

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	30 minutes	<p>Activity 1: Person's story followed by group discussion</p> <ul style="list-style-type: none"> Use the person's story to introduce psychoses Encourage participants to reflect on local understandings of psychoses <p>Presentation to supplement the story Use the story as a basis for discussions on:</p> <ul style="list-style-type: none"> Common presentations of psychosis and bipolar disorder How psychoses impact on a person's life Human rights and psychoses Why it is a public health priority and how can it be managed in non-specialized health settings
	Promote respect and dignity for people with psychoses	20 minutes	<p>Activity 2: Case scenarios: Hallucinations and delusions</p>
2. Assessment of psychoses	Perform an assessment for psychoses	40 minutes	<p>Activity 3: Video demonstration: Assessment Use video/demonstration role play to show an assessment and allow participants to note the principles of assessment (all aspects covered)</p>
	Use effective communication skills when interacting with people with psychoses	30 minutes	<p>Activity 4: Role play: Assessment Feedback and reflection</p>
3. Management of psychoses	Assess and manage emergency presentations of psychoses		
	Assess and manage physical health in psychoses		
	Provide psychosocial interventions to persons with psychoses and their carer	30 minutes	<p>Activity 5: Video demonstration: Management Use video/demonstration role play to evaluate a management session discussing use of pharmacological interventions and psychosocial interventions</p>
	Deliver pharmacological interventions as needed and appropriate in psychoses considering, special populations	20 minutes	<p>Activity 6: Delivering psychoeducation Enable participants to practise delivering key psychoeducation messages</p>
Refer to specialists and links with outside agencies as appropriate and available	25 minutes	<p>Activity 7: Promoting functioning in daily activities Give participants practical experience in understanding how important daily routines and functioning are to recovery</p>	
		35 minutes	<p>Discussion on psychosocial and pharmacological Interventions</p> <ul style="list-style-type: none"> Use the mhGAP-IG to introduce participants to psychosocial and pharmacological interventions and how to deliver them Use case scenarios as examples

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

Step-by-step facilitator's guide

Session 1. Introduction to psychoses

 50 minutes

Session outline

- Introduction to psychoses.
- Assessment of psychoses.
- Management of psychoses.
- Follow-up.
- Review.

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

Activity 1: Person's story followed by group discussion

Activity 1: Person's story

- Present the person's story of what it feels like to live with psychoses.
- First thoughts.

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.

What do local people believe?

- What are the local names for people with psychoses?
- How are individuals with psychoses treated in the local community? How are their family treated?
- Where can the individual and their family seek help?

4

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.

Symptoms

PSYCHOSES

The psychoses module covers management of two severe mental health conditions, psychosis and bipolar disorder. People with psychosis or bipolar disorder are at high risk of exposure to stigma, discrimination and violation of their right to live with dignity.

Psychosis is characterised by distorted thoughts and perceptions, as well as disturbed emotions and behaviours. Incoherent or incoherent speech may also be present. Symptoms such as hallucinations – hearing voices, or seeing things that are not there; delusions – fixed, false beliefs; severe abnormalities of behaviour – disorganised behaviour, agitation, excitement, inactivity, or hyperactivity; disturbances of emotion – marked apathy; or disconnect between reported emotion and observed affect, such as facial expression and body language, may also be detected.

Bipolar disorder is characterized by episodes in which the person's mood and activity levels are significantly disturbed. This disturbance consists on some occasions of an elevation of mood and increased energy and activity (mania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is complete between episodes. People who experience only manic episodes are also classified as having bipolar disorder.

5

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.

6

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.).

7

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.

8

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.

Natural history of bipolar disorder

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

9

Explain that 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.

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

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

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

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

Impact of psychoses

Impact on the individual:

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

Impact on the family:

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

10

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

Allow a brief discussion before revealing the slide.

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

Impact of psychoses

Impact on society:

- Loss of workforce.
- Costly medical interventions and (unnecessarily) lengthy hospitalizations.

Human rights violations:

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

11

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

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

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

Talk through the human rights abuses.

Human rights violations

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

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

12

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

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

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

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

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

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

Discussion

- What stigma and discrimination do people with psychoses face in your community?
- What can you do to reduce the stigma?

13

What you can do to decrease stigma, discrimination and human rights violations

- Treat people with respect and dignity.
- Avoid making assumptions, e.g. The person is dangerous or the person lacks capacity.
- Do not assume that the person is unable to make choices or decisions concerning treatment. Involve the person in the development of their treatment plan.
- Avoid involuntary admission and treatment, seclusions and restraints and other coercive practices.
- Treat psychoses at the non-specialist level which is less stigmatizing, more acceptable and accessible for people.

14

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.

What you can do to decrease stigma, discrimination and human rights violations

- Provide accurate and supportive information to the person concerned and their family:
 - About psychoses as well as treatment and recovery options.
 - Dispel myths about psychoses.
 - Raise awareness on the rights of people with mental disorders including psychoses.
- Raise awareness among other health professionals and colleagues, family members and the wider community in order to dispel the stigma, myths and misconceptions about psychoses.
- Involve people with mental disabilities and their carers in any awareness raising activities. Empower them to speak for themselves.

15

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

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

Global impact of psychoses

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

16

Talk through the points on the slide.

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

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

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

17

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

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

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

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

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

Activity 2: Case scenarios: Hallucinations and delusions

Activity 2: Exploring the symptoms of psychoses

1. Identify whether the person is experiencing a hallucination or delusions? Explain your decisions.
2. Identify how the hallucination or delusion impact on the person's life? Explain your decisions.

18

Duration: 20 minutes.

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

Instructions:

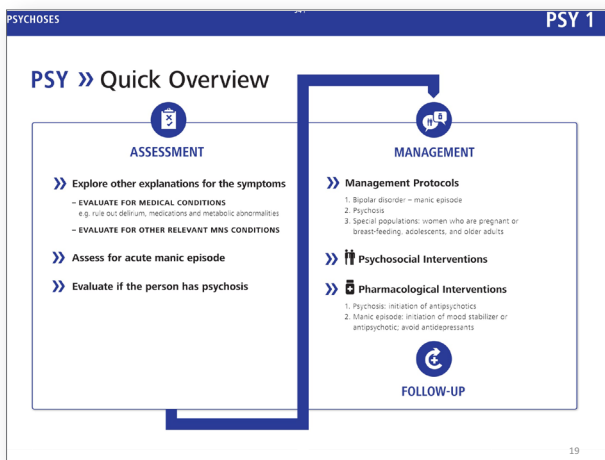
- Divide participants into three small groups.
- Give each group a different case scenario (see PSY supporting material) to discuss and analyse.
- Have participants analyse the case scenarios using the instructions on the card which include:
 - Identify whether the person is experiencing a hallucination 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?

Factors influencing communication

- The person's thoughts might be disorganized and unclear.
- The person might be sharing unusual beliefs.
- The person might refuse to speak.
- The person might avoid any eye contact.
- The person may not feel that they need medical care.
- Often the family will report the issue, not the person.

Now we will discuss how these issues affect your interaction with the person.

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

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

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

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

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

Establish communication and build trust

- Treat the person with respect and dignity.
- Try to understand the person's perspective.
- Introduce your questions in a respectful way.
- Do not rush; it may take several sessions to build trust.
- Do not challenge false beliefs or mock the person.
- Ask how the person's life has been affected.
- Advocate on the person's behalf.

21

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

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

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

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

Activity 3: Video demonstration: Assessment

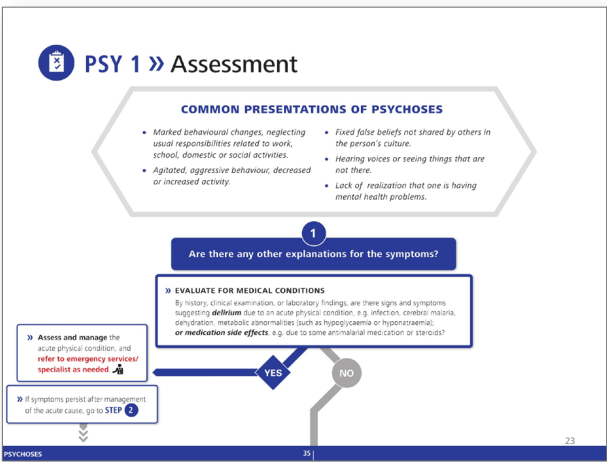
Show the mhGAP-IG psychoses assessment video.

22

Explain to participants that they are going to watch a video of Amir being assessed for possible psychoses. <https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=P LU4ieskOli8GicaEnDweSQ6-yaGxhes5v>.

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

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



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

Seek group consensus.

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

Delirium

An organic brain syndrome characterized by acute onset of:

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

24

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

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

Management of delirium

If you think that a person has delirium:

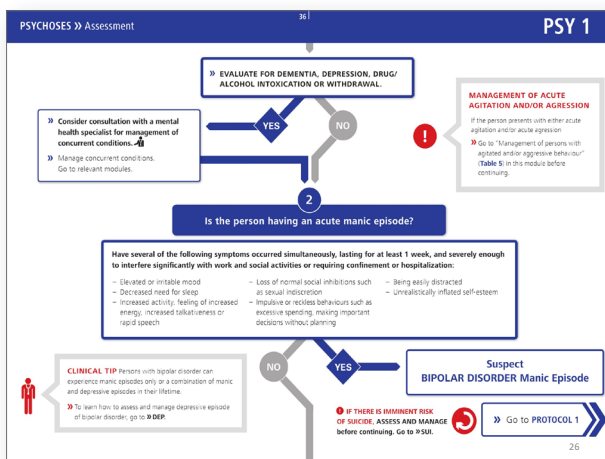
- Try to identify and manage underlying cause.
- Assess for dehydration and give fluid.
- Ensure that the person is safe and comfortable.
- Continue to reassess and monitor the person after initiating management.
- Refer the person to a specialist (e.g. neurologist, psychiatrist, or internal medicine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

25

Talk through the points on the slide.

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

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



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

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

Managing concurrent MNS conditions and psychoses

Psychoses can occur with:

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

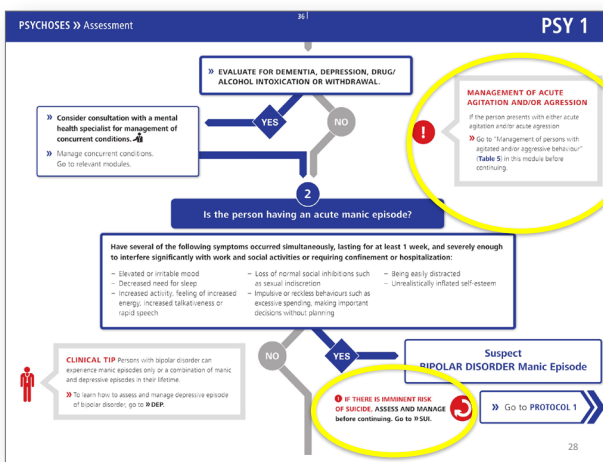
27

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

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

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

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



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

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

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

TABLE 5: Management of Persons with Agitated and/or Aggressive Behaviour

ASSESSMENT	COMMUNICATION	SEDATION AND USE OF MEDICATION
<ul style="list-style-type: none"> Attempt to communicate with the person. Evaluate for underlying cause: <ul style="list-style-type: none"> Check Blood Glucose, if low, give glucose. Check vital signs, including temperature and oxygen saturation. Give oxygen if needed. Rule out delirium and medical causes including poisoning. Rule out drug and alcohol use. <ul style="list-style-type: none"> Specifically consider stimulant intoxication and/or alcohol withdrawal. Go to 9 SUB. Rule out agitation due to psychosis or manic episode in bipolar disorder. Go to Assessment, PSY 1. 	<ul style="list-style-type: none"> Safety is first. Remain calm and encourage the patient to talk about his or her concerns. Use a calm voice and try to address the concerns if possible. Listen attentively. Devote time to the person. Have a laugh at the person. Do not get aggressive back. Try to find the source of the problem and solutions for the person. Involve carers and other staff members. Remove from the situation anyone who may be a trigger for the aggression. If all possibilities have been exhausted and the person is still aggressive, it may be necessary to use medication if available to prevent injury. 	<ul style="list-style-type: none"> Sedate as appropriate to prevent injury. For agitation due to psychosis or mania, consider use of Haloperidol 2mg p.o. (i.e. hourly) up to 5 doses (maximum 10 mg). Caution: high doses of Haloperidol can cause dystonic reactions. Use dependent to treat acute reactions. For agitation due to ingestion of substances, such as alcohol, benzodiazepines or stimulant medications, use diazepam 10-20 mg p.o. and repeat as needed. Go to 9 SUB. In cases of extreme violence: <ul style="list-style-type: none"> Seek help from police or staff. Use haloperidol 5mg i.m., repeat in 15-30mins if needed (maximum 15 mg). Consult a specialist. If the person remains agitated, recheck oxygen saturation, vital signs and glucose. Consider p.o. Refer to hospital. Once agitation subsides, refer to the master chart (MC) and select relevant modules for assessment. Special Populations: <ul style="list-style-type: none"> Consult a specialist for treatment.

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

Case scenario

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

30

Case scenario continued

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

31

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.

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

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

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

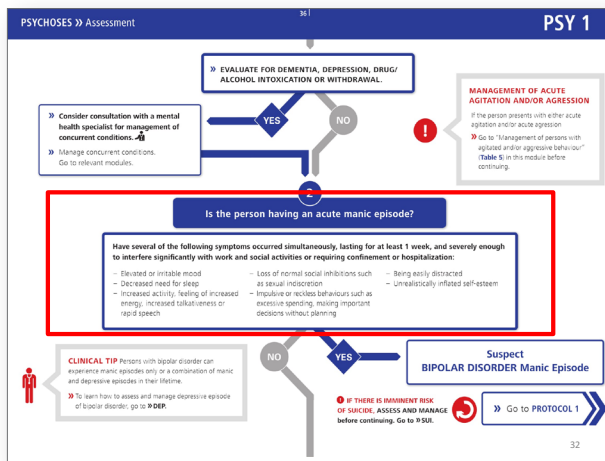
Use a calm voice and try and address any of her immediate concerns.

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

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

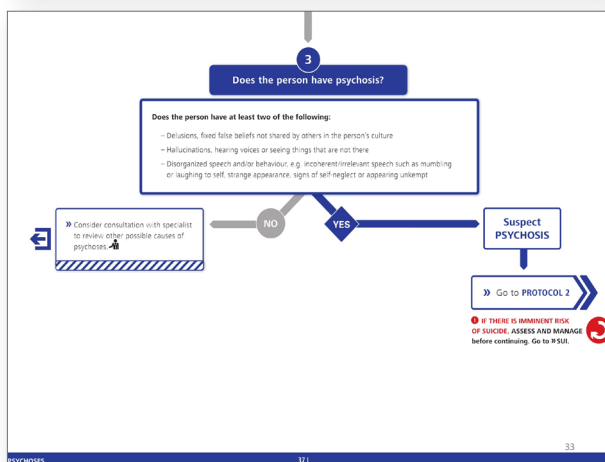
Involve the mother (if the young woman allows it) ask the mother why she thinks this is happening?

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



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

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



Does Amir have psychosis?

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

How to ask about hallucinations and delusions?

Symptoms	Person	Family
Hallucinations	e.g. Do you hear voices or see things that no one else can?	e.g. Do you see the person talking to someone else when alone? As if the person is talking to someone?
Delusions	e.g. Do you believe that someone is planning to hurt you? Do you feel that you are under surveillance?	e.g. Did the person share any ideas that you found strange and unlikely to be true?

34

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

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

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

Activity 4: Role play: Assessment

Activity 4: Role play: Assessment

- 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 ungroomed.
- Assess him according to the psychoses assessment algorithm on page 35 mhGAP-IG.

35

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.

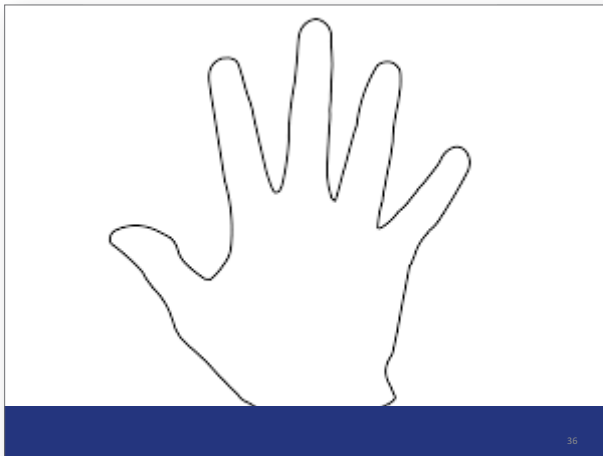
Instructions:

- 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.

PSYCHOSES » Management PSY 2

PSY 2 » Management

PROTOCOL 1

1

Manic Episode in Bipolar Disorder

- Provide **psychoeducation** to the person and carers. (2.1) **††**
- **Pharmacological Intervention**. (2.6) **‡**
- **If patient is on antidepressants – DISCONTINUE** to prevent further risk of mania.
- **Begin treatment** with lithium, valproate, carbamazepine, or with antipsychotics. Consider a short-term (2-4 weeks) maximum bupropion for behavioural disturbance or agitation.
- Promote functioning in daily activities. (2.3)
- Ensure safety of the person and safety of others.
- Provide regular follow-up. **‡**
- Support rehabilitation in the community.
- Reduce stress and strengthen social supports. (2.2)

PROTOCOL 2

2

Psychosis

- Provide **psychoeducation** to the person and carers. (2.1) **††**
- **Begin antipsychotic medication**. (2.5) **‡**
- Start with a low dose within the therapeutic range and increase slowly to the lowest effective dose, in order to reduce the risk of side-effects.
- Promote functioning in daily activities. (2.3)
- Ensure safety of the person and safety of others.
- Provide regular follow-up. **‡**
- Support rehabilitation in the community.
- Reduce stress and strengthen social supports. (2.2)

38

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

Activity 5 Video demonstration: Managing psychoses

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

39

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?

PSYCHOSES » Management PSY 2

PSYCHOSOCIAL INTERVENTIONS ††

2.1 Psychoeducation

Key messages for the person and their carers:

- Explain that the symptoms are due to a mental health condition, that psychosis and bipolar disorder can be treated, and that the person can recover. Clarify common misconceptions about psychosis and bipolar disorder.
- **Do not blame the person or their family** or accuse them of being the cause of the symptoms.
- Ensure the person and the family that the person needs to take the prescribed medication and return for follow-up regularly.
- Explain that return and/or contacting of symptoms are common and that it is important to recognise these early and visit to the health facility as soon as possible.
- Plan a regular visit or school schedule that **avoids sleep deprivation and stress** for both the person and the carers. Encourage the person to seek advice about major decisions especially prior involving family or major commitments.

CLINICAL TIP
Build rapport with the person.
Build trust between the person and the health care provider is critical to ensure treatment adherence and long-term outcomes.

➤ Recommend **avoiding alcohol, cannabis or other non-prescription drugs**, as they can worsen the psychotic or bipolar symptoms.

➤ Advise them about maintaining a healthy lifestyle, e.g. a balanced diet, physical activity, regular sleep, good personal hygiene, and to consider **stop** any recreational substances. **Water (drinking) changes should be continued as long as needed, passively/instinctively.** These changes should be planned **in advance** for sustainability.

2.2 Reduce stress and strengthen social supports

- Coordinate with available health and social resources to meet the family's physical, social, and mental health needs.
- Identify the person's prior social activities that, if reinstated, would have the potential to provide direct or indirect psychological and social support, e.g. family gatherings, outings with friends, visiting neighbors, social activities at work, clubs, sports, and community activities. Encourage the person to resume these social activities and assist family members about this.
- Encourage the person and carers to improve social support systems.

CLINICAL TIP
Encourage people with psychosis are treated with respect and dignity. For further details go to **WEAP**.

2.3 Promote functioning in daily living activities

- Continue regular social, educational and occupational activities as much as possible. It is best for the person to have a job or to be otherwise meaningfully occupied.
- Facilitate inclusion in economic activities, including culturally appropriate supported employment.
- Offer life skills training and/or social skills training to assist independent living skills for people with psychosis and bipolar disorder and for their families and/or carers.
- Facilitate, if available and needed, independent living and supported housing that is culturally and community appropriate in the community.

2.4 General advice for carers

- **Do not try** to convince the person that his or her beliefs or experiences are false or not real. Try to be neutral and supportive, even when the person shows unusual behaviour.
- **Do not** expressing constant or severe criticism or hostility towards the person with psychosis.
- Give the person freedom of movement, avoid restraining the person, while also ensuring that their basic security and that of others is met.
- In general it is better for the person to live with family or community members in a supportive environment outside of the hospital setting. Long-term hospitalization should be avoided.

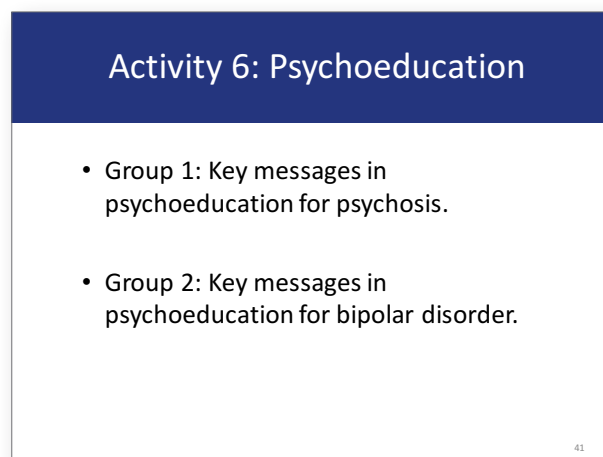
40

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



The slide is titled "Activity 6: Psychoeducation" and contains two bullet points. The first bullet point is "Group 1: Key messages in psychoeducation for psychosis." The second bullet point is "Group 2: Key messages in psychoeducation for bipolar disorder." The slide number "41" is visible in the bottom right corner.

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

Activity 7: Promoting functioning in daily living activities

Promoting functioning in daily living activities is a crucial step in their journey to recovery. It will:

- Help a 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.

42

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.

Initiating antipsychotic medication

Are antipsychotics better started early or late?

Early!

For prompt control of psychotic symptoms, health-care providers should begin antipsychotic medication immediately after assessment. The sooner the better.

43

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.

Initiating antipsychotic medication

Is it better to start with a low dose or a high dose?

Low!

Start with a low dose within the therapeutic range and increase slowly to the lowest effective dose in order to reduce the risk of side-effects. Start low, go slow.

44

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

The answer is a **low dose**.

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

Initiating antipsychotic medication

Which route is preferable?

- oral
- intramuscular.

Oral!

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

45

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

The answer is **oral**.

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

Initiating antipsychotic medication

How many antipsychotic medications should we prescribe at a time?

- one
- more than one.

One!

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

46

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

The answer is **one**.

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

PHARMACOLOGICAL INTERVENTIONS FOR SPECIAL POPULATIONS, (women who are pregnant or breastfeeding, older adults, 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, rigidity, 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 AN ANTI-DEPRESSANTS

- DISCONTINUE ANTI-DEPRESSANTS** 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. Inadequate compliance or stopping lithium treatment suddenly may increase the risk of relapse. Do not prescribe lithium when the lithium level 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 valproate is not available to supervise from 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 concern.

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 behavioral disturbances or agitation:**
 - Persons with mania who are experiencing agitation may benefit from short-term (2-4 weeks maximum) use of benzodiazepines such as diazepam.
 - Benzodiazepines should be discontinued gradually, as withdrawal symptoms may occur 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, olanzapine, or carbamazepine may be used. **Offer maintenance treatment in primary care settings under specialist supervision.**

47

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
<p>2.5 Psychosis</p> <ul style="list-style-type: none"> 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 the 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). <p>CAUTION:</p> <ul style="list-style-type: none"> Extrapyramidal side effects (EPS): akathisia, acute dystonic reactions, tremor, cogwheeling, muscular rigidity and tardive dyskinesia. Treat with anticholinergic medication when indicated and advise 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 characterised by muscular rigidity, elevated temperature, and high blood pressure. 		
<p>2.6 Manic Episode in Bipolar Disorder</p> <p>If patient is on antidepressants:</p> <ul style="list-style-type: none"> DISCONTINUE ANTI-DEPRESSANTS Begin treatment with lithium, valproate, carbamazepine, or with antipsychotics (see Table 3). <p>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. Ensure compliance or stopping lithium treatment suddenly may increase the risk of relapse. Do not prescribe lithium where the lithium body may be frequently interrupted. Obtain kidney and thyroid function, complete blood count, ECG, and pregnancy tests before beginning treatment if possible.</p> <p>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.</p> <p>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 does not a constraint.</p> <p>CAUTION:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 an symptom improves 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 possible, haloperidol, risperidone or carbamazepine may be used. Offer maintenance treatment in primary care settings under specialist supervision. 		

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 antipsychotic medication to see if that improves his symptoms.

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 risperidone ?
- What are the effective doses?
- What are the side-effects for each drug?

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

Find the answers to the following questions on the slide.

Case scenario

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

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

51

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

Mood stabilizers

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

52

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

Review and adherence

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

53

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

Case scenario

A 28-year-old woman called Fatima gave birth to her second child two weeks ago. Her husband explains that she is not sleeping at all and she is struggling to feed the baby. She believes that her baby is in danger but she does not know how to protect it. Sometimes she thinks it would be better if she and the baby were both dead. On one occasion the husband has stopped her from being violent towards the baby.

54

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

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

Special populations
Note that interventions may differ for PSYCHOSES in these populations

WOMEN WHO ARE PREGNANT OR BREASTFEEDING

- Liaise with maternal health specialists to organize care.
- Consider consultation with mental health specialist if available.
- Explain the risk of adverse consequences for the mother and her baby, including obstetric complications and psychotic relapses, particularly if medication stopped.
- Consider pharmacological intervention when appropriate and available. See below.

Pharmacological Interventions

PSYCHOSIS

- In women with psychosis who are planning a pregnancy or pregnant or breastfeeding, low-dose oral haloperidol or chlorpromazine may be considered.
- Anticholinergics should **NOT** be prescribed to women who are pregnant due to extrapyramidal side-effects of antipsychotic medications, except in cases of acute, short-term use.
- Depot antipsychotics should not be routinely prescribed to women with psychotic disorders who are planning a pregnancy, pregnant or breastfeeding because there is relatively little information on their safety in this population.

MANIC EPISODE IN BIPOLAR DISORDER

- **AVOID VALPROATE, LITHIUM and CARBAMAZEPINE** during pregnancy and breastfeeding due to the risk of birth defects.
- Consider **low-dose haloperidol** with caution and in consultation with a specialist, if available.
- Weigh the risks and benefits of medications in women of childbearing age.
- If a pregnant woman develops acute mania while taking mood stabilizers, consider switching to low dose haloperidol.

ADOLESCENTS

- Consider consultation with mental health specialist.
- In adolescents with psychotic or bipolar disorder, **risperidone** can be offered as a treatment option only under supervision of a specialist.
- If treatment with risperidone is not feasible, **haloperidol** or **chlorpromazine** may be used only under supervision of a specialist.

OLDER ADULTS

- Use **lower** doses of medication.
- Anticipate an increased risk of drug-drug interactions.
- **CAUTION**
Antipsychotics carry an increased risk of cerebrovascular events and death in older adults with dementia-related psychosis.

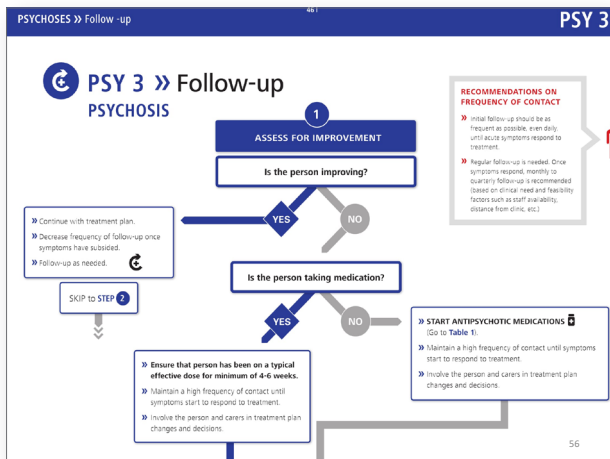
MOSES 39 | 55

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

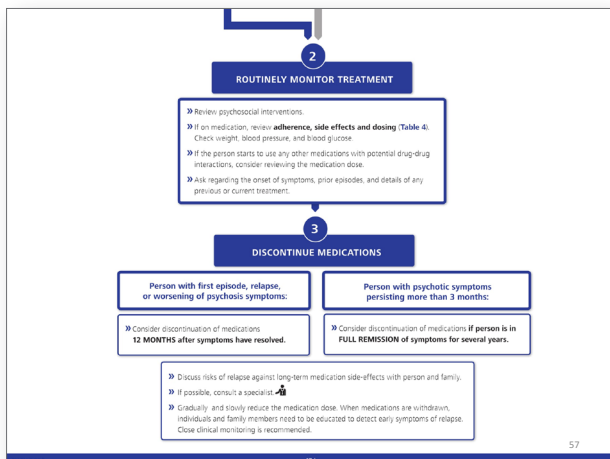
🕒 35 minutes



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.

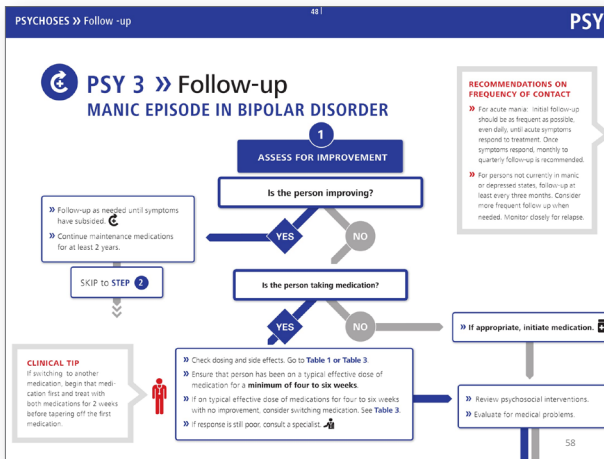
Reflect on how they might support a person to take their medication.



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?

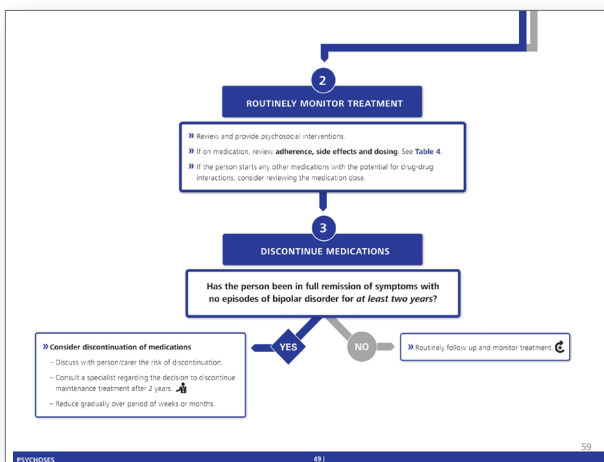
Clarify any concerns or questions they may have about step 3 and the discontinuation of medication.



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

Activity 8: Role play: Follow-up

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

60

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