Mental Health Training for Medical Officers and Health Assistants

Module 2

Facilitator's Guide

Government of Nepal
Ministry of Health
National Health Training Center
March, 2018

Disclaimer

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and

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FOREWORD

Mental, neurological and substance use disorders contribute to 14% of the global burden of disease worldwide. Majority of this burden occurs in low and middle income countries (LMICs). Though there is no nationally representative study, studies conducted in specific at-risk population have demonstrated increased rates of depression, anxiety, PTSD and alcohol use disorders.

There exists a large gap in the management of mental health problems despite their contribution to a huge burden. World Health Organization (WHO) has recently launched "Mental Health Gap Action Programme (mhGAP)" to reduce this treatment gap. According to this concept, mental health services are delivered to the communities in developing countries by primary health care workers through "Task-shifting approach" after training on Mental Health Gap Action Programme-Intervention Guide (mhGAP-IG). Promising results have been seen in a number of districts in Nepal including Chitwan where basic mental health services have been delivered through health workers after adaptation and contextualization of selected mental disorders from mhGAP, as relevant to our setting.

Mental health and psychosocial care related training manual for health workers working in health facility (District Hospital, Primary Health Care Centre and Health Post) - Module 1 and Module 3 and mental health and psychosocial care related training manual for health workers (FCHV)-Module 4 have already been developed by NHTC. In this context, lack of Module 2 for basic "Mental Health Training for Medical Officers and Health Assistants" had been perceived and therefore this training package was prepared. I anticipate that this Module will pave a milestone in the diagnosis and management of mental health problems.

I would like to extend vote of thanks to Dr. Yadu Chandra Ghimire and the entire NHTC team as well as technical experts - Dr. Kapil Dev Upadhyaya, Dr. Kamal Gautam, Mr. Pitambar Koirala, Prof. Dr. Saroj Prasad Ojha, Mr. Sitaram Prasai and Ms. Rekha Rana for their contribution in preparation of the package. I would also like to extend my gratitude to Transcultural Psychosocial Organization Nepal (TPO Nepal) for technical support, Nepal Health Sector Support Programme (NHSSP) for technical and financial support, other supporting organizations and technical experts for their support in preparation of this package. I would like to request concerned stakeholders to deliver quality mental health services through use of this package.

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Shree Krishna Bhatta
Director

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ABBREVIATIONS

ADHD:	Attention Deficit Hyperactivity Disorder
AEDs:	Antiepileptic Drugs
CD:	Conversion Disorder
EPS:	Extra Pyramidal Symptoms
HIC:	High-Income Countries
i.m. :	intramuscular
IMCI:	Integrated Management of Childhood Illness
i.v. :	intravenous
LMIC:	Low- and Middle-Income Countries
MCQs:	Multiple Choice Questions
mhGAP-IG:	Mental Health Gap Action Programme Intervention Guide
MNS:	Mental, Neurological and Substance use (disorders)
SSRIs:	Selective Serotonin Reuptake Inhibitors
STP:	Standard Treatment Protocol
TCAs:	Tricyclic Antidepressants
THC:	Tetra Hydro Cannabinol
ToTs:	Training of Trainers
WHO:	World Health Organization

CHAPTER 1

INTRODUCTION

The facilitator's guide has been designed to facilitate training of Medical Officers and Health Assistants based on the World Health Organization's (WHO) Mental Health Gap Action Programme (mhGAP-V2) for mental, neurological and substance use disorders (MNS) in non-specialized health setting and Standard Treatment Protocol (STP) for delivery of mental health services into the primary health care system developed by the Primary Health Care Revitalization Division (PHCRD) of the Ministry of Health. It also aims to ensure that trainers and co-trainers feel skilled and confident in their ability to train health-care providers to assess and manage priority MNS disorders.

This guide can also be used for Training of Trainers (ToTs). The aim is to generate future trainers and co-trainers who can ultimately be mobilized for training of Medical Officers and Health Assistants in the local level training. In particular, an emphasis has been placed on interactive and contemporary teaching and supervision skills. Time and sessions have been planned in such a way as to ensure that participants receive and can integrate feedback from their peers and the trainer as they learn and develop their skills as trainers.

Learning objectives

The guide aims to ensure that trainers and co-trainers:

1. Promote respect and dignity of people with mental disorders
2. Understand principles of WHO mhGAP-IG and STP
3. Understand teaching and competency principles as directed by mhGAP-IG
4. Can utilize a variety of teaching methods and skills for mental health training with confidence
5. Can perform assessment and feedback from participants on mental health training
6. Promote use and training of mhGAP-IG and STP

Who is this guide for

This guide is designed for use by master trainers, trainers and co-trainers. Master trainers can use this guide to train potential trainers on mental health. Trainers and co-trainers can use this guide for training of MOs and HAs. Master trainers and trainers are specialist (Psychiatrist) trained and experienced in using the adapted Nepali version of mhGAP-IG and STP.

Co-trainers can be:

- Psychiatrist (either trained/untrained on mhGAP and STP) ,
- MBBS doctors who have received the training based on mhGAP and STP and have managed at least 50 cases with MNS disorders,
- Clinical Psychologist,
- Psychologist: Master in Clinical Psychology or Master in Counselling Psychology who have managed at least 50 cases of MNS disorders

There must be at least 3 trainer/co-trainers in daily sessions that includes one mhGAP/Module 2 trained Psychiatrist, one Psychiatrist (either mhGAP/Module 2 trained or untrained) or trained Medical Officer and one Psychologist.

How to use this manual

This guide is a part of Nepali version of mhGAP-IG. This guide should be used together with the reference manual. The trainer and co-trainers should prepare and go through the slides on respective chapters to be familiar with the session and technical content of the deliverables.

ToTs participants

A group size of 16-20 is considered appropriate for ToTs training.

Participants attending the ToTs training should meet at least one of the following criteria:

- Postgraduate qualification in health care with or without specialized work in mental health.
- Medical Officers (MOs) who have received basic mental health training on mhGAP and have managed at least 50 cases with mental disorders
- Clinical Psychologist

Participants of local level training

A group size of 16-20 is considered appropriate for local level training.

Participants attending the local level training should meet at least one of the following criteria:

- Medical Officers (MBBS doctors)
- Health Assistants (HAs)

Training guidelines

Trainers and co-trainers should follow the following guidelines during the training sessions:

1. **Understand the local health-care system** Trainers should be familiar with local health systems, local specialized services and psychotropic medications in the Essential Drug List of Ministry of Health.
2. **Be organized and professional** Trainers set the tone for the training, and should understand the plan, keep to time, be prepared and organized, and show passion and enthusiasm for the content. Trainers should model supportive teamwork and good communication with each other.
3. **Manage time well** There is a large amount of content to cover, and good time management is crucial. Trainers should schedule the arrival and registration prior to training, start and end on time (including breaks), set a clear agenda, discuss timing with the participants, and appoint a participant as a timekeeper.
4. **Model the skills and attitude you want to see** Trainers should use effective communication skills, pay attention to their body language, speak clearly, using non-judgmental language, use open-ended questions, and model respect and dignity to all persons with MNS conditions.
5. **Embrace experiential learning** Adults learn best by observing, doing and interacting, rather than more traditional didactic lectures. Trainers should not spend too much time on the PowerPoint slides.
6. **Be encouraging and positive as participants practise new skills** Trainers should use praise, and, where appropriate, humor, to put the participants at ease and build their confidence.
7. **Encourage participants to come up with their own case examples** Participants should draw on their own experiences and relate the material to their own work.
8. **Allow enough time for feedback** After every activity there should be time for peer and trainer feedback, to help with participant development.
9. **Evaluate the training** Trainers should collect formal feedback through the evaluation forms and informal feedback through discussions with the participants, to ensure training meets participants' needs.

How to conduct training activities

A] Group discussion

Objectives: Group discussions will allow participants to:

- Improve their communication and listening skills.
- Collectively interact with each other and answer questions.
- Share their knowledge and experiences.

Instructions: The facilitator's guide provides specific directions for each discussion, but common themes are:

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

B] Role plays

Objectives: Role plays will allow participants to:

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

Instructions: The facilitator's guide and role plays provide specific timing and instructions, but the general process is:

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

- **Group discussion:** Bring all participants back together to reflect on the exercise.

C] Video demonstrations

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

Objectives: Videos will allow participants to:

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

Instructions: The facilitator's guide provides specific information, but general principles to facilitate a video demonstration are:

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

D] Facilitator demonstrations

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

Objectives: Facilitator demonstrations will allow participants to:

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

Instructions: The facilitator's guide provides specific information on facilitator demonstrations, but general principles are:

- **Introduction:** Trainers should clarify the specific purpose of the demonstration.
- **Allocate roles:** Trainers work with another trainer or a participant who will voluntarily play the role of the person seeking help. The trainer always plays the role of the health-care provider.
- **Follow instructions for the role play:** Facilitator demonstrations usually utilize a role play for the characters.
- **Demonstration:** The trainer can either demonstrate good or poor clinical practice.
- **Group discussion:** The demonstration can be paused or interrupted for clarification. Otherwise there should be discussion at the end for the interaction or an opportunity to answer any questions.

Pre- and post-tests

A pre- and post-test is available for the training. The master trainers/trainers should use it on the first day of training before formal session starts, and again at the completion of training, in order to assess the knowledge and competence of participants. Trainers should ensure that participants are familiar with the assessment methods. The participant must secure at least 80% in the post-test to be eligible for certification and authority to prescribe psychotropic medications after the training.

Evaluation forms

Evaluation forms have been designed to be used across the ToTs and local level training. They should be completed by participants for each chapter and feedback should be reviewed immediately to adapt the course if needed.

Evaluation and summarization

Evaluate the participants through interactive questions of chapters and clarify confusions, if any. Summarize everyday's sessions at the end of the day.

Facilitators' meeting

The facilitators should organize a meeting at the end of each day to discuss and plan the upcoming sessions.

- Discuss on how the training sessions went throughout the day.
- Discuss the genuine feedbacks received from the trainees and try to improve the session delivery by using different techniques.
- Plan for next day session.

TRAINING SCHEDULE

Mental Health Training for Medical Officers and Health Assistants

Content	Methodology	Time schedule	Facilitator
Day 1			
Registration Introduction Welcome speech Pre-Test Expectation collection	 Questionnaire Writing and discussion	10:00 - 10:20 AM 10:20 - 10:30 AM 10:30 – 10:45 AM 10:45 - 11:15 AM 11:15 - 11:30 AM	Participants/Facilitators / NHTC representative Psychiatrist/Clinical Psychologist
Tea Break		11:30 - 11:45 AM	
Ground rules, Session management, Review and Entertainment Objectives of the training Mental health problems: Introduction Causes Common symptoms	Discussion and conclusion PowerPoint Presentation Discussion and PowerPoint Presentation	11:45 - 12:00 PM 12:00 - 12:10 PM 12:10 - 13:00 PM	 Psychiatrist/Clinical Psychologist
Lunch Break		13:00 – 14:00 PM	
Introduction to mhGAP and STP Overview of mhGAP V2 / Standard Treatment Protocol Use of mhGAP and STP	PowerPoint Presentation Discussion PowerPoint presentation Demonstration	 14:00 - 14:45 PM 14:45 - 15:30 PM	 Psychiatrist/Clinical Psychologist
Tea Break		15:30 – 15:45 PM	
Psychiatric History taking and Mental Status Examination (MSE)	Discussion PowerPoint presentation	15:45-16:45 PM	Psychiatrist/Clinical Psychologist
Review of the day		16:45-17:00 PM	Participant
Day 2			
Review of previous day **Depression**	Self or group interaction	10:00 - 10:15 AM	Participant

Introduction Quick overview Assessment	PowerPoint presentation Case study Interactive Discussion Sharing experience	10:15 AM -11:30 AM	Psychiatrist/Clinical Psychologist
Tea Break		11:30 AM - 11:45 AM	
Depression continued Management: Psychosocial Interventions & Pharmacological Interventions	PowerPoint presentation Interactive Discussion Sharing experience	11:45 AM -13:00 PM	Psychiatrist
Lunch break		13:00 – 14:00 PM	
Depression continued Management: Pharmacological Interventions Follow-up	PowerPoint presentation Interactive Discussion Sharing experience Video display	14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Psychoses Introduction Quick overview Assessment	PowerPoint presentation Interactive Discussion Sharing experience Brainstorming	15:45 - 16:45 PM	Psychiatrist
Review of the day		16:45 -17:00 PM	Participant
Day 3			
Review of previous day **Psychoses continued** Management: Psychosocial Interventions and	Self or group interaction PowerPoint presentation	10:00 - 10:15 AM 10:15AM-11:30AM	Participant Psychiatrist

Pharmacological Interventions	Discussion		
Tea Break		11:30 AM - 11:45 AM	
Psychoses continued Follow-up **Self-harm/Suicide** Introduction Quick overview Assessment	PowerPoint presentation Video display PowerPoint presentation Discussion	11:45AM- 12:30PM 12:30-13:00 PM	Psychiatrist
Lunch Break		13:00 – 14:00 PM	
Self-harm/Suicide continued Assessment Management of pesticide Intoxication and referral Psychosocial Interventions Follow-up	Experience sharing Group Discussion PowerPoint presentation	14:00- 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Epilepsy Introduction Quick overview Emergency	PowerPoint presentation Interactive Discussion Sharing experience	15:45 - 16:45 PM	Psychiatrist
Review of the day		16:45-17:00 PM	Participant
Day 4			
Review of previous day **Epilepsy continued** Emergency Assessment Management: Psychosocial Interventions and Pharmacological	Self or group interaction PowerPoint presentation Interactive Discussion	10:00 - 10:15 AM 10:15- 11:30 AM	Participant Psychiatrist

Interventions Follow-up	Sharing experience Video display		
Tea Break		11:30 -11:45 AM	
Conversion disorder (CD) Introduction Quick overview Differences between Epilepsy and CD Assessment and management of CD Follow-up	PowerPoint presentation Case study Interactive Discussion Sharing experience Video display	11:45 AM - 13:00 PM	Psychiatrist
Lunch Break		13:00 - 14:00 PM	
Anxiety Disorder Introduction Quick overview Assessment Management: Psychosocial Interventions and Pharmacological Interventions Follow-up	Discussion PowerPoint presentation	14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Child & Adolescent Mental & Behavioral Disorders Introduction and classification Quick overview Assessment	PowerPoint presentation Discussion Experience sharing	5:45 - 16:45 PM	Psychiatrist
Review of the day	Discussion	6:45-17:00 PM	Participant

Day 5			
Review of previous day **Child & Adolescent Mental & Behavioral Disorders continued** Assessment Management: Psychosocial Interventions	Self or group interaction PowerPoint presentation Experience sharing Discussion Role play	10:00 -10:15 AM 10:15 - 11:30 AM	Participant Psychiatrist
Tea Break		11:30-11:45 AM	
Child & Adolescent Mental & Behavioral Disorders continued Referral Follow up **Dementia** Introduction Quick overview Assessment	PowerPoint presentation Discussion PowerPoint presentation Case study Interactive Discussion Sharing experience	11:45 AM - 12:15 PM 12:15 - 13:00 PM	Psychiatrist
Lunch Break		13:00 -14:00 PM	
Dementia continued Assessment Management: Psychosocial Interventions and Pharmacological Interventions Follow-up	PowerPoint presentation Interactive Discussion	14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Clinical/Hospital visit		15:45 - 16:45 PM	Psychiatrist
Review of the day	Discussion	16:45 - 17:00 PM	Participant

Day 6			
Review of previous day **Disorders due to substance use** Introduction and relevant terminologies Quick overview Emergency	Self or group interaction PowerPoint presentation Discussion Experience sharing	10:00 - 10:15 AM 10:15 - 11:30 PM	Participant Psychiatrist
Tea Break		11:30 - 11:45 PM	
Assessment Management: Psychosocial Interventions and Pharmacological Interventions	PowerPoint presentation Discussion Experience sharing Role play	11:45 - 13:00 PM	Psychiatrist
Lunch Break		13:00 - 14:00 PM	
Disorders due to substance use continued Follow-up **Other significant mental health complaints** Introduction Quick overview Assessment Management Follow up	PowerPoint presentation Discussion PowerPoint presentation Discussion Experience sharing	14:00 - 14: 20 PM 14:20 - 15:30 PM	Psychiatrist
Session on logistics, recording & reporting		15:30 - 15:55 PM	Psychiatrist
Tea Break		15:55 - 16:05 PM	
Post-test		16:05 - 16:20 PM	Psychiatrist
Closing ceremony		16:20-17:00 PM	

DAY 1:

Content	Methodology	Time schedule	Facilitator
Day 1			
Registration Introduction Welcome speech Pre-Test Expectation collection	Questionnaire Writing and discussion	10:00 - 10:20 AM 10:20 - 10:30 AM 10:30 – 10:45 AM 10:45 - 11:15 AM 11:15 - 11:30 AM	Participants/Facilitators/ NHTC representative Psychiatrist/Clinical Psychologist
Tea Break		11:30 - 11:45 AM	
Ground rules, Session management, Review and Entertainment Objectives of the training Mental health problems: Introduction Causes Common symptoms	Discussion and conclusion PowerPoint Presentation Discussion and PowerPoint Presentation	11:45 - 12:00 PM 12:00 - 12:10 PM 12:10 - 13:00 PM	Psychiatrist /Clinical Psychologist
Lunch Break		13:00 – 14:00 PM	
Introduction to mhGAP and STP Overview of mhGAP V2 / Standard Treatment Protocol Use of mhGAP and STP	PowerPoint Presentation Discussion PowerPoint presentation Demonstration	14:00 - 14:45 PM 14:45 - 15:30 PM	Psychiatrist/Clinical Psychologist Psychiatrist/Clinical Psychologist
Tea Break		15:30 – 15:45 PM	
Conducting an MNS assessment: Psychiatric History taking and Mental Status Examination (MSE)	Discussion PowerPoint presentation	15:45-16:45 PM	Psychiatrist/Clinical Psychologist
Review of the day		16:45-17:00 PM	Participant

Introductory session:

Learning objectives

Welcome and introduce each other (participants and facilitators)

Know the defined objectives of the training

Conduct a pre-test for evaluation of knowledge on mental health and psychosocial support

Learn about training methodology

Collect expectations and know the scope of mental health training

Prepare ground rules

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide, attendance sheet

Printed copies of pre-test questionnaire

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises.

Duration

1 hour 55 minutes

Instructions to the trainers

Participant Introduction and Overview

Register the participants and trainers.

Introduce the participants and trainers to each other sharing briefly the designation, health facility and prior experiences with mental health and psychosocial support activities or trainings.

Welcome the trainees to the event and express vote of thanks to the organizer.

Logistics and Practical issues

Discuss the practical and logistic elements of the training such as:

Transportation

Per diem and food arrangements

Time schedule

Certification

Distribute the materials such as notebooks, pens, metacards, and board markers to the participants.

Pre-test:

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

Give the participants pre-test MCQs.

Highlight on mentioning the names and designated health facilities of the participants.

Give participants 15 minutes to complete the test. Participants will be asked to repeat this test on the last day of the training in order to measure knowledge and competence.

Elaborate the sections of questionnaire and on how to answer the questions

Clarify confusion in any questions.

Collect the questionnaires once completed.

Expectation collection:

Distribute metacards and boardmarkers to the participants and ask them to write what they have expected to learn from the training.

Give 5 minutes.

Collect the expectation and describe whether their expectations are met by the training.

Tea Break: 15 minutes

Create **ground rules** with the participants, and makes list of these on a flip-chart that is posted in front of the training hall. For example:

- Be on time;
- Wait for your turn to speak;
- Respect all opinions;
- Do not have side conversations;
- Turn off your mobiles or keep it in mute mode;
- Follow the schedule of the training.

Designate for each day

officer to take over administrative responsibilities of the training like maintaining discipline, punctuality and managerial tasks.

reviewer to summarize the sessions of the day.

entertainer to energize and entertain participants and trainers in between sessions to avoid

boredom.

Make a list on newsprint and paste it on the wall.

Illustrate the objectives of the training.

The objectives of the training are:

- To train the medical officers and health workers on mental health for integrated provision of mental health and psychosocial support services
- To build the capacity of health workers in management of mhGAP priority mental disorders

Distribute the reference manual to the participants.

Proceed to the technical session of the training.

CHAPTER 2

INTRODUCTION TO MENTAL HEALTH

Session 1

Learning objectives:

Understand the concept of health, mental health and mental health problems

Have an overview of "Bio-psychosocial model" of causes of mental health problems

Identify the common signs and symptoms of mental health problems

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Powerpoint slides

Methodology

Lecture, powerpoint presentation, brainstorming, discussions.

Evaluation of each chapter by the participants

Duration

50 minutes

Instructions to the trainers

Start with the definition of "Health" and "Mental Health".

WHO definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

Mental health is defined as "a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her family and community".

Elaborate on mental health problems- causes, types and signs and symptoms.

Causes: Biopsychosocial factors

Definition: the domains of physical, psychological and social well being work jointly in creating a positive mental health condition of the person. Refer to Figure 1.

Figure 1. Bio-psychosocial Model

Trainer should discuss with participants how bio-psycho-social factors are interrelated. Participants are asked to give examples of how a problem in one domain leads to problems or complaints in another domain.

Mental Disorders: Discuss with participants what 'mental disorder' is and ask them to provide examples.

Write the definition of a mental disorder:

- Disturbance which affects emotions, thoughts or behaviour
- Which is out of keeping with cultural beliefs and norms
- Produces negative effects on their lives or the lives of their families

Mental disorders produce the following symptoms

cognitive symptoms (e.g. difficulty thinking clearly, abnormal beliefs, memory disturbance)

emotional symptoms (e.g. feeling sad, scared, or anxious)

behavioural symptoms (e.g. behaving in an aggressive manner, inability to perform routine daily functions, excessive use of substances)

physical symptoms (e.g. aches and sleep disturbance)

perceptual symptoms (e.g. seeing or hearing things that others cannot).

CHAPTER 3

MENTAL HEALTH GAP ACTION PROGRAMME (MHGAP) AND STANDARD TREATMENT PROTOCOL (STP) FOR MENTAL HEALTH SERVICES INTO THE PRIMARY HEALTH CARE SYSTEM

Session 1: mhGAP and STP

Learning objectives

Understand the principles and aims of the Mental Health Gap Action Programme and STP.

Understand the mental health treatment gap in low-, middle- and high-income countries.

Acquire an introduction to mhGAP Intervention Guide (mhGAP-IG) and STP.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Powerpoint slides

Methodology

Lecture, powerpoint presentation, brainstorming, discussions.

Evaluation of each chapter by the participants

Duration

1 hour 30 minutes

Instructions to the trainers

Conduct a brief review on previous chapter.

Introduce WHO mhGAP and Standard Treatment Protocol for delivery of mental health services in primary care setting.

Present slides on mhGAP and STP.

Reflect that the training is based on Nepali adaptation of WHO mhGAP-IG V2.0.

Key messages

The burden of mental, neurological and substance abuse (MNS) disorders is large with a wide treatment gap.

Between 75–90% of people with MNS conditions do not get the treatment they require.

The aim of the mhGAP is to enhance access to non-specialized treatment for people with MNS conditions.

MNS conditions commonly co-occur with other chronic health conditions (e.g. HIV/ AIDS, diabetes,

cardiovascular disease), and, if untreated, worsen the outcome of these conditions. People with MNS conditions and their families are also challenged by stigma that further worsens their quality of life, affects social inclusion, employability and interferes with help-seeking.

mhGAP Intervention Guide is an evidence-based technical tool aimed at supporting non-specialized health-care providers to redistribute clinical tasks previously reserved for mental health specialists.

The training is an interactive training designed to build clinical skills and introduce participants to ways to assess, manage and follow-up people with MNS conditions.

The training does not end in the training room but skills building will continue through ongoing supervision.

Explain that one reason for a large treatment gap is a lack of investment in human resources for mental health care. Explain the statistics in the infographic. Explain that another reason for such a significant treatment gap is that financial resources for developing and maintaining MNS services in LMIC are extremely low.

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

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

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

The priority MNS conditions include:

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

Plenary discussion

Duration: 5 minutes

Process: Ask each participant about their current role and responsibility related to the management of people with MNS disorders. Then ask the entire group the second question about the benefits of integrating MNS care into non-specialized health care. Encourage discussion. To summarize, talk through the seven good reasons for integrating mental health into non-specialized health care.

The burden of mental disorders is great.

Mental and physical health problems are interwoven.

The treatment gap for mental disorders is enormous.

Enhance access to mental health care.

Promote respect of human rights.

It is affordable and cost-effective.

Generates good health outcomes.

Explain that the course takes approximately 6 days. Explain to participants the length of the training and what to expect. The mhGAP-IG training teaches core competencies needed to assess, manage and follow up people with MNS conditions.

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

Elucidate that the Standard Treatment Protocol for delivery of mental health services in primary care setting has been based on WHO mhGAP.

Highlight on the chapters of STP published by Primary Health Care Revitalization Division (PHCRD).

Discuss in groups on how to use the STP while providing mental health services through health facilities.

Focus can be done on algorithms and flowcharts of mhGAP and STP which are convenient and pictorial making it easy to understand.

Session 2: Conducting an MNS assessment

Learning Objectives

Understand the basic principles of communication skills required when carrying out a mental health assessment

Conduct a basic MNS assessment

Methodology

Lecture, brainstorming, discussions, group exercises.

Materials

Flip chat, markers, pen & papers, power point presentation

Duration

1 hour

Start with asking the participants on their knowledge and experiences on psychiatric history taking and examination.

Group work: Conducting an MNS assessment

Duration: 20 minutes

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

Instructions:

- Divide participants into three groups.
- Give Group 1 the heading **Presenting complaint** and **Family history of MNS conditions**.
- Give Group 2 the heading **General health history and past MNS history**.
- Give Group 3 the heading **Psychosocial history**.
- Give each group pieces of flip chart paper and pens.
- Ask each group to create two lists:

1. What information do you want to find out? Why do you want to find out this piece of information?
2. What questions can you ask to find it out?

- Give each group 20 minutes to discuss and create the lists, hang the lists on the wall, bring the groups back together and ask the plenary group to discuss the lists of questions.
- Use the explanations and suggested questions in the slides below to provide any clarification.
- Add any of the questions discussed below to the lists created by the participants.

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

The trainer outlines the basic principles of basic counseling and communication skills.

The trainer outlines the key areas to be covered when taking a mental health history.

In this first role-play, all the participants observe the trainer taking history from a co-facilitator and conducting MSE.

The participants observe and critique.

Assessment, Diagnosis and Formulation

Based on the symptoms elicited, health care workers should come up with a differential diagnosis

Devising a treatment plan

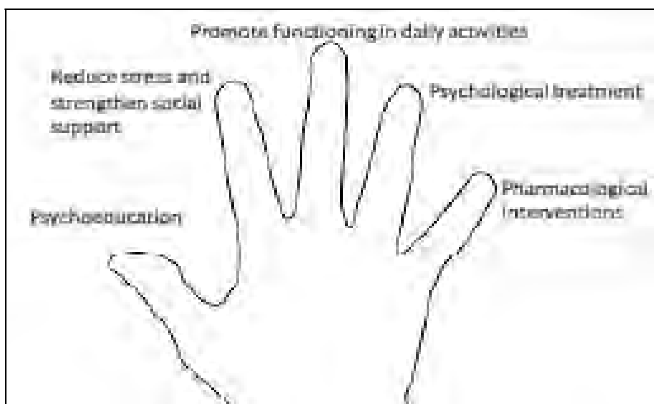
Once a diagnosis has been established, a treatment plan should be developed and should be focused on the biological, psychological and social domains of functioning.

Explain the following:

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

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

1. Psychosocial Interventions:



- psycho-education
- reduce stress and strengthen social supports
- promote functioning in daily activities.

2. Psychological interventions

3. Pharmacological interventions

Summarize the facts and present slides on history taking and mental status examination.

Discuss any queries.

Summarize the session.

DAY 2

Day 2			
Review of previous day **Depression** Introduction Quick overview Assessment	Self or group interaction PowerPoint presentation Case study Interactive Discussion Sharing experience	10:00 - 10:15 AM 10:15 AM - 11:30 AM	Participant Psychiatrist/Clinical Psychologist
Tea Break		11:30 AM - 11:45 AM	
Depression continued Management: Psychosocial Interventions & Pharmacological Interventions	PowerPoint presentation Interactive Discussion Sharing experience	11:45 AM -13:00 PM	Psychiatrist
Lunch break		13:00 – 14:00 PM	
Depression continued Management: Pharmacological Interventions Follow-up	PowerPoint presentation Interactive Discussion Sharing experience Video display	14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Psychoses Introduction Quick overview Assessment	PowerPoint presentation Interactive Discussion Sharing experience Brainstorming	15:45 - 16:45 PM	Psychiatrist
Review of the day		16:45 -17:00 PM	Participant

Instructions to the trainers

Welcome the participants to the second day session.

Ask the allotted participant to review the sessions of the first day over 15 minutes. Clarify the confusions in understanding of the participants.

CHAPTER 4

DEPRESSION

Learning objectives

- Promote respect and dignity for people with depression.
- Recognize common symptoms of depression.
- Know the assessment and management principles of depression.
- Perform an assessment for depression using effective communication skills
- Assess and manage physical health conditions as well as depression.
- Assess and manage emergency presentations of depression (see Chapter: Self-harm/ suicide).
- Provide psychosocial interventions for people with depression and their carers.
- Deliver pharmacological interventions as needed and appropriate, considering special populations.
- Plan and perform follow-up for depression.
- Refer to specialists and link with outside services where appropriate and available.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of each chapter by the participants

Duration

4 hours

Session 1. Introduction to depression

Time: 30 minutes

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

Trainer should introduce the topic of *sadness* by asking the participants why people feel sad or lose interest.

Explain that from time to time every person feels sad or unhappy; this is a normal part of life.

Describe that 'normal sadness' may become a condition for concern if the reaction is too strong, too long, impairs socio-occupational functioning (domestic chores, work, social responsibilities), is associated with additional symptoms (disturbed sleep and appetite) or harm to self or others.

Conduct a plenary discussion on depression.

Present the following questions on the slide and conduct discussion for 5 minutes.

- What is depression?
- What do local people call depression in their day-to-day language?
- What do they think are the causes of depression?

Quick overview of depression: Interactive presentation should be done describing the symptoms of depression. It is important to understand how people with depression in our community present in clinical practice. Facilitator can ask the participants to provide examples of symptoms they have seen in patients in their health facilities, or can demonstrate the symptom by 'acting it'. Highlight the different presentations they will have to be aware of.

Explain that depression results from a complex interaction of social, psychological and biological factors.

Assessment of depression: Ask the participants to go through the section on assessment of depression in the reference manual. Present the slides. Describe the major and minor symptoms of depression.

Highlight the two core symptoms of depression:

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

Common presentations of depression:

Multiple persistent physical symptoms with no obvious cause

Low energy

Fatigue

Sleep problems

Anxiety

Significant change in appetite or weight

Hopelessness, beliefs of worthlessness or helplessness

Excessive guilt

Thoughts or attempts at self-harm

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

- The duration of the symptoms: symptoms must be present for at **least two weeks**
- The effect on daily functioning: a significant impact on the person's ability to function in daily life

Explain to participants that depression is a public health priority.

Emphasize that by 2030, depression is expected to be among the diseases with the highest burden everywhere in the world.

Explain that depression impacts on family life, including: child development (infant growth), family relationships and the way parents raise their children.

Explain the socioeconomic impacts.

Explain that the relationship between depression and physical health is particularly important to focus on in non-specialized health settings.

Session 2. Assessment of depression

Time: 1 hour

Display video of "Sarah" (a depressed woman) and explain that we will study this video in detail to learn about communication and assessing for depression. Highlight key basic communication skills.

Pause the video in between and ask the relevant questions from video. Discuss and clarify the confusions.

In plenary, use the algorithm to decide:

- Does Sarah have depression?
- Did Sarah have at least one of the core symptoms of depression in the past two weeks?

Seek group consensus.

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

Did Sarah have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?

Highlight to the group that in Sarah's case we learned that she had a baby at home. Ask the following question before revealing the answers: With that knowledge, what other information do we want to know about Sarah?

If the woman is **breastfeeding or pregnant**, it may change the decision regarding medications.

Consider physical conditions: Ask the group: How did the healthcare provider rule out other possible explanations for the symptoms? Remind participants that Sarah had her own understanding of what might be happening to her – that she had cancer. Is this possible? How would you check for this?

Physical conditions that resemble depression: Explain that there are several other conditions that resemble depression. Therefore, it may take a number of meetings to establish if the person has depression. Describe the symptoms of anemia, malnutrition and hypothyroidism and how they resemble depression (as described in the slides).

Explain that a thorough psychosocial, medical and mental health assessment is essential. Regular follow-up will help to ensure that the correct identification is made. Advise them to carry out general and systemic physical examination to rule out any physical causes.

Continue with the assessment algorithm in the slides. Explain that depression can be present as a part of bipolar disorder.

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

Explain that depression and mania can follow one another together in the form of bipolar disorder. This will be discussed in more detail in the **Chapter: Psychoses**.

Depression and grief: Explain that in addition to ruling out a history of mania, assess whether there has been a major loss (bereavement) in the past six months. A normal grief reaction could account for the symptoms the person is experiencing.

Responding to a significant loss with grief is normal and the person should be supported to grieve in culturally appropriate ways.

Bring the group's focus back to the assessment of Sarah that they saw in the video and ask the questions on the slide.

Assessing for self-harm/suicide Point out the instruction in the algorithm to ask and assess for an imminent risk of suicide and ask participants: How did the health-care provider address suicide? Explain that depression can be associated with suicide. The assessment and management of self-harm/suicide will be covered in detail later in the training.

In Sarah's case she has emotional distress, she is very tearful and feels hopeless. Should we ask about suicide?

Did Sarah have any other co-occurring priority MNS conditions.

Answer any queries that the participants may have.

Complete the slides on assessment. Demonstrate the flowcharts on slides and ask them to refer to the reference manual.

Session 3. Management of depression

Time: 1 hour 45 minutes

Play the video of Sarah on management of depression. Discuss on key management instructions.

Explain that choosing the appropriate intervention is the first step to developing a treatment plan with the person.

Explain to participants that for the best results, it is essential to involve the person in developing the treatment plan.

The choice of intervention will depend on a collaborative discussion with the person.

Ask them to refer to the management section of the reference manual. Explain that there are two categories of interventions for the management of depression: psychosocial interventions and pharmacological interventions.

Psychosocial interventions: One of the participants should read the psychosocial interventions from the reference manual line by line. Discuss and clarify key psychosocial interventions. Relate to the video of Sarah. Focus on the following messages:

Psycho-education:

- What depression is, and its expected course and outcome.
- Depression is very common and it does not mean that the person is lazy or weak.
- Other people may not understand depression because they cannot see it and they may say negative things to you but depression is not your fault.
- People with depression often have negative thoughts about their life and their future, but these are likely to improve once the depression is treated and starts to improve.
- What carers and families can do to support the person.
- Range of available treatments and their expected risks and benefits.
- Potential side-effects of any medication and how the person and/or family/carer can monitor it.
- Any potential referrals to other organizations that may support them, why this would be done and how it might help.
- Importance of the person being involved in the treatment, i.e. what the person can do to reinforce feeling better.

Reducing stress and strengthening social supports:

- Using psycho-education to explain that when people are depressed they often stop doing the things that make them feel good. This can make the depression worse.
- Activities that used to be fun can help people recover from depression.
- Problem-solving to reduce stress with examples of how they would do that.
- Relaxation activities.
- Activities such as seeking further support from friends/family members that they are close to. Use activities that they know help them. Use reading, religion, inspiring phrases that give them strength.
- Linking people to different organizations to encourage engagement.

Promoting functioning in daily activities:

- Use psycho-education to explain that when people are depressed they often have problems engaging in daily activities.
- Discuss activities and tasks that the person could do to give them a routine and structure to their day.
- Explain that although it may be difficult to get back to the activities the patient enjoys, it is important to slowly start to engage in them again. Discuss with the person and their carer activities that they used to enjoy and how to re-engage with them.
- Try spending time with trusted friends and family members.
- Try to participate in community and other social activities.
- Sleep hygiene messages to promote good sleep.
- Discuss diet and the importance of eating regularly despite change in appetite.
- Discuss the benefits of regular exercise.
- Linking the person to different organizations for educational, social, legal, educational or livelihood support

Pharmacological interventions: Display slides and ask them to refer to the section of pharmacological interventions from the reference manual. Highlight the importance of discussing whether to start antidepressants or not, together with the person. The person should be involved in the decision-making process and understand the risks and benefits of taking medication. Explain how important it is that people understand how to take medication properly and safely. They should know what to expect when taking medication, e.g. any side-effects, when to expect to see an improvement, etc.

Relate to the video of Sarah. Focus on myths related to psychotropic medication uses and share the facts.

Discuss the points on the slide individually, ensuring that people understand when NOT to prescribe antidepressants.

Ask the participants to go through the table of antidepressant medication. Give 10 minutes if needed. Advise them on how to start medication, build dose and wait for response. Highlight common and serious adverse effects. State the contraindications of antidepressants. Advise them to take precautions in special population.

Precautions for TCAs: Use the points on the slide to explain when to avoid using tricyclic antidepressants (TCAs).

- The elderly, people with cardiovascular disease and people with dementia.
- People at risk of self-harm. Explain that the participants should ask the family to monitor the doses of TCAs in people with a risk of self-harm/suicide, as people may hide the tablets and take them all at once as a way of overdosing.

Management with antidepressants

SSRI- Selective Serotonin Reuptake inhibitor:

Capsule Fluoxetine 10 mg should be started **in the morning, after food** and increased to 20 mg after a week. Evaluate after 6 weeks and continue same dose if symptom of depression start decreasing. If there is no change in the symptoms even after 6 weeks, patient should be referred.

F**or MBBS doctors:** Dose of Fluoxetine can be gradually increased by 10 mg every 6 weeks for a **maximum up to 40 mg.** It is important to wait for 6 weeks at every dose to assess the effectiveness of the dose. Refer if treatment seems ineffective even at 40 mg/day.

When insomnia or severe restlessness is present: Add Tab. Diazepam 5 mg PO HS along with Fluoxetine. Decrease the dose to 2.5 mg after 1 week and then stop Diazepam within 2 weeks. Do not give diazepam for more than 2 weeks.

Tricyclic antidepressants: Start with Amitriptyline 25 mg given once daily at night time. Evaluate after 6 weeks. The dose can be increased to 75 mg daily over 6 weeks. MBBS doctors can escalate the dose upto 100 mg/day. Refer if treatment seems ineffective even at 75-100 mg/day.

Stop the medication and refer whenever there are symptoms of mania.

Total duration of treatment: Medication should be given for 9-12 more months after the symptoms improve significantly. Decrease the dose by 10 mg every 4 weeks and stop the medication. If symptoms restart, refer.

Advise them to devise a definite follow up plan with the patient. Focus that the follow up visit should be more frequent in initial phase of treatment.

Show the slides on follow up. Relate to the video of Sarah on follow up. Ask them to go through the follow up flowchart in the reference manual. Specify the following domains to be assessed during follow up visits:

- compliance to medication
- improvement in symptoms
- adverse effects
- drug interactions
- any psychosocial stressors currently
- daily functioning
- symptoms of mania evolving
- imminent risk of suicide

If the patient has improved, ask the participant to continue medication for at least 9-12 months from the day of significant improvement for complete treatment and prevention of recurrence.

Quiz session:

Ask the participants the questions written on the slide. Give them one minute to find the answers. Then reveal the answer.

Role play: Psychosocial interventions

Duration: 20 minutes

Purpose: This role play will give participants an opportunity to practise delivering psychosocial management interventions to a person suffering with depression.

Situation:

A 27-year-old was identified as having depression one week ago. One year ago he was employed in a busy bank and really enjoyed the job. He was in line for a promotion. He was in a relationship, engaged to be married and was really excited about the future. Then his fiancée left him, unexpectedly, for another person. He felt that the stress of work and the impending promotion was too much, and he started to feel

very anxious and worried all the time. He stopped being able to sleep or eat well. As his mood deteriorated and he felt more and more sad and depressed, his personality started to change. He was irritable, forgetful and within weeks he had damaged his reputation at work to the point that he was fired. That was one year ago. Since then he has been very depressed. He is socially isolated, feeling unable to spend time with friends and family as he is embarrassed and ashamed about how his life has changed. He has no work and has money problems. He blames himself for everything that has happened in his life.

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

Session 4. Follow-up

Time: 30 minutes

Emphasize that a crucial part of managing depression is ensuring that the participants are able to monitor and follow-up with the person with depression.

Highlight the clinical tip and explain the recommended frequency of contact.

Explain that at every follow-up session they must assess for any improvement or deterioration in the person's condition.

Possible presentations at follow up: Explain that at each follow-up session they may see the person either improving or remaining the same/deteriorating.

Whichever is the case, it is essential to keep communicating with the person and be flexible, adapting the intervention options as much as possible.

Video demonstration: Show the final part of the mhGAP-IG depression video which involves Sarah returning for a follow-up appointment. Ask the participants the questions on the slide.

Monitoring people on antidepressants: Explain that if prescribing antidepressants, the participants should use the principles of psycho-education to ensure that the individual and the carer understand the risks, benefits, how to take the medication, and what signs to look out for and monitor. Talk through the points on the slide.

Explain that it usually takes approximately four to six weeks to feel the benefits of the medication.

Inadequate response: If, however, a person does not experience any improvement in symptoms four to six weeks after starting antidepressants, you should consider:

- If the original assessment of depression was correct.

- If the person is taking the medication as prescribed.
- Ensure that the dose is adequate.

When and how to stop antidepressant: Explain that, just as in the case of Sarah, quite often people want to stop taking antidepressant medication as soon as they start to feel better – state that it is recommended that people continue to take antidepressants for up to 9–12 months after resolution of symptoms.

Emphasize the importance of assessing any changes in mental state and monitoring if any signs of mania are present.

Session 5. Review

Time: 15 minutes

Purpose: Review the knowledge and skills gained during this training session by delivering questions and facilitating a discussion.

Instructions:

Administer the depression questions to participants.

Discuss the answers as a group.

Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Depression commonly presents with:
  - Multiple persistent physical conditions with no clear cause.
  - Low energy, fatigue and sleep problems.
  - Persistent sadness or depressed mood and anxiety.
  - Loss of interest in activities that are normal and pleasurable.
- Depression results from a combination of biological, psychological and social factors which significantly impact on a person's ability to function in daily life.
- You can use the Module 2 to assess and manage depression.
- You can use effective communication skills to deliver psychosocial interventions to everyone with depression including: –
  - Psycho-education for the person and their carer/family.

  - Strategies to reduce stress and strengthen social support.
  - Promoting functioning in daily activities and community life.
- Many people with depression benefit from brief psychological interventions if available.
- Many people with depression benefit from being prescribed antidepressants that need to be continued for at least 9–12 months after the resolution of symptoms.
- Special populations to consider are children, adolescents and women who are pregnant or breastfeeding.

CHAPTER 5

PSYCHOSES

Learning Objectives

- Promote respect and dignity for people with psychoses.
- List out common presentations of psychoses.
- Name assessment and management principles of psychoses.
- Perform an assessment for psychoses.
- Use effective communication skills when interacting with a person with psychoses.
- Assess and manage physical health concerns in psychoses.
- Assess and manage emergency presentations of psychoses.
- Provide psychosocial interventions to persons with psychoses and their carers.
- Deliver pharmacological interventions as needed and appropriate in psychoses considering special populations.
- Plan and performs follow-up sessions for people with psychoses.
- Refer to specialist and links with outside agencies for psychoses as appropriate and available.

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, case studies, discussions, group exercises, role play, video demonstration.

Evaluation of chapter by the participants

Materials

Flip chat, markers, pen & papers, reference manual, facilitator's guide.

Duration

3 hours

Method:

Session 1. Introduction to psychoses

Time: 35 minutes

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

What do local people believe?

Presentation on psychoses

Ask the participants the questions on what local people believe about psychosis and give them time to discuss (5–10 minutes).

Emphasize that:

Local names and terms may imply the person with psychoses is mad, possessed, stupid, cursed, dangerous etc.

Explain why you want to avoid using those terms (emphasize how damaging those names can be for people who live with them).

Discuss with the participants the impact that negative names can have on the individual and their family.

With the participants seek a sensitive and non-judgmental term that can be applied when talking about psychoses.

Ask the trainees what psychosis means to them.

The facilitator can ask the participants to provide examples of symptoms they have seen in patients, or he/she can demonstrate the symptom by 'acting it'.

Describe the symptoms on cognitive, emotional, behavioral and perceptual symptoms. Remember the term "psychoses" includes psychosis and bipolar disorder.

Symptoms of psychosis: Now take a look at the symptoms of psychosis in more detail.

Explain that psychosis is characterized by **disturbed perceptions** (give examples of hallucinations) and **disturbed thinking** (give examples of delusions).

Disturbed behaviour and emotions: Explain that people with psychosis may show very little emotion on their faces or in the body language and instead appear to be detached and disconnected from their surroundings.

Symptoms of bipolar disorder: Describe the symptoms on the slide and explain that people with bipolar disorder may experience hallucinations and delusions during a manic episode. But they can also have features of depressive episodes. Although bipolar disorder is normally characterized by the changes in

mood (mania to depression), people who experience only manic episodes are also classified as having bipolar disorder.

Natural history of psychosis: Explain that the first symptoms of psychosis usually start between the ages of 15–29 years old.

Natural history of bipolar disorder: Explain that usually people will experience their first symptoms of bipolar disorder between the ages of 15–29 years old.

The changes in mood and symptoms of associated with those changes in mood can vary widely between people. Explain that sometimes people have a couple of bipolar episodes in their lifetime while others have many episodes.

Some people will have just one manic episode in their life and others will experience one manic episode but many more depressed episodes.

Impact of psychoses: Ask the participants how they think psychoses impacts on a person's life?

Allow a brief discussion before revealing the slide.

Discussion: Stigma and discrimination to people with psychosis

Measures to reduce the stigma

Emphasize that the participants have a unique role, because they can treat psychoses.

Showing that psychoses can be treated is an important method to reduce stigma.

Talk through the points on the slide.

Emphasize that the person with mental disabilities and their carers must be involved in the decision-making process about their treatment.

Explain that to decrease stigma, discrimination and human rights abuses participants can:

- Provide families, individuals and communities with accurate information about psychoses.
- Ensure people understand what they can expect from treatment and recovery; support them and give them hope.
- Explain clearly that people can recover from psychotic episodes and that with treatment and support they can lead fulfilling and productive lives.
- Dispel any myths about psychoses and correct any misinformation.
- Raise awareness about human rights abuses and advocate for rights of people with psychoses.

- Involve people with psychoses and their carers in any awareness raising activities. Empower them to speak for themselves.

Why is it important to treat psychosis in non-specialized health setting?

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

Non-specialized treatment is more accessible and less stigmatizing than institutional care.

Explain that there is clear evidence that old-style mental hospitals are not the best way to treat people with psychoses and often violate basic human rights. Therefore, caring for people through non-specialized health settings and in the community is essential.

Session 2. Assessment of psychoses

Time: 1 hour

Talk through the principles of assessment:

- Explore other explanations for symptoms:
  - Evaluate for medical conditions.
  - Evaluate for other relevant MNS conditions.
- Assess for acute manic episode.
- Evaluate if the person has psychosis.

Role play:

Duration: 15 minutes

Instructions:

Two of the trainers/participants (or participants with much experience, such as a psychiatric nurse) play a psychotic patient with an accompanying family member. They consult a doctor 'because they have heard that now the health centre can also cure mental disorders.

During the role play the typical manifestations of psychosis are demonstrated such as

Strange appearance (with inappropriate way of dressing) and bizarre behaviour

Talkative speech or keeping silent

Increased or decreased psychomotor activities

Thoughts: delusion of persecution or reference (or other types of delusions)

Auditory hallucinations

Lack of insight (the person can deny having any illness)

One of the participant acts as a service provider in a health facility and another participant plays the patient who shows behaviour that indicates that the patient may have hallucinations (looking around, as if s/he sees or hear something there, muttering to self, etc.) A third participant/trainer can hide behind the patient to mimic providing auditory hallucination to him.

Discussion: After the role play the participants split into smaller groups and are invited to describe the symptoms they have observed and is then discussed in plenary session (10 minutes).

The trainer needs to be active to correct potential misconceptions among participants especially in concepts of 'hallucination' and 'delusion'.

The trainer should discuss the way the participant who role-played the service provider approached the patient and how to conduct the assessment. Consider the following:

Maintaining a respectful attitude to the patient, building rapport, not laughing or humiliating the patient

Asking questions in a sensitive way

Describe the points on the slide and highlight that these are ways to help improve communication with a person with psychoses.

Video demonstration:

Explain to participants that they are going to watch a video of Amir being assessed for possible psychoses.

After the participants have watched the video ask the group: What symptoms does Amir have?

Are there any other explanations for Amir's symptoms? Seek group consensus. How did the health-care provider assess if there were other explanations?

Delirium: Delirium can present in a similar way to psychoses. Therefore, it is crucial to make sure that there are no acute physical conditions resulting in delirium, i.e. infection, cerebral malaria, dehydration, metabolic abnormalities or medication side-effects.

Did the health-care provider assess Amir for dementia, depression, substance use (alcohol/drug intoxication or withdrawal)?

Managing concurrent MNS conditions and psychoses: If you suspect any other MNS conditions, then consider consultation with a mental health specialist and/or assess and manage the concurrent conditions by using the relevant chapters.

Explain that assessment for self-harm/suicide should be done.

When considering the needs of special populations like pregnant women or women who have just given birth always refer to a specialist where available.

Explain that people with psychoses can present "in crisis" and as emergency cases in a number of ways.

- With thoughts, plans, attempts of self- harm/suicide.
- Acute agitation and/or anger.

Discuss with the participants the principles of managing acute agitation and/or aggression.

Bring the participants attention back to the video of Amir. Seek group consensus as to whether Amir is having an acute manic episode.

In this case, Amir is **not** having an acute manic episode. Therefore, continue to step 3 of the algorithm.

Does Amir have psychosis? The answer should be **yes** as he has hallucinations (hearing voices), signs of self-neglect or appearing unkempt, mumbling speech and reports (from his parents) about laughing to himself.

How to ask about hallucinations and delusions: Discuss for five minutes and establish culturally appropriate questions you could use to ask whether people are experiencing hallucinations and delusions?

Role play: Assessment

Duration: 15 minutes

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

Situation:

- You are a health-care worker in a clinic
- A man who is well known to you, is homeless and lives under the tree opposite your practice, he has been seen talking to himself and laughing to himself, is unkempt and un-groomed.
- Assess him according to the psychoses assessment algorithm.

Instructions:

- Divide the participants into groups of three.
- Instruct one person to play the role of the health-care provider, one the person seeking help and one the observer.

- Distribute the role play instructions to each person depending on their role.
- Ensure that the participants keep to the allotted time.

Session 3. Management of psychoses

Time: 1 hour 15 minutes

Hold up your hand and ask participants to tell you which management interventions should be used when treating people with psychoses.

Briefly talk through the different interventions that could be used in a treatment plan.

Direct participants to the management protocols from reference manual. Choose volunteers to read them out loud.

Video demonstration: Management of psychoses

While watching ask participants to think about these questions:

- How the health-care provider explains the treatment options ?
- Were the risks and benefits of medication explained?
- Were the benefits of psychosocial interventions explained ?

Give the participants time to read through the psychosocial interventions of the reference manual. Emphasize to participants the importance of delivering psychosocial interventions to people with psychoses and their carers. Explain that focusing on a person’s recovery and taking time to ensure that they start to take part in activities of daily living and reconnect with their family and communities is an essential and crucial part of treatment.

Delivering psycho-education

Duration: 15 minutes

Purpose: To enable participants to familiarize themselves with key psycho-education messages and practise delivering those messages to the rest of the group.

Instructions:

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

- Give each group 10 minutes to come up with a creative way to deliver the key psycho-education messages to the other group.
- After 3 minutes of planning. Give each group five minutes to present the key psycho-education messages. Correct any misinformation.

Emphasize the importance of delivering clear psycho-education to carers, including advising carers.

Explain that participants are now going to focus on how to promote functioning in daily living activities for people with psychoses. Ask one participant to read aloud through the reference manual.

Pharmacological interventions

Conduct a short quiz session through the slides.

State that "Early identification and early intervention is linked to better treatment outcomes".

Explain that antipsychotic medication should be offered routinely to a person with psychosis. Highlight the importance of regular monitoring and follow-up of anyone started on antipsychotic medication. Especially important is monitoring for health considerations: weight gain, blood pressure, fasting sugar, cholesterol changes, ECG changes, and extrapyramidal side-effects such as: akathisia, acute dystonic reactions, tremor, muscular rigidity etc.

Direct participants' attention to the instructions in the manual for managing manic episodes with pharmacological interventions. Ask participants: Why a person with mania would be on antidepressants? Remind them that people with bipolar disorders can experience episodes of mania and depression. In fact, remind them that often people with bipolar may experience more episodes of depression, therefore they may have already been prescribed an antidepressant. If they have then point out that if they have had a manic episode, their antidepressants should be stopped. Treatment with Sodium Valproate, Carbamazepine and Risperidone should be considered.

Case scenario

Introduce participants to the story of Amir and explain that after carrying out a thorough assessment you decided to start him on antipsychotic medication as well as delivering psycho-education and psychosocial interventions.
Ask one of the participant to read aloud the antipsychotic and mood stabilizers from the manual.
Discuss on the dosage, frequency, dose increment, adverse effects and duration of medications.

Anti-psychotic medications:

Start with Tab Risperidone 1 mg and 2 mg, increase to 1 mg PO BD after 2 days. Evaluate the improvement after 4 weeks. If symptoms have started improving, continue the same dose. If

symptoms are not improved, dose can be improved up to 2 mg PO BD. (Typical effective dose is 2-4 mg per day).

Refer if symptoms still do not improve.

Treatment Duration

If it is the first episode of psychosis: Continue treatment with regular follow-ups for at least 1-2 years after the resolution of symptoms.

Risperidone can be tapered gradually and stopped. Current dose is decreased to half the dose and gradually stopped over 6-12 weeks, then stopped if no significant distress is noticed. If possible, it is advised to consult with a psychiatrist while attempting to decrease or discontinue the drug.

If it is a case of recurrence of psychosis or chronic psychosis, treatment for longer duration is needed. Consultation with a psychiatrist is needed. Follow up at the primary health care level during routine maintenance can be done.

Side effects of Risperidone:

Common Side effects

Dry mouth, dizziness, weight gain G.I disturbance,

EPS (Tremor, rigidity, akathisia) weight gain, increased prolactin level (breast engorgement, galactorrhoea, amenorrhoea, gynaecomastia), sexual dysfunction

Serious side –effects

Acute dystonia, Tardive dyskinesia

For the treatment of Extra Pyramidal Syndrome (EPS), or Acute Dystonic Reaction:

If possible, dose can be slightly reduced.

Add Tablet Trihexyphenidyl 2 mg TDS immediately. Continue for 6 weeks. After 6 weeks decrease the dose to BD for 1 week, then stop.

If symptoms recur or are severely distressing, refer to higher center.

For acutely agitated patients:

Tablet/Injection Diazepam 5-10 mg can be given for symptom control.

Severely agitated and violent patients usually require admission and hence need referral to a hospital with psychiatric care.

Special populations

- Ask participants to read through the differences in special populations.
- Then ask for a volunteer to give a brief summary of the differences in management of:

- women who are pregnant or breastfeeding
- adolescents
- older adults.

Session 4. Follow-up

Time: 15 minutes

Ask for a volunteer from the participants to read out loud steps of the follow-up from the reference manual and possible outcomes to that step.

Ask participants to reflect on how they will know if the person is improving or not and the reasons why the person may not be taking their medication.

Ask participants to reflect on how could they routinely monitor treatment? What could they do? Who could they ask?

Ask participants to reflect on how will they know if the person is improving?

Clarify any queries or concerns the participants may have with these steps and outcomes. Ask participants to reflect on how they will know if the person is in full remission? Ask participants to consider how they would learn about the number of manic or depressive episodes the person has had? Explain that people with bipolar disorder may have more depressive episodes than manic episodes. Therefore it is important to explore their mental state.

Advise to make an appropriate follow up plan. Follow up visits should be more frequent initially till the patient responds to treatment.

On follow up visits, assess the following:

compliance to medication
improvement in symptoms
adverse effects
drug interactions
any psychosocial stressors currently
daily functioning
imminent risk of suicide

Do not forget to measure body weight, blood pressure and/or blood glucose if feasible during the visit.

If the patient has improved, ask the participants to continue medication for at least 12 months after symptoms have resolved if it is the first episode, relapse or worsening of psychotic symptoms. If the

psychotic symptoms have already persisted for more than 3 months, consider continuation of antipsychotic till full remission of symptoms for several years.

Discontinuation of antipsychotic medication should be done in consultation with a specialist whenever possible. Medication should be stopped gradually in tapering doses over several months to prevent recurrence/relapse.

For psychosis in BPAD, consider continuation of medication for at least 2 years from full remission. Discontinuation of medication should be done in consultation with a specialist whenever possible. Medication should be stopped gradually in tapering doses over several months to prevent recurrence/relapse.

Session 5. Review

Time: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the psychoses MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- sychoses include psychosis and bipolar disorder.
- Common presentations of psychosis include:
  - Marked behavioural changes, neglecting usual responsibilities.
  - Agitation, aggression or decreased activity.
  - Delusions – fixed false beliefs.
  - Hallucinations: hearing voices or seeing things that are not there.
- Bipolar disorder is often characterized by significant disturbance in mood and activity levels with manic episodes (in which the person’s mood is elevated and their activity levels increase) and depressive episodes (in which the person’s mood is lowered (depressive) and their energy levels decrease).
- Psychoses can be managed in non-specialized health settings.

- When assessing for psychoses make sure you assess for and rule out other medical conditions (i.e. delirium).
- Provide both psychosocial and pharmacological interventions as first-line treatments for people with psychoses.
- Most people with psychoses can make a full recovery.
- Seek specialist support when needed.
- The best way to reduce the stigma and discrimination against people with psychoses is to treat them with respect and dignity and integrate them into the community

DAY 3

Day 3			
Psychoses continued Management: Psychosocial Interventions and Pharmacological Interventions	PowerPoint presentation Discussion	10:00 AM-11:30 AM	Psychiatrist
Tea Break		11:30 AM - 11:45 AM	
Psychoses continued Follow-up **Self-harm/Suicide** Introduction Quick overview Assessment	PowerPoint presentation Video display PowerPoint presentation Discussion	11:45 AM- 12:30 PM 12:30-13:00 PM	Psychiatrist
Lunch Break		13:00 – 14:00 PM	
Self-harm/Suicide continued Assessment Management of pesticide Intoxication and referral Psychosocial Interventions Follow-up	Experience sharing Group Discussion PowerPoint presentation	14:00- 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Epilepsy Introduction Quick overview Emergency	PowerPoint presentation Interactive Discussion Sharing experience	15:45 - 16:45 PM	Psychiatrist
Review of the day		16:45-17:00 PM	Participant

CHAPTER 6

SELF-HARM/SUICIDE

Learning objectives

- Promote respect and dignity for people with self-harm/suicide.
- Know the common presentations of self-harm/suicide.
- Know the principles of assessment and management of self-harm/suicide.
- Perform an assessment for self-harm/suicide.
- Assess and manage co-morbid physical health conditions in a person with self-harm/ suicide.
- Assess and manage emergency presentations of self-harm/suicide.
- Provide psychosocial interventions to persons with self-harm/suicide.
- Provide follow-up sessions for people with self-harm/suicide.
- Refer to mental health specialists and links to outside agencies for self-harm/suicide as appropriate.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of each chapter by the participants

Duration

2 hours

Session 1. Introduction to self-harm/ suicide

Time: 15 minutes

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

What is suicide and self harm?

Trainer should give an interactive presentation on definitions of relevant terminologies of suicide.

Brainstorm: Discuss on the following questions-

Have you ever witnessed / heard of suicide or self harm in your community?

What are the risk and protective factors for suicide?

What do you think is the underlying primary cause of suicide?

Is health care system involved in suicide?

Why is suicide a public health concern?

Explain the statistics on the slide. Explain that globally, close to 8,00,000 people die due to suicide every year. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. State that it was the second leading cause of death in 15–29 year-olds globally in 2015. There are indications to suggest that for every suicide there are more than 20 other people attempting suicide. Some 78% of global suicides occurred in low- and middle-income countries in 2015. In high-income countries, men are three times more likely to die from suicide than women. In low- and middle-income countries men are one and a half times more likely to die from suicide than women.

Provide an **introductory outline and overview of suicide**. Clarify certain misconceptions/myths on suicide as: "talking about suicide provokes attempt in a person". In fact asking about suicide helps the person feel understood and explain the reasons for harming themselves.

Emphasize that there are two ways that people with self-harm/suicide access non-specialized health settings:

1. As an emergency presentation of self- harm/suicide.
2. During an assessment for other MNS conditions, chronic pain or extreme emotional distress.

Assessing someone with thoughts, plans or acts of self-harm/suicide requires that you explore:

- any plans
- risk factors
- protective factors

Talk through the list of **risk and protective factors**.

Protective factors:

- Previous coping strategies – have they felt like this before? If so, how did they cope, what did they do? What helped them? Will it help them again?
- Community involvement – are there family members, friends, community members who can help, listen, and support them?
- Religious, cultural beliefs – do they have access to spiritual/religious leaders, important leaders in a community who can support them? Do they have beliefs that give them hope?

- Family and social relationships – are there relationships or people in their lives who give them hope and a sense of having a future?

Session 2. Assessment of self-harm/suicide

Time: 40 minutes

Emphasize the principles of assessment:

1. Assess if the person has attempted a medically serious act of self-harm/suicide.
2. Assess for imminent risk of self-harm/ suicide.
3. Assess for any of the priority MNS conditions.
4. Assess for chronic pain.
5. Assess for emotional distress.

In an emergency assessment of self-harm/suicide attempts look for:

- Signs of poisoning
- Bleeding, loss of consciousness and extreme lethargy

Explain that the next topic is specifically about pesticide poisoning. Read through the points on the slide. Emphasize that it is a suicide method with a high fatality rate and globally, it is one of the most common methods.

Refer participants to the **clinical management of acute pesticide intoxication**. Do not discuss beyond the scope of the chapter.

Once the person is medically stable in a safe environment, return to the assessment algorithm and continue with the appropriate steps of the assessment.

Talk through the suggested questions on the slide.

During an assessment, at the same time as asking about any thoughts/plans of self-harm/ suicide, also ask about any possible protective factors.

Brainstorm culturally relevant questions with the group. Continue with the assessment algorithm.

Explain that previous behaviour is a strong predictor of future behaviour, therefore it is important to ask about any previous acts of self-harm or suicide attempts. If they have had previous acts of self-harm/ suicide then this is also an opportunity to ask what helped them survive those previous act/attempts. How did they cope with those feelings? Can they do the same thing this time?

Role play: Assessment

Duration: 20 minutes

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

Situation: A young man has come to be checked over after having a motorcycle accident. The health-care provider is worried he may have been suicidal at the time of the accident.

Instructions:

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

Session 3. Managing self-harm/suicide

Time: 35 minutes

Explain that the key to the management of self-harm/suicide is to:

- Ensure the person does not have access to means.
- Support the carers.
- Mobilize family and friends to support and make the person feel safe.
- Focus on protective factors.
- Offer psycho-education to ensure the person understands how useful it is to talk about negative feelings and how important it is to identify people to turn to when feeling this way.

Management of co-occuring conditions: It is important to treat any underlying MNS condition, chronic pain and emotional distress.

As self-harm/suicide is always serious, refer the person to a mental health specialist when available and consult them regarding next steps.

Devise a detailed follow up plan with the patient and the carer. The frequency of contact should be increased during the initial period as required.

Talk through the points on the slide.

Psychosocial interventions:

Direct participants to the reference manual and ask a volunteer to briefly talk through the different interventions in detail, answering any questions the group may have.

Remind participants that it is essential to ensure that the person is in a safe and quiet environment when talking about self-harm/ suicide. Remind participants to involve carers, where possible, in the assessment and management of the person with self-harm/ suicide.

Direct participants to continue to read through the psychosocial interventions in the manual. Ask for a different volunteer to continue reading out loud.

Explain that by assessing for protective factors, they have already started to "explore reasons and ways to stay alive". When exploring for reasons and ways to stay alive, one should really listen to the person and try to understand what is the most important for them and avoid giving your own opinions.

Ask the participants to assess and manage suicidal attempts simultaneously. Go to Protocol 1 for management of medically serious suicidal attempts.

State that acute suicidal attempts like acute pesticide intoxication should be managed as per the availability of antidotes and expertise in the health facility. Referral to higher centre can be done once basic management is done.
Continue assessing for imminent risk of suicide.
Imminent risk of self-harm/suicide should be managed according to Protocol 2.
If the risk of suicide is unlikely, assess and manage other priority MNS conditions if present.
Assess and manage other concurrent conditions like chronic pain and emotional distress if present.
If the patient is improving, continue follow up for 2 years.
Continue assessment of suicidal risk till the patient has no further signs and symptoms of self harm.

Session 4. Follow-up

Time : 20 minutes

Talk through the follow-up assessment steps as described on the slide and in the reference manual.

Explain that a person needs to be followed up closely as long as there is still a risk of self-harm/suicide. Different methods can be used to follow- up: scheduling another appointment at the centre, home visits, phone calls, text messages.

The appropriateness of these different methods varies depending on cultural acceptability and on the resources available.

Role play: Follow-up

Duration: 15 minutes

Purpose: To show participants how to work with people during a follow-up session for self-harm/suicide.

Situation: A lady had intentionally ingested a bottle of pesticide in order to kill herself. After she was medically stabilized, you offered her support by using psycho-education, activating psychosocial support networks and problem-solving. You explained to her that you wanted to stay in regular contact to monitor her progress. She has now returned for follow-up.

Instructions:

- Facilitator plays the role of the health-care provider.
- Participants watch.
- After five minutes of the role play, stop and ask participants to suggest ways that the health-care provider could work with the person returning for a follow-up session.
- Then ask a participant volunteer to take over from the facilitator to continue the follow- up interaction.
- This is repeated three times so that at least three participants can play the role of health- care provider.
- After the third change, stop the exercise.
- Reflect as a group on the benefits of follow-up.

Session 5. Review

Time: 10 minutes

Purpose: Review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the SUI MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Common presentations of self-harm/suicide:
  - Extreme hopelessness and despair.
  - Current thoughts/plan/acts of self-harm/suicide or history thereof.
  - Act of self-harm with signs of poisoning/intoxication, bleeding from self-inflicted wounds, loss of consciousness and/or extreme lethargy.

- Anyone with other priority MNS conditions must be assessed for self-harm/suicide.
- Anyone with self-harm/suicide must be assessed for other priority MNS conditions, chronic pain, and emotional distress.
- You can use effective communication skills to provide psychosocial interventions to the person and to the whole family.
- Refer a person with self-harm/suicide to a mental health specialist, if available.
- It is essential to offer regular follow-up care to a person with self-harm/suicide.

CHAPTER 7

EPILEPSY

Learning objectives

- Promote respect and dignity for people with epilepsy.
- Know common presentations of epilepsy.
- Know the assessment principles of epilepsy.
- Use effective communication skills in interactions with people with epilepsy.
- Know the management principles of epilepsy.
- Perform an assessment for epilepsy.
- Assess and manage physical health in epilepsy.
- Assess and manage emergency presentations of epilepsy.
- Provide psychosocial interventions to persons with epilepsy and their carers.
- Deliver pharmacological interventions as needed and appropriate in epilepsy considering special populations.
- Plan and perform follow-up for epilepsy.
- Refer to specialists and link with outside agencies for epilepsy as appropriate and available

Methodology

Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises
Evaluation at the end of chapter by participants

Materials

Flip chat, markers, pen & papers, power point presentation, reference manual, facilitator's guide

Duration

2 hours 15 minutes

Session 1. Introduction to epilepsy

Time: 20 minutes

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

The facilitator introduces the topic by explaining that epilepsy is quite a common disorder.

Person's story followed by group discussion: Tell a person's story of how it feels like to live with epilepsy.

Ask participants to think about people they have cared for in the past with epilepsy? Can they think of any cases? How did the person with epilepsy behave, how did their family and carers cope?

Write a list of local terms and descriptions for epilepsy and compare those with common presentations described in the reference manual.

Brainstorm on local names for epilepsy.

What is epilepsy?

Talk through the points on the slide by explaining that epilepsy is a neurological condition characterized by recurrent seizures.

Justify differences between epilepsy and seizure.

Seizures are brief disturbances in the electrical functions of the brain. There are potentially many different causes of epilepsy but it is not always easy to identify one. Talk through the possible causes.

Signs and symptoms of epilepsy: Explain the signs and symptoms of epilepsy. It is typified by seizures. In order to receive a diagnosis of epilepsy, there needs to have been two or more recurrent unprovoked seizures (in the past 12 months):

- Recurrent = usually separated by days, weeks or months.
- Unprovoked = there is no evidence of an acute cause of the seizure (e.g. febrile seizure in a young child). Seizures are brief disturbances of the electrical function of the brain. Characteristics of seizures vary and depend on where in the brain the disturbances first start and how far it spreads.

Types of epilepsy: Briefly state the types of epilepsy.

Describe the two types of epilepsy as described on the slide. Explain that this module will focus on

convulsive epilepsy, as that is the type associated with more fear, stigma and discrimination. Highlight again that in this module we will concentrate on convulsive seizures as 70% of all seizures are convulsive.

Trainer gives an interactive presentation covering a description of the symptoms of epilepsy, using the PowerPoint Slides.

Convulsive seizures have a high mortality rate, but they can be treated.

Use the slide to explain: **Signs and symptoms of convulsive seizure**

- What a person is likely to experience during a seizure.
- What the person is likely to experience after the seizure. Explain that epilepsy is **not** contagious. Talk through the points on the slide.

Causes of epilepsy: Facilitate a brief discussion about which of these conditions is a common cause of epilepsy in their local community.

Epilepsy in non-specialized health settings:

Emphasize the first point on the slide indicating that epilepsy can be treated effectively in non-specialized health settings.

When people are treated they have a good prognosis. Two to five years' successful treatment and being seizure-free means medication can be stopped in 70% of children and 60% of adults.

Antiepileptic medication is affordable – US$ 5 per year. In low- and middle-income countries about 75% of people with epilepsy may not receive the treatment they need.

In fact, in low- and middle-income countries there is a low availability of antiepileptic drugs (AEDs) – this may act as a barrier to accessing treatment.

Discuss on causes of epilepsy. It is important to emphasize that the cause of epilepsy is not known in majority.

It is important to know and discuss local environmental factors that could contribute to seizures and epilepsy.

Local names for epilepsy: Generate a **brief discussion**.

Revisit the list of local names and terms produced for a person with epilepsy.

Ask the group if some of the names and terms are negative?

How might that make the person/family feel?

How might that impact on their likelihood to seek help?

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

Common misconceptions about epilepsy: It is contagious, and people must be avoided and feared; and that they are possessed by evil spirits and/or bad in some way. People are denied access to health care and treatment, or they are too afraid to seek help. Often children are withdrawn from schools. People with epilepsy are overlooked for jobs (impacting on their ability to earn money and support themselves and their family). People with epilepsy are often unable to get married and sometimes prevented from driving.

Impact of epilepsy: Approximately 50 million people worldwide have epilepsy, making it one of the most common neurological diseases globally. Nearly 80% of the people with epilepsy live in low- and middle-income countries. People with epilepsy respond to treatment approximately 70% of the time. Nearly 75% of people with epilepsy living in low- and middle-income countries do not get the treatment they need. In some regions of the world, like Africa, this can be as high as 85%.

Session 2. Assessment of epilepsy

Time: 30 minutes

Explain that there are two ways that people with epilepsy enter health care services:

- During a seizure – as an emergency presentation.
- After a seizure

Ask participants to read through the assessment principles for epilepsy. Talk through the points on the slide.

Why seizures are treated as emergency? Emphasize why managing seizures is an emergency. Talk through the points on the slide.

Group discussion: Emergency presentations

Duration: 10 minutes

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

Instructions:

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

Focus on ABCs of management. Ask participants to explain and then demonstrate how they put a person in the recovery position.

Emphasize that these vital signs need to be **measured and documented.**

Time the duration of the convulsions.

- Make sure the person is in a safe place – ensure that nothing is likely to fall on them and/or they can't hit anything if they convulse.
- If possible place in an i.v. line for medication/fluids.
- Know when to **refer** – if a person has a head injury, a neuroinfection or focal neurological deficits then **refer to hospital.**

Talk through the next steps highlighting the special population: pregnancy/post-partum and when to suspect **eclampsia**.

A pregnant woman who has no history of epilepsy and presents with seizures may have **eclampsia**. Eclampsia is a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure.

The condition poses a threat to the health of the mother and the baby. If there is a midwife in your clinic call them to assist. They may have training in how to support people with eclampsia.

Refer immediately to a hospital.

Explain that we will look at the management protocols in the next session but for now we will concentrate on the assessments. Ask participants if they know when a person is in status epilepticus. A patient with status epilepticus must be referred to a hospital after basic management.

Remind participants that seizures are symptoms not causes, so you always need to **look for the cause**.

If the person presents convulsing, it is an emergency and needs to be treated urgently as:

- Seizures can be a sign of a life-threatening problem.
- Seizures can result in brain injury or death.

Assessment for underlying causes should be done and managed accordingly.

Talk through the points on the slides.

Refer if neuroinfection, head injury or metabolic abnormalities.

Rule out febrile convulsion in a child between 6 months-6 years. Manage simple febrile seizure while complex febrile seizures should be referred to hospital for admission.

Session 3. Management of epilepsy

Time: 45 minutes

Begin by asking participants what management intervention strategies they think might be appropriate for people suffering with epilepsy.

Explain that managing epilepsy with pharmacological interventions and in special populations will be discussed soon, but first psycho-education will be considered.

Ask the participants to go through the psychosocial interventions in the reference manual and clarify the points if any confusion.

Emphasize that a seizure diary can be very helpful in managing epilepsy. Any record will suffice as long as it includes the details of the event:

- Whether the person was taking the medicines regularly.
- What happened.
- When it happened.
- What/if any triggers were present.

Advise them to assess for other priority MNS disorders including suicide. Any co-morbid condition should be managed referring to that particular module.

Pharmacological interventions:

Group discussion: First, ask participants what medications they use to manage epilepsy and discuss in the group. Give the participants five minutes to read through antiepileptic medication and look.

Ask participants to share what key messages they found most important?

Point out the risks of prescribing medication to special populations. Highlight that once the appropriate medication has been chosen, ensure that it is consistently available.

- Only start one medication.
- Start at the lowest dose.
- “Go slow”, increase the dose slowly until convulsions are controlled.
- Consider monitoring blood count, blood chemistry and liver function, if available.

Psycho-education for medication management

Talk through the points on the slide and use the below for extra emphasis.

Key messages:

- Explain to the person and the carer the need for medication.
- Explain the importance of taking the medication as prescribed.
- Explain that if they take the medication as prescribed they can expect to control the seizures.
- Explain the potential side-effects and what to look out for and what to do.
- Explain the risk of further seizures if doses are missed.

- Plan for a follow-up session to show that you are still there to support them. Ask participants to read through the management options for special populations.

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

Ask participants:

- Why these groups are considered special populations?
- What are the concerns for:
  - Women of childbearing age?
  - Children and adolescents?
  - Persons living with HIV?

Acute Seizure Management:

1. Check and maintain airway, breathing and circulation of the patient.
2. Protect the person from injury (Holding and restraining the patient tightly to prevent convulsive movement can cause fracture so should not be done).
3. Put the patient in left lateral position to prevent aspiration
4. Do not put anything in the patient's mouth
5. Give IV Glucose slowly: 30 drops/min

For Adults – Start IV Diazepam 10 mg slowly (Over 10 minutes)

For Children– IV Diazepam 0.2-0.5 mg/kg slowly, for a maximum up to 10mg

If there is no IV access DO NOT GIVE IM, instead give the same dose PER RECTAL (Push the drug per rectal after removing the needle from the syringe which has been prepared for IV administration).

Status Epilepticus (Seizure lasting more than 5 minutes, or recurrent seizures without regaining of consciousness in between the episode of seizures):

Dose of Diazepam can be repeated after 10 minutes of first dose, then referral is advised.

Maintenance treatment:

Can be done with **Tablet Carbamazepine or Sodium Valproate** given 2 times a day

Treatment with Carbamazepine

Starting dose: Children: 5 mg /kg /day

Adult: 200 mg / day

Maintenance dose: (Gradually increase from the starting dose to reach the maintenance dose over a week)

Children: 10 – 30 mg/kg/day (**Refer to MBBS doctors** if dose needs to exceed 800 mg/day)

Adult: 400 – 800 mg /day (**For MBBS doctors**: Can be increased up to 1400 mg/day)

Treatment with Sodium Valproate

Starting dose: Children: 15-20 mg /kg /day

Adult: 400 mg /day

Maintenance dose: Gradually increase from the starting dose to reach the maintenance dose over a week

Children: 15 - 30 mg/kg/day (**Refer to MBBS Doctors** if dose needs to exceed 1200 mg/day)

Adult: 400 – 1200 mg/day (**For MBBS Doctors:** Can be increased to a maximum of 2000 mg/day)

NOTE: Prescribe tablet Folic acid 5 mg daily along with anti-epileptics especially if it is women of childbearing age.

If there is recurrence of seizure when maintenance dose has been reached:

Ask about any missed drug doses, intake of alcohol, alteration in sleep or eating pattern, any other physical illness or stressful life events.

If no such events have taken place, drug dose can be increased within the range of maintenance dose.

If seizure does not stop with the upper range of maintenance dose, refer to a specialist.

Side effects of Carbamazepine:

Common Side effects	Blurred vision, diplopia (double vision), ataxia (staggering gait), gastrointestinal side effects
Serious side effects	**Bone Marrow depression:** If patient gets fever or repeated infections, anemia, bleeding problems, stop drug immediately and **refer** to hospital. **<u>Skin Rashes</u>**: Stop the drug immediately and **refer.**

Side effects of Sodium Valproate:

Common side effects **Side effects**	Nausea, Sedation, tremor (dose dependent), transient hair loss, weight gain, hepatic dysfunction, gastrointestinal side effects
Serious side effects	**Confusion, Thrombocytopenia, leucopenia, red blood hypoplasia, pancreatitis, appearance of jaundice/ fulminant hepatic failure: refer**

Treatment duration:

Continue for at least 2 more years from the date of last seizure.

While discontinuing the drug after 2 years, medication can be gradually decreased in dose every 2-4 weeks and stopped within 2 months.

If patient had already been treated with antiepileptic drugs in the past too, longer duration of treatment is needed, referral to a specialist may be needed. Some need lifelong treatment.

Role play: Management

Duration: 15 minutes.

Purpose: To enable participants to practise using recommended psychosocial and pharmacological interventions for epilepsy.

Situation:

- A health-care provider assessed this person and their spouse and decided that the person has epilepsy.
- The health-care provider now has the responsibility to develop a treatment plan with the person.
- The treatment plan should include psychosocial and pharmacological interventions as well as instructions to the spouse on how to help the person if they have a convulsive seizure at home and when to refer for medical help.

Instructions:

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

Session 4. Follow-up

Time: 30 minutes

Highlight the recommendations on frequency of contact and explain that follow-up should occur every three to six months.

Ask participants why they think that is?

Talk through steps of the follow- up algorithm and ask participants to brainstorm what questions they could ask at follow-up?

Possible questions could include:

- Has the person been keeping a seizure diary?
- Have there been any drug specific side- effects?
- Are they taking their medication as prescribed? If not, why not?
- Are they having any other issues? Describe what to do if the person is not improving on their current dose, highlighting when they should refer.

During follow up visits, assess the following:

compliance to medication

improvement in symptoms

adverse effects

drug interactions

daily functioning

Describe when to consider stopping medication and why.

Group discussion: How to reduce stigma and discrimination

Duration: 20 minutes

Purpose: To have participants reflect and plan what they can do to help reduce stigma and discrimination against a person with epilepsy and their carer.

Instructions:

- Divide the participants into three groups.
  - One group will represent people with epilepsy.
  - One group will represent non-specialized health-care providers.
  - One group will represent the family and carers of people with epilepsy.
- Give each group three pieces of flip chart paper and pens.
- You are going to ask the groups three different questions.
- They should write down their answers to the questions on three separate pieces of flip chart paper.
- Instruct the participants to write down their answers imagining that they are a person from

  the group they represent

Question 1: Why is it important that **you** respect, protect and promote the rights of people with epilepsy?

Question 2: Can you think of some concrete actions that you could undertake to make the rights of people with epilepsy a reality?

Question 3: What would be the positive impact of these actions for all the groups concerned?

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Epilepsy is not inherited or contagious.
- Assessment includes: – Assessing and managing an acute/emergency presentation. – Assessing for epilepsy and any other underlying causes of the seizures.
- Seizures are symptoms and not the cause, therefore underlying causes should always be explored and assessed.
- To be considered epileptic there must be two or more unprovoked, recurrent seizures.
- Epilepsy can be treated effectively with antiepileptic drugs in non-specialized health settings.
- Psycho-education and psychosocial interventions to promote functioning in daily activities are empowering for the person with epilepsy to enable them to manage their condition.
- Adherence to treatment and regular follow-up are critical.
- People with epilepsy can lead normal lives.
- Children with epilepsy can go to a normal school.

DAY 4

Day 4			
Review of previous day	Self or group interaction	10:00 - 10:15 AM	Participant
Epilepsy continued Emergency Assessment Management: Psychosocial Interventions and Pharmacological Interventions Follow-up	PowerPoint presentation Interactive Discussion Sharing experience Video display	10:15- 11:30 AM	Psychiatrist
Tea Break		11:30 -11:45 AM	
Conversion disorder (CD) Introduction Quick overview Differences between Epilepsy and CD Assessment and management of CD Follow-up	PowerPoint presentation Case study Interactive Discussion Sharing experience Video display	11:45 - 13:00 PM	Psychiatrist
Lunch Break		13:00 - 14:00 PM	
Anxiety Disorder Introduction Quick overview Assessment Management: Psychosocial Interventions and Pharmacological Interventions Follow-up	Discussion PowerPoint presentation	14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Child & Adolescent Mental & Behavioral Disorders Introduction and classification Quick overview Assessment	PowerPoint presentation Discussion Experience sharing	15:45 - 16:45 PM	Psychiatrist
Review of the day	Discussion	16:45-17:00 PM	Participant

CHAPTER 8

CONVERSION DISORDER

Learning objectives:

Identify CD and differentiate between epilepsy and CD

Provide counseling and psycho-education to the family members and individuals with CD

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of the chapter by the participants

Duration

1 hour 15 minutes

Session 1. Introduction to conversion disorder

Time: 15 minutes

Start the session.

Discussion: Ask the participants if they have come across or managed individuals with conversion disorder. If yes, ask them to describe how they present to the health facilities and how they have intervened.

Project the slides on "Conversion Disorder".

Define dissociation or conversion as **"partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensations, and control of bodily movements".**

Give appropriate examples.

Brainstorm on causes of conversion disorder

Time: 5 minutes

Ask the participants to present on the flipchart and hang it on the wall.

Elaborate and summarize the causes.

The interaction of biological, psychological and social factors are often considered as the causes of conversion disorder. Fear of taking examinations, study stress, interpersonal difficulties with friends and family members and traumatic incidents (e.g. physical or sexual abuse) are common precipitating factors.

Session 2. Assessment of conversion disorder

Time: 20 minutes

Describe the common presentations of CD.

Ask the participants to go through the common presentations in the reference manual.

Despite the ascribed psychological causes, physical symptoms are a common manifestation in conversion disorder. These include fainting (non-epileptic seizures), dramatic movements of the limbs, breathing difficulties, possession spells (trance like state) and reduced sensations in body parts (paralysis) as well as headaches and pains in the abdomen, chest and limbs. The condition is observed in individuals and groups. Its manifestation in more than one person at a time is called mass conversion disorder.

Differences between Epilepsy and Conversion Disorder

Features	Seizure	Conversion Disorder
Precipitating factor before	Rare	Often (emotional distress)
Circumstances	Can be everywhere even while	In social situations
State of consciousness	Unconscious	Semi-conscious
Symptoms	LOC a/w abnormal involuntary movements, frothing, tongue	Fainting, hyperventilation, paralysis, trance and possession spells,
Characteristics	Typical symptom presentation that is similar in every episode	Symptom presentation may change from episode to episode
Duration	Lasts mostly for a number of minutes	Lasts mostly for a number of hours
Injury or burns	Present frequently	Not present
Incontinence	Bowel, bladder incontinence may be present	Bowel, bladder incontinence is usually not present
Confusion after seizure	Present	Not present
Flailing of hand test	Positive	Negative

Describe a Case Vignette:

A 16 year old girl student was brought to a hospital by her relatives complaining of fainting attacks and 'possession' symptoms. During possessions she claimed that the goddess was 'playing' on her body and calling for her to carry out religious rituals such as offering prayers to the goddess Kali and the snake god. At the hospital she scolded her relatives for bringing her to the hospital instead of taking her to the Kali temple or to 'Mata' a woman who claimed to have spiritual powers. Her possession episodes lasted for 30 minutes to 1 hour followed by a dramatic recovery. The girl could not remember the episodes and physical examination did not find anything amiss. Investigations revealed that the girl was troubled by having failed her School Leaving Certificate (SLC) exam while most of her friends had passed and started college. Meanwhile her parents had started planning her marriage and blamed her for not passing her SLC. She felt ashamed to be with her friends. She did not have any diagnosable mental illness despite having occasional headaches and shortness of breath.

Discuss on the assessment of CD and mass CD.

Ask the participants to refer to the chapter of the reference manual.

Health workers should **rule out other physical disorders and mental health problems** such as anxiety or depression before diagnosing conversion disorder and the treatment of other physical or mental health problems should be prioritized.

Session 3. Management of conversion disorder

Time: 20 minutes

Focus on the management of CD. Highlight basic management principles.

1. Whenever possible, arrange for a private, comfortable setting to talk to the atient.
2. Provide enough time to hear about the patient's problems and listen attentively.
3. Maintain confidentiality
4. Ensure that the communication is clear, non- judgmental, empathic and espectful.
5. Be sensitive when private and distressing information (suicide, abuse) is provided.
6. Involve parents, family members or teachers appropriately in the management
7. Security of the affected person should be ensured
8. Always be mindful about the presence of physical illness
9. Educate about the illness
10. Prevent access to unnecessary visitors to decrease unnecessary attention and provide calm environment.

Focus on counseling, psycho-education and cut-off of secondary gain.

Reducing secondary gain

Do not try to mitigate symptoms forcefully.

Do not pay extra attention to symptoms.

Behave as if nothing is serious with affected persons.

Encourage persons to manage their responsibilities as they did before when they were not 'sick'. For example, if an affected person has developed an unstable gait, encourage them to walk on their own without support. They are less likely to fall if this is a conversion symptom.
Leave affected persons alone during episodes.
Describe the interventions to affected individual, non-affected individual and family/teachers.
Deep breathing and relaxation exercises are helpful to relieve immediate distress and should be taught appropriately.

Session 4. Follow up

Time: 10 minutes

Offer follow up to individuals with CD.
The follow up can be timed as feasible to the patient.
Avoid unnecessary admission in the health facility.
Assess for improvement in symptoms, stressors, daily activities and secondary gains during follow up visits.
Strengthen social support.
Reinforce deep-breathing and relaxation exercises.
Continue psycho-education.

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

Conversion disorder is a quite common In Nepal.

In Nepal traditional cultural beliefs of symptoms and causation often leads people to seek treatment from traditional healers. It is, however, important to respect cultural beliefs and indigenous healing practices although unnecessary and expensive rituals should be discouraged.

Symptoms can vary from person to person.

CD can be managed with psychosocial care. Medication may be required to treat underlying depression and/or anxiety disorder.

CHAPTER 9

ANXIETY DISORDER

Learning objectives

- Recognize common symptoms of anxiety disorder.
- Know the assessment principles of anxiety disorder.
- Know the management principles of anxiety disorder.
- Perform an assessment for anxiety disorder.
- Use effective communication skills in interactions with people with anxiety disorder.
- Assess and manage physical health conditions as well as anxiety disorder.
- Provide psychosocial interventions for people with anxiety disorder and their carers.
- Deliver pharmacological interventions as needed and appropriate, considering special populations.

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, case studies, discussions, group exercises.

Evaluation of the chapter by the participants

Materials

Flip chat, markers, pen & papers, reference manual, facilitator's guide.

Duration

1 hour 30 minutes

Session 1. Introduction to anxiety disorder

Time: 20 minutes

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

Ask the participants if they have come across or managed individuals with anxiety disorder. If yes, ask them to describe how they present to the health facilities and how they have intervened.

Project the slides on "Anxiety Disorder". Go through the introduction and quick overview sections.

Start with "Anxiety Disorder is one of the most common disorder with which patients present to a primary health care set-up."

State the types of anxiety disorders. However, anxiety disorder in the training is an umbrella term for all types of anxiety disorders and health workers should not differentiate the types.

Brainstorm: 5 minutes

Differentiate between fear and anxiety.

Divide the participants into 2 groups and ask them to write down on flipchart what fear means and the other group to illustrate what anxiety means.

Discuss and clarify the differences.

Session 2. Assessment of anxiety disorder

Time: 30 minutes

Symptoms of anxiety disorder:

- Generalized and persistent anxiety (i.e. anxiety occurring everywhere "free floating")
- Apprehension (worries about future misfortunes, feeling "on edge", difficulty in concentrating, etc.)
- Motor tension (restless fidgeting, tension headaches, trembling, inability to relax)
- Autonomic overactivity (lightheadedness, sweating, tachycardia or tachypnoea, epigastric discomfort, dizziness, dry mouth, etc.).
- May be accompanied by irritability, disturbed sleep, increased emotional sensitivity etc.

To diagnose a case of anxiety disorder:

Most of the symptoms listed above should be present on **most days** for at least **several weeks** at a time, and **usually for several months** affecting daily activity and behavior.

Neurological disorders, cardiac diseases, anemia, thyroid disorders, nutritional deficiency states, hypoglycemia, febrile illness/chronic conditions, alcohol and drug withdrawal should be ruled out. If any physical cause is suspected, referral needs to be considered.

Conduct a role play on anxiety disorder. One of the participant acts as a patient with anxiety symptoms and the other as a service provider in the health facility. Ask other participants to attend carefully and discuss on the presentation, assessment and management of anxiety disorder.

Session 3. Management of anxiety disorder

Time: 20 minutes

Project slides on management of anxiety disorder and discuss psychosocial and pharmacological interventions. Elaborate well.

Special considerations:

It is very common in general health clinics for patient with anxiety disorder to present with multiple physical complaints like non-specific aches and pains, dizziness, tingling (jham- jham) sensation of body. If a patient has multiple healthcare center visits, has been evaluated multiple times with all the relevant investigations which are normal, anxiety disorder needs to be considered and thorough evaluation done.

Pharmacological management with anti-depressant drugs:

Start **Cap. Fluoxetine 10 mg PO OD**. If there are no signs of improvement even after 6 weeks, dose can be increased to 20 mg/day. If still not improved with 20 mg/day after 6 weeks, referral may be needed**.**

For MBBS doctors: Dose can be increased up to 40 mg/day, with careful assessment of drug efficacy every 6 weeks.

Consultation with psychiatrist can be done to increase dose more than 20 mg, after which regular follow up for maintenance phase can be done from primary health care set-up itself.

Diazepam can also be added for initial 2 weeks as in depression when insomnia or restlessness is present.

Total duration of treatment:

Treatment for **6 weeks** then follow up, if symptoms have started improving continue same dose.
Continue the medicine for **at least 9 months after the symptoms have improved significantly.**
Prepare a follow up plan in consensus with the patient and/or family.

Session 4. Follow up

Time: 10 minutes

Highlight the clinical tip and explain the recommended frequency of contact.

Explain that at every follow-up session they must assess for any improvement or deterioration in the person's condition.

Possible presentations at follow up: Explain that at each follow-up session they may see the person either improving or remaining the same/deteriorating.

Whichever is the case, it is essential to keep communicating with the person and be flexible, adapting the intervention options as much as possible.

Monitoring people on antidepressants: Explain that if prescribing antidepressants, the participants should use the principles of psycho-education to ensure that the individual and the carer understand the risks, benefits, how to take the medication, and what signs to look out for and monitor. Talk through the points on the slide.

Explain that it usually takes approximately four to six weeks to feel the benefits of the medication.

Advise to follow up as recommended.

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering questions and facilitating a discussion.

Instructions:

- Administer the questions to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

Anxiety disorder is the most common mental disorder in Nepal.

Symptoms include apprehension, restlessness, autonomic hyperactivity, motor tension, fearfulness, somatic symptoms and disturbed biological functions.

Psychosocial and pharmacological interventions instituted appropriately can treat anxiety disorder.

CHAPTER 10

CHILD & ADOLESCENT MENTAL & BEHAVIORAL DISORDERS

Learning objectives

- Promote respect and dignity for children and adolescents with mental and behavioural disorders.
- Know common presentations of children and adolescents with mental and behavioural disorders.
- Know assessment principles of child and adolescents with mental and behavioural disorders.
- Know management principles of child and adolescents with mental and behavioural disorders.
- Use effective communication skills in interactions with children and adolescents with mental and behavioural disorders.
- Perform an assessment for children and adolescents with mental and behavioural disorders.
- Assess and manage physical conditions of children with mental and behavioural disorders.
- Provide psychosocial interventions to children and adolescents with mental and behavioural disorders and their carers.
- Deliver pharmacological interventions as needed and appropriate to children and adolescents with mental and behavioural disorders.
- Plan and perform follow-up for children and adolescents with mental and behavioural disorders.
- Refer to specialists and link children and adolescents with mental and behavioural disorders with outside agencies where available.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of the chapter by the participants

Duration

2 hours 45 minutes

Session 1. Introduction to child and adolescent mental and behavioural disorders

Time: 30 minutes

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

Local perspectives: Ask participants to explain how the community perceives and understands children and adolescents with mental and behavioural disorders. Ask participants to reflect on the sort of treatment and care children and adolescents with mental and behavioural disorders receive.

Public health concern: Explain that children and adolescents constitute almost a third (2.2 billion individuals) of the world's population and almost 90% live in low- and middle-income countries. Currently 10–20% of children and adolescents worldwide live with mental and behavioural disorders.

Explain that CMH is a public health concern.

Emphasize that with early identification and treatment, the prognosis for a child/ adolescent with mental and behavioural disorders can improve drastically and change the course of a person's entire life.

Explain that children/adolescents with mental and behavioural disorders face major challenges with stigma, isolation and discrimination as well as lack of access to health care and educational facilities.

Talk through the points on the slide and add any other examples of stigma, discrimination and abuse that participants think of.

Explain that the impact of this stigma and discrimination is long lasting.

Group work: Common presentations of developmental, behavioural and emotional disorders

Duration: 20 minutes.

Purpose: Create an interactive discussion between participants whereby participants use the master chart in the mhGAP-IG to learn about the common presentations of children and adolescents with developmental, behavioural and emotional disorders.

Instructions:

- In plenary discussions, show the participants the following four case histories from slides.
- Show one case history at a time and after reading through the history from the slides, and ask the participants to match the descriptions in the case history with those in table of the chapter: Common presentations of child and adolescent mental and behavioural disorders by age group.

Elaborate the common presentations of developmental, behavioral and emotional disorders by age group in children and adolescents.

Discuss on developmental, behavioral and emotional disorders through the slides.

Session 2. Assessment of child and adolescent mental and behavioural disorders

Time: 40 minutes

Read through the assessment principles.

Although we will look at the assessments individually, for now it is important to understand that many children or adolescents who present may have multiple and overlapping symptoms, therefore it is important to carry out a thorough assessment that looks at all areas of the child/adolescent's behaviour and environment.

Explain to participants that this is particularly true for the assessment of the home environment and school environment. When caring for children and adolescents with mental and behavioural disorders it is important to assess the role that the home and family environment may be having on the child/adolescent.

Explain to participants that there are **three core pieces** of information that should be understood when assessing a child/ adolescent for developmental disorders.

1. Does the child/adolescent have problems/difficulties in developmental domains? Remind participants what the developmental domains are (from the discussions at the beginning of the session). If there are problems/difficulties across developmental domains then they should suspect developmental delay/disorder and assess for:
2. Any physical conditions that could explain these problems/difficulties in developmental domains.
3. Any visual and/or hearing impairments.

If the findings for **points 2 and 3** are **yes** then those conditions should be treated, and the person should be referred to a specialist as appropriate. If the answers to **point 1** is **yes** then there are signs of developmental disorder and the participants should manage the disorder using the principles described in Protocol 1.

Emphasize that developmental milestones are used as indicators (targets) of development.

Developmental milestones refer to age ranges by which most children have learned specific skills (sitting up, standing up alone, walking, understanding instructions, using words, etc.).

As you reveal the core pieces of information that need to be understood in order to assess for problems with behaviours.

ADHD:

1. Explain that to assess for problems with inattention and hyperactivity the participants need to understand if the child is overactive, unable to sit still for long, easily distracted, has difficulties completing tasks, moves restlessly?

2. Do those problems remain in all settings or do they only happen at home? Or at school?
3. Are there physical conditions that could resemble these symptoms?

If the answer to point 3 is yes then the physical condition needs to be treated. If the majority of the answers to these questions are yes then ADHD should be suspected and participants should go to Protocol 3.

If the majority of the answers to these questions are **no** then ADHD is unlikely but there remains a problem with behaviours, so participants should go to Protocol 2

Conduct Disorder: As you reveal the points of the slide, ensure that participants are following the assessment algorithm.

1. Explain that to assess for conduct disorder the participants need to learn if the child shows repeated aggressive, disobedient or defiant behaviour?
2. Are these behaviours persistent, severe and inappropriate?

If the majority of the answers to these questions are **yes** then conduct disorder is suspected and participants should go to Protocol 4.

If the majority of the answers to these questions are **no** then conduct disorder is unlikely, but there remains a problem with behaviours and participants should go to Protocol 2.

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out the information they need, especially questions they could ask to find out about the different behaviours. Create a list of the possible questions. Hang those questions up on the wall.

Emotional Disorders: Is the child/adolescent experiencing prolonged, disabling distress involving sadness, fearfulness, anxiety and irritability?

Do these symptoms severely impact on the child/adolescent's ability to function in daily life?

Are there physical conditions that can resemble or exacerbate these emotional symptoms?

If the majority of the answers to **points 1 or 2** are **yes** then the participants should go to Protocol 6 for the management of emotional disorders.

If you suspect depression then go to the chapter: Depression in the manual.

If the child/adolescent has problems with emotions but they are not severely impacting on the child/adolescent’s ability to function then they should go to Protocol 5.

Facilitate a five-minute brainstorming session with the whole group. Ask participants to suggest possible questions they could use to find out the information they need. Create a list of the possible questions Hang those questions up on the wall.

Read through the list of possible questions and add them to the list produced by the participants.

Talk the participants through the assessment algorithm questions for assessing depression.

Highlight again that participants should always rule out a history of mania or manic episodes when assessing for depression.

They should also explore if there has been a major loss in the past six months.

Although depression is common amongst adolescents it is important to also assess for other MNS conditions as well. Ask participants what other priority MNS conditions they believe children and adolescents can experience? Give them two or three minutes to answer before revealing the answers in the next slide.

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

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

Children/adolescents do not grow up in isolation – they have so many competing influences on their environment at home, in school and in the community and these influences need to be understood and included when assessing the child/ adolescent.

Explain the first aim of the home environment assessment. Ask participants how they could assess for this? What questions could they ask? Who could they ask? How could they find this out? Give them a few minutes to answer and then direct them to the clinical tips on the manual.

Ask who they live with? What are the family relationships like? Does it feel like a safe environment? Ask them to describe a typical day at home, what do they do, who are they with etc. That is a useful way to establish what happens in the home environment.

Talk through the points on the slide and emphasize that if the home environment is not distressing and there is no evidence of maltreatment then try and understand if the carer is capable of offering care and support to a child/adolescent with mental and behavioural disorders?

Does the carer have an MNS condition?

Does the carer need further support?

If the carer is able to offer care then is the home environment set up well? Does the child have opportunities to play, socialize, communicate, learn etc.

Assess the school environment accordingly.

Rule out possible secondary causes like nutritional deficiency including iodine deficiency, anemia, malnutrition and acute/chronic diseases. the underlying causes should be managed as per the IMCI guideline.

Also focus on assessment of visual and/or hearing impairment. Refer to a specialist if needed. Manage as per Protocol 1 if associated hearing or visual impairment.

Session 3. Management of child and adolescent mental and behavioural disorders

Time: 1 hour 10 minutes

Ask participants to briefly brainstorm what management interventions they think they could use to manage child and adolescent mental and behavioural disorders.

The protocols have a few interventions in common:

- Psycho-education to the child/adolescent and psycho-education to the carer/family.
- Promote well-being (including strategies to improve child behaviour).
- Carer support.
- Manage stressors.
- Link with community resources/liaise with teachers.

Explain each recommendation individually and answer queries.

Explain that first-line treatment should always be psychosocial interventions.

Refer to specialist for any pharmacological intervention.

Explain that what happens to children/ adolescents in their early years is critical to the kind of adult that they will become.

Psycho-education messages should emphasize the importance of the child/ adolescent:

- getting enough sleep
- eating healthily
- taking the time to be physically active and play
- the importance of education

- the importance of building friendships with people they trust
- avoiding the use of substances.

Acknowledge how difficult and stressful it is to care for a child/adolescent with mental and behavioural disorders but state that the child/adolescent is not to blame. They are not evil or cursed or even doing this deliberately.

They need patience, love, kindness and support.

It is vital to ensure that the carers understand how to protect the dignity and human rights of the child/adolescent and know which agencies they can approach if human rights are being breeched.

Role play: Psychosocial interventions

Duration: 20 minutes.

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

Situation:

- Rajnish (six) and his mother Sita have just heard that he has ADHD.
- The health-care provider will develop a treatment plan and deliver psychosocial interventions to Aziz and his mother including psycho-education.

Instructions:

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

Session 4. Follow-up

Time: 15 minutes

Describe the follow-up algorithm. Ask when they think someone should be referred to a specialist? What could they do if a specialist is not available?

Emphasize the importance of conducting routine assessments at every follow-up visit. Things can change very quickly in the life of a child/adolescent, so it is important to keep regularly monitoring what is happening to them, in their home life, in their social life, at school, etc.

If a child/adolescent has been started on any pharmacological treatments, ensure that they are being monitored closely. Ensure that parents and carers and teachers know and understand what side-effects

to look out for. Facilitate a brief brainstorming session (maximum five minutes). Can participants identify any barriers to providing follow-up care to children/adolescents? How could they overcome those barriers?

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- When assessing children and adolescents, always keep in mind the child's age (developmental stage) and the impact the problem is having on their ability to function in daily life.
- Developmental disorders present as the child showing delayed development in at least one domain of development.
- Behavioural disorders present as excessive over-activity, excessive inattention, disobedient, defiant and/or disturbed behaviours.
- Emotional disorders present as excessive sadness, fear, anxiety and/or irritability.
- In any assessment always assess the home environment and school environment to explore any stressors at home or in school that could be contributing to the child or adolescent's difficulties. Also, to assess if there are any external factors that may be causing the child's behaviour.
- Pay attention to the needs and the resources of the carer. Ensure that carers are supported enough so that they can help the child/adolescent.
- Link and co-ordinate with community resources and organizations including schools during the assessment and management of children and adolescents.
- Use psychosocial interventions to manage children and adolescents with mental and behavioural disorders.
- Follow-up with the children and their carers regularly as life can change quickly for a child.
- Remember that what happens in early childhood and adolescence can impact on that person for the rest of their lives.

DAY 5

Day 5			
Review of previous day **Child & Adolescent Mental & Behavioral Disorders continued** Assessment Management: Psychosocial Interventions	Self or group interaction PowerPoint presentation Experience sharing Discussion Role play	10:00 -10:15 AM 10:15 - 11:30 AM	Participant Psychiatrist
Tea Break		11:30-11:45 AM	
Child & Adolescent Mental & Behavioral Disorders continued Referral Follow up **Dementia** Introduction Quick overview Assessment	PowerPoint presentation Discussion PowerPoint presentation Case study Interactive Discussion Sharing experience	11:45 - 12:15 PM 12:15 - 13:00 PM	Psychiatrist
Lunch Break		13:00 -14:00 PM	
Dementia continued Assessment Management: Psychosocial Interventions and Pharmacological Interventions Follow-up		14:00 - 15:30 PM	Psychiatrist
Tea Break		15:30 - 15:45 PM	
Clinical/Hospital visit		15:45 - 16:45 PM	Psychiatrist
Review of the day	Discussion	16:45 - 17:00 PM	Participant

CHAPTER 11

DEMENTIA

Learning objectives

- Promote respect and dignity for people with dementia.
- Know common presentations of dementia.
- Know the assessment principles of dementia.
- Know the management principles of dementia.
- Perform an assessment for dementia.
- Use effective communication skills in interactions with people with dementia.
- Assess and manage physical health concerns in dementia.
- Provide psychosocial interventions to persons with dementia and their carers.
- Deliver pharmacological interventions as needed and where appropriate.
- Plan and perform follow up for dementia.
- Refer to specialists and link with outside agencies where appropriate and available.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of the chapter by the participants

Time

2 hours 15 minutes

Session 1. Introduction to dementia

Time: 15 minutes

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

Local terms: Write a list of local terms and descriptions for dementia and compare those with the presentations described in the reference manual. (Maximum five minutes)

What is dementia?

Explain the points on the slide.

Emphasize that dementia is **not** a normal part of ageing. Although it generally affects people over 65, people as young as 30, 40 or 50 can have dementia.

Explain that quite often people, and especially carers, think that their loved one's decline in functioning (i.e. starting to lose their memory and their ability to carry out daily tasks) is a normal part of ageing and so rarely seek care and support.

This can cause carers and family members a lot of stress as they often do not understand why their loved one is behaving the way they are and they do not know how to manage and help the person. Therefore, it is important to stress from the beginning of the module that caring for someone with dementia requires that you care for the carer as well.

Common presentations of dementia: Explain that dementia is caused by changes in the brain. The changes are usually chronic and progressive. People with dementia can present with problems in different aspects of functioning, as listed on the slide.

Explain that the most common type of dementia is **Alzheimer's disease**.

Explain that dementia can generally be described in stages: ealry, middle and late.

Early stage: At this stage, carers may notice these symptoms but minimize or ignore them, believing they are a normal part of ageing. Therefore, in non-specialized health settings, you may not see people with dementia until they are already in the middle stages.

Middle stage: Explain that because dementia is progressing, limitations and restrictions on what the person can and can't do are much clearer in the middle stage.

Late stage: Memory disturbances and emotion regulation is not only distressing for the person but is challenging for family members. By the later stages the physical impact of dementia becomes more obvious. Ask participants to imagine how this may impact on the person's life?

Human rights violations: Explain that people with dementia are frequently denied their basic human rights and the freedoms available to others. In many countries, physical and chemical restraints are used extensively in care facilitates for elderly people and in acute care settings, even when regulations are in place to uphold the rights of people to freedom and choice.

Impact on the family and carers: Explain that dementia is overwhelming for the person and their family and carers. Therefore, when treating individuals with dementia we have a responsibility to support the families and carers as well. The emotional and physical stress of looking after a person with dementia (especially in the middle and later stages) is difficult.

Explain that the socioeconomic impact of dementia is also overwhelming, including:

- direct medical costs
- direct social care costs
- costs of informal care (including carers having to take time off work etc.)

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

Explain that:

- Dementia is one of the major causes of disability in later life.
- Dementia is prevalent worldwide but is often misdiagnosed.
- 58% of all people with dementia worldwide live in low- and middle-income countries. By 2030, 75 million people will be living with dementia. By 2050 that number will rise to 132 million. Much of the increase is attributable to the rising number of people with dementia living in low- and-middle income countries.

Dementia in non-specialized health settings Explain that although there is no cure, but with early recognition, especially in non-specialized health settings, and supportive treatment, the lives of people with dementia and their carers can be significantly improved. Physical health, cognition, activity and the well-being of the person with dementia can also be optimized.

Highlight on the principles of care of dementia.

Session 2. Assessment of dementia

Time: 40 minutes

Communicating with patients with dementia: Read out the description on the slides and explain that it may be hard for a person with dementia to follow a conversation, so you will need to talk to the carer and the person about the symptoms to gain a full understanding.

Explain that as dementia progresses it will become harder to communicate. List the ways in which it is harder to communicate as stated on the slide.

Therefore, it is important to find other ways to build a relationship and communicate with the person with dementia.

This can be done by changing your verbal communication to non-verbal communication, e.g. being calm with the person, putting the person at ease wherever possible, and thinking about the environment in which you see the person (can it be familiar, somewhere where they feel safe). Give the person time and do not make them feel rushed. Ensure that you are visible and that they can see you clearly and hear you

clearly. Spend time with the person or work with the carer to understand the person's facial expressions and body language. When asking questions:

- Use closed questions.
- Give clear simple instructions.
- Give clues to try and help them find the words that they forget or allow them the time to find the words if they are forgetting them.

Communicating with carers: The carers may be overwhelmed and feel exhausted from caring for their loved ones.

Therefore, it is important to give them the time and space they need to explain the person's symptoms and explain what has been happening.

Talk through the points on the slide. Ask participants to think of some assessment questions they could ask the carer to assess if a person has dementia?

Talk through the questions on the slide and explain that the answers to these questions can help identify if the person's cognitive functioning has deteriorated. How well are they performing their everyday activities (compared with a few years ago)?

Then explain the key information learned from these questions:

Dementia usually starts later in life (e.g. 60 and 70 years old) although people in their 30s, 40s and 50s can also develop dementia. So, it is important to know when it started.

Onset is gradual over months to years. So, again, it is important to know when they first noticed the symptoms and whether the onset has been slow or fast?

Dementia is progressive. Once it starts it continually deteriorates, although the decline may be slow.

Usually, consciousness is not impaired in people with dementia.

Explain that **impairment of consciousness** can mean a number of different presentations, including fluctuating attention, to coma with only primitive responses to stimuli. The important aspect of an impairment of consciousness is that it is a change from what is normal for that person.

Principles of assessment of dementia:

1. Assess for signs of dementia.
2. Are there any other explanations for the symptoms:

- rule out delirium

- rule out depression (pseudo -dementia).

3. Evaluate for other medical issues.
4. Assess for behavioural or psychological symptoms.
5. Rule out other MNS conditions.
6. Evaluate the needs of carers.

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

Start at the beginning of the assessment algorithm.

Draw the participants' attention to the clinical tip that advises clinicians to interview key informants. Explain that we have looked at some questions that could be asked of carers in order to understand more about the person's symptoms.

Delirium resembling dementia: Delirium resembling dementia is a possible explanation for symptoms. Emphasize that it is possible for someone with dementia to have delirium at the same time. In which case treat the delirium and continue to assess and monitor for symptoms of dementia.

Depression resembling dementia: Ask group how depression can resemble dementia?

Give them a few minutes to answer and then reveal the explanation on the slide.

Explain that depression is common amongst the elderly but if they do not have depression they should also be screened for other priority MNS conditions such as psychoses.

Evaluation for other medical causes:

Ask participants: How should the health-care provider evaluate the person for other medical issues? Instruct the participants to read through step 3 of the assessment for dementia.

Highlight that: Looking for cardiovascular risk factors is very important considering that vascular dementia is the second most common cause of dementia.

Emphasize that:

- Signs of hypothyroidism can present as dementia.
- Head injury and stroke can cause dementia-like symptoms
- Syphilis and HIV can cause dementia
- Anemia and B12 deficiency can cause dementia

Assessing the carer: Remind participants of their responsibility to assess stress in the carer.

Link the carers with appropriate services to help them cope better with the situation.

Around 90% of people affected by dementia will experience behavioural and psychological symptoms. Behaviours such as wandering, night-time disturbance, agitation and aggression can put the person at risk. They can also be very exhausting for carers to manage.

Try to learn as much as possible about these symptoms from the carers.

Explain the behavioral and psychological signs and symptoms of dementia.

Session 3. Management of dementia

Time: 40 minutes

Explain that the management interventions for dementia differ slightly from other MNS conditions. Specifically, there is a focus on improving cognitive functioning; behavioural and psychological symptoms; and supporting the person to live well with their condition.

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

Talk through the different protocols.

Emphasize the importance of delivering psycho-education messages to the person and their carers.

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

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

Carer support:

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

Offer them support.

Empathize: acknowledge their frustrations but remind them to respect the dignity of the person.

Support them to find ways to manage their frustrations such as relaxation strategies, taking a short break etc.

List the different ways in which the health- care provider can support carers.

Ensure that participants read through the interventions in the reference manual.

Managing behavioral and psychological symptoms of dementia:

Explain that the list of behaviours in dementia are a common set of behaviours, psychological symptoms and difficulties with activities of daily living that many people with dementia experience.

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

Similarly, explain that repeated questioning, wandering, aggression etc. are very challenging behaviours and cause the person and the carer distress.

Research has shown that pharmacological interventions are largely ineffective or have serious side-effects for people with dementia. Therefore, psychosocial interventions must be used as first-line treatment options.

Pharmacological interventions

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

State that the participants should **not** consider acetylcholinesterase inhibitors (like donepezil, galantamine and rivastigmine) or memantine routinely for all cases of dementia.

Explain that they should only consider medications in settings where the specific diagnosis of Alzheimer's disease can be made **and** where adequate support and supervision by specialists and monitoring (for side-effects) from carers is available. However, they are not allowed to prescribe.

Emphasize that even if no medications are prescribed, there is much that can be done to improve the quality of life of the person with dementia and their carers.

Focus: Avoid i.v. haloperidol.

Avoid diazepam.

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

Antipsychotics should only be considered if:

- Symptoms persist despite providing psychosocial interventions.
- You assess that there is imminent risk for the person and/or carer.

Session 4. Follow-up

Time: 30 minutes

Discuss the follow-up algorithm from the slide.

Ask volunteers to read out the first decision-making step and options.

Have them suggest questions they could use to find out this information out?

Emphasize that the person MUST be followed up regularly, every three months.

There is currently no cure for dementia, therefore long-term monitoring is the best form of treatment.

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

Ask participants to suggest possible questions they could use to find this information out.

Emphasize that due to the progressive and degenerative nature of dementia, at each follow-up appointment the participants **must assess all the areas** as described in the reference manual.

This way they can assess if there has been deterioration in the person's cognitive, emotional, behavioural and physical functioning and how well they are managing to carry out the activities of daily living.

Explain that they will be practising doing this in a role play.

Role play:

Duration: 20 minutes.

Purpose: To practise using the follow-up algorithm to conduct a routine follow-up appointment including:

- Using effective communication skills.
- Offering routine follow-up assessments.
- Offering new psychosocial interventions to the person and their carer.

Situation:

- A patient with dementia has returned to your clinic three months later for a follow-up appointment along with his son.
- He explains that his father's behavior has deteriorated. He is now waking up at night and wandering around the house. One night last week he fell over a piece of furniture in the house and hurt his leg.
- He has also been going out of the house during the day and getting lost.
- One day it took him over 12 hours to find his father and when he did his father had not eaten or drunk anything all day and was weak and dizzy. He worries about what could have happened to him.

Instructions:

- Divide the participants into groups of four; one person is to play the role of the health- care provider, one son, one patient and one the role of the observer.
- Distribute the role play instructions to each person depending on their role.

- Ensure that the participants keep to the allotted time

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Dementia is not a normal part of ageing.
- Dementia is usually progressive – it gets worse over time.
- Symptoms of depression and delirium in older adults can mimic symptoms of dementia, therefore, a thorough assessment and regular follow-up is essential.
- It is critical to assess the carer's stress and psychosocial well-being and provide psychosocial support.
- There is much that can be done to improve symptoms and the living situation of people with dementia and their carers.
- Psychosocial interventions are the first-line treatment options for people with dementia; pharmacological interventions should not be routinely considered.
- Behavioural and psychological symptoms of dementia can be very distressing for the person and carer; therefore, developing treatment plans that address these symptoms are essential.
- Follow-up should be planned, at minimum, every three months.

Go to next session.

Clinical visit/Psychiatrist Case Conference/Clinical exposure

Duration: 1 hour

Ask the participants that they will be taken for a clinical visit to a nearby health facility.

Consult prior to the visit with the in-charge of the facility about the visit.

Advise them to listen to the experience from the service providers how they have been assessing and managing individuals with mental disorders in the health facility.

Demonstrate a live case under informed consent if feasible.

Discuss in the training hall once the clinical visit is over. Discuss in group what they have learned.

Summarize the session.

Day 6

Day 6			
Review of previous day **Disorders due to substance use** Introduction and relevant terminologies Quick overview Emergency	Self or group interaction PowerPoint presentation Discussion Experience sharing	10:00 - 10:15 AM 10:15 - 11:30 PM	Participant Psychiatrist
Tea Break		11:30 - 11:45 PM	
Assessment Management: Psychosocial Interventions and harmacological Interventions	PowerPoint presentation Discussion Experience sharing Role play	11:45 - 13:00 PM	Psychiatrist
Lunch Break		13:00 - 14:00 PM	
Disorders due to substance use continued Follow-up **Other significant mental health complaints** Introduction Quick overview Assessment Management Follow up		14:00 - 14: 20 PM 14:20 - 15:30 PM	Psychiatrist
Session on logistics, recording & reporting		15:30 - 15:55 PM	Psychiatrist
Tea Break		15:55 - 16:05 PM	
Post-test		16:05 - 16:20 PM	Psychiatrist
Closing ceremony		16:20-17:00 PM	

CHAPTER 12

MENTAL AND BEHAVIORAL DISORDERS DUE TO SUBSTANCE USE

Learning objectives

- Promote respect and dignity for people with disorders due to substance use.
- Know the common presentation of disorders due to substance use.
- Know the assessment principles of disorders due to substance use.
- Know the management principles of disorders due to substance use.
- Perform an assessment for disorders due to substance use.
- Use effective communication skills in interactions with people with disorders due to substance use.
- Assess and manage physical health in disorders due to substance use.
- Assess and manage emergency presentations of disorders due to substance use.
- Provide psychosocial interventions to persons with disorders due to substance use and their carers.
- Deliver pharmacological interventions as needed and appropriate in disorders due to substance use, considering special populations.
- Plan and perform follow up for people with disorders due to substance use.
- Refer to specialists and link with outside agencies when appropriate.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of the chapter by the participants

Duration

2 hours 50 minutes

Session 1. Introduction to mental and behavioral disorders due to substance use

Time: 25 minutes

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

Ask:

– Is substance use common in your society?

– What are the benefits of substance use?

– Are there harms?

– How does your community/society try to balance these benefits and harms?

– Do you agree with the approach taken by your society/community?

Take the opportunity now to define what we mean by alcohol and other substances.

Alcohol

- Alcohol is a psychoactive substance with intoxicating effects.

Opioids

- Opioids includes heroin, opium and prescription drugs such as oxycodone, codeine, morphine and many others.

Benzodiazepines

Benzodiazepines are tranquillizers and they include rohypnol, valium (called diazepam), alprazolam, temazepam and phenazepam.

Cannabis

Explain that cannabis can come in many forms.

The main active ingredient in cannabis is tetrahydrocannabinol (THC).

Stimulants

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

Tobacco

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

Summarize the types of common presentations that participants have already identified. Stress that in general people with substance use disorders will present with immediate concerns about their health or social problems. They will rarely state that they have a problem with substances.

People will present with physical health problems: liver disease, gastrointestinal problems, aches and pains.

- People will present with deterioration in their social functioning and often having many social problems – with work, school, in their studies, with their family and relationships.
- Often, they can smell alcohol, cannabis or tobacco. There may also be other signs of recent substance use including recent injection marks, skin infections etc.).
- Emphasize that often people with disorders due to substances may not present with any problems at all, instead they may return frequently requesting prescriptions for psychoactive medications, they may present with injuries (that they obtained whist using substances) and, in some cases, they may have infections associated with intravenous drug use such as HIV/AIDS, hepatitis C. Explain that at times people will also present as an emergency presentation.

Explain that one emergency presentation is **acute intoxication**. Ask participants for a definition of what we mean by acute intoxication before revealing the answer.

A second emergency presentation is **overdose**. Ask participants for a definition of what we mean by acute intoxication before revealing the answer.

The third emergency presentation is **withdrawal**. Ask participants to give a definition or description of withdrawal before revealing the answer.

Why do people use substance? Reveal the list on the slide and add these point to those highlighted by the participants.

Explain that the fact that people use substances does not always mean that they have a substance use disorder.

There are two types of behaviours that would denote a person has a problem with their substance use:

- harmful use
- dependence.

Encourage a discussion about what people think **harmful use** is before revealing the answers.

Encourage a discussion about what people think **dependence/addiction** is before revealing the answer.

Explain that dependence (sometimes called addiction) is a pattern of symptoms that include:

- Strong cravings – cravings are both physical and mental urges to take the substance – they can be very intense and very difficult to ignore.
- Long-term high level of use associated with: (a) increased tolerance (you need to take more to get the same effect); and (b) withdrawal symptoms if alcohol is stopped.
- Loss of control over alcohol consumption.
- Reduction in other activities which used to have meaning.

What causes withdrawal symptoms?

Then talk through the example of what causes the body to experience withdrawal symptoms. In this case, this is a description of how the body reacts to drug use. However, it can be applied to alcohol as well.

Explain that the neuroscience of substance tolerance, dependence and withdrawal is complicated.

This slide presents an extremely simplified explanation.

Explain that substance dependence is a disease.

Health effects of psychoactive substances: Explain that alcohol and drugs can affect the body and brain in numerous ways.

Effects of substance use on the family: Explain by talking through the lists on the slide that these are some of the effects that substance use can have on a family. These effects look at whether the parent is the person with the substance use disorder or the child. In both scenarios, the family environment can be destabilized which can negatively affect any siblings and the wider family and community.

Global impact of alcohol use: Talk through the statistics on the slide explaining that alcohol is widely used in many cultures. The harmful use of alcohol causes a large disease, social and economic burden in societies. The harmful use of alcohol is a component cause of more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries. 3.3 million global deaths each year can be attributed to alcohol use. In 2012, 5.1 % of the global burden of disease and injury were attributable to alcohol consumption. The level and severity of alcohol related harm is influenced by the quantity of alcohol available in a country, and, in some cases, the quality of that alcohol.

Global impact of drug use: Talk through the points on the slide, explaining that it is estimated that a total of 250 million people, or one out of 20 people between the ages of 15–64, used illicit drugs in 2014. One in 10 of those people are suffering from a form of drug use disorder including drug dependence. Almost half of those people with drug dependence inject drugs, more than 10% are living with HIV and the majority are infected with hepatitis C. Drug use disorders are a major global health problem.

Role of primary health-care providers: Explain that unfortunately outdated views about substance use disorders persist in many parts of the world.

The stigma and discrimination that is commonly applied to substance dependent individuals and professionals working with them have significantly compromised the implementation of quality treatment interventions, undermining the development of treatment programmes and training of health-care professionals.

Even though the evidence clearly shows that substance use disorders are best managed in a public health system, the inclusion of substance use treatment programmes in health care is very difficult.

Session 2. Assessment of mental and behavioral disorders due to substance use

Time: 40 minutes

Explain to participants that there are two ways that people can present with disorders due to substance use in primary health care:

1. As an **emergency presentation** in a state of:

- **withdrawal**
- **intoxication**
- **overdose**.

2. With signs and symptoms of **prolonged, harmful patterns** and/or **dependence**.

Talk through the principles of assessment.

Explain that if it is not an emergency presentation then the assessment seeks to establish:

- Does the person use psychoactive substances ?
- Is there harmful use?
- Does the person have substance dependence ?

Brainstorming session

Reiterate that asking about substance use can be a sensitive topic. Ask participants to suggest open-ended questions they could use to initiate a conversation about someone's substance use.

Make a list of their questions.

Reiterate that there is a lot of shame and stigma attached to substance use therefore people may be very reluctant to talk about it. Ask participants to think what they could do to overcome that reluctance?

Asking about substance use: Explain that they can

- Carry out thorough physical examinations especially on the liver.
- Talk to a family member or a carer (with their consent).
- Conduct an assessment into the person's social history, psychosocial stressors and coping mechanisms.

1. Discuss how the health-care providers should establish whether the person uses substances?
2. Ask participants if they think the man's substance use is **harmful**:

a. How many days per week does the person use the substance? How much do you use per day?
b. Does the substance cause any problems for the person?

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

Ask the participants to answer the following questions:

- Does the man have high levels of frequent use?
- Does he have a strong craving?
- Is there difficulty self-regulating?
- Has he noticed that he is becoming more tolerant of the substance (e.g. does he need a bigger quantity of substance to feel the same affects than before?
- Does he show any signs of withdrawal?

Highlight that if dependence or harmful use is likely it is important to consider if there is an imminent risk of suicide.

Session 3. Management of mental and behavioral disorders due to substance use

Time: 1 hour

Ask participants to suggest any management interventions they can think of or they have used to try and help a person with a substance use disorder?

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

Ask participants to think why the motivation of the person is so important in treating substance use?

Ask a participant to read out loud the management interventions for **harmful use** (Protocol 1) from the reference manual explaining that these are the options in any treatment plan for someone with harmful substance use.

Explain that, as with all MNS conditions, psycho-education is a priority. Explain how the substances are harming the person physically, socially and psychologically as they may not be aware of it.

Support the person to address any immediate social needs and ensure they are safe, i.e. if they need access to food, shelter, clothing etc.

Ask another participant to read out loud **dependence** (Protocol 2). Explain that the management options available for harmful use and dependence are similar, except in people with dependence there is an option to facilitate a safe withdrawal and detoxification.

Psychosocial interventions: Give the participants time to read through the psycho-education interventions and motivational interviewing. Stress that brief interventions using motivational interviewing are typically 5–30 minutes long and aim to assist an individual cease or reduce their use of a psychoactive substance and or deal with other life issues that may be supporting their use of substances.

It seeks to empower and motivate the person to take responsibility and change their substance use behaviour. It can be extended for one or two sessions to help people develop the skills and resources to change or be used in follow-up.

Motivational interviewing: Describe the points on the slide. State that we are now going to look at the different techniques that can be used in motivational interviewing.

A person's motivation to change any pattern of behaviour can be complicated and pass through different stages.

- Stage 1 is understanding why the person wants or needs to change.
- Stage 2 is planning and making the changes.
- Stage 3 is maintaining those changes and coping with any lapses or relapses.

Stage 1: Understanding the need to change- Explain that stage 1 involves helping the person explore their desire to change.

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

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

Step 3: Reasons for their substance use- If the person recognizes that they use substances as a response to other priority MNS conditions and or psychosocial stressors in their life, then continue to

explore why they use substances in a response to those. What does the substance do? How does it help them? What are the perceived benefits of substance use?

Step 4: **Consequences of their substance use-** Ask participants to think about the consequences of their substance use. Having explored their reasons why, ask them what are the consequences of their substance use on themselves (physically, mentally and socially)? What are the consequences on other people (their family, friends, spouse, at work, in their studies etc.)?

Stage 2: **Planning and making changes-** Explain that once the person has decided to make a change then we move to stage 2, which involves supporting the person to plan and to make the changes they need to. Help them set realistic goals and targets. Keep them motivated to make those changes. Discuss the different options that the person has – to make the changes they need to. Explain that in the next few slides we will look at what the health-care provider can do.

Step 5: **Personal goals-** Explain the points on the slide.

Step 6: **Have a discussion-** Explain the points on the slide and emphasize that throughout motivational interviewing, it is important to use communication skills such as summarizing to help people explore how their substance use is impacting them. By using their words and their descriptions you can gently highlight any contradictions in their explanations and motivate them to want to change their behaviour.

Step 7: **Discuss options-**If someone is very motivated and enthusiastic to change they can easily state that they are going to make some unrealistic changes. For example, a person with a dependence on alcohol explaining that they will just stop drinking for good the next day. Although their motivation should be supported they need to have more realistic goals or else they could be setting themselves up for failure. Instead, work with them to find some strategies they could do to reduce their substance use or discuss with them the option of doing a controlled substance withdrawal.

Step 8: **Support the person enact the changes-** Explain the points on the slide.

Stage 3: **Maintaining the change-** Explain that once the person has planned and implemented the changes they want, the final stage is maintaining the change.

Changing a pattern of behaviour (especially a behaviour that has been happening for years, decades and lifetimes) can be very difficult.

It is very common for a person to relapse and slip back into their old behaviour patterns. This is especially so if they are still seeing the same triggers (social events, people, places) where they used to drink alcohol, smoke or use drugs.

Therefore, the maintenance stage is about supporting the person to cope with the relapses, being non-judgmental and helping them make the changes again.

People can spend years in this stage.

Strategies for reducing and stopping use

Explain that if after using motivational interviewing the person identifies that they want to try reducing or stopping their substance use, discuss with them how they might do that.

- Listen to them to help them identify triggers for their use, e.g. social settings in which they use the substance.
- Listen and help them identify emotional cues for their use, e.g. they use substances when they are depressed, they use substances when they are stressed.
- Encourage them to not have any substances in their home at all.

If they struggle ask, "When do you feel the greatest urge to use the substance? When you last used the substance what was happening in your life? Were you having any problems?"

Mutual help groups

If, after motivational interviewing, a person identifies that they feel support from peers would help them to stop using substances then explain that there are mutual help groups such as Alcoholics Anonymous and Narcotics Anonymous.

Strategies for preventing harm

If, after motivational interviewing, a person feels that they are not ready to stop or reduce their alcohol consumption then encourage them to look for ways to minimize the risks involved. For example, they must not drive when intoxicated. They should try and eat food when they use alcohol. They could try changing the type of alcohol they drink to something less strong. If they are injecting opioids, they should ensure the needles are clean, and they should never share a needle with other people.

Carer support

Remind participants of the stories at the beginning of the session and of the stress and impact that alcohol use has on the family, friends and community. As a result, carer support is essential. Offer psycho-education to carers and family members. Assess the immediate needs of the family members including their health, mental health and social needs. If possible, try to meet those needs or link carers and families with other organizations that can meet those needs.

Understanding the role of medications in substance use disorder:

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

Emphasize the importance of understanding which medications should be used in which intervention. Emphasize the importance of understanding dosing and side-effects.

Session 4. Follow-up

Time: 15 minutes

Explain that it is important to follow-up regularly with people who have a disorder due to substance use. This is especially important if they have decided to reduce or cease using substances. Remember to be non-judgmental, especially if they have lapsed.

At every visit, it is important to consider the individual's level of motivation to stop or reduce their substance use.

emotional support to make the commitment every day to not use substances.
Caring for people Changing a person's relationship with a substance requires a daily level of commitment and determination, as it can mean a person changing their normal behaviours.
And, therefore, they need support replacing those activities, finding new things to do, and the
with disorders due to substance use can seem intensive and slow but with encouragement people can recover.

Session 5. Emergency presentations

Time: 15 minutes

Explain that the principles of conducting an emergency presentation:

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

Remind participants that as with any emergency presentation then assessment and management must happen quickly and simultaneously.

Give the participants time to read through common emergency presentations of people with disorders due to substance use.

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

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

Highlight the different assessment and management steps for different substances.

Does the person appear confused? Talk through the steps describing what to do to assess someone who presents in a state of confusion.

Highlight the different assessment and management steps for different substances.

Explain that when responding to an emergency it can be very easy to become focused on a single task and neglect other tasks.

But remember that, where possible, find out if the person has been using substances.
If the person has presented by themselves then ask if other people in the area know them.
Try and find out which substance they may have used and how much.
Asking these questions could save a life.

Session 6. Review

Duration: 10 minutes.
Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.
Instructions:

- Administer the MCQs
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Substance use disorders are associated with health and social problems.
- People with substance use disorders can present as:

– acute intoxication
– overdose
– withdrawal from substance use
– harmful uses
– ependence.

- All health-care providers can make a difference. It is important to ask people about their substance use.

- The withdrawal features from alcohol and benzodiazepines can be life threatening. Ensure that you closely monitor and help people who are withdrawing from substance use and refer to hospitals when required.
- Assess and treat the physical health of people with disorders due to substance use.
- Use psychosocial interventions, including brief motivational interviewing to explore a person's motivation to stop using substances.
- Provide pharmacological interventions when appropriate.
- Offer care and support to the family and carers of people with disorders due to substance use.
- Offer regular follow-up to people with disorders due to substance use.

CHAPTER 13

OTHER SIGNIFICANT MENTAL HEALTH COMPLAINTS

Learning objectives

- Promote respect and dignity for people with other significant mental health complaints.
- Know the common presentation of other significant mental health complaints.
- Know the assessment principles of other significant mental health complaints.
- Know the management principles of other significant mental health complaints.
- Perform an assessment for other significant mental health complaints.
- Use effective communication skills in interaction with people with other significant mental health complaints.
- Assess and manage physical health in other significant mental health complaints.
- Provide psychosocial interventions to persons with other significant mental health complaints and their carers.
- Know there are no specific pharmacological interventions for other significant mental health complaints.
- Plan and perform follow-up for other significant mental health complaints.
- Refer to specialists and links with outside services for other significant mental health complaints where appropriate and available.

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of the chapter by the participants

Time

1 hour 10 minutes

Session 1. Introduction to other significant mental health complaints

Time: 10 minutes

Read through the description on the slide and then explain that the manual covers a range of priority MNS conditions. However, there remain other significant mental health complaints that you will see in your clinical practice that may appear similar to priority MNS conditions (such as depression) but are actually distinct.

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

Common presentations: The most common presentations of people with other significant mental health complaints are as listed in the slide. These are complaints frequently seen in non-specialized health settings.

Difference between depression and other significant mental health complaints: Explain that the distinction between other significant mental health complaints and depression needs to be explored carefully. Read out the points on the slide. Emphasize that the chapter on depression covers the treatment of depression, whereas this chapter includes symptoms of depression not amounting to depression. Explain that people can experience symptoms of depression but not have considerable difficulty with daily functioning. Thus, their symptoms do not amount to depression and they can be assessed and managed using this chapter. Emphasize that the distinction is important as symptoms of depressed mood that do not amount to depression should not be treated with antidepressants but only with the psychosocial interventions described in this chapter.

Stress and other significant mental health complaints: Explain that stress is a normal reaction to stressors. Everyone can feel stressed. Stress can be a useful response as it can be a motivator that drives people to focus, take action and make decisions in their life. However, many people can become overwhelmed by stress and that starts to impact on their ability to cope in daily life. In non-specialized health settings, stress can present with emotional, cognitive, behavioural and physical symptoms.

Medically unexplained somatic symptoms: Explain the points on the slide which are the common presentations of someone with medically unexplained somatic symptoms. Much of the experience that someone with medically unexplained symptoms feels is **pain**. But, they can also be characterized by: excessive negative thinking, worries and anxieties about what is happening to them and what is happening in their life; tiredness, low mood, hopelessness, loss of interest, weight loss and changes in appetite.

Impact of medically unexplained somatic complaints on the individual: Explain to participants that also when a physical explanation for their symptoms cannot be found the symptoms that people experience

are real to the person. To understand the symptoms and the level of distress it is essential to be patient, use effective communication strategies and ask about how they impact on the person's ability to function and in their daily life. It is also important to be empathic and think how hard and stressful it must be to not know what is wrong with you yet continue to feel unwell.

Summary of common presentations: Summarize the common presentations of people with other significant mental health complaints as listed in the slide. It is important to ensure that another priority MNS condition is not present.

Session 2. Assessment of other significant mental health complaints

Time: 20 minutes

Assessing someone with other significant mental health complaints: Start this session by explaining that assessing people with other significant mental health complaints can be challenging, especially if they are returning frequently with medically unexplained somatic symptoms. Talk through the list of challenges listed on the slide. Facilitate a brief discussion (maximum five minutes) about why people with other significant mental health complaints may behave like this.

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

Do the activity before showing the answers on the slide.

Duration: 10 minutes maximum.

Materials: Flip chart and markers.

Instructions:

- Make a two-column table on the flip chart with the headers: DOs, DON'Ts.
- Ask participants to share their thoughts, record their answers (do not record wrong answers), then show the answers on the slide.

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

The **first step** is to assess if there is a physical cause that fully explains the presenting symptoms.

The **second step** is to assess for another priority MNS condition. Ask participants if patient could have depression? Or any other priority MNS condition?

The **third step** is to assess for impact of symptoms on daily functioning.

What questions could health-care providers ask to learn more about this?

Explain that participants could ask:

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

The **fourth step** is to explore exposure to extreme stressors.

Finally, it is important to ask about plans or thoughts of self-harm/suicide.

Session 3. Management of other significant mental health complaints

Time: 20 minutes

Ask participants to suggest which management principles they could use to manage a person with other significant mental health complaints?

List the possible interventions.

Highlight that there are no pharmacological interventions in the manual for the management of other significant mental health complaints.

Explain that for everyone with other significant mental health complaints use Protocol 1 for management.

For people who have been exposed to extreme stressors use Protocols 1 and 2.

Protocol 1: Read through the first two bullet points in the protocol and facilitate a brief discussion on why it is important not to prescribe anti-anxiety or antidepressant medication.

Why is it important **not** to prescribe vitamin injections?

Avoid inappropriate medications:

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

Explain that vitamin injections work as a placebo and do not help the person get to the root cause of what is happening to them and therefore should not be prescribed either.

The health-care provider should discuss self-medication with the person and deliver appropriate advice.

Self-medication is typically not advisable.

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

In **all** cases address current psychosocial stressors, strengthen social supports and teach stress management.

Move on to the next slide to discuss how to address current psychosocial stressors.

How to address current psychosocial stressors: Explain that some psychosocial stressors can be ongoing (e.g. sexual violence, domestic abuse) and sometimes they can help stop it. Problem-solving and relaxation exercises should be tried and strengthening social supports may also help reduce suffering. Explain that providing assistance with current psychosocial stressors may help to relieve some of the symptoms.

Explain that the health-care worker should involve community services and resources as appropriate (e.g. with the person's consent). It may be necessary and appropriate to contact legal and community resources (e.g. social services, community protection networks) to address any abuse (e.g. with the person's consent).

Remind participants of the problem-solving technique.

Explain that this is a very useful and quick technique that they can use to support people to address many psychosocial stressors.

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

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

Activity: Relaxation and stress management

Duration: 10 minutes

Purpose: To have participants practise using different relaxation techniques and support them to find techniques that they feel comfortable with and find helpful.

Instructions:

- Explain that using breathing and relaxation techniques are short and effective interventions that anyone can use anywhere.
- Explain that working in non-specialized health settings is a very stressful job and there are probably many moments throughout the day when they find themselves feeling very stressed and unable to cope.
- If that happens, encourage the participants to use these breathing/relaxation activities on themselves and learn how beneficial they can be.
- Practise using the relaxation exercise on the reference manual in plenary.

Use psycho-education to explain what you are doing at every stage of the treatment plan.

Psycho-education is particularly important when managing physical conditions and somatic complaintswith no physical cause.

In such cases it is important to:

- Avoid ordering more laboratory or other investigations unless there is a clear medical reason.
- In case further investigations are ordered anyway ensure that you reduce any unrealistic expectations that the person may have and prepare them for the fact that the test results may be normal. Support the person to understand that no serious physical condition has been identified, which is a good thing, remember to communicate that even though there is no physical condition there are still psychosocial interventions that can help.
- If the person insists on more tests gently explain that running unnecessary tests can potentially cause the person harm and create worrying side-effects.
- It is important to acknowledge that the symptoms are not imaginary and that it is still important to address symptoms that cause significant distress.
- Ask the person for their own explanation of the cause and the symptoms and listen to their concerns. This can give you clues about the source of the distress and how the person is understanding what is happening to them. Build a supportive and trusting relationship with the person.
- Explain that emotional suffering/stress often involves the experience of bodily sensations, such as stomach aches, muscle tension, etc. Ask the person about potential links between psychological distress and physical distress.
- Encourage the person to engage in daily activities.
- Remember to address current psychosocial stressors, strengthen social support and relaxation techniques.

Protocol 2: Direct participants to Protocol 2. Emphasize that if a person has been exposed to an extreme stressor you will follow Protocols 1 and 2.

It is essential **not** to pressurize the person to talk about the potentially traumatic event. If they want to talk about it then you can listen but do not force them to talk.

Explain that the first steps are to:

Ask about social needs: Ensure that the person's social needs – ensure that they have access to food , shelter, safety, clothes, water and all the basic needs that a person requires to survive.

Help: If they do not have their basic needs met then link them with agencies and people that can help them and ensure that those needs are met.

Protect: Make sure that the person is safe. Talk with them about where they feel safe, discuss risk plans, telephone numbers they can call and link them with family members, other organizations, etc that can help ensure they are not exposed to more harm.

Encourage: Talk to them about the importance of trying to engage with other normal activities as a way of making them feel better; keeping to a routine and/or engaging with other people, being distracted by work and school, all of these things are important for the person.

In case of the loss of a loved one, discuss and support culturally appropriate adjustments and/or mourning processes. Ask participants to brainstorm ways that they could support a person to mourn? How could they make it culturally appropriate?

Ask a different volunteer to read out the steps to manage a person in the case of reactions to exposure to a potentially traumatic event. Highlight that they should refer to a mental health specialist for PTSD, if available.

Session 4. Follow-up

Time: 10 minutes

Ask a participant to read out loud the assessment algorithm.

Ask participants to reflect on how they would react if the person insists on further tests and investigations.

Emphasize that it is important that participants follow-up with the person even if they did not prescribe medication.

Feeling cared for and accepted can help the person.

It is not failure if the symptoms do not improve.

You can help the person by simply showing understanding and building trust.

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

Session 5. Review

Duration: 10 minutes

Purpose: To review the knowledge and skills gained during this training session by delivering MCQs and facilitating a discussion.

Instructions:

- Administer the other MCQs to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

Key messages

- Common presentations of other significant mental health complaints include: depressed mood, irritability, anxiety, stress, extreme tiredness, unexplained physical complaints.
- Other significant mental health complaints are frequently seen in non-specialized health settings, but are often treated inappropriately, with excess investigations and inappropriate medications.
- When assessing a person for other significant mental health complaints ensure to rule out any physical causes for the symptoms.
- Ensure that the person does not have another priority MNS condition.
- Exposure to extreme stressors such as major loss or traumatic events can create acute stress and grief reactions in individuals. Those reactions are normal but if they impact on a person's ability to function or last for longer than is culturally expected the person may need to be referred to a specialist.
- In all people with other significant mental health complains, reduce stress, strengthen social supports and teach stress management such as relaxation techniques.
- Symptoms of depression that do not amount to a depression should not be treated with antidepressants but with psychosocial interventions.
- Be non-judgmental and empathetic when caring for people with other significant mental health complaints.

CHAPTER 14

LOGISTICS, RECORDING AND REPORTING

Learning objectives:

Have an overview of logistic supply of the mental health program and be able to record and report mental disorders according to the HMIS of Nepal Government

Have an evaluation of knowledge on mental health post training

Materials

Newsprints, metacards, board markers, pen, notebooks, reference manual, Facilitator's Guide, Mental Health OPD registers, HMIS indicators of mental health

Methodology

Introduction exercises, lecture, powerpoint presentation, brainstorming, discussions, group exercises

Evaluation of training by the participants

Duration

1 hour 30 minutes

Instructions to the trainers

Ask the allotted participant to review the sessions of the fifth day over 15 minutes.

Clarify if there is any confusion in understanding of the participants. Proceed to the session on logistics, recording and reporting.

Distribute the mental health OPD registers and a copy of HMIS indicators of mental health.

Teach them how to fill the OPD register.

Describe how to report in HMIS.

Demonstrate the Essential Drug List and psychotropic medications included in the list.

Conclude the session.

Tea Break: 10 minutes

Post-test:

Explain that post-test will be conducted to know the changes in knowledge of the participants after the training.

Distribute the questionnaires to the participants.

Highlight on mentioning the names and designated health facilities of the trainees. Elaborate the sections of questionnaire and on how to answer the questions.

Allot 20 minutes for the test.

Clarify confusion in any questions.

Collect the questionnaires once completed.

Closing ceremony and certificate distribution:

Duration: 40 minutes

Closing remarks from organizer, trainer and trainee

Certificate distribution

ANNEX

A] Pre- and post-test questionnaire

1. Which of the following is considered a core effective communication skill? Choose the best answer:

A] Speaking to the person only and not the carer

B] Start by listening

C] Using an open space for safety

D] Limited eye contact

2. Which of the following is consistent with promoting respect and dignity for people with an MNS condition? Choose the best answer:

A] Making decisions on behalf of a person with an MNS condition, with their best interests in mind

B] Using correct medical terminology to explain things, even if complicated

C] Ensuring consent to treatment is received from the carer and/or family

D] Ensuring privacy in the clinical setting

3. Which of the following cluster of symptoms best fits with an episode of depression? Choose only one answer:

A] Marked behavioural change, agitated or aggressive behavior, fixed false beliefs

B] Decline in memory, poor orientation, loss of emotional control

C] Inattentive, over-active, aggressive behavior

D] Low energy, sleep problems, and loss of interest in usual activities

4. Which of the following is a good combination treatment for depression?

A] Vitamin injections and increasing exercise

B] Psychosocial interventions and an antidepressant

C] An antipsychotic medication and a mood stabilizer

D] Hypnotherapy and relaxation

5. Which of the following cluster of symptoms fits best with an acute manic episode? Choose only one answer:

A] Confusion, disorientation to time, place and person, marked functional decline

B] Admits to consuming alcohol, has slurred speech and uninhibited behavior

C] Has recently stopped taking regular benzodiazepines, and presents with agitation, sweating and poor sleep

D] Decreased need for sleep, increased activity and reckless behaviour

6. Which of the following statements concerning psychosis and bipolar disorder is correct? Choose the best answer:

A] People with psychosis or bipolar disorder do not need evaluation for medical conditions

B] People with psychosis or bipolar disorder are best cared for with long-term hospitalization

C] People with psychosis or bipolar disorder are unlikely to be able to work or contribute to society

D] People with psychosis or bipolar disorder are at high risk of stigmatization and discrimination

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

A] Encourage participation in daily activities but recommend against work or serious relationships as they may be too stressful

B] Discuss with the carer and family whether long-term institutionalization may be appropriate

C] Provide psychoeducation, especially to avoid sleep deprivation, stress, and drugs and alcohol

D] Discuss with the carer different ways that they might be able to challenge the delusions of the person

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

A] Epilepsy is a communicable disorder of the brain

B] Epilepsy is a sign of spirit possession

C] Epilepsy is always genetic in cause

D] Epilepsy is one of the most common neurological disorders

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

A] When someone starts to feel that a seizure is imminent

B] If the seizure lasts for more than 1 minute

C] If the seizure lasts for more than 5 minutes

D] If the person is drowsy once the seizure is over

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

A] Child developmental disorders have a relapsing and remitting course

B] Child developmental disorders are always associated with abuse and neglect

C] Child developmental disorders category includes attention deficit hyperactivity disorder and conduct disorder

D] Child developmental disorders involve impaired or delayed functions related to central nervous system maturation

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

A] The carer can use threats or physical punishment if a child has problematic behaviour

B] The carer should remove the child from mainstream school as soon as possible

C] The carer can use other aids such as television or computer games instead of spending time with the child

D] The carer should give loving attention to the child every day and look for opportunities to spend time with them

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

A] Psychosocial intervention

B] Pharmacological treatment

C] Referral to specialist

D] Referral to outside agency

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

A] They should avoid community and other social activities as much as possible

B] They should avoid the use of drugs, alcohol and nicotine

C] They should avoid school if it makes them anxious

D] They should avoid being physically active for more than 30 minutes each day

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

A] Low mood and loss of enjoyment in usual activities

B] Fixed false beliefs and hearing voices

C] Excessive activity and inattention

D] Decline or problems with memory and orientation

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

A] Severe forgetfulness and difficulties in carrying out usual work, domestic or social activities

B] Drowsiness and weakness down one side of the body

C] Fluctuating mental state characterized by disturbed attention that develops over a short period of time

D] Low mood in the context of major loss or bereavement

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

A] Dementia can have a large impact on the person, their carer, family and society at large

B] Dementia can be cured through pharmacological interventions

C] Dementia does not interfere with activities of daily living, such as washing, dressing, eating, personal hygiene and toilet activities

D] Dementia is a normal part of aging

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

A] All people with dementia should have access to pharmacological interventions, regardless of specialist availability

B] Pharmacological interventions, if started early enough, can cure dementia

C] With early recognition and support, the lives of people with dementia and their carers can be significantly improved

D] Psychosocial interventions for dementia should only be provided by a specialist, due to their complexity

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

A] Sedation, unresponsiveness, pinpoint pupils following use

B] Current thoughts of suicide, bleeding from self-inflicted wound, extreme lethargy

C] Strong cravings, loss of control over substance use, withdrawal state upon cessation of use

D] Intravenous drug use once per month, but violent towards others when using

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

A] HIV and hepatitis

B] Wernicke's encephalopathy

C] Epilepsy

D] Thyroid disease

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

A] Medication will be made available so that they can keep the person sedated

B] Restrict the person's contact with family, friends and other concerned individuals in case it is too overwhelming

C] Remove access to any means of self-harm and try and provide extra supervision for the person

D] Forced vomiting is an emergency treatment option if they suspect any self- harm or suicide

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

A] They should talk about the incident as much as possible, even if they do not want to

B] It is normal to grieve for any major loss, in many different ways, and in most cases grief will diminish over time

C] Avoid discussing any mourning process, such as culturally-appropriate ceremonies/rituals, as it may upset them further

D] Refer to a specialist within one week of the incident if they are still experiencing symptoms

22. Which of the following is the best advice for treatment of anxiety disorder?

a. Relaxation exercise and meditation
b. Using alcohol
c. Not sharing one's problems with others

d. Not discussing about treatment with medications

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

i. Depression

ii. Psychoses

iii. Epilepsy

iv. Child and adolescent mental and behavioural disorders

v. Dementia

vi. Disorders due to substance use

vii. Self-harm/suicide

viii. Bereavement

Scenario A: i ii iii iv v vi vii viii

Rajendra is a 20 year-old man who is brought to your clinic by his friends. They are very worried about him because he is afraid that the government are monitoring him, and keeps saying that he can hear people talking about him. When you ask them for more information, they say that he has not been himself for several months, at times does not make sense, and has not been coming to university much. He is about to fail the semester. There is nothing remarkable on physical history, examination or blood tests, and his urine drug screen is negative. When you speak to him, he seems suspicious of you, does not make a lot of sense, and does not think that there is anything wrong with him. He wants to leave, and starts to become quite aggressive when you ask him to stay, saying that he is unsafe here and people are watching him.

Scenario B: i ii iii iv v vi vii viii

Chandrakala is a 17 year-old woman who is brought in by her family after having a period of shaking, rigidity and incontinence at home. She is currently confused and drowsy and does not know where she is. She reports she has always been happy and healthy, did well at school but left last year to start working, which is also going well. She is worried that she has been possessed by a spirit. When you speak to her, she is still not sure what has happened and why she is in hospital. She complains of weakness down one side of her body and feeling sore all over.

Scenario C: i ii iii iv v vi vii viii

Mandip is a 14 year-old boy who is referred to you by his school teacher. The teacher tells you that he has always gotten into trouble at school as he is very disruptive to the other students. He does not seem to be able to concentrate for very long. The teacher wants you to see him in case there is something that can be done. You meet with Mandip, who does not want to sit still to talk to you. In the brief time that you talk he tells you that he hates school and finds it boring. In your assessment you do not think that he is depressed, or that he has any delusions or hallucinations. He denies using any substances. A physical examination is normal. You meet with his parents, who tell you that they have had trouble with him for

years. He can never sit still when they take him somewhere, such as church or a friend's house, he is always getting bad reports at school, and wants to constantly be moving around the house and doing something.

Pre- and Post-Test Answer Key

1. = B	2. = D	3. = D	4. = B	5. = D	6. = D	7. = C
8. = D	9. = C	10. = D	11. = D	12. = A	13. = B	14. = D
15. = A	16. = A	17. = C	18. = C	19. = A	20. = C	21. = B
22. A and	23. A=ii, B = iii, C = iv					

PRE/POST TEST QUESTIONNAIRE

तालिम पूर्व र तालिम पश्चात्को मूल्याङ्कन

मिति :_ _/_ _/_ _ _ _	एउटामा ✓ चिन्ह लगाउनुहोस् ☐ तालिम पूर्व ☐ तालिम पश्चात्

सहभागीको नाम : ....
स्वास्थ्य संस्थाको नाम :

तपाईंले यो भन्दा पहिले कहिल्यै मानसिक स्वास्थ्य सम्बन्धि तालिम लिनु भएको थियो ?

– लिएको थिएँ......................... लिएको थिइनँ...................................

यदि लिनु भएको थियो भने, त्यो तालिमको बारेमा केही लेखिदिनु होला

....

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१) निम्न मध्ये कुनलाई सबैभन्दा प्रभावकारी सञ्चार सीपका रुपमा मानिन्छ ?

क) स्याहारकर्तासँग नबोली व्यक्तिसँग मात्र कुरा गर्ने

ख) व्यक्तिको कुरा ध्यानपूर्वक सुन्दै सञ्चार सुरु गर्ने

ग) सुरक्षाको लागि खुला स्थानमा कुरा गर्ने

घ) आँखाको सिमित सम्पर्क

२) मानसिक, स्नायु तथा लागुऔषध प्रयोग सम्बन्धि रोगहरु **[Mental, Neurological and Substance Use Disorder (MNS)]** भएका व्यक्तिहरूको सम्मान तथा आत्मविश्वासको प्रवर्द्धनको लागि निम्न मध्ये सबैभन्दा उपयुक्त विधि कुन हो ?

क) MNS अवस्था भएका व्यक्तिहरुको चासोलाई ख्याल गर्दै उनीहरुका लागि निर्णय लिइदिने

ख) जटिल भए तापनि उपयुक्त चिकित्सकिय शब्दावली प्रयोग गरी व्याख्या गर्ने

ग) स्याहारकर्ता तथा परिवारबाट उपचारको लागि सहमतिको सुनिश्चितता गर्ने

घ) उपचारको क्रममा गोपनीयताको सुनिश्चित गर्ने

३) निम्न मध्ये कुन लक्षण समूहले डिप्रेसनको श्रृंखलाको उपयुक्त चित्रण गर्छ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) उल्लेखनिय व्यवहार परिवर्तन, उत्तेजित वा आक्रमक व्यवहार, दृढ गलत विश्वासहरू

ख) स्मृतिमा ह्रास, सचेतनाको कमी, भावनात्मक नियन्त्रणको कमी

ग) ध्यान केन्द्रित गर्नमा कठिनाई, अधिक सक्रिय, आक्रामक व्यवहार

घ) शक्तिहिन, निद्रामा गडबडी र नियमित कुराहरुमा रुचि घट्नु

४) निम्न मध्ये डिप्रेशन को उपचारको लागि सबैभन्दा उपयुक्त एकिकृत उपचार विधि कुन हो ?

क) भिटामिन इन्जेक्सन र शारीरीक व्यायम बढाउँदै लैजाने

ख) मनोसामाजिक सहयोग र Antidepressant औषधी

ग) Antipsychotic औषधी र Mood stabilizer

घ) Hypnotherapy र आरामदायी अभ्यास

५) निम्न मध्ये कुन लक्षण समूहले **Mania** को श्रृंखलाको उपयुक्त चित्रण गर्छ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) Confusion, समय स्थान तथा व्यक्तिसँग सजक नहुनु, कार्यक्षमतामा ह्रास हुनु

ख) मादक पदार्थ सेवन गरेको स्वीकार्नु, लरबरिएको बोली तथा अस्वीकार्य व्यवहार देखाउनु

ग) Benzodiazepines को नियमित प्रयोग बन्द गरे पश्चात् छट्पटाहट हुने, पसिना आउनु तथा निद्रामा गडबडी देखिनु

घ) निद्राको आवश्यकताको कमी, अत्याधिक कियाकलाप र लापरवाह व्यवहार

६) साइकोसिस **[Psychosis]** तथा बाइपोलार **[Bipolar disorder]** को बारेमा निम्न भनाईहरु मध्ये कुन चाहिँ ठीक हो ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) Psychosis वा Bipolar भएका व्यक्तिहरुको शारीरिक अवस्था मूल्याङ्कन गर्न आवश्यक छैन

ख) Psychosis वा Bipolar भएका व्यक्तिहरुको सबैभन्दा उपयुक्त उपचार लामो समयसम्म अस्पतालमा भर्ना गर्नु हो

ग) Psychosis वा Bipolar भएका व्यक्तिहरु कामकाज गर्नको लागि अथवा समाजमा योगदान गर्नको लागि योग्य हुँदैनन्

घ) Psychosis वा Bipolar भएका व्यक्तिहरू लाञ्छना तथा भेदभावको उच्च जोखिममा हुन्छन्

७) निम्न मध्ये कुन चाहिँ साइकोसिस **[Psychosis]** भएका व्यक्तिहरुलाई गरिने मनोसामाजिक सहयोगको एउटा भाग हो ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) दैनिक क्रियाकलापहरूमा सहभागी हुनलाई प्रोत्साहन गर्ने तर धेरै तनावपूर्ण हुनसक्ने भएकोले कामकाज वा आत्मीय सम्बन्ध नगर्नको लागि सिफारिस गर्ने

ख) स्याहरकर्ता तथा परिवारसँग लामो समय सम्म संस्थामा राखी उपचार गर्नेबारे छलफल गर्ने

ग) अधुरो निद्रा, तनाव, लागूपदार्थ तथा रक्सी सेवन बाट टाढा रहनको लागि मनोशिक्षा प्रदान गर्ने

घ) स्याहरकर्तासँग व्यक्तिको delusion लाई चुनौती दिन सकिने विभिन्न उपायहरूको बारे छलफल गर्ने

८) छारे रोग बारे निम्न भनाईहरु मध्ये कुन चाहिँ ठीक छ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) छारे रोग दिमाग सम्बन्धि एक सरुवा रोग हो

ख) छारे रोग प्रेत आत्मा को एक संकेत हो

ग) छारे रोग सधैँ वंशाणुगत कारणले लाग्छ

घ) छारे रोग एक प्रकारको स्नायु सम्बन्धि सामान्यतया देखिने रोग हो

९) निम्न मध्ये कुन अवस्थामा आपतकालीन औषधी उपचार आवश्यक हुन्छ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस्।

क) जब व्यक्तिलाई कम्पन आउन थालेको शंका लाग्छ

ख) यदि कम्पन १ मिनेट भन्दा बढी भएमा

ग) यदि कम्पन ५ मिनेट भन्दा बढी भएमा

घ) यदि कम्पन पश्चात् व्यक्ति लठ्ठ परेमा

१०) निम्न मध्ये कुनले बाल विकास सम्बन्धि समस्या **[child development disorder]** को उपयूक्त चित्रण गर्छ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) बाल विकास सम्बन्धि समस्याहरु ठिक हुने र पटक पटक बल्झिने खालका हुन्छन्

ख) बाल विकास सम्बन्धि समस्याहरु सधैं दुर्व्यवहार तथा बेवास्ता सँग सम्बन्धित हुन्छन्

ग) बाल विकास सम्बन्धि समस्याहरु अन्तर्गत Attention Deficit Hyperactivity Disorder [ADHD] र Conduct Disorder पर्दछन्

घ) बाल विकास सम्बन्धि समस्याहरुमा केन्द्रिय स्नायु प्रणलिका कार्यहरुमा असर वा ढिलासुस्ती देखिन्छ

११) बालवालिका तथा किशोरकीशोरीमा हुने मानसिक तथा व्यवहारिक समस्याका लागि निम्न मध्ये सबैभन्दा उपयुक्त सुझाव कुन हो ?

क) समस्याजनक व्यवहार भएमा स्याहारकर्ताले बालबालिकालाई डर त्रास वा शारीरिक दण्ड दिन सक्ने

ख) बालबालिकालाई यथाशिघ्र विद्यालयबाट हटाउन पर्दछ

ग) स्याहारकर्ताले बालबालिकाहरुसँग समय बिताउनुको सट्टा अन्य माध्यमहरू जस्तै: टिभी वा कम्प्युटरका खेलहरूमा सहभागी गराउन सक्ने

घ) स्याहारकर्ताले बालबालिकालाई हरेक दिन स्नेह पूर्वक ध्यान दिने तथा उनीहरूसँगै समय बिताउनको लागि उपयुक्त वातावरण मिलाउने

१२) निम्न मध्ये बालबालिका तथा किशोरकीशोरीमा हुने विकासात्मक समस्याहरुको लागि सबभन्दा उपयुक्त उपचार हो ? एउटा मात्र जवाफ छान्नुहोस् ।

क) मनोसामाजिक सहयोग

ख) औषधी उपचार

ग) विशेषज्ञकहाँ सिफारिस गर्ने

घ) अन्य निकायमा सिफारिस गर्ने

१३) निम्न मध्ये मानसिक तथा व्यवहारिक समस्या भएका किशोरकीशोरीहरुलाई कुन चाहिँ सुझाव सबैभन्दा उपयुक्त हुन्छ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) उनीहरुले सम्भव भएसम्म समुदाय तथा अन्य सामाजिक क्रियाकलापहरूबाट टाढा बस्नुपर्छ

ख) उनीहरुले लागुऔषध, मदिरा तथा सुर्तिजन्य पदार्थको प्रयोगबाट टाढा बस्नुपर्छ

ग) यदि विद्यालयले उनीहरूलाई चिन्तित बनाएमा विद्यालय जान बन्द गनुपर्छ

घ) हरेक दिन आधा घण्टा भन्दा बढी शारीरिक व्यायम नगर्ने

१४) निम्न मध्ये कुन चाहिँ डिमेन्सियाको उपयुक्त प्रस्तुतिकरण हो ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) निराश हुनु तथा नियमित क्रियाकलापहरुमा रमाउन नसक्नु

ख) दृढ झुटो विश्वास तथा काल्पनिक आवाजहरू सुनिनु

ग) अत्यधिक क्रियाकलापहरु तथा ध्यानमा विकर्षण (ध्यान दिन नसक्ने)

घ) स्मृति र सजकतामा ह्रास वा समस्या

१५) निम्न मध्ये कुन चाहिँ डिमेन्सियाको उपयुक्त प्रस्तुतिकरण हो ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) गम्भीर विस्मृति तथा दैनिक कामकाज, घरायसी वा सामाजिक क्रियाकलापहरू गर्नमा कठिनाइ हुनु

ख) लठ्ठ पर्नु तथा शरीरको एक भाग कमजोर हुनु

ग) बदलिँदो मानसिक स्थितिका साथै ध्यान केन्द्रित गर्नमा कठिनाइ हुनु जुन छोटो अवधिमा विकसित हुन्छ

घ) मुख्य क्षति वा शोकको अवस्थामा निराश हुनु

१६) तलका मध्ये कुनले डिमेन्सियाको उपयुक्त ब्याख्या गर्छ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) डिमेन्सियाले व्यक्ति, स्याहारकर्ता, परिवार तथा समाजमा गम्भीर असर गर्दछ

ख) औषधीको प्रयोगबाट डिमेन्सियाको पूर्ण उपचार गर्न सकिन्छ

ग) डिमेन्सियाले व्यक्तिको दैनिक कामकाजहरु जस्तै: धुने, कपडा लगाउने, खाने, सरसफाई तथा शौचालय सम्बन्धि कियाकलापहरुमा असर गर्दैन

घ) डिमेन्सिया वृद्ध अवस्थाको सामान्य अङ्ग हो

१७) निम्न भनाईहरु मध्ये कुनले डिमेन्सियाको सबैभन्दा उपयुक्त उपचार विधिको उल्लेख गर्दछ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) डिमेन्सिया भएका सबै व्यक्तिलाई विशेषज्ञ सेवा उपलब्ध भए वा नभएता पनि औषधी उपचारमा पहुँच हुनुपर्दछ

ख) डिमेन्सियालाई चाँडै उपचार सुरु गरेमा औषधीले पूर्ण रुपमा निको पार्न सक्छ

ग) चाँडै पत्ता लागेमा तथा सहयोग सुरु गरेमा डिमेन्सियाबाट प्रभावित व्यक्ति तथा स्याहारकर्ताहरुको जीवनमा उल्लेखनिय सुधार ल्याउन सकिन्छ

घ) जटिल भएका कारणले डिमेन्सियाका लागि मनोसामाजिक सहयोगहरु विशेषज्ञले मात्र प्रदान गर्नु पर्दछ

१८) निम्न मध्ये कुन चाहिँ लक्षणले लागूऔषध दुर्व्यसनी सम्बन्धि समस्या **[Substance dependence]** को उपयुक्त ब्याख्या गर्छ ? एउटा मात्र जवाफ छान्नुहोस् ।

क) लठ्ठ पर्नु, अचेत हुनु, pinpoint pupils देखिनु

ख) हालसालै आत्महानिको सोचहरु आउनु, आफूले काटेको घाउबाट रगत बग्नु, अत्यधिक निष्क्रियता हुनु

ग) अत्यधिक तलतल, लागूऔषध प्रयोगमा नियन्त्रण गुमाउनु, प्रयोग बढदै गरे पश्चात् withdrawal symptoms देखा पर्नु

घ) सुई प्रयोग महिनाको एक पटक गर्नु तर प्रयोग गर्दा हिंस्रक व्यवहार देखाउनु

१९) सुईबाट **Opioid** प्रयोग गर्ने व्यक्तिहरुमा निम्न मध्ये कुन रोगका लागि जाँच गर्नुपर्छ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) एच.आई.भी. र हेपाटाइटिस

ख) Wernicke's encephalopathy

ग) छारे रोग

घ) थाइरोइड सम्बन्धि रोग

२०) आत्महानि वा आत्महत्याको प्रयास गरेको व्यक्तिको स्याहारकर्तालाई निम्न मध्ये कुनचाहिँ सुझाव दिनुपर्दछ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) व्यक्तिलाई लठ्ठ पारेर राख्नको लागि औषधी उपलब्ध गराउनुपर्छ

ख) व्यक्तिलाई परिवार, साथीभाई तथा अन्य सम्बन्धित व्यक्तिहरूको सम्पर्कबाट निषेध गरेर राख्ने

ग) आत्महानिको लागि प्रयोग हुने श्रोतसाधनहरु पहुँचबाट टाढा राख्ने र व्यक्तिलाई थप निगरानीमा राख्ने

घ) आत्महानि वा आत्महत्याको शंका भएमा forced vomiting एक आपतकालीन उपचारको विकल्प हो

२१) आफ्नो नजिकको व्यक्ति हिंसामा गुमाएको व्यक्तिलाई निम्न मध्ये कुन चाहिँ मनोसामाजिक सहयोगको अंश हुनसक्छ ? सबैभन्दा मिल्दो जवाफ छान्नुहोस् ।

क) व्यक्तिले नचाहे पनि घटनाको बारेमा पटकपटक कुरा गर्ने

ख) कुनै प्रमुख क्षति पश्चात् विभिन्न तरिकाहरु मार्फत शोकमग्न हुनु सामान्य हो र प्रायजस्तो अवस्थामा शोक बिस्तारै कम हुँदै जान्छ

ग) व्यक्तिलाई तनावग्रस्त बनाउन सक्ने भएकोले सांस्कृतिक रुपमा उपयुक्त हुने खालका शोकका प्रक्रियाहरुबारे छलफल नगर्नुहोस्

घ) यदि व्यक्तिले घटनाको १ हप्ता भन्दा बढी समय सम्म लक्षणहरू महसुस गरिरहेमा विशेषज्ञकहाँ सिफारिस गर्नुहोस्

२२) तलका मध्ये **Anxiety Disorder** को उपचारका लागि सबैभन्दा उपयुक्त सुझाव कुन हो?

क) आरामदायी अभ्यास तथा ध्यान गर्ने
ख) मादक पदार्थ सेवन गर्ने
ग) आफ्ना समस्याहरु अरुसँग व्यक्त नगर्ने
घ) औषधी उपचारका लागि छलफल नगर्ने

२३) तलका उल्लेख गरिएका **Scenario** हरू पढनुहोस् र प्रत्येकका लागि सबैभन्दा मिल्दोजुल्दो कुनै एक निदान

[Diagnosis] छान्नुहोस् ।

क) डिप्रेसन [Depression]
ख) साइकोसिस [Psychosis]
ग) छारेरोग [Epilepsy]
घ) बालबालिका तथा किशोर किशोरीहरुमा हुने मानसिक तथा व्यवहारिक समस्याहरु
ङ) डिमेन्सिया [Dementia]
छ) लागूऔषध प्रयोग सम्बन्धि रोगहरु
ज) आत्महानि/आत्महत्या
झ) शोक [Bereavement]

Scenario A

राजेन्द्र एक २० वर्षीय पुरुष हो जसलाई उसका साथीहरुले तपाईंको क्लिनिकमा ल्याएका छन । साथीहरु उसको बारेमा धेरै नै चिन्तित छन् किनभने ऊ आफूलाई सरकारले निगरानी गरिरहेको छ भनेर डराउँछ तथा मान्छेहरुले आफ्नो बारेमा कुरा गरिरहेको सुन्छु भनेर भनिरहन्छ । तपाईं उसका साथीहरूलाई थप जानकारीको लागि सोध्दाखेरि ऊ धेरै महिना देखि पहिले जस्तै छैन भन्छन् साथै कहिलेकाहीँ नबुभिने कुरा गर्छ र विश्वविद्यालय पनि खासै आईरहेको छैन भन्छन् । ऊ परीक्षामा पनि फेल भएको छ । शारीरिक जाँच वा रगत परीक्षणमा त्यस्तो केही पनि छैन साथै उसको urine drug screen पनि नेगेटिभ छ । जब तपाईं उसँग बोल्नुहुन्छ, उसलाई तपाईंमाथि शंका लाग्छ, नबुझिने कुरा गर्छ र उसलाई केही नराम्रो भइरहेको भन्ने कुरा केही पनि सोच्दैन । ऊ जान चाहन्छ र त्यसबेला तपाईंले उसलाई बस्न भन्दा एकदमै आक्रामक हुन थाल्छ र ऊ यहाँ असुरक्षित छु भन्नुको साथै मान्छेहरुले उसलाई हेरिरहेका छन् भन्छ ।

Scenario B

चन्द्रकला १७ वर्षीया महिला हुन जसलाई उनको परिवारले घरमा काँप्ने, rigidity र कपडामै दिशा पिशाब गर्ने समस्या भएर ल्याएका छन् । उनी हाल अलमलमा पर्नुका साथै आफू कहाँ छु भन्ने पनि थाहा छैन । उनी आफू सधैं खुसी तथा स्वस्थ रहेको कुरा भन्छिन, स्कूलमा पनि राम्रो गरेकी थिइन् । तर गएको वर्ष जागिर गर्नका लागि स्कूल छाडिन्, जुन पनि राम्रोसँग नै चलिराखेको छ । उनी आफू कुनै आत्माको अधिनमा छु भन्ने कुराले चिन्तित छिन् । जब तपाईं उनीसँग केही बोल्नुहुन्छ उनी अझै पनि के भयो र आफू किन अस्पातलमा छु भन्ने कुरामा निश्चित छैनन् । उनी शरीरको एक छेउको तल्लो भाग कमजोर रहेको तथा सबैतिर पीडा महसुस भएको बताउँछिन् ।

Scenario C

मन्दिप एक १४ वर्षीय केटा हो जसलाई उसको शिक्षकले तपाईंकहाँ सिफारिस गरेर पठाउनु भएको छ । उसको शिक्षकले बताउनुहुन्छ कि ऊ जहिल्यै स्कूलमा समस्यामा परिरहन्छ र अरु विद्यार्थीहरुलाई वाधा पुऱ्याइरहन्छ । ऊ लामो समयसम्म ध्यान केन्द्रित गर्न सक्छ जस्तो लाग्दैन । उसको शिक्षकले केही गर्न सकिन्छ कि भनेर तपाईंले उनलाई हेर्नुहोस् भन्ने चाहनुहुन्छ । तपाईं मन्दिपलाई भेट्नुहुन्छ जो तपाईंसँग बसेर कुरा गर्न चाहँदैन । कुराकानीको छोटो समयमा उसले तपाईंसँग स्कूललाई घृणा गर्छु भन्छ र अल्छी लाग्दो पनि मान्छ । तपाईंको मूल्याङ्कनमा तपाईंलाई लाग्दैन कि ऊ उदास छ अथवा ऊसँग कुनै delusions अथवा hallucinations छन् । ऊ आफूले कुनै पनि पदार्थहरु प्रयोग गरिरहेको कुरा इन्कार गर्छ । शारीरिक जाँच गर्दा सामान्य नै छ । तपाईं उसको आमाबाबुसँग भेट्दाखेरि उसले उनीहरुलाई धेरै वर्ष देखि दुःख दिइरहेको कुरा भन्छन् । कहिलेकाहीँ उसलाई चर्च वा साथीको घर लाँदा पनि ऊ कहिल्यै चुप लागेर बस्न सक्दैन । उसले विद्यालयबाट सधैं नराम्रा रिपोर्टहरू पाइरहेको हुन्छ र लगातार घर वरिपरि हिँड्न तथा केही न केही गरिराख्न चाहन्छ ।

ANSWERS -pQ/_

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Scenario B= u Epillepsy

Scenario C= 3 Child and Adolescent Mental and Behavioral Disorder

B] Evaluation Form

Participant feedback form for each module

Date of training: Location of training:

Name of facilitator(s)

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

Training of health-care providers

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

Training of trainers and supervisors

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

Please rate the following:	Poor	Average	Excellent	Additional comments
Quality of content and information – was it relevant, well-researched and organized?	1	2	3	
Quality of slides and handouts – were they easy to read and helpful in learning?	1	2	3	
Quality of trainer – were they engaging, enthusiastic and informed?	1	2	3	
Quality of activities/role plays and clarity of instructions	1	2	3	
Length of module – was it too long, too short or just right?	1	2	3	
Number of opportunities for active participation – too many, too few or just right?	1	2	3	
How confident do you now feel about using what you have learned in this module?	1	2	3	
Overall quality of this module	1	2	3	

What was best about this module?

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

What would you suggest to improve this training module?

C] Clinical Referral Form

CLINICAL REFERRAL FORM

Date of referral:

Referral to:

Patient details:

Name:

Age: **Gender:**

Address: **Occupation:**

Provisional Diagnosis:

Reason(s) for referral:

Referred by:

Name:

Designation:

Health Facility:

Contact no.

.

…………………………….

Signature of referee

D] Name of Psychotropic medications included in the Essential Drug List of Nepal Government

1. Tab Chlorpromazine 100 mg
2. Tab Amitriptyline 10 and 25 mg
3. Tab Alprazolam 0.25 mg
4. Tab Phenobarbitone 60 mg
5. Tab Carbamazepine 200 and 400 mg
6. Inj. Diazepam 2 ml
7. Tab Risperidone 1 and 2 mg
8. Cap Fluoxetine 10 and 20 mg
9. Tab Sodium Valproate 200 and 300 mg
10. Tab Diazepam 2 and 5 mg
11. Tab Trihexyphenidyl 2 mg
12. Tab Thiamine 100 mg

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