that you can hear it and it sounds as though the things that the voice is saying to you are very frightening.

Sara: Yes they are frightening. I try to tell myself that he can’t hurt me but sometimes the voice is so loud I feel certain that he is going to get me.

Doctor: That must be very distressing, Sara. You know it isn’t uncommon for people to hear voices when there is nobody there talking to them.

Sara: Isn’t it? I thought I was the only one who heard voices like this.

Doctor: No Sara, I have met lots of people who have heard voices like you and many of them have been able to learn ways of making the voices less distressing.

Sara: I wish I could stop this voice from bothering me. Can you help me do that?

Doctor: I can’t promise that I can make the voices stop completely but I can help you cope with the voices to make them less distressing. Would you like me to tell you more about how we might be able to do this?

Sara appears less tense and more hopeful.

Sara: Yes, I’d like you to tell me more about that.

End of role play.

Role Play 3

Scene: Manik’s husband, calls the health clinic, he is very distressed.

Manik’s husband: My wife Manik is a 31 year old woman. She has started behaving in an unusual manner. She is sleeping much less than usual and is constantly on the move. Manik has stopped looking after the house and our children as efficiently as before. She is talking much more than normal and often says things that are unreal and grand, such as that she can heal other people and that she comes from a very wealthy family (even though I’m a farmer). She has also been spending all our money on things we cannot afford. I tried to bring her to the clinic but she becomes angry and irritable.

Health Professional: Improvise

Manik’s husband: Improvise

Health Professional: Improvise

Manik’s husband: Improvise

Role play 4

Doctor

Who you are: You are a doctor at the local clinic.

Context: You have been called out to the market located outside your clinic. You find a nine year old boy John who is convulsing; his mother is attending to him anxiously. Shortly after you arrive at the scene the convulsions stop, but John is confused and startled.

Your Role: You have to determine what is causing John’s seizures. Ask John and his mother questions; use the mhGAP - IG manual for guidance.
John

Who you are: You are a nine year old boy who has just gone to the market with his mother when suddenly you have a seizure. As this scene takes place, you have just recovered from the seizure, you are frazzled, a doctor and your mother are standing over you.

Context: The seizures started happening about one year ago. You do not know why they happen, otherwise you feel fine most of the time. Most of the time they happen at night and no one except for your family notices, your family has been worried, your mom took you to see multiple healers in the village. “I’m still hoping that if we provide more offerings to the healer the seizures might stop. It is difficult because the family does not have a lot of money and I know the healer asks for a lot. Last month it happened at school, people are saying it is linked with witchcraft. I am really hoping it will never happen at school again; otherwise I might have to stay at home until the healer can make it better.”

Your Role: The doctor will likely ask you a series of questions; you are feeling confused and dizzy. At first act shy, you are afraid to say too much because you are embarrassed and would rather not that everyone around in the market knows that it has been happening repeatedly. As the doctor reassures you that it is ok for you to talk to him/her, slowly give some information (see context above).

Mother

Who you are: You are the mother of a nine year old boy John. You have taken him to the Sunday market to do some shopping when he suddenly has a seizure. This scene takes place right as the seizures are stopping. Someone has called a doctor who is now standing over John examining him.

Context: You have been so worried about John and these strange behaviours. People say witchcraft, you do not know what to believe, but you worry if this does not stop it could ruin the reputation of the family. You have suggested seeing a doctor but your mother-in-law refuses to spend money on the doctor, she thinks the healer is the best option. You feel like the family blames you, you feel guilty. You are unable to sleep and feel constantly tired; you lack motivation in caring for your other children. You no longer want to do things that you found enjoyable before, such as going with your friends to the market.

Your Script: You are shy at first to answer the doctor’s questions. However, you are also hopeful that he may be able to help, so you try to answer some of his questions. These are some examples of the questions he/she may ask and answers you may give.

Has John experienced seizures like this before? Yes.

How long do they typically last? Usually less than ten minutes.

Has he complained about any other physical symptoms? No.

No fever, stiff neck? No.

When did the seizures first start? First seizure was one year ago.

How often does he get the seizures? At least every month.
Role Play 5

Doctor

Who you are: You are a doctor at the local clinic.

Context: A mother and her daughter have just entered your clinic. They have been referred to come see you by a community health worker.

Your Script: You have to diagnose and treat Rashida’s illness. Ask Rashida and her mother questions; use the mhGAP - IG manual for guidance.

Rashida

Who you are: You are Rashida, an eight year old girl, who has come with her mother to see the doctor. You have seen multiple traditional healers for your mysterious illness in the past, although this is the first time you see a modern doctor. You hope that this doctor can cure your illness and that you can go to school like normal children.

Rashida/Context: I feel a bitter taste in my mouth, then I start shaking and fall down.

Other times, I feel like I am being whipped with a cane and then I fall to the ground. Although I fall I am usually conscious of whatever happens around me.

People tease me. They say if I fart and they smell the flatulence, they will be infected with my sickness. So they do not come near me. They even mock me, saying I am possessed by evil spirits. Even when children who are younger than me pass provocative comments about me, I dare not touch them because they will always call in their elder siblings to beat me up.

Your Script: The doctor will ask you a series of questions, answer to the best of your ability, using information given in the context. If information is not provided improvise.

Who you are: You are the mother of Rashida who has been suffering from a mysterious illness for the past four years. You have taken Rashida to see a modern doctor. When the scene takes place you have just entered the doctor’s office.

Rashida’s mother/Context:

Rashida’s condition started while she was living with her grandmother. She used to exhibit signs of dizziness and this later developed into convulsive episodes. We sent her to a traditional healer for treatment and the healer confirmed that Rashida’s illness was convulsion. He requested ten Ghana Cedis (about GBP£ 5.20) and a red cock to make herbal preparations for Rashida, but this did not stop the illness. We went to another traditional healer called Afa Rahimu. He requested twenty Ghana Cedis (that is about GBP£ 10.07) and a bottle of perfume in order to treat our child. After his treatment, Rashida was still experiencing fits, so we sent her to another healer a neighbour recommended to us. This healer also asked for ten Ghana Cedis (about GBP£5.20) and a white goat. The last traditional healer we went to requested for ten Ghana Cedis and a black hen, but there was still no change in Rashida’s condition. So we decided to stop visiting healers and to wait on God.

I faced a lot of stigma in the neighbourhood. I even quarrelled with some neighbours and friends because of derogatory remarks they made about me. Some of my friends do not want their children to play with Rashida. Some people even think that Rashida should be taken away from the community. We have not
enrolled Rashida in school; considering how people behave towards her at home she is likely to suffer the same rejection at school. It is best for her to stay outside school till she gets stabilized.

**Your Script:** Try to answer the doctor’s questions to the best of your ability. Use information given in the context and improvise when needed.

**Role Play 6**

**Who you are:** You are a doctor at the local clinic.

**Context:** A boy and his father have just entered your clinic.

**Your Script:** You have to manage Eugene’s condition. Ask about his medical history since he has suffered from the condition for a long time. Come up with a treatment plan.

**Who you are:** You are Eugene, 16 years old. He has had unexplained seizures since he was eight years old.

**Eugene/Context:**

I first started experiencing symptoms of my illness when I was eight years old. I used to wake up in the middle of the night, talking, shouting and making noise in the dark. My mother and grandmother prepared herbal concoctions for me to drink. My symptoms stopped but this was only temporary.

The stable condition did not last for long. I relapsed and this time it was very bad. My mother decided to send me to my father in Accra. This time I could not do anything on my own. I would wake up in the middle of the night, to me hitting my head.

I was taken to Accra’s psychiatric hospital where they did some scans. The scans did not reveal the cause of my illness, but they still gave me some drugs to take. The drugs improved my condition, but I still had seizures. My father took me to some traditional healer who had a very good reputation. The healer gave me a bottle of Frytol cooking oil to be drunk in the evening and morning. I stopped taking the drugs I had received at the psychiatric hospital and concentrated on the cooking oil, however my symptoms became worse again, I also developed diarrhoea. I finally realized that it was not doing anything, so I started taking the medication from Accra. My parents, still looking for a complete cure, then took me to a pastor who prescribed some herbal remedies. Again I stopped taking the hospital medicine. My illness became much worse at that point. I realized that the medication from the hospital helped. When taking them I would only experience the seizures at night, so no one in the community knew of my condition. I could go on with my everyday life. For instance, I had completed a technical school course in electronics. I was ready to start work, the problem was that I ran out of medication and started experiencing seizures all the time. It was starting to affect my ability to get a job, no one would hire a person who they worried was possessed by evil spirits. My parents had spent all their resources on the various healers. The hospital is also so far away, so just getting there costs a lot of money on top of the cost of the medication. I am really hoping that I can get a job to pay for my medication but I need my seizures to stop first.

**Your Script:** Try to answer the doctor’s questions to the best of your ability. Use information given in the context and improvise when needed.

**Who you are:** You are the father of a 16 year old boy Eugene. Your boy has been suffering from seizures for the last 8 years. As the scene takes place you have just entered the doctor’s office.

**Context:** You and Eugene’s mother live separately. Eugene used to live with his mother but she could not manage his illness. She had tried everything, so she thought that as the father I might be able to
help. Eugene came and lived with me when he was 10 years old. At that stage his condition was very severe. He was not able to do anything on his own. He would wake up everyone in the house at night with his screaming. A neighbour suggested going to see a doctor at the psychiatric hospital. We went to the hospital which was far away and expensive. I had to take time off from work which also meant that I lost salary for that day. The medication they gave Eugene at the hospital improved his condition, but the illness did not go away completely. I was determined not to give up, I asked around and was recommended a very powerful healer. The healer prescribed remedies, and, though expensive, I had more faith in his remedies than in the hospital's. Eugene's condition seemed to get worse, and he went back to the hospital tablets. We tried some other healers, but in the meantime he would go back to the hospital drugs. One day Eugene came up to me and told me that his drugs from the hospital were almost finished. I suggested he only have a fraction of a tablet at a time. However, his condition continued to get worse, now he is starting to have fits in the middle of the day, people are already talking that he is possessed by evil spirits. I have come to the local clinic as a last resource, I hope they are able to help and that they will not charge too much.
Interview Skills Cards

1. Attending Behaviour

2. Questioning Skills
3. Observing Skills

4. Encouragement
5. Summarising

6. Noting feelings
7. Attending Behaviour

8. Questioning Skills