# Module: Psychoses

## Overview

### Learning objectives

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



### Key messages

- Psychoses includes psychosis and bipolar disorder.
- Common presentations of psychosis include:
  - Marked behavioural changes, neglecting usual responsibilities.
  - Agitation, aggression or decreased activity.
  - Delusions – a fixed false beliefs.
  - Hallucinations – hearing voices or seeing things that are not there.
- Bipolar disorder is often characterized by significant disturbance in mood and activity levels with manic episodes (in which the person's mood is elevated and their activity levels increase) and depressive episodes (in which the person's mood is lowered (depressive) and their energy levels decrease).
- Psychoses can be managed in non-specialized health settings.
- When assessing for psychoses make sure you assess for and rule out other medical conditions (i.e. delirium).
- Provide both psychosocial and pharmacological interventions as first-line treatments for people with psychoses.
- Most people with psychoses can make a full recovery.
- Seek specialist support when needed.
- The best way to reduce the stigma and discrimination against people with psychoses is to treat them with respect and dignity and integrate them into the community.

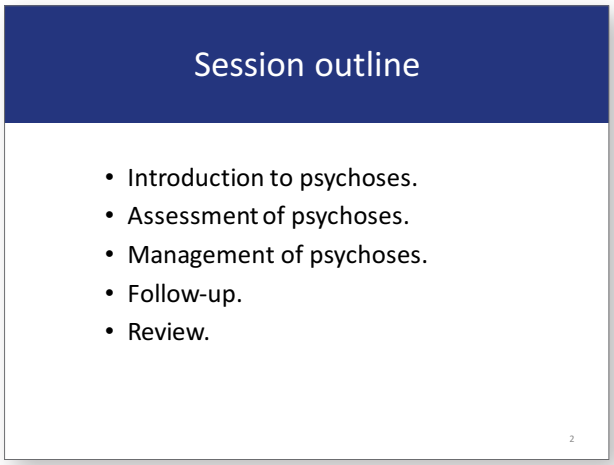
| Session | Learning objectives | Duration | Training activities |
|---|---|---|---|
| 1. Introduction to psychoses | Name common presentations of psychoses<br><br>Promote respect and dignity for people with psychoses<br><br>Understand that psychoses can be treated in non-specialized health settings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

| Session | Learning objectives | Duration | Training activities |
|---|---|---|---|
| 4. Follow-up | Plan and perform follow-up sessions for people with psychoses | 5 minutes<br><br>30 minutes | **Discussion on the principles of follow-up**<br>Use the mhGAP-IG to discuss follow-up for people with psychoses<br><br>**Activity 8: Role play: Follow-up** |
| 5. Review | | 15 minutes | Quiz |
| **Total duration (without breaks) = 4 hours 40 minutes** | | | |

Step-by-step facilitator's guide

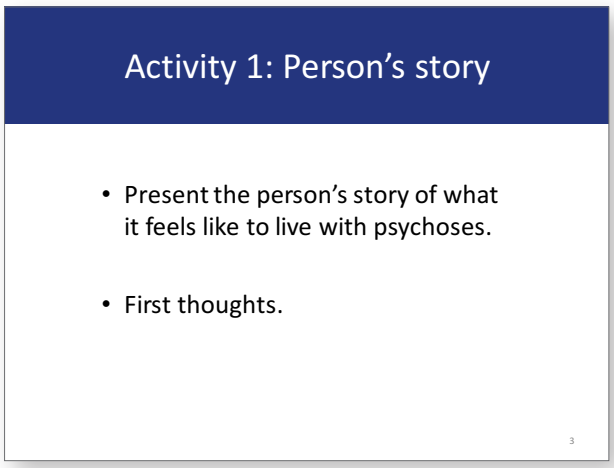
# Session 1. Introduction to psychoses

## 50 minutes



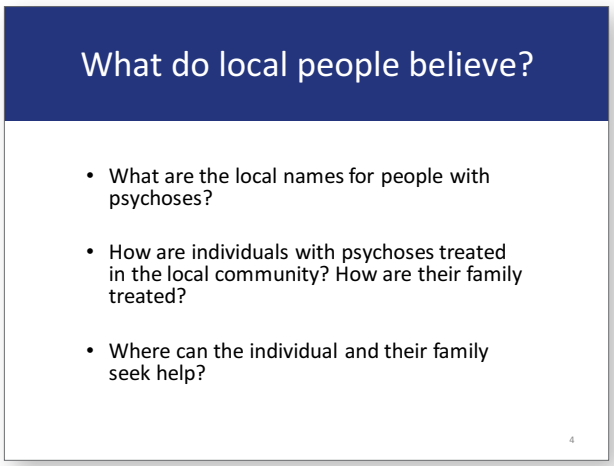

Begin the session by briefly listing the topics that will be covered.

## Activity 1: Person's story followed by group discussion




How to use the person's story

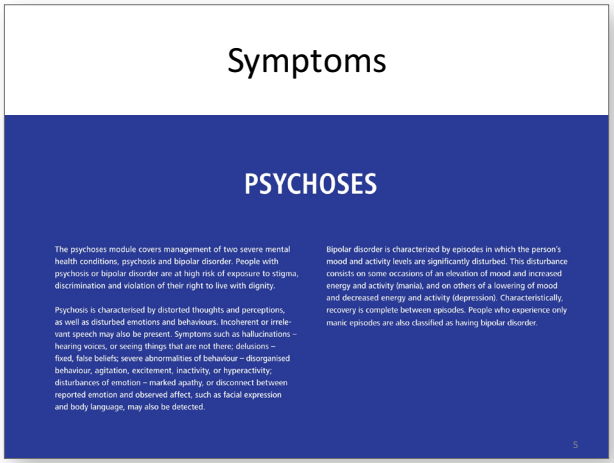
- Introduce the activity and ensure participants have access to pens and paper.
- Tell the story – be creative in how you tell the account to ensure the participants are engaged.
- First thoughts – give participants time to give their immediate reflections on the story. Give participants time to reflect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




**Presentation on psychoses**
Ask the participants these questions and give them time to discuss (5–10 minutes).

Emphasize that:
- Local names and terms may imply the person with psychoses is mad, possessed, stupid, cursed, dangerous etc.
- Explain why you want to avoid using those terms (emphasize how damaging those names can be for people who live with them).
- Discuss with the participants the impact that negative names can have on the individual and their family.
- With the participants seek a sensitive and non-judgemental term that can be applied when talking about psychoses.

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




Direct participants to page 33 mhGAP-IG Version 2.0 and read through the common symptoms of someone with psychosis and bipolar disorder.

Refer back to the story used at the beginning of the session to compare the common presentations with the descriptions in the story.

Ask participants to give examples of any other presentations that they have seen in people with psychosis and people with bipolar disorder in their non-specialized health setting.

## Symptoms of psychosis

**Disturbed perceptions:**
Hallucinations
- *Altered perception,* i.e. hearing voices, seeing or feeling things that are not there.

**Disturbed thinking:**
Delusions:
- *False belief that the person is sure is true,* i.e. person believes family are poisoning her. Or person believes he is royalty. Or person may believe his family are aliens in disguise.

**Disturbed behaviours and emotions**:
- Disturbances of behaviour: social withdrawal, agitation, disorganized behaviour, inactivity or hyperactivity, self-neglect, loss of interest and motivation.
- Disturbances of emotions: marked apathy, poor speech, one word answers, slowed speech, thoughts may be disorganized and hard to follow, disconnect between reported emotion and facial expressions or body language.

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

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

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

Their speech may be slow, and their interactions short. Their thoughts and ideas about what is happening to them as well as their behaviour may be disorganized, erratic and confusing to follow.

## Symptoms of bipolar disorder

**Disturbed mood:**
- Person has episodes where they are manic and other episodes where they are depressed
- Characteristically recovery between the episodes is complete.

**Manic episode:**
Increased activity levels, elevation of mood (potentially very happy and very agitated).
They may talk very rapidly, have lots of different ideas and increased levels of self-worth and self-importance.
They may have hallucinations and delusions, i.e. hear voices and/or believe that they are powerful, that their ideas can change the world.
Engage in risk taking behaviours (gambling, spending money, promiscuity etc.).

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**Symptoms of bipolar disorder**
Describe the symptoms on the slide and explain that people with bipolar disorder may experience hallucinations and delusions during a manic episode. But they can also have features of depressive episodes.

Although bipolar disorder is normally characterized by the changes in mood (mania to depression), people who experience only manic episodes are also classified as having bipolar disorder.

## Natural history of psychosis

- First onset typically between age 15 and 29 years.
- There are three possible clinical courses:
  - The person recovers completely or partially with some symptoms.
  - The person recovers but has a future episode (relapse).
  - Symptoms continue for a longer period.

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Explain that the first symptoms of psychosis usually start between the ages of 15–29 years old. Sometimes this first experience can be called a **psychotic episode**.

How long the episode lasts depends on the causes of the psychosis but they can last for a few weeks, months or even years.

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

## Natural history of bipolar disorder

- First onset typically between the ages of 15–29 years.
- The pattern of mood swings can vary widely between people:
  - Some will have a couple of bipolar episodes in their life time and stay stable in between.
  - Others will have many episodes.
  - Some will only experience manic episodes.
  - Some will experience more depressed episodes than manic episodes.

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

The changes in mood and symptoms of associated with those changes in mood can vary widely between people.

Explain that sometimes people have a couple of bipolar episodes in their lifetime while others have many episodes.

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

## Impact of psychoses

**Impact on the individual:**

- Break up of relationships
- Negative and at times scary experience of symptoms.
- Loss of employment, studies, opportunities.
- Financial consequences.
- Stigma and rejection by community.

**Impact on the family:**

- Medical costs.
- Time and energy looking after the person (carer burden).
- Emotional distress.

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

Allow a brief discussion before revealing the slide.

Psychoses impacts dramatically on all areas of a person's life.

## Impact of psychoses

**Impact on society:**
- Loss of workforce.
- Costly medical interventions and (unnecessarily) lengthy hospitalizations.

**Human rights violations:**
- People with psychoses maybe chained and confined.
- They may be beaten as punishment or treatment.
- They may receive treatments that are ineffective and dangerous due to misunderstanding the causes of psychoses.

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Explain the points in the slide. Add that although people with psychoses can work they are usually marginalized from the workforce because of the stigma and discrimination attached to the disorder.

Because of fear about the disorder, people with psychoses are often admitted to hospital and often abandoned by their families.

This is costly and quite often human rights are abused in the hospital.

Talk through the human rights abuses.

## Human rights violations

Asdila is a young woman who hears voices. As she was wandering on the street and talking out loud, the police arrested her. She had not committed any offence but while in custody she was told that she would be transferred to a psychiatric hospital.

In the hospital she was forced to take high doses of psychotropic drugs which made her extremely unwell. She was bullied and attacked by staff and other male patients. She has no way to challenge her detention.

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Ask the participants to read this example and decide which human rights have been violated?

**Answers:** Adsila is detained in prison and then a psychiatric hospital although she has not committed any offence. Therefore her right to liberty and security (Article 14) in the Convention on the Rights of Persons with Disabilities, to equal protection before the law (Articles 5 and 12) and her right not to be arbitrarily arrested or detained (Article 15) have been violated. The fact that she cannot challenge her detention violates her right to a fair hearing (Article 13). The fact she is bullied and attacked violates her right to not be subjected to torture or to cruel, in human or degrading treatment or punishment (Article 15).

**Note: Convention on the Rights of Person with Disabilities:** Articles related to the treatment of person with psychosis.

The right not to be locked up or detained in mental health facilities against your will (Article 14).

The right to be free from violence and abuse, the right not to be restrained or put in seclusion (Articles 15 and 16).

The right to make decisions and choices rather than having others make decisions for you (Article 12).

## Discussion

- What stigma and discrimination do people with psychoses face in your community?

- What can you do to reduce the stigma?

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The right to give informed consent to treatment and the right to refuse treatment (Article 25).

**Brief discussion (20 minutes)**
Ask participants to think about ways that the human rights of people with psychoses are violated in their community?

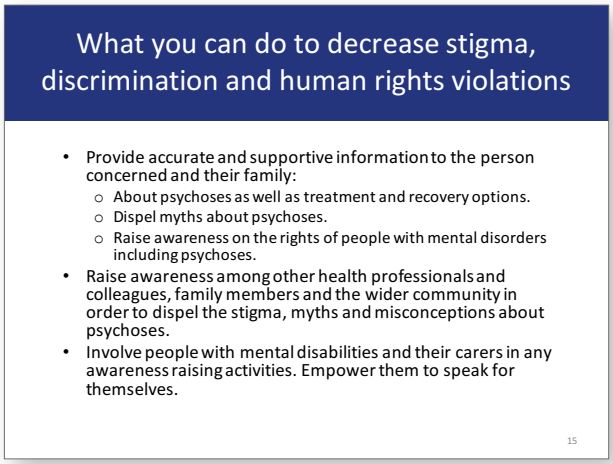
Ask participants to think what they can do to stop these human rights violations?


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

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

Talk through the points on the slide.

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




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

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

## Global impact of psychoses

- Affects 21 million people globally (more common among men – 12 million than women – 9 million).
- Has an early onset in many (15–29 years old).
- People with psychoses are two and a half times more likely to die early than the general population, due to physical illness such as cardiovascular, metabolic and infectious diseases.

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Talk through the points on the slide.

Acknowledge that psychoses does not affect as many people worldwide as other priority MNS conditions. But the impacts that it has on the individual (including human rights violations) and the burden it places on the family make it a critical public health concern.

## Why it is important to treat in non-specialized health settings

- Psychoses is treatable.
- Medicines and psychosocial interventions are effective at treating psychoses.
- People with psychoses can be cared for outside of hospitals – in non-specialized health settings and the community.
- Engaging the family and community in the care of people with psychoses is important.

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Talk through the points of the slides and add the information below to expand on the points.

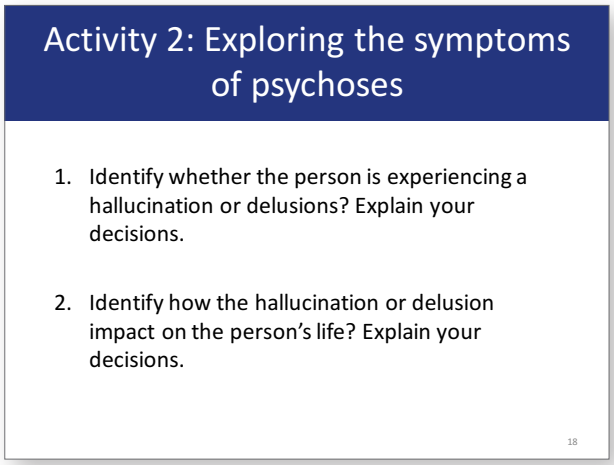
Emphasize that available treatment is effective and can be carried out in non-specialized health settings.

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

Explain that there is clear evidence that old-style mental hospitals are not the best way to treat people with psychoses and often violate basic human rights.

Therefore, caring for people through non-specialized health settings and in the community is essential.

# Activity 2: Case scenarios: Hallucinations and delusions




**Duration:** 20 minutes.

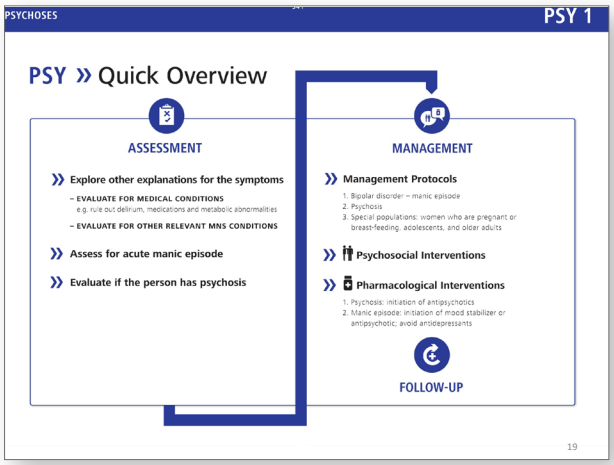
**Purpose:** An interactive discussion using case scenarios that enables participants to explore the experiences of hallucinations and delusions.

**Instructions:**
- Divide participants into three small groups.
- Give each group a different case scenario (see PSY supporting material) to discuss and analyse.
- Have participants analyse the case scenarios using the instructions on the card which include:
  - Identify whether the person is experiencing a hallucination or delusion. Why did the group come to that decision?
  - Identify how that hallucination or delusion is impacting on the person's life. Give as many details as possible.
- Instruct each group to briefly present their case scenario and findings to the rest of the group.
- Facilitate a discussion.

# Session 2. Assessment of psychoses

## 1 hour 10 minutes

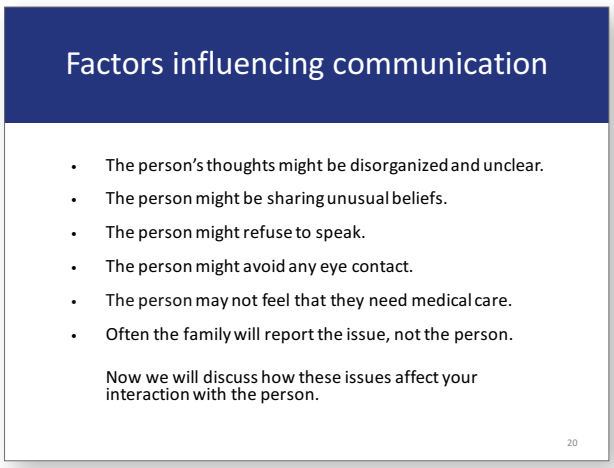
## Activity 3: Video demonstration: Assessment




Instruct participants to turn to the assessment page in the mhGAP-IG Version 2.0 (page 34).

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

Ask participants to give their immediate thoughts about why these particular assessment principles are important?




Explain that they are going to watch a video of an assessment for psychoses.

Explain that many clinicians are unnecessarily uncomfortable in communicating with people with psychoses.

And as we learned from the "hearing voices, seeing things" person story (Activity 1), we know that it can be difficult for the clinician and for the person.

Talk through the points on the slide that highlight why these factors influence communication.

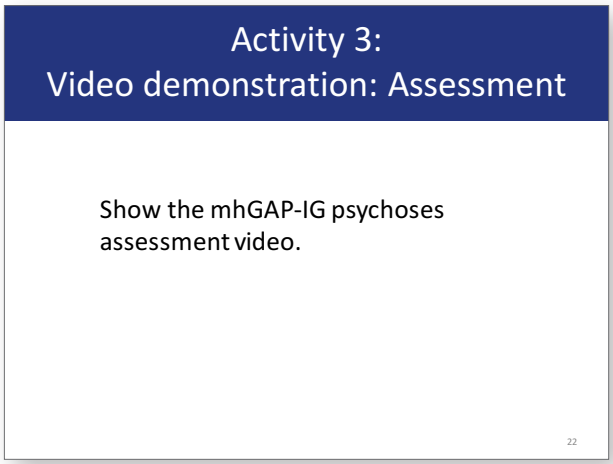
The person may be distracted by their symptoms and may find it hard to concentrate on what is being asked of them.


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

Be patient, treat the person with respect and dignity, use active listening skills to really understand what the person is trying to tell you and establish trust and a rapport with the person.

- Explain that building trust is an extremely important step for helping a person with possible psychoses.
- One goal of the first session is to make the person comfortable enough to return for follow-up.
- Give the following example of how to pose questions without making the person uncomfortable.

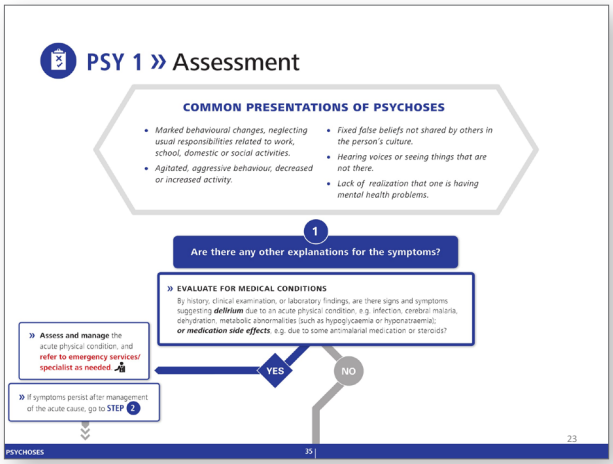
"I would like to ask you a question that might sound strange but is a routine question: Do you hear voices that no one else can hear even when you're with other people?"




Explain to participants that they are going to watch a video of Amir being assessed for possible psychoses. https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v.

During the video, ask participants to scan the psychoses assessment algorithm in the mhGAP-IG to follow the assessment and then discuss it.

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




Use the mhGAP-IG algorithm to decide:
Are there any other explanations for Amir's symptoms?

Seek group consensus.

How did the health-care provider assess if there were other explanations?

## Delirium

An organic brain syndrome characterized by acute onset of:

- Confusion (person appears confused, struggles to understand surroundings).
- Difficulty in focusing, shifting or maintaining attention.
- Changes in feeling (sensations and perceptions).
- Changes in level of consciousness or awareness.
- Disturbance in orientation to time, place and sometimes person.
- Disorganized thinking – speech does not make sense.
- Changes in mood – anger, agitation, anxiety, irritability, anxiety to apathy and depression.

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

Explain the key features of delirium that differentiate it from psychoses i.e. diurnal variation, acute onset, medical history, clouding of consciousness, disorientation.

## Management of delirium

If you think that a person has delirium:

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

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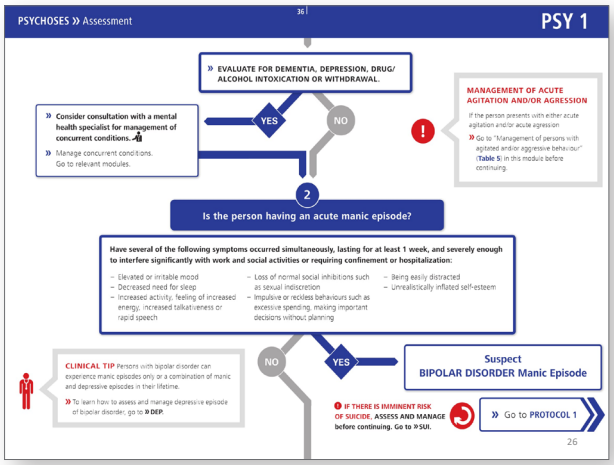
Talk through the points on the slide.

Emphasize that if you do suspect delirium then assess and manage the acute physical condition and refer to emergency services and specialists as needed.

Continue to reassess the person after initial management in order to monitor the state of the person.




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

If you suspect any other MNS conditions, then consider consultation with a mental health specialist and/or assess and manage the concurrent conditions by using the relevant modules in the mhGAP-IG.

## Managing concurrent MNS conditions and psychoses

Psychoses can occur with:

- Depressive episodes – people can experience hallucinations and delusions when depressed.
- Post-partum psychosis – in the days and weeks after giving birth women can experience changes in mood (including mania and depression). They can experience hallucinations and delusions and significant confusion in their thinking and behaviour.
- Substance use disorders – **intoxication** due to substance use can produce significant disturbances in mood and changes in levels of consciousness, confusions and erratic behaviour. **Withdrawal** from substances can also cause confusion, erratic behaviour, changes in consciousness and perception.
- Dementia – people living with dementia can report experiencing changes in perceptions (hallucinations and delusions).

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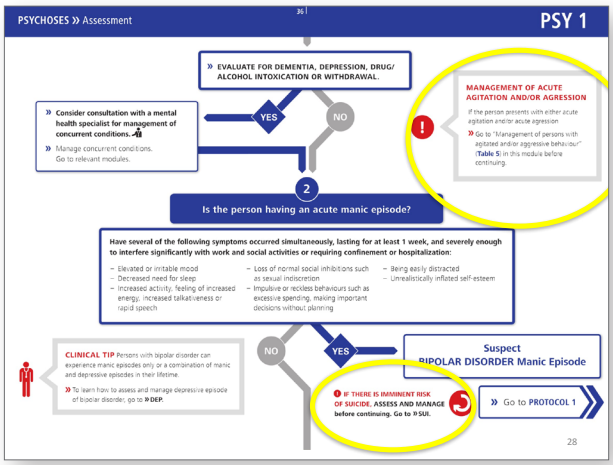
For the management of depression see the Module: Depression in the mhGAP-IG.

For the management of substance use disorders see the Module: Disorders due to substance use in the mhGAP-IG.

To manage psychoses in dementia, see the Module: Dementia.

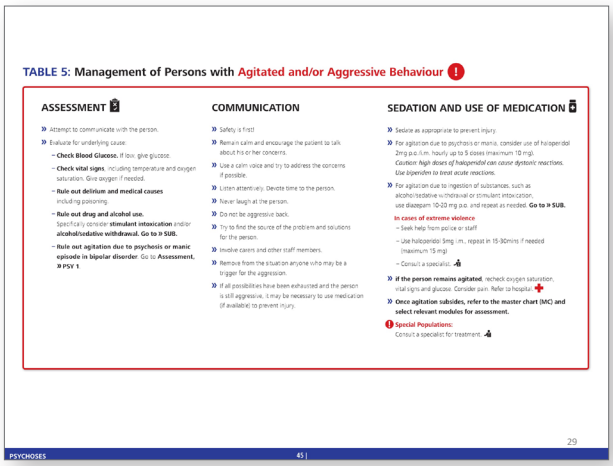
When considering the needs of special populations like pregnant women or women who have just given birth always refer to a specialist where available.




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

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

Explain that assessing for self-harm suicide will be covered in the Module: Self-harm/ suicide.




Remind participants of the principles of managing acute agitation and/or aggression (discussed in the Module: Essential care and practice).

## Case scenario

- A 22-year-old woman is brought to the clinic by her parents. They are concerned about her bizarre behaviour and strange speech. They explain the young woman keeps getting very agitated and angry and states that she wishes to "escape from a terrible monster taking the shape of her father". Today she violently attacked her father.

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Talk through the case scenario.

Using the guidelines in the mhGAP-IG page 45.

Facilitate a brief discussion about how participants could manage this scenario? Would they consider medication? (Five minutes.) Make a note of their answers on a piece of flip chart paper.

## Case scenario continued

- Her father has multiple cuts and bruises on his face and body from where he was attacked.
- The young woman is obviously still agitated and restless. She cannot stay still and keeps trying to get away from her father. She is shouting at him to "go away" "get out" "leave me".
- What can you do to manage the situation?

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Explain that the first step is **safety first**! Therefore, participants should make sure that the girl, her father, mother and themselves are all safe. As the focus of the young woman's agitation is the father, the safest thing to do is ask the father to leave. Or ask the father to see another colleague so they can check his injuries.

**Remain calm and encourage the young woman to talk** by removing the father see if the young woman calms down.

It is important that you remain calm. Ask the woman to tell you why she is feeling so agitated.

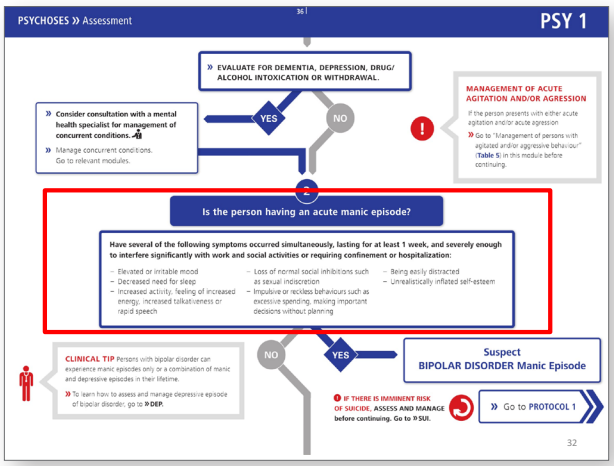
**Use a calm voice and try and address any of her immediate concerns.**

Listen attentively – devote time to this young lady as she is clearly very upset.

**Do not laugh at her, do not be aggressive and do not argue with her beliefs about her father.**

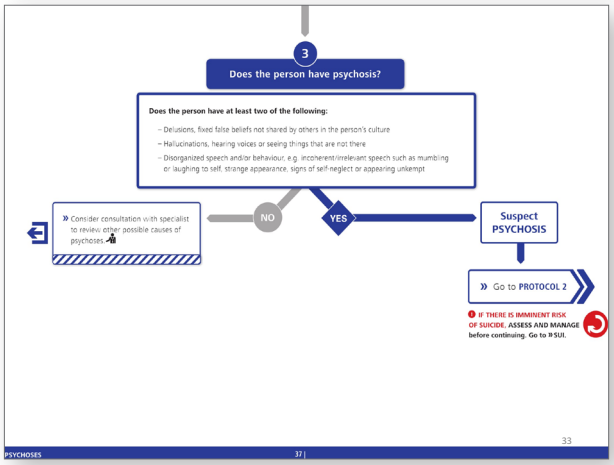
**Involve the mother (if the young woman allows it)** ask the mother why she thinks this is happening?

**If the young woman calms down enough then try and assess her for psychosis.**



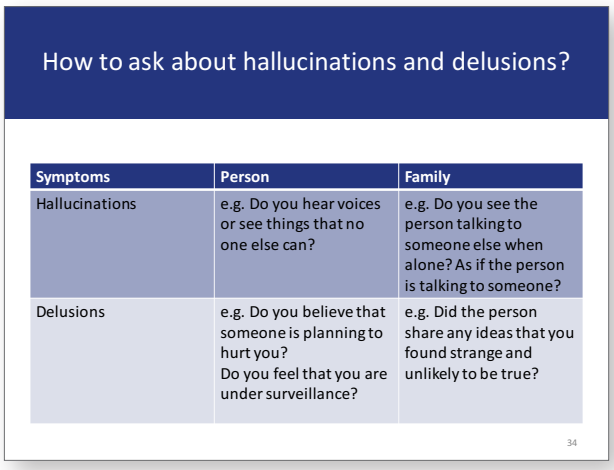

Bring the participants attention back to the video of Amir. Seek group consensus as to whether Amir is having an acute manic episode?

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




Does Amir have psychosis?

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

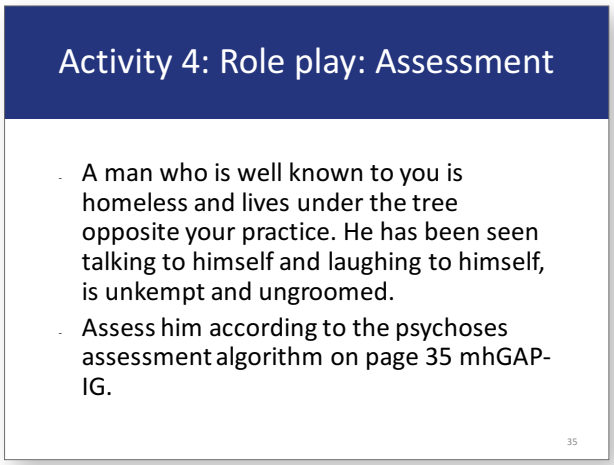



Read out the examples on the slide and ask participants to comment.

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

**Note:** Write those questions and leave them in clear view so that participants can use them when they are doing role plays.

# Activity 4: Role play: Assessment




See PSY supporting material role play 1.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

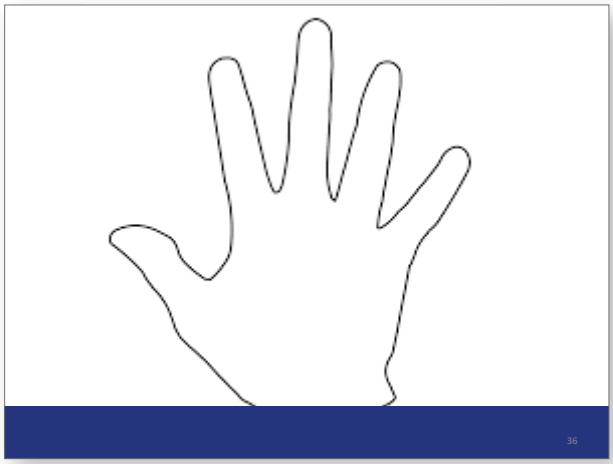
**Purpose:** This role play gives participants an opportunity to practise using the mhGAP-IG to assess for psychoses.

**Situation:**
- You are a health-care worker in a clinic
- A man who is well known to you, is homeless and lives under the tree opposite your practice, he has been seen talking to himself and laughing to himself, is unkempt and un-groomed.
- Assess him according to the psychoses assessment algorithm on page 35 mhGAP-IG Version 2.0.

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

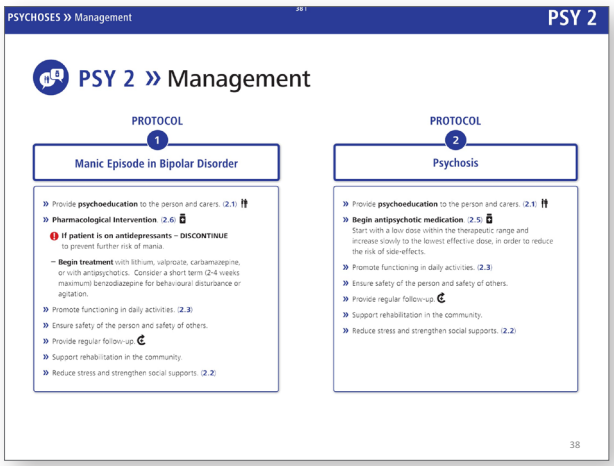
# Session 3.
# Management of psychoses

## 1 hours 50 minutes




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


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

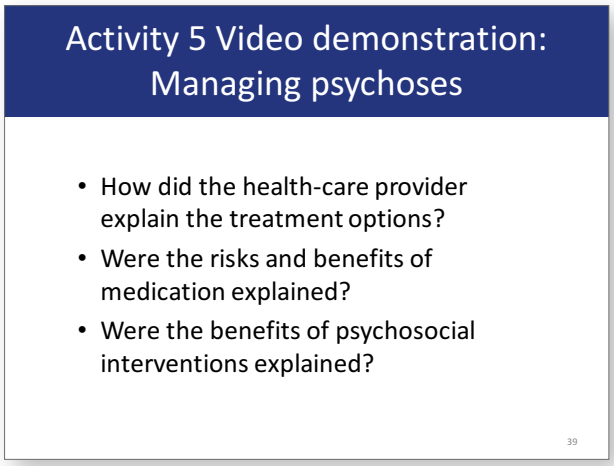



Direct participants to the management protocols on page 38 of the mhGAP-IG Version 2.0.

Choose volunteers to read them out loud.

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

# Activity 5: Video demonstration: Management

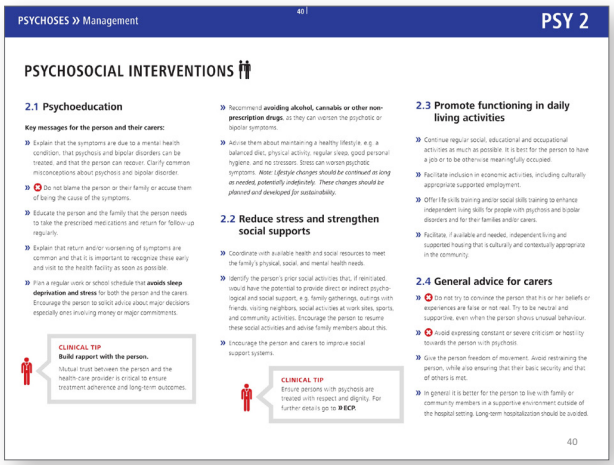



**Duration:** 30 minutes.

**Purpose:** To enable participants to watch how a health-care provider could offer basic management to an individual with psychoses. https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5.

While watching ask participants to think about these questions:

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

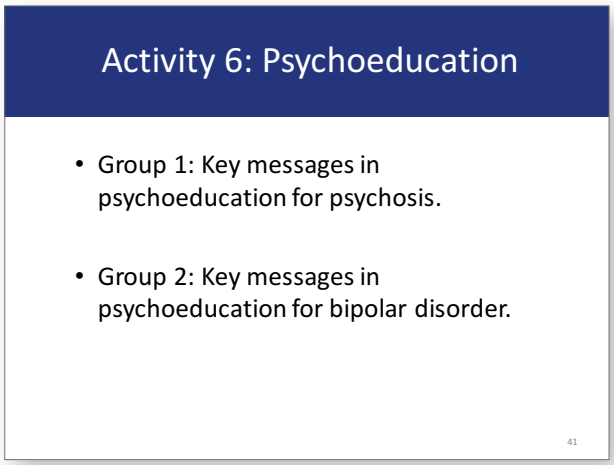



Give the participants time to read through the psychosocial interventions on page 40 mhGAP-IG.

Emphasize to participants the importance of delivering psychosocial interventions to people with psychoses and their carers.

Explain that focusing on a person's recovery and taking time to ensure that they start to take part in activities of daily living and reconnect with their family and communities is an essential and crucial part of treatment.

# Activity 6: Delivering psychoeducation




**Duration:** 20 minutes.

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

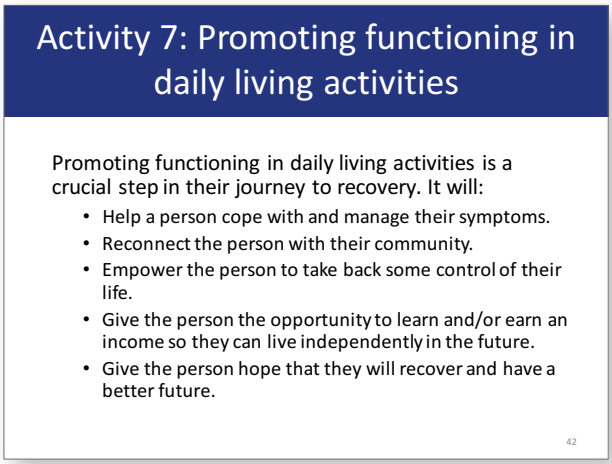
**Instructions:**
- Divide the participants quickly into two groups.
- Give each group paper, pens, flip chart paper, sticky notes etc.
- Give one group the topic: **Psychoeducation for psychosis**.
- Give the other group the topic: **Psychoeducation for bipolar disorder**.
- Give each group 10 minutes to use the mhGAP-IG and come up with a creative way to deliver the key psychoeducation messages to the other group.
- After 10 minutes of planning. Give each group five minutes to present the key psychoeducation messages.

Correct any misinformation.

Emphasize the importance of delivering clear psychoeducation to carers, including advising carers:
- Not to try and convince the person that their beliefs or experiences are false and not real. Explain that instead carers should be open to listening to the person talk about their experience but should not have a judgement or opinion about the experiences. Instead stay neutral.
- Remind carers to stay calm and patient and not to get angry with the person.

Explain that participants are now going to focus on how to promote functioning in daily living activities for people with psychoses.

# Activity 7: Promoting functioning in daily living activities



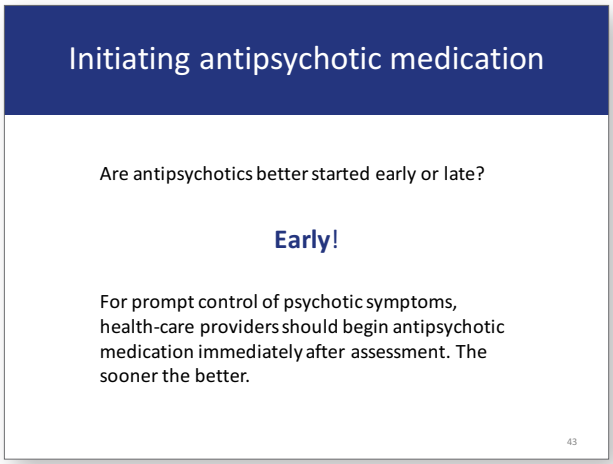

**Duration:** 25 minutes.

**Purpose:** To introduce participants to the importance of promoting functioning in daily living activities for people with psychoses as a way of helping their recovery.

**Instructions:**

- Explain to participants that promoting functioning in daily living activities for people with psychoses is a crucial step in their journey to recovery.
- It is crucial because it will:
  - Help the person cope with and manage their symptoms.
  - Reconnect the person with their community.
  - Empower the person to take back some control of their life.
  - Give the person the opportunity to learn and/or earn an income so they can live independently in the future.
  - Give the person hope that they will recover and have a better future.
- Ask participants to:
  - **Think about a time when you had to recover from something – it can be now or in the past** (two minutes). For example, losing someone you loved, battling a difficult illness, being the survivor of abuse, losing an important opportunity or job? It can be anything you can think of, not necessarily related to mental health.
- Ask participants to:
  - **Think what was difficult about recovering from that situation?**
- After a brief discussion, ask participants the following questions:
  - **Think what helped you get better/overcome this situation?**
- Give participants two minutes to think about or write down their personal recovery experiences and journeys. Ask for one or more volunteers to share their experience. The goal is to let the group think about what is involved in recovery in general. Highlight how important continued functioning and participation in everyday activities were for their own recovery.
- Then ask participants to:
  - **Think what might make recovery more difficult for people with psychoses?**
- Ask the group to brainstorm ideas and write them on the flip chart. Some possible answers are:
  - Major losses of social support – being isolated from friends and family/being physically restrained and isolated.
  - Distress from being abused and mistreated.

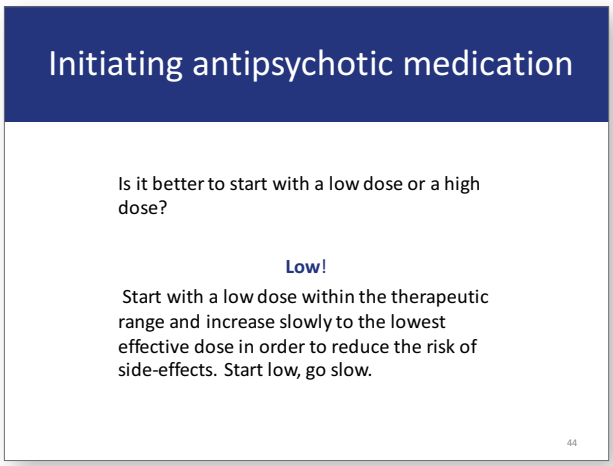
  - Negative effects of medication.
  - Loss of trust in the mental health system.
  - Loss of trust in the community and family.
  - Not being allowed to make decisions for yourself anymore.
  - Feeling that your opinion is not respected.
  - Negative attitudes from health-care providers.
  - Devaluing and disempowering practices attitudes and environments.
  - Stigma and discrimination from the family and the community.
  - Lack of education, income generating, social and other opportunities.
  - Lack of sense of identity, self-respect and hope.
  - Lack of access to treatment and support.
  - Lack of access to other people who have gone through similar things.
  - Lack of information about your condition and situation.
  - Demeaning remarks and maltreatment from others.
  - Being told you will never recover.
  - Being overprotected by family.
- Now that the group has thought about their own personal recovery, identified how important everyday functioning was and identified what might make it difficult for people with psychoses to recover, ask the group to:
  - **Create a treatment plan of steps they could take to promote functioning in daily living activities for people with psychoses in their own communities.**
- Give the participants five minutes to write an individual plan and then ask for volunteers to share their ideas with the rest of the group.
- Discuss any barriers and obstacles that participants identify and try and brainstorm solutions as a group.




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

The answer is **early**.

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




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

The answer is a **low dose**.

Explain that severe side-effects from antipsychotic medication can reduce adherence, therefore to minimize those side-effects we want the lowest therapeutic dose.

## Initiating antipsychotic medication

Which route is preferable?

- oral
- intramuscular.

**Oral!**

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

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

The answer is **oral**.

Oral medication can be more dignified than using intramuscular treatment. It is also empowering as it means the person has to take responsibility in their own recovery by taking medication every day. Only use intramuscular treatment if oral routes are not possible.

## Initiating antipsychotic medication

How many antipsychotic medications should we prescribe at a time?

- one
- more than one.

**One!**

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

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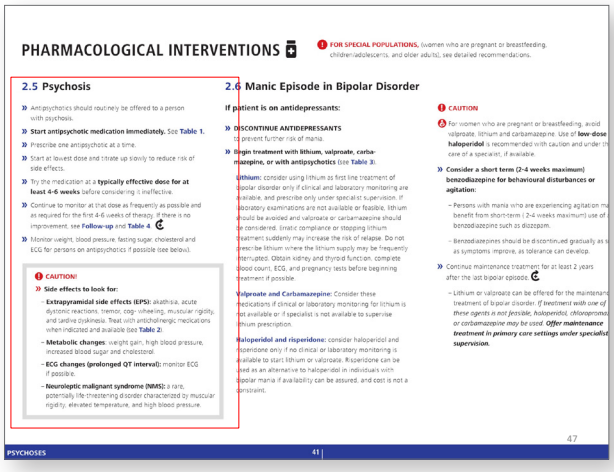
Ask the group the question on the slide and give them time to answer before revealing the answer.

The answer is **one**.

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



PHARMACOLOGICAL INTERVENTIONS

FOR SPECIAL POPULATIONS, (women who are pregnant or breastfeeding, children/adolescents, and older adults), see detailed recommendations.

**2.5 Psychosis**

- Antipsychotics should routinely be offered to a person with psychosis.
- **Start antipsychotic medication immediately.** See **Table 1**.
- Prescribe one antipsychotic at a time.
- Start at lowest dose and titrate up slowly to reduce risk of side effects.
- Try the medication at a **typically effective dose for at least 4–6 weeks** before considering it ineffective.
- Continue to monitor at that dose as frequently as possible and as required for the first 4–6 weeks of therapy. If there is no improvement, see **Follow-up** and **Table 4**.
- Monitor weight, blood pressure, fasting sugar, cholesterol and ECG for persons on antipsychotics if possible (see below).

CAUTION!

- **Side effects to look for:**
  - **Extrapyramidal side effects (EPS):** akathisia, acute dystonic reactions, tremor, cog- wheeling, muscular rigidity, and tardive dyskinesia. Treat with anticholinergic medications when indicated and available (see **Table 2**).
  - **Metabolic changes**: weight gain, high blood pressure, increased blood sugar and cholesterol.
  - **ECG changes (prolonged QT interval):** monitor ECG if possible.
  - **Neuroleptic malignant syndrome (NMS):** a rare, potentially life-threatening disorder characterized by muscular rigidity, elevated temperature, and high blood pressure.

**2.6 Manic Episode in Bipolar Disorder**

**If patient is on antidepressants:**

- **DISCONTINUE ANTIDEPRESSANTS**

  to prevent further risk of mania.

- **Begin treatment with lithium, valproate, carbamazepine, or with antipsychotics** (see **Table 3**):

  **Lithium:** consider using lithium as first line treatment of bipolar disorder only if clinical and laboratory monitoring are available, and prescribe only under specialist supervision. If laboratory examinations are not available or feasible, lithium should be avoided and valproate or carbamazepine should be considered. Erratic compliance or stopping lithium treatment suddenly may increase the risk of relapse. Do not prescribe lithium where the lithium supply may be frequently interrupted. Obtain kidney and thyroid function, complete blood count, ECG, and pregnancy tests before beginning treatment if possible.

  **Valproate and Carbamazepine:** Consider these medications if clinical or laboratory monitoring for lithium is not available or if specialist is not available to supervise lithium prescription.

  **Haloperidol and risperidone:** consider haloperidol and risperidone only if no clinical or laboratory monitoring is available to start lithium or valproate. Risperidone can be used as an alternative to haloperidol in individuals with bipolar mania if availability can be assured, and cost is not a constraint.

CAUTION

- For women who are pregnant or breastfeeding, avoid valproate, lithium and carbamazepine. Use of **low-dose haloperidol** is recommended with caution and under the care of a specialist, if available.
- **Consider a short term (2–4 weeks maximum) benzodiazepine for behavioural disturbances or agitation:**
  - Persons with mania who are experiencing agitation may benefit from short-term ( 2–4 weeks maximum) use of benzodiazepine such as diazepam.
  - Benzodiazepines should be discontinued gradually as soon as symptoms improve, as tolerance can develop.
- Continue maintenance treatment for at least 2 years after the last bipolar episode.
  - Lithium or valproate can be offered for the maintenance treatment of bipolar disorder. *If treatment with one of these agents is not feasible, haloperidol, chlorpromazine or carbamazepine may be used. Offer maintenance treatment in primary care settings under specialist supervision.*

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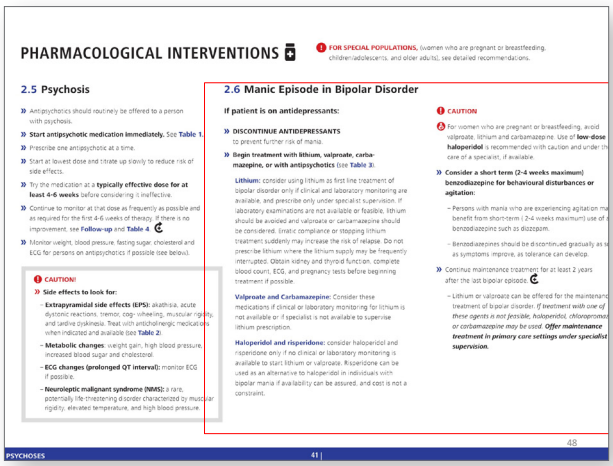
Explain that antipsychotic medication should be offered routinely to a person with psychosis.

Highlight the importance of regular monitoring and follow-up of anyone started on antipsychotic medication.

Especially important is monitoring for health considerations: weight gain, blood pressure, fasting sugar, cholesterol changes, ECG changes, and extrapyramidal side-effects such as: akathisia, acute dystonic reactions, tremor, muscular rigidity etc.



PHARMACOLOGICAL INTERVENTIONS

FOR SPECIAL POPULATIONS, (women who are pregnant or breastfeeding, children/adolescents, and older adults), see detailed recommendations.

2.5 Psychosis

» Antipsychotics should routinely be offered to a person with psychosis.

» **Start antipsychotic medication immediately.** See **Table 1.**

» Prescribe one antipsychotic at a time.

» Start at lowest dose and titrate up slowly to reduce risk of side effects.

» Try the medication at a **typically effective dose for at least 4–6 weeks** before considering it ineffective.

» Continue to monitor at that dose as frequently as possible and as required for the first 4–6 weeks of therapy. If there is no improvement, see **Follow-up** and **Table 4**.

» Monitor weight, blood pressure, fasting sugar, cholesterol and ECG for persons on antipsychotics if possible (see below).

CAUTION!

» **Side effects to look for:**

- **Extrapyramidal side effects (EPS):** akathisia, acute dystonic reactions, tremor, cog-wheeling, muscular rigidity, and sialorrhoea. Treat with anticholinergic medications when indicated and available (see **Table 2**).
- **Metabolic changes**: weight gain, high blood pressure, increased blood sugar and cholesterol.
- **ECG changes (prolonged QT interval):** monitor ECG if possible.
- **Neuroleptic malignant syndrome (NMS):** a rare, potentially life-threatening disorder characterized by muscular rigidity, elevated temperature, and high blood pressure.

2.6 Manic Episode in Bipolar Disorder

**If patient is on antidepressants:**

» **DISCONTINUE ANTIDEPRESSANTS** to prevent further risk of mania.

» **Begin treatment with lithium, valproate, carbamazepine, or with antipsychotics** (see **Table 3**).

**Lithium:** consider using lithium as first line treatment of bipolar disorder only if clinical and laboratory monitoring are available, and prescribe only under specialist supervision. If laboratory examinations are not available or feasible, lithium should be avoided and valproate or carbamazepine should be considered. Erratic compliance or stopping lithium treatment suddenly may increase the risk of relapse. Do not prescribe lithium where the lithium supply may be frequently interrupted. Obtain kidney and thyroid function, complete blood count, ECG, and pregnancy tests before beginning treatment if possible.

**Valproate and Carbamazepine:** Consider these medications if clinical or laboratory monitoring for lithium is not available or if specialist is not available to supervise lithium prescription.

**Haloperidol and risperidone:** consider haloperidol and risperidone only if no clinical or laboratory monitoring is available to start lithium or valproate. Risperidone can be used as an alternative to haloperidol in individuals with bipolar mania if availability can be assured, and cost is not a constraint.

CAUTION

For women who are pregnant or breastfeeding, avoid valproate, lithium and carbamazepine. Use of **low-dose haloperidol** is recommended with caution and under the care of a specialist, if available.

» **Consider a short term (2–4 weeks maximum) benzodiazepine for behavioural disturbances or agitation:**

- Persons with mania who are experiencing agitation may benefit from short-term (2-4 weeks maximum) use of a benzodiazepine such as diazepam.
- Benzodiazepines should be discontinued gradually as soon as symptoms improve, as tolerance can develop.

» Continue maintenance treatment for at least 2 years after the last bipolar episode.

- Lithium or valproate can be offered for the maintenance treatment of bipolar disorder. *If treatment with one of these agents is not feasible, haloperidol, chlorpromazine or carbamazepine may be used. Offer maintenance treatment in primary care settings under specialist supervision.*

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

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

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

If they have then point out that if they have had a manic episode, their antidepressants should be stopped.

Treatment with lithium, valproate and carbamazepine, haloperidol and risperidone should be considered.

## Case scenario

Yosef is 21 years old has been brought to you by his mother.
His mother says that recently Yosef "is not the same." He is no longer studying and prefers to stay home doing nothing.
You notice that Yosef is wearing summer clothes although it is cold and raining. He looks like he has not washed for weeks.
When you talk to him, Yosef 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 seems disconnected from his family and has no energy.
He is refusing to eat food in the home as he believes his mother is trying to poison him.
You assess Yosef and decide to start him on antispyshchotic medication to see if that improves his symptoms.

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Introduce participants to the story of Yosef and explain that after carrying out a thorough assessment you decided to start him on antipsychotic medication as well as delivering psychoeducation and psychosocial interventions.

## Antipsychotic medications

- What are the starting doses for haloperidol, chlorpromazine and riseperdione ?
- What are the effective doses?
- What are the side-effects for each drug?

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Instruct participants to look at tables 1–4 pages 42–44 mhGAP-IG Version 2.0.

Find the answers to the following questions on the slide.

PSY

## Case scenario

Maria is a 35-year-old woman. She is married and has two children (10 and 8 years old). For the last five years she has held a management level position in a local bank and has been enjoying her career. In the last two months she has been experiencing changes in her mood. She has been arguing with people at work and her family at home. She is getting frustrated as she does not feel people are listening to her or understanding her. Her speech is very fast and confusing as she is having so many ideas at the same time. She is spending a lot of money and that is causing arguments with her husband. She is active all the time and is not sleeping well.

After a thorough assessment you decide she is experiencing a manic episode.

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Introduce participants to the story of Maria. After a thorough assessment, you decide that she is having a manic episode and decide to start her on a mood stabilizer.

## Mood stabilizers

- What are the starting doses for lithium, sodium valproate and carbamazepine?
- When should you not use lithium?
- What are the effective doses?
- What are the side-effects of each drug?

52

Instruct the participants to use the mhGAP-IG to answer these questions.

## Review and adherence

- What should you do if Yosef complains of muscle rigidity and stiffness, and you notice that he has involuntary repetitive lip smacking?
- What could you do if a person who has started to take risperidone complains that they feel it is not doing anything to help them?
- How would you help someone who stopped taking sodium valproate because they were gaining too much weight and felt uncomfortable?

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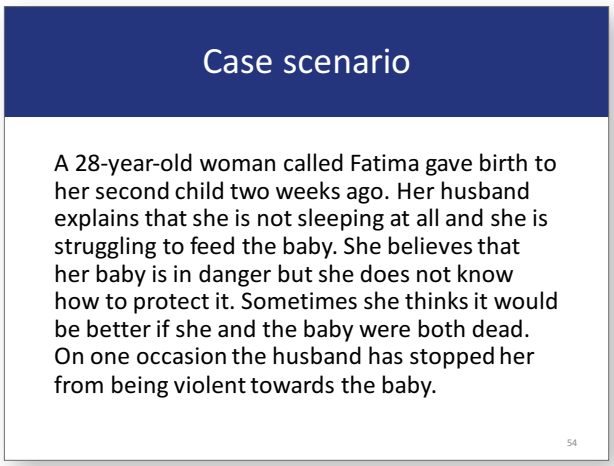
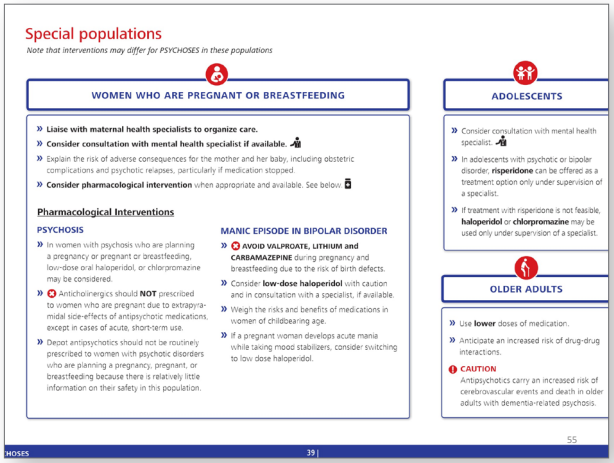
Discuss these answers using Table 4 (page 44 mhGAP Version 2.0).




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

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

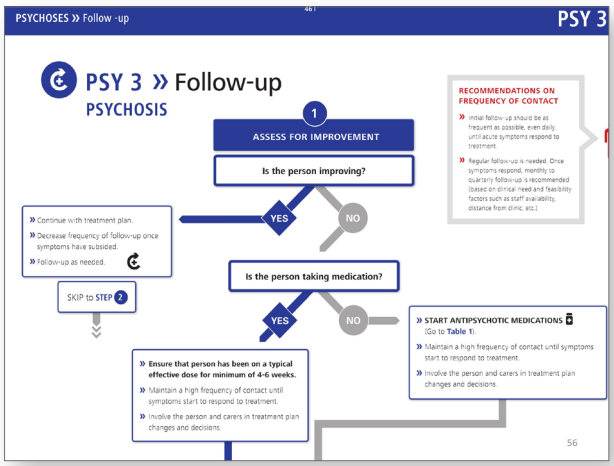



**Special populations**

- Ask participants to read through the differences in special populations.
- Then ask for a volunteer to give a brief summary of the differences in management of:
  - women who are pregnant or breastfeeding
  - adolescents
  - older adults.

# Session 4. Follow-up

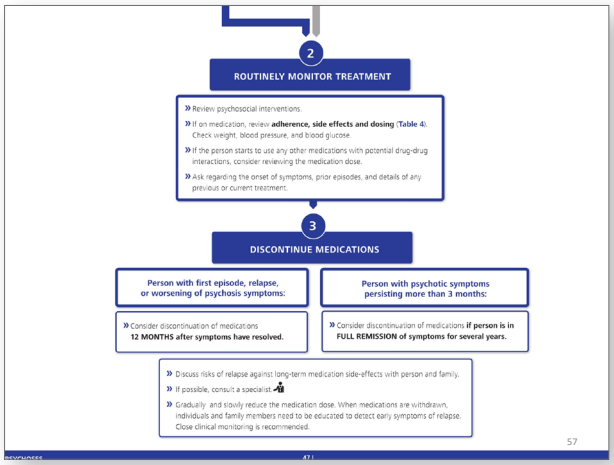
## 35 minutes




Ask for a volunteer from the participants to read out loud step 1 of the follow-up algorithm and possible outcomes to that step.

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

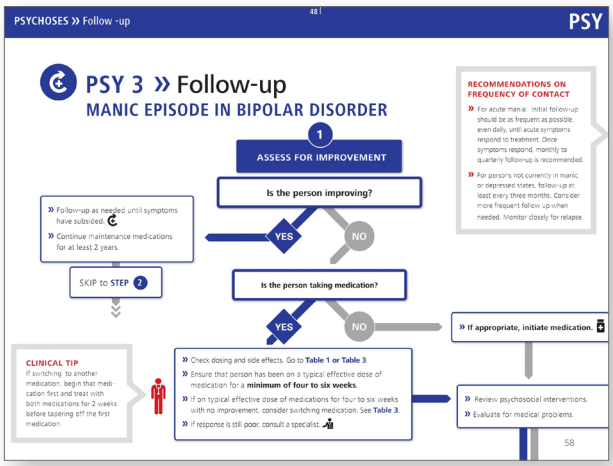
Reflect on how they might support a person to take their medication.




Ask another volunteer to read out loud steps 2 and 3 of the follow-up algorithm.

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

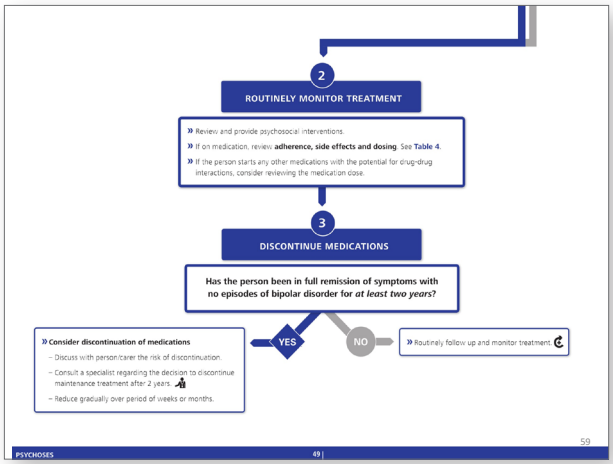
Clarify any concerns or questions they may have about step 3 and the discontinuation of medication.




Ask a volunteer to read out loud step 1 and possible outcomes in the follow-up of bipolar disorder.

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

How will they know if the person is taking medication?




Ask another volunteer to read through steps 2 and 3 of the algorithm and possible outcomes.

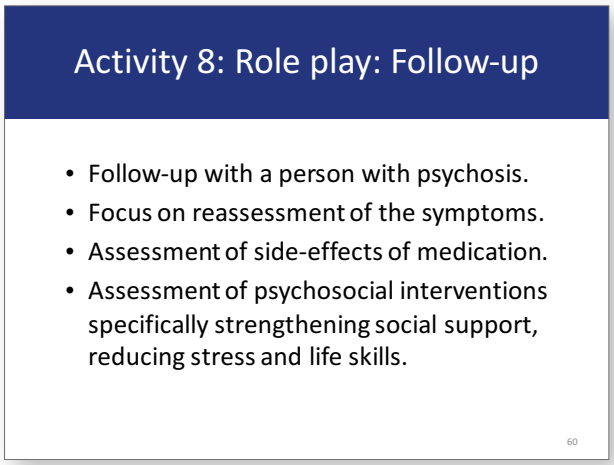
Clarify any queries or concerns the participants may have with these steps and outcomes.

Ask participants to reflect on how they will know if the person is in full remission?

Ask participants to consider how they would learn about the number of manic or depressive episodes the person has had?

Explain that people with bipolar disorder may have more depressive episodes than manic episodes. Therefore it is important to explore their mental state.

# Activity 8: Role play: Follow-up




See PSY supporting material role play 2.

Print the three different instruction sheets for the participants playing the different roles.

Ensure the person playing the role of the observer also has a competency assessment form (see ToHP training forms) in order to assess the participants.

**Duration:** 30 minutes.

**Purpose:** Gives participants the opportunity to practise conducting a follow-up appointment with a person who is being managed for psychosis.

**Situation:**
Follow up with a person with psychosis.
Focus on re-assessment of the symptoms.
Assessment of side-effects of medication.
Assessment of psychosocial interventions specifically strengthening social support, reducing stress and life skills.

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

# Session 5. Review

## 15 minutes

**Duration:** Minimum 15 minutes (depends on participants' questions).

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

**Instructions:**
- Administer the psychoses MCQs (see PSY supporting material) to participants.
- Discuss the answers as a group.
- Facilitate a brief discussion answering any queries or concerns the participants may have.

# PSY PowerPoint slide presentation

**PowerPoint slide presentation available online at:**
**http://www.who.int/mental_health/mhgap/psy_slides.pdf**

# PSY supporting material

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

  Activity 3: mhGAP PSY module – assessment

  https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v

  Activity 5: mhGAP PSY module – management

  https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5

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