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Acknowledgements

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Introduction to mhGAP-HIG training of health-care providers training manual

Introduction to mhGAP-HIG training
The mhGAP Humanitarian Intervention Guide (mhGAP-HIG) is an adaptation of the “WHO mhGAP Intervention Guide (mhGAP-IG) for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings” for use in humanitarian emergencies.

The mental health Gap Action Programme (mhGAP) is a WHO programme that seeks to address the lack of care for people suffering from mental, neurological and substance use (MNS) conditions. mhGAP-IG is a clinical guide for general health-care providers who work in non-specialized health-care settings, particularly in low- and middle-income countries. The mhGAP Humanitarian Intervention Guide (mhGAP-HIG) was developed in order to address specific challenges in humanitarian emergency settings.

mhGAP-HIG provides guidance on the presentation, assessment and management of a range of mental, neurological and substance use conditions, as well as general principles of care. It differs from mhGAP-IG in that it is shorter and has been modified to address key issues faced in humanitarian settings. It only includes information deemed essential in humanitarian settings.

Overview of the training manual
This manual is divided into three parts:

1) Introduction to training: This section includes information on how to use the manual, who the manual is for, overall learning objectives, how to prepare and plan for training and facilitation tips.

2) Step-by-step training modules of MNS conditions: This section provides Facilitator Guides for an introduction, assessment and management module for the MNS conditions. Every Module is designed in the same format and gives objectives, a suggested agenda and step by step descriptions of how to deliver the training.

3) An annex with supporting materials. These include tests (supporting material A), case studies for role-plays and observer checklist (supporting material B), an overview of presenting complaints of conditions covered in this training (supporting material C), a list of relevant video links (supporting material D), and an adaptation template (supporting material E).

Overview of the mhGAP-HIG training modules
The training of mhGAP-HIG has been split into 2 parts: an initial training of 3 days (training 1) and a follow up training of 2 days (training 2). Training 1 covers general principles of care (GPC), acute stress, grief, depression, suicide, psychosis and epilepsy. These 6 conditions cover more than 80% of all MNS cases that trained healthcare providers tend to identify and manage in emergency settings in general health care. Training 2 covers opportunities for further skills training as well as modules on PTSD, harmful use of alcohol and drugs, intellectual difficulties, and other significant mental health complaints.
In **Training 1 (3 days)**, the following topics are covered:

- Introduction to mhGAP-HIG

- General Principles of Care (GPC):
  - GPC Communication (part I)
  - GPC Protection of human rights
  - GPC Attention to wellbeing
  - GPC Assessment
  - GPC Management (includes GPC reducing stress and strengthening social support)

- Conditions:
  - Acute Stress
  - Grief
  - Moderate – severe depressive disorder
  - Suicide
  - Psychosis
  - Epilepsy

In **Training 2 (2 or 3 days)**, the following topics are covered:

- Review of topics covered in Training 1, including relevant clinical experiences after completion of Training 1.

- General Principles of Care (GPC):
  - GPC Communication (part II)

- Conditions:
  - Post-traumatic Stress Disorder
  - Harmful Use of Alcohol and Drugs
  - Intellectual Disability
  - Other Significant Mental Health Complaints

Time keeping is essential to ensure the training schedule can be completed. The schedule should be adapted to circumstances of the provided training.

Each module comprises of a module-specific step by step facilitator guide, which includes role play information, and slideshow, which may need to be adapted to the local context. The slideshows come with notes for the presenter, a range of discussions, role plays, case studies and videos.
### Suggested training schedule

The approximate times for the three modules in training 1 are:

- Module 1: Introduction to mhGAP-HIG – 225 minutes (almost 4 hours)
- Module 2: Assessment of mhGAP-HIG conditions – 355 minutes (almost 6 hours)
- Module 3: Management of mhGAP-HIG conditions - 460 minutes (almost 8 hours)

To cover all the three modules in three days for training 1 the following schedule is suggested:

<table>
<thead>
<tr>
<th>SESSIONS</th>
<th>DURATION (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY 1 (5.9 hrs)</strong></td>
<td></td>
</tr>
<tr>
<td>Module 1: Introduction to mhGAP-HIG</td>
<td>225</td>
</tr>
<tr>
<td>Introduction and aims</td>
<td>25</td>
</tr>
<tr>
<td>Pre-test</td>
<td>25</td>
</tr>
<tr>
<td>Why train on mental, neurological and substance use disorders?</td>
<td>15</td>
</tr>
<tr>
<td>An introduction to mhGAP-HIG</td>
<td>35</td>
</tr>
<tr>
<td>Conditions in mhGAP-HIG</td>
<td>40</td>
</tr>
<tr>
<td>General principles of care (communication, human rights, wellbeing)</td>
<td>85</td>
</tr>
<tr>
<td>Module 2: Assessment of mhGAP-HIG conditions</td>
<td>115</td>
</tr>
<tr>
<td>General Principles of Assessment</td>
<td>40</td>
</tr>
<tr>
<td>Assessment of significant symptoms of acute stress (ACU)</td>
<td>45</td>
</tr>
<tr>
<td>Assessment of significant symptoms of grief (GRI)</td>
<td>30</td>
</tr>
<tr>
<td>Daily evaluation</td>
<td>15</td>
</tr>
<tr>
<td>Total:</td>
<td>355</td>
</tr>
<tr>
<td>Recap day 1</td>
<td>15</td>
</tr>
<tr>
<td>Module 2: Assessment of mhGAP-HIG conditions</td>
<td>240</td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
</tr>
<tr>
<td>Assessment of moderate – severe depressive disorder (DEP)</td>
<td>70</td>
</tr>
<tr>
<td>Assessment of suicide (SUI)</td>
<td>35</td>
</tr>
<tr>
<td>Assessment of psychosis (PSY)</td>
<td>80</td>
</tr>
<tr>
<td>Assessment of epilepsy (EPI)</td>
<td>55</td>
</tr>
<tr>
<td>Module 3: Management of mhGAP-HIG conditions</td>
<td>110</td>
</tr>
<tr>
<td>General Principles of Management</td>
<td>5</td>
</tr>
<tr>
<td>GPC: Reducing stress and strengthening social support</td>
<td>65</td>
</tr>
<tr>
<td>Management of significant symptoms of Acute stress</td>
<td>40</td>
</tr>
<tr>
<td>Daily evaluation</td>
<td>15</td>
</tr>
<tr>
<td>Total:</td>
<td>380</td>
</tr>
<tr>
<td>Recap day 2</td>
<td>15</td>
</tr>
<tr>
<td>Module 3: Management of mhGAP-HIG conditions</td>
<td>310</td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
</tr>
<tr>
<td>Management of significant symptoms of Grief</td>
<td>45</td>
</tr>
<tr>
<td>Management of Depressive disorder</td>
<td>75</td>
</tr>
<tr>
<td>Management of Suicide</td>
<td>35</td>
</tr>
<tr>
<td>Management of Psychosis</td>
<td>75</td>
</tr>
<tr>
<td>Management of Epilepsy</td>
<td>80</td>
</tr>
<tr>
<td>Final course evaluation and post-test</td>
<td>40</td>
</tr>
<tr>
<td>Total:</td>
<td>365</td>
</tr>
</tbody>
</table>
Preparing and conducting the training

Preparing and adaptation of the training

In preparing for the training you will need to prepare yourself, the participants, the training materials and the venue. The HIG manual and training materials (case studies, tests etc) might need to be translated depending on the group of participants. For general guidance on adaptation in mhGAP see the mhGAP Operations Manual (WHO, 2017). To adapt the HIG manual see the adaptation template in the supporting materials E (see Annex). The training will need to be modified according to possible changes made in the training program. Depending on languages in the group and languages spoken by the facilitator there is a need for an interpreter to be part of the training (which will substantially increase the duration of the training). Working with an interpreter needs preparation. Provide all slides in advance and discuss translation of key terms with the interpreter. Even if the training is in English, interpreter can be given the version of HIS in another language, to prepare.

Trainer checklist to prepare for training (adapted from mhGAP-IG ToHP manual)

- Familiarize yourself with the entire HIG and facilitator training manual
- Familiarize yourself with the local humanitarian crises
- Identify best way to conduct training (length and duration)
- Prepare participants by ensuring that they receive an electronic copy of mhGAP-HIG in advance of the training with the request to read through the guide in preparation for the training
- Reserve venue for training
- Adapt the training materials where necessary (pre-test, case studies etc)
- Ensure pens and paper is available
- Ensure a flipchart is available with markers
- Refreshments
- Attendance sheet
- Test audiovisual
- For participants bring copies of:
  - pre- and post-test
  - case studies and observer checklists
  - mhGAP-HIG manual in locally accepted language for health care providers
Training guidelines (adapted from mhGAP-IG ToHP manual)

1. Understand the local context
   External trainers (that is trainers who are not from the local setting) should familiarize themselves with the local context (including relevant aspects of the humanitarian crisis) before conducting training. During the training, external trainers should seek to continue to learn from the participants about the local context and use that knowledge in the training.

2. Be organized and professional
   List of important housekeeping rules to discuss with participants:
   - Start time and end time of course day
   - Breaks (for tea/coffee) and lunch times.
   - Participants are encouraged to ask questions. Sometimes the facilitator will choose to address a question at a later stage or outside the group setting (e.g., in the break). Such questions can be written on a flipchart to be discussed later
   - How to be respectful to each other; everybody is here to learn.
   - Phones on silent and no email checking

3. Time management
   There is a large amount of content to cover in the mhGAP-HIG training so it is crucial to keep time so that the training can be completed as planned. Manage your time well by setting a clear agenda, appointing a participant as timekeeper for breaks, and keeping to the suggested times for activities in the training manual.

4. Model the skills and attitudes you want to see in participants
   Be an example to participants and show the behaviour and attitude you would want them to display.

5. Create a supportive and encouraging learning environment
   Be encouraging and positive as participants practise new skills. Always give feedback in a sensitive way: first ask “what went well” and then “what could be better.”

Specific training techniques

Slides

The accompanying slides are organized per module, so there are separate slide shows for the introduction, assessment and management modules. The slides contain the same notes for the facilitator as in the facilitator guide. The following symbols are used in the presentations:

- This means the slide is animated. This symbol shows that the appearance of the information on the slide is in stages. The slides often contain a question for the group. After receiving some answers from the group the rest of slide with the answers can be revealed.

- This symbol indicates that a group discussion will be conducted about the information on the slide.
**Video demonstrations**

Videos demonstrations can be used in the training to demonstrate good clinical practice.

**Preparations**

- A list of all the videos used in the training can be found in supporting material D (see Annex). Video scripts are available on request.
- In case you plan to use the videos, make sure you have the capacity to show videos with sound in your training venue. Test the video, the internet connection, sound and projection facilities before the training.
- In settings where internet is not very reliable it might be a good idea to download the videos on your computer or flash drive before the training.
- All the videos are in Arabic with French or English subtitles. The videos of SUI, DEP, PSY are also available with Spanish subtitles.
- The videos were developed for the mhGAP Intervention Guide (mhGAP-IG version 1.0) and specifically not for the mhGAP Humanitarian Guide (mhGAP-HIG), so not all the steps in the video will perfectly match the content of mhGAP-HIG.
- If it is not possible to show videos in your training venues, then consider creating slides with the script or provide demonstrations or additional role plays for practice and observation.

**During training**

- Ensure all participants can see the video screen and it is loud enough for all to hear.
- Introduce the participants to the activity explaining that they are going to watch a video demonstration of a clinical interaction between a healthcare provider and a person with a MNS condition.
- This interaction will either show an assessment, management intervention or follow up meeting and is an example of good clinical practice.
- Instruct participants to have their mhGAP-HIGs open at the relevant page so that they can follow the assessment, management intervention or follow up, and explain that at the end of the video there will be a group discussion about the interaction.
- During the group discussion participants will be asked for their opinions on the interaction and to ask questions they may have about any of the clinical points related to assessment, management or follow up. The general principles of care (GPC) may be explored for every video.

**Role plays**

Role Plays are being used in this training to bring real-life scenarios into the classroom. It will give participants an idea on what it is like to use mhGAP-HIG, and accordingly it will help build their clinical skills.
Preparations
- Familiarize yourself with the role play instructions
- Make sure you have enough copies of the instructions to hand out to people playing the person with an MNS condition.
- The duration of 8-10 minutes are to mimic real life scenario’s in which a lot primary health care providers will only have little time per consultation.
- Time management is important in facilitating the role-plays. Make sure you take enough time in the training for the role-plays, but don’t spend more time on them than suggested. It is important that all participants get a chance to practice both the assessment and management of the conditions are covered. The case studies can be found in the supporting material B (see annex).

During training
- Split the participants into groups of 3:
  1. One participant will play a person with an MNS condition seeking help.
  2. One participant will play the healthcare provider who will assess, manage or follow up with the person.
  3. One participant will be an observer/carer. The observer’s role is to monitor the interaction, make sure all assessment, management and GPC areas are covered and offer feedback after the role play. The observer can use the observer checklist (supporting material B) to monitor the role play and provide feedback. The observer can at the same time also play a carer that accompanies the person seeking help. There are specific instructions for carers in some of the case studies. However, it is possible to add a carer to all role plays and this may be a sensible thing to do in societies where people mostly seek health care together with a family member.
- Allow the role play to continue for 8-10 minutes (unless stated otherwise in instructions for that specific role play). Stop the role play and ask the observers to provide feedback to the healthcare providers in their groups of 3.
- Bring the group back together and ask a couple of participants (persons seeking help, healthcare provider, observer/carer) how the exercise went (5 min).

Instructions for facilitator:
- During role plays, the facilitator should move around the groups monitoring progress and making sure that everyone understands the instructions.
- Be sensitive to emotional effects of role plays in the participants. Some of them might have experienced similar emotions as the people in the role plays.
- Ask the healthcare providers to talk to their groups about what is going well and what could be improved.
- Ask the person playing an MNS condition, the observer/carer and the healthcare provider how things are going.
- Make sure to lead the process and ensure that the feedback is given in ways that foster mutual learning. You can do that by saying things like; “What we just saw in the role play, very often happens in clinical reality. What can we do to do it in a different way?”
- Overall, always give feedback in a sensitive way: first ask “what went well” and then “what could be better.”

Instructions for the person seeking help

- As many of the participants, when playing the role of the person seeking help, will be acting out of character for them they will need direction in how to behave. In supporting material B (see annex) there are case studies for the different role-play scenarios which should be printed out and handed to the people playing the role of the person seeking help before the role-play begins.
- When playing the role of help-seeker do not exaggerate the symptoms or present complicated issues. The aim of the roleplay is for the health care provider to practice their assessment and management skills.
- During the role play, the help-seeker should consider some of the following:
  - How comfortable the healthcare provider made you feel.
  - What was good and what could be improved.
  - How the communication skills and body language affected you.
  - How the information given to you made you feel.
- Provide feedback on your most important observations to the healthcare provider.

Instructions for healthcare provider

- The healthcare provider should start the conversation and use the mhGAP-HIG and their communication skills to assess, manage or follow up with the person.

Instructions for the observer/carer

- The observer can also role play the carer.
- During the role play, the observer’s role is to monitor the interaction, make sure all relevant tasks are covered and offer feedback after the role-play. For example, in a role play focusing on assessment, the observer provides feedback to the healthcare provider about performing the key assessment tasks for that condition, such as:
  - Using principles of assessment/management/follow-up
  - Ability to identify the required information
  - Listening and communication skills
  - Overall interaction (warmth, showing understanding, body language etc)
- Provide feedback to the healthcare provider whether he or she used simple language the person could understand.
- Tips on providing feedback are on the observer checklist (supporting material B, see annex)
Step by step training modules of MNS conditions:

The remainder of this manual will give step by step instructions for the facilitator for the following modules:

- Training 1 Module 1: Introduction to mhGAP-HIG
- Training 1 Module 2: Assessment of mhGAP-HIG conditions
- Training 1 Module 3: Management of mhGAP-HIG conditions

A forthcoming revised version of this manual will also cover Training 2.
MODULE 1: INTRODUCTION TO mhGAP-HUMANITARIAN INTERVENTION GUIDE

OVERVIEW
By the end of this module participants should be able to:

- Know the common presentations of mhGAP-HIG conditions.
- Understand the general principles of communication, protection of human rights, and attention to general wellbeing.
- Promote respect and dignity for people with MNS conditions.

<table>
<thead>
<tr>
<th>Session</th>
<th>Objectives</th>
<th>Duration</th>
<th>Training Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction and aims of training</td>
<td>Introduction of facilitators and participants. Explore expectations and explain training objectives.</td>
<td>25 min</td>
<td>Activity 1: Introductions and expectations</td>
</tr>
<tr>
<td>2. Pre-test</td>
<td>Assess pre-existing knowledge and skills.</td>
<td>25 min</td>
<td>Activity 2: Pre-test</td>
</tr>
<tr>
<td>3. Why train on MNS conditions?</td>
<td>Explain the rationale for training in MNS conditions.</td>
<td>15 min</td>
<td>Activity 3: Quiz on MNS conditions</td>
</tr>
<tr>
<td>4. Introduction to mhGAP-HIG</td>
<td>Introduce the mhGAP humanitarian intervention guide.</td>
<td>35 min</td>
<td>Activity 4: MNS care and emergencies Activity 5: Explore mhGAP-HIG</td>
</tr>
<tr>
<td>5. Conditions in mhGAP-HIG</td>
<td>Introduce the conditions in mhGAP-HIG and common presenting complaints.</td>
<td>40 min</td>
<td></td>
</tr>
<tr>
<td>6. General Principles of Care - communication - human rights - wellbeing</td>
<td>Train in good communication skills. Train in protection of human rights. Train in attention to General Wellbeing.</td>
<td>85 min</td>
<td>Activity 6: Good and poor communication Activity 7: Human rights</td>
</tr>
<tr>
<td></td>
<td></td>
<td>225 min (3.8 hrs)</td>
<td></td>
</tr>
</tbody>
</table>
**Session 1.1. Introduction and aims of training (25 min)**

<table>
<thead>
<tr>
<th>Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>mhGAP</strong></td>
</tr>
<tr>
<td>Humanitarian version</td>
</tr>
<tr>
<td>Module 1: Introduction</td>
</tr>
<tr>
<td>Contents</td>
</tr>
<tr>
<td>A. Introduction and aims of training</td>
</tr>
<tr>
<td>B. Why train on mental, neurological and substance use conditions?</td>
</tr>
<tr>
<td>C. Why train on mental, neurological and substance use conditions?</td>
</tr>
<tr>
<td>D. Introduction to mhGAP-HIG</td>
</tr>
<tr>
<td>E. Conditions in mhGAP-HIG</td>
</tr>
<tr>
<td>F. General Principles of Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facilitator Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Welcome everybody and take them through the program of Module 1: Introduction.</td>
</tr>
<tr>
<td>• Explain the structure of the full (2-part) mhGAP-HIG training course.</td>
</tr>
<tr>
<td>• Ask the group what kind of housekeeping rules they would like to see during the training. Write them on a flipchart.</td>
</tr>
<tr>
<td>• Include the core rules described in the introduction of the manual (being on time, breaks, asking questions, phones on silent, no emails, etc).</td>
</tr>
<tr>
<td>• Explain why the pre and post-test are in the training and that the pre-test to Training 1 will soon be administrated.</td>
</tr>
</tbody>
</table>
Activity 1: Introductions and expectations
Duration: 15 minutes
Purpose: Introduce the group and assess the expectations of the group.
Instructions:
• Explain that the introductions will involve moving around the room.
• Draw a map on the ground (or explain the map to people by using materials in the room) of the country/region/area participants might come from or work.
• First ask participants to physically stand in their birthplace.
• Then ask them to move to their workplace.
• Ask them to move around one last time and line up according to years of experience in health or mental health.
• Then ask everybody in the group for a quick introduction by sharing their name, where they work, their current role in MNS care and their expectations of the course.
• Write expectations the participants mention on a flipchart.
• Introduce the learning objectives to the participants.
• Address the expectations that are mentioned in previous discussion, explaining which expectations will be met and why some expectations may not be met.
• Emphasize that in the training the manual will be used a lot since the aim is to give them the skills to work with this manual.

Session 1.2. Pretest (25 minutes)
Preparation for facilitator:
• Print enough copies of the pre-test for all participants (ensure that the answers are not attached or on the back side of any prints).
• Pre-test can be found in supporting material A (see annex).
• You might need to translate pre-tests in multiple languages.
Activity 2: Pre-test
Duration: 20 minutes
Instructions:
• Explain the purpose of the pre-test to participants.
• Explain that the test is not an exam but will give information on the level of knowledge in the group. At the end of the training the same test. Explain that the comparison will show to what extent the trainer team has been successful in delivering the knowledge to the participants and that participants will not be judged or compared with each other. Hand out the Training 1 pre-test and tell the group they have 20 minutes to complete the pre-test.
• Indicate when 10 minutes of time is left; indicate when 5 minutes are left.

Session 1.3. Why train on MNS conditions? (15 min)
Preparation for facilitator:
• If there is any information available on the treatment gap for MNS conditions from the country/region/area, have the local data available during the training.

Presentation
Facilitator Notes
• Ask the group why they think mental, neurological and substance use conditions are grouped together in mhGAP.
• Invite some answers from the group before showing the rest of the slide.
• MNS conditions are a diverse range of conditions that owe their origin to a complex range of genetic, biological, psychological, and social factors.
• Explain that MNS conditions are grouped together because they share several important characteristics as explained on the slide.
• Have a fast plenum discussion about the last question on the slide (max 5 minutes).
Emphasize that by 2030 depression is expected
to be among the diseases with the highest
burden everywhere in the world.
- The term burden reflects both mortality and
disability.
- Mental disorders can be extremely disabling,
causing many people not to function well in
their daily lives and disabling families.
- Thus mental health is an important public
health concern in all countries.

**Source**
These data are from the Global Burden of Disease
study – 2004 data.

Explain that a WHO study in 14 countries has
shown the extent of the treatment gap in
adults.
- 35 to 50% of serious cases did not receive any
treatment within the prior year in developed
countries.
- The percentage of cases not receiving any
treatment in developing countries was much
higher- 76 to 85%.
- Start a brief discussion (max 2 min) by asking
participants: "Is this a surprise or is this what
you expected?"

**Source:** WHO World Mental Health Consortium, JAMA,
2004
**Activity 3: Quiz**

**Duration:** 10 minutes

**Instructions:**

- Explain there will be a quick quiz with true/false questions. Point out one side of the room as ‘True’ and the other as ‘False’.
- Ask participants to move to either the ‘True’ or ‘False’ side depending on their answer.
- Ask the questions on the slide and let people move to either side of the room.
- Ask someone from both sides to explain their answer and before revealing the answer.
- If there is an appropriate example of a famous person from your country with an MNS condition, mention it to the group when discussing the second question.
Session 1.4. Introduction to mhGAP-HIG (40 minutes)

Preparation for facilitator:
- Identify a humanitarian crisis situation you think the group can identify with easily for activity 4.

**Presentation**

- A. Introduction and aims of training
- B. Pre-test
- C. Why train on mental, neurological and substance use conditions?
- D. Introduction to mhGAP-HIG
- E. Conditions in mhGAP-HIG
- F. General Principles of Care

**Facilitator Notes**

- Explain that this version of the manual is specifically developed for use in humanitarian emergencies.
- Explore the understanding of humanitarian emergencies in the group.
- Humanitarian crises include natural disasters (earthquake, tsunami) and human-made emergencies, such as war and refugee situations.

**Activity 4: MNS care and emergencies**

**Duration:** 15 minutes

**Instructions:**
- Identify a humanitarian crisis situation you think the group can identify with easily - e.g. having fled conflict in your town and now being 100 miles away in a refugee camp, or your community has suffered an earthquake destroying your home, and the local school and hospital.
- Ask the group to think of the grief and fear that people may experience.
- Ask the group to think of a family member/somebody they know with severe mental disorder and imagine what he or she would think or feel in this situation.
- Invite some people in group to share.
- In groups of 3 let them discuss how they would like to see health services in their country.
respond to the needs identified in this exercise.

- After the exercise reveal the rest of the slide and go through this information referring back to what participants have mentioned in the discussion.
- Participants might mention other valid challenges in humanitarian settings such as loss of normal services, routines and social supports (that protects vulnerable people from developing MNS conditions and likelihood of relapse).

Discuss the challenges with participants referring back to what they have mentioned earlier.

Ask participants for examples of similar challenges they have experienced in their work.

Briefly discuss the content of mhGAP-HIG.

Have trainees open the guide and open the table of content (page iii).

Explain that this course will cover general principles of care as well as the specific modules on the conditions.

Refer to pages 3 and 4 in the manual for the advice for clinical managers.

Explain that it is important to share the information on pages 3 and 4 with their clinical managers so they know what should be in place to use the mhGAP-HIG manual and implement it in their facilities.

Go through some of the points on the slide (e.g. constant access to essential medicines) and ask the participants who would be responsible for addressing these points in their clinic.
Activity 5: structure of the modules
Duration: 10 minutes
Instructions:
• Let participants open the manual and look at the structure (headings) of the modules depression and psychosis on their own.
• Give the instruction to discuss the structure (headings) of the modules with the person sitting next to them.
• Let two pairs share their observations about the similarities in structure they observed.
• Reveal the 4 points on the lower part of slide.

Part 1: Introduction to condition page p22
• Show similarities by looking at other introduction pages in mhGAP-HIG. The key similarities are:
  - narrative introduction to the condition
  - typical complaints box
• Explain that the typical complaints box contains information on how people with this condition often PRESENT themselves, so these are NOT the criteria of the condition (e.g. body aches are common presentation of depression but are not a specific symptom of depression).

Part 2: Key assessment questions p22
• Look through this depression assessment (page 22) and show similarities by looking at other assessment pages in mhGAP-HIG.
• Point out key similarities and differences:
  - 2 or 3 assessment questions in bold.
  - Use of the question: does the person have the condition?
  - Often there is a question on concurring conditions.

Part 3: Management p23
• Look through this page and show similarities by looking at other management pages in mhGAP-HIG. Point of key similarities:
  - Layout.
  - Separate section on psychosocial and pharmacological interventions.
Session 1.5. Key conditions covered (40 minutes)

Presentation

Conditions covered in this training
1. Significant symptoms of acute stress (ASU)
2. Significant symptoms of grief (GRI)
3. Moderate-severe depressive disorder (MDD)
4. Suicide (SUI)
5. Psychosis (PSY)
6. Epilepsy (EPI)

Facilitator Notes

• Emphasize that this part of the training will briefly introduce the key conditions that will be covered in this training.
• Explain that these 6 conditions cover more than 80% of all MNS cases that trained healthcare providers tend to identify and manage in emergency settings in general health care.
• More detailed information on assessment and management of these conditions will come later in Training 1.
• Training 2 will cover other conditions such as post-traumatic stress disorder, alcohol use disorders, intellectual disability and other significant mental health complaints.

Stress

• What is stress?
• In emergencies people are often exposed to major stressors.
• What stress-related problems do people present within your community?
• In this module we focus on significant symptoms of acute stress and grief (i.e. symptoms that impact functioning).

• Explain that stress is a common reaction to events in emergencies. Everyone can feel stressed. Stress can be a useful response as it stimulates our “fight or flight response” and in many people it can be a motivator that drives them to take action and make decisions in their life.
• However, people can become overwhelmed by stress and that starts to impact on their ability to cope in daily life.
• Have discussion on stress-related problems in the community.
• Explain how stress can present in primary healthcare as follows:
  - somatic complaints
  - sleep problems
  - behavioural changes
  - physical changes
  - extreme emotions
  - cognitive changes
• Give some concrete examples of complaints people often present with such as bedwetting.
and back pain. Ask the participants how people locally present stress related symptoms in primary healthcare.

- Explain that mhGAP-HIG has a module on acute stress and grief to cover the assessment and management of significant symptoms of acute stress and grief.

<table>
<thead>
<tr>
<th>Most people need clinical care after experiencing a potentially traumatic event</th>
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<tbody>
<tr>
<td>False</td>
</tr>
<tr>
<td>Most reactions do not become mental conditions, but some do.</td>
</tr>
<tr>
<td>If people have symptoms you need to distinguish between:</td>
</tr>
<tr>
<td>1. Significant symptoms of acute stress,</td>
</tr>
<tr>
<td>2. MNS conditions (mhGAP), such as depression,</td>
</tr>
<tr>
<td>3. Reactions that are not clinically significant and that do not require clinical management.</td>
</tr>
</tbody>
</table>

- Explain that in emergencies, people may be exposed to a range of potentially traumatic events.
- Ask the group to identify if the statement is true or false.
- Invite some answers before revealing the rest of the slide.
- Explain that most reactions do not become MNS conditions or disorders, but some do.
- Emphasize that many people have no problems or naturally resolving problems.
- Emphasize that stress can contribute to the development of most mhGAP-HIG conditions (with exception of epilepsy and intellectual disability).
- Using the slide, explain that not all stress reactions need clinical care.

<table>
<thead>
<tr>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is depression?</td>
</tr>
<tr>
<td>- Numerous symptoms moderate-severe depressive disorder (depression).</td>
</tr>
<tr>
<td>- What do local people call depression in their day-to-day language?</td>
</tr>
<tr>
<td>- What do they think are the causes of depression?</td>
</tr>
</tbody>
</table>

| Average prevalence of depression in people with physical diseases (70 countries) |

- Give the group instructions to read through the typical presenting complaints of moderate-severe depressive disorder on page 21 of the manual.
- Discuss the symptoms of depression and explain here that depressive symptoms are on a continuum and feeling sad is often normal. This module addresses moderate to severe depressive disorder.
- Mild depressive symptoms will be covered in module OTH in part two in the training.
- Use the questions on the slide to have a plenary discussion of max 5 minutes on the local words and local explanations. Local concepts may have similarities with depression, but also have important differences, and it is important to know these local terms.
- Emphasize that depression is very common in people with chronic physical diseases.
### Depression and humanitarian crises

- Does a humanitarian crises increase the risk of depression? **YES**

*In humanitarian crises significant losses and stress may result in grief, fear, guilt, shame, hopelessness and depression.*

### Suicide

1 death every 40 seconds

- Is the topic of suicide relevant to your community?
- Mental disorder, acute distress and hopelessness are common in humanitarian settings. Such problems may lead to suicide or serious acts of self harm.

### True or False

- Asking people about suicide provokes them to attempt suicide? **FALSE**

*Talking about suicide often reduces the person's anxiety around suicidal thoughts, helps the person feel understood and opens opportunities to discuss the problem further.*

### Instructions

- Raise the question on the slide.
- Invite some people to share their thoughts before revealing the answer.

- Ask whether suicide and suicide attempts occur in the local community. What happens if there is a suicide attempt?
- Explain that close to 800,000 people die of suicide every year. This means 1 death every 40 seconds.
- First leading cause of death among 15-19 year old girls globally.
- Explain that 78% of suicides globally occur in LMICs.
- Using the slide, explain why suicide is a risk in humanitarian settings.

- Ask the group if the statement on slide is true or false.
- Invite some answers from participants before revealing the answer.
- Explain that asking about self-harm/suicide and management of self-harm/suicide will be covered in this course.
Typical presenting complaints of psychosis

- Abnormal behaviour (e.g. strange appearance, self-neglect, incoherent speech, wandering aimlessly, mumbling or laughing to self)
- Strange beliefs
- Hearing voices or seeing things that are not there
- Extreme suspicion
- Lack of desire to be with or talk with others; lack of motivation to do daily chores and work

Psychosis and Humanitarian Crises

During a Humanitarian Crisis:
- extreme stress and fear
- breakdown of social supports and
- disruption of health care services and medicines supply

Can lead to or exacerbate symptoms of psychosis.

People with psychosis in emergencies are extremely vulnerable to various human rights violations (neglect, abandonment, abuse).

• Go through the typical presenting complaints of psychosis with the group and explain symptoms that are not clear to the group.
• Direct participants to read through this information on page 31 of mhGAP-HIG.
• Remind that this same layout is used for each condition.

• Give examples of a human rights violations such as:
  - Person with psychosis is tied to tree and left with some food/water while family flees.
  - Person with intellectual disability is raped during the chaos of an emergency.
  - Person with psychosis is shot for not understanding and following instructions of armed group.

• Ask the participants to give a true or false answer to the questions on the slide.
• Show question and ask the group to raise hands for true and false; then reveal the answer.

• Explore the local views on psychosis by asking the group the 3 questions on the slide. The aim is for a general discussion on local beliefs and views on psychosis.
  - Ask several people about the different terms they may hear used for describing psychosis.
  - Be sensitive and seek culturally appropriate language.
  - In particular emphasise that psychosis is a condition that can be treated.
• Ask the group about their experiences with people who have had convulsive seizures and local ideas about seizures.
• Explain that a convulsive seizure involves sudden involuntary muscle contractions alternating with muscle relaxation, causing the body and limbs to shake or become rigid.
• Explain that we will discuss the definition of convulsive seizures and epilepsy later in course but that epilepsy involves unprovoked seizures. Explain the term ‘unprovoked’ means there is no acute physical cause for the seizure.
• Raise the question on the slide to the group.
• Invite some people to share their thoughts before revealing the answer.

• Ask the group to give a true or false answer to the questions on the slide.
• Show question and ask the group to raise hands for true and false; then reveal the answer.
• Have brief discussion about local terms and beliefs for seizures (5 minutes).

Session 1.6. General Principles of Care (85 minutes)
Preparation for facilitator:
  • Prepare activity 7: depending on the background and experience of the participants decide to go for option 1 or 2.

• Share when the general principles of care will be covered in the training and show where these are in mhGAP-HIG.
• Principles of assessment in assessment part of training (page 6).
• Principles of management and reducing stress in ‘management’ part of training (page 7).
• Principles of communication (page 5), human rights (page 10) and overall well-being (page 11) will be covered now.
Explain that the principles of communication are important for MNS assessments and management.

 Invite some answers from participants before showing the answers.

 Discuss communication with carers in the local context and decide if it is necessary to add a carer to all the role-plays.

**Activity 6: Good and poor communication**

**Duration:** 10 minutes

**Instructions:**

• Ask participants to form pairs for an exercise on bad communication.

• Instruct the pairs to conduct a role-play in which a help-seeker wants to talk about a bad experience with a health-care provider.

• The help-seeker can choose a scenario from the slide or use a case of their own.

• The health-care provider will display at least one of the bad communication activities as mentioned on the slide.

• Let the role-play continue for 3 minutes and then ask for feedback.

• Ask participants: ‘What did you feel / what would you feel if you had been the person seeking help?’
• Refer to the principles of communication in on page 5 of mhGAP-HIG.
• Ask the group to read through the principles.
• Have a discussion about any important aspects as you go:
  - **Create an environment that facilitates open communication**: discuss how it would feel if not welcomed or acknowledged. (If time allows, consider demonstrating this).
  - **Involve the person with the MNS condition as much as possible** – Discuss how it might feel to be talked about, or briefly demonstrate this by asking for 2 volunteers and talking about one of them in front of the other.
  - **Start by listening** – discuss how it feels if someone gives advice or tells you what to do straight away. If time allows, demonstrate this and not listening but giving advice.
  - **Be clear and concise** – discuss what it might feel like to not be clear and concise, or demonstrate both types of talking.
  - **Respond with sensitivity when people disclose difficult experiences** – discuss how someone might feel after a rape or self-harm. Discuss shame and how it feels to disclose such difficult feelings. If time allows, consider demonstrating this.
  - **Do not judge people by their behaviours or beliefs** – discuss in particular laughing at someone or having a bad judgment of them. Discuss how it might feel to be laughed at or if someone says or thinks they are aggressive.
  - **If needed, use appropriate interpreters** – Discuss why an interpreter might be useful and the difficulties in using family members as interpreters.

• Take the group through the list of DO’s and DON’Ts in communication and ask for some examples of what these DON’Ts would look like in the field.
Illustrate the use of open and closed questions by asking some participants ‘Do you like apples?’

Ask the participants what kind of information these answers give. It only shows if people like apples or not and does not give any other information (like what other tastes people might like or not).

Ask participants for an alternative open question (e.g., What fruit do you like? What do you like to eat?)

Other examples of open questions that are good to use in the assessment are: what would be what you think is the cause of your problems “, “what makes it worse and what makes it better”?

Activity 7: group discussion on human rights violations within the community

Duration: 10 minutes

Instructions:
Have a group discussion using option 1 or 2.

Option 1:
• Instruct the group to write down the 5 rights they have that are most important to them personally.
• Let them look at their rights and imagine they have a mental health condition. Let them put an X to the rights they would lose.
• Ask people to raise their hand if they would lose all 5 rights. Then ask people to raise their hand if they would lose 4, 3, 2, 1, and 0 rights.
• What human rights are violated in the lives of people with MNS conditions in your communities?
**Option 2:**

- Ask some people to share the MNS conditions they have in mind. If they mention severe conditions, ask them to imagine if the same would be relevant for someone with depression or anxiety.
- Then direct participants to the top of page 10 and let them read the range of human rights violations people with MNS may experience during humanitarian emergencies.
- In pairs let participants confidentially discuss the human rights violations they may have experienced in their own lives and have them compare those that are on top of page 10 and have them decide in what category they fall.

- Ask for an additional local example of stigma and discrimination for people with severe mental health problems and for depression and anxiety.
- If there are no examples given, you may ask the following questions:
  - Have you seen people being locked up or chained because of their symptoms or behaviour? Highlight that family members often do this to protect their love ones and do not see any appropriate alternatives.
  - Have you seen people being hit because of their symptoms or behaviour?
  - How likely are health workers to openly share they have suffered from mental disorder?

- Pose the question to the group and encourage discussion for 5 minutes.
• Explain that people with severe mental conditions, even in high income countries, live 20 years less largely due to neglect of non-communicable diseases (NCDs).
• Let participants take a look at the IASC intervention pyramid for mental health and psychosocial support (page 11).
• Explain that the role of healthcare providers extends beyond clinical care to advocacy for the overall well-being of people with MNS conditions, which requires advocacy with colleagues working outside the health sector, as shown in the IASC Guidelines pyramid.
MODULE 2: ASSESSMENT OF mhGAP-HIG CONDITIONS

OVERVIEW
By the end of this module participants should be able to:
- Understand the general principles of assessment.
- Know the assessment questions for selected mhGAP-HIG conditions.
- Perform an assessment for selected mhGAP-HIG conditions.

<table>
<thead>
<tr>
<th>Session</th>
<th>Objectives</th>
<th>Duration</th>
<th>Training Activities</th>
</tr>
</thead>
</table>
| 1. General Principles of Assessment | Know the common general principles of assessment  
Understand how to conduct assessment with mhGAP-HIG | 40 min | Activity 8: Assessment with mhGAP-HIG exercise  
Activity 9: Role Play: General principles of assessment |
| 2. Assessment of significant symptoms of acute stress | Know how to assess for significant symptoms of acute stress | 45 min | Activity 10: Acute stress assessment  
Activity 11: Role Play: Assessing for significant symptoms of acute stress |
| 3. Assessment of significant symptoms of grief | Know how to assess for significant symptoms of grief | 30 min | Activity 12: Grief assessment  
Activity 13: Role Play: Assessing for significant symptoms of grief |
| 4. Assessment of moderate-severe depression | Know how to assess for moderate-severe depression | 70 min | Activity 14: Case studies depression  
Activity 15: Video assessment of depression  
Activity 16: Role Play: Assessing for moderate-severe depression |
| 5. Assessment of suicide | Know how to assess for imminent risk of suicide | 35 min | Activity 17: Role Play: Assessing for imminent risk of suicide |
| 6. Assessment of psychosis | Know how to assess for psychosis | 80 min | Activity 18: Case study of psychosis  
Activity 19: Assessment video psychosis  
Activity 20: Role Play: Assessing for psychosis |
| 7. Assessment of epilepsy | Know how to assess for epilepsy | 55 min | Activity 21: Case study epilepsy  
Activity 22: Assessment video epilepsy  
Activity 23: Role Play: Assessing for epilepsy |
| Total | | 355 min (5.9 hrs) |
### Session 2.1. General Principles of Assessment (40 min)

**Preparation for facilitator:**
- Have enough copies of the `Overview of mhGAP-HIG conditions` handout for *activity 8* (see supporting material C in the annex) and case study `Role play general principles of assessment` for *activity 9* (see supporting material B in annex).

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Facilitator Notes</th>
</tr>
</thead>
</table>
| Field test version - October 2017 
DONT UPLOAD ON THE INTERNET  
Humanitarian version  
Module 2: Assessment | • Introduce the assessment section of the training by explaining that this module will start with going through general principles of assessment. This will be followed by the assessment of each of the conditions. |

### Contents - Assessment

A. General principles of care - Assessment  
B. Significant symptoms of acute illness (ACU)  
C. Significant symptoms of grief (DRI)  
D. Moderate-severe depressive disorder (DEP)  
E. Suicide (SU)  
F. Psychosis (PSY)  
G. Epilepsy (EPI)

### Principles of assessment

- What is explored in assessment  
- Ask for:  
  - Presenting complaints  
  - Family/history of MSN conditions  
  - General health/history  
  - Current stressors, coping strategies and social support  
  - Alcohol and drug use  
  - Suicidal thoughts and suicide attempts  
- Observe: overall appearance, mood, facial expression, body language and speech.  
- Conduct: physical examination if necessary.  
- Read page 6 mhGAP-HIG.
Activity 8: Assessment with mhGAP-HIG

Duration: 8 minutes

Purpose: To practice the first step of assessment by looking at descriptions of presenting complaints in mhGAP-HIG.

Instructions:

• Give the participants 2 minutes to decide which conditions they would assess based on the presenting complaints on the slides. (Participants can also describe a local relevant case for this activity.)
• Ask a few responses and then reveal the answer.
• Discuss the answers in the group.

Discussion:

• Mention that the first step in assessment is to decide which condition to assess for.
• Explain that all the modules start with typical presenting complaints of persons with the condition.
• If complaints are indicative for 1 or more of the MNS conditions included in mhGAP-HIG, follow the assessment questions for the relevant conditions.

• Discuss approaches that are used for recording information that are gathered during an assessment. (Also discuss time constraints providers might have in recording information and search for a realistic solution.)
• Explain there is not one single approach to note taking that is ‘correct’ for everyone or for every setting (some people may find writing notes distracting or show that the healthcare provider is unskilled).
• Explain that it is important to have a way to record or remember the information.
• Discuss the confidentiality of “notes” and how to make sure other people don’t have access to it.
• Explain that it is also important to show engagement during assessment (It is odd to write all the time and not look at the person!).

• Explain that it is important to have a way to record or remember the information.
• Discuss the confidentiality of “notes” and how to make sure other people don’t have access to it.
• Explain that it is also important to show engagement during assessment (It is odd to write all the time and not look at the person!).
Activity 9: General principles of assessment role play

Duration: 20 minutes

Purpose: To practice performing assessment using the general principles of assessment.

Instructions:
• Divide the participants into groups of 3.
• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
• Hand out one of the two case studies (see activity 9 ‘General principles of assessment-role play’ in supporting material B) and show the slide with instructions during role play.
• Let the role play continue for max 10 minutes.
• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

Session 2.2. Assessment of significant symptoms of acute stress (45 minutes)

Preparation for facilitator:
• Make sure you have enough copies of the case study `ACU assessment role play` for activity 11 (see supporting material B in annex).

Facilitator Notes
• Explain that in crises stress is extremely common in all ages and groups. The assessment of specific conditions covered in HIG will start with significant symptoms of acute stress and a small exercise.
**Activity 10: Acute stress assessment**

**Duration:** 10 minutes  
**Purpose:** To get familiar with the criteria for significant symptoms of acute stress.

**Instructions:**
- Give instructions to open page 13 and 14 and answer the 2 questions with true or false (5 minutes for both questions).
- Get some answers from the group for question 1 before revealing the answer on the slide.
- Explain this is part of the assessment question for significant symptoms of acute stress:  
  - that people need to have considerable difficulty with daily functioning to meet the criteria for significant symptoms of acute stress.
- Get some answers from the group on the second question before revealing the answer on the slide.
- Direct the group to the manual where it mentions that:
  1. The event must have occurred within approximately 1 month of the event.
  2. If it has occurred more than 1 month ago, we do not use the word **acute** stress anymore and then consider other MSN conditions (depression, PTSD, substance abuse, OTH etc).
- Thus, if the person is having a lot of symptoms and has difficulties functioning in their daily life **more than a month** after the potentially traumatic event because of the symptoms, it is not ‘acute stress’ anymore. It is likely another MNS condition.
- Ask the group what they think is considered a potentially traumatic event.
- Invite a few responses and then reveal the answer.
- Instruct the group to see page 14 of mhGAP guide for assessment questions.
- Ask the group the second question on the slide.
- Listen to a few responses and then reveal the answer.
• Share the bullet points on the slide about how to ask about a potentially traumatic event.
• Start with an open question e.g:
  I’d like to ask you about any bad events you’ve experienced during the disaster/conflict. Are you able to tell me a little bit about what happened? You don’t need to go into details.” I only need to know what you consider important for me to understand what happened to you”.
• Emphasize again to follow the pace of the person, never pressure someone to talk about the issue and that there is no need to know details.
• Explain that some people wish to talk about the issue, and if so it is important to make time to listen and discuss the experience at the pace with which the person is comfortable. It may take someone a long time before they tell you something and that is okay.
• Note that the age, gender and background of person needs to be considered (communication may be different for children).

• Ask the person what symptoms they are experiencing, for how long they have had them, and whether or not the symptoms relate to the previous or current event. This will help decide whether this is acute stress or the exacerbation of another more longstanding problem.
• If person has had symptoms and problems since the attack 5 months ago, it is likely to be another condition as well as / or instead of ACU.
• Explain that they have now learned to assess for significant symptoms of acute stress. Management of these symptoms will be taught later in course.

• Explain that as with other conditions, one also has to check for physical conditions and other MNS conditions. Too often, physical issues are neglected when MNS conditions become the focus of treatment.
• Illustrate the need for this with an example (e.g a child may be bedwetting which may seem a symptom of acute stress but it could be caused by an urinary tract infection; or a person may have sleeping problems which may seem a symptom of acute stress but it could be caused by physical pain or by noise and weather when living in a temporary shelter or tent.)
Activity 11: Role play assessing for significant symptoms of acute stress

Duration: 20 minutes
Purpose: To practice performing assessment for significant symptoms of acute stress.
Instructions:
• Divide the participants into groups of 3.
• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
• Hand out one of the two case studies (see activity 11: ACU assessment role play in supporting material B in annex) and show the slide with instructions during role play.
• Let the role play continue for max 10 minutes.
• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

Session 2.3. Assessment of significant symptoms of grief (25 minutes)

Preparation for facilitator:
• In the footnote of the guide it mentions the normal period of mourning and bereavement may be longer in certain cultures, where religion sanctions more than 6 months of grief. Determine before the training if this is the case in the local setting and adapt training materials as necessary.
• Make sure you have enough copies of case study `GRI assessment role play’ for activity 13.

Presentation

Facilitator Notes

• Have a brief discussion on grief and mourning in local communities/cultures.
Give the group instructions to individually decide if person A and B are likely to experience significant symptoms of grief based on the information on page 17 and 18. Let them write answers (yes or no) on paper. (give them 5 minutes to do this)

Direct the group to assessment question 1 and 2 on page 18 and discuss how person A does not meet the criteria for question 2.

Direct the group to assessment question 1 on page 18 and discuss how person B meets the criteria for question 1 and 2.
• Ask the group for complaints one would often see in people who are grieving (2 min).
• Explain that reactions to bereavement are normal, people grieve in many different ways and there is no good or wrong way to grieve.
• Emphasize that symptoms of grief are considered significant when it meets the two criteria (in bold) on the slide and that people should receive help for it.
• Ask them to read the significant symptoms of grief again (mhGAP-HIG page 17).

• Explain how to ask about a major loss and the questions one could ask.
• Discuss that when prolonged grief disorder is expected a specialist needs to be consulted. Discuss the possibility of doing that in local context.

• Explain that after identifying that there was a major loss, the next step is to assess if the symptoms are significant. Assessment question 2 needs to be asked (page 18).

**Activity 12: Criteria for significant symptoms of grief**
Duration: 5 minutes
Purpose: To practice assessment of significant symptoms of grief.
Instructions:
• Present the two cases of possible significant symptoms of grief and ask the group what additional information is needed for both cases (3 min).
• Ask a few responses before revealing the answers.
Allow a few minutes for participants to come up with physical conditions that might explain symptoms (e.g., tiredness caused by anaemia) that may be misinterpreted as grief.

Activity 13: Role play assessing for significant symptoms of grief
Duration: 20 minutes
Purpose: To practice performing assessment for significant symptoms of grief.

Instructions:
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out one of the two case studies (see activity 13 ‘GRI assessment role play’ in supporting material B in annex) and show the slide with instructions during role play.
- Let the role play continue for max 10 minutes.
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.
- Explain that when it comes to showing empathy the tone (how you say it) is as important as what you say.
- Discuss the impulse to give immediately advice without knowing the situation. Very often health workers state unhelpful platitudes like ‘This is how life is’, ‘one day we all will go’, ‘do not worry, you will forget about it’
Session 2.4. Assessment of moderate-severe depression (70 minutes)

Preparation for facilitator:

- The video for activity 15 is available at https://www.youtube.com/watch?v=hgNAySulsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (duration 7 min and 40 sec). Download the video in advance in case the internet connection in the training venue is not sufficient.
- Make sure you have enough copies of the case study `DEP assessment role play` for activity 16.

Presentation

Facilitator Notes

Activity 14: Case studies depression

Duration: 10 minutes

Instructions:

- Give the group instructions to individually decide if person A and B are likely to have moderate-severe depressive disorder based on the information on page 21 and 22. Let them write answers (yes or no) on paper (5 minutes).
- Ask for some responses from the group for person A before showing the answers on the slide.
- Refer to assessment question 1 and indicate that person 1 does not meet the criteria for part A and part B. That her symptoms are present for less than 2 weeks.
- Ask for some responses from the group for person B before showing the answers on the slide.
- Refer to assessment question 1 and indicate that person 2 meets the criteria for part A and part B. He also has difficulties with daily functioning, meeting criteria C and his symptoms have been present for more than 2 weeks.
- He has a moderate-severe depression.
Ask the group for example questions they can ask for A), B), & C).

Invite some responses from the group and then reveal the examples on the slide.

Explain these are just example questions — have the group identify questions that might work in their specific settings.

Ask for more questions for criterion B.

Share that they can use these questions later in the role play.

Ask the group to read through relevant pages in the manual.

Answer any questions on how to rule out each point on the slide.

Explain that the SUI and SUB modules are particularly important to assess for as they often accompany depression.
Activity 15: Video assessment of depression  
**Duration:** 8 minutes  
**Purpose:** To show the assessment for depression.  
**Instructions:**  
- Ask the group to write down information that will help decide if Sarah has an MNS condition.

- Ask the group what problems they identified, write these on a flip chart, then reveal this list and point out any other additional problems that were missed by the participants.
- Ask group to check assessment question 1 on page 22 and select which symptoms indicate moderate – severe depressive disorder? – tick these on the flip chart
- Answered are revealed on next slide.

- Ask the group if they think Sarah meets criteria C of assessment question 1 (functioning) and why?
- Invite some responses from the group before revealing rest of the slide.
- Explain that Sarah clearly said she was having problems with daily functioning.
• Explain you continue with assessment question 2 on page 22.
• Invite someone to provide an answer before revealing the answer.
• Ask participants how they would rule these explanations out (e.g. asking specific questions to rule out issues).

• Explain that the SUI (suicide page 49) and SUB (page 45 harmful use of alcohol and drug) modules and other MNS modules are used to assess for these.
• Ask if Sarah exhibited problems related to any of these and if the doctor assessed for these.
• Let some people share their answers before revealing the answer. Let the participants reflect on the case and how local cases might be different.

Activity 16: Role play assessing for depression
Duration: 20 minutes
Purpose: To practice performing assessment for depression.
Instructions:
• Divide the participants into groups of 3.
• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
• Hand out case study (see activity 16 ‘DEP assessment role play’ in supportive material B in annex) and show the slide with instructions during role play.
• Let the role play continue for 10 minutes.
• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.
Session 2.5. Assessment of suicide (35 minutes)

Preparation for facilitator:

- Look up the estimated suicide rate for your country in the most recent WHO World Health Statistics (http://www.who.int/gho/publications/world_health_statistics/2017/en/) Make sure you have enough copies of case study `SUI assessment role play’ for activity 17.

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Facilitator Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contents - Assessment</strong></td>
<td>- Ask the group to read through the assessment questions on page 50. Remind the group that asking about suicide does not make it more likely for a person to attempt suicide and that it is important to move through all the three assessment questions of SUI.</td>
</tr>
<tr>
<td>A. General principles of care – Assessment</td>
<td>- Discuss assessment questions 1, 2, and 3 which have to be all addressed in each case (e.g. if a person presents with a suicide attempt, make sure to come back to assessment question 2 and 3 once the person is medically stable).</td>
</tr>
<tr>
<td>B. Significant symptoms of acute stress (ACU)</td>
<td>- Take time to explain the concept of imminent risk of suicide.</td>
</tr>
<tr>
<td>C. Significant symptoms of grief (GRI)</td>
<td>- Emphasize that it is important to know how to talk about suicide and that box SUI 1 on page 50 is important to read.</td>
</tr>
<tr>
<td>D. Moderate-severe depressive disorder (DEP)</td>
<td>- Discuss using questions that lead to following questions so there is an appropriate line of questioning (refer to the example in box 1).</td>
</tr>
<tr>
<td>E. Suicide (SUI)</td>
<td>- In pairs, get individuals to practice asking “Have you had any recent thoughts about ending your life?” in as many different ways you can (i.e. using different phrasings.)</td>
</tr>
<tr>
<td>F. Psychosis (PSY)</td>
<td>- Have a brief discussion about appropriate ways of asking about suicide and write examples down that can be used in the role play.</td>
</tr>
<tr>
<td>G. Epilepsy (EPI)</td>
<td>- Remind the participants that we will cover management of SUI later in the course.</td>
</tr>
</tbody>
</table>

**Assessment questions of suicide**

1. Has the person recently attempted suicide or self-harm?
   - Have you had any recent thoughts of ending your life?
2. Is there imminent risk of suicide or self-harm?
   - Have you ever thought about harming yourself?
3. Are there concurrent conditions associated with suicide or self-harm?
   - How would you harm yourself? What would you do?

**Asking about self-harm/suicide**

Questions to explore thoughts and plans:

- What are the aspects in your life that make it not worth living?
- Have you ever wished to end your own life?
- Have you ever thought about harming yourself?
- How would you harm yourself? What would you do?
Activity 17: Role play assessing for imminent risk of suicide

Duration: 20 minutes
Purpose: To practice performing assessment for suicide.
Instructions:
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out case study (see activity 17 ‘SUI assessment role play’ in supporting material B in annex) and show the slide with instructions during role play.
- Let the role play continue for max 10 minutes.
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

Session 2.6. Assessment of psychosis (80 minutes)

Preparation for facilitator:
- Make sure you have enough copies of case study ‘symptoms of psychosis’ for activity 18.
- The video for activity 19 is available at https://www.youtube.com/watch?v=tPy5NBFmIjY&index=4&list=PLU4ieskOi8GicaEnDwesQ6-yaGxhes5v (duration 6:59 min).
  Download the video in advance in case the internet connection in the training venue is not sufficient.
- Make sure you have enough copies of case study ‘PSY assessment role play’ for activity 20.

Presentation

Facilitator Notes
- Review the symptoms of psychosis.
- Emphasize that it is important to recognize that symptoms appearing as psychosis may be caused by substances such as alcohol or other drugs, and by medical conditions. This makes assessment crucial.
• Have a discussion about what it might be like to have a psychosis (max 7 min).
• Ask participants to share - giving one word for FEELING and one for BEHAVIOUR.
• List FEELINGS and BEHAVIOURS in 2 columns on a flipchart.
• Suggested answers:
  - Feeling: scared, suspicious, lonely, angry.
  - Behaviour: isolation, talking out loud to nobody, harm to self or others, self-neglect, poor motivation.
  - Communication: not trust others, be very guarded, be quiet and not speak, or be defensive as feel in danger.
• Spend 5 min on a discussion about how people would feel and behave towards someone with a psychosis.
• Ask participants to share - giving one word for FEELING and one for BEHAVIOUR.
• List FEELINGS, BEHAVIOURS, EFFECT ON PERSON WITH PSYCHOSIS in 3 columns on a flipchart.
• Examples of answers:
  - feelings: scared, angry, guilty.
  - behaviour: punitive, ‘chaining/locking them up’, mocking/bullying; hiding;
  - effect on person with psychosis: reduce trust and increase fear.
Demonstration of talking when hearing voices

Duration: 5 minutes

Instructions:
• Explain to the group that many people who hear voices and seek help, hear persecutory and derogatory voices.
• Ask for a volunteer to play the role of health care provider. One of the facilitators will play the person seeking help and the other facilitator will play the voice.
• The facilitator playing the voice should avoid making rude or offensive comments as this will distract the person seeking help from the conversation with the health care provider.
• Have the voice sit very close to the person seeking help and whisper and talk into their ear constantly.
• Demonstrate for 2 minutes and ask the group for some reflections on the demonstration.

Communication with person with psychosis

• State that many health care providers are unnecessarily uncomfortable in communicating with people with psychosis and there is usually nothing to fear.
• Emphasize the importance of respect and dignity in communication.
• Ask the group for factors that can complicate communication with a person with psychosis:
  - thoughts disorganized and unclear
  - sharing unusual beliefs
  - refuse to speak
  - experience of voices may distract the person during sessions.
  - not trusting health care provider
  - avoid any eye contact
  - believing that they do not need medical care (often the family will present the issue as a problem, not the person with psychosis).
• Mention that the communication style of a person with psychosis may be different.
• The points on this slide can aid your interaction with the person with possible psychosis.
• One goal of the first session is to make the person comfortable enough to return for follow up.
### Activity 18: Case study symptoms of psychosis

**Duration:** 7 minutes  
**Purpose:** To practice recognizing symptoms of psychosis.  
**Instructions:**
- Hand out the case study to the group (see activity 18 ‘symptoms of psychosis’ in supporting material B in annex).
- Ask the participants to read the case study and write down possible symptoms of psychosis (5 min).
- Invite a few responses before revealing the answer and have a discussion about the symptoms.

### Example symptoms of infections that can cause delirium (and thus psychotic symptoms)
- Cerebral malaria  
- Sepsis  
- Urosepsis

### Example metabolic abnormalities
- Hypoglycaemia  
- Hyponatraemia

### Example of medication side effects and intoxication/withdrawal
- History of use, including what was taken, frequency, and checking for signs of intoxication or withdrawal.

### Example of further assessment for harmful use of alcohol and substance
- SUB module.
• Explain that assessment for a manic episode is important because the management of such episode is different.

• Emphasize that especially in assessing psychosis gathering information from family or friends is very important.
• Discuss asking for person’s consent to speak to family or friends.

**Activity 19: Assessment video psychosis**

**Duration:** 15 minutes (video 6:59 min; 3 min reflection on the video; 5 min discussion)

**Purpose:** To demonstrate the assessment for psychosis.

**Instructions:**
• Give instructions to pay attention to the questions the health care provider asks and how he conducts the assessment. Ask participants to write down any symptoms he identifies and how.
• During the presentation of the video point out:
  - Medical check up
  - Safe and private setting with confidentiality
  - Trust building
  - Not rushing people
  - Not challenging false beliefs (this helps build trust)
  - Questions used by the health care provider
  - (speaking to Amir alone) Asking gently about his beliefs and who he is talking to.
• After the video start a discussion (10 min)
  - ask the group what signs they identified and write them on flipchart.
  - participants should identify: delusions
(persecutory and bizarre thoughts), hallucination (auditory), talking/mumbling to self, disheveled and unkempt (poor self-care).
- Have a short discussion (5 minutes) about what they have learned from the health care provider’s approach.

**Activity 20: Role play assessing for psychosis**  
**Duration:** 20 minutes  
**Purpose:** To practice performing assessment for psychosis.  
**Instructions:**  
- Divide the participants into groups of 3.  
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.  
- Hand out case study (see activity 20 ‘PSY assessment role play’ in the supporting materials B in annex) and show the slide with instructions during role play.  
- Remind the observer/carer that there are instructions in role play for the carer.  
- Let the role play continue for max 10 minutes.  
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

**Session 2.7. Assessment of epilepsy (55 minutes)**  
**Preparation for facilitator:**  
- The video for activity 22 is available at [https://www.youtube.com/watch?v=RURg555xI00&index=6&list=PLU4ieskOlil8GicaEnDweSQ6-yAGxhesSv](https://www.youtube.com/watch?v=RURg555xI00&index=6&list=PLU4ieskOlil8GicaEnDweSQ6-yAGxhesSv) (duration 5 min).  
  Download the video in advance in case the internet connection in the training venue is not sufficient.  
- Make sure you have enough copies of case study ‘EPI assessment role play’ for activity 23.

**Facilitator Notes**

- Explain that the first step in assessment of epilepsy is assessing for seizures (refer to page 36) and then assess for epilepsy.  
- Ask the group to read page 36 and answer the first question on the slide.  
- Ask for some responses in group before showing the answer on the slide.  
- Discuss the terms recurrent and unprovoked in the definition of epilepsy (Epilepsy involves
**True of false?**  
1) Everybody with a convulsive seizure meets the criteria for epilepsy.  
**False**  
- Epilepsy involves 2 or more unprovoked, convulsive seizures on 2 different days in last 12 months.  
2) Epilepsy can be assessed and managed by non-specialists in primary health care.  
**True**  
- People with epilepsy can be assessed and managed by non-specialists in primary health care.

**Assessment question 1**  
Is there a convulsive seizure?  
- Mean criteria for convulsive seizure if convulsive movements lasting longer than 1-2 minutes and AT LEAST TWO of the following:  
  - Loss of or impaired consciousness.  
  - Stiffness or rigidity of the body or limbs lasting longer than 1-2 minutes.  
  - Rotted or bruised tongue or bodily injury.  
  - Loss of bladder or bowel control during the episode.  
  - After the abnormal movements the person may demonstrate confusion, drowsiness, sleepiness or abnormal behaviour. The person may also complain of fatigue, headache or muscle ache.

**Assessment question 2**  
In the case of convulsive seizure, is there an acute cause?  
- Check for signs and symptoms of infection.  
  - Fever, headache, meningial irritation* (e.g. stiff neck)  
- Check for other possible causes of convulsion:  
  - Head/injury, metabolic abnormality* (e.g. hypoglycaemia, hypocalcaemia*), alcohol or drug intoxication or withdrawal  
  - If there is an identifiable acute cause of convulsive seizure, treat the cause.  
  - Refer to a hospital immediately if neuroinfection, head injury or metabolic abnormality is suspected.  
  - Follow up in 3 months to re-assess.

**Assessment question 3**  
In the case of convulsive seizures without an identified acute cause, is this epilepsy?  
- If the person has had 2 or more unprovoked, convulsive seizures on 2 different days in last 12 months then this is epilepsy.
- If there was only 1 convulsive seizure in the last 12 months without an acute cause, then antiepileptic treatment is not required. Follow-up in 3 months.

recurrent unprovoked seizures; unprovoked means without an acute cause).  
- Ask true or false question number 2.  
- Emphasize that epilepsy can be managed by non-specialists.  
- Explain that epilepsy is a chronic (long-term) condition.  
- State that this module covers the most prevalent type of epilepsy – convulsive epilepsy (manifested by convulsive seizures).

- Ask the group what a convulsive seizure looks like.  
- Review criteria for a convulsive seizure.  
- Ask if there are any questions about the presentation of these symptoms.

- Explain that if the person has convulsive seizures as assessed by the first assessment question, the next step is to assess if there is an acute cause for the seizures. This important to know for not only the assessment but also the management of the seizures.  
- Take the group through the listed possible acute causes.  
- Attend to questions of the group.

- Discuss slide and summarize that assessing for convulsive epilepsy involves 3 questions:  
  1. Does the person meet the criteria for convulsive seizure?  
  2. In the case of convulsive seizure, is there an acute cause?  
  3. In the case of convulsive seizure without an identified acute cause, is this epilepsy?
**Activity 21: Assessing for epilepsy**

**Duration:** 7 minutes  
**Purpose:** To practice assessing symptoms of epilepsy.  
**Instructions:**  
- Give the group 4 minutes to read the information on the slide and identify what information is lacking to assess for epilepsy using page 36.  
- Ask for the lacking information before revealing the answers.

---

**Activity 22: Video Assessment of epilepsy**

**Duration:** 10 minutes  
**Purpose:** To demonstrate assessment of epilepsy.  
**Instructions:**  
- Give instructions to the group to note down:  
  - any symptoms of epilepsy identified by the health care provider.  
  - what the health care provider does to build a relationship and obtain accurate information.  
- Ask the group about the symptoms health care provider identified in the video. Write correct ones on a flipchart.  
- Reveal the answer on the slide and add symptoms that were not mentioned yet to the flipchart.  
- Ask what the group has noticed the health care provider in the video did to build a relationship and get accurate information.  
- Numbers in brackets denote moment of time in video:  
  - Asks Faten to explain what has happened instead of speaking only to her mother (0.31).  
  - Empathises with Faten – “it must be very scary for you” (0.42).  
  - Asks mother for information (0.46).  
  - Shows understanding to mother – “you must be very worried” (1.09).  
  - Asks clarifying questions (e.g. how long did it last) (1.20).  
  - Normalises loss of bladder control. (1.50)  
  - Does not challenge traditional beliefs (3.54).
Activity 23: Role Play Assessing for epilepsy

Duration: 20 minutes

Purpose: To practice performing assessment for epilepsy.

Instructions:
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out case study (see activity 23 ‘EPI assessment role play’ in the supporting materials B in annex) and show the slide with instructions during role play.
- Remind the observer/carer that there are instructions for their role as well.
- Let the role play continue for max 10 minutes
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.
MODULE 3: MANAGEMENT OF mhGAP-HIG CONDITIONS

OVERVIEW
By the end of this module participants should be able to:

- Understand the general principles of management.
- Provide psychosocial interventions to persons with selected mhGAP-HIG conditions and their carers.
- Know when and how to provide pharmacological interventions for selected mhGAP-HIG conditions.
- Manage physical health among people with mhGAP-HIG conditions.
- Plan and perform follow up for mhGAP-HIG conditions.
- Refer people with selected mhGAP-HIG conditions to specialists and link with outside agencies.
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<tr>
<td>1. General Principles of Management</td>
<td>Introduce the general principles of management in mhGAP-HIG</td>
<td>5 min</td>
<td></td>
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</table>
| 2. GPC- Reducing stress and strengthening social support | Learn to provide stress reduction techniques and strengthening social support | 65 min | Activity 24: Exploring stressors and social support  
Activity 25: Problem solving techniques  
Activity 26: Breathing exercise |
| 3. Management of significant symptoms of acute stress | Learn how to manage significant symptoms of acute stress | 40 min | Activity 27: Case study management of significant symptoms of acute stress  
Activity 28: Role play: management of significant symptoms of acute stress |
| 4. Management of significant symptoms of grief | Learn how to manage significant symptoms of grief | 45 min | Activity 29: Case study Management of significant symptoms of grief  
Activity 30: Role play: management of significant symptoms of grief |
| 5. Management of moderate-severe depression | Learn how to manage moderate severe depression | 75 min | Activity 31: Video management of depression  
Activity 32: Role play: management of depression: psycho-education  
Activity 33: Role Play Management of depression: pharmacological |
| 6. Management of suicide | Learn how to manage suicide | 35 min | Activity 34: Brainstorm: management of suicide  
Activity 35: Video management suicide |
| 7. Management of psychosis | Learn how to manage psychosis | 75 min | Activity 36: Video management of psychosis  
Activity 37: Role play: management of psychosis |
| 8. Management of epilepsy | Learn how to manage epilepsy | 80 min | Activity 38: Psycho-education epilepsy  
Activity 39: Video management of epilepsy  
Activity 40: Role Play: management of epilepsy |
<p>| 9. Post-test and course evaluation | | 40 min | Activity 41: Post-test |
| Total | | 460 min (7.6 hrs) | |</p>
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<td><strong>Session 3.1. General Principles of Management (10min)</strong></td>
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<tr>
<td><strong>Humanitarian version</strong></td>
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<tr>
<td><strong>Module 3: Management</strong></td>
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</table>
| A. GPC – Management  
B. GPC – Reducing stress and increasing social support  
C. Management of significant symptoms of acute stress  
D. Management of significant symptoms of grief  
E. Management of moderate – severe depressive disorder  
F. Management of suicide  
G. Management of psychosis  
H. Management of epilepsy |
| • Introduce the management module.  
• Explain that before going to the management of specific conditions first the general principles of management and reducing stress and increasing social support will be covered.  
• Direct the group to page 7 with the general principles of management and explain the 6 points on the slide.  
• Let the group read through the different principles one by one and give them a chance to ask questions. |
| **Principles of management** |
| • Manage both mental and physical conditions in people with MNS conditions.  
• Actions to complete at first visit.  
  – Develop a management plan that person (and carer) understand and agree on.  
  – Arrange follow up visits.  
• Actions to complete at each follow-up visit.  
  – Assess for signs that require further management.  
  – Maintain in contact and have a plan if person worsens or does not show up. |
Session 3.2. Reducing stress and increasing social support (65 min)

Preparation for facilitator:
- Familiarize yourself with the stress reduction techniques in this module. You need to be able to demonstrate them to the group.

Presentation

Facilitator Notes

- Direct the group to page 8 of the manual with the ‘Principles of Reducing Stress and Strengthening Social Support’.
- Explain why this topic is included in the manual by going through the slide.
- Mention that the discussed techniques for reducing stress and strengthening social support are helpful in any stress people experience, so also if they don’t meet the criteria of one of the MHGAP-HIG conditions.
- Make a brief comment on how the techniques can also be used as self-care for health staff. This is relevant in case the participants themselves experience stress.

- Explain that these are the 4 areas that we will consider in this section.
  - *(related to point 1)* The aim of exploring stressors and the availability of social support is to identify ways to reduce the stress.
  - *(related to point 2)* The aim is to be aware of signs of physical or sexual abuse, including domestic violence or neglect can be the main source of the person’s mental health problems.
  - *(related to point 3)*. Depending on the source of the stress, different strategies should be tried.
  - *(related to point 4)*. Supporting the carers is very important as they will be able to help people with MNS problems much better if they have less stress.
• Direct participants to the questions on page 8 to identify possible stressors and availability of social support.
• Explain that through asking these questions you are hoping to get an understanding of:
  - main stresses they face.
  - supports that may help them.
• With this information you can:
  - Help identify stressors and sources of support.
  - Use this information to inform the application of a problem solving technique (to be covered later).
• Point out that all the questions are open questions.

**Activity 24: Exploring stressors and social support**
**Duration:** 10 minutes
**Purpose:** To practice exploring stressors and social support.
**Instructions:**
• Ask participants to take 5 minutes to think about their own life and write down stressors and sources of social support by answering these questions themselves.
• Have 5 min discussion on the exercise. Ask participants what it was like to do this exercise. For example were there people in their lives available for social support who they had not thought of before? What was it like to be specific about your worries?

• In humanitarian crises and refugee context people (especially children, older people and people with disabilities) are more vulnerable to neglect.
• Ask the group to read through the guidance on page 8 on how to pay attention to signs of abuse or neglect.
• The person’s domestic situation (e.g. abuse in the household) may be a greater stressor than the humanitarian situation affecting the community.
• Discuss how to discuss and address signs of abuse if the person is not alone (i.e., with a carer).
• Emphasize that violence against women is a common cause of depression.
• Ask and discuss the formal services and informal supports in the community for protection of women and children.
Three strategies to address stress

1. Problem Solving
2. Strengthening social support
3. Stress management
   - Applicable to both people having MNS conditions and their carers.

• Explain that these 3 strategies to reduce stress will be covered in the course.
• These strategies complement any protection strategies.

Strategy 1. Problem solving

Problem solving involves the following steps:

1. Introduce problem solving,
   - “You’ve mentioned quite a few problems, we can spend some time now seeing if we can identify possible ways to help you cope with a problem.”
2. Identify the problem,
   - “Out of the problems you’ve mentioned which one shall we focus on? Which one is causing you the biggest problem right now?”
   - Ensure the problem you identify is one that can potentially be helped by finding a way to cope.

• Take the group through the four steps of problem solving on the 2 slides.
• Ask participants how familiar they are with problem solving techniques.
• If some are familiar then ask two to give a demonstration, if not give the demonstration yourself with someone from group.
• Ask participants about common problems faced by people in their context.

Activity 25: Problem solving techniques

Duration: 10 minutes

Purpose: To practice problem solving techniques with someone.

Instructions:
• Ask the group to work in pairs and practice the problem solving steps. Ask trainees to think about a current problem they have and are fine to share with a colleague. Ask them to ensure the problem is a practical problem and not overly complex.
• Give the group 5 minutes to practice this part with each other.
• Have 5 min discussion on the exercise.
• In the discussion it is essential to mention that it is important that the person seeking help comes up with the decision about the solution to the problem and not the health care provider.
Read through this technique on page 8.

Ask the group how familiar they are with helping build social support.

If people indicate familiarity, ask for examples of what they do.

Explain the first step is to help people identify already existing support system and the second step is to refer them to other community resources.

Demonstrate the technique with a volunteer from the group as helper.

Share the example questions that can be used when identifying positive ways to relax (page 8).

Explain that multiple stress management approaches can be used, including the suggested slow breathing exercise.

Before going to the breathing exercise ask the group how familiar they are with stress management approaches.

Divide the group into 4 small groups and give the groups 3 minutes to come up with as many unique activities that could help reduce stress.

After 3 minutes give all the groups a chance to read their list of activities. Give a small reward (for example being the first to be served at tea break or lunch) to the group with the most unique activity.

Explain that the aim of the exercise is to slow breathing down in a relaxed way to help people feel relaxed.

Demonstrate the relaxation technique to the group using the text on page 9 of mhGAP-HIG (3 min).

If members of the group feel raised anxiety, it may be because they are trying too hard to “do it right” or breathing too much.

**Taking in too much air, i.e. breathing too quickly can lead to people feeling more anxiety and feel physical symptoms such as dizziness, muscle aches and chest pain. This is what people experience when hyperventilating.**

Explore other techniques people know of or use to reduce stress.
Activity 26: Breathing exercise
Duration: 10 minutes
Purpose: To practice instructing a breathing exercise.
Instructions:
• Give the group instructions to practice the slow breathing instructions in pairs (3 min each).
• Shortly discuss how this exercise in group and ask if there are any questions (3 min).
• Ask participants to practice the breathing exercise as homework for the next day.

Also: Address stress of the carers
1) Ask carers about worries around caring, social support, challenges, fatigue and psychological well-being.
2) Address carers’ needs and concerns by giving information, linking them with services, discussing needs care, perform problem solving or stress reduction techniques.
3) Acknowledge it is stressful to care for people with MNS conditions.
   • Carers can also have MNS conditions; assess and manage them accordingly.
   • Involved carers can be an important source of support in the management of MNS conditions.
   
Session 3.3. Management of significant symptoms of acute stress (40 min)
Preparation for facilitator:
• The basic psychosocial support in mhGAP-HIG module on acute stress is the same as psychological first aid (PFA). For more information on PFA see http://www.who.int/mental_health/publications/guide_field_workers/en/
• Have enough copies of case study ‘ACU management role’ for activity 28.

Presentation
Facilitator Notes
• Introduce the management of significant symptoms of acute stress.
• Ask the group to name the assessment criteria for significant symptoms of acute stress.
• Invite some answers from the group before showing the second slide.
Let group open page 15 and 16 to make a basic management plan for significant symptoms of acute stress for a person with sleep problems.

**Activity 27: case study management of significant symptoms of acute stress**

**Duration:** 10 minutes

**Instructions:**
- Show the case study on the first part of slide.
- Give 7 min to answer the questions.
- Ask a few responses and then reveal the rest of the slide with the answers.
- Explain that people commonly develop sleep problems (insomnia) after experiencing extreme stress and that it is important that is covered in the psycho-education.

For each area discuss any questions or concerns in implementing.

Specific areas to address for each section:
1. (all cases) Provide basic psychosocial support (i.e., psychological first aid) + educate about normal reactions.
2. (on sleep problems) Highlight how it is important to identify problems in environment and advise on sleep hygiene. Only prescribe medicines in exceptional circumstances. Discuss why benzodiazepines should only be used short term (may cause dependency) and should not be used at all in children and adolescents.
3. (bed wetting in children) Highlight the importance of ruling out physical cause (e.g., urinary tract infection), psychoeducation and need to be supportive. Discuss how to provide simple behavioural interventions (such as the star chart) and that punishing the child will not help.
Encourage participants to read at home the guide for management of hyperventilation and dissociative symptoms as symptoms of acute stress. These symptoms are less common than sleep problems or bed wetting.

<table>
<thead>
<tr>
<th>Activity 28: Role play management of significant symptoms of acute stress</th>
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</thead>
<tbody>
<tr>
<td><strong>Duration:</strong> 20 minutes</td>
</tr>
<tr>
<td><strong>Purpose:</strong> To practice performing assessment for significant symptoms of acute stress.</td>
</tr>
<tr>
<td><strong>Instructions:</strong></td>
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<tr>
<td>• Divide the participants into groups of 3.</td>
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<tr>
<td>• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.</td>
</tr>
<tr>
<td>• Hand out one of the two case studies (see activity 28 ‘ACU management role play’ in the supporting materials B in annex) and show the slide with instructions during role play.</td>
</tr>
<tr>
<td>• Let the role play continue for max 10 minutes.</td>
</tr>
<tr>
<td>• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.</td>
</tr>
<tr>
<td>• Ask participants about experiences of providing basic psychosocial support, discussing sleep hygiene and doing the breathing exercise.</td>
</tr>
</tbody>
</table>
### Session 3.4. Management of significant symptoms of grief (45 min)

**Preparation for facilitator:**
- The basic psychosocial support in mhGAP-HIG for grief is the same as psychological first aid (PFA). For more information on PFA see [http://www.who.int/mental_health/publications/guide_field_workers/en/](http://www.who.int/mental_health/publications/guide_field_workers/en/)
- Have enough copies of case study `GRI management role play` for **activity 30**.

#### Presentation

**Contents management module**

A. GPC – Management of grief
B. GPC – Reducing stress and increasing social support
C. Management of significant symptoms of acute stress
D. Management of significant symptoms of grief
E. Management of moderate – severe depressive disorder
F. Management of suicide
G. Management of psychosis
H. Management of agitation

**Recap: significant symptoms of grief**

- Major loss in last 6 months.
- Symptoms started after loss.
  - Sadness, anxiety, anger, despair
  - Warning and preoccupation with loss
  - Intrusive memories or thoughts of deceased
  - Loss of appetite
  - Loss of energy
  - Sleep problems
  - Concentration problems
  - Social isolation and withdrawal
  - Medication non-compliance
  - Grief related specific grief reactions
  - Difficulty in functioning or seeking help.

**Case study management of significant symptoms of grief**

Someone lost her mother 3 months ago and has significant symptoms of grief. There are no concurrent conditions. Sleep problems, bedwetting and dissociation.

- According to mhGAP-HIG what will be the basic management plan look like?
  - Basic psychosocial support
  - Additional psychosocial support
  - Psychoeducation
  - Discus culturally appropriate mourning processes
  - Encourage to return to previous activities
  - Follow-up
  - Which additional information is needed?
    - Is this a vulnerable person who needs protection?

#### Facilitator Notes

- Introduce the management of significant symptoms of grief.
- Ask the group to name the assessment criteria for significant symptoms of grief.
- Invite some answers from the group before showing the second slide.

**Activity 29: case study management of significant symptoms of grief**

**Duration:** 8 minutes

**Instructions:**
- Show the group the first part of slide with the case study.
- Give 7 min to answer the questions.
- Ask a few responses and then reveal the rest of the slide with the answers.
• Show this slide before teaching management in more detail.
• Explain that steps 1 to 4 are the same as for significant symptoms of acute stress and that steps 5 and 6 (discuss culturally appropriate mourning processes and return to previous normal activities) are added to the list.

• Let the group read through each of the management advice sections mentioned on the slide and let them ask questions.
• (steps 1,2) Highlight common psychosocial support strategies. Listening, identifying and address needs and concerns, protect.
• (step 3) Highlight how this is about normalising the experience of the individual and explaining that there is no one way to grieve. Ask people to read the text on page 19.
• (step 5) Highlight how alternative rituals can help the person to grieve, especially when remains or a body are not present, as may happen in humanitarian emergencies. Ask for local practices.
• (step 6) discuss what these activities may be (e.g. school, work).

• Let the group read through the management advice for each of these items on page 20.
• (step 7) Highlight that these should be addressed like just discussed in ACU and can be found on page 15 and 16 of manual.
• (step 8) Highlight that young children often have questions about death and the importance of building trust and answering questions honestly.
• Check if the group understands the concept `magical thinking` and explain how to correct magical thinking in children.
• (step 9) Highlight the needs of such people for continuity of care and ongoing protection. Highlight that children who have lost parents will do better with relatives they know and love.
• Follow up in 2-4 weeks — Explain how this is the same follow up period as ACU.
**Activity 30: Role play management of significant symptoms of grief**

**Duration:** 20 minutes  

**Purpose:** To practice management of significant symptoms of grief.

Be aware of that most likely the participants have had or experience grief themselves. This role play may thus trigger strong emotions. Instruct people to take a break if needed and be ready to support someone if necessary.

**Instructions:**
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out one of the two case studies (see activity 30 ‘GRI management role play’ in supporting material Bin annex) and show the slide with instructions during role play.
- Let the role play continue for max 10 minutes.
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

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**Session 3.5. Management of moderate-severe depression (75 minutes)**

**Preparation for facilitator:**
- The video for activity 31 is available at https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2 (duration 3 min and 50 sec). Download the video in advance in case the internet connection in the training venue is not sufficient.
- Have enough copies of case study `DEP management role play: psycho-education` for activity 32.
- Have enough copies of case study `DEP management role play: pharmacological` for activity 33.
**Facilitator Notes**

- Ask the group for the criteria of moderate-severe depression.
- Invite some answers from the group before showing the slide.

<table>
<thead>
<tr>
<th>Contents management module</th>
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<tbody>
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<td>A. GPC – Management</td>
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<td>B. GPC – Reducing stress and increasing social support</td>
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<td>C. Management of significant symptoms of acute stress</td>
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<td>D. Management of significant symptoms of grief</td>
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<tr>
<td>E. Management of moderate-severe depressive disorder</td>
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<td>F. Management of suicide</td>
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<td>G. Management of psychosis</td>
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<td>H. Management of epilepsy</td>
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</table>

**Recap: Moderate – severe depressive disorder**

- At least one core symptom for at least two weeks.
  - Persistent depressed mood.
  - Markedly diminished interest in or pleasure from activities.
- Several other symptoms for at least two weeks.
  - Disturbed sleep; change in appetite; worthlessness or guilt; fatigue; concentration problems; indecisiveness; agitation or restlessness; talking or moving slow; hopelessness; suicidal thoughts.
- Difficulty with daily functioning.

**Moderate – severe depressive disorder**

**Basic management plan overview**

- Psychosocial interventions
  - Offer psycho-education
  - Offer psychosocial support
  - If trained and supervised therapists are available, consider use of a brief psychological treatment
- Pharmacological interventions
  - Consider antidepressants
  - Choose an appropriate antidepressant
- Follow up (all cases)

**Psycho-education for depression: key messages**

- Depression is common and can happen to anybody.
- It does not mean the person is weak.
- Others might have negative attitudes because depression is not a visible condition.
- People with depression have unrealistically negative opinions about themselves, their life and future.
- Person should try:
  - Starting activities they enjoyed
  - Be physically active
  - Have regular sleep and eating pattern
  - Participate in community and spend time with friends and family
  - Person should be aware of thoughts of self-harm or suicide. They should never act on such thoughts but rather talk someone.
Let the group read through the management advice part 1 on offering psycho-education (page 23).

Answer any questions related to this guidance.

Highlight that offering psychosocial support as described in the Principles of Reducing Stress and Strengthening Social Support, is a core part of management:
- Explore possible stressors and the availability of social support.
- Be aware of signs of abuse or neglect. Emphasize that one key reason for depression in women is gender-based violence (domestic violence, rape).
- Based on information gathered, consider strategies to help the person.
- Address stress of the carers.

Remind them to look at page 8 on the Principles of Reducing Stress and Strengthening Social Support. Share that if trained and supervised therapists are available, consider use of a brief psychological treatment – Answer any questions related to these therapies and their local availability.

**Activity 31: Video management of depression**

**Duration:** 10 minutes

**Purpose:** To demonstrate the management of depression.

**Instructions:**
- Explain you will show management of DEP in the first visit and the follow-up visit of Sarah who is suffering from depression.
- Give instructions to the group to identify when Dr Jad performs the actions mentioned on the slide.
- Consider stopping the video from time to time and asking participants when an example of a topic from this slide is shown.
Activity 32: Role play management of moderate-severe depression: psycho-education

Duration: 20 minutes

Purpose: To practice giving psycho-education as management of depression.

Instructions:
• Divide the participants into groups of 3.
• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
• Hand out case study (see activity 32 ‘DEP management role play: psycho-education in the supporting materials B in annex) and show the slide with instructions during role play.
• Let the role play continue for max 10 minutes.
• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

Pharmacological interventions

• Do not prescribe an antidepressant if:
  - The person has depressive symptoms but not moderate-severe depression.
  - There is a recent history of bereavement or major loss.
  - The depression is due to a physical cause. Always manage that condition first.
  - The person is a child younger than 12.
  - The person is an adolescent 12–18 years of age as first-line treatment. Offer psychosocial interventions first.
  - The person is pregnant/breastfeeding. As first-line treatment offer psychosocial interventions first.

• Introduce pharmacological treatment to the group and refer group to mhGAP-HIG page 24.
• Begin with overview when not to prescribe an antidepressant.
• Ask participants to read Point 1, second column of Page 24.

Choosing an appropriate antidepressant

• Give the group instructions to read Point 2 on page 24: ‘If it is decided to prescribe antidepressants, choose an appropriate antidepressant’. Also ask them to go through table DEP 1 on page 24.
• Begin the quiz after 5 min.
True or False

- **Antidepressants are addictive**

  **FALSE**

  - Antidepressants are not addictive.
  - It is very important to take the medicine every day as prescribed.
  - It usually takes several weeks before improvements in mood, interest or energy can be noticed.

True or False

- **Antidepressants impair memory, concentration and rational thought**

  **FALSE**

  - Antidepressants can cause fatigue initially, but concentration usually improves with the symptoms of depression.
  - Some side-effects may be experienced within the first few days but they usually resolve.

Q&A

**Which antidepressant would you recommend for adolescents 12 years and older?**

Consider **fluoxetine** (but no other SSRIs or TCAs) only when symptoms persist or worsen despite psychosocial interventions.

Q&A

**Which antidepressant would you recommend for children under the age of 12?**

**NO** antidepressants. Use only psychosocial techniques.
Activity 33: Role play management of moderate-severe depression: pharmacological

Duration: 20 minutes

Purpose: To practice pharmacological management of depression.

Instructions:
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out case study (see activity 33 ‘DEP management role play: pharmacological’ in the supporting material B in annex) and show the slide with instructions during role play.
- Let the role play continue for max 10 minutes.
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.
• Explain that regular follow-up should be offered for psychosocial and pharmacological interventions, with the first one within 1 week and thereafter depending on course of disorder.
• Explain that it may take a few weeks for antidepressants to show effect. There may be some initial improvement after 2 weeks, such as sleep but full response takes longer. Monitor the response carefully before increasing the dose. It is expected that people will have a positive response, but there are some situations that will require action.
• If symptoms of a manic episode develop stop the medicines immediately and go to >> PSY module for management. Explain that antidepressants can elevate mood and lead to a manic episode in people with bipolar disorder. For that reason they should always be prescribed together with a mood stabilizer for bipolar disorder.
• Trainees should refer to a specialist if Bipolar Disorder is suspected.
• Explain what to do when no response or inadequate response.
• Explain to consider tapering off the medicines 9–12 months after the resolution of symptoms. Reduce the dose gradually over at least 4 weeks.

Session 3.6. Management of self-harm/suicide (35 minutes)

Preparation for facilitator:
• The video for activity 35 is available at available athttps://www.youtube.com/watch?v=4gKleWfGlE1&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaxhes5v (duration 9 min and 22 sec). Download the video in advance in case the internet connection in the training venue is not sufficient.

Facilitator Notes
• Start this section by asking the group to recall how to assess for suicide, keeping in mind to go through all the three assessment questions in all cases (also once a person is medically stable after a suicide attempt)
Emphasize in the management of attempted suicide:
- Provide medical care for injury or poisoning
- Treat person with care, respect and privacy. Do not punish the person.
- Mention that mhGAP HIG refers to WHO guidance on management of acute pesticide intoxication.
- Discuss that in case of prescribed medication overdose, where medication is still required it is important to choose least harmful alternative medication and to prescribe for short periods only to prevent another overdose.
- Last 3 management actions on the slide will be covered below.

Activity 34: brainstorm management of self-harm/suicide
Duration: 10 minutes
Instructions:
Ask the group to split into two large groups;
- One group is to formulate a list of ways in which a healthcare provider would monitor a person with a suicide attempt or an imminent risk of suicide.
- The other group is to formulate a list of ways in which a healthcare provider would offer psychosocial support for a person with a suicide attempt or an imminent risk of suicide.
- Allow 5 minutes for groups to come up with their lists, and 2 minutes each to read out their lists.
• Emphasize that the same management plan (parts 1 and 2) discussed here for imminent risk of suicide also needs to be applied in case of suicide attempt.
  - **Monitor**: remove means of self-harm/ suicide – pesticides, rope, medications; Do not leave the person alone; needs to be monitored 24 hours a day.
  - **Psychosocial support**: try to give hope.
    - When talking about “Explore reasons and ways to stay alive”, you should be careful as to what to say and not to say; trying not to induce further feelings of guilt about wanting to die;
    - The best reason that one can give a person for living is the assurance that the person can be helped to feel better;
    - When exploring for reason and ways to stay alive, one should listen well to the person and try to understand what matters most for the person.
  - **Consult a mental health specialist**:
    - Make an appointment for person with specialist and help the person to get there and check if person showed up for the appointment with specialist.
    - If mental health specialist is not available: mobilize family, friends and other concerned individuals or available community resources to monitor and support the individual during the imminent risk period.
    - **Follow up**: a concrete plan for follow-up should be made; maintain regular contact; frequent contact initially (e.g. weekly for the first 2 months) and less frequent contact as the person improves (e.g. once every 2–4 weeks); need to follow up for as long as suicide risk persists; at every contact, routinely assess thoughts, plans and acts of self-harm/suicide.
Activity 35: video assessment and management of attempted suicide

Duration: 10 minutes

Purpose: To demonstrate the assessment and management of attempted suicide.

Instructions:
• Explain the video shows an example of the management of suicide.
• Tell the group to note down questions or remarks.
• Give some time for questions and discussion afterwards (5 min).

Session 3.7. Management of psychosis (75 minutes)

Preparation for facilitator:
• The video for activity 36 is available at https://www.youtube.com/watch?v=Ybn401R2glI&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5 (6 min 50 sec). Download the video in advance in case the internet connection in the training venue is not sufficient.
• Have enough copies of case study ‘PSY management role play’ for activity 37.

Facilitator Notes
• Introduce the topic of psychosis by asking the group to recall the symptoms of psychosis.
• Emphasize the importance of knowing about acute physical causes and possible mania because the pharmacological management is different from psychosis without acute physical causes.
• Emphasize that management of PSY includes guidance for both pharmacological and psychosocial interventions and that the psychosocial interventions should be given to all cases.

• Antipsychotics should routinely be offered to a person with psychosis without acute physical cause.
• Instruct the group to read through the top half of page 33 pharmacological interventions and explain that a quiz will follow about pharmacological interventions for psychosis without physical causes.
• Invite some answers from the group before revealing the answers on the slides.
Quiz pharmacological interventions for psychosis without acute physical cause

Which route is preferable?
- Oral
- Intramuscular

Oral

Consider Intramuscular treatment only if oral treatment is not feasible. Do not prescribe long-term injections (depot) for control of acute psychotic symptoms.

Quiz pharmacological interventions for psychosis without acute physical cause

True or false
In psychosis without acute physical cause, anti-psychotics should be used for 2 weeks before considering it ineffective?

FALSE

In psychosis without acute physical cause, anti-psychotics should be taken at the suggested typically effective dose for at least 4-6 weeks before considering it ineffective.

Quiz pharmacological interventions for psychosis without acute physical cause

- What do we do for women who are planning pregnancies, pregnant, or breast-feeding?
  - Use the lowest effective oral dose.

Quiz pharmacological interventions for psychosis without acute physical cause

What if the person is still too agitated?

If agitation cannot be adequately managed by an antipsychotic alone, give a dose of benzodiazepine (e.g., diazepam, maximum 5mg orally) and consult a specialist immediately.
Take the group through information on how to manage side effects of medicines.

- Extrapyramidal: abnormalities in muscle movement, mostly caused by antipsychotic medicines. These include muscle tremors, stiffness, spasms and/or akathisia.
- Dystonia: acute spasm of muscles, typically of neck, tongue and jaw.

Explain that while antipsychotics should routinely be offered to a person with psychosis **without acute physical cause**, this is not the case for psychotic symptoms from acute physical causes (e.g. delirium or alcohol withdrawal).

- Antipsychotics should not be prescribed in case of alcohol withdrawal. Explain that in case of psychosis induced by alcohol withdrawal, it should be managed as described on page 48 box 1 (SUB). This will not be covered today.
- In case of acute physical causes other than alcohol withdrawal (e.g. in case of delirium), prescribe an oral antipsychotic medication as needed. Explain the following 3 points:
  1. Only prescribe the antipsychotic
medication at a moment when there is a need to control agitation, psychotic symptoms or aggression.
2. Stop the medication as soon as these symptoms resolve.
3. Consider intramuscular treatment only if oral treatment is not feasible.

### Pharmacological Interventions for manic episodes

- Explain that for a manic episode the first phase of the pharmacological treatment is exactly the same as for psychosis without acute physical causes.
- Refer to point 1 under pharmacological interventions on page 33; and repeat that exactly the same steps should be followed for acute manic episode.
- After the manic episode is managed the person needs be assessed for bipolar disorder.

### Psychosocial interventions for all cases

- Emphasize psychosocial interventions are for all cases with psychosis (with/without acute physical cause and mania).
- Psychoeducation: Explain that psychoeducation will be discussed on the next slide.
- Facilitate rehabilitation back into the community: Discuss as a group what resources may be available in the local community for people with psychosis and how participants may help to facilitate this. Community resources include: such as community-based healthcare provider, protection service workers, social workers and disability service workers.
- Ensure care for carers: Explain that it is very important for the wellbeing of the person with an MNS condition that the carers remain well.
- Let the group read through the psychoeducation part. Explain there are key message to person and key messages to carer(s).
- Discuss the importance of providing these key messages to carers; E.g.:
  - Ensures safety (e.g. of newborn, ensures person get help if symptoms get worse).
  - Ensures person is treated appropriately.
  - Help to ensure that medicines will continue to be provided.
  - Addresses beliefs such as restraining someone, or that psychosis is caused by witchcraft or spirits.
C. Follow Up

- Schedule and conduct regular follow-up sessions.
- Schedule the second visit within one week and subsequent visits depending on the course of the condition.
- Continue the antipsychotic treatment until at least 12 months after complete resolution of symptoms.

- Remind the group of the ‘Principles of management in General Principles of Care’ for the follow up (on page 7 of manual).
- Explain that a second visit should be scheduled within 1 week (as with depression).
- Continue the antipsychotic treatment at least 12 months after complete resolution of symptoms. If possible, consult a specialist regarding the decision to continue or discontinue the medicine.

Activity 36: Video management of psychosis
Duration: 7 minutes

Purpose: To demonstrate management of psychosis.

Instructions:
- Show the video and have a short discussion afterwards

Activity 37: Role play management of psychosis
Duration: 20 minutes

Purpose: To practice performing management of psychosis.

Instructions:
- Divide the participants into groups of 3.
- Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
- Hand out case study (see activity 37 ‘PSY management role play’ in the supporting material B in annex) and show the slide with instructions during role play.
- Remind the carers that there is a role description for them as well.
- Let the role play continue for max 10 minutes.
- Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.
Session 3.8. Management of epilepsy (75 minutes)

Preparation for facilitator:

- Familiarize yourself with the recovery position and prepare your demonstration. Make sure you can show A, B, C and D during the demonstration.
- The video for activity 39 is available at https://www.youtube.com/watch?v=LTS-cMy56w&index=7&list=PLU4ieskJl8GicaEnDweSQ6-yaGxhes5v (6 min 23 sec).
- Download the video in advance in case the internet connection in the training venue is not sufficient.
- Have enough copies of case study `EPI management role play` for activity 40.

Presentation

Facilitator Notes

• Start the section by asking the group to recall the criteria for convulsive seizures and epilepsy.

The management of EPI deals with both managing seizures and managing epilepsy. Take them through the information on the slide and explain this is framework of basic management of epilepsy and seizures.

• Identify that there is an educational component, pharmacological and follow up (as in depression and psychosis).

• Explain that the management part has additional management information for women who are pregnant, breastfeeding, or childbearing age (box EPI 1) and for a person who is convulsing or unconscious following seizure (box EPI 2).
### Activity 38: psycho-education epilepsy
**Duration:** 7 minutes
**Instructions:**
- Split the trainees into pairs.
- The trainees should practice on each other how they would explain the 2 questions on the slide to a person recently diagnosed with epilepsy and their carer.
- Facilitators should encourage trainees to read page 37 of the guide, to help them with this exercise, and so that they cover all important points.
- Let pairs change roles after 3 minutes.

### Activity 39: Video Management of epilepsy
**Duration:** 7 minutes
**Purpose:** To demonstrate management of epilepsy.
**Instructions:**
- Explain you will now show a video of epilepsy management.
- Facilitate a discussion on what the doctor did. In particular ensure to point out:
  - Psychoeducation
  - Normalising concerns
  - For the group to think of specific cultural concerns that may be relevant to their setting and situation.
2. Initiate or resume antiepileptic drugs

- Check if the person has ever used an antiepileptic medicine that controlled the seizure.
  - YES: resume the same medicine at the same dose.
  - NO or new medicine available: start a new medicine.
- Choose only one (see Table EPI 1); start with lowest dose and increase gradually until complete seizure control is obtained.

• Discuss “Initiate or resume antiepileptic drugs” as the second component of management in epilepsy and refer to page 38.

Choice of antiepileptic drug

- Try to prescribe a drug that is most likely always available in your area.
- Avoid prescribing expensive drugs:
  - Good choices include phenobarbital, carbamazepine, phenytoin, or valproate (valproic acid).
- Which antiepileptic drugs are available in your area?

• Begin a general discussion about what drugs are available at what costs (max 5 min).
• Point out how one drug can be more suitable than others in specific situations.
  - For example, avoid phenobarbital or phenytoin in children with intellectual disability or behavioural disorders.
• In this training we will focus on phenobarbital and carbamazepine, but mhGAP-HIG also covers valproate and phenytoin.
• Emphasize the importance of prescribing an antiepileptic drug that will mostly likely continue to be available in the area.

Antiepileptic medicines

- What is the starting dose for adults? Maintenance dose?
- Is the antiepileptic medicine given once or twice daily?
- What is the starting dose for children? Maintenance dose?
- What are the common side effects?
- With whom should you avoid certain antiepileptics?

• Have the group read page 38 and answer the question for the most available local antiepileptic mentioned on page 38.
• Let the group ask questions about things that are unclear.

Special management of epilepsy in case of pregnancy

- Always give women of childbearing age folate 5 mg/day to prevent birth defects.
- If pregnant:
  - Consult with a specialist for management.
  - Avoid valproate which can cause birth defects.
  - Avoid using more than one antiepileptic drug.
  - Avoid hospital delivery and more frequent antenatal visits.
  - At delivery, give 1 mg vitamin K (IM) to the newborn.
- The antiepileptic medicines presented in this module are safe for breastfeeding. However, please be aware that some other antiepileptic medicines may NOT be safe. Always consult the specialist.

• Refer to box 1 on page 39 for further information.
• Refer to table EPI 1 for the side-effects of antiepileptic medication.
• Let the group ask questions about things that are unclear.
• Explain that the picture on the right is of a man with Stevens-Johnson Syndrome, a rare autoimmune reaction. This is a life-threatening reaction associated with carbamazepine/phenobarbital/phenytoin.
• The medicines should be ceased and the person sent to hospital immediately.

3. Follow-up

• Ensure regular follow-up:
  - Once a month first 3 months.
  - Every 3 months if seizures are controlled.
  - Principles of Management (GPC) for more detailed advice on follow-up.
• Each follow-up:
  - Check how seizures are controlled.
  - Maintain or adjust medicines.
  - Consider stopping antiepileptic if no seizure occurred in last 2 years ( taper down slowly).
  - Review lifestyle issues + psychosocial education.

• Emphasize the importance of follow up in the management of epilepsy (page 39).
• Discuss the importance of aligning the frequency of appointment with the drug delivered pattern by pharmacist (e.g. in a lot of countries people get 1 month of anti-epileptic medicines – therefore the provider has to plan for monthly appointment).
• Refer to the Principles of Management (GPC) for more detailed advice on follow-up.
• Ask the group for possible questions to ask during follow up:
  - Is seizure frequency getting better or worse? Have there been drug specific side effects?
  - Make sure to check the list of possible side effects.
  - Assess treatment adherence.
  - Have they taken their medicines as directed? If not, why?
  - Any other issues e.g. problems in the community or family?
• Ask the group to read through the information on what to do when seizures (page 39) are not controlled and discuss this in the group.

Assessment and management of a person who is convulsing or is unconscious following a seizure

**Activities:**
- Box EPI 2: Assessment and Management of a person who is convulsing or is unconscious following a seizure

Assessment and management of acute seizures should proceed simultaneously

• Explain that box EPI 2 on page 40 explains what to do when a person is convulsing or is unconscious following a seizure.
• Let the group read through the information and encourage to ask questions if things are unclear.
Activity 40: Role play management of epilepsy
Duration: 20 minutes
Purpose: To practice performing management of epilepsy.
Instructions:
• Divide the participants into groups of 3.
• Instruct 1 person to play the role of the healthcare provider, 1 person to play the role of the person seeking help and 1 person to play the role of the observer/carer.
• Hand out case study (see activity 40 ‘EPI management role play’ in the supporting material B in annex) and show the slide with instructions during role play.
• Remind the carers that there are instructions for them in the case study
• Let the role play continue for max 10 minutes.
• Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 min.

3.9. Evaluation of training
Preparation for facilitator:
• Print enough copies of the post-test for all participants (ensure that the answers are not attached or on back page of prints).
• Post-test can be found in the supporting materials A (see Annex). You might need translated post-tests in multiple languages.

Activity 41: Post-test
Duration: 25 minutes
Instructions:
• Handout the post-test to participants and share that they have 20 minutes to complete it.
• Indicate when 10 minutes of time is left; indicate when 5 minutes are left.

• Ask participants for feedback on the training. What were the things they found most useful, what could be changed, how can it be improved or made more relevant?
Annex

Supporting materials:

A  Pre-post test
B  Case studies for role plays and observer checklist
C  Overview of mhGAP-HIG conditions
D  Links for mhGAP-videos
E  Adaptation template
A: PRE AND POST TEST

Pre- and Post-Test for mhGAP-HIG Course (Training 1)
(Duration 20 min)

A. Put ✓ in the correct column.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>All people with depression should be treated with antidepressants.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>It is important to speak to adults with a possible mental disorder in private.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If someone presents with family members, it is important to involve the family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>People with mental disorders cannot make decisions about their treatment/health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Asking about suicide increases the likelihood of suicide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Only mental health professionals can assess and treat individuals with mental disorders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>People with mental disorder should be separated from the family and society.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Most people with mental disorders will not recover.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Most people who experience war or a devastating natural disaster will develop a mental disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Follow up meetings should be conducted with persons with mental, neurological or substance use conditions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Put ✓ for the correct answer. There is only one correct answer for each question.

11. Which of the following statements concerning moderate to severe depressive disorder is correct
   ____ a. People often present with physical symptoms with no clear cause.
   ____ b. People often present with delusions and hallucinations.
   ____ c. People often present with confusion.

12. Concerning antidepressants which of the following is correct
   ____ a. Anti-depressant medication should be prescribed in primary health care to depressed children younger than 12.
   ____ b. Antidepressant medication usually has to be continued for at least 9-12 months.
   ____ c. In people with bipolar disorder, antidepressants are the only medicines required for treatment.

13. For significant symptoms of grief, you should:
   ____ a. Prescribe medication to manage symptoms.
   ____ b. Tell the person they should not cry much.
   ____ c. Listen, try to understand the person and assess if he or she has support.
14. A 22 years old male presents with possible symptoms of moderate-severe depressive disorder and hearing voices. You should:
   ___ a. Assess and manage symptoms of depression and then psychosis.
   ___ b. Prescribe antidepressants first.
   ___ c. Exclude physical causes first.

15. Concerning the management of psychosis
   ___ a. Medicines by injection will be required for most cases.
   ___ b. The person needs to be followed up after initial treatment.
   ___ c. The person should be physically restrained (e.g. chained).

16. Concerning epilepsy, which of the following is correct
   ___ a. If the person has had 1 convulsive seizure without an acute cause in the last 12 months, then antiepileptic medication is required.
   ___ b. The person has likely epilepsy if the person has had 2 or more unprovoked, convulsive seizures on 2 different days in the last 12 months.
   ___ c. Once the diagnosis of epilepsy is made in a woman with epilepsy, she should not have children.

C. Please circle the number that indicates your agreement with each statement below:

   1: I do not agree at all  2: I do not agree  3: I slightly agree  4: I agree  5: I strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Circle the number</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. I can assess a person with a mental disorder</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>18. I can manage a person who is experiencing psychosis</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>19. I can monitor some psychotropic medications</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>20. I can follow up on the care of people with mental disorders appropriately</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>21. I can give advice to people with mental disorders on their condition</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>22. I can explain mental health conditions to people suffering from these conditions</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>23. I can provide psychosocial support to the person with a mental disorder and their family</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>24. I know when to refer to a specialist</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
OBSERVER CHECKLIST:
When providing feedback to your colleague playing the health care provider:
- Consider that the person who plays the health care provider may feel anxious or vulnerable to do a role play in front of peers, so do not criticize that person, but rather give feedback in a way that will help the person to improve his or her skills.
- Do not only mention what went wrong, but especially also what went well.
- Use ‘positive language’ e.g.: “one thing that went well was . . . . One thing that can be improved was . . . .

During the role-play assess the health care provider on:
- Are all the assessment/management steps of mhGAP-HIG followed?
- Principles of communication:
  - Creating environment that facilitate open communication
  - Involving person with MNS condition as much as possible
  - Listening skills
  - Being clear and concise
  - Respond with sensitivity to what people share
  - Do not judge people by their behaviours
  - If needed, use of interpreters
CASE STUDIES FOR MODULE 2: ASSESSMENT OF MH-GAP-HIG CONDITIONS

Activity 9: General principles of assessment role play
Instructions for the person seeking help:
Case study 1:
- You have headaches and some stomach pains and your heart feels like it is beating very fast. You have little energy.
- You have 3 children and your husband had to leave your village due to violence. Your husband can therefore no longer do his job and you have financial problems.
- Your mother passed away 3 months ago and you miss her very much.
- 3 weeks ago you witnessed a bad accident involving two motorbikes. One driver died on the scene and the other is in critical conditions in the hospital. You often have nightmares about the accident and you are anxious about getting on the back of a motorbike, which is sometimes necessary for you to get to places (market, health center).
- You have friends and other people in your community who have supported you.
- You are not using alcohol or drugs and are not suicidal.
- You find that your faith helps you during this difficult time
- You were not experiencing these problems before the accident.

Case study 2:
- Six months ago, you had to flee your home due to fighting. You saw and heard of many people killed during that time.
- You, your wife/husband and two children made it into a refugee camp, where you have been given shelter and get some food from agencies.
- More recently, rebels attacked near the camp and some of your friends were killed. You cannot sleep very well and are always feeling on edge.
- You cannot work, have little money and little food.
- Your children have been sick and unhappy. You and your wife/husband are both unhappy and feel very sad for having lost everything.
- You have headaches and some stomach pains and your heart feels like it is beating very fast.
- You have friends in your community who have supported you and you have access to help when your children have been sick.
- You are not using alcohol or drugs and are not suicidal.
- You find practising your religion helps you feel better.
- You were not experiencing these problems before having to flee your home.

Activity 11: ACU assessment role play
Instructions for the person seeking help:
Case study 1:
- You experienced an earthquake/flood/hurricane 3 weeks ago that destroyed your house and most houses in your neighbourhood. Fortunately nobody died.
- You are afraid of it happening again, and feel anxious a lot of the time.
- You have lost your appetite, and have sleep problems now.
- You feel headaches and stomach pains sometimes.
- You feel on edge a lot of the time.
- You sometimes feel you have to breathe really fast as you cannot get enough air and you would like help for that.
- All these symptoms started after the earthquake and did not improve during the 3 weeks
Case study 2:
- Rebels attacked your village and burned houses 3 weeks ago. A lot of houses are totally destroyed and some of the community members died.
- Nobody of your family died, but you are very scared that the rebels may come again and you and your family escaped to a refugee camp in a neighbouring country.
- Since you arrived in the refugee camp you have a lot of physical complaints like headaches, stomach pains, and dizziness.
- You easily get into fights with other people in the camp and do not feel like your normal self anymore.
- Sometimes you feel shortness of breath and start to breathe really fast.
- You have trouble sleeping and the lightest noise will make you jump up at night.

Activity 13: GRI assessment role play
Instructions for the person seeking help:

Case study 1:
- You live in a refugee camp with your family after having to flee your village 2 years ago. Your mother passed away 3 months ago due to heart problems, and yet it feels as though it happened just yesterday.
- You have lost your appetite, are low in energy and have serious sleep problems.
- You feel on edge a lot of the time and argue a lot with other people in the camp.
- You find it hard to talk about her death.

Case study 2:
- Your community was hit by an earthquake/flood/hurricane 4 months ago, destroying much of the houses in your area. You were in another province when it happened and only found out a day later how hard your community was hit.
- When arriving home you found out that your brother was out with friends when the disaster happened and has still not reported to any of your family members or friends.
- You stay with your family in a local shelter and are still trying to find your brother.
- You go to your normal day job in an area that was not affected, but struggle to concentrate on your work. You feel sad and sleep very bad.
- Your friends ask you to do fun things with them sometimes, but you spend a lot of time searching for your brother and think about him constantly.

Activity 16: DEP assessment role play
Instructions for the person seeking help:

You are 35 years old and married.
- You and your family had to flee your home city due to violence 4 years ago and now stay in a city in a neighbouring country.
- You feel sad all day and you do not know why.
- You do not enjoy most of the things you used to do.
- You are cancelling appointments with friends because you do not feel like seeing anyone.
- You’re exhausted all the time and cannot seem to concentrate at work, but you cannot sleep!
- You are never hungry and you think you’ve lost weight.
- You are not suicidal and never have been.
Activity 17: SUI assessment role play
Instructions for the person seeking help:
- You should act very sad and quiet. Do not look the healthcare provider in the eyes.
- You might have depression, but you have no other MNS condition.
- You do not have chronic pain.
- You have been feeling worse and worse since your baby was born 3 months ago.
- The baby cries all the time and you cannot sleep at all. You do not know what to do.
- You have been feeling down and irritable. You have no desire to hold your baby. All you want to do is stay in bed and sleep.
- You say you are “tired all the time”. You have no appetite and little interest in your normal activities.
- You have been thinking about killing yourself for the last two weeks.
- You feel it is the only way you can cope with all this pressure.
- You have access to a rope and pesticides.
- For the past week you have been thinking about hanging yourself or drinking the pesticides supplies in the house.
- You are still feeling like you want to die.

Activity 18: Case study symptoms of psychosis
You are working in a PHC centre and have the following consultation:
- Michael, 17 years old, has been brought to you by his mother.
- His mother says that recently Michael "is not the same." He is no longer studying and prefers to stay home doing nothing.
- You notice that Michael is wearing summer clothes although it is cold and raining. He looks like he has not washed for weeks.
- When you talk to him, Michael avoids eye contact. He gazes at the ceiling as if looking at someone. He mumbles and gestures as if he is talking to someone.
- He does not want to see his friends. He always looks indifferent to any good or bad news.
- One night he refused the dinner that she prepared for him. He said the food was poisoned.
- He refused to go to the health center. The mother asked the neighbour to help her bring him in to the center.
- The mother reports that Michael asked "Why are you taking me to the center when I’m not sick?"

Activity 20: PSY assessment role play
Instructions for the person seeking help:
- You are a 20-year-old young man living in a refugee settlement since having to flee your village 1 year ago due to violence.
- You live with your parents, brothers and sisters.
- You used to be active when you were younger, but since a few years you have become withdrawn, and you have isolated yourself.
- A couple of years ago, while still living in your village, you have stopped playing sports and did not visit friends very often.
- You used to go the church/mosque/temple once a week but have now stopped doing so because you think that God is talking to you directly. In the camp you also do not attend the church/mosque/temple.
- Only your mother (and not anyone else) is allowed to prepare your food, because you think it can be poisoned.
- You do not take good care of yourself and you prefer to stay in your family’s shelter.
- During the interview you are laughing to yourself for no clear reason.
Instructions for the carer:
- You are the mother/father of the help-seeker
- You are very worried about your son because he is not taking good care of himself and lost a lot of weight.
- He refuses to eat food that is made by his older sister who often helps you to make food.
- You are wondering if you did something bad and are being punished by God. You want to know how you can help him to be healthy again.

Activity 23: EPI assessment role play

Instructions for the person seeking help:
- You are 26 years old.
- You say you have had a fainting spell about a week ago.
- You did not think it was a big deal, but your parents have insisted that you see the doctor because you were shaking on the floor.
- Your parents said you had lost control of your bladder, which you are very ashamed of and do not want to speak about.
- You felt dizzy and confused when you woke up from this.
- You have not had any relevant health problems before.
- This happened once before about 6 months ago.
- You do not want to tell anyone as you fear it might be caused by a spirit.

Instructions observer/carer:
- You accompany your son/daughter to the clinic because you are very worried.
- A week ago you heard a noise in your shelter and found out he/she fell on the floor and was shaking a lot for about 2 minutes.
- You tried to make contact as soon as the shaking stopped but that was not possible for 5 minutes, but he/she was breathing.
- You were really scared and did not know what to do.

CASE STUDIES FOR MODULE 3: MANAGEMENT OF MH-GAP-HIG CONDITIONS

Activity 28: ACU management role play

Instructions for the person seeking help:
Case study 1:
- You experienced an earthquake/flood/hurricane 3 weeks ago that destroyed your house and most houses in your neighbourhood. Fortunately nobody died.
- You are afraid of it happening again, and feel anxious a lot of the time.
- You have lost your appetite, and have sleep problems now.
- You feel headaches and stomach pains sometimes.
- You feel on edge a lot of the time.
- You sometimes feel you have to breathe really fast as you cannot get enough air and you would like help for that.
- All these symptoms started after the earthquake and did not improve during the 3 weeks.
- Share with the health care provider that you often wake up in the middle of the night with nightmares and then get out of bed and make some coffee for yourself.
- Also mention that sometimes you drink alcohol to make you sleep better.
Case study 2:
- Rebels attacked your village and burned houses 3 weeks ago. A lot of houses are totally destroyed and some of the community members died.
- Nobody of your family died, but you are very scared that the rebels may come again and you and your family escaped to a refugee camp in a neighbouring country.
- Since you arrived in the refugee camp you have a lot of physical complaints like headaches, stomach pains, and dizziness.
- You easily get into fights with other people in the camp and do not feel like your normal self anymore.
- Sometimes you feel shortness of breath and start to breathe really fast.
- You have trouble sleeping and the lightest noise will make you jump up at night.
- Share with the health care provider that you often wake up in the middle of the night with nightmares and then get out of bed and make some coffee for yourself.
- Also mention that sometimes you drink alcohol to make you sleep better.

Activity 30: GRI management role play
Instructions for the person seeking help:
Case study 1:
- You live in a refugee camp with your family after having to flee your village 2 years ago. Your mother passed away 3 months ago due to heart problems, and yet it feels as though it happened just yesterday.
- You have lost your appetite, are low in energy and have serious sleep problems.
- You feel on edge a lot of the time and argue a lot with other people in the camp.
- You find it hard to talk about her death.
- You smoke a lot at night to calm yourself down.
- You feel very weak and share with the healthcare provider that you think you crazy for feeling so sad.
- You were not able to attend your mother’s (because you were in another province and did not make it back in time) and that gives you a lot of pain because you feel like you did not have a chance to say goodbye.
- You do not know how to make the pain and sadness disappear.

Case study 2:
- Your community was hit by an earthquake/flood/hurricane 4 months ago, destroying much of the houses in your area. You were in another province when it happened and only found out a day later how hard your community was hit.
- When arriving home you found out that your brother was out with friends when the disaster happened, and he has died.
- You stay with your family in a local shelter.
- You go to your normal day job in an area that was not affected, but struggle to concentrate on your work. You feel sad and sleep very bad.
- Your friends ask you to do fun things with them sometimes, but you spend most of your time thinking of your brother.
- You smoke a lot at night to calm yourself down.
- You feel very weak and share with the healthcare provider that you think you crazy for feeling so sad.
- You were not able to attend your mother’s (because you were in another province and did not make it back in time) and that gives you a lot of pain because you feel like you did not have a chance to say goodbye.
- You do not know how to make the pain and sadness disappear.
Activity 32: DEP management role play: psycho-education

Instructions for the person seeking help:
- When the healthcare provider is providing psycho-education for depression, ask questions, such as:
  - When will it improve?
  - What can I do to make it improve?
  - What about seeing a traditional healer, would that help?
  - Is this happening because I am not religious enough?
  - People are telling me it is because I am weak and need to be stronger.
- Explain that a major reason you are feeling like this is that you are depressed and worried because of a problem (e.g. you cannot get support to look after your children). (this should lead the healthcare provider to using the problem solving strategy and a conversation to identify sources of support). Different resources are available that may help with your problem:
  - Husband / wife, children, extended family.
  - An organisation offering support for such a problem (e.g. microfinance, child protection, protection services)
  - There are also other people / organisations in your community which can offer support with your problem.
- Provide information on sources of support to the healthcare provider as they use the problem solving techniques and help you to identify sources of social support.

Activity 33: DEP management role play: pharmacological

Instructions for the person seeking help:
- You are nervous about taking medication, but you are willing to give it a try. Ask questions about the medication. E.g:
  - Is it addictive?
  - What are the side effects?
  - Do I need to take them every day?
  - Can I stop it if I do not like it?
  - How long do I have to take it for?
- You have not had any ideas, plans or acts of self-harm or suicide.
- You have no other significant medical history.
- You have no history of cardiovascular disease.
- You have no history of mania.

Activity 37: PSY management role play

Instructions for the person seeking help:
- There have not been any further symptoms or signs of psychosis.
- You have been taking the medication regularly as directed.
- Your mother has been helping to make sure that no doses are missed.
- The only possible side effect has been a slight tremor in your hands.
- This tremor has not had a significant effect on your life, but it is quite irritating.

Instructions for carer:
- You think your son is taking better care of himself after starting the medication and it is easier to communicate with him.
- He has gained some weight.
Activity 40: EPI management role play

Instructions for the person seeking help:
- You have been assessed as having epilepsy.
- You are willing to try medication, but have not tried one before.
- You work in a rice field every day. The field is covered in water up to the knee.
- You also cook dinner for the family with an open fire every night.
  (Alternatively you can work in factory with machinery or ride a motor)

Instructions for carer:
- You are concerned about your child and want to know what you can do to help.
- You are anxious that you did something that caused this.
C: OVERVIEW OF MGHAP-HIG CONDITIONS

OVERVIEW OF MHGAP-HIG CONDITIONS

- Common Presentations

  - Acute Stress (ACU)
    - Symptoms are reactive to potentially traumatic event within last month
    - Symptoms range of non-specific psychological and medically unexplained physical

  - Grief (GRI)
    - Symptoms are reactive to loss
    - Symptoms range of non-specific psychological and medically unexplained physical

  - Depression (Dep)
    - Little interest or pleasure from activities
    - Persistent sadness or depressed mood, anxiety
    - Persistent physical symptoms with no clear cause
    - Low energy, fatigue, sleep problems

  - Psychoses (PSY)
    - Abnormal behavior (e.g., strange appearance, self-destruct, incoherent speech, wandering aimlessly)
    - Hallucinations or hearing things that aren’t there
    - Strange beliefs
    - Extreme suspicion
    - Lack of desire to be with or talk with others
    - Lack of motivation to do daily chores and work

  - Epilepsy (EPI)
    - A history of convulsive or movement seizures

  - Suicide (SU):
    - Past attempts of self-harm (e.g., acute pesticide intoxication, medication overdose, self-inflicted wounds)
    - Feelings extremely upset or depressed

- Overview of MHGAP-HIG Conditions

- Field Testing Draft - Do Not Upload Online
D: LINKS to mhGAP VIDEOS

**A Depression**

Part 1 Assessment: [https://www.youtube.com/watch?v=hgNAySuI5jY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v](https://www.youtube.com/watch?v=hgNAySuI5jY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v) (duration 7:40)

Spanish: [https://www.youtube.com/watch?v=MYi1b7VfcxU](https://www.youtube.com/watch?v=MYi1b7VfcxU) (duration 10:19)

Part 2 Management: [https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2](https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2) (duration 3:54)

Spanish: [https://www.youtube.com/watch?v=4LkPsrl9br0](https://www.youtube.com/watch?v=4LkPsrl9br0) (duration 3:59)

Part 3 Follow-up: [https://www.youtube.com/watch?v=F3MKvTxQv4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3](https://www.youtube.com/watch?v=F3MKvTxQv4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3) (duration 5:22)

Spanish: [https://www.youtube.com/watch?v=Z8NpPfFpQQ](https://www.youtube.com/watch?v=Z8NpPfFpQQ) (duration 5:29)

**B Suicide**

[https://www.youtube.com/watch?v=4gKleWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v](https://www.youtube.com/watch?v=4gKleWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v) (duration: 9:22)

Spanish: [https://www.youtube.com/watch?v=de9jnZlyPTo](https://www.youtube.com/watch?v=de9jnZlyPTo) (duration 10:46)

**C Psychosis**

Part 1 Assessment: [https://www.youtube.com/watch?v=tP5NBFmlJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v](https://www.youtube.com/watch?v=tP5NBFmlJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v) (duration 6:59)

Spanish: [https://www.youtube.com/watch?v=eB3cj7IM9Do](https://www.youtube.com/watch?v=eB3cj7IM9Do) (duration 9:22)

Part 2 Management: [https://www.youtube.com/watch?v=Ybn401R2g4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5](https://www.youtube.com/watch?v=Ybn401R2g4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5) (duration 6:05)

Spanish: [https://www.youtube.com/watch?v=XoqtYmi-dkO](https://www.youtube.com/watch?v=XoqtYmi-dkO) (duration 6:30)

**D Epilepsy**

Part 1 Assessment: [https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v](https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v) (duration 5:00)

Part 2 Management and follow up: [https://www.youtube.com/watch?v=LTS-cMy56w&index=7&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v](https://www.youtube.com/watch?v=LTS-cMy56w&index=7&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v) (duration 6:23)
### Section: Common presentations

Is there robust evidence that the common presentation is different in your specific country? What local idioms for signs and symptoms of mental, neurological and substance use disorders are used?

[ACU 13; GRI 17; DEP21; PTSD 27; PSY31; EPI35; ID 41; SUB 45; SUI 49; OTH 53]

### Section: Physical illness

Given what is known about the epidemiology in the country, should the examples of physical diseases, for differential diagnosis, be revised?

[ACU-; GRI-; DEP22; PSY32; EPI36; ID-; SUB-; SUI-; OTH-]

### Section: Management

“Consult with a specialist”. What does consult mean for this condition (phone? refer?)? What specialist should be consulted for this condition (psychiatric nurse? psychiatrist?)?

### Section: Psychosocial interventions

Review the interventions listed in the module; are these interventions available now or expected to be within the next few years? If Yes, list available services by location (as an Annex) and indicate how persons are referred to receive them. If No, consider the pros and cons of keeping or removing some or all of the current text. Consider adding basic principles of problem-solving counselling to training materials.

[ACU-; GRI-; DEP23; PTSD 29; PSY34; EPI-; ID-; SUB47; SUI-; OTH]

### Section: Psycho-education

Review the key-messages and adjust if necessary for local context

[ACU 15; GRI 19; DEP 23; PTSD 29; PSY 34; EPI 37; ID 43; SUB 47; SUI 51; OTH 55]

### Section: Pharmacological interventions

Review the listed medications. If other psychotropic medications are widely available/accessible and affordable and are in line with national protocols/guidelines, these may be added for use in adults (but not in children or adolescence, where fluoxetine remains the only medication)

[ACU-; GRI-; DEP24; PTSD-; PSY34; EPI38; ID-; SUB48; SUI-; OTH-]

### Section: Follow-up

Review the recommendations on frequency of contact and adapt if needed, based on local context. If relevant, identify the venue of follow-up and health personnel involved in follow-up.

[ACU 16; GRI 20; DEP25; PTSD 29; PSY34; EPI39; ID 43; ; SUB47; SUI 51; OTH55]

### Section: Other module-specific adaptations

- **General Principles of Care (GPC) module** [page 5-11]
  - Include relevant articles / clauses from national/regional mental health legislation or regulations.
- **Grief (GRI) module** [page 18]
  - The normal period of mourning and bereavement may be longer in certain cultures. Adjust the time criteria if needed.
- **Intellectual disabilities (ID) module** [page 44]
  - Include local warning signs to developmental milestones.
- **Suicide (SUI) module**: discuss legal issues and possible adjustments

### Other comments: