mhGAP

mhGAP Humanitarian Intervention Guide (mhGAP-HIG) training of health-care providers

Training manual

World Health Organization

UNHCR
The UN Refugee Agency
聯合國難民署

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Contents

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

Introduction to the mhGAP-HIG training

The *mhGAP Humanitarian Intervention Guide* (mhGAP-HIG) is an adaptation of the World Health Organization (WHO)'s *mhGAP Intervention Guide (mhGAP-IG) for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings*, intended for use in humanitarian emergencies.

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

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

Aim and structure of the training manual

This training manual is designed to guide facilitators in training non-specialist health care providers to use the mhGAP-Humanitarian Intervention Guide (mhGAP-HIG) to assess and manage mental, neurological and substance use (MNS) conditions. It could also be used to demonstrate the training of health care providers in a Training of Trainers (ToT). The manual does not include ToT content, but a test for the purpose of a ToT can be found in annex A.

This manual is divided into three parts:

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

2. **Step-by-step training modules for MNS conditions:** This section provides facilitator guides for all the training modules. Each module comprises a module-specific step-by-step facilitator guide, which includes role-play information and a set of slides, which may need to be adapted to the local context. The slides come with notes for the presenter, a range of discussions, role-plays, case studies and videos.

3. **An annex with supporting materials**. These include:

- Annex A: Pre-and post-tests
- Annex B: Observer checklist and case studies for role-plays
- Annex C: Overview of mhGAP-HIG conditions (Training 1)
- Annex D: List of relevant video links
- Annex E: Adaptation template for the mhGAP-HIG
- Annex F: Handout: recommendations for care for child development
- Annex G: FRAMES approach.

Overview of the mhGAP-HIG training package

The training for mhGAP-HIG has been split into *two parts*:

1. **Training 1:** an initial training of three days. Training 1 covers General Principles of Care (GPC), acute stress, grief, depression, self-harm/suicide, psychosis and epilepsy. These six conditions account for more than 80% of all MNS cases that trained health-care providers tend to identify and manage in emergency settings in general health care.

2. **Training 2:** follow-up training of two days. Training 2 covers opportunities for further skills training as well as sessions on PTSD, harmful use of alcohol and drugs, intellectual difficulties and other significant mental health complaints.

Training 1 (initial training of 3 days)	Training 2 (follow up training of 2 to 2.5 days)
Can be given on its own	**Needs to be preceded by Training 1**
Introduction to mhGAP-HIG	Review of topics covered in Training 1, including relevant clinical experiences after completion of Training 1.
General Principles of Care (GPC): • GPC Communication (part I) • GPC Protection of human rights • GPC Attention to well-being • GPC Assessment • GPC Management (includes GPC Reducing Stress and Strengthening Social Support)	**General Principles of Care (GPC):** • GPC Communication (part II)
Conditions: • Acute Stress (ACU) • Grief (GRI) • Moderate–severe Depressive Disorder (DEP) • Suicide (SUI) • Psychosis (PSY) • Epilepsy/Seizures (EPI)	**Conditions:** • Post-traumatic Stress Disorder (PTSD) • Harmful Use of Alcohol and Drugs (SUB) • Intellectual Disability (ID) • Other Significant Mental Health Complaints (OTH)

Suggested training schedules

Training 1 and Training 2 have been developed as two trainings that can be given at separate times (for example, with a couple of months between them). Training 1 can be given without Training 2, but Training 2 will need to be preceded by Training 1, as Training 1 covers the General Principles of Care needed for the assessment and management of conditions covered in Training 2.

The suggested schedules presented below should be adapted to the circumstances of the training. As mentioned above, Training 1 covers six conditions that account for more than 80% of all MNS cases that trained health-care providers tend to identify and manage in emergency settings in general health care. Therefore, Training 1 would be recommended as the first training to conduct in an emergency setting. When resources allow, Training 2 can be conducted at a later stage. It is also possible to merge sessions from the two trainings to cover all conditions prioritized in your particular setting.

Training 1

The approximate times for the three sessions in Training 1 are:

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

To cover all three of the sessions for Training 1 (approx. 18 hours) in three days, the following schedule is suggested:

	Sessions	Duration (in minutes)
DAY 1 ***(5.5 hrs)***	**Session 1: Introduction to mhGAP-HIG**	**195**
	Introduction and aims	20
	Pre-test	25
	Why train on mental, neurological and substance use disorders?	15
	An introduction to mhGAP-HIG	35
	Conditions in mhGAP-HIG	50
	General principles of care (communication, human rights, well-being)	50
	Session 2: Assessment of mhGAP-HIG conditions	**130**
	General Principles of Assessment	40
	Assessment of significant symptoms of acute stress (ACU)	45
	Assessment of significant symptoms of grief (GRI)	45
	Daily evaluation	**15**
	Total:	**340**
DAY 2 ***(6 hrs)***	**Recap day 1**	**15**
	Session 2: Assessment of mhGAP-HIG conditions (continued)	**235**
	Assessment of moderate – severe depressive disorder (DEP)	70
	Assessment of suicide (SUI)	35
	Assessment of psychosis (PSY)	75
	Assessment of epilepsy (EPI)	55
	Session 3: Management of mhGAP-HIG conditions	**110**
	General principles of Management	5
	GPC- Reducing Stress and Strengthening Social Support	65
	Management of significant symptoms of acute stress	40
	Daily evaluation	**15**
	Total:	**375**
DAY 3 ***(6 hrs)***	**Recap day 2**	**15**
	Session 3: Management of mhGAP-HIG conditions (continued)	**310**
	Management of significant symptoms of grief (GRI)	45
	Management of depressive disorder (DEP)	75
	Management of self-harm/suicide (SUI)	40
	Management of psychosis (PSY)	75
	Management of epilepsy (EPI)	75
	Final course evaluation and post-test	**40**
	Total:	**365**

Time-keeping is essential to ensure that the training schedule can be completed

Training 2

The approximate times for the five sessions in Training 2 are:

- Session 1: Introduction to mhGAP-HIG training Part 2 – 100 minutes (approx. 1.5 hours)
- Session 2: Intellectual Disability (ID) – 145 minutes (approx. 2.5 hours)
- Session 3: Harmful Use of Alcohol and Drugs (SUB) – 105 minutes (approx. 1.5 hours)
- Session 4: Post-traumatic Stress Disorder (PTSD) (+recap GRI and ACU) – 185 minutes (approx. 3 hours)
- Session 5: Other Significant Mental Health Complaints (OTH) (+recap DEP) – 130 minutes (approx. 2 hours).

To cover all of the five sessions for Training 2 (approx. 12 hours) in two days, the following schedule is suggested:

	Sessions	Duration (in minutes)
DAY 1 ***(6 hrs)***	**Session 1: Introduction to mhGAP-HIG training Part 2**	**100**
	Introduction and aims	10
	Pre-test	30
	Experiences with the mhGAP-HIG so far	20
	Communication skills (recap SUI)	40
	Session 2: Intellectual Disability (ID)	**145**
	Introduction and assessment of ID	80
	Management of ID	65
	Session 3: Harmful use of Alcohol and Drugs (SUB)	**105**
	Introduction and assessment of SUB	55
	Management of SUB (+ recap PSY and EPI)	50
	Daily evaluation	**15**
	Total:	**365**
DAY 2 ***(6 hrs)***	**Recap day 2**	**15**
	Session 4: Post-traumatic Stress Disorder (PTSD)	**185**
	Introduction and assessment of PTSD (+recap GRI and ACU)	120
	Management of PTSD	65
	Session 5: Other Significant Mental Health Complaints (OTH)	**130**
	Introduction and assessment of OTH (+recap DEP)	80
	Management of OTH	50
	Daily evaluation	**40**
	Total:	**370**

• An additional day can be scheduled before the two days to spend more time on reviewing the conditions in Part 1 of the training. Another half-day can be added to this two-day schedule to practise further with comorbid cases.

Preparing and conducting the training

Preparing and adapting the training

In preparing for the training you will need to prepare yourself, the participants, the training materials and the venue. The HIG manual and training materials (case studies, tests, etc.) might need to be translated, depending on the group of participants. Some translation of the HIG manual are available on WHO's website.[1] For general guidance on adaptation in mhGAP, see the mhGAP Operations Manual (WHO, 2017)[2]. To adapt the HIG manual, see the adaptation template in Annex E. The training will need to be modified according to possible changes made in the training programme. Depending on languages in the group and languages spoken by the facilitator, there may be a need for an interpreter to be part of the training (which will substantially increase its duration). Working with an interpreter needs preparation. Provide all slides in advance and discuss translation of key terms with the interpreter. Even if the training is in English, the interpreter can be given the version of the mhGAP-HIG in another language, in order to prepare.

The training is best delivered by two facilitators. Preferable they have completed a Training of Trainers on mhGAP-HIG. They should be familiar with the mhGAP-HIG and the training manual.

Trainer checklist to prepare for training (adapted from the mhGAP-IG ToHP manual[3])

- Familiarize yourself with the entire mhGAP-HIG and facilitator training manual.
- Familiarize yourself with the local humanitarian crisis.
- Familiarize yourself with the mental health and psychosocial services available in the community.
- Identify the best way to conduct the training (length and duration).
- Prepare participants by ensuring that they receive an electronic copy of the mhGAP-HIG in advance of the training, with a request to read through it in preparation.
- Reserve the venue for training.
- Adapt the training materials where necessary (pre-test, case studies, etc.).
- Ensure that pens and paper are available.
- Ensure that a flipchart is available, with markers.
- Refreshments
- Attendance sheet
- Test audiovisual
- For participants, bring copies of the:
  - » pre- and post-test
  - » case studies and observer checklists

[1] Translations of the manual can be found here: https://www.who.int/publications/i/item/9789241548922
[2] mhGAP operations manual: mental health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2018.
[3] mhGAP Training of Health-care Providers (ToHP) training manual

mhGAP-HIG manual in locally accepted language for health-care provider

Training guidelines (adapted from the mhGAP-IG ToHP manual[1])

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

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

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

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

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

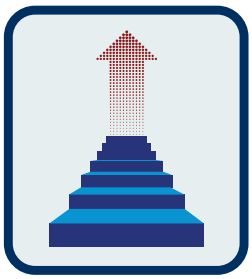
> Be an example to participants and show the behaviour and attitude you would want them to display"

[1] mhGAP Training of Health-care Providers (ToHP) training manual

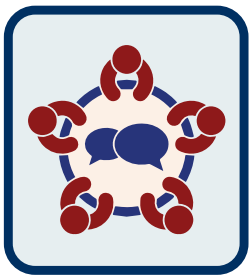
Specific training techniques

Slides

The accompanying slides are organized into the different sessions of Training 1 and Training 2. The slides contain the same notes for the facilitator as the notes in this facilitator guide. The following symbols are used in the presentations:



This symbol means that the information on the slide appears in stages. Such slides often contain a question for the group. After receiving some answers from the group, the rest of the slide with the answers can be revealed.



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

Video demonstration

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

Preparations

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

During training

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

Role-plays

Role-plays are used in this training to bring real-life scenarios into the classroom. They will give participants an idea of what it is like to use the mhGAP-HIG, which will help to build their clinical skills.

Preparations

- Familiarize yourself with the role-play instructions.
- Make sure that you have enough copies of the instructions to hand out to people playing the person with an MNS condition.
- The role-plays have a duration of 8–10 minutes, which is intended to mimic real-life scenarios where many primary health-care providers will have only a short time for each consultation.
- Adapt case studies to be more relevant to the context when necessary.
- Some role-plays have two case studies. Decide which one will work best in your context.
- Time management is important in facilitating the role-plays. Make sure that you allocate enough time for them in the training, but don't spend more time on them than suggested. It is important that all participants get a chance to practise both the assessment and management of the conditions covered. The case studies can be found in Annex B.

> It is important that all participants get a chance to practise both the assessment and management of the conditions covered"

During training

Split the participants into groups of three:

1. One participant will play a person with an MNS condition seeking help.
2. One participant will play the health-care provider, who will assess, manage or follow up with the person.
3. One participant will be an observer/carer. The observer's role is to monitor the interaction, make sure that all assessment, management and GPC areas are covered and offer feedback after the role-play. They can use the observer checklist (Annex B) to do this. The observer can also at the same time play the role of a carer accompanying the person who is seeking help. There are specific instructions for carers in some of the case studies. However, it is possible to add a carer role to all role-plays, and this may be a sensible thing to do in societies where people mostly seek health care together with a family member.

- Allow the role-play to continue for 8–10 minutes (unless stated otherwise in the instructions for that specific role-play). Stop the role-play and ask the observers to provide feedback to the health-care providers in their groups of three.
- Bring the group back together and ask a couple of participants (persons seeking help, health-care providers, observers/carers) how the exercise went (5 minutes).

Instructions for the facilitator:

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

Instructions for the person seeking help:

- As many of the participants will be acting out of character when playing the role of the person seeking help, they will need direction on how to behave. Annex B contains case studies for the different role-play scenarios; these should be printed out and handed to the people playing the role of the person seeking help before the role-play begins.
- When playing the role of help-seeker, do not exaggerate the symptoms or present overcomplicated issues. The aim of the role-play is for the health-care provider to practise their assessment and management skills.

- During the role-play, the help-seeker should consider some of the following:
  - How comfortable the health-care provider made you feel
  - What was good and what could be improved
  - How their communication skills and body language affected you
  - How the information given to you made you feel.
- Provide feedback on your most important observations to the health-care provider.

Instructions for the health-care provider:

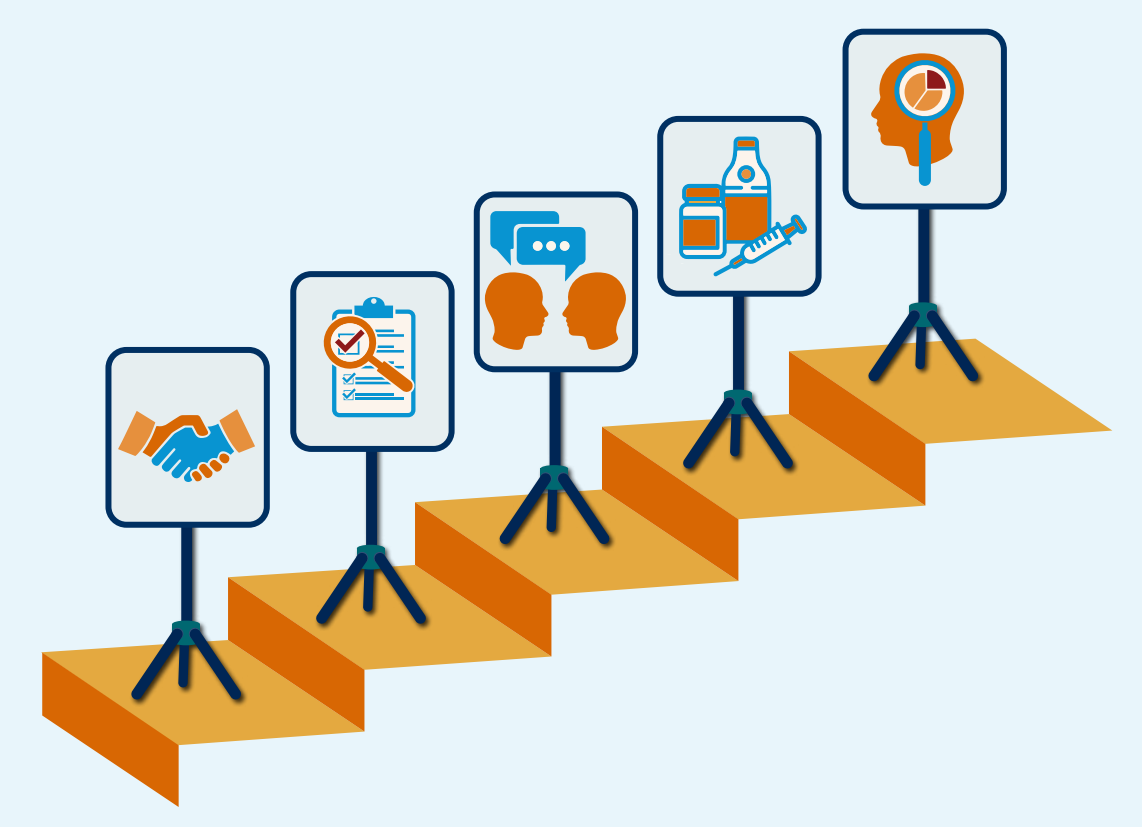
- The health-care provider should start the conversation and use the mhGAP-HIG and their communication skills to assess, manage or follow up with the person.

Instructions for the observer/carer:

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

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

2 | Step-by-step training sessions for MNS conditions



The remainder of this manual gives step-by-step instructions for the facilitator to train on the following sessions:

Training 1

- Session 1.1: Introduction to the mhGAP-HIG
- Session 1.2: Assessment of mhGAP-HIG conditions
- Session 1.3: Management of mhGAP-HIG conditions

Training 2

- Session 2.1: Introduction to mhGAP-HIG training Part 2
- Session 2.2: Intellectual Disability (ID)
- Session 2.3: Harmful Use of Alcohol and Drugs (SUB)
- Session 2.4: Post-traumatic Stress Disorder (PTSD)
- Session 2.5: Other Significant Mental Health Complaints (OTH)

TRAINING 1

Session 1.1: Introduction to the mhGAP Humanitarian Intervention Guide (mhGAP-HIG)

Overview

By the end of this session, participants should:

- Know the common presentations of mhGAP-HIG conditions;
- Be able to understand the general principles of communication, protection of human rights and attention to general well-being;
- Be able to promote respect and dignity for people with MNS conditions.

Sessions	Objectives	Duration (+/-)	Training activities
1.1.1. Introduction and aims of training	Introduction of facilitators and participants Explore expectations and explain training objectives	20 min	Activity 1.1: Introductions and expectations
1.1.2. Pre-test	Assess pre-existing knowledge and skills	25 min	Activity 1.2: Pre-test
1.1.3. Why train on MNS conditions?	Explain the rationale for training on MNS conditions	15 min	Activity 1.3: Quiz on MNS conditions
1.1.4. Introduction to the mhGAP-HIG	Introduce the mhGAP Humanitarian Intervention Guide	35 min	Activity 1.4: MNS care and emergencies Activity 1.5: Structure of the modules
1.1.5. Conditions covered in the mhGAP-HIG	Introduce the conditions covered in the mhGAP-HIG and commonly presented complaints covered in Part 1 training	50 min	
1.1.6. General Principles of Care • communication • human rights • well-being	Train in good communication skills Train in protection of human rights Train in attention to general well-being	50 min	Activity 1.6: Good communication and poor communication Activity 1.7: Group discussion on human rights violations within the community
Total time		195 min (approx. 3 hrs)	

Session 1.1.1: Introduction and aims of training (20 minutes)

Presentation	Facilitator notes
	• Welcome everybody and take them through the programme of *Session 1: Introduction.*
	• Explain the structure of the full (two-part) mhGAP-HIG training course. • Ask the group what kind of housekeeping rules they would like to see during the training. Write them on a flipchart. • Include the core rules described in the introduction of the manual (being on time, breaks, asking questions, phones on silent, no emails, etc.). • Explain why the pre- and post-tests are included in the training and that the pre-test for Training 1 will be done soon.

Presentation

Facilitator notes

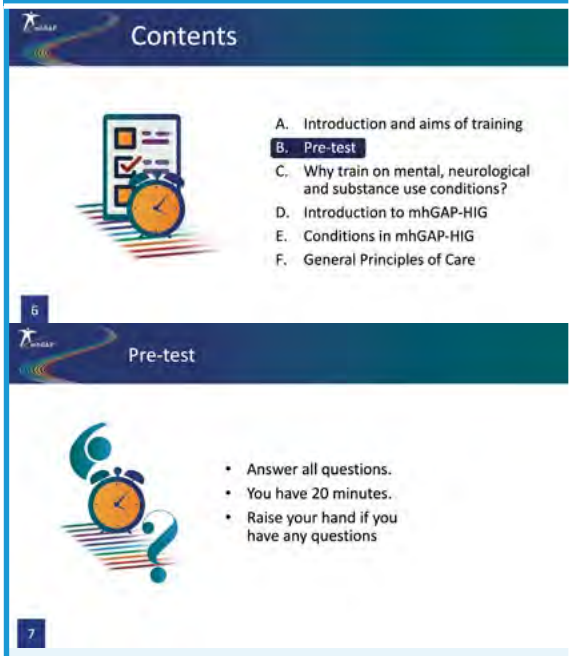
Activity 1.1: Introductions and expectations
Duration: 15 minutes
Purpose: Introduce the group and assess people's expectations.
Instructions:

- Explain that the introductions will involve moving around the room.
- Draw a map on the ground (or explain the map by using materials in the room, by using objects to represent locations) of the country/region/area participants might come from or work in.
- First ask participants to physically stand in their birthplace.
- Then ask them to move to their workplace.
- Ask them to move around one last time and line up according to years of experience in health or mental health.
- Then ask everybody in the group for a quick introduction sharing their name, where they work, their current role in MNS care and their expectations of the course.
- Write the participants' expectations on a flipchart.
- Introduce the learning objectives to the participants.
- Address the expectations mentioned by the participants, explaining which expectations will be met and why some may not be met.
- Emphasize that in the training the mhGAP-HIG manual will be used a lot since the aim is to give them the skills to work with this manual.

Session 1.1.2: Pre-test (25 minutes)

Preparation for facilitator:

- The pre-test can be found in Annex A.
- Print enough copies of the pre-test for all participants (ensure that the answers are not attached or on the reverse side of any print-outs).
- You might need to translate the pre-test into multiple languages.

Presentation	Facilitator notes
	**Activity 1.2: Pre-test** **Duration:** 20 minutes **Instructions:** • Explain the purpose of the pre-test to participants. • Explain that the test is not an exam but will give information on the level of knowledge in the group. At the end of the training the same test will be done again. Explain that a comparison of the two will show to what extent the trainer team has been successful in delivering knowledge to the participants, and that participants will not be judged or compared with each other. Hand out the Training 1 pre-test and tell the group that they have 20 minutes to complete it. • Indicate when 10 minutes of time is left; indicate when 5 minutes are left.

Session 1.1.3: Why train on MNS conditions? (15 minutes)

Preparation for facilitator:

- If there is any information available on the treatment gap for MNS conditions in the country/region/area, have the local data available during the training.

Presentation	Facilitator notes
	• Ask the group why they think mental, neurological and substance use (MNS) conditions are grouped together in mhGAP. • Invite some answers from the group before showing the rest of the slide. • MNS conditions are a diverse range of conditions that owe their origin to a complex range of genetic, biological, psychological and social factors. • Explain that MNS conditions are grouped together because they share several important characteristics, as explained on the slide. • Hold a quick plenum discussion about the last question on the slide (max. 5 minutes).
	• Emphasize that by 2030 depression is expected to be among the diseases with the highest burden in all parts of the world. • The term burden reflects both mortality and disability. • Mental disorders can be extremely disabling, causing many people not to function well in their daily lives and disabling families. • Thus mental health is an important public health concern in all countries. **Source:** These data are from the Global Burden of Disease study – 2004 data.

Session 1.1.3: Continued

Presentation	Facilitator notes
	• Explain that a WHO study in 14 countries has shown the extent of the treatment gap in adults. • In developed countries, 35–50% of serious cases did not receive any treatment during the previous year. • In developing countries, the percentage of cases not receiving any treatment was much higher, at 76–85%. • Start a brief discussion (max. 2 minutes) by asking participants: "Is this a surprise or is this what you expected?" **Source:** These data are from the Global Burden of Disease study – 2004 data
	**Activity 1.3: Quiz on MNS conditions** **Duration:** 10 minutes **Instructions:** • Explain that there will be a quick quiz with true/false questions. Designate one side of the room "True"' and the other "False". • Ask participants to move to either the "True" or "False" side of the room, depending on their answer. • Ask the questions on the slide and let people move to either side of the room. • Each time, ask someone from the true and someone from the false side to explain their answer, before revealing the correct answer. • If there is an appropriate example of a famous person from your country with an MNS condition, mention this to the group when discussing the second question.

Session 1.1.4: Introduction to the mhGAP-HIG (35 minutes)

Preparation for facilitator:

- Identify a humanitarian crisis situation that you think the group can identify with easily for **Activity 1.4.**

Presentation	Facilitator notes
	• Explain that this version of the manual has been specifically developed for use in humanitarian emergencies. • Explore the group's understanding of humanitarian emergencies. • Humanitarian crises include natural disasters (e.g. earthquake, tsunami) and human-made emergencies, such as war and refugee situations.
	**Activity 1.4: MNS care and emergencies** **Duration:** 15 minutes **Instructions:** • Identify a humanitarian crisis situation that you think the group can identify with easily – e.g. having fled conflict in your town and now being 100 miles away in a refugee camp, or your community has suffered an earthquake that has destroyed your home, the local school and the hospital. • Ask the group to think of the grief and fear that people might experience. • Ask the group to think of a family member/somebody they know with a severe mental disorder and imagine what he or she would think or feel in this situation. • Invite some people in the group to share. • In groups of three, let participants discuss how they would like to see health services in their country respond to the needs identified in this exercise.

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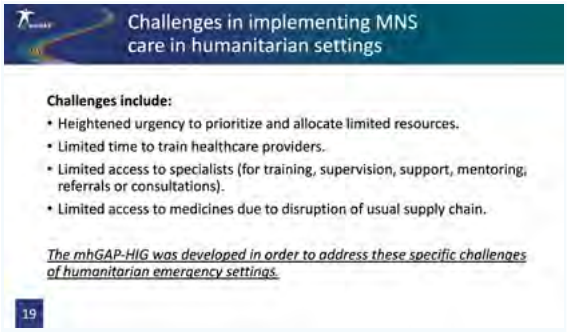
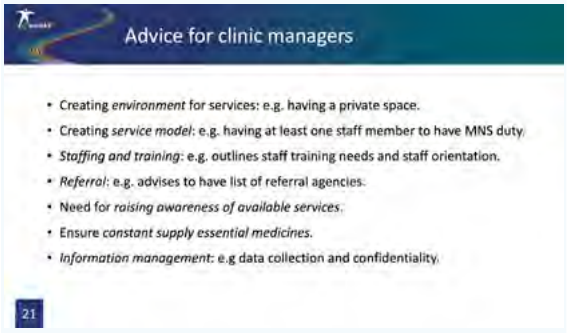
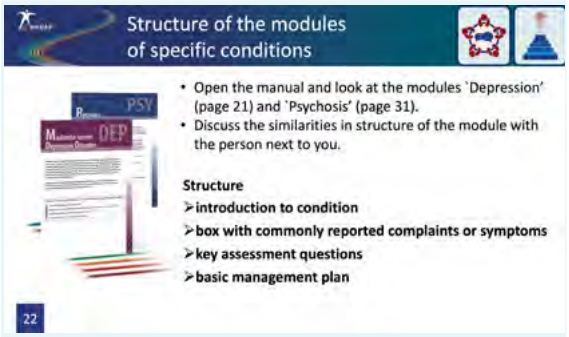
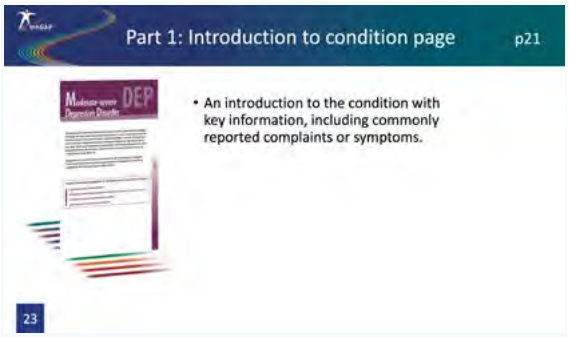
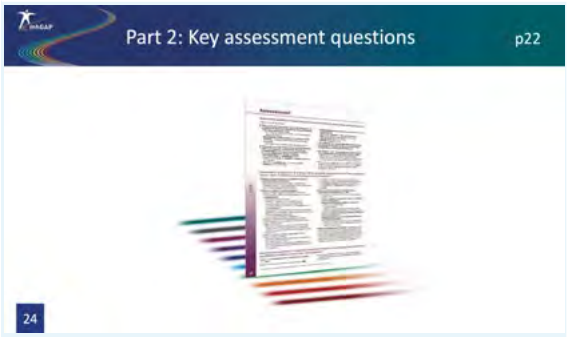
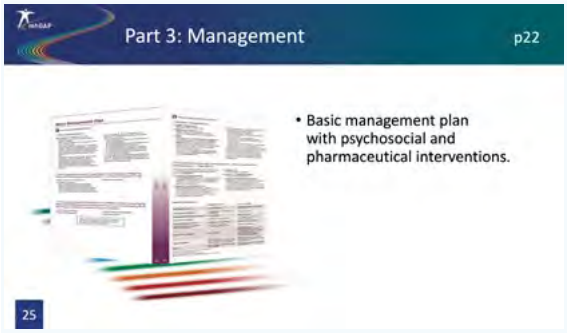
Session 1.1.4: Continued

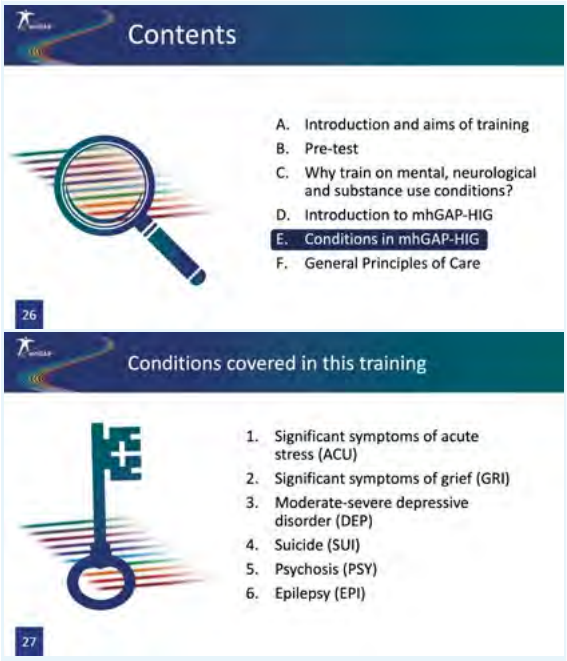
Presentation	Facilitator notes
	• After the exercise, reveal the rest of the slide and go through this information, referring back to what participants have mentioned in the discussion. • Participants might mention other valid challenges in humanitarian settings, such as loss of normal services, routines and social supports (which protect vulnerable people from developing MNS conditions and the likelihood of relapse).
	• Discuss the challenges with participants, referring back to what they have mentioned earlier. • Ask participants for examples of similar challenges that they have experienced in their work.
	• Briefly discuss the content of the mhGAP-HIG. • Have trainees open the guide to the table of contents (page iii). • Explain that this course will cover General Principles of Care (GPC) as well as the specific modules on the MNS conditions listed here.
	• Refer to pages 3–4 of the manual for advice for clinic managers. • Explain that it is important to share this information with their clinic managers so that they know what should be in place in order to use the mhGAP-HIG manual and implement it in their facilities. • Go through some of the points on the slide (e.g. constant access to essential medicines) and ask the participants who would be responsible for addressing these points in their clinic.

Presentation	Facilitator notes
	**Activity 1.5: Structure of the modules** **Duration:** 10 minutes **Instructions:** • Let participants open the manual and look at the structure (headings) of the modules for Depression (page 21) and Psychosis (page 31) on their own. • Ask them to discuss the structure (headings) of the modules with the person sitting next to them. • Let two pairs share their observations about the similarities in structure they have observed. • Reveal the four points on the lower part of slide.
	• Show similarities by looking at other introduction pages in the mhGAP-HIG. The key similarities are: » narrative introduction to the condition » box on typical complaints. • Explain that the box on typical complaints contains information about how people with this condition often PRESENT themselves, so these are NOT the criteria for the condition (e.g. body aches are a common presentation of depression but are not a specific symptom of depression).
	• Look through this assessment for depression (page 22) and show similarities by looking at other assessment pages in the mhGAP-HIG. • Point out key similarities and differences: » 2–3 assessment questions in bold. » Use of the question: does the person have the condition? » Often there is a question on concurrent conditions.

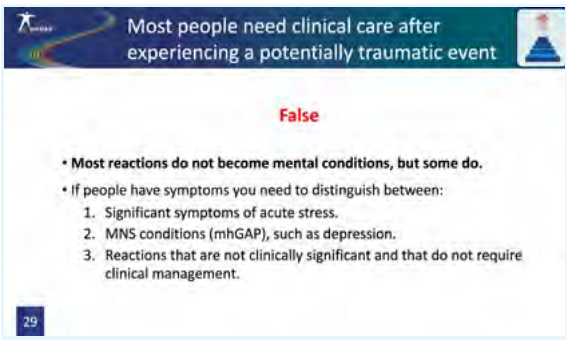
Session 1.1.4: Continued

Presentation	Facilitator notes
	• Look through pages 23–24 and show similarities by looking at other management pages in the mhGAP-HIG. Point out key similarities: » Layout » Separate section on psychosocial and pharmacological interventions.

Session 1.1.5: Key conditions covered in Part 1 training (50 minutes)

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

Session 1.1.5: Continued

Presentation	Facilitator notes
	• Explain that stress is a common reaction to events in emergencies. Everyone can feel stressed. Stress can be a useful response as it stimulates our "fight or flight" response and in many people it can be a motivator that drives them to take action and make decisions in their lives. • However, people can become overwhelmed by stress, and that starts to affect their ability to cope in daily life. • Have a discussion about stress-related problems in the community. • Explain how stress can present in primary health care as follows: » somatic complaints » sleep problems » behavioural changes » physical changes » extreme emotions » cognitive changes. • Give some concrete examples of complaints that people often present with, such as back pain and bedwetting in children. Ask the participants how people locally present with stress-related symptoms in primary health care. • Explain that the mhGAP-HIG has a module on acute stress and one on grief to cover the assessment and management of significant symptoms of these conditions.
	• Explain that, in emergencies, people may be exposed to a range of potentially traumatic events. • Ask the group to identify whether the statement on the slide is true or false. • Invite some answers before revealing the rest of the slide. • Explain that most reactions do not become MNS conditions or disorders, but some do.

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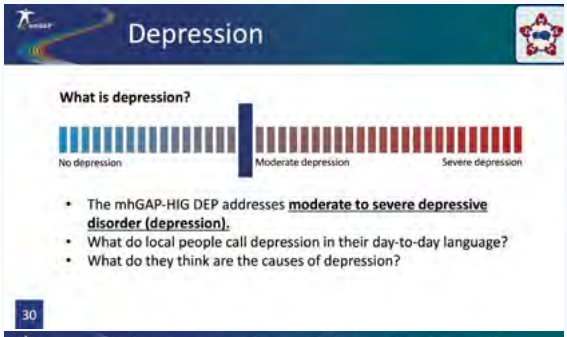
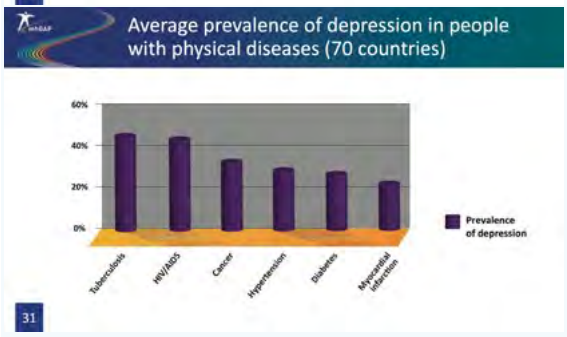
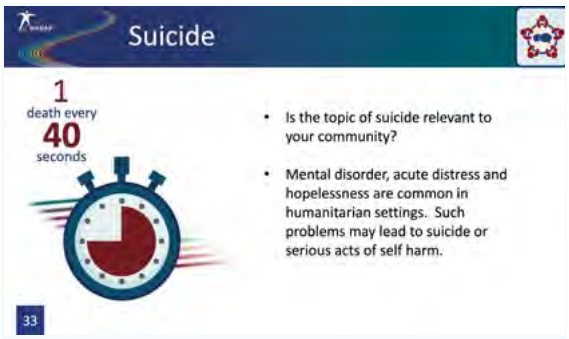
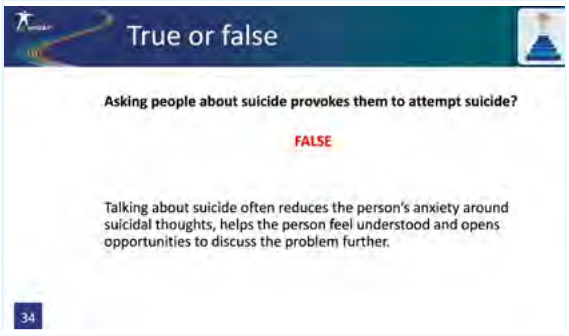
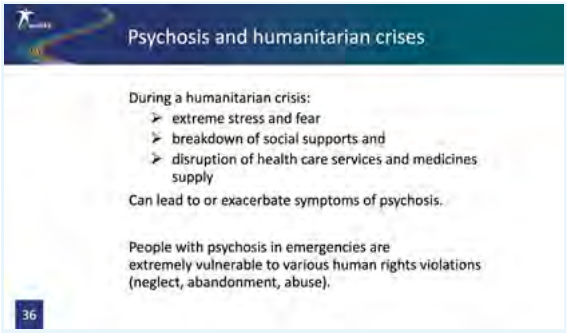
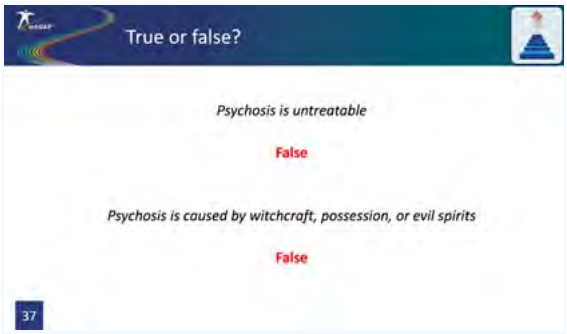
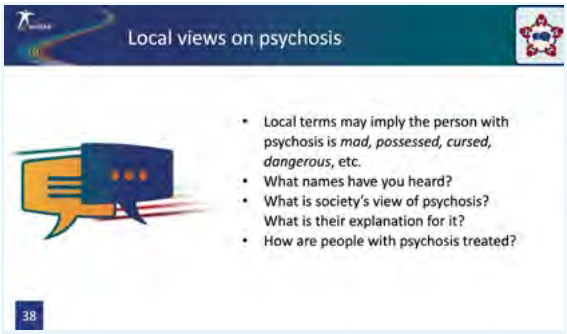
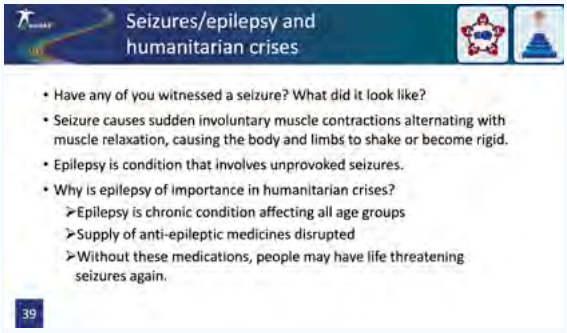
Session 1.1.5: Continued

Presentation	Facilitator notes
	• Emphasize that many people have no problems, or that problems naturally resolve. • Emphasize that stress can contribute to the development of most of the conditions covered in the mhGAP-HIG (with the exceptions of epilepsy and intellectual disability). • Using the slide, explain that not all stress reactions need clinical care.
 	• Instruct the group to read through the list of complaints that people with moderate–severe depressive disorder typically present with, on page 21 of the manual. • Discuss the symptoms of depression and explain that depressive symptoms are on a continuum and that feeling sad is often normal. This module addresses moderate to severe depressive disorder. • Mild depressive symptoms will be covered in the OTH module in Part 2 of the training. • Use the questions on the slide to prompt a plenary discussion (max. 5 minutes) about the words and explanations for depression used locally. Local concepts may have similarities with depression but may also have important differences, and it is important to know these local terms. • Emphasize that depression is very common in people who have chronic physical diseases. **Source:** WHO World Health Surveys, 2007, Lancet

Session 1.1.5: Continued

Presentation	Facilitator notes
	• Ask the question on the slide. • Invite some of the group to share their thoughts before revealing the answer.
	• Ask whether suicide and suicide attempts occur in the local community. What happens if there is a suicide attempt? • Explain that close to 800 000 people die due to suicide every year. This means one death every 40 seconds. • Suicide is the leading cause of death globally among girls aged 15–19 years. • Explain that 78% of suicides globally occur in lower- and middle-income countries (LMICs). • Using the slide, explain why suicide is a risk in humanitarian settings.
	• Ask the group if the statement on the slide is true or false. • Invite some answers from participants before revealing the answer. • Explain that asking about self-harm/ suicide and management of self-harm/suicide will be covered in this course.
	• Go through the typical presenting complaints of psychosis with the group and explain any symptoms that are not clear to them. • Direct participants to read through this information on page 31 of the mhGAP-HIG. • Remind them that this same layout is used for each condition in the manual.

Session 1.1.5: Continued

Presentation	Facilitator notes
	• Give examples of human rights violations, such as: » A person with psychosis is tied to a tree and abandoned with some food/water while their family flees. » A person with intellectual disability is raped during the chaos of an emergency. » A person with psychosis is shot because they do not understand or follow the instructions of an armed group.
	• Ask the participants to give a "true" or "false" answer to the questions on the slide. • Show each question and ask the group to raise their hands for "true" or "false"; then reveal the answer.
	• Explore local views on psychosis by asking the group the three questions on the slide. The aim is to prompt a general discussion about local beliefs and views on psychosis. » Ask several people about the different terms they may hear used for describing psychosis. » Be sensitive and seek to use culturally appropriate language. • In particular, emphasize that psychosis is a condition that can be treated.
	• Ask the group about their experiences with people who have had convulsive seizures and local ideas about seizures. • Explain that a convulsive seizure involves sudden involuntary muscle contractions alternating with muscle relaxation, causing the body and limbs to shake or become rigid.

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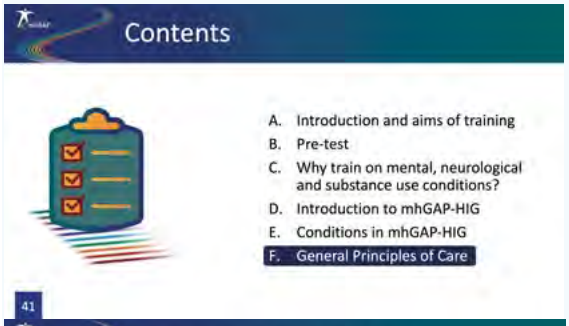
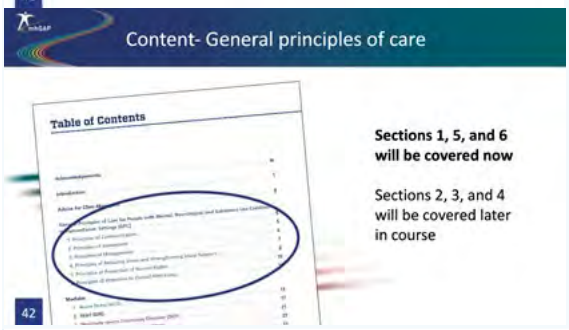
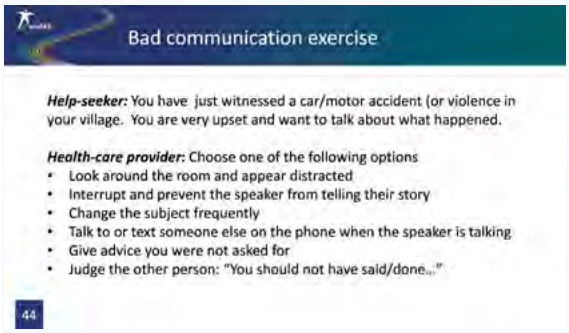
Session 1.1.5: Continued

Presentation	Facilitator notes
	• Explain that we will discuss the definition of convulsive seizures and epilepsy later in the course, but that epilepsy involves unprovoked seizures. Explain that the term "unprovoked" means that there is no acute physical cause for the seizure. • Put the question on the slide to the group. • Invite some members of the group to share their thoughts before revealing the answer.
	• Ask the group whether the statements on the slide are true or false. • Show each statement and ask the group to raise their hands for true or false; then reveal the answer. • Have a brief discussion about local terms for seizures and local beliefs about them (5 minutes).

Session 1.1.6: General Principles of Care (50 minutes)

Preparation for facilitator:

- Prepare **Activity 1.7**: depending on the background and experience of the participants, decide whether to use Option 1 or Option 2.

Presentation	Facilitator notes
 	• Share when the General Principles of Care (GPC) will be covered in the training and show where they are described in the mhGAP-HIG. • Principles of Assessment in the "Assessment" part of training (page 6). • Principles of Management and Principles of Reducing Stress and Strengthening Social Support in the "Management" part of training (pages 7–8). • Principles of Communication (page 5), Protection of Human Rights (page 10) and Attention to Overall Well-being (page 11) will be covered now.
	• Explain that the principles of communication are important for MNS assessments and management. • Invite some answers from participants before showing the answers. • Discuss communication with carers in the local context and decide whether it is necessary to add a carer role to all the role-plays.
	**Activity 1.6: Good communication and poor communication** **Duration:** 10 minutes **Instructions:** • Ask participants to form pairs for an exercise on bad communication. • Instruct the pairs to conduct a role-play in which a help-seeker wants to talk with a health-care provider about a bad experience. • The help-seeker can choose a scenario from the slide or use one of their own.

Continues on next page

Session 1.1.6: Continued

Presentation	Facilitator notes
	• The health-care provider will display at least one of the bad communication behaviours mentioned on the slide. • Let the role-play continue for 3 minutes and then ask for feedback. • Ask participants: "What did you feel/ what would you feel if you had been the person seeking help?" • Refer to the principles of communication on page 5 of the mhGAP-HIG. • Ask the group to read through the principles. • Have a discussion about any important aspects as you go: » *Create an environment that facilitates open communication:* Discuss how it would feel if you were not welcomed or acknowledged. (If time allows, consider demonstrating this.) » *Involve the person with the MNS condition as much as possible:* Discuss how it might feel to be talked about, or briefly demonstrate this by asking for two volunteers and talking about one of them in front of the other. » *Start by listening:* Discuss how it feels if someone gives advice or tells you what to do straight away. If time allows, demonstrate this and also not listening but giving advice. » *Be clear and concise:* Discuss what it might feel like to not be clear and concise, or demonstrate both types of talking. » *Respond with sensitivity when people disclose difficult experiences:* Discuss how someone might feel after a rape or episode of self-harm. Discuss shame and how it feels to disclose such difficult feelings. If time allows, consider demonstrating this.

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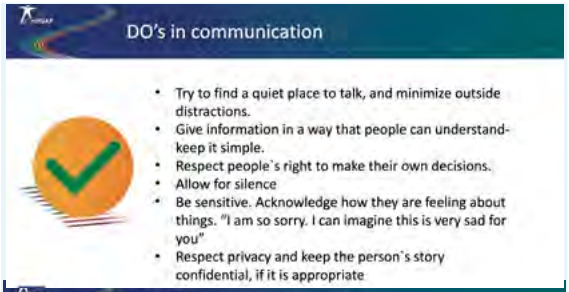
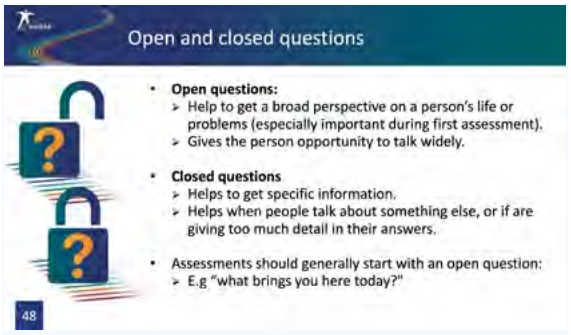
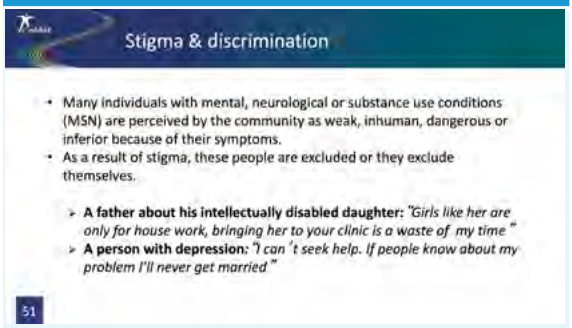
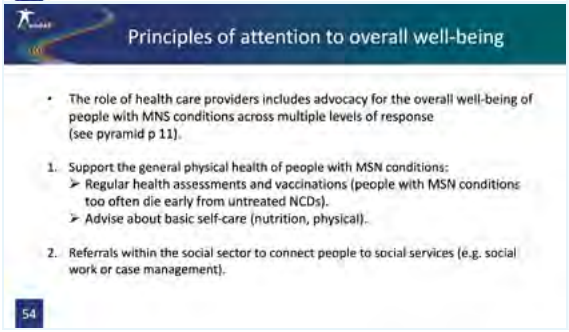
Presentation	Facilitator notes
	» *Do not judge people on their behaviours or beliefs:* Discuss in particular laughing at a person or having a bad judgement of them. Discuss how it might feel to be laughed at or if someone says or thinks you are aggressive. » If needed, use appropriate interpreters: Discuss why an interpreter might be useful and the difficulties involved in using family members as interpreters.
 	• Take the group through the list of DOs and DON'Ts in communication and ask for some examples of what the DON'Ts would look like in the field.
	• Illustrate the use of open and closed questions by asking some participants e.g. "Do you like apples?" • Ask the participants what kind of information these answers give. They only show whether people like apples or not and do not give any other information (e.g. what other tastes people might like or not). • Ask participants for an alternative open question (e.g. "What fruit do you like?" "What do you like to eat?") • Other examples of open questions that are good to use in the assessment would be: "What do you think is the cause of your problem?", "What makes it worse and what makes it better?"

Presentation	Facilitator notes
 	**Activity 1.7: Group discussion on human rights violations within the community** **Duration:** 10 minutes **Instructions:** Have a group discussion using either Option 1 or Option 2. *Option 1:* • Instruct the group to write down the five rights they have that are most important to them personally. • Let them look at their rights and imagine that they have a mental health condition. Let them put an X next to the rights they would lose in that case. • Ask people to raise their hands if they would lose all five rights. Then ask people to raise their hands if they would lose 4, 3, 2, 1 and 0 rights. • What human rights are violated in the lives of people with MNS conditions in your community? *Option 2:* • Ask some participants to share the MNS conditions they have in mind. If they mention severe conditions, ask them to imagine if the same would be relevant for someone with depression or anxiety. • Then direct participants to the top of page 10 in the mhGAP-HIG and let them read the range of human rights violations that people with MNS conditions may experience during humanitarian emergencies. • In pairs, let participants discuss in confidence the human rights violations they may have experienced in their own lives and have them compare them with those on page 10 and decide what category they fall into.

Session 1.1.6: Continued

Presentation	Facilitator notes
	• Ask for an additional local example of stigma and discrimination for people with severe mental health problems and for depression and anxiety. • If no examples are given, you may ask the following questions: » Have you seen people being locked up or chained because of their symptoms or behaviour? (Highlight that family members often do this to protect their loved ones and do not see any appropriate alternatives.) » Have you seen people being hit because of their symptoms or behaviour? » How likely are health workers to openly share that they have suffered from mental disorders themselves?
	• Put the question to the group and encourage discussion for 5 minutes
 	• Explain that people with severe mental conditions, even in high-income countries, live 20 years less, largely due to neglect of noncommunicable diseases (NCDs). • Let participants take a look at the IASC intervention pyramid for mental health and psychosocial support (page 11). • Explain that the role of healthcare providers extends beyond clinical care to advocacy for the overall well-being of people with MNS conditions, which requires advocacy with colleagues working outside the health sector, as shown in the IASC intervention pyramid.

Session 1.2: Assessment of mhGAP-HIG conditions

OVERVIEW

By the end of this session, participants should:

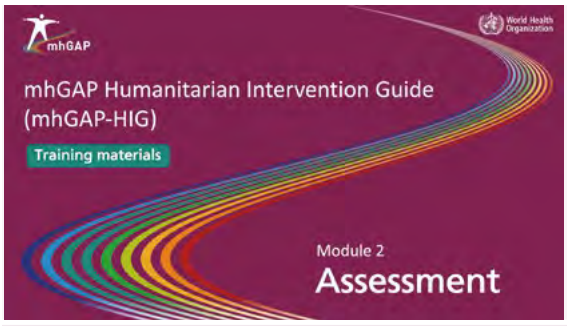
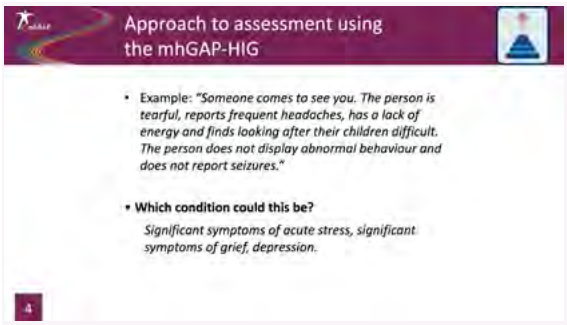
- Understand the general principles of assessment;
- Know the assessment questions for selected mhGAP-HIG conditions;
- Be able to perform an assessment for selected mhGAP-HIG conditions.

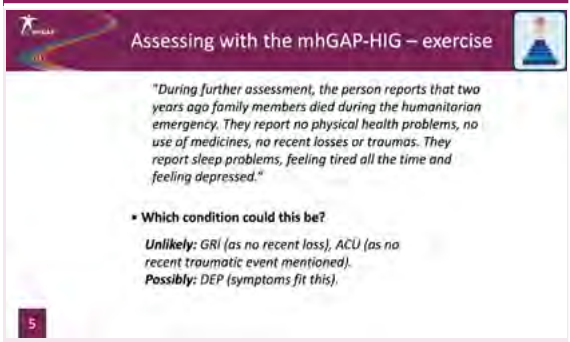
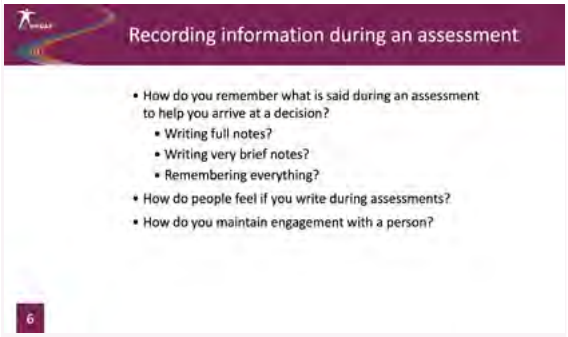
Sessions	Objectives	Duration (+/-)	Training activities
1.2.1. General principles of assessment	Know the common general principles of assessment Understand how to conduct assessments with the mhGAP-HIG	40 min	Activity 1.8: Assessment with mhGAP-HIG Activity 1.9: Role-play – general principles of assessment
1.2.2. Assessment of significant symptoms of acute stress	Know how to assess for significant symptoms of acute stress	45 min	Activity 1.10: Acute stress assessment Activity 1.11: Role-play – assessing for significant symptoms of acute stress
1.2.3. Assessment of significant symptoms of grief	Know how to assess for significant symptoms of grief	45 min	Activity 1.12: Criteria for significant symptoms of grief Activity 1.13: Role-play – assessing for significant symptoms of grief
1.2.4. Assessment of moderate–severe depression	Know how to assess for moderate–severe depression	70 min	Activity 1.14: Case studies – depression Activity 1.15: Video – assessment for depression Activity 1.16: Role-play – assessing for moderate–severe depression
1.2.5. Assessment of self-harm/suicide	Know how to assess for imminent risk of suicide	35 min	Activity 1.17: Role-play – assessing for imminent risk of suicide
1.2.6. Assessment of psychosis	Know how to assess for psychosis	75 min	Activity 1.18: Case study – symptoms of psychosis Activity 1.19: Video – assessment for psychosis Activity 1.20: Role-play – assessing for psychosis
1.2.7. Assessment of epilepsy	Know how to assess for epilepsy	55 min	Activity 1.21: Case study – assessing for epilepsy Activity 1.22: Video - assessment for epilepsy Activity 1.23: Role-play – assessing for epilepsy
Total time		365 min (approx. 6 hrs)	

Session 1.2.1: General principles of assessment (40 minutes)

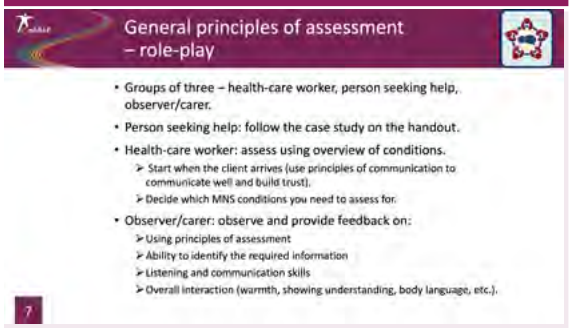
Preparation for facilitator:

- Have enough copies of the "Overview of mhGAP-HIG conditions" handout for **Activity 1.8** (see Annex C) and the case study 1 or 2 "Role-play – General principles of assessment" for **Activity 1.9** (see Annex B).

Presentation	Facilitator notes
	• Introduce the assessment section of the training by explaining that this session will start by going through the general principles of assessment. This will be followed by assessment for each of the conditions.
	• Ask the group to name issues that are explored in an assessment. • Reveal the rest of the slide. • Explain that page 6 of the mhGAP-HIG lays out the general principles of assessment and that these questions form the basis for an assessment. • Ask the group to read through page 6 of the guide. • Have a discussion: » Ask which questions may be difficult to ask in some contexts (e.g. questions around suicide or alcohol/drug use). » Ask why each section is important. » Explain that it is important to keep the assessment very focused, since consultations are usually very brief in a non-specialized setting.
	• Mention that the first step in assessment is to decide which condition to assess for. • Explain that all the modules start with typical presenting complaints of persons with that condition. • If complaints are indicative of one or more of the MNS conditions included in the mhGAP-HIG, follow the assessment questions for the relevant conditions.

Presentation	Facilitator notes
	**Activity 1.8: Structure of the modules** **Duration:** 10 minutes **Purpose:** To practise the first step of assessment by looking at descriptions of presenting complaints in the mhGAP-HIG. **Instructions:** • Introduce the assessment section of the training by explaining that this session will start by going through the general principles of assessment. This will be followed by assessment for each of the conditions. • Give the participants 2 minutes to decide which conditions they would assess for, based on the presenting complaints given on the slides. (Participants can also describe a relevant local case for this activity.) • Ask for a few responses and then reveal the answer. • Discuss the answers with the group
	• Discuss approaches that are used for recording information gathered during an assessment. (Also discuss time constraints that providers might have in recording information and search for a realistic solution.) • Explain that there is no single approach to note-taking that is "correct" for everyone or for every setting (some help-seekers may find writing notes distracting, or it may suggest that the health-care provider is unskilled). • Explain that it is important to have a way to record or remember the information. • Discuss the confidentiality of notes and how to make sure that other people do not have access to them. • Explain that it is also important to show engagement during assessment (It is odd to write all the time and not look at the person!).

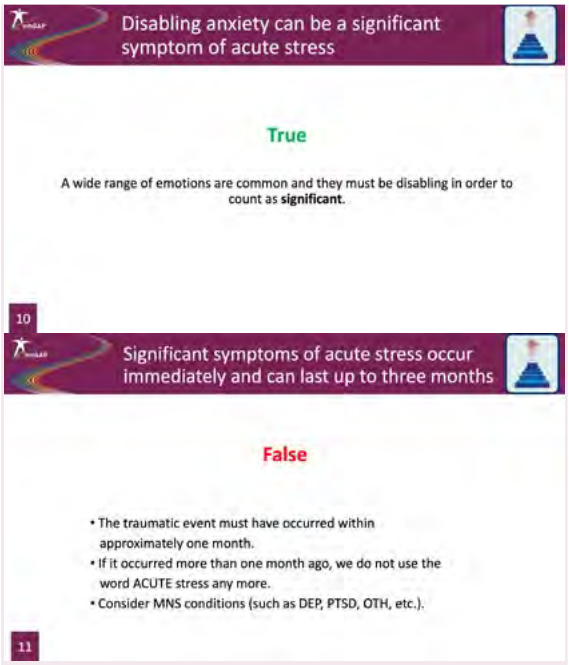
Session 1.2.1: Continued

Presentation	Facilitator notes
	**Activity 1.9: Role-play – general principles of assessment** **Duration:** 20 minutes **Purpose:** To practise performing assessments using the general principles of assessment. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 1.9: Role-play- general principles of assessment" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 1.2.2: Assessment of significant symptoms of acute stress (45 minutes)

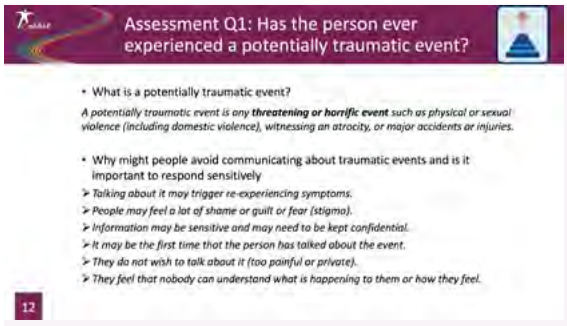
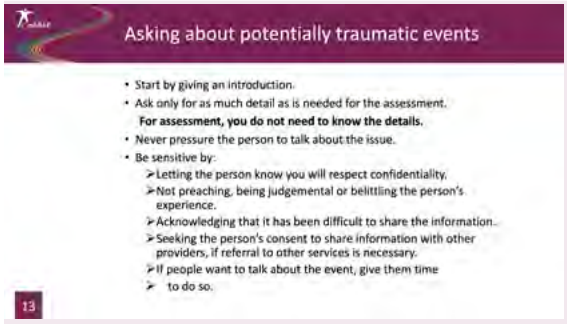
Preparation for facilitator:

- Make sure that you have enough copies of case study 1 or 2 "Role-play– assessing for significant symptoms of acute stress" for **Activity 1.11** (see Annex B; the case studies are the same as for activity 1.9).

PRESENTATION	Facilitator notes
	• Explain that in crises stress is extremely common in all ages and groups. The assessment of specific conditions covered in the mhGAP-HIG will start with significant symptoms of acute stress and a short exercise.
	***Activity 1.10: Acute stress assessment*** **Duration:** 10 minutes **Purpose:** To become familiar with the criteria for significant symptoms of acute stress. **Instructions:** • Give instructions to open pages 13–14 of the mhGAP-HIG and answer the two questions on the slide with either "true" or "false" (5 minutes for both questions). • Get some answers from the group for question 1 before revealing the answer on the slide. • Explain that this is part of the assessment question for significant symptoms of acute stress: • People need to have considerable difficulty with daily functioning to meet the criteria for significant symptoms of acute stress.

Continues on next page

Session 1.2.2: Continued

Presentation	Facilitator notes
	• Get some answers from the group on the second question before revealing the answer on the slide. • Direct the group to the guide, which states: 1. The event must have occurred within approximately one month of the person presenting. 2. If it occurred more than one month ago, we do not use the word **acute** stress anymore and must then consider other MNS conditions (depression, PTSD, substance abuse, OTH, etc.). • Thus, if the person is having a lot of symptoms and has difficulties functioning in their daily life because of the symptoms **more than a month** after a potentially traumatic event, it is not "acute stress" anymore. It is likely to be another MNS condition.
	• Ask the group what they think is considered to be a potentially traumatic event. • Invite a few responses and then reveal the answer. • Instruct the group to read page 14 of the mhGAP-HIG for assessment questions. • Ask the group the second question on the slide. • Listen to a few responses and then reveal the answer.
	• Share the bullet points on the slide about how to ask about a potentially traumatic event. • Start with an open question, e.g.: • "I'd like to ask you about any bad events you've experienced during the disaster/conflict. Are you able to tell me a little bit about what happened? You don't need to go into details. I only need to know what you consider important for me to understand what happened to you."

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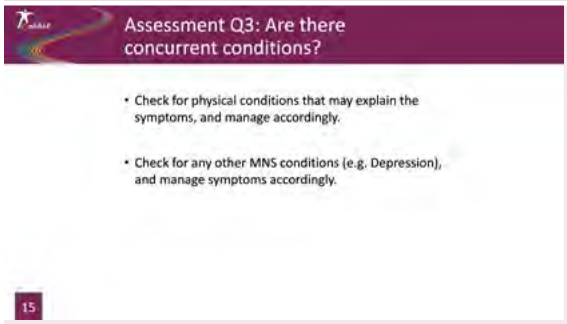
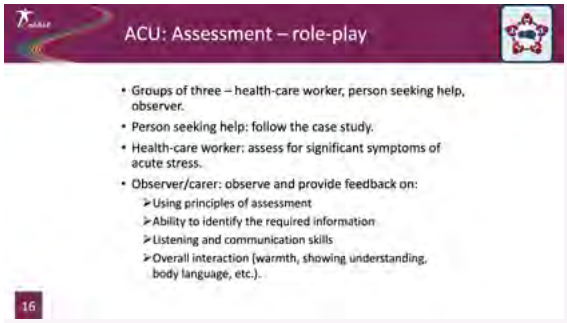
Session 1.2.2: Continued

Presentation	Facilitator notes
	• Emphasize again that health-care providers should follow the pace of the person and never pressure anyone to talk about an issue, and that there is no need to know details. • Explain that some people will wish to talk about the issue, and if they do it is important to make time to listen and discuss the experience at a pace with which the person is comfortable. It may take someone a long time before they tell you something, and that is okay. • Note that the age, gender and background of the person need to be considered (communication may be different for children).
	• Ask the person what symptoms they are experiencing, for how long they have had them, and whether or not the symptoms relate to the previous or current event. This will help to decide whether this is acute stress or an exacerbation of another, more longstanding problem. • If the person has had symptoms and problems since e.g. an attack five months ago, it is likely to be another condition as well as or instead of ACU. • Explain to the group that they have now learned how to assess for significant symptoms of acute stress. Management of these symptoms will be taught later in the course.

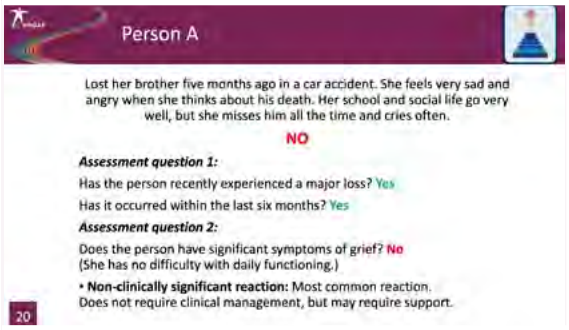
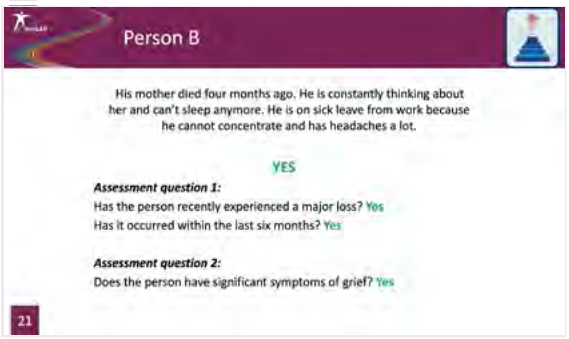
Session 1.2.2: Continued

Presentation	Facilitator notes
	• Explain that, as with other conditions, one also has to check for physical conditions and other MNS conditions. Too often, physical issues are neglected when MNS conditions become the focus of treatment. • Illustrate the need for this with an example (e.g. a child may be bedwetting, which may seem to be a symptom of acute stress, but it could be caused by a urinary tract infection; or a person may have sleeping problems, which may seem to be a symptom of acute stress, but it could be caused by physical pain or by noise and weather conditions when living in a temporary shelter or tent).
	**Activity 1.11: Role-play – assessing for significant symptoms of acute stress** **Duration:** 20 minutes **Purpose:** To practise performing assessments for significant symptoms of acute stress. **Instructions:** • Divide the participants into groups of three. Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 1.11: Role-play – assessing for significant symptoms of acute stress" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

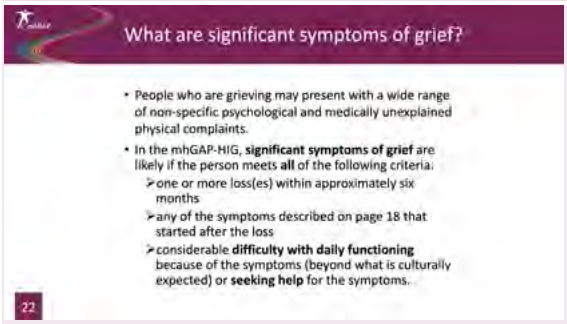
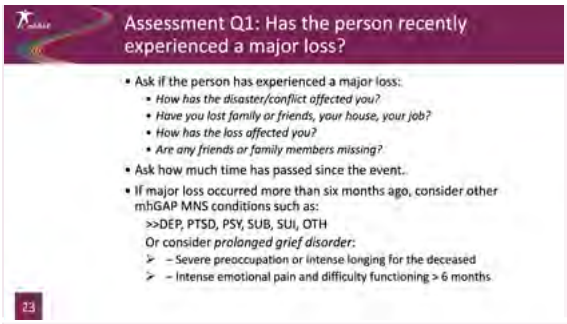
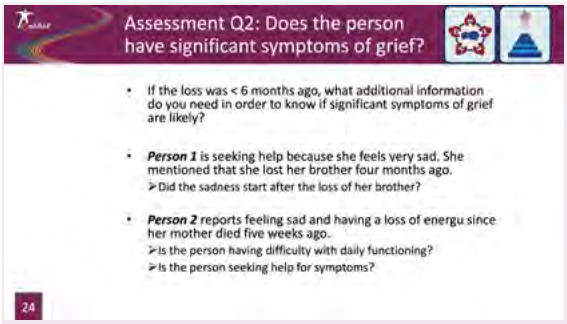
Session 1.2.3: Assessment of significant symptoms of grief (45 minutes)

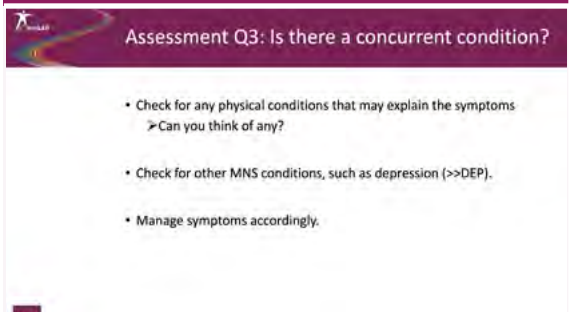
Preparation for facilitator:

- The footnote on page 18 of the mhGAP-HIG points out that the normal period of mourning and bereavement may be longer in certain cultures, where religious belief sanctions more than six months of grief. Determine before the training if this is the case in the local setting and adapt training materials as necessary.
- Make sure that you have enough copies of the case study "Role-play – assessing for significant symptoms of grief" for **Activity 1.13** (see Annex B).

Presentation	Facilitator notes
	• Have a brief discussion about grief and mourning in local communities/ cultures.
	• Give the group instructions to individually decide if Person A and Person B are likely to experience significant **symptoms of grief based** on the information given on pages 17–18 of the mhGAP-HIG. Let them write answers (yes or no) on paper (give them 5 minutes to do this).
	• Direct the group to assessment questions 1 and 2 on page 18 and discuss how Person A does not meet the criteria for question 2.
	• Direct the group to assessment question 1 on page 18 and discuss how Person B meets the criteria for questions 1 and 2.

Session 1.2.3: Continued

Presentation	Facilitator notes
	• Ask the group for complaints that one would often see in people who are grieving (2 minutes). • Explain that reactions to bereavement are normal, people grieve in many different ways and there is no good or wrong way to grieve. • Emphasize that symptoms of grief are considered significant when they meet the two criteria (in bold) on the slide and that people should receive help for this. • Ask participants to read the section on significant symptoms of grief again (mhGAP-HIG page 17).
	• Explain how to ask about a major loss and the questions one could ask • Discuss that when prolonged grief disorder is suspected a specialist needs to be consulted. Discuss the possibility of doing that in the local context.
	• Explain that after identifying that there has been a major loss, the next step is to assess if the symptoms are significant. Assessment question 2 needs to be asked (page 18). **Activity 1.12: Criteria for significant symptoms of grief** **Duration:** 5 minutes **Purpose:** To practise assessment of significant symptoms of grief. **Instructions:** • Present the two cases of possible significant symptoms of grief and ask the group what additional information is needed in both cases (3 minutes). • Ask for a few responses before revealing the answers.

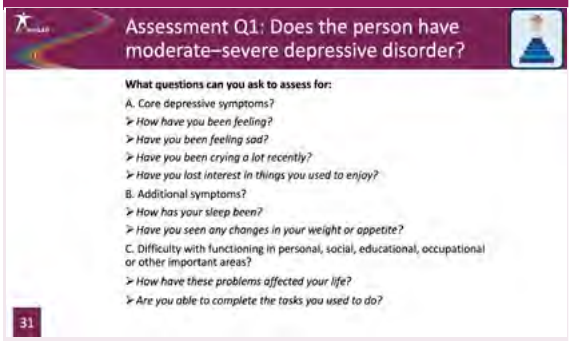
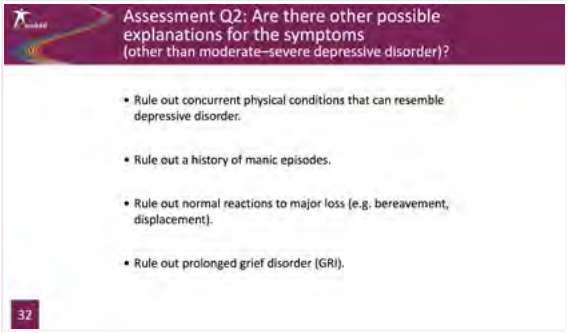
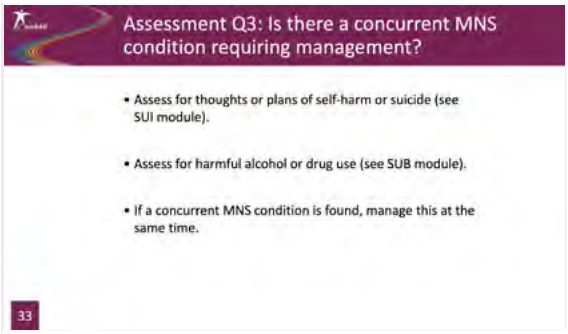
Presentation	Facilitator notes
	• Allow a few minutes for participants to come up with physical conditions that might explain symptoms (e.g. tiredness caused by anaemia) that may be misinterpreted as grief.
	**Activity 1.13: Role-play – assessing for significant symptoms of grief** **Duration:** 20 minutes **Purpose:** To practise performing assessments for significant symptoms of grief. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 1.13: Role-play – assessing for significant symptoms of grief" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes. • Explain that when it comes to showing empathy, the tone (how you say it) is as important as what you say. • Discuss the impulse to immediately give advice without knowing the situation. Some health workers use unhelpful platitudes like "This is how life is", "One day we all will go", "Do not worry, you will forget about it".

Session 1.2.4: Assessment of moderate–severe depression (70 minutes)

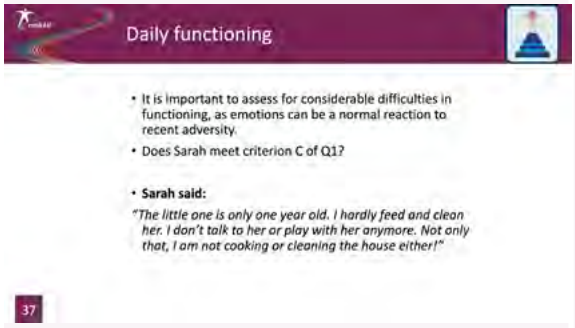
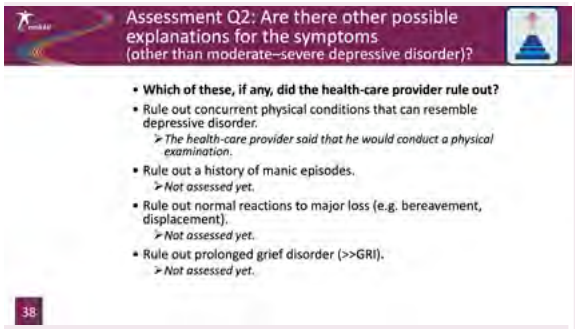
Preparation for facilitator:

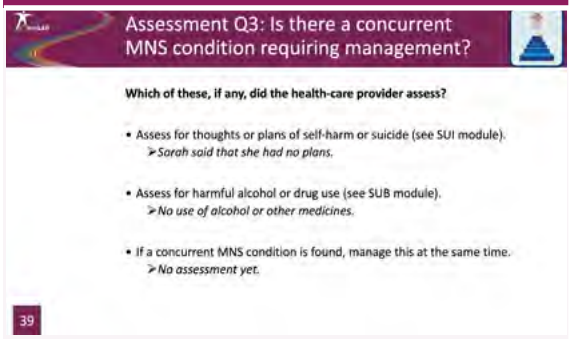
- The video for **Activity 1.15** is available at https://www.youtube.com/watch?v=hgNAySuIsjY&index=1&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (duration 7:40 minutes). Download the video in advance in case the Internet connection at the training venue is not adequate.
- Make sure that you have enough copies of the case study "Role-play – assessing for moderate–severe depression" for **Activity 1.16** (see Annex B).

Presentation	Facilitator notes
	***Activity 1.14: Case studies – depression*** **Duration:** 10 minutes **Instructions:** • Instruct the group to individually decide if Person A and Person B are likely to have moderate–severe depressive disorder based on the information on pages 21–22 of the mhGAP-HIG. Let them write their answers (yes or no) on paper (5 minutes) • Ask for some responses from the group for Person A before showing the answers on the slide. • Refer to assessment question 1 and indicate that Person A does not meet the criteria for part A and part B, because her symptoms have been present for less than two weeks. • Ask for some responses from the group for Person B before showing the answers on the slide. • Refer to assessment question 1 and indicate that Person B meets the criteria for part A and Part B. He also has difficulties with daily functioning, meeting criterion C, and his symptoms have been present for more than two weeks. • He is likely to have moderate–severe depression.

Presentation	Facilitator notes
	• Ask the group for example questions they can ask for criteria A, B and C. • Invite some responses from the group and then reveal the examples on the slide. • Explain that these are just example questions – have the group identify questions that might work in their specific settings. • Ask for more questions for criterion B. • Tell them that they can use these questions later in the role-play.
	• Ask the group to read through page 22 in the manual. • Answer any questions on how to rule out each point on the slide.
	• Explain that complaints in the SUI and SUB modules are particularly important to assess for as they often accompany depression.
	**Activity 1.15: Video – assessment for depression** **Duration:** 8 minutes **Purpose:** To show the assessment for depression. **Instructions:** • Before showing the video, ask the group to write down information that will help decide if Sarah has an MNS condition.

Session 1.2.4: Continued

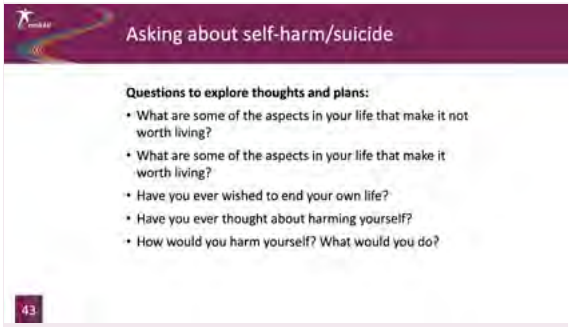
Presentation	Facilitator notes
	• Ask the group what problems they identified and write these on a flipchart, then reveal the list on the slide and point out any other additional problems that were missed by the participants. • Ask the group to check assessment question 1 on page 22 and select which symptoms indicate moderate–severe depressive disorder. Tick these on the flipchart list. • Answers are revealed on the next slide.
	
	• Ask the group if they think that Sarah meets criterion C of assessment question 1 (daily functioning) and why? • Invite some responses from the group before revealing the rest of the slide. • Explain that Sarah clearly said that she was having problems with daily functioning.
	• Explain that you will continue with assessment question 2 on page 22. • Invite someone to provide an answer before revealing the answer on the slide. • Ask participants how they would rule out these explanations (e.g. asking specific questions to rule out particular issues).

Presentation	Facilitator notes
	• Explain that the SUI (self-harm/suicide, page 49) and SUB (harmful use of alcohol and drugs, page 45) modules and other MNS modules are used to assess for these. • Ask if Sarah exhibited problems related to any of these and if the health-care provider assessed for these. • Let some participants share their answers before revealing the answer on the slide. Let the group reflect on the case and how local cases might be different.
	***Activity 1.16: Role play – assessing for moderate–severe depression*** **Duration:** 20 minutes **Purpose:** To practise performing assessment for depression. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study ("Activity 1.16: Role-play – assessing for moderate–severe depression" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 1.2.5: Assessment of self-harm/suicide (35 minutes)

Preparation for facilitator:

- Look up the estimated suicide rate ((http://www.who.int/gho/publications/world_health_statistics/2017/en/) for your country in the most recent WHO World Health Statistics (). Make sure that you have enough copies of the case study "Role-play – assessing for imminent risk of suicide" for **Activity 1.17** (see Annex B).

Presentation	FACILITATOR NOTES
	• Ask the group to read through the assessment questions on page 50 of the mhGAP-HIG. Remind them that asking about self-harm or suicide does not make it more likely that a person will attempt suicide and that it is important to move through all three of the assessment questions for SUI. • Discuss assessment questions 1, 2 and 3, which all have to be addressed in each case (e.g. if a person presents after a suicide attempt, make sure to come back to assessment questions 2 and 3 once the person is medically stable). • Take time to explain the concept of imminent risk of suicide.
	• Emphasize that it is important to know how to talk about self-harm and suicide and that it is important to read Box SUI 1 on page 50. • Discuss asking questions that naturally lead to other questions so there is an appropriate line of questioning (refer to the example in Box SUI 1). • In pairs, get individuals to practise asking "Have you had any recent thoughts about ending your life?" in as many different ways you can (i.e. using different phrasings). • Have a brief discussion about appropriate ways of asking about self-harm and suicide and write down examples that can be used in the role-play. • Remind the participants that we will cover management of SUI later in the course.

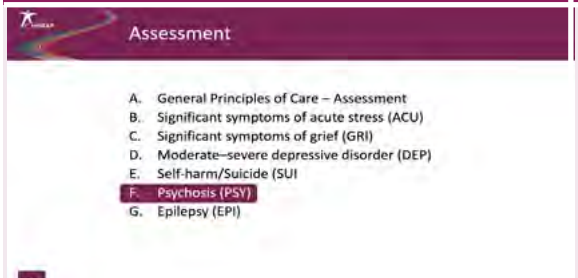
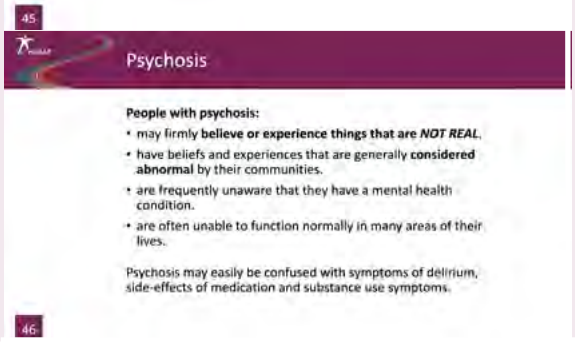
Session 1.2.5: Continued

Presentation	Facilitator notes
	**Activity 1.17: Role-play – assessing for imminent risk of suicide** **Duration:** 20 minutes **Purpose:** To practise performing assessment for self-harm/suicide. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (Activity 1.17: "Role-play – assessing for imminent risk of suicide" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

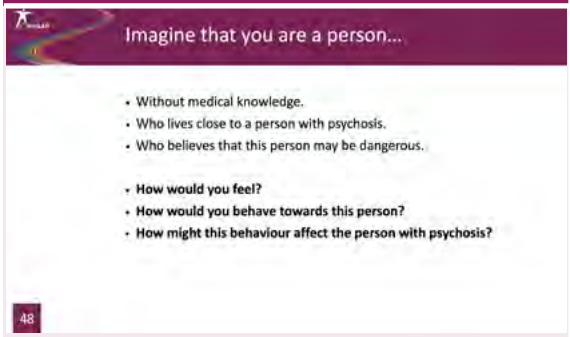
Session 1.2.6: Assessment of psychosis (75 minutes)

Preparation for facilitator:

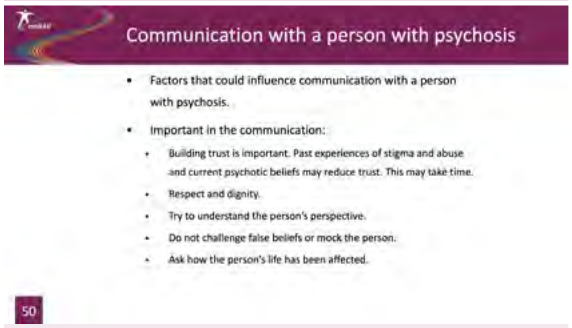
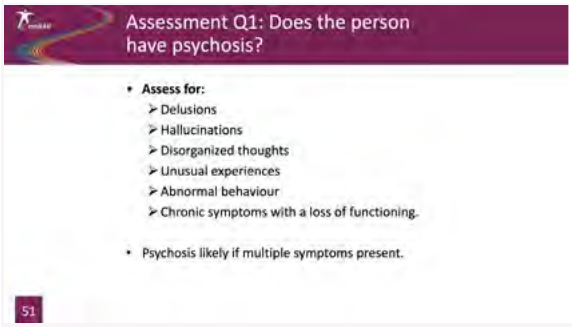
- Make sure that you have enough copies of "Case study - symptoms of psychosis" for **Activity 1.18** (Annex B).
- The video for **Activity 1.19** is available here (duration 6:59 minutes). Download the video in advance in case the Internet connection at the training venue is not adequate.
- Make sure that you have enough copies of the case study "Role-play – assessing for psychosis" for **Activity 1.20** (Annex B).

Presentation	Facilitator notes
	• Review the symptoms of psychosis. • Emphasize that it is important to recognize that symptoms appearing to be psychosis may be caused by substances such as alcohol or other drugs, and by medical conditions. This makes assessment crucial.
	
	• Have a discussion about what it might be like to have psychosis (max. 7 minutes). • Ask participants to share – giving one word for FEELING, one for BEHAVIOUR and one for COMMUNICATION. • List FEELINGS, BEHAVIOURS and COMMUNICATION in three columns on a flipchart. • Suggested answers: » Feelings: scared, suspicious, lonely, angry. » Behaviours: isolation, talking out loud to nobody, harm to self or others, self-neglect, poor motivation. » Communication: not trusting others, being very guarded, being quiet and not speaking, or being defensive as you feel in danger.

Session 1.2.6: Continued

Presentation	Facilitator notes
	• Spend 5 minutes on a discussion about how other people would feel and behave towards someone with psychosis. • Ask participants to share – giving one word for FEELING and one for BEHAVIOUR. • List FEELINGS, BEHAVIOURS and EFFECT ON PERSON WITH PSYCHOSIS in three columns on a flipchart. • Examples of answers: » Feelings: scared, angry, guilty. » Behaviours: punitive, chaining/ locking them up, mocking/bullying; hiding; » Effect on person with psychosis: reduced trust and increase in fear.
	**Demonstration of talking when hearing voices** **Duration:** 5 minutes **Instructions:** • Explain to the group that many people who seek help for hearing voices hear persecutory and derogatory voices. • Ask for a volunteer to play the role of health-care provider. One of the facilitators will play the person seeking help and the other facilitator will play the voice. • The facilitator playing the voice should avoid making rude or offensive comments, as this will distract the person seeking help from the conversation with the health-care provider. • Have the voice sit very close to the person seeking help and whisper and talk into their ear constantly. • Demonstrate for 2 minutes and ask the group for some reflections on the demonstration.

Session 1.2.6: Continued

Presentation	Facilitator notes
	• State that many health-care providers are unnecessarily uncomfortable about communicating with people with psychosis and there is usually nothing to fear. • Emphasize the importance of respect and dignity in communication. • Ask the group for factors that can complicate communication with a person with psychosis: » Thoughts disorganized and unclear » Sharing unusual beliefs » Refusing to speak » Experience of voices may distract the person during sessions » Not trusting health-care provider » Avoiding any eye contact » Believing that they do not need medical care (often the family will present the issue as a problem, not the person with psychosis). • Mention that the communication style of a person with psychosis may be different. • The points on this slide can aid your interaction with the person with possible psychosis. • One goal of the first session is to make the person feel comfortable enough to return for follow-up.
	• Refer to the first assessment question for psychosis on page 32. • Ask the group for their understanding of and examples for each of the symptoms. » **Delusions** – e.g. belief that someone is poisoning them, belief that he/she is royalty, belief that friends are aliens. » **Hallucinations** – e.g. hearing the voice of someone or something, seeing or feeling things that are not there.

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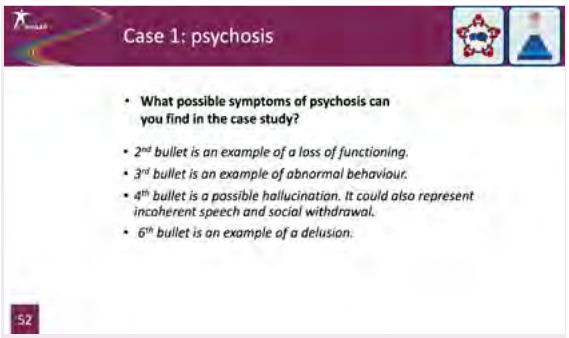
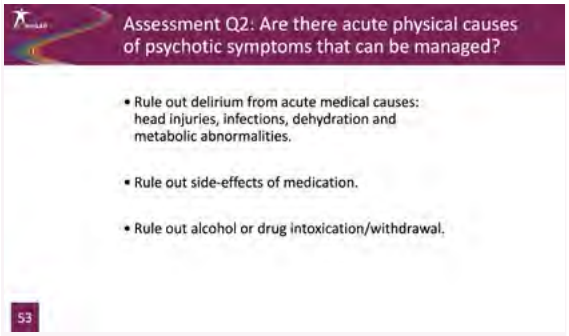
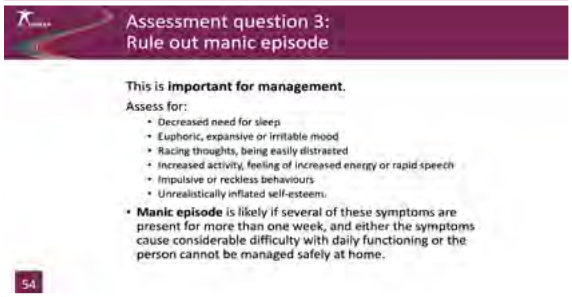
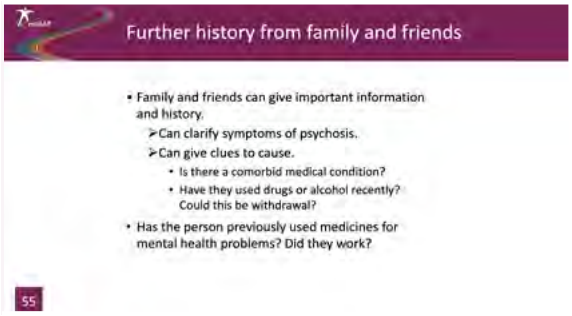
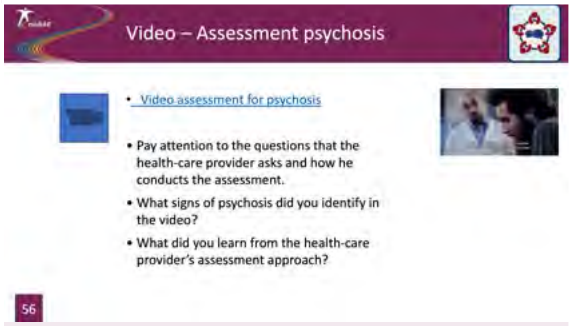
Presentation	Facilitator notes
	» **Disorganized thoughts/speech** – e.g. speech is hard to follow, frequently changes or stops. "I woke up this morning…. I uh, my grandmother lives far away," one-word answers. » **Unusual experiences** – e.g. believing that one's thoughts are being broadcast. » **Abnormal behaviour** – e.g. maintaining an odd posture for a long time, behaviour that seems chaotic or strange, not moving at all. » **Chronic symptoms** – self-neglect, low motivation to do chores, social withdrawal.
	***Activity 1.18: Case study – symptoms of psychosis*** **Duration:** 7 minutes **Purpose:** To practise recognizing symptoms of psychosis. **Instructions:** • Hand out the case study to the group ("Activity 1.18: Case study - symptoms of psychosis" in Annex B). • Ask the participants to read the case study and write down possible symptoms of psychosis (5 minutes). • Invite a few responses before revealing the answer and have a discussion about the symptoms.
	• Examples of infections that can cause delirium (and thus psychotic symptoms) are cerebral malaria, sepsis, urosepsis. • Examples of metabolic abnormalities are hypoglycaemia and hyponatraemia. • Medication side-effects and intoxication/withdrawal are assessed by taking a history of use, including what was taken, frequency and checking for signs of intoxication or withdrawal. • Explain that further assessment for harmful use of alcohol and substance use can be done with the SUB module.

Session 1.2.6: Continued

Presentation	Facilitator notes
	• Explain that assessment for a manic episode is important because the management of such an episode is different.
	• Emphasize that, especially in assessing psychosis, gathering information from family or friends is very important. • Discuss asking for the person's consent to speak to family or friends.
	**Activity 1.19: Video – assessment for psychosis** **Duration:** 15 minutes (video 6:59 min; 3 minutes reflection on the video; 5 minutes discussion) **Purpose:** To demonstrate the assessment for psychosis. **Instructions:** • Ask the group to pay attention to the questions that the health-care provider asks and how he conducts the assessment. Ask participants to write down any symptoms he identifies and how. • During the presentation of the video, point out: » Medical check-up » Safe and private setting with confidentiality » Trust building » Not rushing people » Not challenging false beliefs (this helps build trust) » Questions used by the health-care provider » When speaking to Amir alone, asking gently about his beliefs and who he is talking to.

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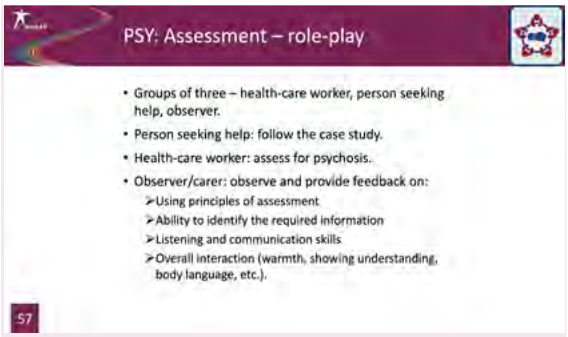
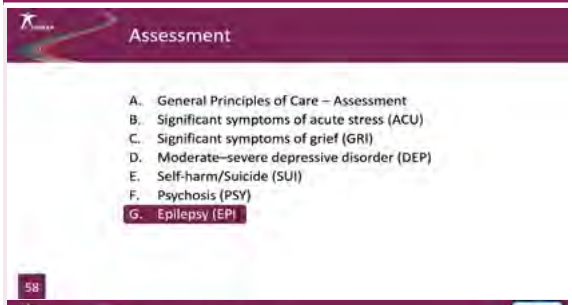
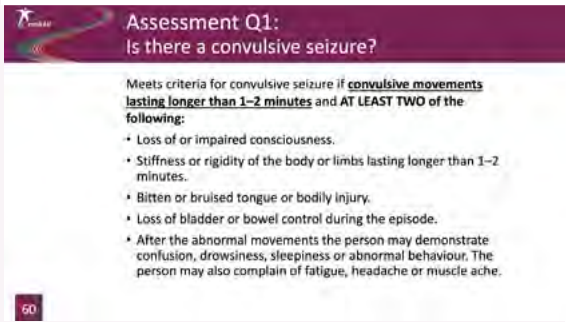
Session 1.2.6: Continued

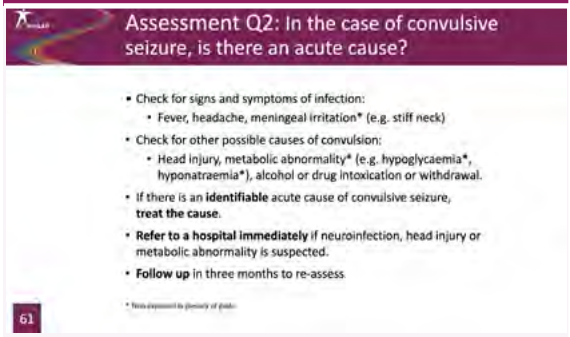
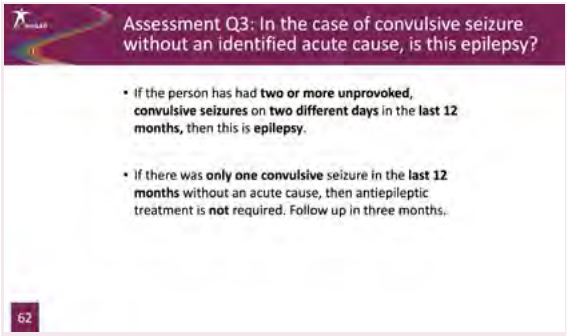
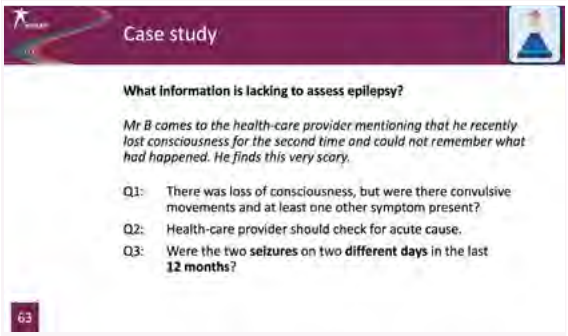
Presentation	Facilitator notes
	• After the video start a discussion (10 minutes): » Ask the group what signs they identified, and write them on a flipchart. » Participants should identify: delusions (persecutory and bizarre thoughts), hallucination (auditory), talking/mumbling to self, dishevelled and unkempt appearance (poor self-care). » Have a short discussion (5 minutes) about what they have learned from the health-care provider's approach.
	**Activity 1.20: Role-play – assessing for psychosis** **Duration:** 20 minutes **Purpose:** To practise performing assessment for psychosis. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study ("Activity 1.20: Role-play – assessing for psychosis" in Annex B) and show the slide with instructions during the role-play. • Remind the observer/carer that there are instructions in the role-play for them. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

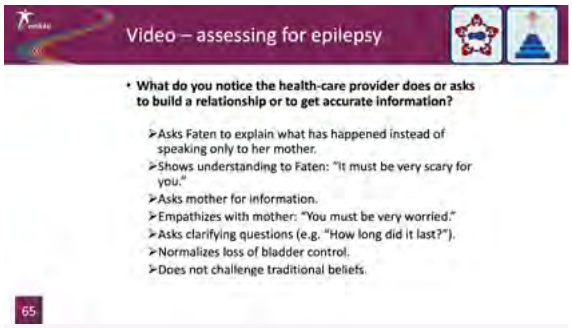
Session 1.2.7: Assessment of epilepsy (55 minutes)

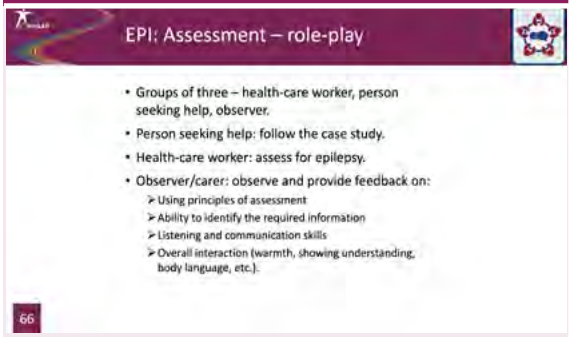
Preparation for facilitator:

- The video for **Activity 1.22** is available at https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (duration 5 minutes). Download the video in advance in case the Internet connection at the training venue is not adequate.
- Make sure that you have enough copies of the case study "Role-play – assessing for epilepsy" for **Activity 1.23** (see Annex B).

Presentation	Facilitator notes
 	• Explain that the first step in assessment of epilepsy is assessing for seizures (refer to page 36 of the mhGAP-HIG) and then assessing for epilepsy. • Ask the group to read page 36 and answer the first question on the slide. • Ask for some responses from the group before showing the answer on the slide. • Discuss the terms "recurrent" and "unprovoked" in the definition of epilepsy (epilepsy involves recurrent unprovoked seizures; unprovoked means without an acute cause). • Ask "True or false?" for question number 2. • Emphasize that epilepsy can be managed by non-specialists. • Explain that epilepsy is a chronic (long-term) condition. • State that this module covers the most prevalent type of epilepsy – convulsive epilepsy (manifested by convulsive seizures).
	• Ask the group what a convulsive seizure looks like. • Review criteria for a convulsive seizure. • Ask if there are any questions about the presentation of these symptoms.

Presentation	Facilitator notes
	• Explain that if the person has convulsive seizures as assessed by the first assessment question, the next step is to assess if there is an acute cause for the seizures. This is important to know not only for the assessment but also for management of the seizures. • Take the group through the possible acute causes listed. Explain that terms with an asterisk are explained in the glossary of the mhGAP-HIG. • Deal with any questions from the group.
	• Discuss the slide and summarize that assessing for convulsive epilepsy involves three questions: 1. Does the person meet the criteria for convulsive seizure? 2. In the case of convulsive seizure, is there an acute cause? 3. In the case of convulsive seizure without an identified acute cause, is this epilepsy?
	**Activity 1.21: Case study – assessing for epilepsy** **Duration:** 7 minutes **Purpose:** To practise assessing symptoms of epilepsy. **Instructions:** • Give the group 4 minutes to read the information on the slide and identify what information is lacking to assess for epilepsy, using page 36 of the mhGAP-HIG. • Ask for the missing information before revealing the answers.

Presentation	Facilitator notes
	**Activity 1.22: Video – assessment for epilepsy** **Duration:** 10 minutes **Purpose:** To demonstrate assessment of epilepsy. **Instructions:** • Instruct the group to note down: • any symptoms of epilepsy identified by the health-care provider; • what the health-care provider does to build a relationship and obtain accurate information. • Ask the group about the symptoms that the health-care provider identified in the video. Write correct ones on a flipchart. • Reveal the answer on the slide and add symptoms that have not yet been mentioned to the flipchart.
	• Ask what the group noticed that the health-care provider in the video did to build a relationship and to get accurate information. • Numbers in brackets denote moment of time in video: » Asks Faten to explain what has happened instead of speaking only to her mother (0.31). » Empathizes with Faten: "It must be very scary for you" (0.42). » Asks mother for information (0.46). » Shows understanding to mother: "You must be very worried" (1.09). » Asks clarifying questions (e.g. "How long did it last?") (1.20). » Normalizes loss of bladder control (1.50). » Does not challenge traditional beliefs (3.54).

Presentation	Facilitator notes
	**Activity 1.23: Role-play – assessing for epilepsy** **Duration:** 20 minutes **Purpose:** To practise performing assessment for epilepsy. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study ("Activity 1.23: Role-play – assessing for epilepsy" in Annex B) and show the slide with instructions during the role-play. • Remind the observer/carer that there are instructions for their role as well. • Let the role-play continue for max. 10 minutes • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 1.3: Management of mhGAP-HIG conditions

OVERVIEW

By the end of this session, participants should:

- Understand the general principles of management;
- Be able to provide psychosocial interventions to persons with selected mhGAP-HIG conditions and their carers;
- Know when and how to provide pharmacological interventions for selected mhGAP-HIG conditions;
- Be able to manage physical health among people with mhGAP-HIG conditions;
- Be able to plan and perform follow-up for mhGAP-HIG conditions;
- Be able to refer people with selected mhGAP-HIG conditions to specialists and link with outside agencies.

Sessions	Objectives	Duration (+/-)	TRAINING ACTIVITIES
1.3.1. General principles of management	Introduce the general principles of management in the mhGAP-HIG	5 min	
1.3.2. GPC – Reducing Stress and Strengthening Social Support	Learn to provide stress reduction techniques and strengthen social support	65 min	Activity 1.24: Exploring stressors and social support Activity 1.25: Problem-solving techniques Activity 1.26: Breathing exercise
1.3.3. Management of significant symptoms of acute stress	Learn how to manage significant symptoms of acute stress	40 min	Activity 1.27: Case study - management of significant symptoms of acute stress Activity 1.28: Role play – management of significant symptoms of acute stress
1.3.4. Management of significant symptoms of grief	Learn how to manage significant symptoms of grief	45 min	Activity 1.29: Case study – management of significant symptoms of grief Activity 1.30: Role-play – management of significant symptoms of grief
1.3.5. Management of moderate–severe depression	Learn how to manage moderate–severe depression	75 min	Activity 1.31: Video – management of depression Activity 1.32: Role-play – management of depression: psychoeducation Activity 1.33: Role-play – management of depression: pharmacological

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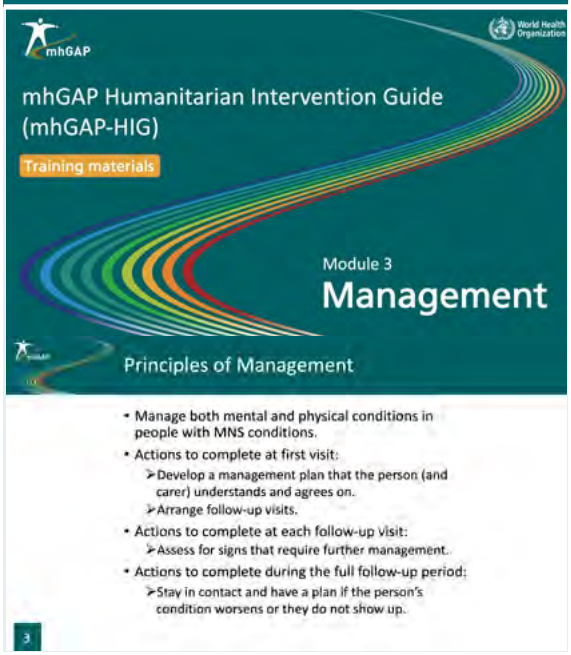
Session 1.3: Continued

SESSIONS	OBJECTIVES	DURATION (+/-)	TRAINING ACTIVITIES
1.3.6. Management of self-harm/suicide	Learn how to manage moderate–severe depression	40 min	**Activity 1.34: Brainstorm – management of self-harm/suicide** **Activity 1.35: Video – management of self-harm/suicide**
1.3.7. Management of psychosis	Learn how to manage self-harm/ suicide	75 min	**Activity 1.36: Video – management of psychosis** **Activity 1.37: Role-play – management of psychosis**
1.3.8. Management of epilepsy	Learn how to manage psychosis	75 min	**Activity 1.38: Role-play - psychoeducation for epilepsy** **Activity 1.39: Video – management of epilepsy** **Activity 1.40: Role-play – management of epilepsy**
1.3.9. Post-test and course evaluation	Learn how to manage epilepsy	40 min	**Activity 1.41: Post-test**
Total time		460 min (approx. 7.5 hrs)	

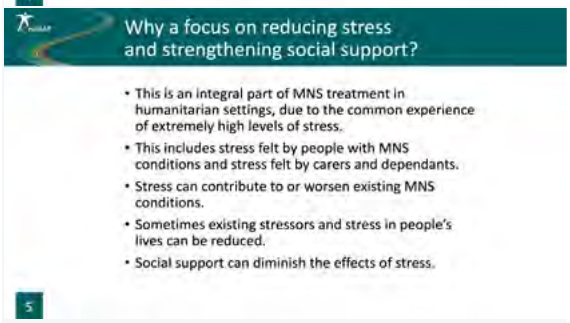
Session 1.3.1: General principles of management (5 minutes)

Presentation	Facilitator notes
	• Introduce the Management session. • Explain that, before going into the management of specific conditions, first the general principles of management and Reducing Stress and Increasing Social Support will be covered. • Direct the group to page 7 of the mhGAP-HIG where the general principles of management are set out and explain the four points on the slide. • Let the group read through the different principles one by one and give them a chance to ask questions.

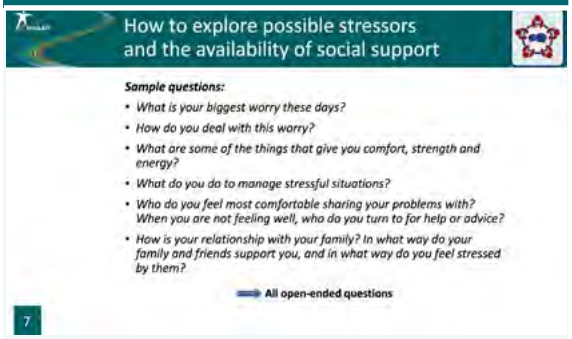
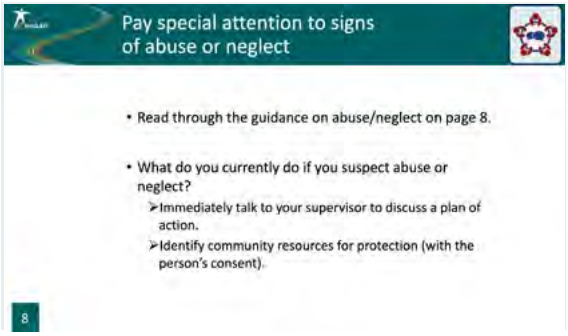
Session 1.3.2: Reducing Stress and Increasing Social Support (65 minutes)

Preparation for facilitator:

- Familiarize yourself with the stress reduction techniques in this session. You need to be able to demonstrate them to the group.

Presentation	Facilitator notes
 	• Direct the group to page 8 of the manual and the principles of reducing stress and strengthening social support. • Explain why this topic is included in the manual by going through the slide. • Mention that the techniques discussed for reducing stress and strengthening social support are helpful for any kind of stress that people experience, even if they don't meet the criteria for one of the MHGAP-HIG conditions. • Make a brief comment on how the techniques can also be used as self-care for health staff. This is relevant in case the participants themselves experience stress.
	• Explain that these are the four areas that we will consider in this section: » **(Point 1)** The aim of exploring stressors and the availability of support is to identify ways to reduce the stress. » **(Point 2)** The aim is to be aware of signs of physical or sexual abuse, including domestic violence, or neglect, which can be the main source of the person's mental health problems. » **(Point 3)** Depending on the source of the stress, different strategies should be tried. » **(Point 4)** Supporting carers is very important as they will be able to help people with MNS problems much better if they are experiencing less stress themselves.

Session 1.3.2: Continued

Presentation	Facilitator notes
	• Direct participants to the questions on page 8 of the manual to identify possible stressors and the availability of social support. • Explain that through asking these questions you are hoping to get an understanding of: » the main stresses they face; » supports that may help them. • With this information you can: » help identify stressors and sources of support; » use it to inform the application of a problem-solving technique (to be covered later). • Point out that all the questions are open questions. **Activity 1.24: Exploring stressors and social support** **Duration:** 10 minutes **Purpose:** To practise exploring stressors and social support. **Instructions:** • Ask participants to take 5 minutes to think about their own life and write down stressors and sources of social support by answering these questions themselves. • Have a 5-minute discussion on the exercise. Ask participants what it was like to do this exercise. For example, were there people in their lives available for social support who they had not thought of before? What was it like to be specific about their worries?
	• In humanitarian crises and refugee contexts, people (especially children, older people and people with disabilities) are more vulnerable to neglect. • Ask the group to read through the guidance on page 8 on how to be attentive to signs of abuse or neglect.

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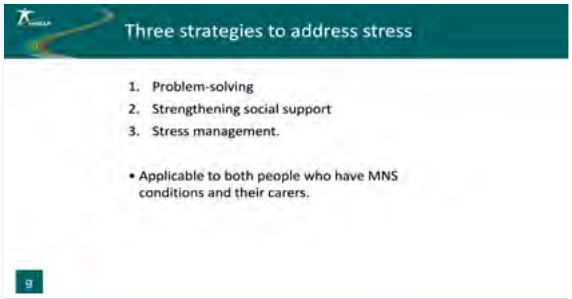
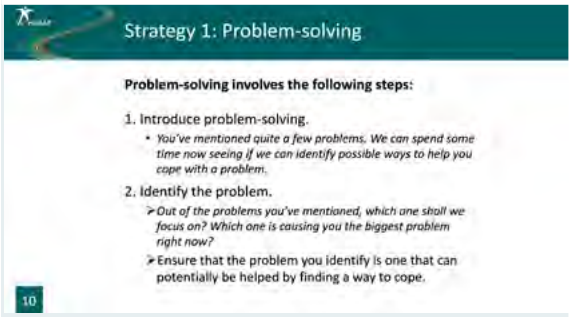
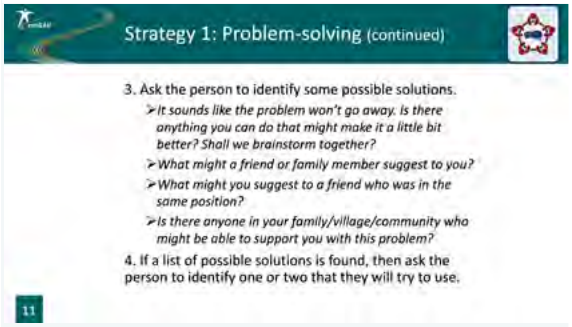
Presentation	Facilitator notes
	• The person's domestic situation (e.g. abuse in the household) may be a greater stressor than the humanitarian situation affecting the community. • Discuss how to talk about and address signs of abuse if the person is not alone (i.e. with a carer). • Emphasize that violence against women is a common cause of depression. • Ask about and discuss formal services and informal supports in the community for the protection of women and children.
	• Explain that these three strategies to reduce stress will be covered in the course. • These strategies complement any protection strategies that may be in place.
	• Take the group through the four steps of problem-solving on the two slides. • Ask participants how familiar they are with problem-solving techniques. • If some participants are familiar with them, then ask two of them to give a demonstration; if not, give the demonstration yourself with someone from the group. • Ask participants about common problems faced by people in their contexts.
	**Activity 1.25: Problem-solving techniques** **Duration:** 10 minutes **Purpose:** To practise problem-solving techniques with someone. **Instructions:** • Ask the group to work in pairs and practise the problem-solving steps. Ask trainees to think about a current problem they have and are happy to share with a colleague. Ask them to ensure that the problem is a practical one and not overly complex.

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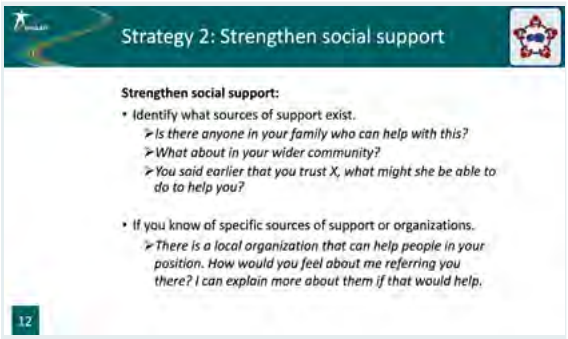
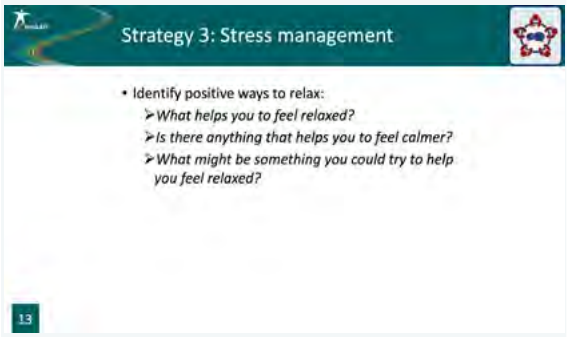
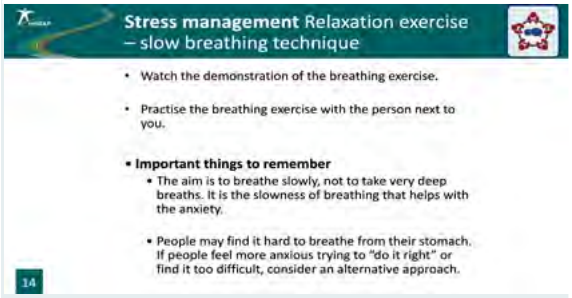
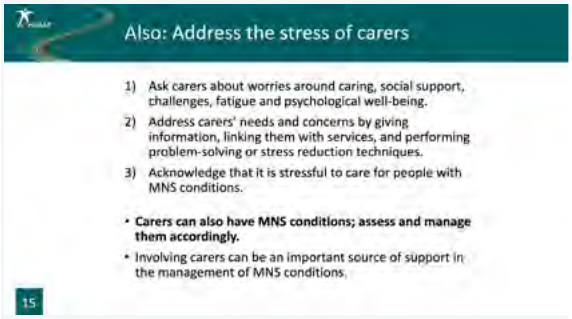
Session 1.3.2: Continued

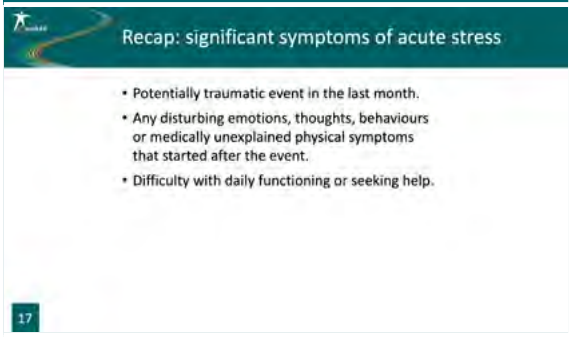
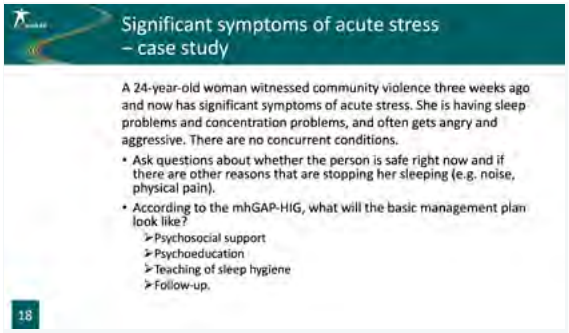
Presentation	Facilitator notes
	• Give the group 5 minutes to practise this part with each other. • Have a 5-minute discussion about the exercise. • In the discussion, it is essential to mention that it is important that the person seeking help comes up with a decision about a solution to the problem, and not the health-care provider.
	• Read through this technique on page 8 of the manual. • Ask the group how familiar they are with helping to build social support. • If people indicate familiarity, ask for examples of what they do. • Explain that the first step is to help people identify existing support systems, and the second step is to refer them to other community resources. • Demonstrate the technique, with a volunteer from the group as helper.
	• Share the example questions that can be used when identifying positive ways to relax (page 8). • Explain that multiple stress management approaches can be used, including the slow breathing exercise suggested here. • Before going to the breathing exercise, ask the group how familiar they are with stress management approaches. • Divide the group into four small groups and give the groups 3 minutes to come up with as many activities that could help reduce stress as they can. • After 3 minutes, give all the groups a chance to read out their list of activities. Give a small reward (for example, being the first to be served at tea break or lunch) to the group with the most original activity.

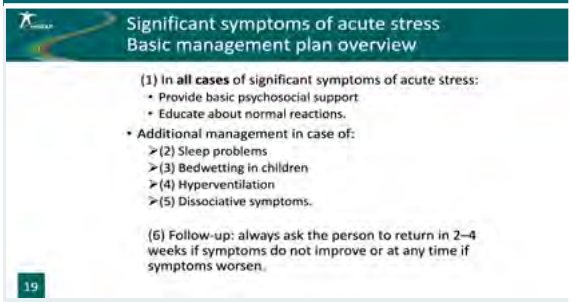
Presentation	Facilitator notes
	• Explain that the aim of the exercise is to slow breathing down to help people feel relaxed. • Demonstrate the relaxation technique to the group using the text on page 9 of the mhGAP-HIG (3 minutes). • Explain that taking in too much air, i.e. breathing too quickly, can lead to people feeling more anxiety and feeling physical symptoms such as dizziness, muscle aches and chest pain. This is what people experience when hyperventilating. • Explore other techniques that people know of or use to reduce stress. **Activity 1.26: Breathing exercise** **Duration:** 10 minutes **Purpose:** To practise instructing someone on how to do a breathing exercise. **Instructions:** • Ask the group to practise the slow breathing instructions in pairs (3 minutes each). • Discuss briefly with the group how this exercise went and ask if there are any questions (3 minutes). • Ask participants to practise the breathing exercise as homework for the next day.
	• Explain that "carers" is the term we use for people (e.g. family members) who help people with MNS conditions. • Carers are not only exposed to the stressors of the humanitarian context but also to those of caring for a vulnerable person with an MNS condition. • Instruct the group to read through the three bullet points and sub-bullets on "addressing stress of carers" on page 8. • Ask if there are any questions about how to address the stress of carers.

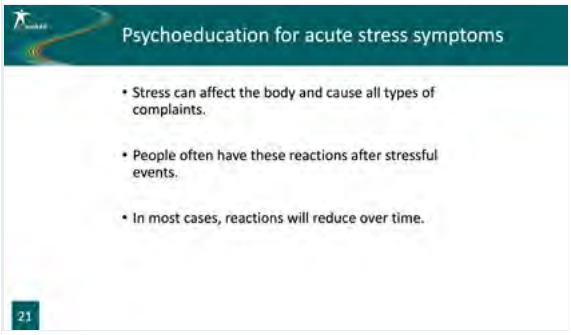
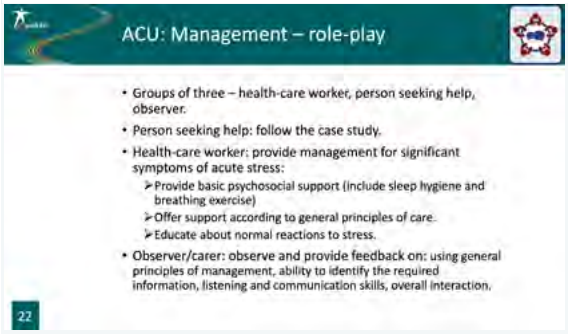
Session 1.3.3: Management of significant symptoms of acute stress (40 minutes)

Preparation for facilitator:

- The basic psychosocial support described in the mhGAP-HIG module on acute stress is the same as psychological first aid (PFA). For more information on PFA, see http://www.who.int/mental_health/publications/guide_field_workers/en/
- Have enough copies of the case study "Role play – management of significant symptoms of acute stress" for **Activity 1.28** (see Annex B).

Presentation	Facilitator notes
	• Introduce the management of significant symptoms of acute stress. • Ask the group to name the assessment criteria for significant symptoms of acute stress. • Invite some answers from the group before showing the second slide.
	• Let the group look at pages 15–16 of the mhGAP-HIG to make a basic management plan for significant symptoms of acute stress for a person with sleep problems. **Activity 1.27: Case study – management of significant symptoms of acute stress** **Duration:** 10 minutes **Instructions:** • Show the case study on the first part of slide. • Give participants 7 minutes to answer the questions. • Ask for a few responses and then reveal the rest of the slide with the answers. • Explain that people commonly develop sleep problems (insomnia) after experiencing extreme stress, and it is important that this is covered in the psychoeducation for acute stress.

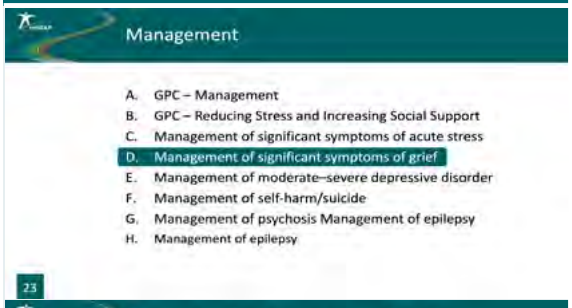
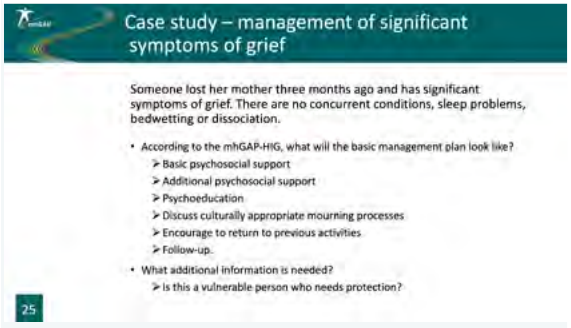
Presentation	Facilitator notes
	• For each area, discuss any questions or concerns about implementing the plan. • Specific areas to address for each section: 1. **All cases:** Provide basic psychosocial support (i.e. psychological first aid) and educate about normal reactions. 2. **Sleep problems:** Highlight that it is important to identify any environmental problems and advise on sleep hygiene. Only prescribe medicines in exceptional circumstances. Discuss why benzodiazepines should only be used in the short term (they may cause dependency) and should not be used at all in children and adolescents. 3. **Bedwetting in children:** Highlight the importance of ruling out physical causes (e.g. urinary tract infection), of psychoeducation and of the need to be supportive. Discuss how to provide simple behavioural interventions (such as a star chart) and emphasize that punishing the child will not help. • Encourage participants to read at home the guide for management of hyperventilation and dissociative symptoms as symptoms of acute stress. These symptoms are less common than sleep problems or bedwetting.
	• Ask the group about the only scenario in which you would consider prescribing medicines for significant symptoms of acute stress. • Invite some answers from the group before revealing the rest of the slide. • Emphasize that the reason for caution and the short duration of the prescription is the risk of dependence.

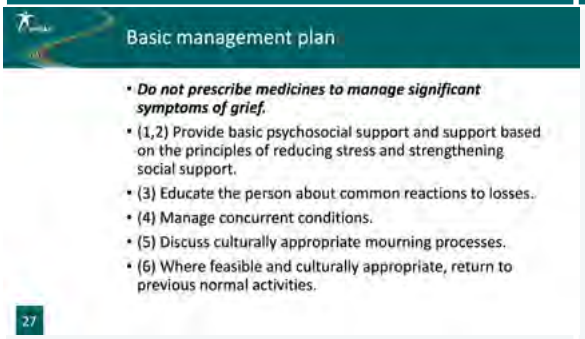
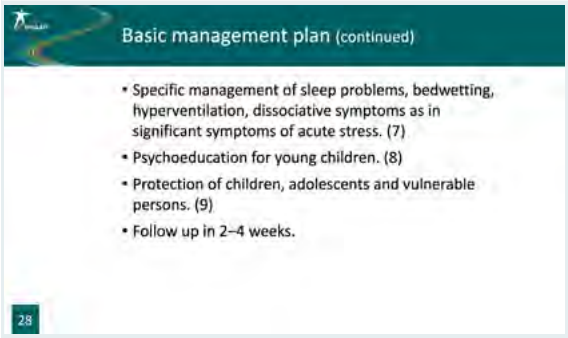
Presentation	Facilitator notes
	• Psychoeducation for acute stress symptoms is a key strategy as it can help reduce people's worry about these symptoms.
	**Activity 1.28: Role-play – management of significant symptoms of acute stress** **Duration:** 20 minutes **Purpose:** To practise performing assessment for significant symptoms of acute stress. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 1.28: Role play – management of significant symptoms of acute stress" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes. • Ask participants about their experiences of providing basic psychosocial support, discussing sleep hygiene and doing the breathing exercise.

Session 1.3.4: Management of significant symptoms of grief (45 minutes)

Preparation for facilitator:

- The basic psychosocial support in the mhGAP-HIG for grief is the same as psychological first aid (PFA). For more information on PFA, see http://www.who.int/mental_health/publications/guide_field_workers/en/
- Have enough copies of the case study "Role-play – management of significant symptoms of grief" for **Activity 1.30** (see Annex B).

Presentation	Facilitator notes
	• Introduce the management of significant symptoms of grief. • Ask the group to name the assessment criteria for significant symptoms of grief. • Invite some answers from the group before showing the second slide.
	
	***Activity 1.29: Case study – management of significant symptoms of grief*** **Duration:** 8 minutes **Instructions:** • Show the group the first part of the slide with the case study. • Give them 7 minutes to answer the questions. • Ask for a few responses and then reveal the rest of the slide with the answers.
	• Show this slide before teaching management in more detail. • Explain that steps 1–4 are the same as for significant symptoms of acute stress, and that steps 5–6 (discuss culturally appropriate mourning processes and return to previous normal activities) have been added to the list.

Presentation	Facilitator notes
	• Let the group read through each of the management advice sections listed on the slide and let them ask questions. • **Steps 1, 2:** Highlight common psychosocial support strategies – listening, identifying and addressing needs and concerns, protecting. • **Step 3:** Highlight how this is about normalizing the experience of the individual and explaining that there is no one way to grieve. Ask people to read the text on page 19 of the manual. • **Step 4:** Explain that any physical or MNS condition that can explain the symptoms should be managed accordingly. • **Step 5:** Highlight how alternative rituals can help the person to grieve, especially when remains or a body are not present, as may happen in humanitarian emergencies. Ask about local practices. • **Step 6:** Discuss what these activities may be (e.g. school, work).
	• Let the group read through the management advice for each of these points on page 20. • **Step 7:** Highlight that these should be addressed as just discussed for ACU and can be found on pages 15–16 of manual. • **Step 8:** Highlight that young children often have questions about death and emphasize the importance of building trust and answering questions honestly. • Check whether the group understands the concept of "magical thinking" and explain how to correct magical thinking in children. • **Step 9:** Highlight the needs of such people for continuity of care and ongoing protection. Highlight that children who have lost parents will do better with relatives they know and love. • **Follow up in 2–4 weeks:** Explain how this is the same follow-up period as for ACU.

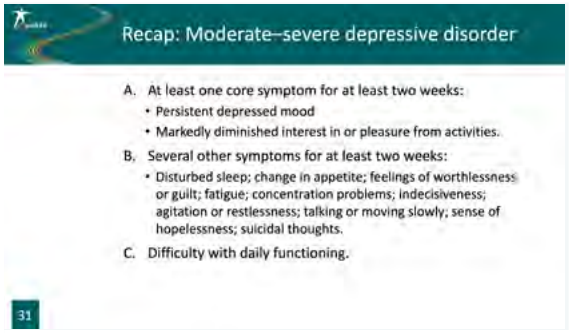
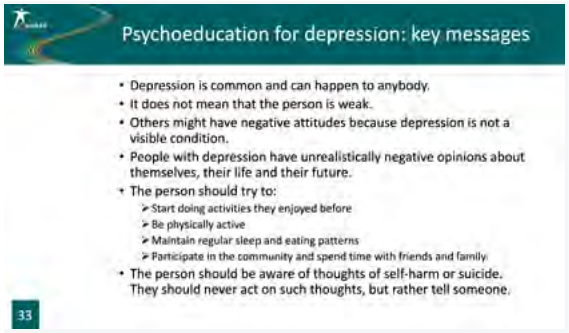
Session 1.3.4: Continued

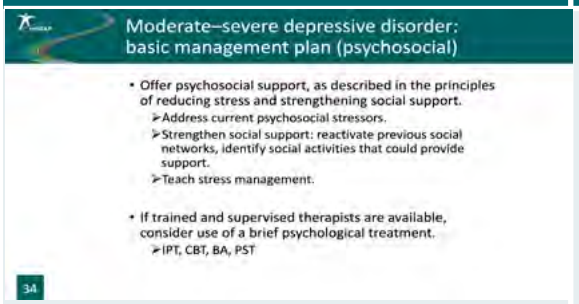
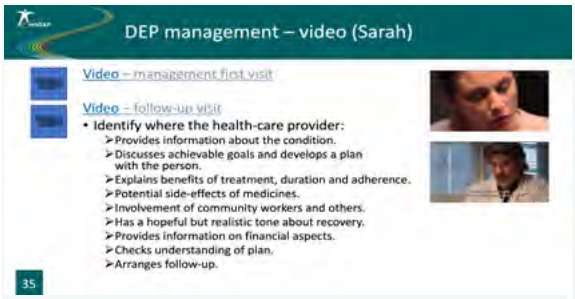
Presentation	Facilitator notes
	**Activity 1.30: Role-play – management of significant symptoms of grief** **Duration:** 20 minutes **Purpose:** To practise management of significant symptoms of grief. ⚠ Be aware that most likely the participants will have had experience of grief themselves. This role-play may thus trigger strong emotions. Instruct people to take a break if needed and be ready to support individuals if necessary. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 1.30: Role-play – management of significant symptoms of grief" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

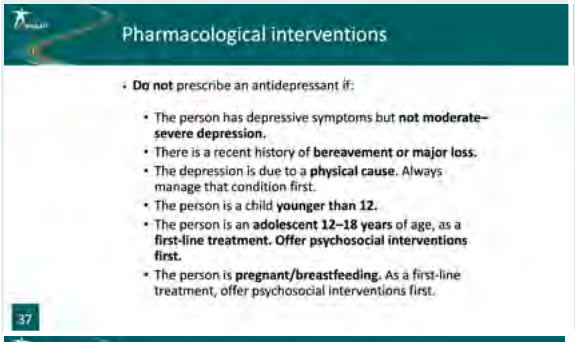
Session 1.3.5: Management of moderate–severe depression (75 minutes)

Preparation for facilitator:

- The videos for **Activity 1.31** is available at https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=2 (duration 3:50 minutes).
- https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=3 (duration 5:22 minutes)
- Download the videos in advance in case the Internet connection at the training venue is not adequate.
- Have enough copies of the case study "Role-play – management of depression: psychoeducation" for **Activity 1.32** (see Annex B).
- Have enough copies of the case study "Role-play – management of depression: pharmacological" for **Activity 1.33** (see Annex B).

Presentation	Facilitator notes
	• Ask the group what are the criteria for moderate–severe depression. • Invite some answers from the group before showing the slide.
	• Explain that psychoeducation and psychosocial support should be offered to everybody with a depressive disorder. • In addition, psychological treatment (e.g. cognitive behavioural therapy (CBT)) and/or pharmacological interventions should be considered. • As with all the other conditions, follow-up is very important.
	• Let the group read through part 1 of the management advice on psychoeducation (page 23). • Discuss how these messages could be explained in the local context.

Presentation	Facilitator notes
	• Answer any questions relating to this guidance. • Highlight that offering psychosocial support, as described in the principles of reducing stress and strengthening social support, is a core part of management: » Explore possible stressors and the availability of social support. » Look out for signs of abuse or neglect. Emphasize that one key reason for depression in women is gender-based violence (domestic violence, rape). » Based on information gathered, consider strategies to help the person. » Address the stress of carers. • Remind them to look at page 8: the principles of reducing stress and strengthening social support advise that if trained and supervised therapists are available, you should consider the use of a brief psychological treatment. Answer any questions related to these therapies and their local availability.
	**Activity 1.31: Video – management of depression** **Duration:** 10 minutes **Purpose:** To demonstrate the management of depression. **Instructions:** • Explain that you will show the management of DEP in the first visit and the follow-up visit of Sarah, who is suffering from depression. • Ask the group to identify when the health-care provider performs the actions mentioned on the slide. • Consider stopping the video from time to time and asking participants when an example of a topic from this slide is shown.

Presentation	Facilitator notes
	**Activity 1.32: Role-play: management of moderate–severe depression – psychoeducation** **Duration:** 20 minutes **Purpose:** To practise giving psychoeducation to manage depression. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 1.32: Role-play – management of depression: psychoeducation" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.
	• Introduce pharmacological treatment to the group and refer them to the mhGAP-HIG, page 24. • Begin with an overview of when not to prescribe an antidepressant. • Ask participants to read point 1 in the second column of page 24 ("Discuss with the person…").
	• Ask the group to look at Box DEP 2 on page 25. Explain that it is important to discuss the use of the mood stabilizer Valproate, which is mentioned in the management of depression in someone with a history of manic episodes (table DEP 2), epilepsy and psychosis. • Discuss the use of valproate in women of childbearing age and the availability of specialists for referral.

Session 1.3.5: Continued

Presentation	Facilitator notes
	• Ask the group to read point 2 on page 24: "If it is decided to prescribe antidepressants, choose an appropriate antidepressant." Also ask them to go through the table "DEP 1: Antidepressants" on page 24. • After 5 minutes, begin the quiz.

Continues on next page

Presentation	Facilitator notes
	
	**Activity 1.33: Role-play – management of moderate–severe depression: pharmacological** **Duration:** 20 minutes **Purpose:** To practise pharmacological management of depression. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer.

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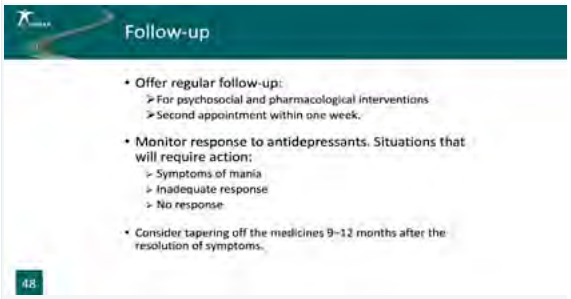
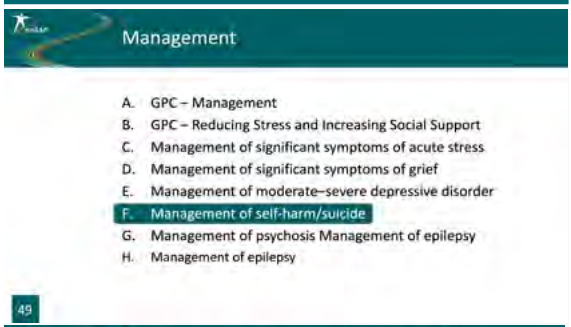
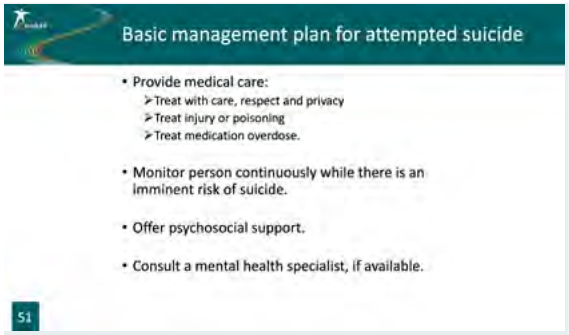
Session 1.3.5: Continued

Presentation	Facilitator notes
	• Hand out the case study (see "Activity 1.33: Role-play – management of depression: pharmacological" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.
	• Explain that regular follow-up should be offered for psychosocial and pharmacological interventions, with the first follow-up within one week and thereafter depending on the course of the disorder. • Explain that it may take a few weeks for antidepressants to show an effect. There may be some initial improvement after two weeks, such as with sleep, but full response takes longer. Monitor the response carefully before increasing the dose. It is expected that people will have a positive response, but there are some situations that will require action. • If symptoms of a manic episode develop, stop the medicines immediately and go to the >> PSY module for management. Explain that antidepressants can elevate mood and lead to a manic episode in people with bipolar disorder. For that reason, they should always be prescribed together with a mood stabilizer for bipolar disorder. • Trainees should refer to a specialist if bipolar disorder is suspected. • Explain what to do when there is no response or an inadequate response. • Explain that it is usual to consider tapering off the medicines 9–12 months after the resolution of symptoms. Reduce the dose gradually over at least four weeks.

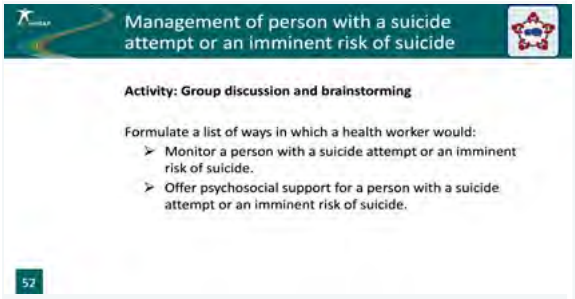
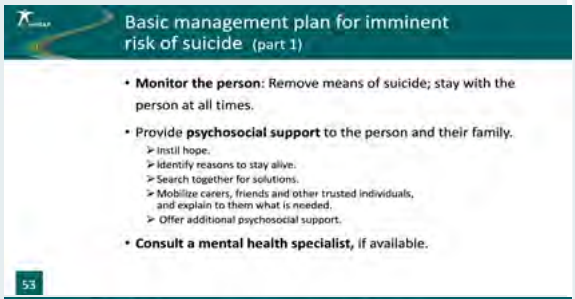
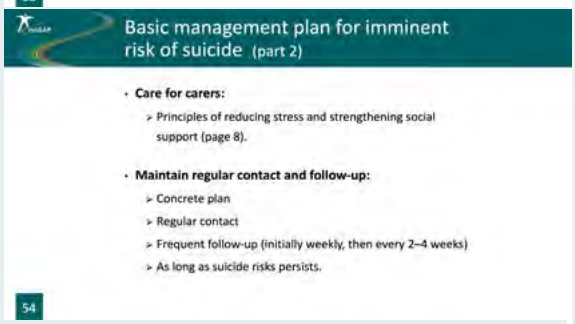
Session 1.3.6: Management of self-harm/suicide (40 minutes)

Preparation for facilitator:

- The video for Activity 1.35 is available at https://www.youtube.com/watch?v=4gKIeWfGIEI&index=16&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (duration 9:22 minutes). Download the video in advance in case the Internet connection at the training venue is not adequate.

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

Session 1.3.6: Continued

Presentation	Facilitator notes
	**Activity 1.34: Brainstorm - management of self-harm/suicide** **Duration:** 10 minutes **Instructions:** Ask the group to split into two large groups. • One group formulates a list of ways in which a health-care provider would **monitor a person** who has made a suicide attempt or is at imminent risk of suicide. • The other group formulates a list of ways in which a health-care provider would **offer psychosocial support** for a person who has made a suicide attempt or is at imminent risk of suicide. • Allow 5 minutes for groups to come up with their lists, and 2 minutes each to read out their lists.
 	• Emphasize that the same management plan (Parts 1 and 2) discussed here for imminent risk of suicide also needs to be applied in the case of a suicide attempt. » **Monitor:** Remove means of self-harm/suicide –e.g. pesticides, ropes, medications. Do not leave the person alone; they need to be monitored 24 hours a day. » **Psychosocial support:** Try to give hope. » When exploring reasons and ways to stay alive, you should be careful as to what to say and what not to say; in particular, try not to induce further feelings of guilt about wanting to die. » The best reason that one can give a person for wanting to live is an assurance that they can be helped to feel better. » When exploring reasons and ways to stay alive, one should listen carefully to the person and try to understand what matters most for them.

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Presentation	Facilitator notes

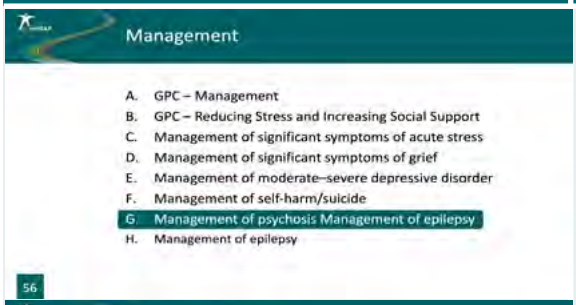
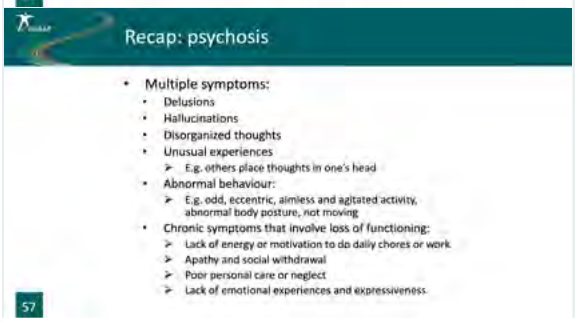
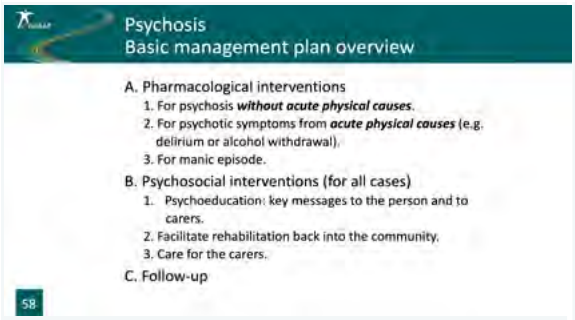
	» **Consult a mental health specialist, if available:**
	  » Make an appointment for the person with the specialist, help them to get there and check if they showed up for the appointment.
	  » If a mental health specialist is not available: mobilize family, friends and other concerned individuals or available community resources to monitor and support the person during the imminent risk period.
	  » Follow-up: A concrete plan for follow-up should be made. Maintain regular contact, with frequent contact initially (e.g. weekly for the first two months) and less frequent contact as the person improves (e.g. once every 2–4 weeks). It is necessary to follow up for as long as the suicide risk persists. At every contact, routinely assess thoughts, plans and acts of self-harm/suicide.

	**Activity 1.35: Video – management of attempted suicide** **Duration:** 10 minutes **Purpose:** To demonstrate the assessment and management of attempted suicide. **Instructions:** • Explain that the video shows an example of the management of attempted suicide. • Tell the group to note down any questions or remarks. • Give them some time for questions and discussion afterwards (5 minutes).

Session 1.3.7: Management of psychosis (75 minutes)

Preparation for facilitator:

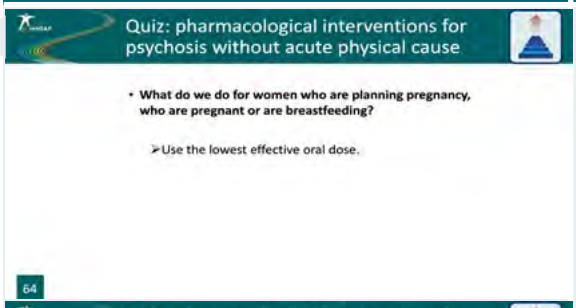
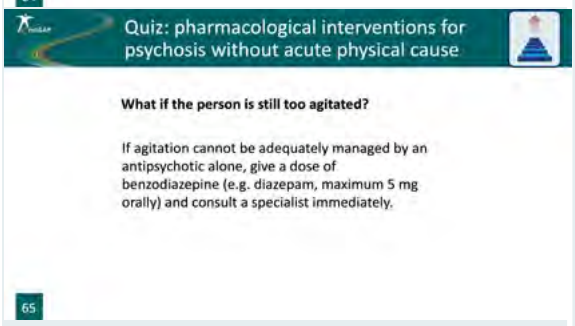
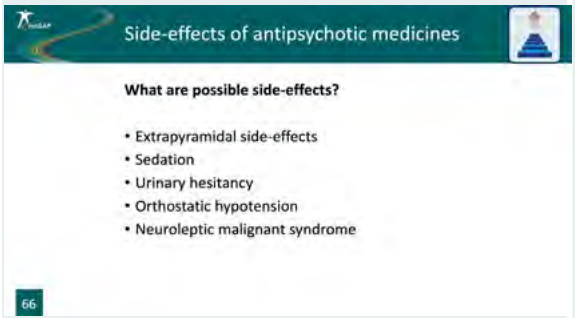
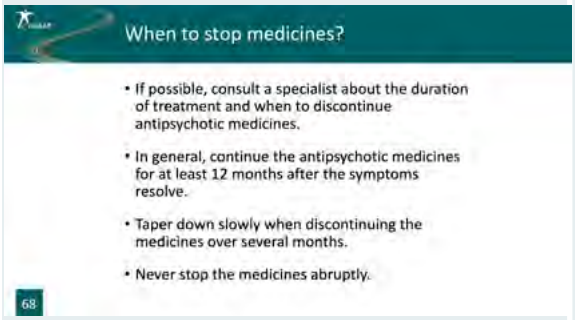
- The video for **Activity 1.36** is available at https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v&index=5 (6:05 minutes). Download the video **in advance** in case the Internet connection at the training venue is not adequate.
- Have enough copies of the case study "Role-play – management of psychosis" for **Activity 1.37** (see Annex B).

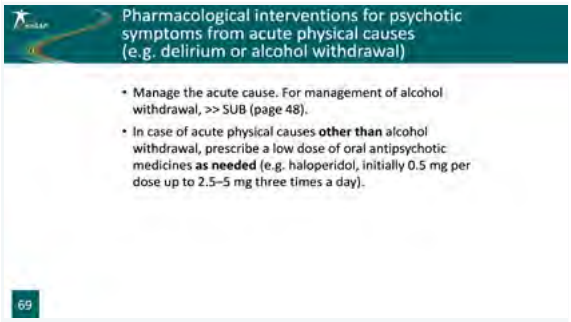
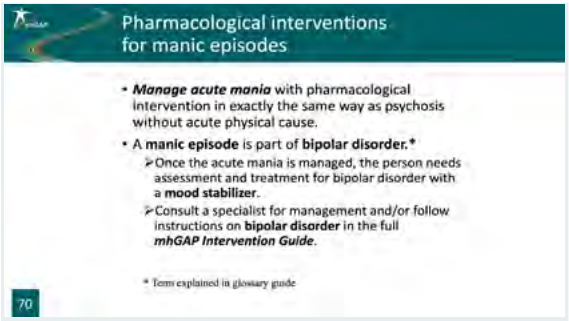
Presentation	Facilitator notes
 	• Introduce the topic by asking the group to recall the symptoms of psychosis.
	• Emphasize the importance of knowing about acute physical causes and possible mania because in such cases pharmacological management is different from psychosis without any acute physical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

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

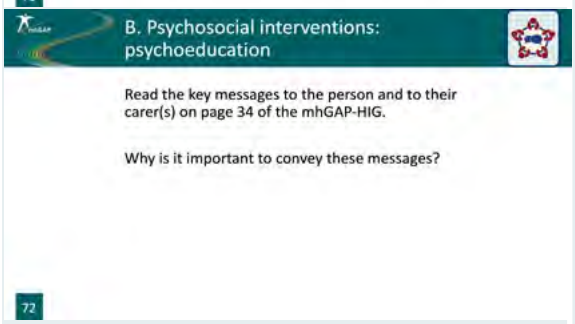
Continues on next page

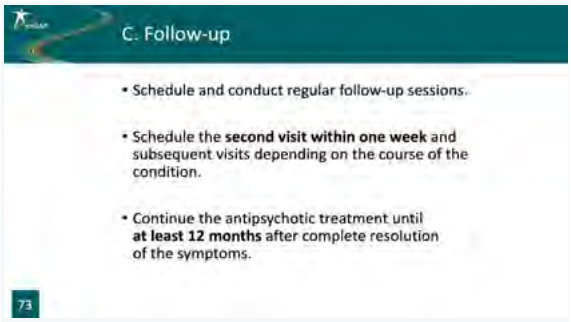
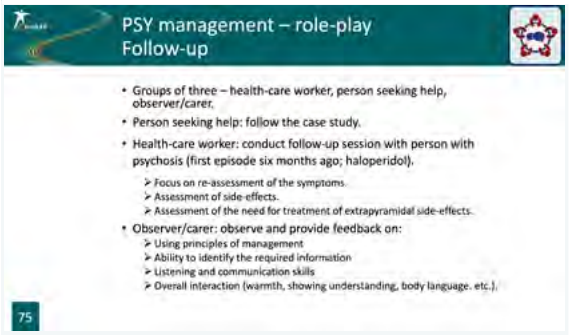
Session 1.3.7: Continued

Presentation	Facilitator notes
  	
	• Take the group through the information on how to manage side-effects of medicines. • Extrapyramidal: abnormalities in muscle movement, mostly caused by antipsychotic medicines. These include muscle tremors, stiffness, spasms and/or akathisia. • Dystonia: acute spasm of muscles, typically of neck, tongue and jaw.
	

Presentation	Facilitator notes
	• Explain that while antipsychotics should routinely be offered to a person with psychosis without acute physical cause, this is not the case for psychotic symptoms from acute physical causes (e.g. delirium or alcohol withdrawal). • Antipsychotics should not be prescribed in cases of alcohol withdrawal. Explain that in a case of psychosis induced by alcohol withdrawal, it should be managed as described in Box SUB 1 on page 48 of the mhGAP-HIG. This will not be covered today. • In cases of acute physical causes other than alcohol withdrawal (e.g. in cases of delirium), prescribe an oral antipsychotic medication as needed. Explain the following three points: 1. Only prescribe the antipsychotic medication at a moment when there is a need to control agitation, psychotic symptoms or aggression 2. Stop the medication as soon as these symptoms resolve. 3. Consider intramuscular treatment only if oral treatment is not feasible.
	• Explain that for a manic episode the first phase of the pharmacological treatment is exactly the same as for psychosis without acute physical causes. • Refer to point 1 under pharmacological interventions on page 33, and repeat that exactly the same steps should be followed for an acute manic episode. • After the manic episode is managed, the person needs be assessed for bipolar disorder.

Session 1.3.7: Continued

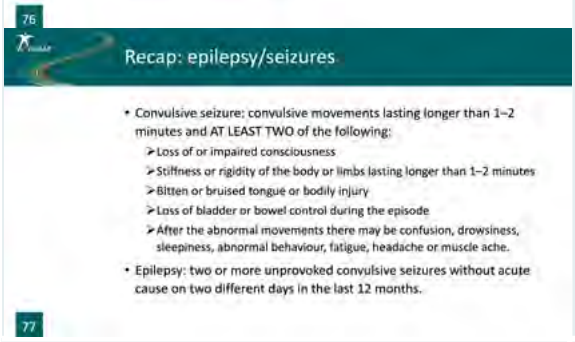
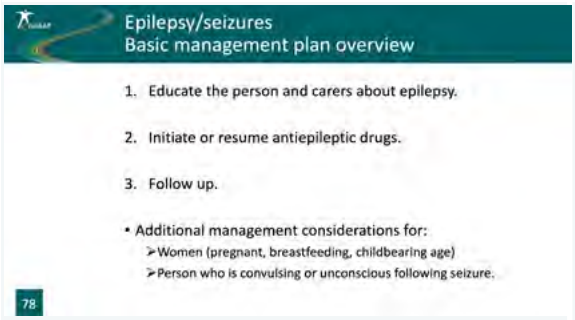
Presentation	Facilitator notes
 	• Emphasize that psychosocial interventions are for all cases with psychosis (with/without acute physical cause and mania). • **Psychoeducation:** Explain that psychoeducation will be discussed on the next slide. • **Facilitate rehabilitation back into the community:** Discuss as a group what resources may be available in the local community for people with psychosis and how participants may help to facilitate this. Community resources may include community-based health-care providers, protection service workers, social workers and disability service workers. • **Ensure care for carers:** Explain that it is very important for the well-being of the person with an MNS condition that their carers remain well. • Let the group read through the psychoeducation part on page 34. Explain that there are key messages for the person and key messages for their carer(s). • Discuss the importance of providing these key messages to carers, e.g. they: » ensure safety (e.g. of newborns, ensure that person gets help if symptoms get worse); » ensure that person is treated appropriately; » help to ensure that medicines continue to be provided; » address beliefs such as around restraining a person, or that psychosis is caused by witchcraft or spirits.

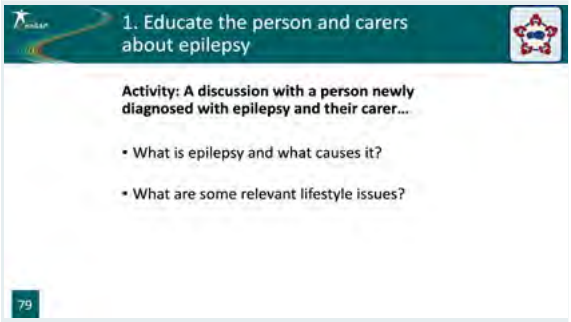
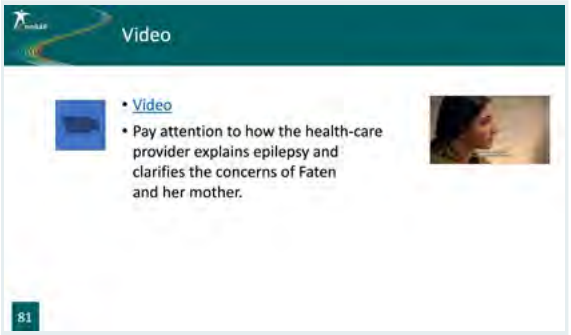
Presentation	Facilitator notes
	• Remind the group of the principles of management in the general principles of care for follow-up (on page 7 of the manual). • Explain that a second visit should be scheduled within one week (as with depression). • Continue the antipsychotic treatment for **at least 12 months** after complete resolution of symptoms. If possible, consult a specialist regarding the decision to continue or discontinue the medicine.
	**Activity 1.36: Video – management of psychosis** **Duration:** 6 minutes **Purpose:** To demonstrate management of psychosis. **Instructions:** • Show the video and have a short discussion afterwards.
	**Activity 1.37: Role-play – management of psychosis** **Duration:** 20 minutes **Purpose:** To practise performing management of psychosis. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 1.37: Role-play – management of psychosis" in Annex B) and show the slide with instructions during the role-play. • Remind the carers that there is a description of the role for them as well. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 1.3.8: Management of epilepsy (75 minutes)

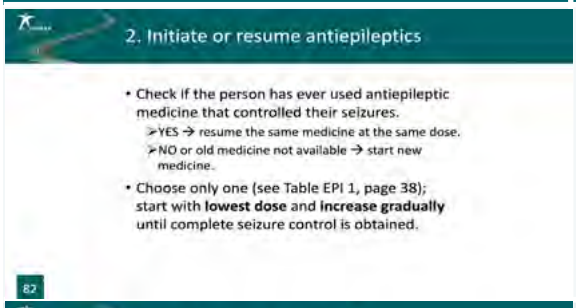
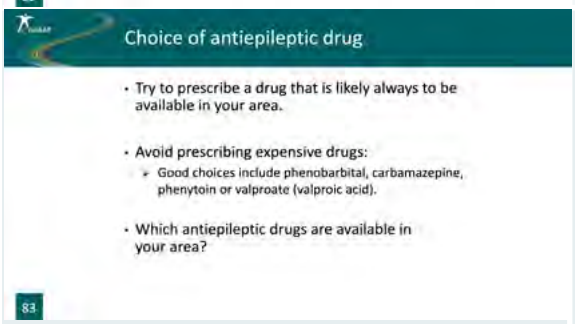
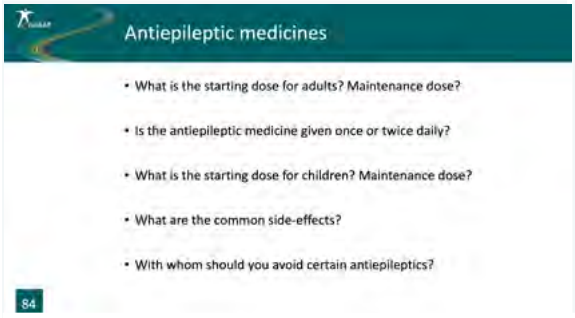
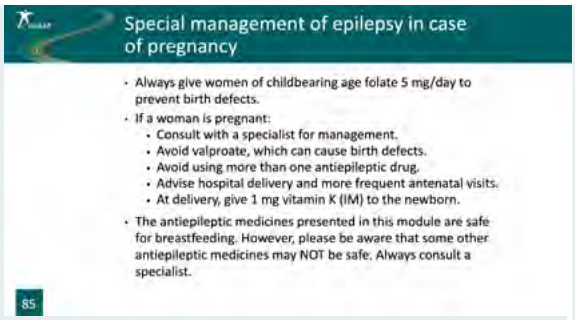
Preparation for facilitator:

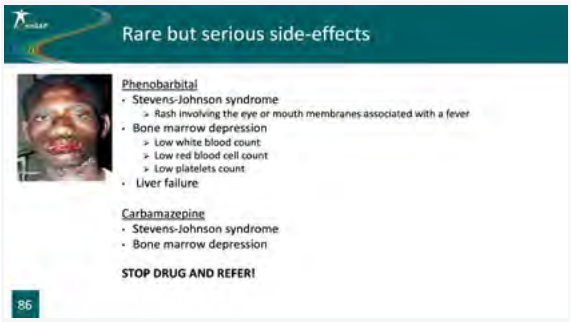
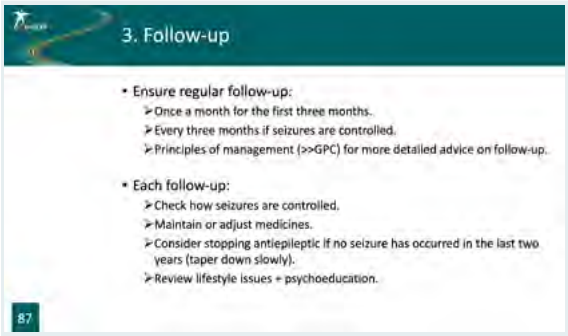
- Familiarize yourself with the recovery position and prepare your demonstration. Make sure that you can show phases A, B, C and D during the demonstration.
- The video for **Activity 1.39** is available at https://www.youtube.com/watch?v=-LTS-cMy56w&index=7&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (6:23 minutes).
- Download the video in advance in case the Internet connection at the training venue is not adequate.
- Have enough copies of the case study "Role-play - management of epilepsy" for **Activity 1.40** (see Annex B).

Presentation	FACILITATOR NOTES
 	• Start the section by asking the group to recall the criteria for convulsive seizures and epilepsy.
	• The management of EPI deals with both managing seizures and managing epilepsy. Take the group through the information on the slide and explain that this is the framework for the basic management of epilepsy and seizures. • Identify that there is an educational component, pharmacological intervention and follow-up (as in depression and psychosis). • Explain that the management part has additional management information for women who are pregnant, breastfeeding or of childbearing age (Box EPI 1 on page 39 of the mhGAP-HIG) and for a person who is convulsing or unconscious following a seizure (Box EPI 2 on page 40).

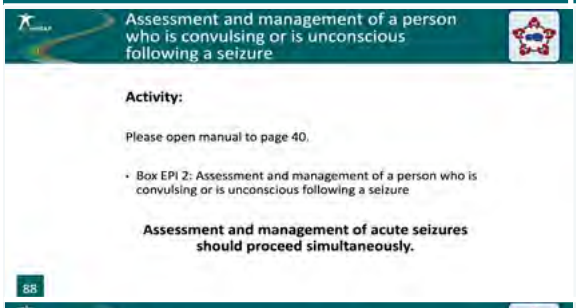
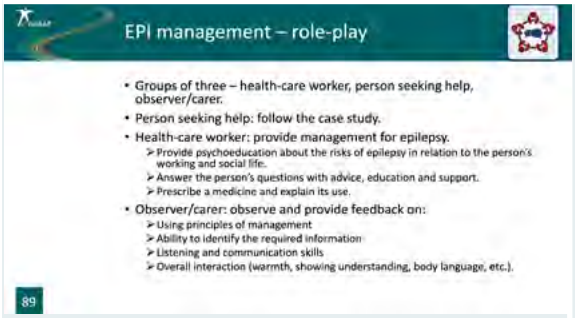
Presentation	Facilitator notes
	**Activity 1.38: Role-play- Psychoeducation for epilepsy** **Duration:** 7 minutes **Instructions:** • Split the trainees into pairs. • The trainees should practise on each other how they would explain the two questions on the slide to a person recently diagnosed with epilepsy and their carer(s). • Facilitators should encourage trainees to read page 37 of the manual to help them with this exercise, and so that they cover all the important points. • Let the pairs change roles after 3 minutes.
	• Let the group read through the points under "What to do at home when seizures occur" (page 37). • Ask a volunteer from the group to demonstrate the recovery position. • Do the demonstration slowly and make sure that phases A, B, C and D are clear. • Have trainees practise using the recovery position in pairs. • Request one of the pairs to demonstrate how they would introduce this to a parent/carer. • Ask participants to go to Box EPI 2 on page 40, and explain the medical management of seizures to the group.
	**Activity 1.39: Video – management of epilepsy** **Duration:** 7 minutes **Purpose:** To demonstrate management of epilepsy. **Instructions:** • Explain that you will now show a video of epilepsy management. • Facilitate a discussion on what the health-care provider in the video did. In particular, ensure that you point out: » Psychoeducation » Normalizing concerns » For the group to think of specific cultural concerns that may be relevant to their setting and situation.

Session 1.3.8: Continued

Presentation	Facilitator notes
	• Discuss "Initiate or resume antiepileptic drugs" as the second component of management in epilepsy; refer to page 38.
	• Begin a general discussion about what drugs are available, at what costs (max. 5 minutes). • Point out how one drug can be more suitable than others in specific situations. » For example, avoid phenobarbital or phenytoin in children with intellectual disability or behavioural disorders. • In this training we will focus on phenobarbital and carbamazepine, but the mhGAP-HIG also covers valproate and phenytoin. • Emphasize the importance of prescribing an antiepileptic drug that will most likely continue to be available in the area.
	• Have the group read page 38 and answer the question about the most widely available antiepileptic in the local context. • Let the group ask questions about anything that is unclear.
	• Refer to Box EPI 1 on page 39 for further information.

Presentation	Facilitator notes
	• Refer to Table EPI 1 on page 38 for the side-effects of antiepileptic medication. • Let the group ask questions about anything that is unclear. • Explain that the picture on the right is of a man with Stevens-Johnson syndrome, a rare autoimmune reaction. This is a life-threatening reaction associated with carbamazepine/ phenobarbital/ phenytoin. • The medicines should be stopped and the person sent to hospital immediately.
	• Emphasize the importance of follow-up in the management of epilepsy (page 39). • Discuss the importance of aligning the frequency of appointments with the drug delivery pattern of pharmacists (e.g. in a lot of countries people get one month's supply of antiepileptic medicines at a time – therefore the provider has to plan for monthly appointments). • Refer to the principles of management (>>GPC) for more detailed advice on follow-up. • Ask the group for possible questions to ask during follow-up: » Is the frequency of seizures getting better or worse? » Have there been drug-specific side-effects? » Make sure to check the list of possible side-effects. » Assess adherence to treatment. » Has the person taken their medicines as directed? If not, why? » Any other issues e.g. problems in the community or family? • Ask the group to read through the information on what to do when seizures are not controlled (page 39) and discuss this with them.

Session 1.3.8: Continued

Presentation	Facilitator notes
	• Explain that Box EPI 2 on page 40 explains what to do when a person is convulsing or is unconscious following a seizure. • Let the group read through the information and encourage them to ask questions if things are unclear.
	**Activity 1.39: Role-play – management of epilepsy** **Duration:** 20 minutes **Purpose:** To practise performing management of epilepsy. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 1.40: Role-play - management of epilepsy" in Annex B) and show the slide with instructions during the role-play. • Remind the carers that there are instructions for them in the case study. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 1.3.9: Evaluation of training (40 minutes)

Preparation for facilitator:

- Print enough copies of the post-test for all participants (ensure that the answers are not attached or on the reverse of print-outs).
- The post-test can be found in the Annex A. You might need to translate the post-tests in multiple languages.

Presentation	Facilitator notes
	***Activity 1.41: Post-test*** **Duration:** 25 minutes **Instructions:** • Hand out the post-test to participants and tell them that they have 20 minutes to complete it. • Indicate when 10 minutes of time is left; indicate when 5 minutes are left.
	• Ask participants for feedback on the training. What were the things they found most useful, what could be changed, how could it be improved or made more relevant?

TRAINING 2

Session 2.1: Introduction TO mhGAP-HIG traing pt 2

Overview

By the end of this session, participants should:

- Know the training group and aims of Training 2 and the conditions covered;
- Be able to understand the general principles of communication.

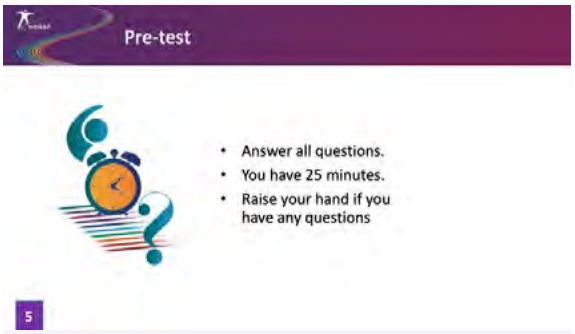
SESSIONS	OBJECTIVES	DURATION (+/-)	TRAINING ACTIVITIES
2.1.1. Introduction, aims of training and pre-test	Introduction of facilitators and participants Explore expectations and explain training objectives Assess pre-existing knowledge and skills	60 min	**Activity 2.1: Pre-test** **Activity 2.2: Introductions and experience with the mhGAP-HIG**
2.1.2. Communication	Train in good communication skills	40 min	**Activity 2.3: Case study – adolescents**
Total time		100 min (approx. 1.5 hrs)	

Session 2.1.1: Introductions and pre-test (60 minutes)

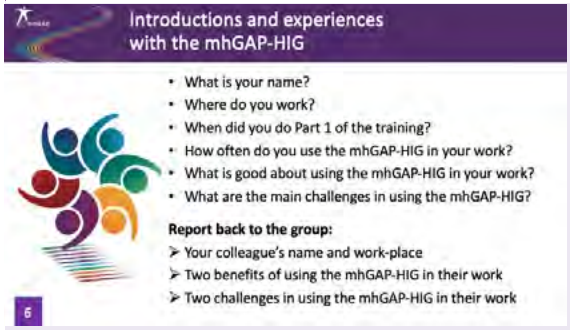
Preparation for facilitator:

- Print enough copies of the pre-test (**Activity 2.1**) for all participants (ensure that the answers are not attached or on the reverse side of any print-outs). The pre-test can be found in Annex A.
- You might need to translate the pre-test into multiple languages.

Presentation	Facilitator notes
	• Welcome everybody to Part 2 of the mhGAP-HIG training.

Presentation	Facilitator notes
	• Explain that the mhGAP-HIG training course consists of two parts and that this is Part 2 of the training. • Mention that the conditions covered in Part 1 of the training will be reviewed briefly in this training, but that much of the emphasis will be on learning about the assessment and management of ID, SUB, PTSD and OTH.
	• Introduce the learning objectives to the participants. • Emphasize that in the training the manual will be used a lot, since the aim is to give them the skills to work with this manual.
	***Activity 2.1: Pre-test*** **Duration:** 30 minutes **Instructions:** • Explain the purpose of the pre-test to participants: the test is not an exam, but it will give information on the level of knowledge in the group. At the end of the training the same test will be done again. A comparison of pre- and post-test will show to what extent the trainer team has been successful in delivering knowledge to the participants. • Explain that participants will not be judged or compared with each other. • Hand out the Training 2 pre-test (see Annex A) and tell the group that they have 25 minutes to complete it. • Indicate when 10 minutes of time is left; indicate when 5 minutes are left.

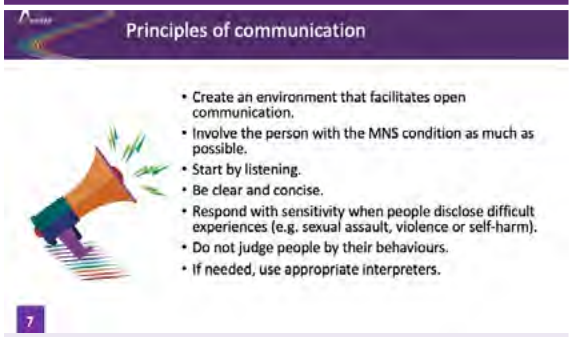
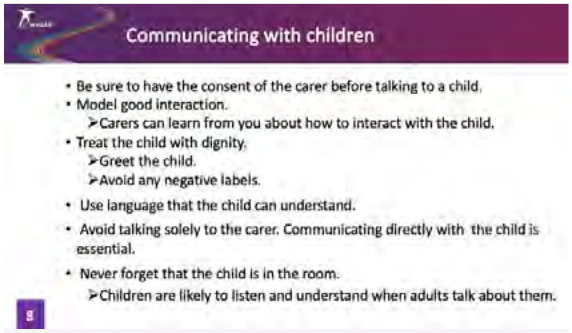
Session 2.1.1: Continued

Presentation	Facilitator notes
	**Activity 2.2: Introductions and experience with the mhGAP-HIG** **Duration:** 30 minutes **Purpose:** Introduce the group and assess their previous experience and challenges with the mhGAP-HIG. **Instructions:** • Explain that the next 30 minutes will be used to get to know each other and discuss the use of the mhGAP-HIG in the field. • Ask the group to get into pairs and discuss the points on the slide. They will have 10 minutes; remind them to switch after 5 minutes. • Stop the exercise after 10 minutes and ask the participants to report back to the group pair by pair. • Write down the benefits and challenges that are mentioned by participants on a flipchart. • Ask the group how relevant the challenges are that have been reported and whether they have suggestions about how to overcome them.

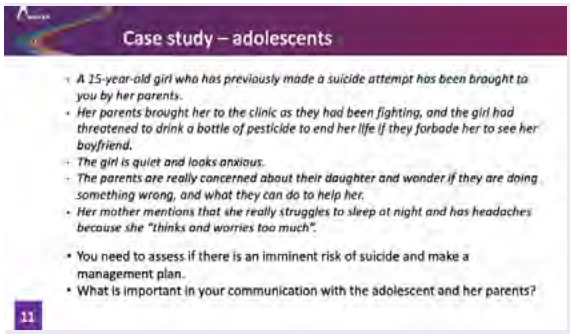
Session 2.1.2: Communication (40 minutes)

Preparation for facilitator:

- Print enough copies of the case study for **Activity 2.3** (see Annex B).

Presentation	FACILITATOR NOTES
	• Refer the group to the general principles of care (GPC), specifically communication. Explain that in Part 2 of the training communication skills and the other GPC will be evaluated through the different role-plays. • Ask the group about challenges they have experienced in communication when using the mhGAP-HIG. • The second part of this activity covers communication with different populations (children, adolescents and carers).
	• Ask the group what is important to keep in mind and what is important to do or not do when communicating with a child. • Elicit some answers from the group before showing the slide. • Explain that dealing with a child requires a unique set of skills. At times, a playful approach is highly recommended. • Explain that this area will also be covered in more depth in the module on intellectual disability.
	• Ask the group about their experiences in communicating with adolescents and the challenges they face. • Explain that, like children, adolescents require a different approach from adults. • It is important to remember that adolescents are not children but also not quite adults, so you must approach them with respect and sensitivity. • Trust and open communication are critical, but may take some time to develop. • Explain confidentiality: it should be made clear that adolescents' sense of autonomy and need for privacy are respected and that therapeutic

Continues on next page

Presentation	Facilitator notes
	confidentiality is essential for effective treatment, but that there are limitations to this confidentiality. When disclosure to a carer is needed, it makes both clinical and ethical sense to tell the adolescent – beforehand, if possible – what information will be shared, and when. Ideally, the adolescent would be part of such a conversation.
	• Go through each point and encourage group involvement and discussion. • Emphasize the importance of carers in understanding how a person is progressing. • Be sure to encourage participants to ask how carers are coping with what is happening. Ongoing support for carers is critical.
	**Activity 2.3: Case study – adolescents** **Duration:** 20 minutes **Purpose:** Discussing communication skills with adolescents. **Instructions:** • Ask the group to get into pairs and review the assessment and management of imminent risk of suicide in the mhGAP-HIG (pages 50–51). • Let them discuss the case and make a plan for potential challenges in communicating with the adolescent and the parents. • Ask them to note down what is important in this communication to ensure that assessment and management are successful. • After 10 minutes in pairs, discuss the main points as a group. • Make sure to cover the following: Confidentiality and protection: did the adolescent want to know what you wanted to share with their carer? Discuss what to do if an adolescent is self-harming and does not want the carer to know, or if they reveal a severe risk or something that you are obliged by law to share with others, such as being harmed by another person.

Session 2.2: Intellectual disability

OVERVIEW

By the end of this session, participants should:

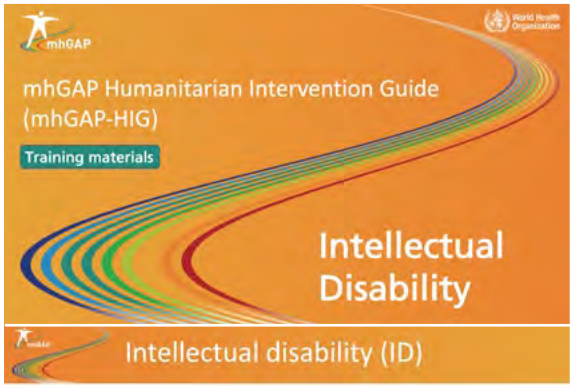
- Know the common presentations of intellectual disability;
- Know the assessment questions for intellectual disability;
- Be able to perform an assessment for intellectual disability;
- Be able to provide psychosocial interventions to persons with intellectual disability and their carers;
- Be able to plan and perform follow-up for intellectual disability;
- Be able to refer people with intellectual disability to specialists and link with outside agencies.

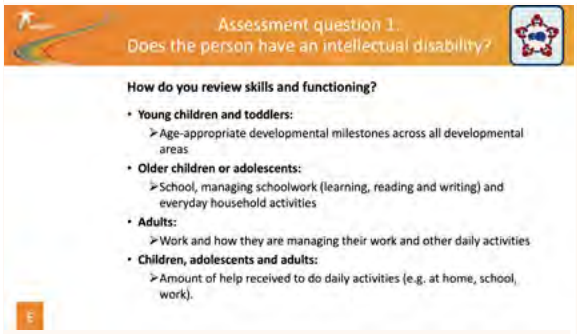
SESSIONS	OBJECTIVES	DURATION (+/-)	TRAINING ACTIVITIES
2.2.1. Introduction and assessment of intellectual disability	Introduce the condition Intellectual Disability (ID) and the common presenting complaints Know how to assess for intellectual disability	80 min	**Activity 2.4: Discussion- developmental milestones** **Activity 2.5: Video – assessment of intellectual disability** **Activity 2.6: Role-play – assessment of intellectual disability**
2.2.2. Management of intellectual disability	Learn how to manage intellectual disability	65 min	**Activity 2.7: Discussion - human rights and intellectual disability** **Activity 2.8: Video – management of intellectual disability** **Activity 2.9: Role-play – management of intellectual disability**
Total time		145 min (approx. 2.5 hrs)	

Session 2.2.1: Introduction and assessment of intellectual disability (80 minutes)

Preparation for facilitator:

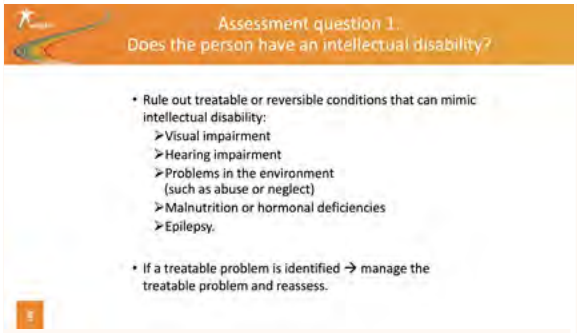
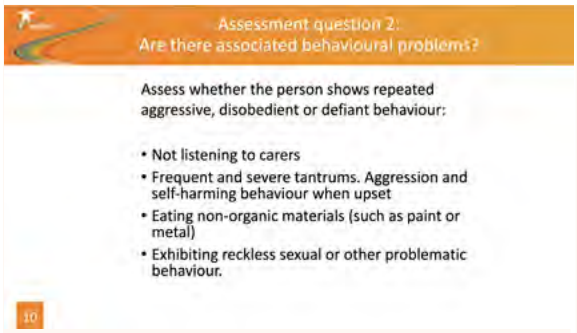
- The video for **Activity 2.5** is available at: http://youtu.be/zkPMGcFV2kc (for part 1, duration 5:50 minutes). Download it in advance.
- Make sure that you have enough copies of the case study "Role-play – assessment of intellectual disability" for **Activity 2.6** (see Annex B).

Presentation	Facilitator notes
  	• Ask the group how a person with an intellectual disability might present. Have a brief discussion (5 minutes) and ensure that the main points on the "Introduction" slide are emphasized. • Give examples of areas of development/ competency (cognitive, language, etc.) and explain their developmental nature. • Then ask the group to read the list of typical presenting complaints of intellectual disability on page 41 of the mhGAP-HIG. • Stress that intellectual disability is understood in a wide variety of ways by families and communities. • Explain the importance of a nurturing environment for children. • Initiate a discussion (5 minutes) on local ideas about intellectual disability. • Explain that these disorders are not caused by vaccines or evil spirits. • Allow some time for discussion about neglect, **discrimination and abuse**. • **Background information** on neglect, discrimination and abuse: » People with ID may be bullied by siblings or others. » They may be excluded from schools. » They may not be brought for vaccination/essential health care. » They may be tied up, abandoned or left alone in the house. » In poor families, they may receive less food. » They may be subject to harmful forms of traditional healing (e.g. beating a spirit out). » They may be harshly treated or beaten by frustrated parents.

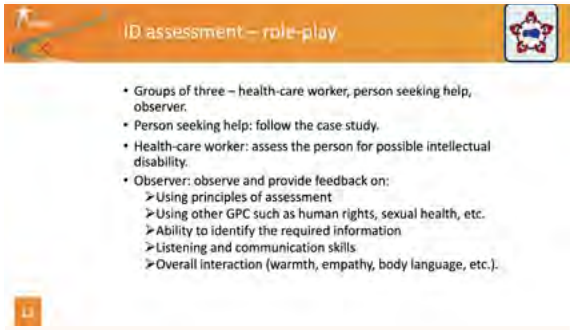
Presentation	Facilitator notes
	• Ask the group to think of someone they know with an ID or use a presentation of ID that was shared with the group for the previous slide. Ask participants to think for a couple of minutes about how this person would experience a humanitarian crisis and what could happen to them. Give prompts like, "Think of someone with an ID who loses their home, their relatives and their routines". • Invite some participants to answer before revealing the rest of the slide.
	• Explain that the assessment of ID in the mhGAP-HIG consists of two assessment questions: » Assessment question 1 has two components: 1. reviewing skills and functioning; and 2. ruling out other conditions. » The second question is to assess associated behavioural problems. • Explain that there are three additional assessment questions that are not explicit in the mhGAP-HIG: » Are there emotional problems? » Are there comorbidities (especially epilepsy or psychosis)? Mention that EPI is a common comorbidity with ID. » How is the home environment?
	• Ask the participants how they would assess skills and functioning in the age groups mentioned (5 minutes). • Invite some participants to answer before revealing the answers for the specific age groups. • Stress that mild levels of intellectual disability might sometimes become obvious only in adolescence or early adult life (when daily demands are higher). • Refer to page 42 of the manual for more details on assessing skills and functioning.

Continues on next page

Presentation	Facilitator notes
	• Would you change these questions when talking to people in your community? • Examples? Ask the audience to give 3–4 examples (time permitting). • Discuss how skills and functioning can be reviewed in the limited amount of time that trainees have available in their setting.
	**Activity 2.4: Discussion - developmental milestones** **Duration:** 10 minutes **Purpose:** Discuss the milestones in the development of children. **Instructions:** • Divide the group in small groups of 3–4 people. • Explain that the exercise will involve finding out how much they know about what children are able to do at different ages. • Ask the group to close their humanitarian guides and write down a list of what they think are warning signs for different age groups (7 minutes). • After 7 minutes, ask them to open their manuals to page 44, Box ID 1, "Developmental milestones: warning signs to watch for". • Let them compare their groups' answers with the list in the guide. • Then ask the group as a whole: » **How close was your group to being correct?** » **Did any warning signs surprise you?** • Take 3–4 responses from participants regarding any warning signs that were surprising to them. • Remind the group that they don't need to know all these milestones exactly as they can always refer to the mhGAP-HIG.

Presentation	Facilitator notes
	• Explain that the second step of assessment question 1 is to rule out treatable or reversible conditions that can mimic intellectual disability. • Ask the group for examples of conditions that can look like ID and what is important to rule out. Ask for locally relevant conditions that can mimic ID (such as iodine poisoning). After getting some examples, show the list of conditions to rule out. • Ask the group what should be done when these conditions are identified. • Direct participants to page 42 of the mhGAP-HIG and review the section "Manage the identified treatable problems and follow up to reassess whether the person has intellectual disability".
	• Ask participants to read the slide (give the group the handout in Annex F). • Afterwards, invite one or two people to share with everybody what they liked.
	• Explain that knowing about these behavioural problems is useful for psychoeducation and further management. • Tantrum = emotional outbursts with crying, screaming, hitting, etc; brief tantrums (less than 5 minutes) without self-injury are age-appropriate for toddlers. • Non-organic materials: give an example of eating non-organic materials (such as paint or metal). • Discuss the response of the community to these behavioural problems. Are people sympathetic or judgemental?

Session 2.2.1: Continued

Presentation	Facilitator notes
	**Activity 2.5: Video – assessment of intellectual disability** **Duration:** 10 minutes **Purpose:** Demonstration of assessment of intellectual disability. **Instructions:** • Show the video from the beginning to 5:50 (part 1, do not show parts 2 or 3 yet). • Have a brief group discussion about the video and then move to the exercise (next slide). Note that we will analyse the video in greater detail later. • Note that the video is not completely consistent with the mhGAP-HIG but it still gives a good indication of how to assess for problems.
	**Activity 2.5: Role-play – assessment of intellectual disability** **Duration:** 20 minutes **Purpose:** To practise performing assessments for intellectual disability. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out one of the two case studies (see "Activity 2.6: Role-play – assessment of intellectual disability" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

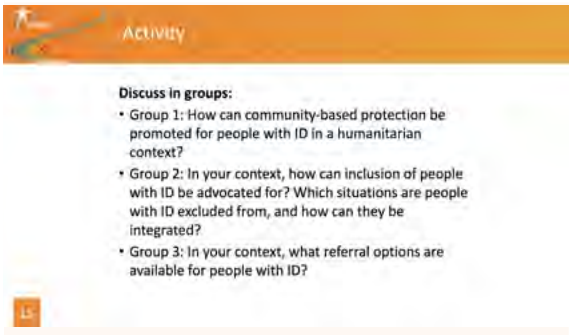
Session 2.2.2: Management of intellectual disability (65 minutes)

Preparation for facilitator:

- The same video is used for **Activity 2.8** and is available at: http://youtu.be/zkPMGcFV2kc (5:50 to 11:40 minutes). Download it in advance.
- Make sure that you have enough copies of the case study "Role-play – management of intellectual disability" for **Activity 2.9** (see Annex B).

Presentation	Facilitator notes
	• Explain that the first management step for ID is to provide psychoeducation. Explore the experience that group members have had in providing this for ID. • Ask the group for a local case and for examples of how the disability can be explained. Correct any misconceptions. • Point out that providing psychoeducation for ID is rather complex as you are dealing with the needs of person with ID and at the same time it is important to consider potential problems such as strain on carers, neglect of the rest of the family and overprotection. • Make the point that it can also be very rewarding to have a person with ID in the family. • Emphasize that providing training on parenting skills can help reduce behavioural problems. • Skills that can help reduce behavioural problems include the following: » Carers should understand the importance of training the person to perform self-care and hygiene (e.g. toilet training, brushing teeth). » Carers should have very good knowledge of the person. They should know what stresses them and what makes them happy, what causes behavioural problems and what prevents them, what the person's strengths and weaknesses are and how the person learns best. » Carers should keep the person's daily activities, such as eating, playing, learning, working and sleeping, as regular as possible.

Continues on next page

Presentation	Facilitator notes
	» Give clear, simple and short instructions on what the person should do, rather than what they should not do. Break complex activities into smaller steps so that the person can learn and be rewarded one step at a time (e.g. learning to put trousers on before buttoning them up). It is important to explain what can be considered a reward and an absence of reward in practical terms. » When the person does something good, offer a reward. Distract the person from things that he/she should not do. However, such distraction should not be pleasurable or rewarding for the person. This should be applied consistently by different carers. » In many settings families cannot afford material rewards and this is not the best strategy anyway. » Positive attention and praise can be a reward, and ignoring poor behaviour can diminish it. » DO NOT use threats or physical punishments when behaviour is problematic.
	**Activity 2.7: Discussion - human rights and intellectual disability** **Duration:** 15 minutes **Purpose:** Discuss different ways that the human rights of people with intellectual disability can be enhanced. **Instructions:** • Ask the group to open the manual to the basic management plan for ID on page 43. » Give everyone in the group a number – 1, 2 or 3. Ask them to get into their groups and discuss the following for 5 minutes:

Continues on next page

Presentation	Facilitator notes
	» Group 1: Discuss how to promote community-based protection. What NGOs and organizations exist in their area that could provide community-based protection? Ask them to consider identifying a list of organizations they could contact in their local area and how these protection mechanisms might be strained by a humanitarian emergency. » Group 2: Discuss ways to advocate for inclusion in their context (prompt: barriers to access to services, finance, transport, etc.). » Group 3: List what referral options are available. • Ask each small group to report back to the main group after 7 minutes. Make sure that the referral options and ways to advocate for inclusion are documented so that these can be given to participants as extra material at the end of the training.
	• Go back to the basic management plan for ID. For steps 4 and 6, remind the group of the general principles of care on pages 7–9 of the manual. • Explain briefly how to provide support for carers: » Ask carers how they provide care. » Acknowledge that it is stressful and burdensome to care for someone with so much need, particularly in a humanitarian setting. » Acknowledge carers' emotions (e.g. anger, sadness, anxiety). » If the stress is overwhelming for the main carer, see if other members of the family or community can provide respite care and give them a break. • Explain cerebral palsy (it is a disorder of motor and intellectual ability caused by early, permanent damage to the developing brain).

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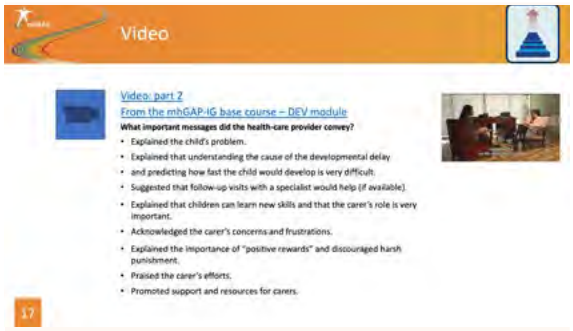
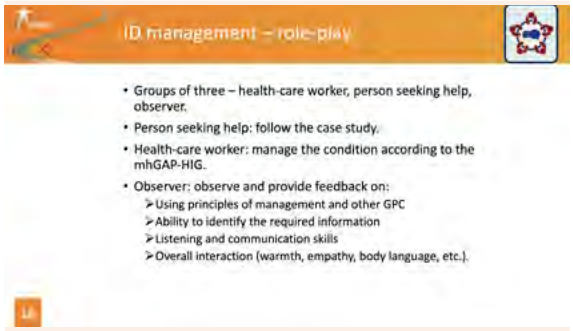
Session 2.2.1: Continued

Presentation	Facilitator notes
	• Explain that follow-up appointments should be scheduled based on the GPC: » Create a follow-up plan. » Initial follow-up visits should be more frequent until symptoms decrease . » Once symptoms start improving, less frequent but regular appointments are recommended.
	**Activity 2.8: Video – management of intellectual disability** **Duration:** 10 minutes **Purpose:** Demonstrate the management of intellectual disability. **Instructions:** • Show the second part of the video (from 5:50 to 10:30) and ask the group to note what important messages the health-care provider conveys. • After showing the second part of the video, ask some people in the group to recall some important messages that were conveyed by the health-care provider, before revealing the answers. • Then show part 3 of the video from 10:30 to the end; this part explains the important messages of psychoeducation.
	**Activity 2.9: Role-play – management of intellectual disability** **Duration:** 20 minutes **Purpose:** Practise performing management of intellectual disability. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer.

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Presentation	Facilitator notes
	• Hand out one of the two case studies (see "Activity 2.9: Role-play – management of intellectual disability" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.
	• Ask the group one by one to identify a take-home message from this session on ID. • After going round the group, share the slide with key points.

Session 2.3: Harmful pattern of use of alcohol and drugs

Overview

By the end of this session, participants should:

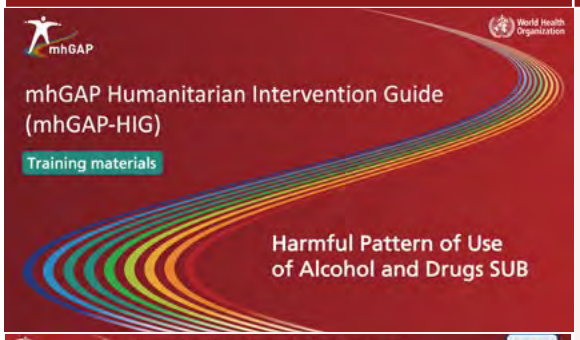
- Know the common presentations of harmful pattern of use of alcohol and drugs;
- Know the assessment questions for harmful pattern of use of alcohol and drugs;
- Be able to perform an assessment for harmful pattern of use of alcohol and drugs;
- Be able to provide psychosocial interventions to persons with harmful pattern of use of alcohol and drugs and their carers;
- Be able to provide pharmacological interventions to persons with harmful pattern of use of alcohol and drugs and their carers;
- Be able to plan and perform follow-up for harmful pattern of use of alcohol and drugs;
- Be able to refer people with harmful pattern of use of alcohol and drugs to specialists and link with outside agencies.

SESSIONS	OBJECTIVES	DURATION (+/-)	TRAINING ACTIVITIES
2.3.1. Introduction and assessment of harmful pattern of use of alcohol and drugs	Introduce harmful pattern of use of alcohol and drugs and the common presenting complaints Know how to assess for harmful pattern of use of alcohol and drugs	55 min	**Activity 2.10: Video – assessment of harmful pattern of use of alcohol and drugs** **Activity 2.11: Role-play – assessment of harmful pattern of use of alcohol and drugs**
2.3.2. Management of harmful pattern of use of alcohol and drugs	Learn how to manage harmful pattern of use of alcohol and drugs	50 min	**Activity 2.12: Video – management of harmful pattern of use of alcohol and drugs: motivational interviewing** **Activity 2.13: Role-play – management of harmful pattern of use of alcohol and drugs: brief intervention**
Total time		145 min (approx. 2.5 hrs)	

Session 2.3.1: Introduction and assessment of harmful pattern of use of alcohol and drugs (55 minutes)

Preparation for facilitator:

- The video for **Activity 2.10** is available at: https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6- yaGxhes5v&index=15 (duration 8:29 minutes). Download it in advance.
- Have enough copies of the case study "Role-play – assessment of harmful pattern of use of alcohol and drugs" for **Activity 2.11** (see Annex B).

Presentation	Facilitator notes
	**Preparation** It is important, as a facilitator, to obtain some background information if you do not know the local context in which you are training (e.g. what the commonly used drugs are locally, and their local slang/ street names). • Have a brief discussion on legal and illegal substances that are commonly used in the community and make a list of them.
	
	• Introduce the spectrum of conditions related to the use of alcohol and drugs. • Mention that the definitions are different from those in the mhGAP-HIG manual as they have been updated to be consistent with ICD-11 (International Classification of Diseases; https://icd.who.int/en). • Explain that withdrawal symptoms depend on the substances used and vary in degree of severity and duration based on the substance and amount and the pattern of use.

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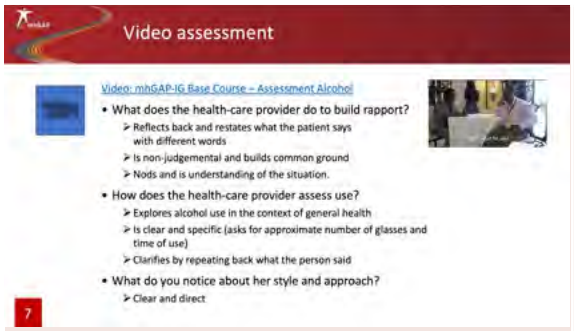
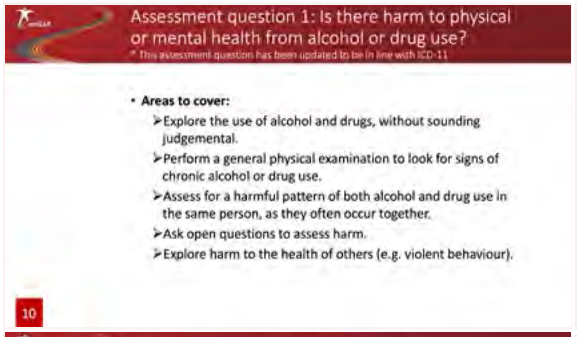
Session 2.3.1: Continued

Presentation	Facilitator notes
	• Explain that this module focuses on harmful pattern of use of alcohol and drugs and includes a box on life-threatening alcohol withdrawal (>> Box SUB 1, page 48). For other aspects of alcohol or drug use (dependence, overdose and withdrawal from other substances), see alcohol and drug use modules in the full mhGAP Intervention Guide 2.0.
	• Ask the group why extra attention is needed to harmful pattern of use of alcohol and drugs in humanitarian crises. • Invite some answers from the group before revealing the rest of the slide.
	***Activity 2.10: Video – assessment of harmful pattern of use of alcohol and drugs*** **Duration:** 15 minutes **Purpose:** To demonstrate the assessment of harmful pattern of use of alcohol and drugs. **Instructions:** • Before showing the video, explain that it was made during an mhGAP workshop and involved two experienced clinicians. The lady seen at the back was summarizing the situation during the workshop. • Ask the group to write down what the health-care provider is doing. • Reveal the answers after showing the video, and have a brief discussion. • Explain: » Building rapport initially; » An assessment of how much the person is drinking. The health-care provider is being very clear and precise; » The pattern of drinking is clarified; » The consequences of drinking are explored – how alcohol has affected the person's life.

Presentation	Facilitator notes
	• Ask the group if they think that the man's substance use pattern is harmful, what they consider to be harmful, and what the harmful behaviours are. • Invite some participants to share their ideas, before revealing the answers on the slide.
	• Ask the group for presenting complaints of people affected by drugs or alcohol. • Invite some participants to present cases they have seen in their work.
	• Explain that the first step in the assessment is to find out if someone is experiencing harm to their physical or mental health from harmful pattern of alcohol or drug use by asking them a number of questions.
	• Discuss how to explore the use of alcohol and drugs. • Remind the group to be aware of the GPC and of how to discuss sensitive subjects such as substance use. It may be taboo, and people will not answer unless there is an effort to build trust and the questions are framed sensitively. • Discuss: **Some good examples of how to ask about alcohol use:** » Do you drink alcohol? » Do you drink? » Do you drink alcohol at all?

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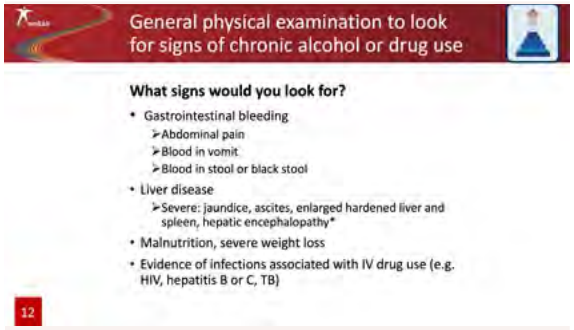
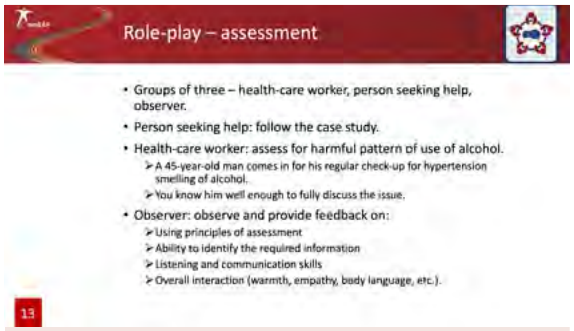
Presentation	Facilitator notes
	Some examples of how NOT to ask about alcohol use: » Do you have a problem with alcohol? » Are you an alcoholic? » Do you drink too much? » Do you drink a lot? » You are a woman, so I assume you do not drink alcohol. Am I right?
	• Invite some members of the group to give answers before revealing the answers on the slide. • Ask the group for other questions that can be used to explore the use of drugs. • Let the group read the full list of questions and areas for assessment on page 46 of the mhGAP-HIG. • Discuss the questions suggested in the manual and whether they should be adapted in the local context.
	**Activity 2.11: Role-play – assessment of harmful pattern of use of alcohol and drugs** **Duration:** 20 minutes **Purpose:** To practise assessing harmful pattern of use of alcohol and drugs. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out copies of the case study (see "Activity 2.11: Role-play – assessment of harmful pattern of use of alcohol and drugs" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 2.3.2: Management of harmful pattern of use of alcohol and drugs (50 minutes)

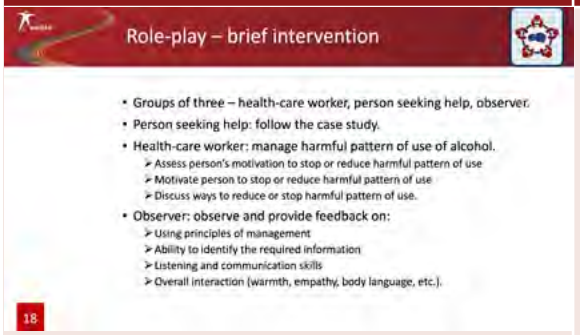
Preparation for facilitator:

- Read the handout describing the FRAMES approach (see Annex G) and make sure that you have enough copies to hand out to the group.
- For more information on brief interventions for substance use, see: https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf
- The video for **Activity 2.12** is available at: https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8GicaEnDweSQ6-yaGxhes5v (duration 3:41 minutes). Download it in advance.
- Have enough copies of case study "**Activity 2.13**: Role-play – management of harmful pattern of use of alcohol and drugs: brief intervention" for **Activity 2.13** (see Annex B; the case study is the same as for **Activity 2.11**).

Presentation	Facilitator notes
	• Ask the group to read page 47 of the manual. • For point 1, elaborate on: » providing necessary medical care (e.g. drug injection HIV, hepatitis, skin infections, other infections) and manage symptoms due to drug withdrawal (e.g. nausea, vomiting, muscle aches, pain, anxiety, insomnia). Common health problems could be due to e.g. living conditions, TB, dental caries, STIs; » management of concurrent mhGAP conditions (for example depression) » addressing social consequences: e.g. liaise with protection services in cases of abuse, such as gender-based violence; child protection; poverty; other psychosocial issues facing individual or family. • Points 2, 3 and 4 form part of the brief motivational conversation that will be discussed in the following slides. • For point 5, have a brief discussion on how the general principles of care (GPC) may help someone with harmful pattern of use of drugs or alcohol. • Explain that complex cases should be referred to specialized substance abuse facilities if these are available.

Session 2.3.2: Continued

Presentation	Facilitator notes
	• Give the group the FRAMES handout (see Annex G). • Explain that FRAMES includes a number of consistent features which appear to contribute to the effectiveness of brief interventions for substance use conditions. • Briefly discuss the framework with the group. • Introduce motivational interviewing as one of the effective brief interventions that is included in the mhGAP-HIG. • Explain it is important that the tone and language used are motivating and not critical or judgemental. • Discuss the strategies listed on page 47 of the manual to reduce or stop harmful patterns of use, consider which of these strategies can be used locally, and discuss any other strategies that participants identify.
	**Activity 2.12: Video – management of harmful pattern of use of alcohol and drugs: motivational interviewing** **Duration:** 10 minutes **Purpose:** To demonstrate motivational interviewing. **Instructions:** • Instruct the group to watch the video and observe what the health-care provider is doing. Ask them to write down things that are good to do in motivational interviewing (DO's) and things that are not good to do in motivational interviewing (DON'Ts). • After showing the video, invite some participants to answer the questions on the slide, before revealing the answers. Discuss why these are either DO's or DON'Ts. • If you have the time and think it is needed, you could demonstrate how to do motivational interviewing BADLY.

Presentation	Facilitator notes
	**Activity 2.13: Role-play – management of harmful pattern of use of alcohol and drugs: brief intervention** **Duration:** 20 minutes **Purpose:** To practise performing management of harmful pattern of use of alcohol and drugs. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 2.13: Role-play – management of harmful pattern of use of alcohol and drugs: brief intervention" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.
	• Explain that withdrawal from other substances is not covered in this module but should be managed in line with mhGAP 2.0. • Box SUB 1 on page 48 describes how to assess for and manage life-threatening alcohol withdrawal. • Explain that the first step is to establish if alcohol withdrawal is the cause of the symptoms; therefore other causes should be ruled out. The second step is to assess if the withdrawal symptoms are life-threatening. • Ask the group to read what to do for assessment question 1 on page 48.

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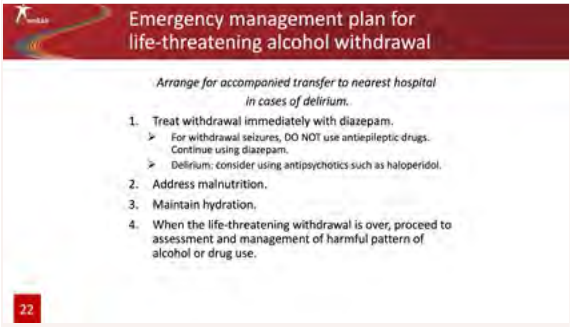
Session 2.3.2: Continued

Presentation	Facilitator notes
	• Discuss: » Ruling out other causes: cover all other possible causes, and ensure that participants are familiar with these. » Alcohol history: take a history of when the problems started (e.g. how long after the last drink did symptoms start). Discuss questions to ask when taking an alcohol history. Consider a demonstration. • If the person presents with seizures or hallucinations and alcohol withdrawal is not suspected, assess for epilepsy (EPI) or psychosis (PSY). • Review the presenting problems for EPI and PSY with the group, using the chart in Annex C. • If alcohol withdrawal is suspected, go to assessment question 2. • Discuss if there are any concerns or if anything is unclear.
	• Cover in detail what life-threatening features are and what risk factors are for their development. Ensure that participants know how to recognize these.

Presentation	Facilitator notes
	• Ask the group to read the second half of page 48 of the mhGAP-HIG. • Ask them to read the table (on diazepam), then point out particular key elements: » 10–20 mg, four times a day. » Cease if the person is drowsy. • Refer the group to the mhGAP-IG 2.0 for information about the emergency management of other drugs (e.g. withdrawal from opioids, overdose, etc.). • Discuss local management and whether it is possible to prescribe a high dose of diazepam in the community.
	• When discussing the key messages, emphasize that is important to always ask about alcohol and drug use during the assessment.

Session 2.4: Post-traumatic stress disorder (PTSD)

OVERVIEW

By the end of this session, participants should:

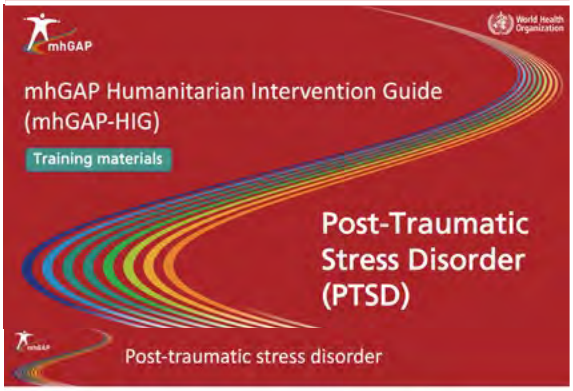
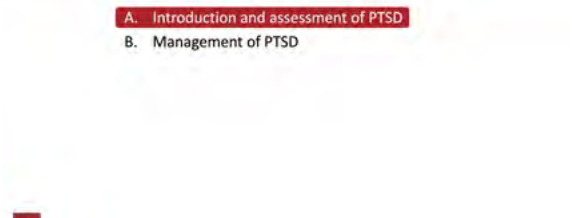
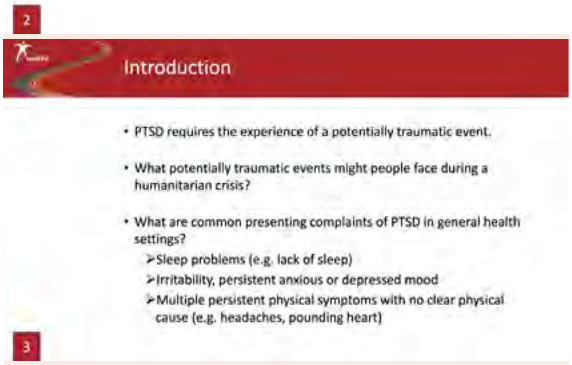
- Know the common presentations of PTSD;
- Know the assessment questions for PTSD;
- Be able to perform an assessment for PTSD;
- Be able to provide psychosocial interventions to persons with PTSD and their carers;
- Be able to provide pharmacological interventions to persons with PTSD;
- Be able to plan and perform follow-up for PTSD;
- Be able to refer people with PTSD to more specialized providers and link with outside agencies.

Sessions	Objectives	Duration (+/-)	Training activities
2.4.1. Introduction and assessment of PTSD	IIntroduce the condition post-traumatic stress disorder and the common presenting complaints Know how to assess for PTSD and how to differentiate it from other conditions	120 min 65 min	**Activity 2.14: Case-studies - assessment of PTSD** **Activity 2.15: Video – assessment of PTSD** **Activity 2.16: Role-play – assessment of PTSD**
2.4.2. Management of PTSD	Learn how to manage PTSD		**Activity 2.17: Role play -educate on PTSD** **Activity 2.18: Video – management of PTSD** **Activity 2.19: Video and practice - breathing exercise** **Activity 2.20: Role-play – management of PTSD**
Total time		185 min (approx. 3 hrs)	

Session 2.4.1: Assessment of post-traumatic stress disorder (120 minutes)

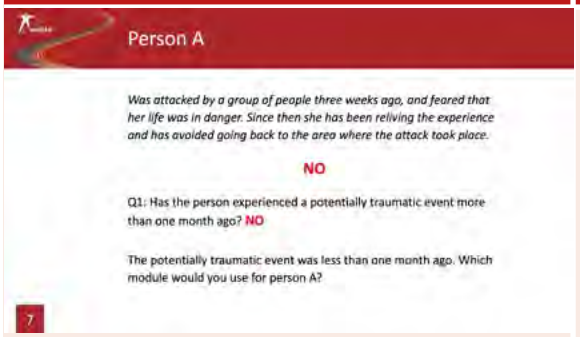
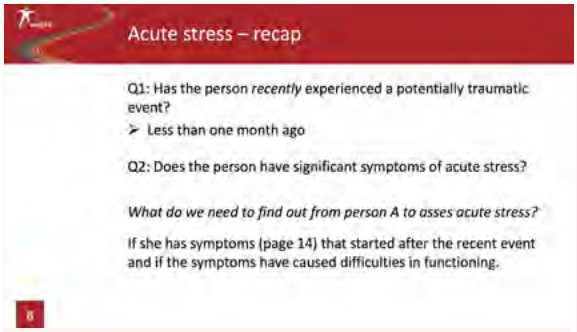
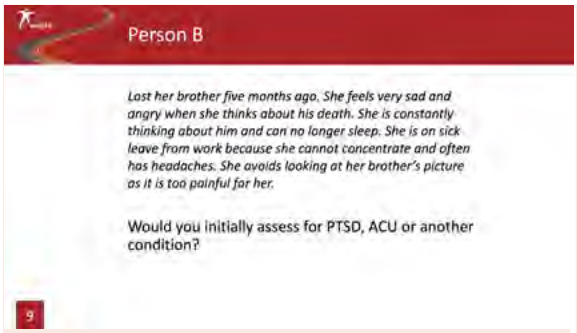
Preparation for facilitator:

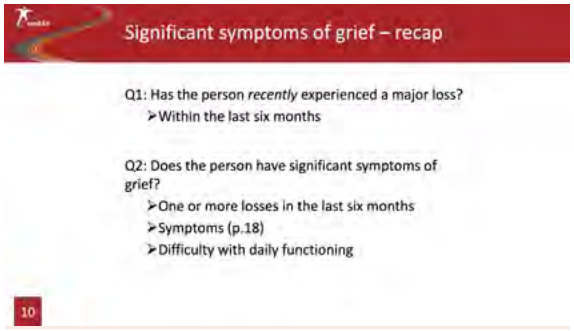
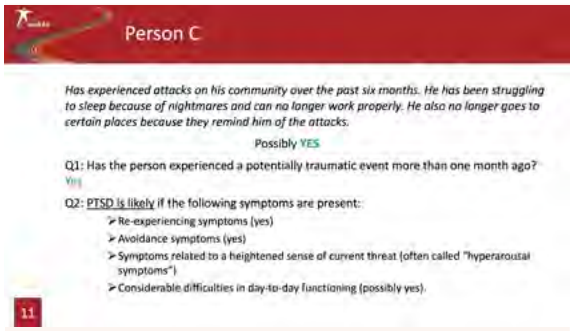
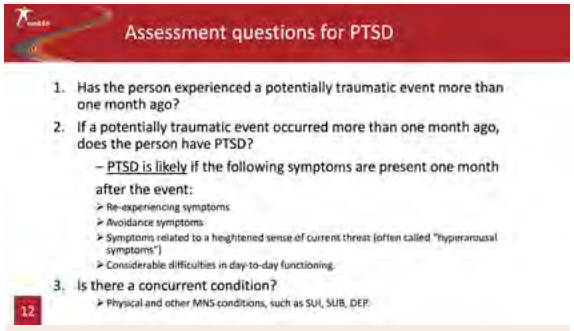
- The video for **Activity 2.15** is available at https://www.youtube.com/watch?app=desktop&t=447&v=k0JXpg_pS98&feature=youtu.be (duration 6:13 minutes). Download it in advance.
- Have enough copies of case study 1 or 2 "Role-play – assessment of PTSD" for **Activity 2.16** (see Annex B).

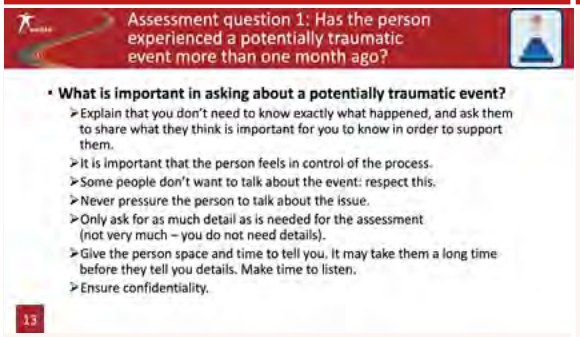
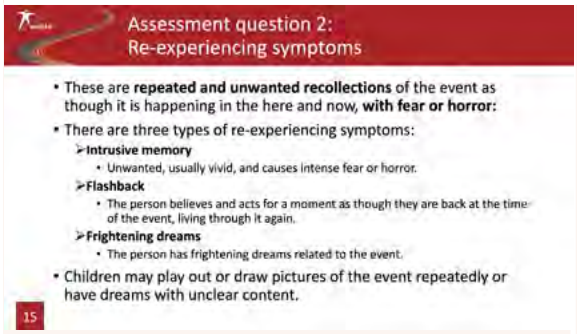
Presentation	Facilitator notes
  	• Explain that PTSD is a condition that requires a person to have experienced a potentially traumatic event. • If the training is given during an emergency, ask the group: "In this emergency, in general, what are some of the upsetting or stressful events that the population have experienced?" You need to be careful how this question is asked to make sure that it is in general and that you are not asking for people's personal or specific experiences, as this might be upsetting for some. Indeed, you might specify that you are NOT asking people to share individual or personal experiences. If the training is given in a preparedness phase, ask participants this question for future common emergencies (e.g. flooding, earthquakes etc.) • Potentially traumatic events that people might face during a humanitarian crisis include: » physical or sexual violence (including domestic violence) » armed conflict and natural disasters » sudden loss of a loved one » witnessing of atrocity » destruction of the person's house » major accidents or injuries. • Ask the group to share examples of cases where people had mental health problems related to experiencing a potentially traumatic event. • Typical presenting complaints of PTSD are often non-specific symptoms such as:

Continues on next page

Presentation	Facilitator notes
	» sleep problems (e.g. lack of sleep – this is very common) » irritability, persistent anxious or depressed mood » multiple persistent physical symptoms with no clear physical cause (e.g. headaches, pounding heart). • When people have PTSD, they present in the clinic with non-specific symptoms that are similar to the presenting symptoms of other conditions, such as depression. Yet, as we shall see later, PTSD involves a very specific set of symptoms.
	• Ask the group to read page 27 of the manual on PTSD and decide whether the two statements on the slide are true or false (2 minutes). • Ask for some responses from the group before revealing the answers. • Explain that not all people who have experienced or witnessed a traumatic event will develop PTSD, only a minority. At high risk are, for example, survivors of rape and torture. • Whether or not a person develops PTSD will depend on various factors, such as the nature of the traumatic event, the level of exposure, their individual characteristics and the recovery environment. • Make sure to mention that any other mental disorder can occur or relapse after events of this kind. Mention psychosis and explain that it is important to assess for other conditions as well during and after adverse events.

Presentation	Facilitator notes
	**Activity 2.14a: Case-study- assessment of PTSD** **Duration:** 7 minutes **Purpose:** Practise with assessment of PTSD **Instructions:** • Ask the group to turn to page 28 of the mhGAP-HIG (assessment questions 1–3) and decide whether person A is likely to have PTSD (2 minutes). • Get some answers from the group before revealing the answer on the slide. • Point out that the ACU module should be used to assess for acute stress.
	• Ask the group to recall the assessment questions for acute stress. • Get some answers from the group with regards to the symptoms and criteria of acute stress (on page 14). • For assessment question 1, ask the group what "recent" means, then show the answer on the slide (i.e. one month). • Go back to the case description of Person A (previous slide) and ask what additional information is needed to assess for ACU. • Get some answers from the group before showing the answer on the slide.
	**Activity 2.14b: Case-study - assessment of PTSD** **Duration:** 5 minutes **Purpose:** Practise with assessment of PTSD **Instructions:** • Ask the group whether person B is likely to have PTSD • Get some answers from the group for person B before going on to the next slide, which recaps significant symptoms of grief.

Presentation	Facilitator notes
	• Ask the group to recall the assessment questions for GRI. • Get some answers from the group with regards to the symptoms and criteria of grief (page 18 of the mhGAP-HIG).
	**Activity 2.14c: Case-study - assessment of PTSD** **Duration:** 7 minutes **Purpose:** Practise with assessment of PTSD **Instructions:** • Ask the group whether person C is likely to have PTSD • Get some answers from the group for person C before revealing the answer on the slide. • Discuss how it is likely that the person could be suffering from PTSD and explain that you will need to ask more questions to determine whether this is the case, as it is unclear whether the person meets the criteria described in the bottom two bullet points. Ask the group what questions these might be.
	• Run again quickly through the three assessment questions for PTSD. • Emphasize that a considerable impairment in daily functioning and certain symptoms must be present for PTSD to be considered. • Mention that it is important to assess for other concurrent conditions and that this will be covered in a later slide. • Tell the group that you will now look more closely at the assessment questions.

Presentation	Facilitator notes
	• Ask the group to give examples of what is important to do and what not to do when asking about a potentially traumatic event. • Ensure that all the points on the slide are discussed, and additionally explain that: » Some people may avoid talking about traumatic events because this may trigger re-experiencing symptoms, or they simply do not wish to talk. » Explain that it is important to tell the person that you don't need to know exactly what happened and that they should only share what they think is important for the health-care provider to know in order to help them. Focus on how the event has affected the person and his/her life so you can provide support. » It is important to discuss the experience at a pace with which the person feels comfortable, and only if the person feels safe to do so.
	• Ask the group, in pairs, to try different ways of asking about potentially traumatic events, and let some participants share how they felt with certain questions. • Make a list of questions that are acceptable for the group to use in the current context.
	• The second assessment question for PTSD is about the presence of different types of symptom. • One type is re-experiencing symptoms. • Ask the group for examples of flashbacks and intrusive memories. **Flashbacks:** An episode where the person believes and acts for a moment as though they are back at the time of the event, living through it again. People experiencing flashbacks briefly lose touch with reality, usually for a few seconds or minutes.

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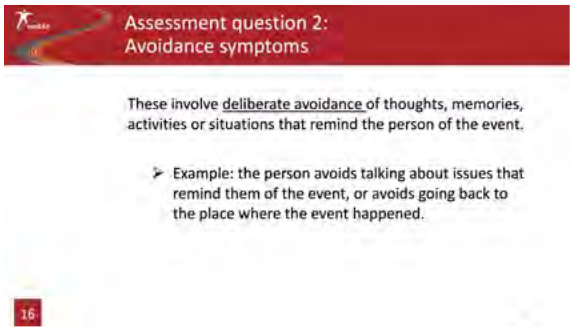
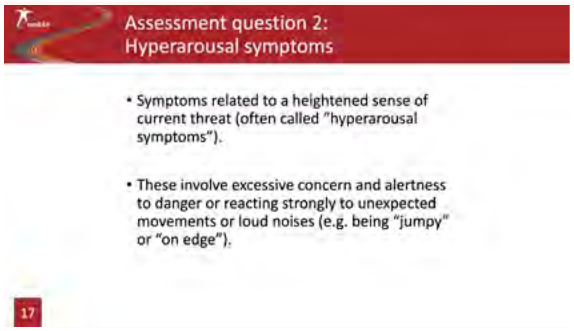
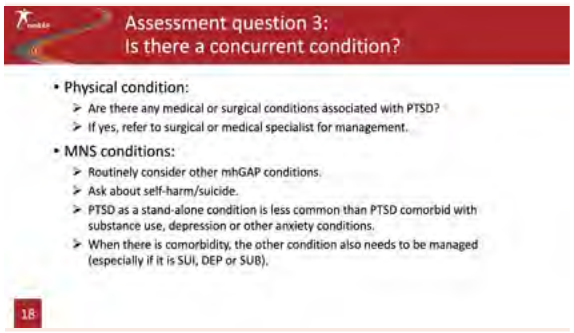
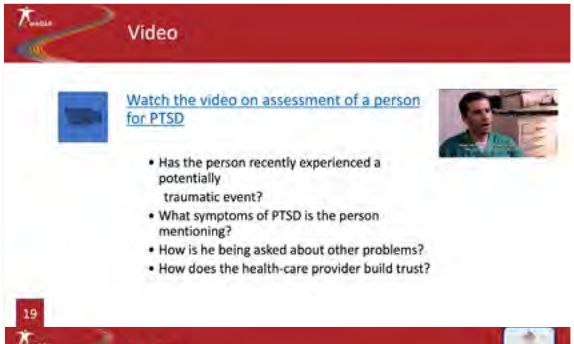
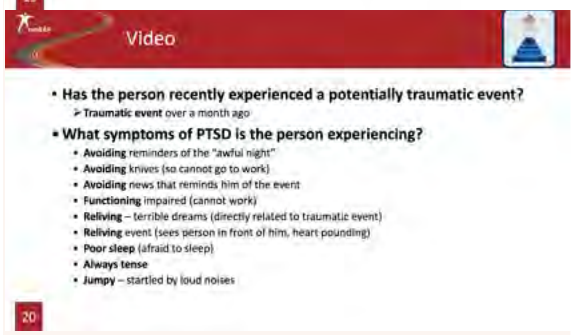
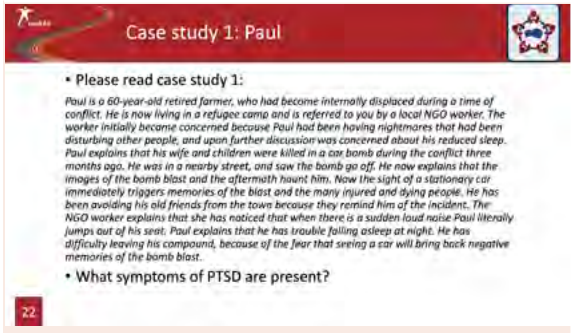
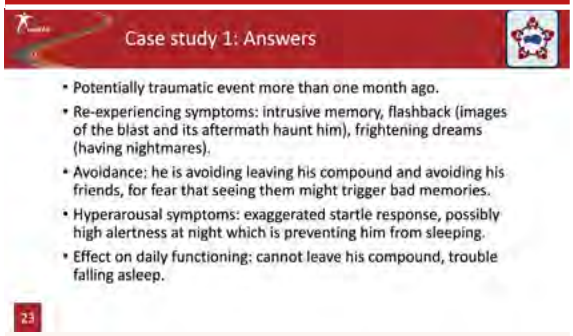
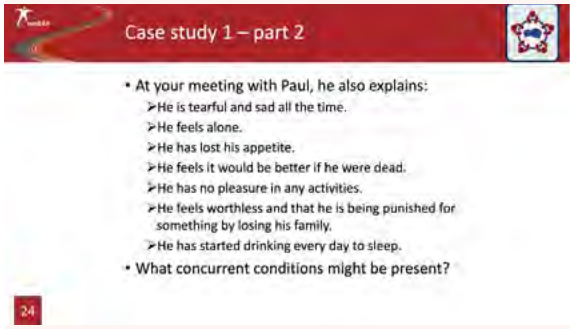
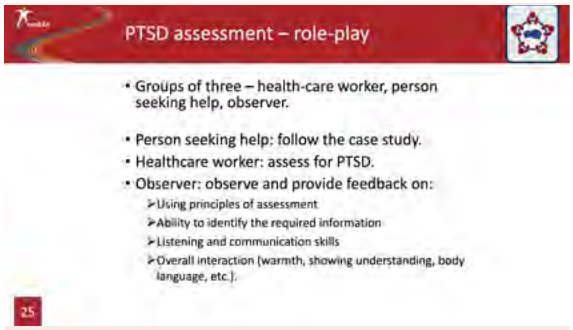
Session 2.4.1: Continued

Presentation	Facilitator notes
	Intrusive memories: Recurrent, unwanted, distressing memories of a traumatic event. • Emphasize that a considerable impairment in daily functioning must be present for PTSD to be considered.
	• Ask for questions and for examples of avoidance symptoms.
	• Ask for questions and for examples of hyperarousal symptoms.
	• Routinely consider a range of mhGAP disorders beyond PTSD in people exposed to extreme stress. • Assess for a concurrent physical condition and other mhGAP conditions that may explain symptoms.

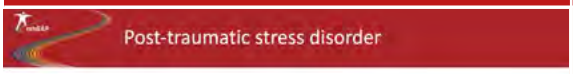
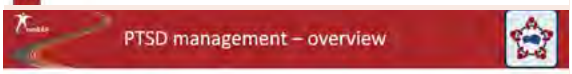
Presentation	Facilitator notes
	**Activity 2.15: Video – assessment of PTSD** **Duration:** 11 minutes **Purpose:** To demonstrate the assessment of post- traumatic stress disorder. **Instructions:** • Explain that the earlier part of the video dealt with acute stress and that the person is returning to the clinic for a follow-up. • Explain that the person was stabbed in an attack, so we know they experienced a traumatic event (If there is time, you may show this first part of the video, but prioritise the needs of the group and what is covered in the mhGAP-HIG). • Show the video (4:35-10:43) • Ask the group to: » Write down the symptoms of PTSD that the person is experiencing; » Identify what kind of questions the health-care provider is asking about other problems; » Observe how trust is being built between them. • After the video, invite some answers from the group before revealing the answers on the next two slides. • People may raise questions about the style of asking questions. If this happens, explain that the way the actor asks the questions is a bit abrupt, and ask how this could be improved, if at all (e.g. different sitting position, slightly softer tone).
	
	
	• Ask the group to read the case study on the slide and write down which symptoms of PTSD are present. • After 5 minutes, ask which symptoms of PTSD can be seen in the case. • Take answers from the group for 3 minutes, and then discuss the answers on the following slides.

Presentation	Facilitator notes
 	• Discuss the answers on the first slide. • For the second slide, discuss the new information about Paul and what potential concurrent conditions might be present. • Answers: » Grief/acute stress » Depression » Self-harm/Suicide » Psychosis may be mentioned on the grounds that he believes he is being punished. Explain that this is a common belief, but it might be worthwhile exploring this further to see if there is anything unusual about it. Explain that this belief about punishment should be assessed to see if it is a delusion (a fixed false belief or suspicion that is firmly held even when there is evidence to the contrary) by asking what the person means, and careful listening. » Substance use.
	**Activity 2.16: Role-play – assessment of PTSD** **Duration:** 20 minutes **Purpose:** To practise the assessment of PTSD. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer. • Hand out one of the case studies (see "Activity 2.16: Role-play – assessment of PTSD" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for 15 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 2.4.2: Management of post-traumatic stress disorder (65 minutes)

Preparation for facilitator:

- Unfortunately, there is no time to discuss in detail what is involved in cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR).[1] Dedicated training and supervision are needed to learn these interventions.
- It is assumed that the workshop participants have previously learned how to prescribe antidepressants (through training on the mhGAP-HIG Depression module). If not, spend more time on explaining how to prescribe antidepressants by using the depression session materials.
- The video for **Activity 2.18** (duration 1:15 minutes) is the same as for activity 2.15 and is available at https://www.youtube.com/watch?app=desktop&t=447&v=k0JXpg_pS98&feature=youtu.be (duration 1:15 minutes).
- The video for **Activity 2.19** is the same as for activity 2.15 and 2.18 and is available at https://www.youtube.com/watch?app=desktop&t=447&v=k0JXpg_pS98&feature=youtu.be (duration 3:35 minutes).
- Have enough copies of case study 1 or 2 "Role-play – management of PTSD " for **Activity 2.20** (see Annex B; the case studies are the same as for activity 2.16).

Presentation	Facilitator notes
 A. Introduction and assessment of PTSD B. Management of PTSD	• Give an overview of the management of PTSD. • Remind the group that it is important to manage concurrent conditions, especially depression or substance abuse.
26  1. *Educate on PTSD.* 2. *Offer psychosocial support* as described in the principles of reducing stress and strengthening social support (GPC), including stress management. 3. If trained and supervised therapists are available, *consider referring* for cognitive behavioural therapy with a trauma focus, or EMDR. 4. *Antidepressants* should not be considered as first-line treatments. Only consider in adults when CBT, EMDR or stress management do not work or are unavailable. 5. Follow-up. **Manage concurrent condition!** 27	**Activity 2.17: Role-play: educate on PTSD** **Duration:** 10 minutes **Instructions:** • Explain that the first part of managing PTSD is to educate people on the condition. • Give the group instructions to read "Educate on PTSD" on page 29 of the mhGAP-HIG (2 minutes). • Let them pair up and discuss what they have just read.

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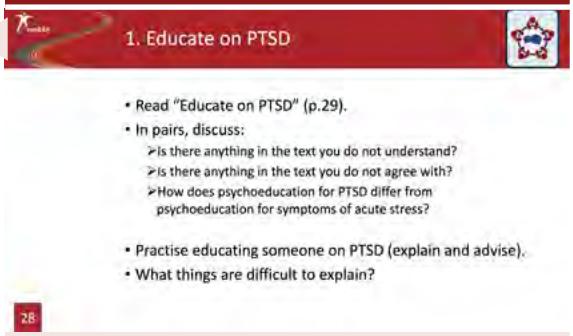
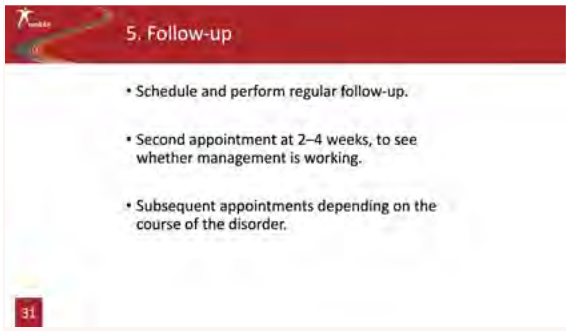
[1] Eye movement desensitization and reprocessing (EMDR) therapy is based on the idea that negative thoughts, feelings and behaviours are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements. Like CBT, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure or (d) homework.

Session 2.4.2: Continued

Presentation	Facilitator notes
	• Then give them 5 minutes to educate each other on PTSD as if one were a person with PTSD and the other a health-care provider. • Ask some of the pairs to share their discussions and experience in plenum. • Have a brief discussion about any difficulties raised by participants. Ask specifically about things that were hard to explain. • Discuss ways to explain these psychoeducational messages in the local context.
	• Discuss the forms of support that someone with PTSD might require. • Explain that current stressors can also include daily stressors that are more continuous, such as financial problems. • With regards to addressing psychosocial stressors discuss: » Where to refer a victim of severe human rights violations (e.g. torture, ethnic cleansing, sexual violence); » What support a victim of severe human rights violations might require; » What organizations or support are available in the local area. • Ask how to: » Strengthen social support; » Teach stress management: discuss e.g. identifying ways to relax and stress management techniques (such as breathing exercises), and ask for local techniques for stress management; • Emphasize the importance of practising stress management and strengthening social support activities on a regular basis.

Presentation	Facilitator notes
	• Explain that, if the resources are available, it is important to refer someone with PTSD to a professional therapist for CBT or EMDR and that these are two psychotherapeutic techniques that have the best evidence of effectiveness with PTSD. • Ask the group if they know of CBT or EMDR therapists available in the area they are working in. Write their suggestions in a list. • Explain that research indicates that antidepressants tend to be only mildly effective for PTSD (they tend to work on average a bit better than a placebo). • Emphasize that antidepressants are a last option if stress management or psychological interventions do not work or are not available, and that these should not be used to manage PTSD in children and adolescents.
	• Follow-up may be done in different ways (e.g. in person at the clinic, by phone or through a community health worker). • Have a brief discussion about what kind of follow-up is most feasible in the local health system. • The timings mentioned on the slide are for routine follow-up. Anyone who feels that their symptoms are getting worse should be encouraged to return whenever they wish.
	**Activity 2.18: Video – management of PTSD** **Duration:** 7 minutes **Purpose:** To demonstrate the management of PTSD. 10.43 **Instructions:** • Explain that the video shows part of the management of PTSD. Show the video (from 10:39 to 11:54) • Ask the group to make notes on what aspects of management the health-care provider is covering. • After showing the video, invite some answers from the group before revealing the answers on the slide.

Session 2.4.2: Continued

Presentation	Facilitator notes
	***Activity 2.19: Video and practice – breathing exercise*** **Duration:** 10 minutes **Purpose:** To demonstrate the management of PTSD. **Instructions:** • Show the video (from 11:55 to 15:30). • Explain that this is an example of the exercise under GPC. • After showing the video, let participants practise the breathing exercise in pairs. • After 7 minutes (after all participants have practised giving the instructions), ask for feedback on what they found difficult during the exercise.
	***Activity 2.20: Role-play – management of PTSD*** **Duration:** 20 minutes **Purpose:** To practise providing education for PTSD. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 2.20: Role-play - management of PTSD" in Annex B) and show the slide with instructions during the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Session 2.5: Other significant mental health complaints

Overview

By the end of this session, participants should:

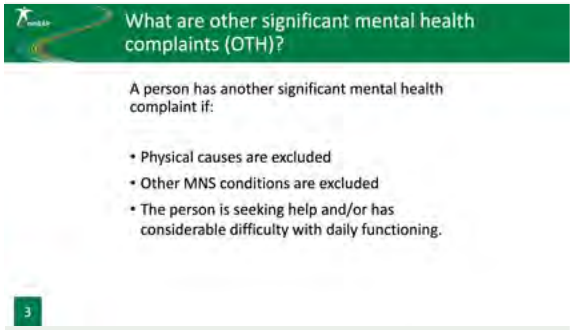
- Know the common presentations of other significant mental health complaints;
- Know the assessment questions for other significant mental health complaints;
- Be able to perform an assessment for other significant mental health complaints;
- Be able to provide psychosocial interventions to persons with other significant mental health complaints;
- Be able to plan and perform follow-up for other significant mental health complaints;
- Be able to refer people with other significant mental health complaints to specialists and link with outside agencies.

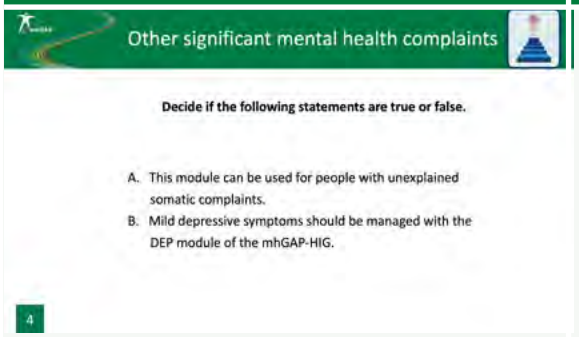
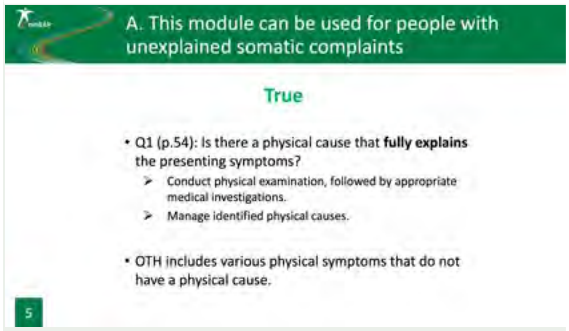
SESSIONS	OBJECTIVES	DURATION (+/-)	TRAINING ACTIVITIES
2.5.1. Introduction and assessment of other significant mental health complaints	Introduce the condition other significant mental health complaints Know how to assess for other significant mental health complaints	80 min	**Activity 2.21: Introducing OTH** **Activity 2.22: Video – assessment of OTH** **Activity 2.23: Role-play – assessment of OTH**
2.5.2. Management of other significant mental health complaints	Learn how to manage other significant mental health complaints	50 min	**Activity 2.24: Role-play - acknowledging symptoms** **Activity 2.25: Video – management of OTH** **Activity 2.26: Role-play – management of OTH**
Total time		130 min (approx. 2 hrs)	

Session 2.5.1: Introduction and assessment of other significant mental health complaints (80 minutes)

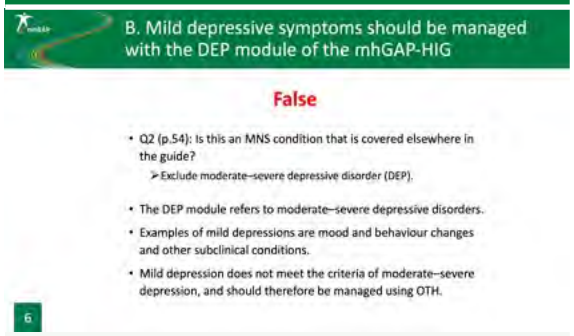
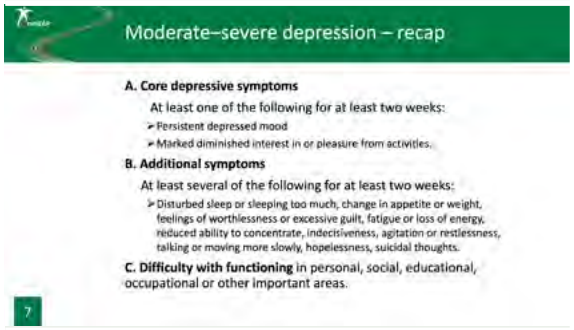
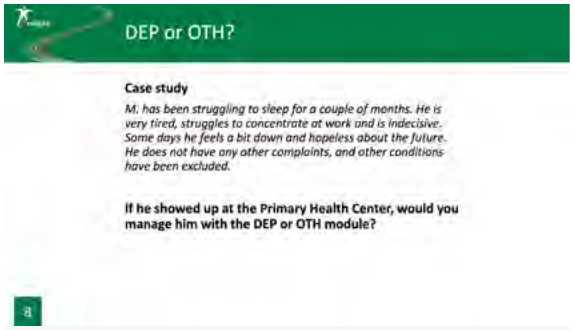
Preparation for facilitator:

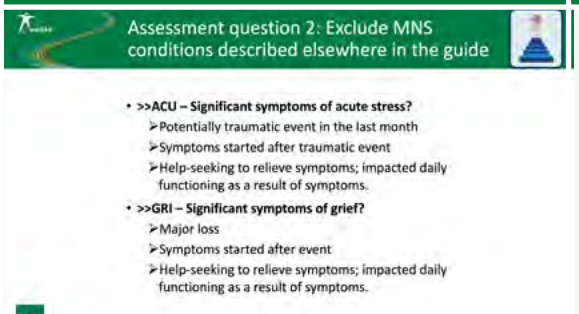
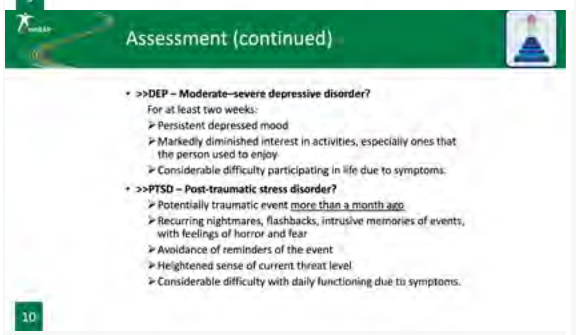
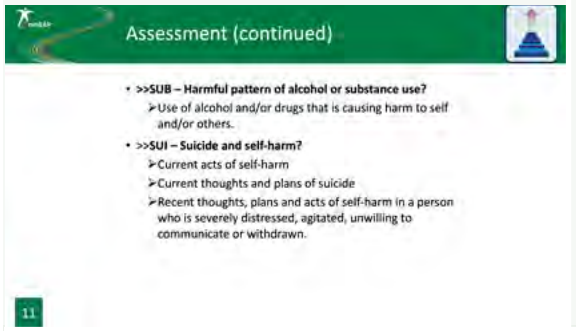
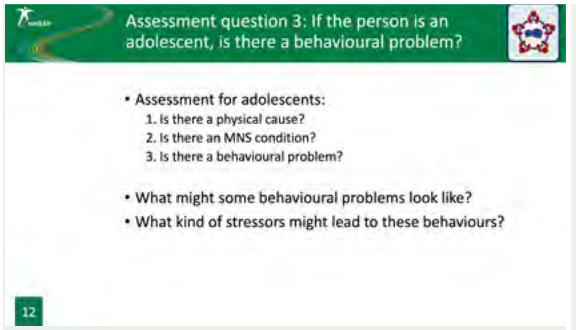
- The video for **Activity 2.22** is available at https://www.youtube.com/watch?v=rb3E4Ky_HmU (4:16 minutes). Download it in advance.
- Have enough copies of the case study "Role-play – assessment of OTH" for **Activity 2.23** (see Annex B).

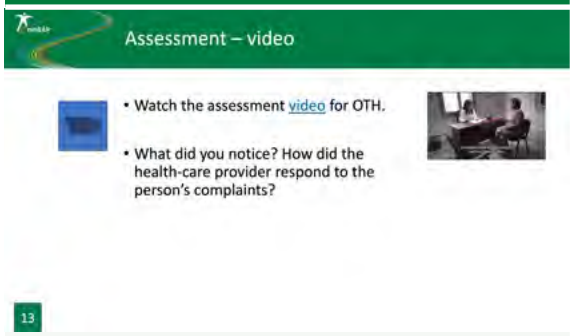
Presentation	Facilitator notes
	• Introduce the last module of the mhGAP-HIG. • Explain that this module aims to provide basic guidance on initial support for adults, adolescents and children who are suffering from mental health complaints that are not covered elsewhere in the mhGAP-HIG.
	• Emphasize that OTH covers a variety of physical and mental symptoms. • Explain that for this module a main task during assessment is to distinguish between mental disorders, physical conditions and other significant mental health complaints. Note that it usually takes more than one meeting to exclude physical causes and MNS conditions. • Ask the group when complaints are significant. • Invite some answers from the group before showing the rest of the slide. • A person has another significant mental health complaint if: » Physical causes are excluded; » Other MNS conditions are excluded; » The person is seeking help and/or has considerable difficulty with daily functioning.

Presentation	Facilitator notes
	**Activity 2.21: Introducing OTH** **Duration:** 15 minutes **Purpose:** To introduce the OTH module. **Instructions:** • Introduce this module by asking the group if they ever see people who do not meet the criteria for any of the specific conditions covered in the mhGAP-HIG. Ask them to give some examples and ask how these persons are managed. • Explain that this last module is designed to deal with persons of this kind. • Ask the group to read pages 53–54 of the mhGAP-HIG and decide if the two statements are true or false (5 minutes for both). • Get some answers from the group for statement A before revealing the answer on the next slide.
	• Refer to assessment question 1 and the fact that OTH includes physical symptoms (such as headaches, backaches, stomach pains, etc.) that cannot be fully explained by a physical cause. • Emphasize that it is important for the physical examination to be followed by appropriate medical investigations, because conducting a physical examination alone cannot always provide all the answers for somatic complaints. Discuss how diagnostic tests are often limited during humanitarian emergencies (e.g. perhaps only blood/urine and electrocardiogram (ECG) tests are available).

Session 2.5.1: Continued

Presentation	Facilitator notes
	• Get some answers from the group for statement B before revealing the answer on the slide. • Explain that mild depression is not covered in the DEP module and that OTH should be used to manage these symptoms, because antidepressants are not recommended for mild depression. • Emphasize that OTH can be used to manage mood and behaviour changes that do not meet the diagnostic criteria for any specific condition (e.g. mild depressive disorder and subclinical conditions). • Ask the group for some presentations of symptoms that OTH could be used for.
	• Ask the group to recap the assessment questions for moderate–severe depression. • Get some answers from the group before showing the slide.
	• Ask the group to read the case study on the slide. • Give them a couple of minutes to think about the answer to the question on the slide. • Get some answers from the group and discuss why the person should be managed with OTH: » They don't meet the criteria for the DEP module: no core depressive symptoms (e.g. low mood, lack of interest).

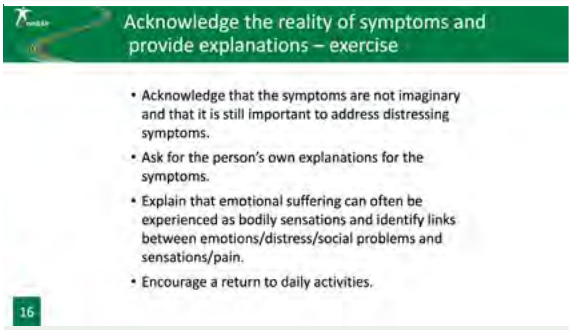
Presentation	Facilitator notes
  	• Explain that after conducting a physical examination (assessment question 1), other mhGAP MNS conditions need to be excluded (assessment question 2). • Ask the group to close their manuals and invite them to identify key symptoms of the mhGAP-HIG conditions covered before revealing the answers. After that, refer participants to page 54 of the mhGAP-HIG, which lists core features of the conditions that need to be ruled out. • Make it clear that if any other conditions are suspected, it is necessary to go to the relevant module and assess the person and provide management.
	• Explain that for adolescents there is an extra assessment question regarding behavioural problems to inform the management plan. • When the person is an adolescent you need to conduct assessment questions 1 and 2 before assessment question 3. • Have a brief discussion about what behavioural problems might present in adolescents. • Examples include: » Initiating violence » Drug use » Bullying or being cruel to peers » Vandalism » Risky sexual behaviour.

Presentation	Facilitator notes
	**Activity 2.22: Video – assessment of OTH** **Duration:** 10 minutes **Purpose:** To demonstrate the assessment of OTH. **Instructions:** • Show the video from the beginning to 4:16. • Have a brief discussion about the video, covering the following points (2 minutes): » The health-care provider did not judge the person. » She acknowledged the pain as being real, even with no physical explanation. » She asked questions relating to other mhGAP conditions.
	**Activity 2.23: Role-play – assessment of OTH** **Duration:** 20 minutes **Purpose:** To practise the assessment of OTH. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 2.23: Role-play – assessment of OTH" in Annex B) and show the slide with instructions during the role-play. • Remind the observer/carer that there are instructions for the carer in the role-play. • Let the role-play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

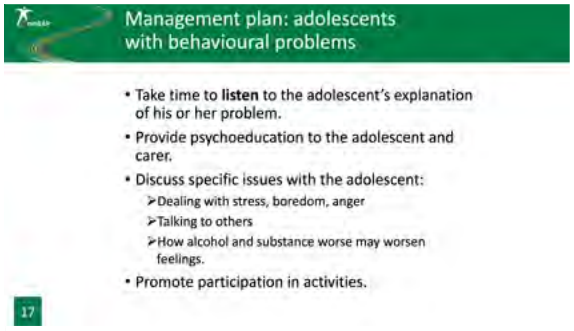
Session 2.5.2: Management of other significant mental health complaints (50 minutes)

Preparation for facilitator:

- The video for **Activity 2.25** is available at https://youtu.be/rb3E4Ky_HmU?t=382 (5:00 minutes). You have downloaded the whole video already for activity 2.22.
- Have enough copies of the case study "Role-play – management of OTH" for **Activity 2.26** (see Annex B).

Presentation	Facilitator notes
	• Explain that the management of other significant mental health complaints does not involve medicines but consists of offering basic psychosocial support (as described in the general principles of reducing stress and strengthening social support): • Addressing current psychosocial stressors » Problem-solving techniques » Strengthening social support » Teaching stress management. • Where necessary, review and practise GPC principles of reducing stress and strengthening social support.
	**Activity 2.24: Role-play - Acknowledging symptoms** **Duration:** 10 minutes **Purpose:** To practise acknowledging symptoms and providing an explanation. **Instructions:** • Instruct the group to read point 2 on page 55 of the manual. • Emphasize that it is important to validate what the person is feeling, and that asking for their explanation can help build trust and also give the health-care provider better insight into the actual cause, as well as boosting the likelihood of adherence to a treatment plan. • Activity: ask the participants to get into pairs (one help-seeker and one health-care provider) and practise

Continues on next page

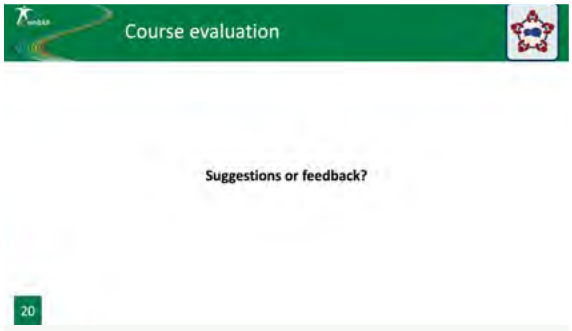
Presentation	Facilitator notes
	acknowledging the reality of symptoms and providing explanations to a person who has presented with headache, backache and stomach pain but for which no physical cause has been found (or let them make up their own case). • Ask them to switch roles after 3 minutes, and after 6 minutes have a brief discussion about this exercise.
	• Discuss the different suggestions on page 55 for the management of adolescents and discuss possible examples of local adaptation.
	**Activity 2.25: Video – management of OTH** **Duration:** 7 minutes **Purpose:** To demonstrate management of other significant mental health complaints. **Instructions:** • Show the video from 4:16 to the end. • After watching the video, have a brief discussion about it, covering the following points (2 minutes). • The health-care provider: » did not judge the pain » explained that the physical pain was real and was related to the help-seeker's emotional state (she gave a clear rationale, and did not dismiss the pain as unreal with no physical cause); » asked the person to explain the symptoms in her own words; » was clear about what works and does not work; » did not challenge the person or make her feel bad (about buying more vitamin injections); » asked for follow-ups.

Presentation	Facilitator notes
	**Activity 2.26: Role play – management of OTH** **Duration:** 20 minutes **Purpose:** To demonstrate the management of other significant mental health complaints. **Instructions:** • Divide the participants into groups of three. • Instruct one person to play the role of the health-care provider, one person to play the role of the person seeking help and one person to play the role of the observer/carer. • Hand out the case study (see "Activity 2.26: Role-play – management of OTH" in Annex B) and show the slide with instructions during the role-play. • Remind the observer/carer that there are instructions for them in the role-play. • Let the role play continue for max. 10 minutes. • Bring the group back together and ask a couple of participants how the exercise went; have a discussion of 5 minutes.

Evaluation of training (40 minutes)

Preparation for facilitator:

- Print enough copies of the post-test for all participants (ensure that the answers are not attached or on the reverse side of print-outs).
- The post-test can be found in Annex A. You might need to translate the post-test in multiple languages.

Presentation	Facilitator notes
	**Activity 2.27: Post-test** **Duration:** 25 minutes **Instructions:** • Hand out the post-test to participants and explain that they have 20 minutes to complete it. • Indicate when 10 minutes of time is left; indicate when 5 minutes are left.
	• Ask participants for feedback on the training. What did they find most useful, what could be changed, and how could it be improved or made more relevant?

3 | Annexes: Supporting materials

Annex A: Pre- and post-tests

Annex B: Observer checklist and case studies for role-plays

Annex C: Overview of mhGAP-HIG conditions (Training 1)

Annex D: List of relevant video links

Annex E: Adaptation template for the mhGAP-HIG

Annex F: Handout: Recommendations for care for child development

Annex G: FRAMES approach handout

Annex A: PRE- AND POST-TESTS

TRAINING 1 | Pre- and post-test for the mhGAP-HIG course

(Duration: 20 minutes)

A. Put ✓ in the correct column:	True	False
1. All people with depression should be treated with antidepressants.		
2. It is important to speak to the person alone.		
3. If someone presents with family members, it is important to involve the family.		
4. People with mental disorders cannot make decisions about their treatment/ health.		
5. Asking about suicide increases the likelihood of suicide.		
6. People should be given information about the potential benefits of treatment and potential side-effects.		
7. Medication is effective in stress management.		
8. People with mental disorders are at reduced risk of human rights abuses.		
9. After a potentially traumatic event, most people will have a mental disorder.		
10. Valproate is the recommended mood stabilizer in pregnant women'		

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

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

12. Concerning antidepressants, which of the following is correct?
    ____ a. Antidepressant medication should always be prescribed to depressed children younger than 12.
    ____ b. Antidepressant medication usually has to be continued for at least 9–12 months.
    ____ c. In people with bipolar disorder, antidepressants should be prescribed without a mood stabilizer.

13. For significant symptoms of grief, you should:
    ____ a. Prescribe medication to manage symptoms
    ____ b. Tell the person that they should not cry, as it is weak
    ____ c. Provide basic psychosocial support.

14. A 22-year-old male presents with possible symptoms of moderate–severe depressive disorder and hearing voices. You should:
    ____ a. Assess and manage symptoms of depression and then psychosis
    ____ b. Assess and manage all symptoms
    ____ c. Exclude physical causes first.

15. Concerning the management of psychosis, which of the following is correct?
    ____ a. Medicines by injection will be required for most cases.
    ____ b. The person needs to be followed up.
    ____ c. The person should always be physically restrained (e.g. chained).

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

(Duration: 15 minutes)

A. Put ✓ in the correct column:	True	False
1. PTSD is the only condition that occurs after exposure to potentially traumatic events.		
2. In adults with PTSD, stress management should be offered when cognitive behavioural therapy (CBT) or EMDR are not available.		
3. Intellectual disability exists from birth or start in childhood.		
4. Community-based protection and inclusion in community activities form part of the management plan for intellectual disability.		
5. Alcohol withdrawal can be life-threatening.		
6. Medication should be provided for someone with vague physical complaints that do not have a clear medical cause.		
7. Vitamin injections are recommended for vague physical complaints that do not have a clear medical cause.		

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

8. If someone has a harmful pattern of use of alcohol or drugs, you should:
   ____ a. Tell them that substance use is immoral and that they should stop immediately
   ____ b. Tell them only about the harm caused by their behaviour
   ____ c. Start a brief motivational conversation, which includes a discussion of the perceived benefits and harms.

9. Concerning the management of a child with developmental delay, which of the following is correct?
   ____ a. The child should never be allowed to attend a normal school.
   ____ b. Medication can reverse the condition.
   ____ c. Explain to the family that the child can learn new skills.

10. Concerning the management of a child with persistent aggressive and disobedient behaviour, which of the following is correct?
    ____ a. Provide advice to family and teacher.
    ____ b. Punishment for unwanted behaviours is the best method to improve behaviour.
    ____ c. Medication should be considered as soon as possible.

Pre- and post-test for the mhGAP-HIG training of trainers and supervisors workshop

(Duration: 10 minutes)

A. Put ✓ in the correct column:	True	False
1. Health-care providers learn best about mental disorders through lectures only.		
2. Role-plays are an ineffective method of teaching.		
3. The main skills for supervision include building trust, communication and listening.		
4. Providing training without follow-up by supervision is not very effective.		
5. Active participation in training increases learning.		
6. Supervision includes asking people how they are coping with their own stress.		
7. In using the mhGAP-HIG, practice and skills are the essential components.		

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

8. Which of the following teaching methodologies are effective for an mhGAP course?
   ____ a. Case studies
   ____ b. Small group discussions
   ____ c. Demonstrations
   ____ d. All of the above
   ____ e. None of the above

9. Concerning the management of a child with developmental delay, which of the following is correct?
   ____ a. The child should never be allowed to attend a normal school.
   ____ b. Medication can reverse the condition.
   ____ c. Explain to the family that the child can learn new skills.

10. Concerning the management of a child with persistent aggressive and disobedient behaviour, which of the following is correct?
    ____ a. Provide advice to family and teacher.
    ____ b. Punishment for unwanted behaviours is the best method to improve behaviour.
    ____ c. Medication should be considered as soon as possible.

C. Please circle the number that indicates how you feel about each statement below:

1: I don't agree at all 2: I don't agree 3: I slightly agree
4: I agree 5: I strongly agree

Annex A: Continued

Statement	Circle the number
11. I can assess a person with a mental health condition.	1 2 3 4 5
12. I can manage a person who is experiencing an episode of psychosis.	1 2 3 4 5
13. I can prescribe and monitor psychiatric medications in the mhGAP-HIG.	1 2 3 4 5
14. I can follow up persons with mental disorders appropriately.	1 2 3 4 5
15. I can give advice to people with mental health complaints on their condition.	1 2 3 4 5
16. I can provide psychosocial support to a person with a mental health condition and their family.	1 2 3 4 5
17. I can decide when to refer to a specialist.	1 2 3 4 5
18. I can improve individual/family/community access to treatment for mental disorders.	1 2 3 4 5
19. I can teach health-care providers about the mhGAP-HIG course.	1 2 3 4 5
20. I can use role-plays when teaching about mental disorders.	1 2 3 4 5
21. I can supervise health-care providers in assessing and managing HIG conditions.	1 2 3 4 5

Pre- and post-test answer keys

Training 1: Pre- and post-test for the mhGAP-HIG course

1. False
2. True
3. True
4. False
5. False
6. True
7. False
8. False
9. False
10. False
11. a.
12. b.
13. c.
14. c.
15. b.
16. b.

Training 2: Pre- and post-test for the mhGAP-HIG course

1. False
2. True
3. True
4. True
5. True
6. False
7. False
8. c.
9. c.
10. a.

Part 3: Pre- and post-test for the mhGAP-HIG training of trainers and supervisors workshop

1. False
2. False
3. True
4. True
5. True
6. True
7. False
8. d.
9. d.
10. d.

Annex B: OBSERVER CHECKLIST AND CASE STUDIES FOR ROLE-PLAYS

OBSERVER CHECKLIST

When providing feedback to your colleague playing the role of the health-care provider:

- Bear in mind that the person who plays the role of the health-care provider may feel anxious or vulnerable about doing a role-play in front of peers, so do not criticize them but rather give feedback in a way that will help them to improve their skills.
- Start by identifying and praising what went well, followed by what could be improved or done differently.
- Use positive language, e.g. "One thing that went well was… One thing that could be improved was…"

During the role-play, assess the health-care provider on the following:

- Are they following all the assessment/management steps of the mhGAP-HIG?
- Are they following the principles of good communication by:
  - » creating an environment that facilitates good communication
  - » involving the person with an MNS condition as much as possible
  - » demonstrating good listening skills
  - » being clear and concise
  - » responding with sensitivity to what people share
  - » not judging people on their behaviours
  - » appropriate use of interpreters, if needed.

CASE STUDIES – TRAINING 1

CASE STUDIES FOR SESSION 2: ASSESSMENT OF mhGAP-HIG CONDITIONS

Activity 1.9: Role-play- general principles of assessment
Activity 1.11: Role-play– assessing for significant symptoms of acute stress
Instructions for the person seeking help:

Case study 1:

- » You experienced an earthquake/flood/hurricane three weeks ago that destroyed your house and most houses in your neighbourhood. Fortunately, nobody died.
- » You are afraid of it happening again, and feel anxious a lot of the time.
- » You have lost your appetite, and have sleep problems now.
- » You have headaches and stomach pains sometimes.
- » You feel on edge a lot of the time.
- » You sometimes feel that you have to breathe really fast as you cannot get enough air, and you would like help for that.
- » All these symptoms started after the earthquake and have not improved during the past three weeks.

Case study 2:

- Rebels attacked your village and burned down houses three weeks ago. A lot of houses are totally destroyed and some community members died.
- Nobody in your family died but you were very scared that the rebels might come again, and so you and your family escaped to a refugee camp in a neighbouring country.
- Since you arrived in the refugee camp you have had a lot of physical complaints like headaches, stomach pains and dizziness.
- You easily get into fights with other people in the camp and do not feel like your normal self anymore.
- Sometimes you feel a shortness of breath and start to breathe really fast.
- You have trouble sleeping and the slightest noise at night will make you jump up.

Activity 1.13: Role-play – assessing for significant symptoms of grief
Instructions for the person seeking help:

Case study 1:

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

Case study 2:

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

Activity 1.16: Role-play – assessing for moderate–severe depression
Instructions for the person seeking help:

- You are 35 years old and married.
- You and your family had to flee your home city due to violence four years ago and now live in a city in a neighbouring country.
- You feel sad all day and you do not know why.
- You do not enjoy most of the things you used to do.
- You are cancelling appointments with friends because you do not feel like seeing anyone.
- You're exhausted all the time and cannot seem to concentrate at work, but you cannot sleep!

- You are never hungry and you think you've lost weight.
- You are not suicidal and never have been.

Activity 1.17: Role-play – assessing for imminent risk of suicide
Instructions for the person seeking help:

- You should act very sad and quiet. Do not look the health-care provider in the eye.
- You might have depression, but you have no other MNS condition.
- You do not have chronic pain.
- You have been feeling worse and worse since your baby was born three months ago.
- The baby cries all the time and you cannot sleep at all. You do not know what to do.
- You have been feeling down and irritable. You have no desire to hold your baby. All you want to do is stay in bed and sleep.
- You say you are "tired all the time". You have no appetite and little interest in your normal activities.
- You have been thinking about killing yourself for the last two weeks.
- You feel it is the only way you can cope with all this pressure.
- You have access to a rope and pesticides.
- For the past week you have been thinking about hanging yourself or drinking the pesticide supplies in the house.
- You are still feeling like you want to die.

Activity 1.18: Case study – symptoms of psychosis
You are working in a PHC centre and have the following consultation:

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

Activity 1.20: Role-play – assessing for psychosis
Instructions for the person seeking help:

- You are a 20-year-old young man, and have been living in a refugee settlement since you had to flee your village one year ago due to violence.

» You live with your parents and your brothers and sisters.
» You used to be active when you were younger, but over the past few years you have become withdrawn, and you have isolated yourself.
» A couple of years ago, while still living in your village, you stopped playing sports and did not visit friends very often.
» You used to go the church/mosque/temple once a week but have now stopped doing this because you think that God is talking to you directly. You do not attend the church/mosque/temple in the camp either.
» Only your mother (and no-one else) is allowed to prepare your food, because you think it might be poisoned.
» You do not take good care of yourself and you prefer to stay in your family's shelter.
» During the interview you are laughing to yourself for no clear reason.

Instructions for the carer:

» You are the mother/father of the help-seeker.
» You are very worried about your son because he is not taking good care of himself and has lost a lot of weight.
» He refuses to eat food that is made by his older sister, who often helps you to make food.
» You are wondering if you have done something bad and are being punished by God. You want to know how you can help him to be healthy again.

Activity 1.23: Role-play – assessing for epilepsy
Instructions for the person seeking help:

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

Instructions for the observer/carer:

» You accompany your son/daughter to the clinic because you are very worried.
» A week ago you heard a noise in your shelter and found that he/she had fallen on the floor and was shaking a lot for about 2 minutes.
» You tried to talk to them as soon as the shaking stopped but that was not possible for 5 minutes, although he/she was breathing.
» You were really scared and did not know what to do.

Annex B: Continued

CASE STUDIES FOR SESSION 3: MANAGEMENT OF mhGAP-HIG CONDITIONS

Activity 1.28: Role play – management of significant symptoms of acute stress
Instructions for the person seeking help:

Case study 1:

- You experienced an earthquake/flood/hurricane three weeks ago which destroyed your house and most houses in your neighbourhood. Fortunately, nobody died.
- You are afraid of this happening again, and feel anxious a lot of the time.
- You have lost your appetite, and have problems sleeping now.
- You sometimes have headaches and stomach pains.
- You feel on edge a lot of the time.
- You sometimes feel like you have to breathe really fast as you cannot get enough air, and you would like help for that.
- All these symptoms started after the earthquake and have not improved over the past three weeks.
- Share with the health-care provider that you often wake up in the middle of the night with nightmares, and then get up and make some coffee for yourself.
- Also mention that sometimes you drink alcohol to help you sleep better.

Case study 2:

- Rebels attacked your village and burned houses three weeks ago. A lot of houses were totally destroyed and some community members died.
- Nobody in your family died, but you are very scared that the rebels might come again, and you and your family have escaped to a refugee camp in a neighbouring country.
- Since you arrived in the refugee camp you have had a lot of physical complaints such as headaches, stomach pains and dizziness.
- You easily get into fights with other people in the camp and do not feel like your normal self anymore.
- Sometimes you feel a shortness of breath and start to breathe really fast.
- You have trouble sleeping, and the slightest noise will make you jump up at night.
- Share with the health-care provider that you often wake up in the middle of the night with nightmares, and then get up and make some coffee for yourself.
- Also mention that sometimes you drink alcohol to help you sleep better.

Activity 1.30: Role-play – management of significant symptoms of grief
Instructions for the person seeking help:

Case study 1:

- You live in a refugee camp with your family, after you had to flee your village two years ago. Your mother passed away three months ago due to heart problems, and yet it feels as though it happened just yesterday.
- You have lost your appetite, are low in energy and have serious sleep problems.
- You feel on edge a lot of the time and argue a lot with other people in the camp.
- You find it hard to talk about her death.
- You smoke a lot at night to calm yourself down.

- You feel very weak and share with the health-care provider that you think you are crazy because you feel so sad.
- You were not able to attend your mother's funeral (because you were in another province and did not make it back in time) and that gives you a lot of pain, because you feel as if you did not have a chance to say goodbye.
- You do not know how to make the pain and sadness disappear.

Case study 2:

- Your community was hit by an earthquake/flood/hurricane four months ago, which destroyed many of the houses in your area. You were in another province when it happened and only found out a day later how hard your community had been hit.
- When you arrived home, you found that your brother was out with friends when the disaster happened, and he has died.
- You are living with your family in a local shelter.
- You go to your normal day job in an area that was not affected, but you struggle to concentrate on your work. You feel sad and sleep very badly.
- Your friends ask you to do fun things with them sometimes, but you spend most of your time thinking about your brother.
- You smoke a lot at night to calm yourself down.
- You feel very weak and share with the health-care provider that you think you are crazy because you feel so sad.
- You were not able to attend your brother's funeral (because you were in another province and did not make it back in time), and that gives you a lot of pain because you feel as if you did not have a chance to say goodbye.
- You do not know how to make the pain and sadness disappear.

Activity 1.32: Role-play – management of depression: psychoeducation
Instructions for the person seeking help:

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

Annex B: Continued

Activity 1.33: Role-play – management of depression: pharmacological
Instructions for the person seeking help:

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

Activity 1.37: Role-play – management of psychosis
Instructions for the person seeking help:

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

Instructions for the carer/observer:

- » You think your son is taking better care of himself after starting the medication and it is easier to communicate with him.
- » He has gained some weight.

Activity 1.40: Role-play - management of epilepsy
Instructions for the person seeking help:

- » You have been assessed as having epilepsy.
- » You are willing to try medication, but have not tried any before.
- » You work in a rice field every day. The field is covered in water up to your knees.
- » You also cook dinner for the family every night using an open fire.
- » (Alternatively, you can work in a factory with machinery or ride a motorbike to work.)

Instructions for the carer/observer:

- » You are concerned about your adult child and want to know what you can do to help.
- » You are anxious that you have done something that has caused this.

CASE STUDIES – TRAINING 2

CASE STUDY FOR SESSION 1 : INTRODUCTION

Activity 3: Case study – adolescents

- A 15-year-old girl who has previously made a suicide attempt has been brought to you by her parents.
- Her parents brought her to the clinic as they had been fighting, and the girl had threatened to drink a bottle of pesticide to end her life if they forbade her to see her boyfriend.
- The girl is quiet and looks anxious.
- The parents are really concerned about their daughter and wonder if they are doing something wrong, and what they can do to help her.
- Her mother mentions that she really struggles to sleep at night and has headaches because she "thinks and worries too much".

CASE STUDIES FOR SESSION 2: Intellectual Disability (ID)

Activity 2.6: Role-play – assessment of intellectual disability
Instructions for the person seeking help:

Case study 1:

- You are a mother concerned about your three-year-old son.
- You are very anxious because all the other children in your community are talking already.
- You have never heard your child say a word, although he does make grunting sounds.
- Your child plays games with the other children and can feed himself with a fork.
- You have noticed that he doesn't seem to react when you call him by name, but he responds to other loud sounds.
- He does not appear to have visual problems.
- He has no other significant medical history. He has never had a seizure.
- You are at home during the day looking after your other two children. You spend as much time as you can with your child.
- Your child is very well fed.
- You are not depressed.

Activity 2.9: Role-play – management of intellectual disability
This role-play continues on from the assessment role-play.
Additional notes for the mother:

- You are aware of your child's delay in development and you are anxious to know what can be done to solve the problem as quickly as possible.
- You are afraid that your child will not be accepted in pre-school.
- Your husband sometimes gets nervous and punishes the child for not listening to him.
- You are relieved that the health-care provider is offering help.

Annex B: Continued

CASE STUDIES FOR SESSION 3: Harmful pattern of use of alcohol and drugs (SUB)

Activity 2.11: Role-play – assessment of harmful pattern of use of alcohol and drugs, and
Activity 2.13: Role-play – management of harmful pattern of use of alcohol and drugs: brief intervention
Instructions for the person seeking help:

- You are dependent on alcohol.
- You need to have up to 10–12 drinks daily.
- If you stop drinking for six hours, you start shaking and craving alcohol.
- You are not working and you take your partner's (wife's/husband's) money to buy alcohol.
- You admit that you drink quite a bit of alcohol but you do not think that this is a problem.
- You have no other mhGAP-HIG condition.
- You used to drink after work, but you lost your job when the factory closed and now you are drinking all day.
- You are sober during the interview.

CASE STUDIES FOR SESSION 4: Post-traumatic Stress Disorders (PTSD)

Activity 2.16: Role-play – assessment of PTSD and
Activity 2.20: Role-play - management of PTSD

Case study 1

- You are seeking help for insomnia.
- You were involved in a potentially traumatic event two years ago – you were robbed at gunpoint while in a car (or injured in a bad car crash)
- You have horrible nightmares in which you relive the incident.
- You avoid riding in cars now and when you are in a car you are extremely stressed.
- Your avoidance of cars has caused problems with your work and with buying food for your family.
- You are not suicidal and do not have many symptoms of depression.

Case study 2

- You are a 32-year-old refugee that came to this country with your family last year.
- From a young age you have worked hard to save money to fulfil your dream of building a life for you and your family abroad.
- The trip to where you are now was difficult. You were on a boat with 30 others. You were tied and sometimes beaten. Food was not good, and some refugees even died on the boat.
- One day the boat sunk and you could escape but many others died.
- You keep thinking about your experiences on the boat. You often dream about is and awake up screaming. You often see the face of some of the traffickers.
- You are happy with your family and playing games with friends cheer you up. Your appetite is good.

» You struggle to concentrate at work and often make mistakes.
» You don't want to talk about what happened when people ask.
» You also don't want to talk to or see people that were on the same boat as it brings back memories.

CASE STUDIES FOR SESSION 5: Other Significant Mental Health Complaints (OTH)

Activity 2.23: Role-play – assessment of OTH, and
Activity 2.26: Role-play - management of OTH
Instructions for the person seeking help:

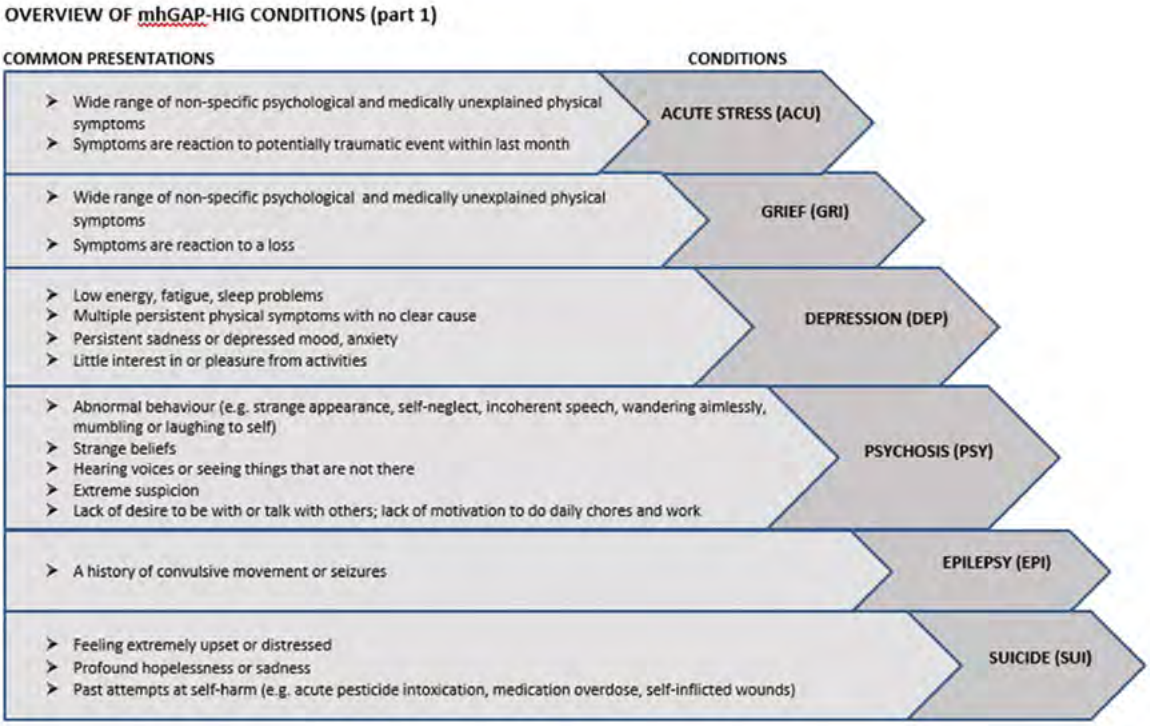
Case study 1:

» You do not have any significant medical history or any other priority condition.
» You have aches and pains in your lower back and shoulders, but with no apparent source.
» You have difficulty sleeping.
» You have not been feeling sad and have never had ideas of self-harm or suicide.
» The aches and pains make it difficult to concentrate, but you go to work every day.
» You feel lonely at times.
» You have been coming to the centre a lot recently with different symptoms.
» It all started two months ago when many humanitarian agencies stopped working in the area.
» You insist that you need medication.

Case study 2:

» You have aches and pains in your lower back and shoulders, with no apparent source.
» You experience pain that gets worse when you feel stressed or sad, especially when you have an argument or fight with a family member.
» Ask the health-care provider to do more tests.
» Tell the health-care provider that the pain is real and you are not making it up.
» Tell the health-care provider that you want medication to help you.
» Agree to try some of the stress management approaches they suggest.

Annex C: OVERVIEW OF MHGAP-HIG CONDITIONS (TRAINING 1)



Annex D: LIST OF RELEVANT VIDEO LINKS

A. Depression

Part 1: Assessment
https://www.youtube.com/watch?v=hgNAySuIsjY&index=1&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration 7:40 minutes)

Spanish: https://www.youtube.com/watch?v=MYi1b7VFcxU (duration 10:19 minutes)

French: https://www.youtube.com/watch?v=sX_WVqWkOr0&t=910s (duration 19:16 minutes)

Part 2: Management
https://www.youtube.com/watch?v=hdR8cyx2iYU&list=PLU4ieskOli8GicaEnDweSQ6-yaGx-hes5v&index=2 (duration 3:54 minutes)

Spanish: https://www.youtube.com/watch?v=4LkPsrJ9br0 (duration 3:59 minutes)

Part 3: Follow-up
https://www.youtube.com/watch?v=F3MKvTxQvF4&list=PLU4ieskOli8GicaEnDweSQ6-yaGx-hes5v&index=3 (duration 5:22 minutes)

Spanish: https://www.youtube.com/watch?v=2Q8NvPfFuQQ (duration 5:29 minutes)

B. Post-Traumatic Stress Disorder

https://www.youtube.com/watch?v=k0JXpg_pS98&feature=youtu.be&t=280 (duration 17:39 minutes)

Spanish: https://www.youtube.com/watch?v=rlVbnFyOfrk&list=PL6hS8Moik7kvuFw5r4fh-vDLClJG__X4us&index=16 (duration 17:38 minutes)

French: https://www.youtube.com/watch?v=XLpYRGUr_iY (duration 17:39 minutes)

C. Psychosis

Part 1: Assessment
https://www.youtube.com/watch?v=tPy5NBFmIJY&index=4&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration 6:59 minutes)

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

French: https://www.youtube.com/watch?v=Fqk9zXl3Y2A (duration 15:53 minutes)

Part 2: Management
https://www.youtube.com/watch?v=Ybn401R2gl4&list=PLU4ieskOli8GicaEnDweSQ6-yaGx-hes5v&index=5 (duration 6:05 minutes)

Spanish: https://www.youtube.com/watch?v=XoqtYmi-dk0 (duration 6:30 minutes)

Annex D: Continued

D. Epilepsy
Part 1: Assessment
https://www.youtube.com/watch?v=RUlRg555xl0&index=6&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration 5:00 minutes)

Spanish: https://www.youtube.com/watch?v=lSezrWNUoSs&list=PL6hS8Moik7kvuFw5r4fh-vDLClJG__X4us&index=8 (duration 21:08 minutes)

French: https://www.youtube.com/watch?v=YNw5HNl-NRc (duration 20:23 minutes)

Part 2: Management and follow-up
https://www.youtube.com/watch?v=-LTS-cMy56w&index=7&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration 6:23 minutes)

E. Intellectual Disability
http://youtu.be/zkPMGcFV2kc (duration 11:40 minutes)

Spanish: https://www.youtube.com/watch?v=aVIBP3oblKw&list=PL6hS8Moik7kvuFw5r4fh-vDLClJG__X4us&index=9 (duration 11:08 minutes)

French: https://www.youtube.com/watch?v=66ZMxalrE8o (duration 11:20 minutes)

F. Harmful Pattern of Use of Alcohol and Drugs
Part 1: Assessment
https://www.youtube.com/watch?v=XEHZijvafQQ&list=PLU4ieskOli8GicaEnDweSQ6- yaGx-hes5v&index=15 (duration 8:29 minutes)

Part 2: Motivational interviewing
https://www.youtube.com/watch?v=i1JtZaXmNks&index=14&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration 3.41 minutes)

G. Self-harm/Suicide
English: https://www.youtube.com/watch?v=4gKIeWfGIEI&index=16&list=PLU4ieskOli8Gi-caEnDweSQ6-yaGxhes5v (duration: 9:22 minutes)

Spanish: https://www.youtube.com/watch?v=de9jnZIyPTo (duration 10:46 minutes)
French: https://www.youtube.com/watch?v=DS5SWphWoXM (duration 11.14 minutes)

H. Other Significant Mental Health Complaints
https://www.youtube.com/watch?v=rb3E4Ky_HmU (duration 9:16 minutes)

Spanish: https://www.youtube.com/watch?v=HKwMjhvu76o (duration 9:30 minutes)

French: https://www.youtube.com/watch?v=2jgUVr1oIZQ (duration 9:16 minutes)

Annex E: ADAPTATION TEMPLATE FOR THE mhGAP-HIG

Adaptation template for the mhGAP-HIG Module name ————————————————		
Section (page numbers in modules mhGAP-HIG)	**Page**	**Adaptations**
Common presentations Is there robust evidence that the common presentation is different in your specific country? What local idioms for signs and symptoms of mental, neurological and substance use (MNS) disorders are used? *(ACU 13; GRI 17; DEP 21; PTSD 27; PSY 31; EPI 35; ID 41; SUB 45; SUI 49; OTH 53)*		
Physical illness Given what is known about the epidemiology in the country, should the examples of physical diseases for differential diagnosis, be revised? *(ACU-; GRI-; DEP 22 ; PSY 32; EPI 36; ID 42; SUB-; SUI-; OTH-)*		
Management "Consult with a specialist". What does "consult" mean for this condition (phone? refer?)? What specialist should be consulted for this condition (psychiatric nurse? psychiatrist?)?		
Psychosocial interventions Review the interventions listed in the module; are these interventions available now or are they expected to be available within the next few years? If yes, list available services by location (as an annex) and indicate how persons are referred to receive them. If no, consider the pros and cons of keeping or removing some or all of the current text. Consider adding basic principles of problem-solving counselling to training materials. *(ACU-; GRI-; DEP 23; PTSD 29; PSY 34; EPI-; ID-; SUB 47; SUI-; OTH)*		
Psychoeducation Review the key messages and adjust if necessary for the local context. *(ACU 15; GRI 19; DEP 23; PTSD 29; PSY 34; EPI 37; ID 43; SUB 47; SUI 51; OTH 55)*		

Annex E: Continued

Section (page numbers in modules mhGAP-HIG)	Page	Adaptations
Pharmacological interventions Review the listed medications. If other psychotropic medications are widely available/ accessible and affordable and are in line with national protocols/guidelines, these may be added for use in adults (but not in children or adolescents, for whom fluoxetine remains the only medication). *(ACU-; GRI-; DEP 24; PTSD -; PSY 34; EPI 38; ID-; SUB 48; SUI-; OTH-)*		
Follow-up Review the recommendations on frequency of contact and adapt if needed, based on the local context. If relevant, identify the venue for follow-up and health personnel involved in follow-up. *(ACU 16; GRI 20; DEP 25; PTSD 29; PSY 34; EPI 39; ID 43; SUB 47; SUI 51; OTH 55)*		
Other module-specific adaptations General principles of care (GPC) module (pp.5–11) Include relevant articles/clauses from national/ regional mental health legislation or regulations. Grief (GRI) module (p.18) The normal period of mourning and bereavement may be longer in certain cultures. Adjust the time criteria if needed. Intellectual disability (ID) module (p.44) Include local warning signs for developmental milestones. Self-harm/Suicide (SUI) module (p.49) Discuss legal issues and possible adjustments.		

Other comments:

Annex F: HANDOUT: RECOMMENDATIONS FOR CARE FOR CHILD DEVELOPMENT

Recommendations for
Care for Child Development

NEWBORN, BIRTH UP TO 1 WEEK	1 WEEK UP TO 6 MONTHS	6 MONTHS UP TO 9 MONTHS	9 MONTHS UP TO 12 MONTHS	12 MONTHS UP TO 2 YEARS	2 YEARS AND OLDER
Your baby learns from birth  **PLAY** Provide ways for your baby to see, hear, move arms and legs freely, and touch you. Gently soothe, stroke and hold your child. Skin to skin is good.  **COMMUNICATE** Look into baby's eyes and talk to your baby. When you are breastfeeding is a good time. Even a newborn baby sees your face and hears your voice.	 **PLAY** Provide ways for your child to see, hear, feel, move freely, and touch you. Slowly move colourful things for your child to see and reach for. *Sample toys: shaker rattle, big ring on a string.*  **COMMUNICATE** Smile and laugh with your child. Talk to your child. Get a conversation going by copying your child's sounds or gestures.	 **PLAY** Give your child clean, safe household things to handle, bang, and drop. *Sample toys: containers with lids, metal pot and spoon.*  **COMMUNICATE** Respond to your child's sounds and interests. Call the child's name, and see your child respond.	 **PLAY** Hide a child's favourite toy under a cloth or box. See if the child can find it. Play peek-a-boo.  **COMMUNICATE** Tell your child the names of things and people. Show your child how to say things with hands, like "bye bye". *Sample toy: doll with face.*	 **PLAY** Give your child things to stack up, and to put into containers and take out. *Sample toys: Nesting and stacking objects, container and clothes clips.*  **COMMUNICATE** Ask your child simple questions. Respond to your child's attempts to talk. Show and talk about nature, pictures and things.	 **PLAY** Help your child count, name and compare things. Make simple toys for your child. *Sample toys: Objects of different colours and shapes to sort, stick or chalk board, puzzle.*  **COMMUNICATE** Encourage your child to talk and answer your child's questions. Teach your child stories, songs and games. Talk about pictures or books. *Sample toy: book with pictures*

• Give your child affection and show your love • Be aware of your child's interests and respond to them • Praise your child for trying to learn new skills

Annex G: FRAMES APPROACH HANDOUT

FRAMES APPROACH: COMPONENTS OF BRIEF INTERVENTIONS THAT WORK FOR SUBSTANCE USE CONDITIONS

Research into effective brief interventions for alcohol and other substance use have found that they include a number of consistent features which appear to contribute to their effectiveness. These have been summarized using the acronym FRAMES – Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.

Feedback: The provision of personally relevant feedback is a key component of brief interventions and generally follows a thorough assessment of alcohol and drug use and related problems. Feedback can include information about the individual's alcohol and drug use and problems, information about personal risks associated with current substance use patterns and general information about substance-related risks and harms. If the person's presenting complaint could be related to substance use, it is important to inform them about the link as part of feedback. Feedback may also include a comparison between the person's substance use patterns and problems and the average patterns and problems experienced by other similar people in the population.

Responsibility: A key principle of intervention with substance users is to acknowledge that they are responsible for their own behaviour and that they can make choices about their substance use. The messages that "What you do with your substance use is up to you" and "Nobody can make you change or decide for you" enable the person to retain personal control over their behaviour and its consequences. This sense of control has been found to be an important element in motivation for change and to decrease resistance.
Advice: The central component of effective brief interventions is the provision of clear advice regarding the harms associated with continued use. Persons are often unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems will increase their awareness of their personal risk and provide reasons to consider changing their behaviour.

Menu of alternative change options: Effective brief interventions and self-help resources provide the person with a range of alternative strategies to cut down or stop their substance use. This allows them to choose the strategies that are most suitable for their situation and that they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making changes and can help to strengthen the person's motivation for change. Giving people the *"Substance user's guide to cutting down or stopping"*[6] is a good first step because this contains strategies for helping them to change their behaviour, and can be used alone or in conjunction with a number of other options. Examples of options for persons to choose could include:

[6] https://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf

- Keeping a diary of substance use (where, when, how much, who with, why)
- Helping persons to prepare substance use guidelines for themselves
- Identifying high-risk situations and strategies to avoid them
- Identifying other activities as alternatives to alcohol or drug use – hobbies, sports, clubs, gym, etc.
- Encouraging the person to identify people who could provide support and help for the changes they want to make
- Providing information about other self-help resources and written information
- Inviting the person to return for regular sessions to review their substance use and to work together through the *"Substance user's guide to cutting down or stopping"*
- Providing information about other groups or counsellors who specialize in drug and alcohol problems
- Putting aside the money they would normally spend on substances for something else.

Empathy: A consistent component of effective brief interventions is a warm, reflective, empathic and understanding approach by the person delivering the intervention. Use of a warm, empathic style is a significant factor in the person's response to the intervention and leads to reduced substance use at follow-up.

Self-efficacy (confidence): The final component of effective brief interventions is to encourage persons' confidence that they can make changes in their substance use behaviour. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour. It is particularly helpful to elicit self-efficacy statements from people, as they are likely to believe what they hear themselves say.

For more information, see:
Humeniuk R, Henry-Edwards S, Ali R, Poznyak V, Monteiro MG (eds). The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care. World Health Organization, 2010.

https://www.who.int/substance_abuse/publications/assist_sbi/en/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