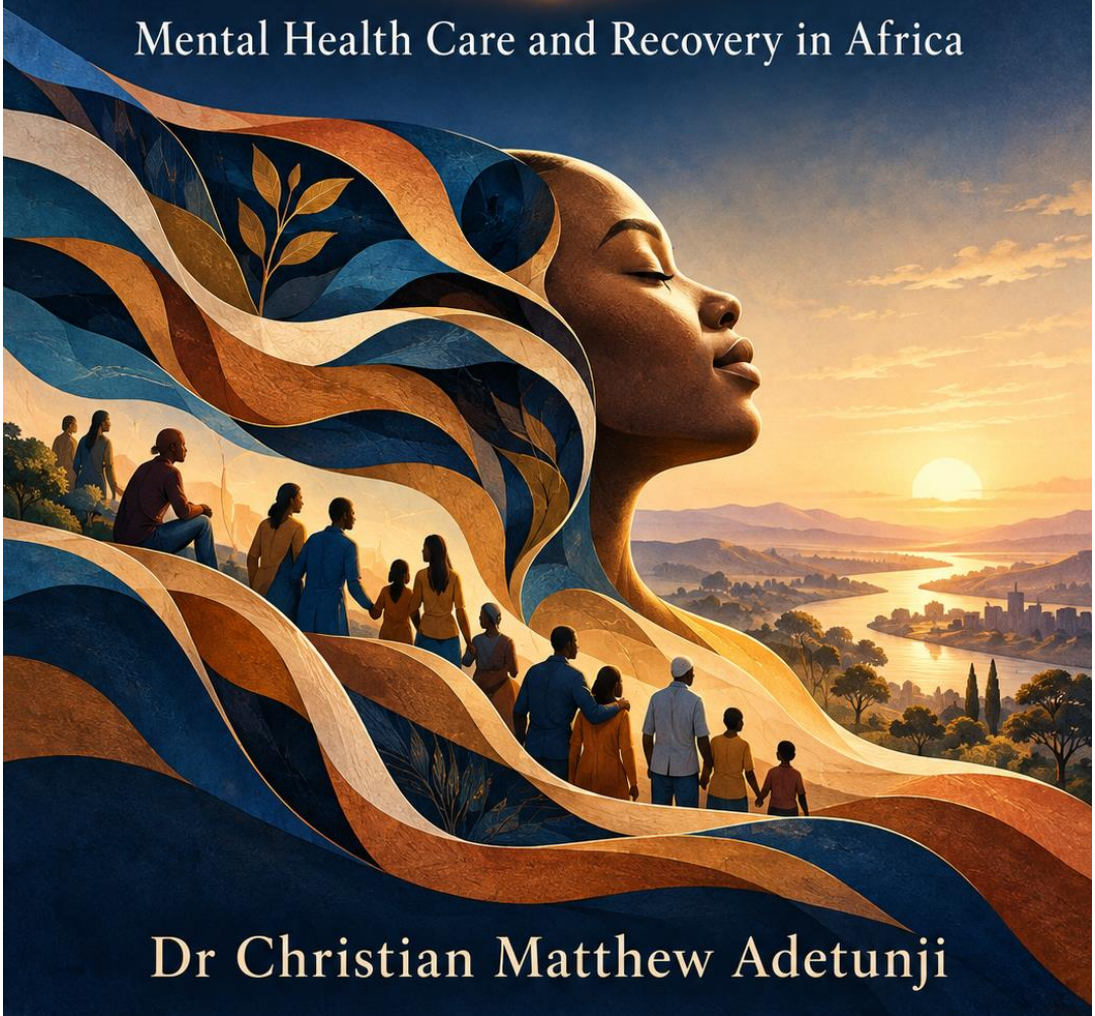
RESTORING MINDS
REBUILDING LIVES

Mental Health Care and Recovery in Africa



Dr Christian Matthew Adetunji

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Rebuilding Lives

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ISBN: **978-99977-0-830-4**
Publication date: 31/10/26

Published by

CMAT Family Training Centre Ltd

KN2, Avenue 23, Kigali, Rwanda

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Dedication

To people living with mental health difficulties, whose lives and aspirations are greater than any diagnosis.

To families, friends, and caregivers who continue to offer support, often while carrying burdens of their own.

And to practitioners and communities working to make compassionate, competent care available to everyone who needs it.

Preface

What is happening in the person's life while treatment continues? A crisis may have settled and prescriptions may be renewed on schedule. Yet the person may still struggle to work, think clearly, sustain relationships or talk about treatment effects. This book asks how services can respond to what the person is experiencing beyond the appointment.

I begin with respect for people seeking help and for the people who provide it. Practitioners and families often face demands that exceed the time, staff and resources available. Better coordination and investment can ease those pressures and give people room to raise concerns when care no longer meets their needs.

Reports of weight gain, sleepiness, restlessness, sexual difficulties or trouble concentrating deserve attention. If someone stops taking a medicine, listening may uncover side effects, costs, fears or practical difficulties that the treatment plan needs to address.

People deserve an honest account of what recovery can involve. Some difficulties resolve, others recur, and some require continuing support. New symptoms deserve attention even when a diagnosis is already on record.

The book draws on evidence from Africa and elsewhere. Differences in health systems, language, family life and resources shape what people can obtain and what services can offer. Those differences also show where more local research is needed.

The Context of This Book

This book examines how treatment can respond to the person's wider circumstances, including medication effects, disrupted routines, family conflict and unemployment.

A plan that works in one city may need substantial adaptation in a rural district, a displaced community or a setting with few specialists. Transport, affordability, language, professional training and spiritual beliefs can all affect which options are feasible.

The book is for people receiving care, families, counselling students, practitioners, faith leaders, service managers and policymakers. A relative may need help preparing questions for an appointment. A counsellor may need to recognise when medical referral is necessary. A manager may need to make follow-up accessible.

Ask about side effects to inform treatment review and about physical symptoms to guide assessment. Discuss daily routines with curiosity about what the person can change and what support would make change possible.

Recovery can involve symptom relief, improved daily functioning, personal meaning and participation in community life. The person's priorities help determine which changes to pursue and how to judge progress.

A Note to Readers

PP and QQ are teaching cases adapted from accounts supplied by the author. They illustrate questions for assessment and collaboration. Their clinical details have no independent verification. The other named cases are fictional. Exclude details that could identify individuals. A recognisable account requires appropriate permission before publication.

Professional settings use terms such as patient, client and service user. This book centres the person's dignity, preferences, rights and role in decisions.

Interpret research findings in light of the population, intervention and follow-up studied. International guidance can inform local judgement alongside national requirements and individual assessment.

Introduction

What is the person experiencing? Is anything urgent? What has helped, and what has become harder? The answers may draw on several professional perspectives and on the person's own account.

Coordinated care gives the person a meaningful role in decisions and connects the services they need. It may include medical assessment, medication, psychological treatment, rehabilitation, family education or practical support.

Medication, psychological treatment and combined care each have a place. For less severe depression, the National Institute for Health and Care Excellence (NICE, 2022) advises against routinely offering antidepressants as first-line treatment unless the person prefers them. For first-episode psychosis, NICE (2014) recommends offering an oral antipsychotic alongside individual cognitive behavioural therapy and family intervention.

A trigger may help explain why distress worsened at a particular time. A maintaining condition can keep the difficulty active after the original event has passed. Improvement after changing a routine can guide further care, while the cause of the illness and the need for follow-up may remain open questions.

References and links appear at the end of each chapter. The discussion identifies the setting and limits of the research when they affect how a finding can be used.

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National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Prevention and management (CG178)*. https://www.nice.org.uk/guidance/cg178

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Chapter 1

Seeing the Person Before the Diagnosis

What a person brings into the room

A person enters a consulting room carrying more than symptoms. There may be fear about what a diagnosis will mean, embarrassment about lost work, anger about an earlier encounter, or uncertainty about whether the family can afford another visit. There may also be determination, humour, faith, loyalty, and a clear idea of the life the person wants to recover. If the professional notices only the complaint written on the referral form, important parts of the encounter remain unseen. The first task is therefore to make room for a person rather than merely to receive a case.

Consider the difference between asking whether someone is taking tablets and asking what it has been like to live with the treatment. The first question has a necessary place. The second may reveal why the first question has become difficult. Someone may have returned to work but be falling asleep during the day. Another person may be avoiding friends because a change in body size has attracted humiliating comments. A third may be taking medicine consistently while feeling unable to discuss a sexual side effect. These concerns belong within care because they affect the life that treatment is intended to support.

A respectful welcome does not require the professional to agree with every explanation offered. It requires an atmosphere in which disagreement can be explored safely. The person should be able to say that medicine feels harmful without being dismissed as uncooperative. A relative should be able to express exhaustion without being condemned as uncaring. A psychiatrist should be able to explain uncertainty without appearing indifferent. These conversations become possible when people are not forced to defend their dignity before their concerns can be heard.

Starting with the person's account changes what counts as progress. A quieter household may be welcome, while the person may be hoping to finish a course, return to worship, resume parenting or speak to neighbours without fear. These goals can inform diagnosis, treatment and review.

Mental health is wider than a diagnostic category

Everyday discussion often uses mental health and mental illness as though they mean the same thing. For the purposes of this book, mental health includes the person's emotional, psychological, and social functioning, while a mental health condition refers to a difficulty that may require a more specific assessment and response. Ordinary sadness is not automatically depression. A period of worry is not automatically an anxiety disorder. Equally, being able to smile, hold a conversation, or

appear well dressed does not establish that someone has no serious difficulty. Assessment requires context, duration, impact, and careful inquiry.

The World Report by WHO calls for considering the environmental factors that affect mental health, the delivery system, and the societal perception of the importance of mental wellness. This approach is crucial because an individual's problems often intertwine with housing, income, safety, discrimination, education, and family issues. An intervention strategy that acknowledges these links can assess what support is required without necessarily assuming that all difficulties are a problem of a medical nature and that all illnesses are just responses to problems (World Health Organization [WHO], 2022).

Imagine a university student who has stopped attending classes. One explanation offered by the family is laziness; another is spiritual attack; a third is depression. None should settle the matter before the student is heard. Perhaps the student is frightened after an assault, struggling with substance use, experiencing unusual perceptions, or unable to pay fees. Several difficulties may coexist. Beginning with an accusation narrows the inquiry. Beginning with a careful account of what changed, when it changed, and how daily life has been affected opens a route to appropriate help.

This distinction also prevents overmedicalising ordinary human responses. Grief, disappointment, conflict, and uncertainty deserve companionship and practical care even when they do not meet criteria for a disorder. At the same time, relatives should not use an understandable loss or stressor to dismiss a severe or persistent condition. The useful position is neither to diagnose everyone nor to deny illness. It is to take suffering seriously enough to investigate proportionately and respond to the actual level of need.

What diagnosis can and cannot do

A diagnosis can organise a confusing experience. It can provide a shared language for professionals, support access to services, and guide a treatment discussion. For some people, receiving a name for a longstanding difficulty brings relief. It may replace accusations of weakness or deliberate misconduct with an explanation that can be examined. For others, the same name may arrive without adequate explanation and become frightening. The effect of diagnosis depends partly on what follows it: a conversation, a plan, a respectful relationship, or merely a label on a file.

A diagnosis does not tell the whole story of a person’s character, aspirations, relationships, or future. It also does not establish that every later complaint arises from the same condition. A person with a recognised psychiatric disorder still needs

attention when new pain, confusion, skin changes, or physical weakness appear. The temptation to interpret everything through an existing label should be resisted. Asking whether a new problem needs a fresh assessment is a sign of clinical responsibility, not an attack on the validity of mental health care.

The opposite error occurs when concern about labelling becomes a reason to dismiss illness altogether. Telling someone immediately that nothing is wrong may sound comforting while closing an important door. The person might have struggled for months to acknowledge the need for help. A more reliable response is to communicate that the concern is welcome and that careful assessment is possible. Reassurance should address the person’s worth and the availability of support before it makes claims about the absence of a condition.

Diagnostic humility means holding an explanation with appropriate confidence and appropriate openness. Some conclusions are well supported; others remain provisional. Where a professional is uncertain, the next task is to identify what information would help and who is qualified to obtain it. This is particularly important when several practitioners are involved. A counsellor can contribute observations and questions without presenting an unverified alternative diagnosis as fact. A prescriber can welcome those observations while

retaining responsibility for medical decisions. The person benefits when professionals treat uncertainty as a shared problem to resolve.

Reading PP's story with compassion and caution

In the author's account, PP approached his office and announced that he had a mental problem. Conversation subsequently revealed substantial daily alcohol use, cigarette smoking, late bedtimes, and a recent loss of financial support. These are important details. They suggest that an assessment limited to an existing label or a medication list would leave significant questions unanswered. They do not, however, establish PP's diagnosis, the origin of his difficulties, or whether a previous professional assessment was correct. The responsible lesson is that the history needs to become fuller.

The desire to welcome PP warmly is valuable. The form that warmth takes should respect his preferences and boundaries. A greeting, a calm voice, an invitation to sit, and attentive listening can communicate acceptance without assuming that an embrace or holding the wrists will be comfortable. Touch requires sensitivity to consent, trauma history, culture, and the professional relationship. Eye contact likewise should not become a test of honesty or cooperation. The aim is to help the person feel safe enough to speak, rather than to prescribe one universal performance of empathy.

Author's useful opening: "Thank you for telling me. What has been happening, and what makes you describe it that way?" does not affirm a diagnosis and does not deny the experience. It invites PP to explain his own meaning. He might be referring to frightening perceptions, a history of treatment, family criticism, problems with memory, or fear that he will develop a condition affecting a relative. Each possibility leads to different questions. The professional should also clarify ambiguous information, including who is receiving any medicine mentioned and whether PP is taking anything prescribed for someone else.

Sleep deprivation and alcohol or drug misuse can be associated with psychotic symptoms, which have several possible explanations. PP's report calls for medical and mental health assessment. Abrupt, unsupported cessation can be dangerous when alcohol dependence is possible. WHO guidance recommends medically managed withdrawal and a higher level of care for people at risk of severe complications (National Institute of Mental Health [NIMH], n.d.-b; WHO, 2012).

Responsibility without blame

The phrase you are making yourself ill can contain an intention to encourage change, yet it can also leave a person feeling accused. A more constructive conversation distinguishes responsibility for future choices from blame for the whole condition. PP may have actions he can take, but those actions

need to be realistic, safe, and supported. Finding out how alcohol helps him will be revealing whether he feels lonely, stressed out, or under peer pressure. Understanding these functions does not excuse harm. It identifies what must be addressed if change is to last.

The same distinction applies to sleep. Going to bed late does not by itself establish insufficient sleep; the professional needs to ask when the person wakes, how well the person sleeps, and what interferes with rest. Work patterns, noisy housing, pain, caregiving, and fear may matter. A recommendation that ignores these conditions can sound simple while being impossible to follow. A useful plan begins with the actual day the person lives, rather than the ideal day imagined by the professional.

Agency should therefore be supported through manageable decisions. PP might agree to a medical appointment, keep a record of sleep and substance use, identify someone he trusts, and discuss a safe treatment plan. The details depend on assessment. What matters here is the method: make the next step understandable, agree who will help, and review what happened. A person who cannot complete the first plan needs an inquiry into barriers rather than an automatic judgement about motivation. The plan may have been too demanding, too costly, or poorly matched to the problem.

This approach also protects families from receiving an impossible instruction. Relatives cannot guarantee recovery through affection or supervision. They can contribute information, encouragement, transport, practical support, and a less humiliating environment. They may also need their own assistance and boundaries. Responsibility becomes fairer when it is distributed according to role, capacity, and resources. The person retains a voice; the family receives guidance; professionals remain accountable for competent care; and institutions address barriers that no household can remove alone.

Reading QQ's story without jumping to a conclusion

QQ's account raises another set of questions. He had reportedly received antipsychotic treatment over many years and had been hospitalised. His wife described repeated departures from the house at night and asked for an increased dose. Further conversation suggested that he had stopped taking medicine because of adverse effects. The author also reports a longstanding headache history and abnormal-looking palms. These observations deserve attention, but they do not establish a neurological diagnosis, prove a mistaken psychiatric diagnosis, or identify the cause of the skin changes. Several matters need separate assessment.

One immediate lesson is that apparent treatment failure and actual exposure to treatment are different questions. Before concluding that a medicine is ineffective, the care team needs an accurate and non-punitive account of what the person has been taking. This includes difficulty obtaining medicine and reasons for avoiding it. A relative's request for a larger dose is information about concern, not a sufficient basis for prescribing. The person receiving treatment should be heard directly wherever possible. Otherwise, a decision intended to solve distress may fail to address the reason treatment became unacceptable.

The night-time behaviour also requires description rather than interpretation alone. What did QQ believe he was doing? Was he awake and oriented? Was there fear, unusual certainty, confusion, intoxication, or another change? What was different from his usual pattern? His wife's doubts about the explanation do not establish what happened elsewhere. The care team can acknowledge the household's concern about safety while avoiding a contest over whose account is morally superior. A careful timeline is often more useful than an argument about whether the person is deliberately difficult.

Accompanying QQ to an appointment can support collaboration when he agrees and confidentiality is respected. A practising companion may point out any problems seen, enquire about the

rationale behind any diagnosis or treatment, and state what information would be helpful in coordinating care. Any history of headaches warrants a medical history. A qualified clinician should decide what examination, tests, or specialist referral are indicated. The constructive question is what needs reassessment, rather than whether one profession can overturn another's work from a brief encounter.

Looking beyond a psychiatric explanation when needed

The importance of medical assessment does not depend on denying psychiatric illness. Neurological, general medical, substance-related, and psychiatric difficulties can coexist. A person may need both a review of headaches and continuing treatment for a well-established mental health condition. In practical terms, the team should avoid forcing the person into an either-or choice between the brain, the body, and emotional life. The boundaries between professional services are administrative arrangements; the person lives with all these experiences together.

Imaging illustrates the need for proportionate reasoning. A CT scan or MRI can answer some questions about brain structure, but it is not a universal test that confirms or excludes schizophrenia. NICE's technology appraisal does not recommend structural neuroimaging routinely for every first episode of psychosis. That recommendation does not mean

scans are never appropriate. It means investigation should be guided by the clinical picture and the question being asked. A request for imaging should therefore be linked to a reasoned concern, rather than presented as a necessary proof that modern care has been provided (NICE, 2008).

Families understandably want certainty after years of difficulty. A costly scan may appear to promise an answer that conversation has not delivered. Professionals should explain what an investigation might clarify, what it cannot establish, and how the result would change care. This discussion can prevent both under-investigation and unnecessary expense. It also respects the family's effort to understand without endorsing the mistaken belief that every mental health problem has a visible structural cause waiting to be photographed.

The practical principle is openness to relevant evidence. An old diagnosis should not block a new examination. A normal investigation should not be used to declare that distress is imaginary. A new physical finding should be interpreted by someone qualified to do so. Where the evidence remains incomplete, the care plan can still address symptoms, safety, daily functioning, and follow-up. Responsible uncertainty is compatible with active care; it does not require abandoning the person while waiting for a perfect explanation.

When treatment helps and also creates difficulty

One of the strongest concerns in the author's account is that people may continue treatment while feeling burdened by its effects. This deserves a serious response. Antipsychotics differ in their benefits and adverse-effect profiles. Comparative research does not support treating all medicines within a generation as interchangeable or assuming that newer always means more suitable. Choice requires attention to the individual medicine, the person's history, and the outcomes that matter in that person's life (Huhn et al., 2019).

Metabolic effects deserve particular attention when a person reports weight gain. Pillinger and colleagues' comparative analysis found substantial differences among antipsychotics in their effects on metabolic measures. The practical message is to assess and monitor rather than dismiss the complaint. It would be inaccurate to turn the research into a ranking that every person should follow independently. A medicine with a difficult adverse-effect profile may still have an important role for someone whose illness has responded poorly to alternatives. Benefits and harms need to be weighed together (Pillinger et al., 2020).

Inactivity should also be explored rather than assigned a single explanation. What does the person mean by inactive? Is there sleepiness, lack of opportunity, low mood, fear of neighbours,

loss of confidence, or physical discomfort? What changed after treatment began, and what was present beforehand? These questions can guide a more useful review than telling the person simply to exercise. They also make room for the possibility that treatment effects and social circumstances are interacting, without assuming in advance how much each contributes.

A shared review should connect clinical decisions to practical goals. The person might say that being alert enough to work matters most, while the family fears another crisis. Both concerns deserve discussion. The prescriber can assess options, monitoring, and risks; the counsellor can help the person prepare questions and describe experiences; relatives can contribute observations with consent. No one should quietly alter someone else's prescription. Reporting an adverse effect is participation in treatment, and a responsive service should make that participation easier (NIMH, 2023).

Combined care needs a precise meaning

The call to bring medication and psychotherapy together expresses a valuable objection to fragmented care. It becomes stronger when it avoids absolute claims. Different conditions and stages of illness call for different treatment choices. People who have moderate depression do not necessarily need to take medication due to the availability of psychotherapy. According to NICE guidelines, it is recommended to discuss all the choices

and usually delay prescribing antidepressants. This example shows why a general commitment to integration must leave room for treatment that is appropriately selective (NICE, 2022). For psychosis and schizophrenia, NICE recommends antipsychotic medication together with interventions such as individual cognitive behavioural therapy and family intervention. These recommendations support a broader care pathway than repeated prescription alone. They do not imply that every conversation is a specialised therapy or that a poorly supported counsellor can provide any intervention without training. Access matters, but so does competence. A referral should identify what help is needed and whether an appropriately trained practitioner is available (NICE, 2014).

The idea of coordination extends beyond combining two appointments. A fictional example makes this clear. Amina sees a prescriber, a counsellor, and a community worker. Each is diligent, yet none knows that she has stopped attending the others because transport costs have risen. A treatment plan may look comprehensive on paper while being unusable in practice. With her agreement, one worker helps organise contact, clarify priorities, and communicate barriers. The improvement lies in making the parts work together, not simply increasing the number of professionals attached to her name.

Coordinated specialty care for early psychosis provides one researched example of a multi-component approach, including medication management, psychotherapy, family support, employment or education support, and case management. It is not a ready-made template for every African district, but it offers a useful question: which combination of clinical and practical support would make care usable here? Local staffing, language, funding, and referral arrangements must shape the answer. The person's own goals remain central to deciding whether the service is succeeding (NIMH, n.d.-b).

African settings should shape the conversation

The expression African mental health care covers settings with very different histories and resources. A district hospital, an urban private practice, a refugee settlement, a university clinic, and a rural primary care centre face different demands. The book's examples should therefore be read as invitations to inquiry rather than descriptions of every community. A recommendation is more credible when it identifies the setting in which it might work and the support required to implement it. Cultural relevance cannot be achieved merely by changing names in a case study.

Language is one starting point. People may describe distress through the body, relationships, spiritual concerns, or local expressions that do not correspond neatly to a diagnostic term.

The professional can ask what the expression means to the speaker, what others in the community understand by it, and how it affects daily life. An interpreter, where needed, should understand confidentiality and the purpose of the encounter. Assuming that a familiar English word captures the person's experience can create a false sense of understanding.

African research also provides evidence for psychological interventions rather than leaving psychotherapy to be presented as an imported aspiration. In rural Uganda, Bolton and colleagues tested group interpersonal psychotherapy for depression in a randomised trial. In Zimbabwe, Chibanda and colleagues evaluated a primary care psychological intervention delivered by trained lay health workers. These studies support attention to accessible psychological care in their studied settings. They do not establish that the same intervention treats every disorder or that untrained informal advice is equivalent to a researched programme (Bolton et al., 2003; Chibanda et al., 2016).

Faith and family relationships likewise require questions rather than assumptions. A person may find prayer deeply supportive and still want medical treatment. Another may fear disclosure within a religious community. Relatives may provide safety and affection or may be a source of pressure and harm. Asking whom the person trusts is more useful than declaring that a

particular institution must be involved. Culturally attentive care takes shared meanings seriously while retaining a clear commitment to safety, consent, and the person's voice.

Recovery needs more than one measure

The word healing carries hope, but it needs explanation when used in a mental health book. Some readers understand it to mean that symptoms have ended permanently and treatment is no longer required. Others mean that life has become meaningful again, even with continuing support. These meanings should not be allowed to drift into each other. For clarity, this book uses symptom improvement to describe reduced difficulties, remission to describe a period below relevant symptom thresholds, and personal recovery to describe movement toward a valued life. None of these terms alone establishes permanent cure.

This distinction is not an attempt to reduce hope. It protects hope from promises that can later become accusations. If a person is told that sufficient discipline, prayer, insight, or family support guarantees cure, recurrence may be interpreted as moral failure. A more durable message is that improvement is possible, support can be adjusted, and a difficult period does not erase earlier gains. Continuing treatment may be part of living well rather than evidence that the person has failed to recover.

Statistics need the same care. A claim that a certain percentage recover has little meaning without knowing the condition, population, treatment, definition of recovery, and length of follow-up. Did the study measure symptoms, hospital use, employment, or the person's own judgement? Were participants receiving care that is available locally? Were people who left the study accounted for? A responsible writer asks these questions before carrying a number from one setting into a claim about all African communities. Broad racial categories should not be treated as simple biological explanations for differences in outcomes.

For everyday care, several measures can sit alongside one another. A person may report less fear, more regular sleep, renewed contact with friends, and better ability to manage a household. The clinical team may track symptom changes and adverse effects. The family may notice fewer crises. Where these accounts differ, the difference is worth discussing. Progress should not be defined solely by whoever has the strongest voice in the room. A good review asks what has improved, what remains difficult, and whose priorities the next plan will address.

Reducing triggers without promising a single cause

The author's suggestion that reducing enhancing influences may help manage a condition is a productive starting point when

expressed carefully. In this book, an enhancing influence is described more precisely as a trigger, aggravating factor, or maintaining condition, depending on its role. A trigger helps explain timing; an aggravating factor increases difficulty; a maintaining condition keeps a problem going. The same circumstance can play different roles at different times. These distinctions help a team ask what can be changed without pretending that the whole explanation has been found.

A fictional example illustrates the reasoning. After losing his job, Samuel begins drinking more and sleeping irregularly. He becomes frightened and withdraws from others. It would be premature to decide that the job loss, drinking, or sleep pattern alone explains everything. A timeline can show how the difficulties developed and guide assessment. Practical help with employment, a safe substance-use plan, and treatment for identified symptoms may all be relevant. Improvement after one change provides useful information, but it does not settle every causal question.

The proposition that blocking the cause will heal the condition must therefore remain conditional. If an identified reversible medical or substance-related cause is adequately treated, symptoms may resolve, but the result depends on the actual condition and the individual. Many presentations have multiple interacting influences or no single established cause. Removing

a stressor may improve life substantially while some symptoms persist. Honest care should be able to celebrate that improvement without describing it as proof that all future support is unnecessary.

This position has an ethical benefit. It keeps the search for modifiable influences active while protecting people from being blamed when improvement is incomplete. The question becomes what else might help, rather than why the person has failed to heal. It also encourages practical experimentation within safe care: agree on a change, identify what will be observed, review the result, and adjust. These are collaborative steps toward understanding, not a substitute for necessary medical assessment or an instruction to stop prescribed treatment.

Modern care needs judgement as well as technology

Modern treatment should be discussed with openness and restraint. ECT is an established intervention for selected serious conditions, delivered with anaesthesia and muscle relaxation in appropriately equipped services. It can be effective, and it also carries risks, including memory difficulties. Describing it as simply realigning the brain creates an inaccurate picture of both the procedure and the evidence. A meaningful discussion explains the clinical indication, alternatives, expected benefits,

adverse effects, consent process, and follow-up rather than relying on a mechanical metaphor (NIMH, n.d.-a).

Other brain stimulation approaches, including transcranial magnetic stimulation, have different procedures and indications. Their availability and suitability cannot be inferred from the fact that they are newer or less familiar. A person needs to know whether a proposed intervention is established for the condition in question, what evidence supports it, and what a local service can safely provide. An account of modern discovery should distinguish clinical practice from research findings that have not yet become reliable individual treatment tools (NIMH, n.d.-a).

Technology also has an opportunity cost. A service may acquire equipment while struggling to ensure follow-up, explain prescriptions, or provide transport-sensitive appointments. The point is not to oppose investment in advanced care. It is to ask how that investment fits the whole pathway. The value of an investigation depends partly on whether its result can lead to useful action. The value of a treatment depends partly on whether the person can access it, understand it, and receive ongoing support afterwards.

The same scrutiny should apply to ordinary procedures. A careful interview can be modern care when it is systematic, respectful, and informed by current evidence. A computerised

service can remain poor care when it ignores what the person says. Progress should therefore be judged by the quality of decisions and outcomes, not by the presence of impressive equipment. The most useful service combines appropriate tools with practitioners who know their limits and can explain their reasoning clearly.

Stigma changes the conditions of care

The comparison with diabetes, high blood pressure, and spectacles expresses a clear moral demand: mental health difficulties should never reduce a person's claim to dignity. The comparison needs one qualification. Physical conditions can also attract discrimination, and people with chronic illness or disability may experience exclusion. The ethical argument does not depend on proving that mental health stigma is unique. It rests on the principle that nobody should be humiliated, denied opportunity, or treated as less human because of a health condition.

Stigma can appear in ordinary decisions. A family may speak about someone as though the person were absent. A workplace may treat a disclosed diagnosis as proof of permanent incapacity. A religious leader may insist on public testimony before the person is ready. A clinic may address relatives while ignoring the adult sitting beside them. Each action narrows participation. Challenging stigma therefore involves more than

changing a word in a public speech; it requires examining who is heard, who makes decisions, and whose privacy is protected. The WHO and the Office of the United Nations High Commissioner for Human Rights place rights, dignity, and reform of mental health systems at the centre of their joint guidance. For the purposes of this book, that orientation means asking whether people can obtain care, participate in decisions, seek redress, and live without degrading treatment. These principles need translation into national law, institutional practice, and everyday conduct. The importance of a policy statement lies in the ability of an individual to make use of it and get a justifiable reaction (WHO & OHCHR, 2023).

People with lived experience should help shape that response. Their contribution is not limited to providing an inspiring story after a programme has already been designed. They can identify inaccessible appointment systems, humiliating language, unrealistic expectations, and outcomes that professionals overlook. Their involvement should be voluntary, confidential where requested, and properly supported. A service learns something important when a person can disagree without fear that the disagreement will be interpreted automatically as a symptom.

Shared work and a better next appointment

Psychiatrists contribute medical assessment and treatment review. Psychological practitioners provide interventions within their training, while nurses and primary care clinicians help maintain continuity and monitor physical health. Social and community services address practical needs. Local regulations shape these roles, and communication should follow an agreement with the person.

The WHO (2023) mhGAP guideline supports evidence-based care by trained non-specialist workers in low- and middle-income settings. The WHO Regional Office for Africa (2022) outlines priorities for strengthening the regional response. A local plan can translate these into supervision, referral routes, access to treatment and follow-up.

At the next appointment, ask what has improved, what has become harder and what the person wants to change. Agree on a few priorities and specify who will act and when to review them. A new urgent concern should change the plan.

PP's account raises questions about substance use, sleep, stress and what the experience meant to him. QQ's raises questions about adverse effects, actual medicine use, physical symptoms and family distress. Both show why a review should start with the person's account and lead to specific actions.

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Chapter 2

Understanding Causes, Triggers and Maintaining Conditions

Asking what happened without deciding too soon

A family may arrive for help with a confident explanation. Their daughter changed after joining a new friendship group. Their father became withdrawn after retirement. Their brother began behaving unusually after losing money. These observations matter because relatives often notice changes that are difficult to reconstruct later. Yet the event closest to a visible change is not necessarily its complete cause. What appears to be the beginning may be the point at which a longer difficulty became impossible to overlook. Careful inquiry respects the observation while keeping the explanation open.

The question of cause is rarely merely academic. It influences whom a family consults, which treatment seems acceptable, whether the person is blamed, and how much hope remains. If the difficulty is described as deliberate misconduct, punishment may follow. If it is attributed entirely to a medicine, treatment may be stopped without review. If it is described as permanent damage, opportunities for improvement may be neglected. Explanations therefore carry practical consequences, even when they are offered casually. A responsible practitioner asks how an explanation was reached and what actions it is encouraging.

This chapter distinguishes vulnerabilities, contributing causes, triggers and conditions that aggravate or sustain a difficulty. These distinctions can guide assessment and action even when the full explanation remains uncertain.

Different questions hidden inside the word cause

When someone asks why a difficulty developed, several questions may be present. Why was this person vulnerable? Why did the change occur at this particular time? Why is it continuing? Why did a previous treatment fail to produce the hoped-for result? These questions overlap, but they are not interchangeable. A recent bereavement may help explain timing without accounting for all the person's earlier experiences. A continuing housing problem may sustain distress after the initial loss has been addressed. A treatment barrier may explain persistence without explaining original onset.

In this book, a contributing cause is an influence that helps bring about a condition or symptom. A vulnerability increases susceptibility without making the outcome inevitable. A trigger helps precipitate an episode or a noticeable worsening. The aggravating influence refers to factors that make the problem more difficult to manage. The maintaining factor plays a part in the ongoing presence of the problem. The protective factor is one that helps decrease risks and harm and facilitates recovery

from the problem. These are functional definitions useful for discussion.

Take the case of Kofi, a fictional employee, who feels upset after being dismissed from his job. Job loss might be said to be the precipitating factor in this situation. Drinking to manage worry could become an aggravating influence. Avoiding all contact with former colleagues might remove useful support and become part of the continuing problem. A trusted cousin could offer practical assistance. This account is a provisional teaching formulation, not a diagnosis. Its value is that it directs attention to several questions and possible supports, rather than insisting that one event explains everything about Kofi's mind and future.

A risk factor is not a prediction of destiny

Risk describes probability, not certainty. If a characteristic is associated with greater likelihood of a condition in a population, it does not follow that every individual with that characteristic will develop the condition. Nor does the absence of a recognised risk factor guarantee protection. Families can misunderstand this distinction when they hear about inherited vulnerability. An association may be interpreted as a sentence passed on every child. The professional's task includes explaining the limits of what is known and avoiding language that turns family history into a prediction.

NIMH describes schizophrenia as involving many possible genetic influences rather than one gene that determines the disorder. This supports a careful conversation about susceptibility. A family history can be relevant to assessment, but it cannot establish a diagnosis in a relative who has not been assessed. It also cannot tell the whole story of an individual's capacities, treatment response, or relationships. The information should guide appropriate attention, not exclusion from education, employment, marriage, or ordinary participation (National Institute of Mental Health [NIMH], n.d.-a).

Unemployment, violence and alcohol use can all matter during assessment. Ask how each experience relates to the symptoms and what support it calls for before drawing a diagnostic conclusion.

Biology and experience belong in the same conversation

People sometimes encounter competing explanations: one professional speaks about the brain, another about childhood, and another about the present environment. The person is then asked, directly or indirectly, to choose which explanation is real. A more useful approach asks whether the accounts address different parts of the difficulty. Biological susceptibility, the meaning of an experience, and current circumstances can all be relevant. Recognising several levels of explanation does not

require claiming that every factor contributes equally. It requires being specific about what evidence supports each proposed contribution.

NIMH's account of psychosis describes a complex combination of influences and recognises that psychotic symptoms can occur in different conditions. Sleep deprivation, some prescribed medicines, and alcohol or drug misuse are among the possibilities that assessment may need to consider. This is a reason to investigate thoughtfully, not a reason to tell every person experiencing psychosis that the explanation must be lifestyle or substance use. A symptom is a starting point for assessment; it does not disclose its own cause simply by being noticeable (NIMH, n.d.-c).

A practical conversation can remain understandable without reducing the condition to one chemical or one life event. The practitioner might explain that the team is considering several possible contributors and will review them as information develops. The person can be invited to describe patterns without being required to endorse a theory. Where medical assessment, psychological work, and practical assistance are all indicated, the plan can explain the purpose of each. The benefit of an integrated explanation lies in clearer decisions, rather than in an impressive but unfalsifiable statement that everything affects everything else.

Building a timeline before building a theory

A timeline helps separate observation from interpretation. The person and practitioner can begin with the earliest changes the person remembers, then add major events, sleep changes, substance use, medicines, treatment contacts, and periods of relative wellbeing. Exact dates may be unavailable. School terms, harvests, relocations, family ceremonies, or the birth of a child can provide useful anchors. The purpose is not to cross-examine memory. It is to understand sequence well enough to ask better questions and identify what information remains uncertain.

Suppose a relative says that a young man's difficulties began when he started drinking. The young man recalls drinking only after months of frightening experiences. Both accounts may contain useful information. The discrepancy requires clarification: which change came first, how much alcohol was involved, and what happened during periods of different use? Treatment records may help if the person agrees and access is appropriate. A timeline can reveal that a behaviour described as a cause may also have been an attempted response to symptoms. That possibility changes the care discussion without making the behaviour harmless.

The record should distinguish what someone observed, what the person reported, and what the team inferred. For example, three

nights of little recorded sleep is different from a relative's conclusion that the person never sleeps. These distinctions protect accuracy and reduce unnecessary conflict. A timeline should also include improvement: what was different when life was more manageable? Helpful information may lie in a stable routine, a supportive relationship, better access to treatment, or several simultaneous changes. The task is to preserve these possibilities rather than rush toward a single explanation that later becomes difficult to question.

What association can and cannot establish

Two things can occur together without one being the sole cause of the other. Financial strain and distress may be linked, but distress can also interfere with work and deepen financial problems. A third influence, such as chronic illness, might affect both. This does not make the association irrelevant. It means that the direction and mechanism need examination before a causal conclusion is drawn. The distinction is especially useful when a family presents a persuasive story that contains a clear sequence but little evidence about alternatives.

The broader evidence also requires this discipline. Lund and colleagues reviewed research on social determinants of mental disorders and considered pathways relevant to sustainable development. Their work supports looking beyond the individual consultation when understanding mental health. It

does not provide a framework for assigning a specific cause to each individual experiencing poverty, discrimination, or hardship. Population-level information can help set research and inquiry priorities, but a personal explanation needs to consider individual history and circumstances (Lund et al., 2018).

Even an improvement resulting from a change should be interpreted carefully. A woman may feel better due to both her move to a less stressful environment and her new therapy routine and consistent sleep patterns. While the improvement is valuable, it cannot be automatically attributed to the move. Several changes may have contributed, and symptoms may also vary over time. A responsible account can say what improved and what changed without claiming more certainty than the situation allows. This protects the reader from turning one person's experience into advice that every other person should follow, regardless of diagnosis, safety, resources, or preference.

Sleep as a contributor, a symptom and a target for care

Sleep is particularly useful for illustrating different causal roles. A person may sleep poorly because of worry, pain, noise, substance use, or an emerging condition. Insufficient or disrupted sleep may then make the next day harder. The direction of influence cannot be assumed from a complaint alone. Assessment should ask about actual sleeping and waking

times, opportunity to sleep, daytime effects, and what changed. Going to bed at two in the morning is not enough information: someone who works late and sleeps adequately afterwards has a different pattern from someone who sleeps only a few hours.

The OASIS trial provides an important example of testing an intervention rather than relying only on association. Freeman and colleagues studied digital cognitive behavioural therapy for insomnia among university students at 26 UK universities. Improving sleep was accompanied by reductions in paranoia and hallucinatory experiences compared with usual care. The authors also noted that generalisation beyond the student population required testing. The finding supports taking sleep seriously while leaving clear limits: it does not establish that sleep treatment alone cures schizophrenia or that the same digital programme is suitable for every African service (Freeman et al., 2017).

Sleep advice should therefore be linked to assessment and context. A caregiver who wakes repeatedly for an ill relative needs a different plan from someone working rotating shifts. A person who feels unusually energetic despite very little sleep may require assessment for a mood episode rather than a routine lecture about discipline; decreased need for sleep is among the features described in mania. The distinction between wanting sleep but being unable to obtain it and feeling little need for

sleep is clinically useful, though neither observation alone determines a diagnosis (NIMH, 2025).

Alcohol may change both the presentation and the response

Alcohol history should be obtained in a way that makes accuracy possible. Asking only whether someone drinks often produces little useful detail. A fuller account asks about the type and amount, frequency, timing, variation, recent reductions, and the person's reasons for drinking. Local measures and shared containers may complicate estimates. The practitioner can clarify quantities without turning the interview into an accusation. People may minimise use when they fear judgement, but they may also give imprecise estimates simply because nobody has asked them to describe the pattern carefully.

The PP teaching case from Chapter One shows why these questions matter. Heavy reported alcohol use alongside disrupted routines should prompt assessment rather than a confident claim that the whole condition is self-created. The team needs to consider whether symptoms preceded use, occur during intoxication or withdrawal, or persist in other circumstances. These are questions for appropriately qualified assessment. A counsellor can contribute the person's account and support engagement, while a medical practitioner evaluates physical risk and the appropriate treatment pathway. The work

belongs to a coordinated response rather than an exclusive professional territory.

Safety becomes especially important when dependence is possible. WHO recommends supported withdrawal and recognises the need for inpatient management for some people at risk of severe withdrawal or with serious coexisting conditions or inadequate support. Alcohol withdrawal can involve seizures and delirium. Encouraging a dependent person to stop suddenly at home without assessment can therefore create danger. The relevant lesson is not that drinking should continue indefinitely; it is that change needs a safe plan. Completing withdrawal also does not address every reason alcohol became important in the person's life, so continuing care remains necessary (World Health Organization [WHO], 2012).

Tobacco, other substances and the missing conversation

Tobacco use can be discussed without interpreting it as proof of poor character or the universal cause of a psychiatric condition. The conversation should include the person's pattern, wishes, earlier attempts to change, and the support available. Other substances also require a respectful history, including stimulants, cannabis, sedatives, non-prescribed medicines, and products used for energy or sleep. A person may not classify a familiar product as a drug. Asking what is used and how it is

obtained is often more informative than relying on broad categories that mean different things to different speakers.

Tobacco smoke can affect how the body processes some medicines. Stopping or reducing smoking can raise clozapine levels and may affect olanzapine. The interaction relates to smoke exposure, so switching to nicotine replacement can still affect medicine levels. Tell the prescriber about a change in smoking so that monitoring or dose review can be arranged if needed (NHS Specialist Pharmacy Service, 2023).

This example shows why lifestyle and medical care should not be separated. A change usually described as healthy can alter treatment needs. A hospital admission, where smoking opportunities change, may also change the context. The person needs an agreed way to report what has happened and obtain advice. The broader lesson is that a useful plan anticipates consequences instead of assuming that every recommendation can be implemented in isolation. Encouragement works better when it is accompanied by access to the professional support needed to make the change safely.

Physical illness deserves its own assessment

The possibility of a medical contributor should be considered without implying that psychiatric conditions are less real than other health conditions. Sudden confusion, for example, is different from a longstanding pattern that has already been

assessed. MedlinePlus describes delirium as a rapid change in brain function and identifies causes that can include illness, medicines, and substance-related factors. A rapid change in mental status requires medical attention. It should not be dismissed as ordinary difficult behaviour or assumed to be explained by an existing psychiatric diagnosis (MedlinePlus, n.d.).

The QQ teaching case raises a related question about longstanding physical symptoms. A headache history deserves an account of onset, pattern, changes, associated symptoms, previous assessment, and treatments tried. Its presence does not establish that a schizophrenia diagnosis is wrong, nor does it justify ignoring it. The useful response is to determine what requires medical reassessment and how that work will connect with existing care. A counsellor can help the person articulate concerns and seek appropriate review without claiming to diagnose a neurological condition from the story.

Chronic physical illness can also be linked with depression through several pathways, including the burden of living with illness and, in some circumstances, treatment or disease-related effects. NIMH emphasises that the relationship between depression and chronic disease deserves attention in both directions. The practical implication is to ask about physical health during mental health care and emotional functioning

during care for chronic illness. Neither inquiry should replace examination or assume that every symptom is psychological. The person benefits when professionals can communicate rather than make the individual carry conflicting explanations between separate services (NIMH, n.d.-b).

Medication can be beneficial and still require review

A person can benefit from medication and experience an unwanted effect at the same time. Recognising this combination prevents two unhelpful conclusions: that a complaint proves the medicine has no value, or that benefit makes every adverse effect acceptable. A careful review asks what improved, what became more difficult, how the timing relates to treatment, and whether other explanations are possible. It should also establish the medicines actually taken, including occasional products, borrowed prescriptions, supplements, and treatments for physical illness. A prescription list alone may not reflect the person's daily experience.

Huhn et al. (2019) found differences in efficacy and tolerability among individual antipsychotics. Pillinger et al. (2020) found differences in metabolic effects. These findings support considering the particular medicine, the person's needs and the effects that matter to them during a prescriber review.

Medication review also needs to avoid a causal shortcut. A symptom appearing after a new prescription deserves

investigation, but timing alone does not establish causation. The prescriber may need to consider dose, interactions, other conditions, and the course of the original problem. Counsellors can help people record experiences and prepare questions. Families can offer observations with appropriate consent. These contributions should support a qualified review, not become an informal instruction to increase, share, restart, or stop medicine. The goal is to make treatment both effective and tolerable enough to remain usable.

Adversity can begin a problem or keep it active

Distress occurs within material circumstances. A person may be trying to attend treatment while facing eviction, unpaid fees, unsafe work, or an unreliable food supply. Describing these conditions as background can make them appear peripheral to care. Yet they may shape whether the person sleeps, travels to appointments, obtains medicine, or feels able to consider the future. WHO's work on social determinants of mental health encourages attention to social and economic inequalities across the life course. This perspective broadens the questions asked without turning hardship itself into a diagnosis (WHO & Calouste Gulbenkian Foundation, 2014).

Consider a fictional mother, Mariam, who misses three counselling appointments. The record describes poor engagement. Further inquiry reveals that attendance requires

leaving paid work, arranging childcare, and paying transport twice because the clinic is far from home. Her difficulty is real even if she values treatment. A plan that consists only of urging commitment misunderstands the barrier. A discussion about timing, referral closer to home, childcare support, or another feasible contact method may be more useful. The example illustrates a service question, not a claim that one arrangement is available everywhere.

Attention to adversity should also avoid romanticising resilience. A person may have survived many difficulties and still need help. Admiration can become neglect when it is used to imply that the person should cope indefinitely without resources. Equally, practical assistance should not require the person to prove complete psychological recovery before receiving it. The care plan can recognise strengths, offer treatment where indicated, and pursue material support. These are compatible actions. Their coordination helps prevent a person from being repeatedly treated for distress while returning to avoidable conditions that make participation in care difficult.

Trauma requires attention without becoming an explanation for everything

Exposure to an extremely threatening or horrific event can be followed by post-traumatic stress disorder, although most people exposed to potentially traumatic events do not develop

PTSD (WHO, 2026). Assessment should consider the person's experience, symptoms and functioning.

Acknowledge the person's experience without requiring a detailed account of the violence. Explain why particular information is needed and ask permission to discuss it.

Current safety may require attention before extended exploration of the past. A woman still facing violence needs a response that considers protection and appropriate services; teaching relaxation alone would leave a central danger untouched. Family involvement must be evaluated carefully if someone in the family may be responsible for harm.

The language of triggers can be useful when reminders are linked with distress, but it should be used precisely. A reminder may evoke a response without recreating the original event, while a new threat may represent continuing danger rather than merely an internal reaction. The distinction affects the plan. A person may need help responding to reminders, help changing an unsafe environment, or both. Trauma-informed care, as used here, means taking that possibility seriously and avoiding unnecessary humiliation or pressure. It does not mean assuming that a particular history has been established before the person has spoken.

Relationships can become part of a continuing cycle

Family members often want an explanation that identifies who started the difficulty. Sometimes identifying harmful conduct is essential, particularly when there is abuse. In other situations, a continuing interaction deserves attention even when no one intended the result. A relative becomes frightened by withdrawal and asks repeated questions. The person experiences the questions as criticism and withdraws further. The relative then intensifies supervision. This fictional cycle is not evidence that the family caused the condition. It illustrates how understandable responses can become entangled with a difficulty that already exists.

Mapping an interaction should never erase power or responsibility. Violence, threats, confinement, and financial control should not be softened into neutral descriptions of a shared pattern. The person being harmed should not be asked to improve communication as a substitute for safety. Where the difficulty involves ordinary misunderstanding rather than coercion, however, a more specific conversation can help. What is each person trying to achieve? What does the other person experience? What happens next? These questions focus on changeable behaviour rather than turning either party into the permanent problem.

A practical agreement might concern how to ask about medicine, when to discuss a concern, or what support the person actually welcomes. It should be negotiated rather than imposed as a test of obedience. The family may need education about symptoms and treatment, while the person may need space to describe which forms of support feel helpful. Caregivers also need limits and relief. A plan that requires a spouse to monitor every movement indefinitely is unlikely to support either person's wellbeing. The aim is a relationship that can carry care without reducing one adult to the role of guard and the other to the role of suspect.

Meaning, faith and cultural interpretation

People interpret distress through the language and explanations available to them. A spiritual account may provide comfort, responsibility, or a sense of belonging. It may also coexist with a wish for medical care. The practitioner should ask what the belief means to the person, how it affects decisions, and whether anyone is using it to create pressure. Respect does not require endorsing an unverified supernatural cause. It requires listening without ridicule and ensuring that the person can access appropriate care and make informed choices.

The same discipline applies to professional explanations. A person may accept a biomedical account yet feel frightened by a careless statement that the brain is permanently damaged.

Another may find a psychological explanation useful but interpret it as proof that the family is to blame. The professional needs to check what the person understood, not merely what was said. An explanation is clinically incomplete when it sounds scientifically impressive but leaves the person with a false prediction or no idea what the next step involves.

In a fictional example, Emmanuel wants prayer alongside treatment, but fears that disclosing medicine use will lead to public criticism. The question is not whether faith or medicine should win. The care discussion can explore whom he trusts, what may be shared, and how he can obtain spiritual support without surrendering privacy. With consent, an appropriate faith leader might become a helpful partner; without consent, disclosure could create another source of distress. Cultural responsiveness requires this attention to the individual situation. A general description of African spirituality cannot tell a practitioner what Emmanuel wants or what his community will do.

A formulation should be a shared working explanation

A formulation is a working explanation of the present difficulty. It connects the timing of symptoms, factors that may worsen or sustain them, available support and questions that still need assessment. Use language the person understands and invite corrections.

One useful drafting method is to distinguish the presenting difficulty, earlier vulnerabilities, recent precipitating events, continuing influences, and protective resources. These categories are prompts rather than a validated prediction instrument. They should not be filled with assumptions simply because a form has empty spaces. It is acceptable to record that the relationship between two events remains uncertain. It is also important to include the person’s disagreement. A formulation that treats every objection as lack of insight becomes impossible to test and risks reproducing the very silencing that collaborative care is meant to prevent.

Turn the formulation into a few priorities. For each, agree what will be done, who will do it and when the team will review it.

Testing the explanation in an ordinary life

Consider a fictional teacher, Bisi, who has been treated for a mental health condition and now reports fatigue, withdrawal, and difficulty returning to school. A superficial account might call her inactive. A fuller discussion reveals that she fears colleagues' comments, finds mornings difficult, has stopped attending a supportive group, and is uncertain whether medicine contributes to the tiredness. The first task is to avoid deciding which detail is the explanation before each has been explored. A medical review, a discussion of treatment effects, and practical planning may all be appropriate.

The working formulation could identify several questions: What was Bisi's energy level before treatment? Is there a physical contributor? What happens when she anticipates returning to school? What support does she want from the head teacher? Does she wish to reconnect with the group? With her agreement, the team can choose feasible steps. These might include a clinical appointment and a carefully planned conversation about work. The example does not establish that these actions will resolve her difficulties. It shows how an account can connect assessment with the priorities she identifies.

At review, the team should ask what actually happened. Perhaps the appointment clarified a treatment issue while the workplace conversation was postponed because Bisi did not yet feel safe disclosing anything. That is information for adjusting the plan. It should not be recorded simply as failure. The team can ask what would make the next step acceptable and whether another route is available. A formulation earns its place by helping people learn from experience. If every outcome is interpreted as confirming the original theory, the theory is no longer functioning as a useful working explanation.

Protective resources need to be specific and available

It is easy to write that a person has family support. The statement becomes more useful when it specifies what the

family can actually provide and what the person welcomes. One relative may offer transport but be unavailable at night. Another may listen well but be unable to contribute financially. A trusted friend may live abroad and have unreliable connectivity. A support system should be described as a set of actual relationships and capacities rather than an ideal picture of what relatives are expected to do.

Protection can also come from predictable routines, accessible care, safe housing, practical knowledge, meaningful activity, and a relationship in which concerns can be expressed. These are areas to explore, not guarantees against future difficulty. A person can have loving relatives and still experience a serious episode. Another may have limited family contact yet build useful support elsewhere. The assessment should recognise resources without assuming that their presence cancels symptoms or that their absence proves hopelessness. Where support is fragile, the plan needs to acknowledge that fragility and consider alternatives.

Resources also change. A sister who previously sent money may lose employment. A community worker may be transferred. A clinic may move. The person may decide that a formerly trusted relationship no longer feels safe. Reviewing support is therefore part of continuing care. The question is not simply who could help in principle, but who is available now,

for which task, with what consent. This level of detail helps avoid a familiar failure: a discharge plan or referral depends on support that everyone mentions but nobody has confirmed. Good intentions become more useful when linked to practical arrangements.

Reducing contributors without promising a cure

Identify contributors that can be addressed and review what changes. Better sleep opportunity may ease one difficulty. Treatment for alcohol dependence or a medication review may make it easier to address another.

Treating a reversible contributor can bring substantial relief. The outcome depends on the cause, the treatment and any coexisting conditions. Follow-up helps determine whether symptoms have resolved and whether continuing support is needed.

End the discussion by explaining what is known, what remains uncertain and what happens next. The next chapter considers how assessment can guide urgent care, investigation and referral.

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Chapter 3

Getting the Assessment Right

Assessment should lead to a useful decision

An assessment should help the person understand what needs attention, what remains uncertain and what happens next. It may lead to urgent medical care, further assessment, treatment review or practical support.

The NHS describes mental health assessment as a conversation about the support a person needs, including their physical health and social circumstances (NHS, n.d.-b). The service arrangements reflect the UK setting. The emphasis on understanding needs can inform assessment elsewhere.

This chapter focuses on adults. Children, adolescents, people with pregnancy-related concerns and people with particular communication or developmental needs may require additional expertise. Families and counsellors can contribute by describing changes accurately and recognising when a qualified assessment is needed.

Begin by making the encounter understandable

The person may not know why the appointment has been arranged. A relative may have said that it is only a conversation while privately expecting a diagnosis or prescription. A referral letter may contain language the person has never heard. Beginning with an explanation of the practitioner's role, the

purpose of the meeting, and the likely next steps reduces this uncertainty. It also makes it easier to correct a misunderstanding before the encounter becomes an experience of being examined without meaningful participation.

Consent should be supported through understandable information and an opportunity to ask questions. Privacy and its limits should be explained, including circumstances in which safeguarding or an immediate serious safety concern may require further action under applicable law and professional duties. A diagnosis alone should not be treated as proof that the person cannot participate in decisions. The practical implication from WHO and OHCHR's guidance is to promote participation and prevent coercion from becoming the automatic reaction when there is a difference of opinion (WHO & OHCHR, 2023).

Imagine a fictitious man named Joseph coming in accompanied by his elder brother. The brother begins answering every question and asks for the same medicine Joseph received years earlier. The practitioner can acknowledge the brother's effort while asking Joseph what he understands about the visit and whether he wishes his brother to remain. An opportunity to speak privately may reveal concerns that cannot be expressed in front of family. This is not a rejection of family involvement. It is a way to establish whose information is being obtained, what

consent exists, and how each person can contribute appropriately.

Let the person's concern establish the starting point

The referral may describe aggression, withdrawal, poor adherence, or strange behaviour. These descriptions should be explored, but they should not replace the person's own account. An opening invitation such as asking what has been most difficult gives the person room to identify the problem in everyday language. The answer may concern fear, shame, a bodily sensation, a conflict, loss of sleep, or an unwanted treatment effect. The professional can then clarify rather than assume that the referral already contains the complete explanation.

Listening openly does not require postponing direct questions indefinitely. The practitioner can begin broadly and then ask about onset, frequency, duration, severity, and impact. What does the experience feel like? When does it occur? What is different from usual? What has the person tried? The aim is to turn a general description into information that can guide judgement. Where there are signs of immediate danger or serious physical deterioration, urgent assessment takes priority over completing the usual interview sequence.

Words need clarification even when they sound familiar. Feeling weak may mean physical exhaustion, discouragement,

dizziness, or fear of failing one's family. Saying that the head is not working may refer to memory, concentration, unusual thoughts, pain, or an explanation learned from others. A useful response asks for an example from a recent day. The person who cannot remember a shopping list needs a different inquiry from someone who believes neighbours can read private thoughts. Neither account should be interpreted solely through the professional's first understanding of a phrase.

Identify urgent medical concerns before extending the interview

A quiet room and a patient conversation are valuable, but some presentations require urgent medical evaluation. Sudden changes in awareness or attention, a seizure, severe physical deterioration, or a concerning new neurological symptom should not be treated as ordinary counselling material. A person may have both a psychiatric history and an acute medical problem. The existing diagnosis does not make a new examination unnecessary. The initial question is whether the person is medically safe enough for the planned encounter and what action the practitioner's role permits.

Delirium is particularly important because it can be missed when someone is withdrawn rather than visibly agitated. NICE's guidance for hospitals and long-term care emphasises recent changes or fluctuations over hours or days in cognition,

perception, movement, or social behaviour. Its revised assessment recommendation involves the 4AT test, with other tools for critical care or postoperative settings. These are tools for appropriately trained staff within clinical pathways; a counsellor's task may instead be to recognise a rapid change and arrange medical assessment (NICE, 2023).

In a fictional example, an older woman with a history of depression becomes unusually sleepy and intermittently confused over two days. Her family assumes that depression has returned. The correct lesson is not to diagnose delirium from the story. It is to recognise that a recent change in awareness and thinking requires prompt medical attention. Continuing a routine discussion about motivation would leave an important possibility unaddressed. Clear referral should describe the change, its timing, and any known illness or medication changes, while the receiving clinician determines the necessary examination and investigations.

Ask directly about safety without pretending to predict the future

Questions about suicide, self-harm, harm from others, and possible harm to others belong within assessment when relevant. Avoiding them because they feel uncomfortable can leave the person's immediate needs unclear. A respectful question about current suicidal thoughts should be followed by

appropriate inquiry into intent, planning, access to means, past behaviour, and the person's ability to obtain help. The purpose is to understand what response is needed now. Asking should be calm and straightforward, without turning disclosure into an accusation or a promise of automatic punishment.

NIMH's adult outpatient brief suicide safety assessment guide illustrates a structured follow-up after a positive ASQ screen. It is intended for specified clinicians and distinguishes screening from further assessment. Current suicidal thoughts call for urgent evaluation and appropriate supervision while that evaluation is arranged. The guide also distinguishes collaborative safety planning from a promise or contract to remain safe. A person's assurance alone should not be used to close an assessment when the wider situation remains concerning (NIMH, n.d.-a).

A separate caution concerns numerical prediction. NICE advises against using risk scales to predict future suicide or repeated self-harm, or using broad categories such as low, medium, and high risk to determine treatment or discharge. An assessment should instead lead to an account of needs, current safety concerns, and a practical response. For example, a trusted relative's availability may change between the appointment and the evening. A score cannot show that the individual will stay

safe in changing conditions. Expert opinion, effective communication, and follow-up remain essential (NICE, 2022).

Describe the course rather than collecting isolated symptoms

One unusual experience does not explain the whole presentation. The practitioner needs to understand when changes began, whether they were continuous or episodic, how functioning changed, and what was happening around them. Earlier periods of wellbeing are also informative. A person's current appearance may conceal a serious episode that occurred recently, while a dramatic complaint may represent a longstanding experience with a different level of immediate urgency. Sequence helps distinguish these possibilities and directs further questions without deciding the diagnosis in advance.

The history should include previous episodes, treatment contacts, hospital admissions, benefits, adverse effects, and reasons care was interrupted. A person may have attended several services under different descriptions. With consent and appropriate access, earlier records can clarify what was assessed and what treatment was actually tried. A note that someone was given an antipsychotic does not establish why it was prescribed, whether it was taken, or whether the diagnosis remained the

same. The medication class is information about care, not a substitute for the clinical history.

NIMH's discussion of bipolar disorder shows why the longitudinal picture matters. Evaluation depends on the extent, time span, and reoccurrence of mood and behaviour changes; some people tend to report seeking treatment during depressive states, with their past hypomanic symptoms being ignored. Health problems and medications may even exacerbate the mood symptoms. This is why it is important to enquire about the pattern of the disorder over time rather than rely solely on the mood that is present now. Questions must be detailed enough for the patient to discern a regular joyful state from a significant one (NIMH, 2025).

Observe the present without turning observation into judgement

The mental state examination describes the person's current presentation through observation and conversation. It commonly considers appearance and behaviour, speech, mood and emotional expression, thinking, perception, cognition, and the person's understanding of the situation. An NHS clinical resource presents these domains as part of a structured clinical examination. The examination is one component of assessment; it does not replace history, physical evaluation, or contextual understanding. Its findings should be described clearly enough

that another practitioner can understand what was observed (NHS Greater Glasgow and Clyde, n.d.).

Description is more useful than a moral label. Instead of writing that a person was rude, record the relevant behaviour and circumstances. Did the person raise their voice after a question about a distressing subject? Did they decline to answer because a relative was present? Was there difficulty hearing or understanding? These possibilities do not make all behaviour harmless. They make the record more accurate and the interpretation more accountable. Words such as manipulative or difficult often hide the very information the next practitioner needs.

The person should also be told why particular questions are being asked. Questions about unusual perceptions can feel threatening when asked abruptly or as a test. A practitioner can acknowledge that people sometimes have experiences they find difficult to explain and invite a description. The response should neither ridicule the experience nor affirm an unverified belief as fact. The task is to understand its nature, meaning, impact, and safety implications. A single answer should be interpreted within the wider encounter, with attention to language, culture, physical health, and the person's usual functioning.

Assess cognition in context

Memory, concentration, and orientation can be affected by many circumstances, including the immediate setting. A person may struggle to respond because the language is unfamiliar, hearing is impaired, anxiety is intense, or formal schooling was limited. These possibilities should be considered before a poor performance is interpreted as evidence of a cognitive disorder. Equally, the presence of a communication barrier should not become a reason to ignore a clear decline from previous functioning. The useful question is what has changed and how the change affects daily life.

Practical examples often reveal more than general assurances. Can the person manage familiar journeys, recognise people, follow a usual task, or keep track of medicine as previously? Does difficulty fluctuate? Who has noticed it, and over what period? A relative’s observations can be valuable, but the assessor should distinguish the person’s account from an informant’s interpretation. If specialised cognitive testing is needed, it should use an appropriate method and be interpreted by a qualified practitioner. A brief informal exercise should not be presented as a definitive examination of intelligence or decision-making ability.

The assessment can also ask what accommodations make participation easier. Quiet surroundings, a hearing aid, glasses,

breaks, familiar language, or a different pace may help the person communicate. These arrangements should be documented where they influence interpretation. A person's ability to understand an explanation should be assessed after reasonable support, rather than assuming incapacity because the first explanation failed. This principle improves the quality of the encounter and reduces the risk that an inaccessible assessment will be mistaken for an accurate description of the person.

Functioning reveals what a symptom list can miss

Symptoms matter, but care also needs a picture of ordinary life. Ask what the person can do, what has become difficult, what assistance is already provided, and which activities the person most wants to regain. The questions should reflect the person's setting. Household work, subsistence farming, informal trade, study, caregiving, religious participation, and paid employment may all be relevant. A measure that notices only formal employment could overlook substantial responsibility or improvement. A comparison ought to be done with the individual's past performance and aims rather than any restricted social model of functioning.

The WHO's WHODAS 2.0 offers an organised method of assessing functioning with regard to cognitive, mobility, self-care, interpersonal, life, and participatory domains. This

instrument may supplement clinical evaluation if properly employed. It doesn't offer information about the causality of any problem or substitute for the individual's opinion on what is important to him/her. A functioning score is most useful when it helps identify practical needs and track change rather than becoming another number disconnected from care (WHO, n.d.). A fictional market trader, Ruth, may report fewer frightening experiences but still be unable to manage a full trading day. Assessment should ask what interrupts the day: fatigue, fear, concentration, transport, physical symptoms, or loss of working capital. Different barriers suggest different forms of assistance. The point is not to explain every difficulty through mental illness. It is to identify what prevents participation and whether the care plan addresses it. A quieter symptom profile and a restricted life can coexist, and both deserve attention in reviewing progress.

Make physical health part of mental health assessment

Physical assessment should not be reserved for people whose mental health diagnosis is doubtful. A person with an established condition still needs appropriate attention to pain, weight change, sleep, movement, sexual health concerns, and other bodily symptoms. The medical history and examination help identify illness that may coexist with, resemble, or contribute to the presentation. They can also establish a baseline

for treatment. NICE recommends a multidisciplinary assessment for psychotic symptoms that includes medical history and physical examination, alongside other domains (NICE, 2014).

The clinician conducting the examination should explain what is proposed and obtain appropriate consent. A person should not be expected to accept an unexplained examination because the appointment concerns mental health. Privacy, a suitable environment, and a chaperone where appropriate are part of competent care. If a practitioner cannot perform an examination, the task is to arrange assessment by someone who can. The absence of equipment in a counselling office should lead to a clear referral pathway, not an assumption that physical concerns lie outside the person's care needs.

The QQ account illustrates the issue without establishing a diagnosis. Headache and abnormal-looking skin require their own history and clinical evaluation. The practitioner who notices them can report what was seen and what the person said. Describing the palms as infected without examination would go beyond the available evidence. Describing the longstanding headache as proof of a neurological explanation would do the same. Accurate observation keeps the concern visible while leaving the diagnostic judgement with the clinician who examines the person and interprets the relevant evidence.

Reconcile medicines before deciding treatment has failed

A medicine review begins with what is actually being taken. This may differ from the prescription in the file. The person may be using a lower amount, taking it intermittently, obtaining a different product, or avoiding it because of an unwanted effect. Other prescribed medicines, over-the-counter products, herbal preparations, supplements, and substances should be included. A useful account records names where possible, how products are used, when they changed, and what the person experienced. Packaging or a written list can help when recall is difficult.

The conversation needs to make disclosure safe. A person who expects anger may report perfect adherence even when treatment has become intolerable. Asking what makes the prescription easy or difficult to use is more informative than demanding obedience. The team should distinguish affordability, availability, understanding, memory, preferences, and adverse effects. These barriers may require different responses. A reminder is unlikely to solve a supply problem; a lecture about commitment is unlikely to resolve distressing restlessness. Accurate information is needed before the prescriber decides whether apparent non-response reflects the medicine, its use, or another difficulty.

Treatment monitoring also requires objective information where indicated. NICE’s antipsychotic guidance includes

baseline measures such as weight, waist circumference, blood pressure, glucose regulation, lipids, prolactin, and movement assessment, with ECG in specified circumstances. The aim here is to facilitate safe prescribing and monitoring and not diagnose a mental health condition using these measures. Tests should be selected and interpreted by qualified clinicians, with a plan to act on results. A person reporting significant weight gain deserves a review that goes beyond reassurance that it is an expected inconvenience (NICE, 2014).

Choose investigations to answer a clinical question

People sometimes assume that good assessment means ordering many tests. The more useful standard is whether an investigation addresses a plausible concern and can influence management. Some tests look for another condition that may explain symptoms. Others establish whether a proposed treatment is safe or help monitor its effects. These purposes should be explained separately. A normal test result may reduce one concern without explaining all the person's distress, and an abnormal result may require interpretation before its significance is clear.

For example, NIMH notes that physical examination and laboratory testing may help identify medical conditions with symptoms resembling depression. The NHS similarly explains that tests may be used to investigate alternatives such as an

underactive thyroid, while depression itself is not diagnosed by a simple physical test. These statements support medical judgement based on history and examination. They do not justify a universal laboratory panel for every distressed person or a claim that a normal blood result proves that nothing is wrong (NIMH, n.d.-b; NHS, n.d.-a).

In African settings, cost and access are part of the discussion, but they should not become an unspoken reason for abandoning a clinically important investigation. The clinician can explain the concern, the urgency, available alternatives, and what will happen while the investigation is arranged. The person should know who will review the result and how they will receive it. A test without an arrangement for interpretation can create expense and anxiety without completing the assessment. Where resources are limited, transparent prioritisation is more responsible than either indiscriminate testing or unexplained refusal.

Brain imaging requires an honest account of the evidence

CT and MRI can identify some structural abnormalities, but they are not universal tests that confirm or exclude schizophrenia. NICE's technology appraisal recommends against routine structural imaging for every first episode of psychosis. The recommendation concerns routine investigation, not a prohibition on imaging when the clinical picture raises a

concern. A person with relevant findings may need imaging or specialist assessment. The reason should be explained in terms of the question being investigated, rather than the assumption that every mental health diagnosis requires a visible lesion (NICE, 2008).

Blackman et al. (2023) found clinically relevant MRI findings in 5.9% of people with first-episode psychosis across the studies they reviewed. A finding counted as clinically relevant if it changed diagnosis or management. Results varied considerably between studies. The authors favoured routine MRI, while NICE (2008) advises against routine structural imaging in the initial investigation of first-episode psychosis. Individual decisions should consider the clinical presentation and applicable local guidance.

Headache and neurological changes need a proportionate response

The duration of a headache alone does not establish its cause or urgency. Assessment should clarify the pattern, whether it is new or changing, associated symptoms, medicines used, and previous evaluation. NICE's headache guidelines list factors that need to be considered for further investigation or referral, such as sudden severe onset, headache progressively getting worse with fever, and new neurological deficit. It is not a complete list of criteria for emergencies. An alarming case

needs urgent medical assessment; it is up to the physician to choose the action plan for all the signs (NICE, 2012).

The author can transform their concerns about QQ into meaningful questions. What was before the headache? Was the headache constant, recurring, or varying? Were there changes in awareness, movement, vision, or speech? What has already been examined? The account that headaches occurred before a psychiatric diagnosis is important history, but chronology alone cannot prove causation. The team should neither dismiss the symptom because of the diagnosis nor use it to promise discovery of an alternative explanation that will remove every difficulty.

Referral should identify the actual reason for concern. A request saying only to rule out everything is less helpful than an account of the symptom, course, relevant observations, and the question needing assessment. Counsellors and relatives can contribute accurate descriptions without requesting a particular conclusion. When a specialist review finds no explanation for all the symptoms, the work should continue. The person may still need pain care, psychiatric treatment, psychological support, or further follow-up. A disappointing search for one unifying cause should not leave several treatable needs unattended.

Screening tools organise questions but do not settle diagnosis

A screening questionnaire is designed to identify people who may need further assessment. It differs from a diagnostic evaluation and from a measure used to follow symptom severity after assessment. The same instrument may contribute to more than one purpose, but the purpose must be clear. A positive screen does not establish a condition by itself, and a negative screen does not justify ignoring a concerning history. The result should be interpreted alongside clinical information and the tool's validation evidence.

Local evidence matters. Nakku and colleagues evaluated Luganda versions of the PHQ-9 and PHQ-2 in two rural primary care facilities in Uganda. The study illustrates the work required to examine a measure in a particular language and setting. It does not mean that a cut-off can be carried unchanged into every African population, language, age group, or service. Translation, cultural meaning, literacy, administration, and the reference assessment all affect how findings should be understood. Choosing a familiar questionnaire is only the beginning of responsible measurement (Nakku et al., 2016).

A practical service should decide what will happen after screening before distributing forms. Who reviews a concerning response? What help is available? How are privacy and records

protected? A questionnaire can make disclosure easier, but it can also leave a person exposed if no one responds. Scores should support rather than displace conversation. Repeating a measure may help track change, yet the person should still be asked whether daily life has improved and whether treatment has created new problems. Measurement becomes useful when the result leads to a proportionate action.

Culture, language and belief belong within assessment

Culture should not be confined to a final question about ethnicity or religion. It can shape how distress is described, which explanations seem credible, whose advice matters, and which treatments feel acceptable. The American Psychiatric Association provides a Cultural Formulation Interview and related resources to support inquiry into such matters. Its assessment resources are intended to inform clinical judgement rather than serve as the sole basis for diagnosis. The relevant lesson is to ask about meaning instead of assuming it from a person's group identity (American Psychiatric Association, n.d.).

An interpreter may be necessary, but the arrangement requires care. The person should understand the interpreter's role and the expectation of confidentiality. A family member may not be an appropriate interpreter for discussion of violence, sexuality, substance use, or conflict. Where a trained interpreter is

unavailable, the limitations should be recognised and sensitive decisions approached cautiously. The assessment record should state the language used and any important communication difficulties, rather than presenting an uncertain exchange as though it occurred without barriers.

Unusual beliefs also require context. A belief shared within a religious or cultural community should not be labelled pathological simply because the assessor does not share it. At the same time, cultural familiarity does not remove the need to assess distress, functioning, danger, or marked change from the person's usual state. The practitioner can ask how the belief is understood by the person and relevant community, how firmly it is held, and what actions follow from it. Respect and clinical inquiry can coexist without ridicule or uncritical endorsement.

Safeguarding questions need privacy and a response pathway

An account of anxiety or withdrawal may be connected with abuse, exploitation, or fear at home. Asking about safety in front of the person who may be responsible can prevent disclosure and create danger. WHO's guidance on responding to violence against women emphasises appropriate clinical support and attention to safety. The principles should inform a private, respectful inquiry and referral arrangements. They should not

be reduced to asking a standard question without considering what happens if the person answers yes (WHO, 2013).

A fictional woman, Asha, says she cannot sleep because she is afraid at night. Her partner answers that she worries unnecessarily. A private discussion, where safely possible, may reveal whether there is violence, another source of fear, or a different explanation. The practitioner should not assume the answer, promise confidentiality beyond applicable duties, or confront a suspected perpetrator without considering the consequences. The plan needs to protect the person's agency and immediate safety, including the safety of children or dependent adults where relevant.

The same care applies when the person has a psychiatric diagnosis. An allegation of harm should not be dismissed automatically as part of the illness. It requires proportionate inquiry and safeguarding action according to the circumstances. Equally, an assessor should not treat every family disagreement as proven abuse. Accurate records distinguish the report, the observations, the uncertainties, and the action taken. The person should know which information may be shared, with whom, and why, unless circumstances prevent that explanation at the time. Safety work is a responsibility, not an excuse for unnecessary disclosure.

Use collateral information without replacing the person

The information may help to explain a presentation if the individual has forgotten about the event(s) or if changes happened outside of the consultation period. We must address confidentiality and handle exceptions in a legal and professional manner. The assessor should record the source and the limits of the information. A relative's direct observation of three nights without usual sleep differs from an assumption about what happened elsewhere. Both may prompt questions, but they should not be given identical evidential weight.

Not all disagreements indicate a lying individual. Factors such as memory, fear, different times of observations, and conflict within a relationship can account for such a discrepancy. The professional can ask for specific examples and compare timelines without turning the consultation into a public contest. Where private conversations are appropriate, they should be arranged in a way that does not punish disclosure. Relevant information may also be available from prior practitioners, but records should be obtained through authorised channels rather than circulated casually among colleagues.

QQ's wife's concern about night-time departures is therefore useful information, but it does not settle what he believed or where he went. His explanation and the reported interruption of medication also matter. The assessor's task is to bring these

accounts together, evaluate what can be established, and identify what requires further assessment. A request from a relative to increase medicine should be heard as a concern to investigate. It should not become the prescribing decision before the person, treatment history, and current presentation have been reviewed.

Turn uncertainty into a differential and a plan

A differential diagnosis is a reasoned consideration of possible explanations. It should not be an indiscriminate list of every condition that might conceivably produce a symptom. The clinician identifies plausible possibilities, considers the evidence for and against them, and decides what additional assessment could change management. Several conditions may coexist. The purpose is to avoid premature closure while keeping the inquiry proportionate. A provisional conclusion can support care when its uncertainty and review arrangements are clear.

Professional boundaries matter here. A counsellor may recognise that a reported experience needs medical assessment and describe the reasons. A clinician may ask for psychological assessment to clarify another aspect of functioning. These contributions should be stated within competence. Referral is stronger when it asks a focused question rather than asserting an alternative diagnosis that has not been established. The

person should not be left believing that accepting a medical review means rejecting psychological care, or that attending psychotherapy proves the previous diagnosis was wrong.

The practical plan should connect each unresolved concern to an action. If tests are pending, identify who reviews them. If a medicine review is needed, establish how the prescriber will receive the concern. If the person needs urgent care, arrange a direct and safe pathway rather than handing over an address. If the assessment remains incomplete because the person is exhausted or communication support is unavailable, record the limitation and organise continuation. Uncertainty becomes safer when it is acknowledged, assigned, and reviewed instead of hidden inside a confident label.

Close with shared understanding and continuing care

Review the immediate priorities, options, likely benefits and burdens with the person. NICE (2021) recommends checking understanding, including through teach-back. Ask the person to describe the agreed next step so the practitioner can clarify anything that was poorly explained.

Distinguish the person's report, observations, tests, working conclusions, safety concerns, consent and the agreed plan in the record. Describe any barrier to following the plan and who will help address it. Explain how follow-up will happen and when to seek earlier help.

Review the assessment when new information, unexpected treatment effects or changes in support alter the situation. WHO's mhGAP intervention guide (WHO, 2016) outlines a clinical process, and its later guideline (WHO, 2023) provides evidence-based recommendations. Both depend on appropriate training, supervision and local referral arrangements.

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Chapter 4

Medicines That Help and Side Effects That Matter

Treatment should help a person live

A family may be relieved that a crisis has settled while the person receiving treatment feels unable to return to ordinary life. The frightening experiences may have reduced, yet mornings are difficult, concentration feels slower, or clothes no longer fit. These accounts do not necessarily contradict one another. They may describe different parts of the same treatment experience. A useful review makes room for both benefit and burden, then asks how the plan can better serve the person. Relief from symptoms matters, and so does the life made possible by that relief.

A medication review should clarify what the medicine is for, what has changed and how the person experiences its benefits and burdens. Reports of adverse effects warrant an assessment and a discussion of what to do next.

This chapter discusses medicines used in adults and the questions that can inform a qualified review. Age, pregnancy and physical health may affect decisions. Prescribers and pharmacists can advise on medicines, and counsellors can help the person describe concerns and seek review.

Understand the purpose of the particular medicine

Mental health medicines include several groups with different purposes. Antipsychotics may be used for psychotic symptoms and selected other indications; antidepressants are used for depression and some other conditions; mood stabilisers have important roles in bipolar disorder; and some medicines address particular short-term symptoms. A medicine's name or class does not by itself establish the person's diagnosis. The reason for the prescription should be explained directly. The selection of NIMH as stated is based on personal needs and responsiveness, usually with other types of care as well (NIMH, 2023).

It avoids a common misconception. A person sees the word antipsychotic on a leaflet and concludes that every professional has concealed a schizophrenia diagnosis. Another sees a medicine used for seizures and assumes that the prescription must be mistaken. The appropriate response is to ask the prescriber what the medicine is intended to address in this case. Some medicines have more than one clinical use. The explanation should identify the target problem and expected benefit without relying on a label that may mean something different to the reader.

The person should also know which medicines are intended for continuing use and which require a short review interval.

Instructions such as take when needed need clarification: needed for what, within what prescribed limits, and when should lack of improvement lead to contact? A relative's earlier experience cannot supply those answers. Neither should a person borrow another household member's prescription because the symptoms seem similar. The prescription belongs within an individual assessment that considers medical history, other treatments, and the circumstances in which the medicine will be used.

Generations are broad categories rather than a personal ranking

The distinction between first- and second-generation antipsychotics can help organise information, but it does not provide a simple rule that older medicines are always worse or newer medicines always better. Individual medicines differ, as do the people taking them. Huhn and colleagues compared the efficacy and tolerability of 32 oral antipsychotics for acute treatment in adults with multi-episode schizophrenia. Their findings support attention to differences between medicines rather than treating each generation as a uniform product. The study does not identify one universally best prescription (Huhn et al., 2019).

A person may obtain substantial benefit from an older medicine and find a newer alternative difficult to tolerate. Another may

experience the opposite. The relevant discussion considers previous response, adverse effects, physical health, the treatment goal, availability, cost, and the person's preferences. Claims about average effects should be explained as averages. They cannot predict with certainty which experience an individual will have. A choice can therefore be reasonable at the start and still require revision after the person's actual response becomes clearer.

In African services, availability can narrow the practical options. That constraint should be acknowledged rather than disguised as evidence that the only available product is necessarily ideal. Equally, a more expensive medicine should not be presented as a symbol of superior care without examining its suitability. The person deserves an explanation of the options that can actually be obtained, their trade-offs, and what will happen if the preferred option is unavailable. Good prescribing involves judgement under real conditions, accompanied by efforts to improve those conditions where they limit appropriate care.

Define benefit before waiting for improvement

The purpose of a treatment trial becomes clearer when the team identifies what it hopes will change. Is the medicine intended to reduce distressing voices, stabilise a severe mood episode, improve persistent depressive symptoms, or help prevent

recurrence? The person may also identify a practical goal, such as returning to study or managing a market stall. These goals should be connected without pretending that one prescription will automatically resolve every social or functional difficulty. A reduction in symptoms can create an opportunity for rehabilitation and psychological work without completing that work by itself.

An early discussion should identify the expected review process rather than promise a fixed date on which the person will be well. Some effects may change before others, and a meaningful evaluation depends on the medicine, condition, dose prescribed, and actual use. The person needs to know whom to contact if symptoms worsen or an adverse effect becomes difficult. Waiting for a routine appointment should not be the only available response to a serious new problem. A plan that includes contact arrangements is more useful than reassurance without a route back to care.

Progress can be recorded in ordinary terms. A fictional student, Daniel, may report less fear but continued difficulty following lectures. The next conversation should explore both observations, including sleep, treatment effects, the original condition, and academic support. Calling the treatment a complete success or a complete failure would lose information. The review can instead ask what improved, what remains

difficult, what changed unexpectedly, and which priority matters most now. This makes the person's experience part of the evidence used to refine care.

Sedation should be discussed in relation to the day being lived

Sleepiness can be an important adverse effect of antipsychotic treatment, with differences between medicines and between people. The Royal College of Psychiatrists includes sedation among the effects that may require discussion. It should not be confused automatically with recovery, nor should all fatigue be attributed to medication without assessment. The person's account needs detail: when does the sleepiness occur, how severe is it, what changed after treatment began, and what activities have become unsafe or difficult (Royal College of Psychiatrists, 2019)?

The same degree of sleepiness may have different consequences for a person working at home and someone driving passengers, climbing, operating equipment, or caring for an infant. The prescriber and pharmacist should explain relevant precautions for the actual medicine. Someone who is drowsy or impaired should avoid activities such as driving that could endanger themselves or others and obtain clinical advice. Relatives should not interpret this caution as permission to confine the

person indefinitely. The objective is a safe and workable plan, with a review of the impairment.

Consider a fictional tailor, Esther, who says that she cannot complete orders because she falls asleep over her work. Her family says she should be grateful that she now sleeps. A more useful conversation recognises the relief and asks about daytime functioning. The team can investigate possible contributors and discuss appropriate adjustments within prescribing care. The counsellor can help Esther describe the pattern and prepare questions. The answer should not be a demand that she endure indefinitely or an instruction from an unqualified helper to alter the prescription independently.

Movement symptoms can be mistaken for behaviour

Some antipsychotic adverse effects involve movement. Akathisia can include distressing restlessness; other effects can include stiffness, tremor, abnormal muscle contractions, or involuntary movements. These descriptions are prompts for clinical review rather than a way to diagnose the cause from appearance alone. A person who repeatedly stands, paces, or says that sitting is unbearable may be experiencing something different from deliberate disruption. The practitioner should ask what the movement feels like and how it relates to treatment changes (Royal College of Psychiatrists, 2019).

Misinterpretation can produce an unhelpful sequence. A person's restlessness is labelled worsening agitation, the complaint is not explored, and the person becomes less willing to attend care. The correct response is a qualified assessment that considers both illness and possible treatment effects. Timing, prescribed medicines, actual use, other substances, and examination findings all matter. A counsellor who notices the pattern should describe it accurately to the prescriber, with appropriate consent. The aim is to prevent an observation from being converted too quickly into a judgement about character or diagnosis.

New involuntary movements deserve assessment, and the person should not have to wait until they become embarrassing or disabling before receiving attention. Severe muscle symptoms with fever or a change in mental state can indicate a medical emergency, including the possibility of neuroleptic malignant syndrome. Urgent medical evaluation is needed rather than a routine counselling response. The Royal College of Psychiatrists identifies this rare complication as an emergency requiring acute hospital care. This is an example of why information about serious reactions belongs in treatment education, alongside a realistic explanation that most people do not experience them (Royal College of Psychiatrists, 2014).

Sexual and hormonal concerns deserve privacy

A person may value treatment and still be distressed by reduced sexual desire, erectile difficulties, changes in orgasm, menstrual changes, or other intimate concerns. These experiences may be difficult to disclose in a crowded clinic or in front of relatives. The prescriber should make space for a private discussion without assuming that the person is sexually inactive or that the concern is unimportant. Some effects can be related to medication, but physical illness, distress, relationship circumstances, and other treatments may also require consideration.

The risperidone leaflet lists raised prolactin and possible associated sexual and breast symptoms (Dexcel Pharma Ltd., 2026). A clinical review can consider the medicine, timing and other possible explanations, with examination or investigation where indicated.

The relationship consequences also matter. A partner may interpret reduced interest as rejection or infidelity. With the person's agreement, a carefully framed conversation can explain that health and treatment effects may need review, without making an unconfirmed causal claim. Counselling can address misunderstanding and support communication while the prescriber evaluates the medical concern. Privacy remains the person's right; a spouse's involvement should not be

assumed automatically. Effective care includes the ability to raise a sensitive issue without public embarrassment or pressure to disclose more than is necessary.

Weight gain is a health concern rather than a moral failure

The concern that people become inactive and gain weight deserves more than general advice to eat less. Pillinger and colleagues found substantial variation in metabolic effects across 18 antipsychotics, including changes in weight and measures of glucose and lipids. This supports early attention to the specific medicine and the person's physical health. It does not mean that every weight change has one cause or that switching treatment is always the best response. The advantages of psychiatric treatment and physical risk factors should be taken into account collectively (Pillinger et al., 2020).

The experience of weight gain can also affect confidence, clothing costs, social participation, and willingness to continue treatment. Someone may be mocked for a change that has occurred during care, then blamed for avoiding the next appointment. These consequences should be heard without turning the consultation into a judgement about appearance. Ask what changed, how quickly, what the person eats and can afford, how activity has changed, and whether fatigue or physical symptoms limit movement. This provides a fuller starting point than assuming poor discipline.

The exercise and nutritional needs should be suited to the individual's situation. A recommendation to join a gym may be irrelevant where cost, distance, safety, or physical capacity make it impractical. A household may need guidance on affordable food options and realistic shared routines. These measures should accompany appropriate medical review rather than become a reason to postpone it. The person should not have to demonstrate perfect lifestyle behaviour before a significant treatment-related concern receives clinical attention. The care plan should identify what can be changed now and how its effects will be reviewed.

Monitoring should produce action rather than a collection of results

Monitoring is part of treatment, not a separate administrative exercise. NICE's antipsychotic guidance includes baseline and follow-up attention to physical measures and relevant investigations, including weight, waist circumference, blood pressure, glucose regulation, lipids, movement symptoms, and other checks according to clinical need. People should understand which checks apply to their medicine and why. The schedule needs to follow current guidance and the individual's circumstances rather than an improvised rule taken from a general book (NICE, 2014).

The practical questions are straightforward. Who arranges the blood test? Who pays for it? Who reviews the result? How will the person hear the explanation? What happens if an abnormality is found? A result stored in one clinic while another prescriber renews the medicine may leave an important concern unattended. Shared care requires explicit responsibility. If follow-up is transferred, both the receiving service and the person should know what is expected and how unresolved questions will be communicated.

A fictional driver, Musa, reports increasing weight and intense thirst during a review. The practitioner should arrange appropriate medical assessment rather than assume that both complaints can be addressed at the next annual check. The case does not establish diabetes or any particular medication effect. It illustrates the need to respond to a new concern rather than allow the routine schedule to replace clinical judgement. Monitoring should establish a baseline, detect changes, and lead to an appropriate response. Its value lies in what the team does with the information, not how many boxes are completed.

Metabolic treatment may require more than lifestyle advice

When weight or metabolic difficulties emerge, the team can consider several possible responses rather than automatically choosing between enduring the problem and stopping psychiatric treatment. These may include tailored lifestyle

support, a review of the current medicine, treatment of an identified physical condition, or an additional intervention where appropriate. Each option has potential benefits and burdens. Switching an effective antipsychotic may carry risks; adding another medicine also requires a reason and monitoring. The decision belongs in a qualified discussion informed by the person's priorities.

Fitzgerald and colleagues developed guidance for metformin in the management of antipsychotic-induced weight gain in adults with psychosis. The work supports considering a medical intervention for this adverse effect rather than treating it solely as a matter of personal willpower. It provides no evidence that metformin can be self-initiated, that everybody requires it, or that a physical examination is essential. There are some things that must be considered. The guidance addresses a defined population and should be interpreted within current local practice (Fitzgerald et al., 2022).

The useful change in thinking is that physical and mental health care should work together. A person should not have to choose which part of their health is allowed to matter. The psychiatric prescriber, primary care clinician, and other relevant specialists can agree who will address the metabolic concern and how changes will be reviewed. Counsellors can support realistic routines and help the person communicate concerns. Families

can assist with practical changes when welcomed. None of these contributions substitutes for evaluating the actual medical problem and the treatment options available.

Recent discoveries need careful interpretation

Semaglutide was researched as a medication in antipsychotic-treated individuals with schizophrenia, prediabetes and obesity/overweight in Denmark in the 2025 HISTORI randomised trial over 30 weeks with positive results on glucose control and weight loss compared to placebo. This development is significant in view of the current quest for more effective means of managing metabolic issues. However, the study is not an indication that semaglutide cures schizophrenia or that all patients who experience weight gain have to use it. Further investigation of long-term effects, possible side effects, cost and appropriateness of treatment for an individual is required (Ganeshalingam et al., 2025).

As for developments related to the direct treatment of schizophrenia, in September 2024, Cobenfy, containing xanomeline with trospium chloride, was FDA-approved in the United States as a treatment for adult patients with schizophrenia. Cobenfy is another type of schizophrenia drug with a different mechanism from known drugs. Although the FDA approval provides an alternative option for patients in the United States, it does not guarantee superior effects, the absence

of side effects, or availability in any specific African country. There is a list of side effects provided by the FDA (FDA, 2024). Modern discovery should therefore be communicated with both interest and proportion. A new mechanism, a promising trial, and a locally accessible treatment are different things. The person needs to know which evidence applies to their condition and what practical access exists. Advertising language can create disappointment when it implies that a discovery has made individual assessment unnecessary. A responsible service can discuss new evidence while ensuring that people continue to receive appropriate care now. Innovation is most useful when it expands meaningful choices rather than becoming a reason to abandon a treatment that is helping without a safe alternative plan.

Clozapine needs access accompanied by appropriate safeguards

Clozapine has an important role for some people whose psychotic disorder has not responded adequately to other treatment. WHO's 2023 recommendations support its consideration for treatment-resistant psychotic disorders under specialist supervision. Its potential benefit should not be overlooked simply because it requires more organised care. Equally, the service must be able to provide the assessment, monitoring, and follow-up needed for safe use. A family should

receive an explanation of why this medicine is being considered and what the care pathway involves (WHO, 2023b).

The U.S. Food and Drug Administration (FDA, 2025) removed the clozapine REMS programme effective 13 June 2025. The FDA continues to recommend absolute neutrophil count monitoring in line with the prescribing information because severe neutropenia remains a risk. Check local requirements when explaining this U.S. regulatory change.

The FDA (2020b) warns that clozapine-associated constipation can lead to serious bowel complications. Significant bowel symptoms need timely assessment. If clozapine is interrupted for more than 48 hours, contact the treatment team for specialist advice and re-titration before restarting (NHS Specialist Pharmacy Service, 2024a).

Long-acting injections should be a choice discussed with the person

Long-acting injectable antipsychotics can be an alternative to oral treatment for some adults who require continuing care. The advice from WHO focuses on effectiveness, side effects, and personal preference. An injection is not automatically a punishment, and a tablet is not automatically a more respectful option. The discussion should explain the particular medicine, administration arrangements, follow-up, and what happens if a dose is missed. The person should have room to express

preferences without being assumed incapable of contributing because treatment has previously been difficult (WHO, 2023b). The same medicine can produce systemic adverse effects in either formulation. The Royal College of Psychiatrists also notes injection-related issues such as discomfort at the injection site. Longer intervals may be convenient for some people, but attendance and supply arrangements still matter. An injectable formulation does not remove the need for physical health checks or review of how the person feels. Nor should it be presented as a guarantee that symptoms will never recur (Royal College of Psychiatrists, n.d.).

In a fictional example, Peter prefers fewer daily reminders of illness and is interested in an injection. His concern is whether travelling to the clinic will interfere with work. The useful conversation addresses both preference and feasibility. Another person may strongly prefer tablets and need help resolving a supply problem. These are different situations, even if both have been described as adherence difficulties. The treatment choice should emerge from an individual discussion, not from a service habit that uses the same formulation for everyone who has ever missed a dose.

Antidepressant treatment requires its own conversation

Antidepressants should not be discussed as though they were interchangeable with antipsychotics or short-term sedatives.

Their purpose, expected course, adverse effects, and review arrangements differ. NIMH describes benefits that may develop over time and recognises effects such as gastrointestinal discomfort and sexual difficulties. The prescriber should explain what to expect for the particular medicine and what requires earlier contact. A person should not be left to interpret every early sensation as either proof that treatment is working or proof that it is harmful (NIMH, 2023).

Treatment selection also depends on severity and preference. Antidepressants should not be offered as the first choice for mild depression unless that is what the individual prefers. This allows for discussions regarding proper psychological approaches and other alternatives rather than a blanket statement that every case of distress needs medication. If medication is necessary, it must be linked to a review process. Furthermore, depression symptoms mean that it must be considered if there have been any prior mood episodes or if there is bipolar disorder (NICE, 2022a; NIMH, 2025).

Clinicians must immediately assess any suicidal ideation, increased agitation, or uncharacteristic behaviour or changes in mood. Urgent danger should lead to emergency care rather than waiting for an ordinary review. The purpose of discussing this possibility is to support timely help, not to suggest that antidepressants inevitably cause such experiences. Families can

be useful observers when the person agrees, but they should receive guidance on what to notice and how to report it. A vague instruction to watch closely can produce anxiety without improving the response to a meaningful change.

Lithium is useful care that depends on reliable monitoring

Lithium requires regular monitoring of blood levels, kidney and thyroid function, and other measures (NHS Specialist Pharmacy Service, 2024b). The person should know when tests are due and who reviews the results. Discuss practical barriers before tests are missed.

Illness, dehydration, changes in salt intake and medicine interactions can affect safe lithium use. Signs of toxicity can include confusion, tremor, weakness, difficulty coordinating movement or speaking, and digestive symptoms. Suspected lithium toxicity calls for emergency medical assessment and withholding lithium while that assessment is arranged (NHS, 2023).

The practical relevance can be considerable in hot weather, during diarrhoeal illness, or where access to safe water is unreliable. A worker who becomes unwell while away from home needs a contact plan, not simply a reminder to return for the next blood test. The pharmacist should know about lithium when other medicines are supplied, including non-prescription products. A written medicine list or treatment record may help

communication between services. These measures are not signs that the medicine is inherently unsuitable. They are part of making an effective treatment safe enough to use in the person's actual circumstances.

Reproductive plans should be part of safe prescribing

People receiving psychiatric treatment may wish to become parents, avoid pregnancy, or discuss changes in fertility and sexual functioning. These questions should be asked respectfully and privately, without assuming that a diagnosis removes reproductive choice. The discussion should begin before a crisis where possible. A person needs accurate advice about the particular medicine and access to the appropriate specialist review. The balance can involve risks associated with both treatment and untreated illness; a general statement that all psychiatric medicines must be stopped in pregnancy would be unsafe.

Valproate illustrates why specific information matters. WHO's 2023 safety statement advises against prescribing valproic acid to women and girls of childbearing potential because of the risks of birth defects and developmental disorders following exposure in the womb. It also calls for counselling and review for those already receiving it. The statement does not mean that someone should abruptly stop treatment without specialist advice, nor that alternatives recommended for epilepsy can

automatically be substituted for treatment of bipolar disorder. The indication and individual circumstances must guide the response (WHO, 2023c).

The broader service responsibility is to make a specialist conversation possible without shame or delay. Someone who thinks they may be pregnant while taking a relevant medicine should seek prompt clinical advice. Clinicians must check current local safety requirements, which can change, rather than rely indefinitely on an old leaflet or a book. Partners may be included with consent, but they should not take over the decision or use reproductive concerns as a reason to withhold care. Accurate information, appropriate contraception advice where relevant, and planned review support agency rather than restrict it.

Short-term calming medicines need an explicit review point

Benzodiazepines can have a role in treatment. The FDA (2020a) warns about misuse, addiction, physical dependence and withdrawal, and about serious harm when they are combined with alcohol or opioids. Physical dependence can develop even when a person takes the medicine as prescribed. Explain the intended duration and how the prescription will be reviewed.

The concern that someone may remain merely calmed for years should lead to a careful medication history rather than an accusation based on the medicine’s appearance or the length of

the file. Which medicine is being used? For what indication? What is helping? What is becoming difficult? Has the purpose been reassessed? Some long-term situations require complex decisions, and an abrupt stop may create harm. A competent review acknowledges the original reason for treatment and asks whether the current balance still justifies the plan.

Counselling and practical support can address needs that a sedative does not resolve. A person may need help with fear, grief, substance use, relationship difficulty, or returning to daily activity. These interventions should be selected through assessment, not used as a blanket substitute for medication. The important service question is whether ongoing symptoms and treatment effects are being reviewed, and whether appropriate psychological care is accessible. A prescription renewed out of habit can become detached from its original goal; an organised review reconnects it to the person's present life.

Interactions make the whole medicine list important

The person should be encouraged to describe everything used for health, sleep, energy, pain, or spiritual and traditional purposes. This includes prescribed medicines, over-the-counter products, herbs, supplements, alcohol, and other substances. The conversation should be curious rather than contemptuous. If people expect ridicule for using a familiar remedy, they may omit it. The prescriber and pharmacist then lose information that

could matter. A useful review asks what the product is, how it is used, and whether its packaging or ingredients can be checked.

NIMH (2023) explains that some combinations of medicines or supplements that affect serotonin can cause serotonin syndrome. A change in tobacco smoking can also affect clozapine treatment (NHS Specialist Pharmacy Service, 2023). Tell the prescriber or pharmacist about changes so they can assess the need for monitoring or review.

The practical response is to maintain an accurate list and update it when something changes. A person who stops smoking, develops a new physical illness, or receives treatment from another clinic should know to tell the psychiatric team where relevant. Professionals should also communicate through appropriate channels rather than relying entirely on the person to reconcile conflicting instructions. A counselling conversation can help identify a missing part of the history, but interaction checking belongs with an appropriately qualified professional using current information about the actual products.

Understand why a treatment plan is not being followed

The word adherence can become a judgement if it is used without inquiry. NICE recommends assessing medicine use without blame and distinguishing concerns or beliefs from practical barriers. Someone may avoid treatment because of an

adverse effect, forget doses because the schedule is confusing, or miss them because the supply has ended. These situations require different responses. The professional should ask what happened and what would make the agreed plan more workable, rather than treating every interruption as refusal to cooperate (NICE, 2009).

QQ's account is relevant here. Before increasing a prescription because behaviour appears worse, the team needs to know what the person has actually taken and why. A spouse may be sincerely worried but unaware that the medicine was stopped because of an unwanted effect. The person's account should be heard directly where possible. The subsequent decision requires clinical review, not a contest over whether the person or relative deserves to be believed. Accurate information can prevent treatment from being changed on the basis of an incomplete picture.

Support should match the barrier. Clearer instructions may help uncertainty. A reminder may help forgetfulness if welcomed. A closer dispensing point may help access. A prescriber discussion may be needed for a burdensome adverse effect. None is a universal solution. Concealing medicine in food should not become an informal family practice that bypasses consent and professional safeguards. Where capacity or immediate serious safety concerns complicate care,

appropriately qualified professionals should use lawful, rights-respecting processes. Trust is part of treatment, and practical support should not quietly become coercion.

Continuing treatment and stopping treatment are both clinical decisions

Feeling better is a reason to review progress, not automatic proof that treatment is no longer needed. Continuing medication may help prevent recurrence for some conditions. The WHO guidance on a first episode of psychosis in remission states that the maintenance of treatment should be continued for a minimum of seven to twelve months. This recommendation does not mean that the person should be stopped at the one-year mark. The recommendation is neither a time limit that should be applied for all diagnoses or subsequent episodes (WHO, 2023a).

It is crucial to differentiate between withdrawal symptoms and the symptoms of recurrence. In the guidance on the medicines related to dependence or withdrawal provided by NICE, there is recognition that the symptoms can persist and be diverse and withdrawal can be an extended and personalised process. If a person experiences ill-being after tapering off medication, they should be assessed for other causes than assuming that the initial illness recurred or that the medication was unnecessary (NICE, 2022b).

The plan should explain who will supervise any reduction, what changes should prompt contact, and how support will continue. It should not be copied from another person's experience or reduced to a universal percentage schedule. Some people need continuing treatment; others may consider changes after review. Neither decision should be framed as a test of strength. Apart from urgent reactions requiring immediate medical action, independent stopping, restarting, or doubling doses can create avoidable risk. A good service makes it possible to discuss the wish to stop without losing access to respectful care.

Access and affordability belong within the treatment decision

Ask about supply, travel, fees, laboratory costs and time away from work before agreeing on a plan. The person should know whom to contact if a medicine becomes unavailable or required monitoring is difficult to arrange.

Repeated visits can also cost relatives time and income. Discuss these costs openly and identify public services, shared care or other support that is available locally.

Procurement, staffing, access to pharmacists and laboratory capacity shape what individual prescribers can offer. People with lived experience can identify problems that administrative reports miss, including the fear of reporting an adverse effect. The next chapter considers access to psychological care.

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Chapter 5

Psychotherapy That Meets the Person and the Context

Making room for a different kind of care

A woman sits opposite a counsellor after months of poor sleep, grief and difficulty working. At home, relatives tell her to be strong. At the clinic, she has received a prescription. At worship, she has been encouraged to pray. Each encounter may contain kindness, yet she still has nowhere to examine what has happened, what she fears and what might help her move forward. Psychotherapy can provide that space, together with a method for using it.

In this fictional scene, the woman has received plenty of advice. A psychological intervention offers a different experience through an agreed goal, a working relationship and a method suited to what she needs.

The role of psychotherapy depends on the difficulty, its severity, the evidence and the person’s preferences. It may be offered on its own or alongside medication, specialist treatment or social assistance. An acute medical or psychiatric emergency may require urgent care first.

The question for services is how to make effective psychological help affordable, culturally responsive and safe in the settings where people live.

What makes a conversation psychotherapy?

An ordinary conversation may comfort someone. A trusted friend may notice suffering before any professional does. Such support deserves respect. Psychotherapy, on the other hand, entails a planned intervention carried out by an individual who has the necessary preparation and responsibility. It must have a clearly defined objective and a means of measuring whether the intervention is effective. Various interventions target thoughts, behaviour, feelings, interpersonal relations, or any other process related to the psychological problem (NIMH, 2024).

The distinction protects patients from inflated promises. A practitioner should be able to explain what they propose, why it fits the presenting difficulty, what participation involves and where their competence ends. A certificate bearing the word counselling does not establish competence in every disorder. Equally, a professional title does not guarantee skill in every form of psychotherapy. Credentials, registration requirements and permitted activities vary between countries and professions. A prospective client might ask: What training have you received for this problem? How will we decide what to work on? What happens if I become more distressed? How do you obtain supervision? These are reasonable questions, especially where the word therapist is loosely regulated.

Psychological treatment should never depend on a practitioner's mystique. Clients need not understand every technical detail, but they should understand the broad plan. If an explanation leaves someone feeling foolish for asking, an opportunity for trust has already been missed. Good practice makes the treatment understandable without pretending that human suffering is simple.

Building an alliance without taking over

The therapeutic relationship is a working partnership. Warmth can help someone enter that partnership, particularly after humiliating encounters elsewhere. Yet warmth must be shaped by consent. A clinician should not assume that a hug, prolonged eye contact, touch or a familiar form of address will feel safe. Culture, trauma history, gender, religion and personal preference all influence how a gesture is received.

The same principle applies to reassurance. When someone says, "I think I have a mental problem," immediately denying it can unintentionally close the conversation. A more useful response is: "I am glad you told me. Please help me understand what you have been experiencing." This leaves room for assessment while affirming the person's dignity. Acknowledging symptoms does not reduce a person to a diagnosis.

Partnership also requires room for disagreement. A client may think the therapist has misunderstood a family obligation or

dismissed a spiritual concern. The therapist should invite correction, examine the misunderstanding and adjust where appropriate. Respect does not require agreement with every explanation; it requires taking the person's experience seriously.

Professional boundaries support this relationship. Fees, contact outside sessions, gifts and confidentiality should be discussed clearly. Sexual exploitation, financial manipulation and demands for personal loyalty are incompatible with therapeutic care. The relationship exists to serve the client's recovery. It should leave the person more able to exercise judgement, not increasingly dependent on the therapist's approval (American Psychiatric Association, n.d.).

Turning an assessment into shared goals

Before selecting a method, the practitioner needs a working understanding of the difficulty. What is happening? When did it begin? What makes it worse or better? What physical illnesses, medicines, substances, relationships and living conditions may matter? A formulation brings these observations together as a revisable explanation. It should guide work without claiming certainty that the assessment cannot support.

The client's goals may differ from the professional's initial priorities. A clinician may focus on a symptom score while the person wants to return to trading, care for a child or sleep

without fear. These goals can often be connected. A useful plan translates broad hopes into observable changes while preserving what makes those changes meaningful.

For example, “feel better” might become “resume one manageable morning activity on four days each week.” This is an illustrative goal, not a prescription for everyone. Someone with an exhausting physical illness or unsafe home may need a different starting point. Goals should be achievable under present circumstances and open to revision.

Agreement should include practical expectations: likely frequency, costs, attendance arrangements and how progress will be reviewed. Confidentiality and its limits need explanation in accessible language. The person should know that they may ask questions, decline a proposed exercise or discuss another approach. Consent is a continuing conversation. Signing a form cannot replace understanding what is happening in the room.

Cognitive therapy and the realities of hardship

Cognitive behavioural therapy examines relationships between thoughts, feelings and actions. Its value is easily distorted when it becomes a demand for positive thinking. A person facing unemployment, discrimination or violence may be making accurate observations about serious problems. Therapy should not reinterpret structural hardship as an attitude defect.

Instead, collaborative questions can distinguish what is known from what is feared, what can be influenced from what cannot, and what a particular conclusion does to everyday functioning. Consider an illustrative client who says, “Because I lost my job, I am worthless.” The loss is real. The conclusion about personal worth deserves examination. A therapist might explore the person’s contributions, alternative explanations for the dismissal and the practical effects of withdrawing from everyone.

The aim is neither argument nor forced optimism. It is greater flexibility and a more useful response to experience. A person can acknowledge an unjust situation while questioning the belief that nothing they do can ever matter. Sometimes the appropriate action is advocacy, a welfare referral or help finding work rather than another thought exercise.

CBT is one of the recommended structured forms of psychological treatment for moderate-to-severe depression among adults, according to WHO. That recommendation does not mean that every client needs the same worksheet. Examples, language, literacy demands and tasks should fit the person while preserving the intervention’s therapeutic purpose.

Helping life begin moving again

Depression can narrow a person’s life. Activities disappear, contact reduces and opportunities for satisfaction become

scarce. Behavioural activation works with patterns of activity and avoidance, helping the person take feasible steps towards meaningful engagement. NICE recognises behavioural activation as a method used in treating depression (National Institute for Health and Care Excellence [NICE], 2022).

The phrase can sound like an instruction to become busy. That interpretation misses the care required. Someone who spends much of the day in bed may be affected by depression, medication, pain, anaemia, poor sleep or several factors together. Assessment and coordination matter. “Try harder” is not an intervention.

A practical starting point might be opening the shop for a short period, washing a few items of clothing or sitting outside with a trusted neighbour. These examples illustrate how activity can be graded; none is suitable for every person. The therapist explores what matters, anticipates obstacles and reviews what actually happened. A small action that restores a sense of choice may be more useful than an ambitious timetable that repeatedly collapses.

Rest remains legitimate. The aim should be a sustainable life that includes recovery time as well. Family members should understand this distinction. Encouragement can help; ridicule and surveillance can undermine the work. When a planned step does not happen, the response is curiosity about barriers. A

missed task provides information about the plan and the person's circumstances, not proof of moral failure.

Solving a problem without blaming its owner

Problem-solving approaches help people define difficulties, consider options, choose workable steps and review results. This can be particularly useful when distress feels like one overwhelming mass. Separating transport costs, debt, conflict and missed appointments may reveal different actions and different sources of assistance.

Consider an illustrative market trader who repeatedly misses treatment because attending the clinic means losing that day's income. Exploring the problem may identify an appointment change, a trusted person to cover the stall or a nearer service. Yet none of these options can simply be assumed. The therapist should ask what is realistic and who would bear the cost.

Some problems cannot be solved within a consulting room. Displacement, inaccessible services and domestic violence may require protection, legal support, public investment or collective action. Psychological work can help someone navigate these circumstances while recognising that the circumstances themselves must change. Teaching coping skills should not become an excuse for institutions to tolerate avoidable harm.

Practical plans should identify a next step, a likely barrier and a review point. If an option fails, the person and practitioner

reconsider it together. They should also distinguish an unsuccessful attempt from a refusal to engage. This distinction matters where patients have often been labelled difficult for describing constraints that professionals did not see. A useful intervention increases the person's options; it does not assign them sole responsibility for a broken environment.

Relationships, grief and changing roles

Interpersonal psychotherapy focuses on the relationship between symptoms and significant interpersonal difficulties. These may include grief, conflict and transitions in social roles. A bereaved spouse, a new parent or a young adult moving away from home may need help understanding both emotional pain and changes in everyday relationships.

A landmark randomised trial in rural Uganda found that group interpersonal psychotherapy improved depression and functioning compared with the control condition. Its importance includes the demonstration that a structured approach could be adapted and evaluated in an African community setting (Bolton et al., 2003). The finding supports a particular intervention in a particular study; it does not establish that every group conversation is effective therapy.

Relational work requires cultural care. A person may be supported by extended family while also feeling constrained by obligations. Therapy should explore both realities. It should not

impose an assumption that independence is always healthier than interdependence, or that preserving a relationship is always preferable to leaving it.

In grief, the practitioner should make room for mourning practices and religious meanings without assuming that everyone from the same community experiences loss identically. Distress does not automatically signify disorder. Where symptoms are persistent, severe or disabling, assessment can clarify what support is needed. The aim is not to erase love or prescribe a timetable for mourning. It is to help the person live with loss while regaining connection and the ability to participate in life.

Approaching fear with consent

Some anxiety treatments involve gradually approaching situations or sensations that a person has come to fear and avoid. The process requires explanation, agreement and a suitable assessment. It should never be confused with humiliating someone, surprising them with a feared experience or forcing them to endure actual danger.

An illustrative client who avoids travelling after a frightening panic episode may begin by discussing what happens in the body and identifying a manageable practice step. The next step depends on their circumstances and the treatment model. A therapist should distinguish feared catastrophe from genuine

hazards, including unsafe transport or harassment. Anxiety work becomes careless when every fear is treated as irrational. The person should understand the purpose of practice, what support is available and how difficulty will be adjusted. The practitioner must also consider medical explanations for symptoms where indicated. Breathlessness, dizziness or chest discomfort cannot be assigned to anxiety solely because a person has previously received a mental health diagnosis.

Improvement may involve learning that discomfort can be tolerated and that avoidance is not always necessary. It need not mean never feeling afraid again. Family members can support planned practice, but pressure and ridicule are unhelpful. A person who hesitates may need a smaller step, a clearer explanation or another assessment. Treatment should develop confidence through collaboration, not through a contest in which the therapist proves control over the client.

Trauma treatment requires more than retelling

After violence, people may experience intrusive memories, avoidance, persistent threat and changes in mood or beliefs. They may also face ongoing danger, injury, bereavement and poverty. A trauma assessment needs to consider these conditions rather than treating every difficulty as a memory problem.

In the Democratic Republic of Congo, a controlled trial among women who had survived sexual violence found greater improvement in several mental health and functioning outcomes with a cognitive processing therapy programme than with individual support. The intervention involved trained providers and a defined treatment structure (Bass et al., 2013). The study offers important African evidence, while its population, comparison and follow-up limit how broadly its results can be applied.

Evidence-based trauma work is not compulsory disclosure. The practitioner should explain the chosen approach and obtain informed agreement. Some treatments work directly with memories; others address related meanings and responses. NICE suggests trauma-focused interventions for the treatment of PTSD and also warns against psychosocial debriefing as both a preventive measure and a treatment (NICE, 2018).

Safety is key. The survivor might require confidentiality, medical help and protection from more abuse. Requiring a detailed narrative before offering practical help can become another barrier. Therapy should return choice to the person, including choices about pace and disclosure. Temporary distress during agreed therapeutic work must be distinguished from persistent deterioration, coercion or avoidable harm.

Review and supervision help the practitioner make that distinction responsibly.

Working with psychosis without a contest over reality

Psychotherapy for a person experiencing psychosis requires both clinical understanding and respect. The professional should neither endorse every unusual belief nor turn the session into an argument. A useful starting point is the person's distress, sleep, safety, relationships and desired changes.

For example, someone who feels watched may be willing to discuss how fear affects leaving home even when they do not share the clinician's explanation. Collaborative exploration can examine experiences and coping strategies while preserving engagement. These examples illustrate an approach to conversation; they are not instructions for untrained workers to manage complex psychosis independently.

NICE recommends cognitive behavioural therapy and family intervention within care for psychosis and schizophrenia, alongside appropriate medical treatment (NICE, 2014). Psychological support should therefore be available beyond the immediate crisis. Stabilisation can create an opportunity for work on daily functioning, relationships and personally valued goals.

At the same time, therapy must not delay urgent assessment when a person is severely agitated, unable to meet basic needs

or otherwise at serious risk. The plan needs a clear route to qualified clinical care. Psychotherapists and prescribers should communicate, with appropriate consent and confidentiality, about difficulties that affect treatment. Side effects, substance use and practical barriers deserve attention. A person should not have to choose between a clinician who listens and one who can provide necessary medical treatment. A coordinated service should offer both.

Protecting stability in bipolar disorder

Bipolar disorder brings a particular need for coordination. Psychological work can help a person understand patterns, protect routines, identify warning signs and improve relationships. It should not encourage someone to reinterpret a potentially dangerous change in mood as merely increased confidence or spiritual growth.

NIMH describes psychotherapy as a component of bipolar disorder treatment, often alongside medication. Treatment approaches can involve work on social skills and social rhythms or familial issues (NIMH, 2025). The practical message is that skills and prescribed treatment can support each other. Decisions about medication belong in discussion with the treating clinician.

A collaborative plan might record the person's own early signs of becoming unwell and identify who to contact. Reduced sleep,

unusual spending or escalating conflict may have particular significance for an individual, but interpretation requires context and assessment. Offering family observations in a constructive manner may prove useful. On the other hand, surveillance and blame might have the opposite effect. A schedule needs to be reasonable. Someone who has shift work, a baby or someone who lives in crowded conditions is unlikely to be able to have a routine sleep pattern. Therapy should assist in making reasonable changes. The purpose is to strengthen stability while preserving agency. When warning signs escalate, the response should include timely clinical review rather than simply adding more counselling sessions.

Substance use and a conversation that opens doors

Alcohol and other substances can contribute to mental health difficulties, complicate assessment and affect treatment. Their use may also serve an understandable purpose for the person: easing distress, fitting into a social group or trying to sleep. Understanding that purpose does not minimise harm. It helps the practitioner discuss change without reducing the person to a bad habit.

A useful conversation explores what the person values about use, what concerns them and what they would like to change. Contradictions can be considered respectfully. Someone may value evening drinking while also wanting better sleep and less

conflict at home. Shame often narrows the conversation; curiosity can make accurate disclosure more likely.

Heavy or dependent use requires medical assessment. In particular, abrupt alcohol withdrawal can be dangerous, and a therapist should not advise a potentially dependent person simply to stop without appropriate clinical support. The guidelines on substance use disorders by WHO's mhGAP focus on integrated mental health care (WHO, 2023).

Work may include identifying cues, developing alternative responses and reconnecting with supportive people. The plan should also address the setting: availability of substances, unemployment, trauma and peer pressure can all matter. A return to use should prompt review of safety and the treatment plan. It should not automatically end care. The therapeutic task is to keep pathways to help open while making risks and responsibilities clear.

Bringing families into care thoughtfully

Families often provide transport, money, meals, reminders and companionship. They may notice changes before a clinic does. Their involvement can strengthen recovery, yet it should be negotiated rather than assumed. An adult's relative is not automatically entitled to every detail discussed in therapy.

The practitioner should ask whom the person wants involved, what may be shared and what support would be useful. A family

session might clarify warning signs, medication concerns, communication patterns or the distribution of care. It can also give relatives room to describe exhaustion without blaming the person who is unwell. Supporters need support themselves.

Family involvement becomes more complicated where there is coercion or violence. Joint sessions may expose someone to retaliation after leaving the clinic. A partner's insistence on attending can be a warning rather than a sign of commitment. WHO guidance on responding to intimate partner and sexual violence emphasises safety, privacy and appropriate support (WHO, 2013).

The therapist should avoid treating reconciliation as the necessary outcome of every conflict. Sometimes boundaries, separation or protection are the safer goals. Children should not be made responsible for managing an adult's illness. In every arrangement, ask whether participation increases the person's safety and freedom to speak. A family can be a powerful healing environment when its involvement rests on respect, practical support and clear limits rather than control.

Culture belongs inside the method

Cultural adaptation begins with questions. What words does the person use for distress? Who would usually be consulted? What does recovery mean to them? The answers may be shaped by language, age, education, migration, religion, disability and

local history. No single account can represent an entire African country, let alone the continent.

A practitioner should explore local expressions of suffering without assuming that a familiar expression has one fixed clinical meaning. Asking someone to explain their own words is often more useful than fitting them immediately into a checklist. Translation requires attention to meaning, not merely equivalent vocabulary.

Adaptation can involve oral exercises, relevant examples, different ways of describing emotions or practical changes to session delivery. It should also preserve the active work of the intervention. Replacing a structured method entirely with general advice while retaining its name makes claims about evidence difficult to justify. Adaptation, according to WHO's manual on how the process works, is a subset of the general services process that involves preparation, implementation, and assessment (WHO, 2024).

Power issues arise in this process. The client could be agreeing politely since the practitioner seems highly knowledgeable and socially powerful. One can involve inviting dissent and verifying comprehension. The therapist should ask what is practical, awkward, and impractical for them. Respect for culture includes respect for individuals who question customary expectations. Cultural sensitivity should expand choice rather

than require every person to conform to an assumed community identity.

Faith, meaning and professional responsibility

For many people, faith provides comfort, identity, community and a reason to continue through adversity. Psychotherapy can make room for these resources when the client wishes. A therapist need not share the person's beliefs to explore how those beliefs support or complicate coping.

The boundary is consent. Prayer should not be imposed, and a client's doubts should not be treated as evidence of moral failure. Pastoral care and psychotherapy may overlap in their concern for suffering, but their training, responsibilities and methods are not interchangeable. A religious leader can be an important supporter while referring clinical needs to appropriately qualified services.

A person may fear that seeking treatment betrays their faith. Exploring that concern respectfully may open a path to care. With permission, collaboration with a trusted faith leader can sometimes help. Confidential information must not be shared simply because the leader is influential or knows the family.

Spiritual explanations also require careful assessment when unusual experiences are accompanied by marked distress, impaired functioning or danger. The practitioner should avoid both casual dismissal and uncritical acceptance. What matters

clinically includes the person's context and the consequences of the experience. No account of faith should justify abuse, coercion or denial of necessary care. Psychological treatment should help the person examine meaning while retaining access to evidence-based support and the freedom to decide how religion belongs in their recovery.

What African trials teach us

African research provides evidence that psychological interventions can be delivered beyond specialist consulting rooms. In Zimbabwe, the Friendship Bench trial evaluated a structured problem-solving intervention delivered by trained, supervised lay health workers in primary care. Participants receiving it had better common mental health symptom outcomes at six months than those receiving enhanced usual care (Chibanda et al., 2016).

In urban Kenya, a trial of the brief Problem Management Plus intervention among women with a history of gender-based violence found improvement in psychological distress compared with enhanced usual care at three months. Delivery involved lay workers and a defined programme (Bryant et al., 2017). These findings strengthen the case for developing accessible services while leaving questions about longer-term outcomes and other populations open.

The lessons are practical. An intervention needs a clear structure; workers need preparation and supervision; outcomes need evaluation. Calling a community programme counselling does not establish that it reproduces the treatment tested in a trial. Similarly, positive results in one setting do not remove the need to assess language, referral capacity, costs and acceptability elsewhere.

These studies should also change how expertise is understood. Specialist knowledge can support care through training, consultation and supervision, allowing more people to receive help. Community workers bring valuable knowledge of daily life. An effective service combines these strengths while maintaining clear responsibilities. Access grows most responsibly when quality grows with it.

Taking an unexpected result seriously

Evidence-based writing must include findings that complicate a hopeful story. Nigeria's STEPCARE trial compared a stepped-care intervention with enhanced usual care in primary care patients with major depression. It did not demonstrate additional benefit on the primary remission outcome at twelve months. Both groups received more than an absence of care: the comparison included enhanced usual care supported by mhGAP guidance (Gureje et al., 2019).

This result should not be presented as proof that psychotherapy fails in Nigeria. Nor should it be omitted because other studies are encouraging. It asks a more precise question: what did this added programme achieve beyond the care available to the comparison group, under the conditions tested?

A responsible discussion considers the intervention, comparator, participants, delivery and outcome. It also distinguishes failure to demonstrate an added benefit from proof that two approaches are identical. A single trial cannot settle every question about a treatment or a population.

For policymakers, such findings encourage evaluation before large-scale claims. For practitioners, they encourage humility about favourite methods. For patients, they support the right to ask whether a service is producing meaningful benefit. We should avoid translating selected study results into a universal percentage of Africans who can be healed. Different diagnoses, definitions, follow-up periods and service conditions produce different findings. Honest uncertainty strengthens the credibility of a book that argues for better care.

Sharing tasks while protecting quality

A shortage of specialists makes task sharing essential in many settings. It means preparing workers to deliver defined interventions with supervision, referral arrangements and

support. It should not mean assigning unlimited responsibility to the least supported member of the workforce.

Competence must be demonstrated in practice. A worker needs to listen respectfully, apply the method, recognise limits and respond appropriately when needs exceed their role. Training attendance alone cannot show all of this. Supervisors need time to review difficult cases, observe skills where appropriate and help workers improve. The implementation manual of WHO locates workforce training in the broader context of the integration of psychological interventions within services (WHO, 2024).

The service also needs somewhere to refer people. A worker who identifies severe illness but cannot obtain clinical help has been given a responsibility without an adequate system. Referral routes should identify who receives the person, how urgent needs are handled and how information returns to the original provider.

Staff wellbeing matters too. Repeated exposure to trauma, high caseloads and uncertain pay can undermine delivery. Supervision should support workers while preserving accountability. Governments and organisations should budget for these functions from the start. A programme is not inexpensive merely because its hidden costs are carried by unpaid workers or distressed families. Sustainable access

requires a workforce whose skills, limits and working conditions are taken seriously.

Making the work possible between appointments

A therapy plan enters a real household when the session ends. A written exercise may be impossible for someone who cannot read comfortably or whose partner searches their belongings. A daily practice may compete with long working hours, childcare and unreliable electricity. These are treatment design issues, not evidence that the person lacks motivation.

The practitioner and client should agree on a feasible way to continue the work. This might involve an oral reminder, a brief activity linked to an existing routine or practice during the session itself. Any record should be safe to keep. The purpose is to support learning and change, not to collect completed worksheets.

Group delivery will help to diminish isolation and increase accessibility, although some explanations about its limitations are necessary. The facilitator can set up the rules of confidentiality without making sure that all members of the group will abide by them. Attendance arrangements should avoid unnecessarily revealing who is receiving mental health care.

Digital sessions raise similar questions about privacy, data costs, shared phones and interruptions. Convenience for the

provider does not establish accessibility for the client. The plan should include what happens if a connection fails or an urgent concern arises. Whatever the format, ask whether the person can participate freely, understand the work and obtain appropriate help. A service becomes accessible through these practical details, not through its advertised availability alone.

Affordability is part of the treatment plan

A recommendation for weekly therapy means little if reaching the clinic requires money that a household needs for food. Fees are only one part of the cost. Transport, missed work, childcare and mobile data can determine whether a person returns. Providers should discuss these realities early, without making the client repeatedly prove poverty or embarrassment.

Scheduling can sometimes reduce the burden. Appointments might be coordinated with other clinic visits, and services can explain available lower-cost options transparently. These arrangements require local judgement: a group may be economical but unsuitable for a particular person's privacy needs, while a remote session may save transport costs but expose private conversation in a crowded home. The cheapest format on paper may not be workable in practice.

Public responsibility extends beyond encouraging people to seek help. Funding should support competent staff, supervision, accessible premises and continuity. Employers and educational

institutions can also make attendance possible through reasonable arrangements that protect confidentiality. Community education should explain what psychological care involves so that people can recognise a credible service and understand their choices.

When a client misses an appointment, a service should have a respectful, previously agreed approach to contact. Messages must not disclose sensitive information to someone using a shared phone. A missed visit may reflect expense, fear, illness or dissatisfaction with treatment. Exploring the reason can improve care. Excluding someone automatically can deepen the very barriers the service was established to overcome. A treatment plan becomes more credible when the person can realistically follow it without sacrificing basic needs.

Reviewing benefit, recognising harm and ending well

Review progress against agreed goals, daily functioning, symptoms and the person’s experience. Use questionnaires alongside conversation about changes and any continuing difficulties at home or work.

Ask whether the person feels pressured, misunderstood or increasingly dependent, and whether distress has worsened. Persistent difficulty can call for supervision, a change in approach or referral.

Discuss ending before the final meeting. Review what helped, identify remaining needs and agree how to seek help again or continue support.

Psychological care earns trust when practitioners explain their approach, review progress with the person and coordinate with other services when needed.

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Chapter 6

Everyday Conditions That Support Recovery

Recovery continues after the appointment

A treatment plan must survive the journey home. The person who has just received thoughtful clinical care may return to a noisy room, an uncertain meal, unpaid bills and relatives who misunderstand the illness. Another person may have a comfortable home but remain isolated, frightened of side effects or unable to stop drinking. Clinical treatment enters these conditions; its success cannot be understood apart from them.

This chapter examines how sleep, food, movement, substance use, meaningful activity and social support can affect recovery and participation in treatment.

Healthy routines can support recovery while other vulnerabilities and needs remain. Discuss changes in light of the person's health, circumstances and experience.

People can choose priorities and try workable routines. Practitioners can help identify barriers, while families, employers and communities can make those changes easier to sustain.

Understanding what a daily pattern means

The same visible behaviour can have different explanations. Someone who stays indoors may be depressed, sedated by medication, physically unwell, afraid of harassment or unable

to afford transport. Several explanations may apply together. Before prescribing activity, the professional needs to understand why activity has become difficult.

A useful conversation follows an ordinary day. When does the person wake? What happens before the first meal? How are medicines taken? What work or care responsibilities follow? When do worry, alcohol use or exhaustion become most noticeable? The aim is to understand a pattern without turning the interview into an interrogation about personal discipline.

Timing can reveal opportunities. A missed morning dose may follow an early journey to work. Heavy evening drinking may occur when loneliness becomes hardest to tolerate. A long daytime sleep may follow repeated night-time interruptions. These observations suggest questions and possible interventions; they do not establish causation by themselves.

A short, agreed record can sometimes help identify patterns. It might capture sleep, mood, activity and important events in the person's own words. Recording should be manageable and safe. A complicated diary may add burden, while a written record may be unsuitable in a home where privacy is limited. The information belongs in a collaborative discussion. Its purpose is to improve care, not to provide relatives or professionals with evidence for criticism.

Sleep is a clinical concern

Sleep difficulties deserve attention in their own right. They should not automatically be dismissed as an unavoidable part of mental illness or treated only with general advice. The clinician needs to distinguish trouble falling asleep, repeated waking, an altered sleep schedule and excessive daytime sleepiness. Each can require a different response.

As far as most adults are concerned, the amount of sleep usually suggested is between seven and nine hours, keeping in mind the varying requirements of different individuals (NHLBI, 2022a). The number is a general reference point, not a test of character. Sleep quality, regularity and daytime functioning also matter. A person lying in bed for many hours may still be sleeping poorly. An illustrative worker in Lagos may spend several hours commuting and then care for children after returning home. Telling this person to sleep earlier does not create more hours in the day. The discussion may need to include household duties, work arrangements and travel. In another household, noise, heat, crowding or fear may be the central obstacle.

Services should ask about these conditions before assuming that the person is choosing poor sleep. Practical adjustments may help, but some needs require support beyond the consultation. Sleep advice becomes more credible when the plan identifies

which conditions can change, who can help and what to do if sleep remains disturbed despite those efforts.

When a bedtime routine is not enough

A predictable wind-down period, a reasonably consistent schedule and attention to stimulating substances can support sleep. These measures are useful starting points, but persistent insomnia may need specific treatment. NHLBI describes CBT-I as a therapy for insomnia that addresses patterns and beliefs associated with sleep (NHLBI, 2022b). General sleep advice should not become the only response to a problem that remains disabling.

Assessment also needs to consider other sleep disorders. Loud snoring, witnessed pauses in breathing and substantial daytime sleepiness can warrant evaluation for sleep apnoea. Diagnosis may require a sleep study and consideration of other medical factors (NHLBI, n.d.). A mental health diagnosis should not prevent this investigation when it is indicated.

Medication effects, pain and other health problems may also need review. A person who is struggling to stay awake should discuss this with the treating clinician, especially where driving, machinery or safety-sensitive work is involved. Adding stimulants or altering prescribed medicines without advice can complicate the situation.

The point is not to medicalise every restless night. It is to respond proportionately. Occasional disruption after a difficult event differs from a persistent pattern that interferes with life. The person should know when to seek further assessment and what information would help. A clear route back to care prevents repeated reassurance from becoming prolonged neglect of a treatable difficulty.

Protecting daily rhythms in bipolar disorder

In bipolar disorder, changes in sleep and activity may be clinically important. A person who needs markedly less sleep and becomes unusually energetic may require prompt review, particularly if other familiar warning signs appear. This differs from someone who is exhausted because they cannot sleep. Interpretation depends on the person's history and a qualified assessment.

The National Institute of Mental Health suggests having certain routines related to food, sleep, and physical activities as a way to manage bipolar disorder together with necessary treatment (National Institute of Mental Health [NIMH], 2025). Such routines might have a stabilising effect, but they should not be considered substitutes for necessary medicines and treatments.

An achievable plan starts with current commitments. Night work, a new baby or religious activities may affect sleep. The person and clinician can discuss how to reduce disruption and

when changes should trigger contact with the service. A family member may help notice a pattern, provided this role has been agreed and does not become intrusive monitoring.

Celebrating every increase in energy can be unhelpful when a person has a history of mania. Equally, treating ordinary enthusiasm as illness can undermine autonomy. Shared knowledge of the individual's usual pattern helps avoid both errors. The goal is timely, respectful support. When warning signs escalate, the response should include clinical assessment rather than simply urging the person to restore their routine by willpower.

Movement that begins where the person is

Physical activity can support physical health, sleep and mental wellbeing. WHO recommends that adults aim for 150 to 300 minutes of moderate aerobic activity each week, or an equivalent amount of vigorous activity, with muscle-strengthening activity on at least two days. Some activity is better than none, and activity should be adapted to ability and health circumstances (World Health Organization [WHO], 2020b).

These population recommendations are not an immediate starting prescription for every person recovering from illness. Someone who has been inactive, is frail or has a relevant medical condition may need a gradual plan and clinical advice.

Starting below the recommended amount can still represent meaningful progress.

Movement need not require a gym. Walking, dancing, suitable household tasks and adapted seated activity may be options. The appropriate choice depends on safety, enjoyment, disability and the person's daily demands. An individual who already performs exhausting manual work may need recovery time and treatment support rather than an additional burden of exercise.

An illustrative client might choose a short walk with a trusted neighbour on three mornings. Another might prefer gentle activity at home because public spaces feel unsafe. These are examples of adapting a plan, not universal programmes. Reviewing what feels manageable and worthwhile can help the person continue. Activity should be an invitation to greater wellbeing, never a punishment for symptoms or body size.

Making room for fatigue and physical illness

Fatigue can make ordinary tasks feel disproportionately difficult. It may be associated with depression, poor sleep, medication or a physical health condition. A professional should resist the temptation to explain it entirely through motivation. The person's description deserves assessment, especially when fatigue is new, severe or changing.

Physical well-being of individuals with severe mental illnesses according to WHO guidelines requires recognition and

treatment of other comorbid illnesses along with their associated risks (WHO, 2018). The link between mental health care and general medical care therefore needs to be maintained. Taking care of the mind doesn't mean ignoring the body.

Day-to-day plans need to include both exercise and rest. An ambitious schedule that consumes all available energy may leave a person unable to attend appointments or prepare food. A smaller, sustainable routine may be more useful. The person can help identify which tasks are necessary, which are meaningful and which can temporarily be shared or postponed. Supporters should be careful with comparisons. Someone who managed a task yesterday may struggle today. Variation does not automatically indicate manipulation or lack of effort. At the same time, a persistent decline needs review rather than indefinite accommodation without assessment. The aim is to understand what has changed and adjust support accordingly. Compassion and clinical curiosity work together: neither demands performance that is currently impossible, and neither assumes that every difficulty must simply be endured.

Food that is nourishing and available

Nutrition advice should begin with the food a person can obtain, afford, prepare and eat. WHO identifies adequacy, balance, moderation and variety as the key elements of a nutritious diet, understanding that the precise dietary composition is unique to

the individual's specific requirements and cultural background (WHO, 2026). This leaves room for locally appropriate planning rather than a fashionable imported menu.

Depending on availability and individual requirements, familiar foods such as beans, vegetables, whole grains, fruit, eggs or fish may contribute to a varied diet. No example is a complete meal plan for every person. Medical conditions, allergies, pregnancy and other needs can require individual advice.

The conversation should include practical questions. Is there enough food? Does the person have cooking fuel, safe water and somewhere to store ingredients? Do symptoms or side effects interfere with shopping or preparation? Does household food distribution leave the person with adequate meals? Advice about variety cannot resolve an empty cupboard.

Nutrition also involves dignity. A client should not be made ashamed of ordinary local foods or pressured to buy expensive products to demonstrate commitment to recovery. A realistic plan may start with regular access to an affordable meal and assistance with preparation. Where food insecurity is present, referral to available social support and attention to the household's resources belong within care planning. Information is helpful only when the person has some means to act on it.

Weight gain needs care rather than ridicule

Weight change can become a painful part of treatment. A person may feel distressed by changes in appearance, mobility or appetite while fearing that raising the issue will be interpreted as resistance to medication. Services should make discussion possible before shame drives the person away from care.

The explanation may involve several factors, including medicines, illness, activity, sleep and access to food. NICE recommends attention to weight and metabolic health in people receiving antipsychotic treatment, with appropriate action when problems arise (National Institute for Health and Care Excellence [NICE], 2014). Clinical review should accompany practical support; telling someone to exercise does not resolve every medication-related problem.

The person can be encouraged to describe when the change began, how it affects life and what they have tried. The prescriber can assess treatment options and relevant monitoring. A counsellor can help with distress, goals and barriers within their competence. No professional needs to dismiss another's contribution for this work to succeed.

Family comments about size can undermine both confidence and treatment participation. A more useful response is to ask what support the person wants: help attending a review, preparing meals or finding enjoyable movement. Goals should

focus on health and functioning as well as the person's priorities. Punitive restriction, public weighing and humiliating comparisons have no place in a supportive recovery environment.

Being cautious about miracle nutrition

People who are tired of symptoms or side effects may be especially receptive to claims about detoxification, supplements and foods said to repair the brain. Hope deserves respect, but a confident testimonial is not evidence that a product can replace treatment. A person may improve for reasons that a seller's account does not examine.

Claims should be specific enough to evaluate. What condition is the product intended to treat? What evidence supports that use? What are the ingredients, risks and costs? Can it interact with prescribed medicines? A product described as natural should still be discussed with a qualified clinician or pharmacist when relevant. Unclear ingredients make evaluation harder, not less necessary.

A balanced diet supports health; that statement does not establish that a particular diet cures schizophrenia, bipolar disorder or every form of depression. Similarly, identifying and treating a nutritional deficiency is different from recommending supplements indiscriminately. The person's clinical circumstances should guide investigation and treatment.

Professionals should invite disclosure without ridicule. If the patient expects disdain, he may not reveal what he is consuming, and this will create a partial view for the team members. Open discussion would help analyse both the individual's expectations and the claims made by the product.

The impact on finances is a key aspect too. Spending family resources on a non-evident remedy can limit their access to food, transport, and proven treatment. Responsible hope preserves family resources but leaves room for evidence-based treatment.

A careful discussion about alcohol is essential.

Alcohol abuse needs to be discussed without moralising language. WHO recognises that alcohol contributes to significant problems for health and society and claims that there is no safe amount of its consumption (WHO, 2024). This information is relevant to an individual depending on the dose, patterns, circumstances, and other health risks.

Questions about the presence or absence of alcohol abuse are often insufficient. It's important to discuss the type of alcohol, the dose, the frequency, and what happens during and after. Sizes of bottles and alcohol contents differ, so the number of bottles consumed is not enough. The clinician also needs to know about medicines and other substances.

For someone using alcohol to cope with distress, change requires attention to what drinking provides. It may offer temporary relief, companionship or an escape from an intolerable evening. An effective plan considers alternative support and the circumstances sustaining use. Criticism alone rarely provides these alternatives.

Heavy or dependent use requires appropriate medical assessment. Abrupt withdrawal can be dangerous, so a potentially dependent person should not be instructed simply to stop without a safe clinical plan. The mhGAP guidelines from WHO address substance use disorders in the context of overall medical care (WHO, 2023). Recovery may require coordination between substance use and mental health services. The person should encounter a route into help rather than being passed between services that each insist the other problem must be solved first.

Tobacco change and medicine review belong together

Supporting someone to stop smoking is part of protecting health. It should involve a discussion of dependence, previous attempts, preferences and available cessation support. People receiving mental health treatment deserve access to this help rather than an assumption that smoking is their only comfort and must therefore be ignored.

There is an important clinical interaction. NICE warns that reducing cigarette smoking can significantly affect the metabolism of some medicines, particularly clozapine and olanzapine (NICE, 2014). A person taking these medicines should inform the prescriber about a planned or actual change in smoking. Monitoring and possible dose adjustment require qualified clinical oversight.

This is a reason to coordinate quitting with care, not a reason to discourage it. A household member or counsellor should not calculate a new dose independently. The person also needs advice if smoking resumes after a period of stopping, including after discharge from a smoke-free setting.

Practical support can include identifying difficult situations, arranging follow-up and discussing approved cessation options with a suitable professional. A return to smoking should prompt review rather than humiliation. Dependence can require repeated attempts and continuing support. The central message is that health improvement and medication safety belong in the same conversation. A service that encourages change should also make the clinical arrangements that allow the change to happen safely.

Looking beyond alcohol and cigarettes

Other substances also belong in assessment, including cannabis, stimulants, sedating medicines used outside prescribing advice

and products with uncertain ingredients. A non-judgemental question is more useful than assuming that age, religion or social position excludes use. People may not regard a familiar preparation or a borrowed tablet as a substance worth mentioning.

The US National Institute on Drug Abuse describes evidence linking cannabis use with psychosis-related risks, including earlier onset among some people with genetic vulnerability and worse symptoms in those already affected. It also highlights concerns associated with higher THC concentrations (National Institute on Drug Abuse [NIDA], n.d.). These findings do not mean that every user develops psychosis, or that cannabis explains every psychotic experience.

A useful record includes what was taken, how often, when symptoms occurred and whether several substances were combined. The person's own explanation matters, but chronology alone cannot establish the diagnosis. Qualified assessment may be needed to distinguish substance-related effects, another condition or both.

Support should also consider the social setting. A person may need alternatives to a peer group organised around substance use, help with pain or treatment for persistent distress. Simply removing a product can leave the original need untouched. The plan should address immediate safety and the reasons use

continues, while keeping medical and psychological care available. Accurate information and continuing engagement are more useful than frightening claims that cannot be defended.

Caffeine and the search for enough energy

Tea, coffee and energy drinks may be part of work, study or social life. The amount consumed, its timing and individual sensitivity matter. Caffeine and nicotine can interfere with sleep (NHLBI, 2022c). Ask how these substances fit into the person's routine.

An illustrative student studies late, uses caffeinated drinks to remain alert and then struggles to settle. The next day, exhaustion prompts more caffeine. This case highlights one potential pattern of anxiety and insomnia, but it does not explain all the reasons behind these issues experienced by students. In assessment, it is important to look at workload, health, and housing as well as other drugs.

Discussing a manageable change may be useful. The person could review labels, notice when they consume stimulating drinks and discuss a gradual adjustment with an appropriate professional if needed. Removing caffeine should not be promised as a cure for a psychiatric disorder. Symptoms that persist need to be evaluated.

The wider issue is the pressure to override exhaustion. A workplace that depends on relentless hours may make stimulant

use seem necessary. A student may be combining study with paid work and family responsibilities. Advice should therefore include the demands that create the search for energy. It is reasonable to ask what can be reduced, shared or rescheduled. Supporting rest requires more than telling an overburdened person to avoid another cup of coffee.

Stress regulation in an imperfect environment

Stress management can help people respond to difficult experiences without requiring the experiences to disappear first. WHO's guide Doing What Matters in Times of Stress offers practical skills for coping with adversity, including grounding, making room for difficult feelings and acting in accordance with values (WHO, 2020a). These skills can complement clinical care when appropriate.

A simple practice might involve noticing the present surroundings and reconnecting with a chosen activity. Any exercise should be explained and offered rather than imposed. If a technique feels uncomfortable or increases distress, the person can stop and discuss another approach. The helper should not assume that one exercise will suit everyone.

Skills become more useful when linked to a real situation. Someone who becomes overwhelmed before an appointment may practise briefly before travelling. Another may use an agreed pause during a tense conversation. These examples need

adaptation, especially where conflict involves danger. Calming oneself does not make an abusive environment safe.

Stress regulation should therefore sit alongside practical action. Debt advice, protection, medical review or a change in workload may be necessary. A person cannot reasonably be expected to breathe their way out of every structural problem. The value of a skill lies in what it helps the person do next: think more clearly, seek assistance, communicate a need or take a manageable step. It should strengthen agency rather than teach passive endurance.

Meaningful activity without a demand to perform

Recovery often involves finding a place in ordinary life again. Paid employment may matter greatly, but meaning can also come from learning, creative work, worship, friendship, caring and participation in community activities. The person should help define what feels worthwhile rather than having a timetable imposed on them.

An illustrative retired teacher might value helping a grandchild read. A young adult might want to repair a bicycle, return to study or reconnect with a friend. Such goals can make recovery concrete. They should remain proportionate to current energy, symptoms and safety.

Activity can also become burdensome when relatives interpret every sign of improvement as readiness to resume all previous

responsibilities. A person who manages one useful task has not necessarily regained the capacity for an entire working day. Planning should include rest, review and permission to adjust. Achievement matters, but it should not become the price of being treated with dignity.

The conversation could address what brings back connection and what creates unnecessary tension. Roles that are important to the individual could be temporarily adjusted. Other roles could have caused suffering by imposing unreasonable expectations or exploiting them. Reintegration does not always mean going back to the way things were before without change. It could involve finding ways to live sustainably. Professionals could link everyday needs and treatment in this process, recognising that an individual's value exists regardless of productivity.

Work and learning need adjustment as well.

Work allows for money, meaning and interaction. However, these aspects might make recovery harder due to long hours, bullying, uncertainty and inflexible schedules. According to WHO's recommendations for mental health at work, organisational interventions, reasonable adjustments and participation/return to work should be considered (WHO, 2022).

An adjustment might involve appointment time, a gradual return or a temporary change in duties, depending on the role and local arrangements. It should be developed with the worker, with attention to confidentiality and safety. Employers do not need unrestricted access to therapy discussions to consider a practical adjustment.

Informal work needs equal attention. A street vendor or smallholder may have no human resources department, paid leave or replacement income. Planning may involve family assistance, a cooperative or community resources where available. These possibilities should be explored rather than assumed. The person may have good reasons for declining help that appears simple to an outsider.

Students may likewise need an agreed approach to attendance, assessment or workload. Neither employers nor institutions should require a public account of illness as a condition of compassion. Appropriate procedures can support accountability while protecting privacy. Returning to work or study should be reviewed as a process, not treated as a single test that proves recovery. If difficulties appear, the next step is to understand and adjust rather than immediately interpret the attempt as failure.

Contact that the person can trust

Being surrounded by people is different from feeling supported. A congested home can actually make one feel lonely, whereas a few positive relations might provide ample satisfaction. The Commission on Social Connectedness from WHO has stressed the importance of tackling loneliness and isolation (WHO, 2025).

A recovery plan can ask who the person trusts, what kind of contact feels welcome and which relationships are draining or unsafe. The answer may include relatives, friends, neighbours, peers or a faith community. It may also reveal that familiar contacts have become sources of stigma. Contact should be chosen for its quality, not simply increased in quantity.

A practical step might be arranging a brief visit, returning to a suitable group or identifying someone who can accompany the person to an appointment. These examples should not become obligations to socialise on command. Someone recovering from an exhausting episode may need short, predictable contact rather than frequent visitors.

Supporters can ask what is helpful instead of assuming. A person may want company without discussing symptoms, or practical assistance without advice. Clear expectations can prevent disappointment on both sides. The person should also retain the right to privacy and quiet. Social support strengthens

recovery when it offers belonging and practical help while respecting choice. It becomes another burden when access to care is tied to pleasing everyone who wishes to be involved.

Housing safety and the limits of private effort

A stable routine is difficult to establish where a person does not know where they will sleep. Housing insecurity, violence and repeated displacement can disrupt food, medicine storage, appointments and privacy. These conditions belong within the recovery conversation even when the clinician cannot resolve them directly.

Questions should be practical and respectful. Is there somewhere safe to sleep tonight? Can medicines be kept securely and according to storage instructions? Can the person attend follow-up from their current location? Are they afraid of someone in the household? Answers may change the urgency and direction of the plan.

A recommendation to use a quiet room is meaningless if no such room exists. The professional can acknowledge the constraint, explore available support and document the unmet need where appropriate. Social services, protection agencies or housing organisations may be relevant, depending on the setting. A referral is useful only if the person understands how to reach it and whether assistance is actually available.

Responsibility should not disappear into the word lifestyle. When conditions obstruct recovery, institutions and policymakers have work to do. This chapter cannot provide one housing solution for all African settings, but it can insist on an essential principle: people should not be blamed for failing to follow advice that requires resources they do not possess. Care becomes more honest when those resource gaps are named and addressed.

Making treatment participation possible

Taking medicines as agreed and attending psychological care can support recovery, but participation should be understood rather than merely demanded. A missed appointment or dose can reflect side effects, cost, confusion, forgetfulness, stigma or a considered concern about the plan. The appropriate response depends on the reason.

The person should understand what the treatment is for, how to use it and whom to contact with problems. Questions about side effects deserve a clear route to the prescriber. A counsellor can help the person prepare those questions, but should not independently instruct changes to a prescription. Practical reminders may help when the person wants them and understands the plan.

Sharing responsibility can make participation easier. A trusted supporter might help organise transport or remind the person of

an appointment. Such help should be negotiated. Secret administration, threats and humiliating supervision can damage trust and may raise serious ethical and legal concerns. Complex questions about capacity and emergency care require appropriate professional processes.

The service also has responsibilities: reliable appointments, understandable instructions, affordable access and a way to respond when difficulties emerge. It is unfair to discuss adherence as though the patient controls medicine supply, clinic opening times and transport costs. A workable plan asks what each participant will do and how the arrangement will be reviewed. Cooperation grows when treatment is experienced as useful, understandable and responsive.

A small plan that can survive a difficult week

A recovery plan does not need to change everything at once. Too many simultaneous demands can make it difficult to identify what helps and can leave the person feeling defeated. A useful starting point is one or two priorities selected together because they matter and appear feasible.

Consider an illustrative adult recovering from depression who wants to improve sleep and return to a valued activity. The first plan might involve discussing persistent sleep problems with the clinician and arranging a short visit with a trusted friend. It would also identify transport, privacy and energy barriers. This

example is deliberately modest; it describes a planning process, not an outcome from a real case.

Each agreed step needs enough detail to be usable. What will happen? When? What might get in the way? Who can help? What is the alternative if the day becomes difficult? The fallback should preserve some continuity without turning the original goal into an all-or-nothing test.

Review can focus on what was learned. If the visit did not happen because the friend was unavailable, that differs from overwhelming anxiety or worsening illness. If sleep deteriorates, the plan needs clinical reconsideration rather than stronger encouragement alone. Flexibility helps maintain direction while responding to reality. The purpose of the plan is to support the person through changing conditions, not to create another standard against which they can be judged.

Noticing change without living under surveillance

Monitoring can help recognise progress and emerging difficulties. It can also become intrusive if every feeling, meal or hour of sleep is examined by others. The person should help decide what information is useful, how it will be recorded and who may see it.

A brief review might consider sleep, functioning, distress and a personally valued goal. Clinical measures can add information where appropriate, but changes should be interpreted in context.

A good day does not prove that treatment is no longer needed. A difficult day does not automatically signal relapse. Patterns, severity and the person's history matter.

An agreed response plan should distinguish routine concerns from situations requiring urgent help. Severe confusion, dangerous intoxication or withdrawal, a marked escalation in mood symptoms, inability to meet basic needs or immediate risk of harm can require prompt assessment. A lifestyle plan should never delay necessary emergency care.

Supporters need to know their role and its limits. They can notice, ask and assist without becoming amateur diagnosticians. The person should also have opportunities to speak privately with professionals. Good monitoring strengthens communication and timely care. Surveillance can do the opposite by encouraging concealment. A respectful service makes it possible to report difficulty without expecting punishment, loss of dignity or automatic removal of ordinary choices.

The conditions in which recovery becomes possible

A daily plan can begin with the concern that matters most to the person, such as getting more sleep or resuming a valued activity. Consider what has already helped and what might make the next step feasible.

When a change helps, review which symptoms or difficulties have improved and which still need care. Continue to assess any underlying condition and support needs.

A workable plan connects the person’s choices to competent care and practical assistance. Ask about cost and safety, and identify barriers the service can help remove.

A conversation about meals, sleep or getting to an appointment may reveal why a clinical plan is hard to follow. The next chapter considers what families and communities can do to help.

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Chapter 7

Families, Communities and Healing Environments

The environment receives the person too

When a person leaves a clinic, a household receives more than a prescription. It receives someone who may be frightened, hopeful, tired or uncertain about what comes next. The welcome matters. So do the conversations, demands and practical arrangements that follow. Recovery can be supported by ordinary acts of inclusion, or made harder by suspicion and humiliation.

A healing environment protects dignity, safety and access to care. Family responses can influence whether someone feels able to disclose a difficulty, attend treatment or take part in daily life.

This chapter considers the roles of relatives, caregivers, children, faith communities, peers and services. It asks what people can do together and what institutions must provide so that one relative does not carry the whole burden.

WHO's guidance places people and their rights at the centre of community mental health service design (World Health Organization [WHO], 2021a). At home and in the neighbourhood, that principle means respecting the person's choices and making room for participation during treatment and recovery.

Asking who the family actually is

The word family can conceal important differences. A person may live with a spouse, siblings, grandparents, an adult child or unrelated people who provide dependable care. Relatives abroad may contribute money while knowing little about daily difficulties. A neighbour may offer more practical support than a formally recognised next of kin.

Before arranging family involvement, ask whom the person considers important and trustworthy. Kinship, proximity and safety are separate questions. A close relative may be unavailable; a distant friend may be deeply trusted. Care planning should reflect actual relationships rather than an assumed household structure.

An illustrative young adult in Kigali might want an older sister involved but prefer not to share personal discussions with an uncle who pays the rent. That preference needs exploration and respect. Financial support does not automatically confer unrestricted access to confidential information. The service should explain what involvement is proposed and what consent is needed.

There may also be competing responsibilities. A relative who wants to help may live far away, have limited money or care for several children. Asking what each person can realistically offer is more useful than making general appeals to family duty. A

map of available support can include transport, company, meals, appointment assistance and emergency contacts. Its purpose is to identify workable contributions while keeping the person receiving care involved in decisions about their own life.

Listening to the person before convening everyone

Family meetings can be useful, but the person should ordinarily have an opportunity to speak privately first. They may need to explain concerns about a relative, clarify what can be shared or describe a problem that would be unsafe to raise in a group. A crowded consultation can conceal these needs.

The professional can ask what the person hopes a meeting will achieve. Would it help to explain the treatment plan, discuss household responsibilities or resolve a misunderstanding? What subjects should remain private? Who should attend, and who should not? These questions make involvement purposeful rather than ceremonial.

The person may decline a meeting. That decision should not automatically be interpreted as lack of insight or rejection of support. The clinician can explore the reasons, explain options and consider any relevant safety or legal duties. Complex circumstances require careful professional judgement, including appropriate support for decision-making, rather than a blanket rule that relatives must always decide.

A meeting should also be revisable. One individual may begin by welcoming a lot of participation but eventually discover that he prefers having only a few people involved.

Another individual may start to feel comfortable disclosing information. Consent needs attention as relationships and needs change. A healing environment gives people room to express these preferences without threatening to withdraw practical support. Partnership becomes credible when the person can influence the form that help takes.

Knowledge can reduce unnecessary conflict

Families may be asked to support a condition they do not understand. They may interpret withdrawal as disrespect, slowing as laziness or unusual experiences as deliberate misconduct. Accurate information can help them respond more thoughtfully, provided it is linked to the person's actual assessment rather than speculative diagnosis.

Psychoeducation needs to address the disorder, treatment options, possible problems and ways to obtain help. Psychoeducation also needs to embrace the uncertainty that exists. Symptoms can change, side effects need review and progress is not always smooth. Information should be presented in accessible language with opportunities for questions. A leaflet handed to a worried relative is not the same as a conversation that establishes understanding.

NICE recommends family intervention and education and support for carers in care for psychosis and schizophrenia (National Institute for Health and Care Excellence [NICE], 2014). This supports organised family work; it does not mean that a general talk can replace a structured intervention delivered by a competent practitioner.

Families also need permission to question myths. A diagnosis does not establish that a person is incapable of all decisions, unable to work or inevitably dangerous. Equally, affection alone does not determine what clinical treatment is required. The aim is a shared understanding that makes daily support more accurate. When everyone knows whom to contact and which concerns deserve review, household disagreement is less likely to become the only available response to uncertainty.

Communication that lowers the temperature

A household under strain can develop a pattern in which every discussion begins as an accusation. One person demands an explanation, another withdraws, and a third joins to settle the matter. The original concern becomes harder to address as voices rise. This description is an illustrative interaction, not a diagnosis of a particular family.

A useful alternative begins with one specific observation and a clear request. “You missed the appointment; can we discuss what happened?” invites a different conversation from “You

never care about anyone." Specific language leaves room for information about transport, side effects, fear or disagreement with care.

Timing also matters. Difficult conversations are less likely to be productive when someone is exhausted, intoxicated or highly distressed. Where it is safe, a planned pause and a time to return to the issue may help. A pause should not become a threat of abandonment, nor should it be used to avoid every important discussion indefinitely.

Listening does not require agreement with every belief. A supporter can acknowledge fear without confirming its explanation. "That sounds frightening; let us seek help" may preserve connection more effectively than ridicule or a prolonged argument. Families should not be expected to master specialist therapy techniques. They can, however, develop habits of speaking respectfully, asking before assuming and seeking professional assistance when a conversation exceeds what the household can safely manage.

Support that preserves adulthood

After a serious episode, relatives may take over many tasks because they are worried. Some temporary assistance can be necessary and welcome. Problems arise when the arrangement continues without review and the person is treated as

permanently incapable, even where they could participate with support.

A useful question is what the person can do independently, what they can do with assistance and what currently requires someone else's help. The answers may differ across activities. Someone might manage meals while needing support with appointments. Yet another may know all about treatment but lack transportation or the ability to read.

Support can be graded and reviewed. An illustrative person returning to work might initially want accompaniment on the journey, then prefer a check-in afterwards. The arrangement should change as needs change. Improvement should create opportunities for choice rather than merely more responsibilities.

The WHO and OHCHR (2023) guidance emphasises support for decision-making. In practice, ask what the person wants and help relatives discuss their concerns without taking over decisions. The person should be able to disagree while continuing to receive support.

Sharing care before someone breaks down

Practical care can accumulate unnoticed. One relative accompanies appointments, buys medicine, manages meals, responds to night-time distress and absorbs lost income. Others

may assume that this person is coping because they have continued doing the work. Silence can hide exhaustion.

A family discussion can identify the tasks rather than simply naming a primary caregiver. Who arranges transport? Who can provide a meal? Who can help with children while an appointment takes place? Who will contact the clinic if the usual supporter is unavailable? Specific responsibilities are easier to review than promises that everyone will help.

Contributions need not be identical. A relative abroad may contribute to agreed costs, while someone nearby offers time. Yet the plan should not allow the person with the least bargaining power to carry every unpleasant or unpaid task. Gender and seniority can shape these expectations, and they deserve examination rather than automatic acceptance.

The person receiving care should participate where possible and should not be discussed as a burden in their presence. Sharing tasks is a way of supporting a household, not assigning blame for illness. Services can help families make realistic arrangements, but some needs require formal assistance. A rota cannot create money, respite services or available relatives. Where the family reaches its limits, the response should include additional support rather than stronger moral appeals to sacrifice.

Caregivers need care in their own right

A supporter can love someone and still feel exhausted, frightened or resentful. These feelings deserve a place in care without being used to justify mistreatment. The professional should ask about the caregiver's sleep, health, work and access to support, while preserving the patient's separate rights and confidentiality.

NICE (2020) recommends that support for adult carers account for carers' own needs. The guideline applies in its own legal setting. Check local entitlements and services when using that principle elsewhere.

A caregiver may need a private appointment, a support group, temporary relief from tasks or treatment for their own condition. They should not have to disclose sensitive personal concerns in front of the relative they support. Nor should the person receiving care be made responsible for managing the caregiver's distress.

Praise alone is insufficient. Calling someone a strong mother or devoted spouse may feel affirming, yet it can also make requesting help seem like failure. A better response combines appreciation with concrete questions about limits and resources.

A sustainable environment allows supporters to rest and maintain other parts of their lives. Protecting caregivers is part

of keeping care available; it also recognises their worth beyond the work they perform for someone else.

What Ethiopian research adds to the picture

The RISE trial in rural Ethiopia evaluated community-based rehabilitation added to facility-based care for people with schizophrenia. With regard to primary disability measures, the combination intervention performed better than facility-based care only at the 12-month mark (Asher et al., 2022). The study supports attention to functioning and the community conditions surrounding clinical treatment.

Its design also matters. The comparison was not community support against no treatment. Both groups had access to facility-based care. The findings therefore support a particular added programme under the conditions studied, rather than a claim that informal community goodwill can replace clinical services. Results from one rural district cannot simply be converted into a continental recovery rate.

A later analysis examined caregiver outcomes in the same trial. It was unable to demonstrate any wide-ranging advantages in the other outcomes studied, such as carer stigma, unemployment, and depression (Dijkstra et al., 2025). The analysis reinforces the need to assess caregivers directly rather than assuming that improvement for the patient automatically resolves every family difficulty.

Taken together, these studies suggest a practical direction: combine clinical care with support for participation, and evaluate the effects on both patients and supporters. The household may still need income assistance, respite or help with stigma even when symptoms and functioning improve. Research becomes useful when its distinctions guide service design. Hope is strengthened by understanding what an intervention achieved, whom it helped and which needs remained.

Children should be included without carrying the illness

Children living with an adult who is unwell may notice far more than adults realise. Changes in mood, hospital visits and whispered conversations can create uncertainty. An age-appropriate explanation can reassure a child that the situation is being addressed and that they are not responsible for causing or curing it.

The explanation should be truthful without exposing private details unnecessarily. A parent might say that a family member is receiving help for a health condition that affects feelings, thinking or energy. The wording should fit the actual situation and the child's understanding. Children need room to ask questions repeatedly as circumstances change.

They also need dependable daily arrangements. Who will take them to school, prepare meals and respond at night if the usual

adult cannot? Practical continuity may be more reassuring than a long explanation. A child should know which trusted adult to approach with worries.

Care must not quietly become a child's full-time responsibility. Young people should not be expected to supervise medication, manage severe crises or keep frightening secrets to protect the family name. If concerns about neglect, abuse or safety arise, appropriate safeguarding assessment and local procedures are needed. Supporting the adult and protecting the child are compatible responsibilities. A household becomes more healing when children can remain children while adults and services organise the care that the situation requires.

Marriage and partnership during recovery

An intimate partner may become a supporter while also grieving changes in companionship, affection, finances or shared plans. These experiences can be discussed without implying that the person who is ill has failed as a spouse. Both partners need room to describe their needs and limits.

A diagnosis should not become the explanation for every disagreement. Couples can have ordinary conflicts about money, relatives or responsibilities alongside a mental health condition. Conversely, behaviour that signals deterioration should not be dismissed as merely a marital quarrel. Qualified

assessment and careful relational work can help distinguish these issues.

An illustrative couple might negotiate a temporary redistribution of tasks after hospital discharge and agree to review it. The conversation could include rest, appointment support and how each partner will obtain time away from caring duties. They need to be clear so that hidden expectations do not build up.

Intimacy requires consideration. Discussing symptoms, fatigue, or medication reactions with the right people can help address any potential impact on sexual health. Consent is important even in marriage. Illness does not remove either partner's right to bodily autonomy. Where there is intimidation or violence, ordinary couple work may be unsafe and protection takes priority. Supporting a relationship means attending to the welfare and agency of both people, including the possibility that some arrangements need significant change rather than a simple return to how things were before.

When home is part of the danger

A home can provide shelter while remaining emotionally or physically unsafe. Violence, coercive control, exploitation and neglect require a different response from ordinary family disagreement. Mental illness should neither be used to excuse abuse nor assumed to explain every account of danger.

A person needs an opportunity to disclose concerns privately. Asking about safety in front of the suspected perpetrator can increase risk or prevent an honest answer. Information sharing, contact arrangements and records should be considered carefully. A well-intended message to a shared phone may reveal more than the person wanted disclosed.

WHO guidance on responding to intimate partner and sexual violence emphasises appropriate clinical support, privacy and safety (WHO, 2013). The professional should follow relevant safeguarding duties and referral procedures while explaining options and limits of confidentiality. Where urgent danger exists, immediate protective assistance may be necessary.

Reconciliation is not the automatic goal. A family meeting can expose a person to pressure or retaliation if power and violence are ignored. Likewise, returning someone to the same household without checking conditions can undermine an otherwise thoughtful discharge plan. A healing environment sometimes requires boundaries, alternative accommodation or separation from a harmful person. The essential question is whether the proposed arrangement improves safety and choice. Family unity has value when it supports people’s wellbeing; it cannot justify leaving someone exposed to continuing harm.

Faith communities can make belonging practical

Faith communities may offer a familiar place to seek comfort, meals, friendship and meaning. Their contribution can be substantial when support respects the person's preferences and remains connected to appropriate care. A visit, transport assistance or help with ordinary tasks can express solidarity without requiring the person to explain their illness publicly.

Prayer and spiritual conversation should be offered with consent. A person may welcome them, decline them or want them alongside clinical treatment. None of these choices should determine whether practical help continues. Spiritual care becomes coercive when belonging depends on accepting a particular explanation or abandoning prescribed treatment.

Public testimony requires particular care. A person may feel pressured to announce complete healing, disclose a diagnosis or describe experiences before they are ready. Consent given to a respected leader may reflect unequal power. Leaders should create space for refusal and recognise that recovery can remain valuable even when continuing care is needed.

A community can also review its language. Labelling all mental illnesses as weakness in faith, as punishment, or as spiritual failure can dissuade people from seeking help. A more appropriate message includes dignity, assistance, and assessment. Religious leaders do not need to become clinicians

to contribute meaningfully. They need clear boundaries, reliable referral relationships and a willingness to protect the person from humiliation. Such collaboration allows spiritual resources to support recovery without competing with medical and psychological care.

Collaboration needs evidence and firm boundaries

The COSIMPO trial studied collaborative care between trained traditional or faith healers and primary health-care workers in Nigeria and Ghana. Individuals under the collaborative model showed superior results in reducing psychosis symptoms compared to those receiving enhanced care as usual after six months (Gureje et al., 2020). This is important evidence about an organised model of collaboration.

The result does not validate every practice used by every healer. The intervention included defined training and shared care arrangements. The trial also assessed harmful practices. These decreased in both groups, without a significant difference between groups on that comparison. It would therefore be inaccurate to claim that the collaboration alone proved a superior reduction in such practices.

The broader lesson is to examine what partnership actually does. Who assesses clinical needs? How are medicines and possible interactions managed? What happens when a person refuses an intervention? Where can complaints be made?

Respectful dialogue does not require silence about harmful conduct.

Chaining, beating, sexual exploitation and deprivation of basic needs should never be presented as culturally acceptable therapy. Cultural understanding can help professionals engage with communities while maintaining clear protections. A useful partnership expands access to competent care and makes responsibilities visible. It should be judged through patient experience, safety and outcomes, with independent accountability rather than the prestige or popularity of the organisations involved.

Peer support brings another kind of knowledge

People who have lived through mental health difficulties may offer understanding that differs from professional expertise. A peer can recognise the uncertainty of returning to work, the embarrassment of a clinic visit or the difficulty of discussing side effects. Shared experience can create connection without requiring identical diagnoses or life histories.

The Technical Package of WHO on peer support defines services which facilitate a people-centred and human rights-based approach. (WHO, 2021b). Peer involvement should be organised in a way that protects choice and supports the people providing it. Lived experience has value, but a personal recovery story is not a universal treatment plan.

A peer worker should not pressure someone to stop medication because they stopped theirs, or imply that continued symptoms reflect insufficient determination. Appropriate boundaries, training, supervision or organisational support and referral routes remain important. Peers also deserve fair working conditions rather than an assumption that personal experience obliges them to volunteer indefinitely.

Participation should be optional. Some people prefer individual contact; others value a group. Privacy expectations and their limits need explanation, especially where participants know one another outside the service. A good peer setting permits difference: different beliefs, different treatments and different speeds of recovery. Its strength lies in companionship and credible hope, not in demanding that everyone reproduce one person's path. It can complement clinical care while giving participants a stronger voice within the wider system.

A community response begins with ordinary behaviour

Community inclusion is visible in small decisions. Is a neighbour still greeted? Is a person invited to a suitable activity? Can someone return to a trading association without becoming the subject of jokes? These actions affect belonging even when no formal mental health programme exists.

Local leaders can help establish expectations of respectful conduct. They may fight off humiliations, safeguard privacy,

and promote seeking assistance. Yet awareness events should avoid exposing identifiable people as examples without freely given consent. A campaign that attracts attention by revealing someone's distress can reproduce the exclusion it claims to oppose.

Practical engagement can include any number of activities, such as clubs, cooperatives, sports, arts, or faith-based organisations, depending on personal preferences and needs. Referrals must take into consideration the affordability, availability, and level of welcomingness of the environment. The mere act of referring an isolated individual to a group does not ensure their safety and acceptance therein.

The WHO Commission for Social Engagement underscores the health necessity of tackling isolation and loneliness (WHO, 2025). A community contribution should therefore be more substantial than telling people to socialise. It can create accessible opportunities, reduce harassment and support continued membership when someone becomes unwell. Inclusion means that help is available without requiring public gratitude or a dramatic recovery story. Ordinary membership itself can be part of rebuilding life.

Preparing the journey from hospital to home

Discharge is a transition that needs practical preparation. The person and relevant supporters should understand the follow-up

arrangements, treatment instructions and whom to contact with concerns. Information should be accessible and checked for understanding rather than delivered only at a hurried final encounter.

The home circumstances also need attention. Is there safe accommodation? Are food and transport available? Does the person know how to obtain medicines or attend psychological care? If a supporter is involved, have they agreed to the tasks expected of them? A discharge plan should not silently assign extensive responsibility to someone who was never consulted.

An illustrative arrangement might identify one follow-up appointment, a transport plan and an agreed contact if difficulties arise. It would also record who may receive information. The details should reflect the local service and the person’s preferences. Promising a telephone response that the clinic cannot provide is less helpful than explaining the actual route to assistance.

The first days should allow adjustment. Families may expect immediate return to work or all previous duties; the person may still be tired or uncertain. A phased plan can be reviewed with professionals as needed. Community care is weakened when hospital departure is treated as the end of responsibility. Continuity requires a functioning connection between services

and home, including a way to address problems before the next crisis forces another emergency encounter.

Planning for a difficult day in advance

A crisis plan is easier to discuss when the person has time and support to express preferences. It can identify familiar early changes, helpful responses, unwanted approaches and contacts for clinical assistance. The plan should remain concise enough to use under stress and should be reviewed when circumstances change.

A supporter might be asked to offer quiet company, help arrange transport or contact the treating team. These actions should fit the person's history and the level of concern. A plan must also distinguish routine difficulties from situations requiring urgent assessment, including immediate risk of harm, severe confusion or inability to meet basic needs.

The family should not be expected to manage every emergency alone. Their role is to seek appropriate assistance and support safety within their abilities. Physical confrontation, punishment and attempts to overpower a distressed person can increase danger. Where urgent help is needed, use the locally available emergency or clinical pathway.

WHO and its partners describe psychological first aid as humane, supportive and practical assistance after distressing events (WHO, War Trauma Foundation, & World Vision

International, 2011). This can inform an initial response, but it is not a substitute for indicated medical or psychiatric care. Preparing together can reduce uncertainty. It should not become a document that authorises relatives to ignore preferences or treat every disagreement as a crisis.

Outreach should reach people without exposing them

Some people cannot regularly reach a clinic because of disability, distance, transport costs or other barriers. Outreach can connect services with daily life, but a home visit can also reveal that someone is receiving mental health care. The person should help decide how contact will occur and what arrangements protect privacy.

The visit needs a defined purpose. It might be necessary to evaluate practical barriers or help someone access suitable services. Staff should explain their role and avoid collecting unnecessary information from neighbours. A conspicuous visit should not become an informal announcement to the whole community.

Contact through phones also needs planning. Confidential communication can become challenging due to shared devices and connectivity issues. Before sending reminders or sensitive details, establish what is safe and who may read a message. A familiar relative answering the phone is not automatic permission to disclose the person’s information.

Outreach must connect to an actual service response. Identifying a need without access to assessment or follow-up can leave both the worker and the household unsupported. Clear referral arrangements, supervision and reliable scheduling matter. The purpose is to make care more reachable while preserving dignity. Services should ask whether outreach reduces barriers from the person's perspective, rather than judging success only by the number of visits recorded.

Livelihood and participation belong in recovery

A person may improve clinically while remaining unable to pay rent, resume school or regain customers. These needs require attention because recovery includes the opportunity to participate in life. Psychological care can support confidence and problem-solving, but it cannot create income by itself.

A community programme can explore relevant employment, education and social protection resources. The person must set goals that align with their interests and abilities. A job reinstatement might require some changes and evaluation. The guidelines of WHO on mental well-being in the workplace emphasise inclusion and accommodation (WHO, 2022).

Informal work requires practical imagination. A cooperative might discuss a manageable return to trading; a relative might help temporarily with transport or childcare. These are possible arrangements, not assumptions about what every household can

provide. Money-related decisions need to be transparent, particularly if another person is handling money or running a business in one's sickness.

Protection from exploitation matters. Unpaid labour should not be presented as therapy merely because a person has a diagnosis. Neither should participation in a programme require surrendering benefits or income without informed understanding. A healing environment supports contribution while preserving rights. It recognises that people may need ongoing support and still have valuable skills, relationships and ambitions. Clinical improvement and social opportunity should be pursued together rather than making one a distant reward for completing the other.

A family meeting that produces an achievable agreement

A useful meeting begins with a purpose that everyone understands. It might aim to clarify the next fortnight after discharge or agree how to respond to a recurring difficulty. An agenda should leave room for the person receiving care to speak and for supporters to describe practical limits.

The facilitator can separate observations, concerns and proposals. "The journey costs more than we expected" identifies a problem that can be discussed. "Nobody cares" may express genuine pain but leaves the next action unclear. Helping

people translate broad distress into specific needs can make agreement more possible without dismissing emotion.

An illustrative meeting might end with a transport arrangement, a clinician contact and one shared household task. Each person would understand what they have agreed to do and when the arrangement will be reviewed. The record should be concise and shared only as appropriate. Sensitive disclosures need not become part of a family circulation document.

Not every disagreement will be resolved. A meeting can still be useful if it improves understanding, establishes safety or identifies the need for another service. Where coercion or violence is present, the facilitator must reconsider whether a joint meeting is appropriate. Agreement is valuable only when people can participate freely. A plan built on fear may look cooperative on paper while leaving the underlying danger untouched.

Knowing whether the environment is helping

A programme should evaluate more than attendance and treatment compliance. Does the person feel safer and more respected? Can they reach care? Are meaningful activities becoming possible? Do supporters have manageable responsibilities? Has the household gained useful information without losing privacy or choice?

These questions can be discussed alongside suitable clinical and functioning measures. No single score captures every aspect of a healing environment. The person and supporters may describe different experiences, and both should be heard without automatically granting one account priority. Private opportunities to speak can reveal concerns hidden by a group discussion.

Evaluation should also look for unintended harm. A family programme might increase surveillance. A community campaign might expose someone's diagnosis. A livelihood initiative might create debt or unpaid obligations. Identifying such problems is part of improving care rather than discrediting the idea of support.

Services should avoid promising a fixed recovery rate for all participants. Outcomes depend on who enters, the conditions addressed, the care provided and the period of follow-up. African trials offer valuable evidence while leaving questions about adaptation and longer-term effects. Good evaluation keeps those limits visible. It also makes change possible: if a programme benefits patients but leaves caregivers exhausted, the answer is to address caregiver needs directly rather than declare the whole household successfully rehabilitated.

Belonging without surrendering the self

Relatives and community members can offer transport, companionship and opportunities to participate. Agree what help the person wants and how it connects with professional care.

Protect the person's safety and confidentiality, including when relatives pay for care. Caregivers also need access to help and time to rest.

Ask whether the person can speak freely, whether children are safe, whether carers can take a break and how the household can obtain clinical help when needed.

Recovery takes different forms. Families can help people stay connected and services can give those families practical support. The next chapter asks how newer treatments and technology can contribute to that work.

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Chapter 8

Modern Treatments and the Limits of Technology

Progress should be measured in lives

A family that has watched someone suffer for years may understandably ask whether a newer treatment could help. A clinician who has tried several approaches may ask the same question. Scientific progress creates real possibilities, particularly for people whose symptoms remain severe or whose treatment produces unacceptable side effects. Hope belongs in this discussion.

A striking image or online testimonial offers little basis for judging an intervention. Ask who was studied, what changed and whether the benefit applies to the people a service aims to reach.

The chapter covers brain stimulation, newer medicines, genetic information, digital care and artificial intelligence. Each raises questions about evidence, access and what specialist support is required.

For a health system, the benefits of a new intervention depend partly on whether people can reach it, staff can deliver it safely and follow-up can be sustained.

Different questions require different tools

Before discussing a device or test, establish the question it is meant to answer. Is the purpose diagnosis, investigation of

another possible condition, treatment selection, symptom relief or continuing support? These are related tasks, but a tool that serves one does not automatically serve the others.

A scan may identify a structural abnormality without explaining every symptom. A questionnaire may indicate that further assessment is needed without establishing a diagnosis. A treatment may reduce symptoms without proving a particular theory about their cause. Confusing these roles can lead to unnecessary tests, misplaced reassurance and exaggerated claims.

An illustrative client might be told that a sophisticated assessment will identify exactly what is wrong and select the perfect treatment. Before agreeing, the person could ask what decision the result will change. If the answer remains vague, the expense may be difficult to justify. The same question applies to a low-cost test as to an expensive machine.

Clinical judgement should connect the information to the person’s history, examination, circumstances and preferences. This does not make technology unimportant. It establishes the work the technology must do. A useful innovation adds reliable information or improves care in a way that can be explained. Its value should remain open to evaluation after it has entered a clinic, because attractive equipment and confident marketing cannot establish that patients are benefiting.

Brain scans can investigate without settling everything

CT and MRI can be important when symptoms suggest a neurological or other physical condition. Their use should follow a clinical question and relevant guidance. A person with a mental health diagnosis still deserves appropriate medical investigation when new findings or a changing history warrant it.

However, a routine structural scan does not confirm or exclude schizophrenia. NICE's guidance on first-episode psychosis does not recommend structural neuroimaging as a routine component of every initial investigation (National Institute for Health and Care Excellence [NICE], 2008). This is a specific guideline position, not a rule that imaging should never be used. Practice and evidence should be reviewed in the relevant clinical setting.

A normal result cannot establish that all symptoms are imagined or that no significant illness exists. An abnormal finding also needs interpretation: it may be relevant, incidental or require further assessment. The meaning comes from the relationship between the result and the clinical picture.

Requests for scans often express a reasonable wish for clarity. Professionals should explain why a particular investigation is or is not indicated and what other assessment is needed. Dismissing the question can damage trust; ordering every

requested scan can create cost without benefit. The more responsible path is an understandable explanation of the problem being investigated, the information expected and how the result would influence care.

Tests should change a decision

Laboratory investigations can help examine physical contributors, monitor treatment and identify safety concerns. The appropriate tests depend on the person and the clinical question. There is no universal package that can uncover every cause of mental distress or certify that a treatment is safe indefinitely.

A useful discussion connects each proposed investigation with its purpose. Is it checking a concern raised by the history, establishing a baseline before treatment or monitoring a recognised risk? What happens if the result is abnormal? Who will review it, and when? A test without a plan for interpretation and action is an incomplete intervention.

Costs need attention too. Families may borrow money for extensive investigations because they assume that more testing always means better care. Clinicians can help by distinguishing necessary, potentially useful and currently unhelpful investigations. Resource limitations do not justify ignoring indicated tests, but they make clear prioritisation particularly important.

The same discipline applies after results arrive. An electronic report should not remain unread because the ordering clinician has moved or the patient missed an appointment. Services need a dependable system for reviewing significant findings and contacting people appropriately. Technical accuracy is only one part of useful testing. The whole pathway includes explanation, collection, interpretation, communication and follow-up. Each part can determine whether the investigation actually improves the person’s care.

What modern ECT involves

Electroconvulsive therapy, commonly called ECT, is a medical procedure in which electrical stimulation produces a controlled seizure for therapeutic purposes. Modern modified ECT involves a general anaesthetic, a muscle relaxant and clinical monitoring. It is delivered by a trained team rather than through an ordinary counselling encounter (American Psychiatric Association, n.d.).

This description should replace images of punishment or uncontrolled electric shock. It should also replace the suggestion that ECT mechanically realigns a displaced brain. Such language may sound reassuring, but it does not accurately explain the procedure. Patients deserve an account of what is done, why it is proposed and what uncertainty remains.

A discussion should include preparation, the treatment setting, recovery after each session and practical restrictions explained by the treating team. The person should know whom to contact about adverse effects or concerns between sessions. Family involvement can help with transport and support when the person wants it, but relatives should not become the sole source of information.

Accurate explanation permits a more balanced conversation. Fear may reflect films, stories, previous mistreatment or a genuinely difficult experience with treatment. The professional should ask what concerns the person rather than simply correcting them. A procedure becomes more understandable through careful dialogue, not through insisting that modern technology removes every reason for anxiety.

When ECT may be considered

ECT is not a general treatment for every mental health condition. According to NICE, this treatment should be used in cases of severe depression under specific conditions, such as when a quick effect is needed, previous therapies have been unsuccessful, or the patient prefers it based on their past experiences with medication (NICE, 2022).

Urgency may alter the order of things. A person whose severe condition threatens basic functioning or survival may need specialist intervention without waiting through repeated routine

appointments. Conversely, a stable person asking about ECT should have time to understand the proposal and consider alternatives. The same procedure can arise in very different clinical circumstances.

The referral should explain the treatment goal. What symptoms are being targeted? What improvement would matter to the person? How and when will response be reviewed? A family may hope that the procedure will resolve years of relationship strain or restore lost employment immediately. These hopes deserve discussion because symptom improvement does not automatically repair every consequence of illness.

Specialist assessment should also consider physical health and anaesthetic safety. Eligibility cannot be established by an online description, a friend's experience or the fact that another treatment has been disappointing. The value of ECT lies in an appropriate clinical use, with safeguards and continuing care. Presenting it as either a universal rescue or an inherently unacceptable treatment prevents the careful judgement that patients need.

Memory effects deserve an honest discussion

ECT can involve confusion and memory difficulties, and the possibility should be discussed before treatment. The Royal College of Psychiatrists describes both short-term difficulties and the possibility of more persistent memory loss for some

people (Royal College of Psychiatrists, n.d.). Reassurance should not erase the significance of this risk for an individual.

Memory has personal meaning. A student may worry about learning; a parent may fear losing important experiences; a worker may be concerned about responsibilities. These concerns belong in the decision, alongside the effects of the illness itself and the expected benefits of treatment. Different priorities can lead reasonable people to weigh the same information differently.

The group must explain the monitoring of cognition and the individual's experience. The observation of a relative may provide useful insight, but it should not replace the patient's narrative. In case of an issue reported, the solution must include a review and not an assumption that the individual misunderstood the procedure.

Consent should be reviewed during the course of the intervention. Professionals must address questions related to decision-making capacity, emergencies, and the law to facilitate the individual's participation. Responsible care leaves room for uncertainty and disagreement while addressing clinical need. Its credibility grows when benefits and harms are described clearly, without pressure to accept a treatment simply because it is available.

The course ends before the care does

A successful procedure is part of a longer recovery plan. The treating team needs to discuss what happens after an acute course, including appropriate continuing treatment and review. ECT should not be presented as a procedure that necessarily removes the need for further care (American Psychiatric Association, n.d.).

Practical arrangements can influence the experience. Who helps with travel? What advice has the team given about work or driving? How will concerns be reported? Is the person returning to a supportive and safe setting? These questions should be answered by the service, with relevant supporters involved by agreement.

The review should consider symptoms, functioning, cognition and the person's own priorities. Improvement can create an opportunity to resume psychological work, address social needs and rebuild daily routines. It does not require the person to return immediately to every previous responsibility. Some consequences of illness may take longer to address than the acute symptoms.

Services should also document what was helpful and what was difficult. That information can guide future decisions if symptoms return. A person who has benefited from treatment may still have concerns about repeating it, while someone who

experienced adverse effects deserves to have those effects taken seriously. Continuing care preserves the value of an intervention by connecting it with the life the person is trying to regain.

Magnetic stimulation offers another option

Repetitive transcranial magnetic stimulation, or rTMS, uses magnetic pulses to influence activity in targeted brain regions. It is generally delivered while the person is awake and does not ordinarily require general anaesthesia. It differs from ECT in its procedure and intended stimulation pattern (National Institute of Mental Health [NIMH], n.d.-a).

For a patient, the useful questions concern suitability, likely benefit, adverse effects and the demands of attendance. A course can require repeated visits, so travel, time away from work and accommodation may matter. A procedure that appears convenient within a specialist centre may be difficult for someone travelling from another district.

NICE’s guidance supports use of rTMS for depression with appropriate clinical governance, consent and audit, while recognising variability in response and the need for further evidence in some areas (NICE, 2015). This does not establish that it is appropriate for every form of depression or preferable to every alternative.

The clinician should explain the particular protocol being proposed and why it fits the person's condition. Screening and safety advice belong to a trained service. The absence of anaesthesia does not make professional assessment optional. Nor should the word non-invasive be used to imply that adverse effects are impossible. An informed choice compares the whole treatment pathway with other reasonable options, including the practical burden of receiving it.

Faster protocols still need careful evaluation

Some newer stimulation protocols aim to shorten the time needed to deliver treatment. NIMH describes accelerated rTMS approaches in which multiple sessions may be delivered within a shorter period (NIMH, n.d.-a). A shorter timetable can be attractive, especially for people who must travel or take leave from work.

The important question is what evidence supports the exact protocol, device and patient group. One clinic's method should not be assumed to reproduce another study merely because both are advertised as accelerated treatment. Session schedules, eligibility and other details can affect how findings should be interpreted.

Patients can ask how outcomes are measured and what happens after the intensive phase. Does the price include assessment, follow-up and management of adverse effects? Is there a plan if

the person does not improve? A short treatment course does not automatically mean a short illness or a permanent result.

Services should communicate uncertainty without making the patient responsible for judging specialist evidence alone. The professional's task is to explain relevant findings and limitations in understandable terms. Marketing should not turn speed into a promise of certainty. A rapid response can be clinically valuable; its value still depends on safety, durability, functioning and the person's experience. Innovation should improve these outcomes rather than merely compressing the appointment calendar.

Implanted devices and experimental stimulation

Some brain stimulation approaches involve implanted equipment, while others remain experimental for particular psychiatric uses. NIMH distinguishes authorised uses from investigational approaches and describes interventions such as vagus nerve stimulation and deep brain stimulation within this evolving field (NIMH, n.d.-a). Their roles cannot be inferred simply from the general phrase brain stimulation.

An implanted device raises questions about surgery, maintenance, follow-up and what happens if complications arise. Access to the initial procedure is only the beginning. A patient who travels abroad needs to know who will provide

continuing care at home and whether the relevant expertise is available.

Experimental treatment requires an equally clear explanation. Participation in research can be valuable, but it should be identified as research. The person needs to understand the purpose, uncertainties, alternatives and arrangements for adverse events. Hope for personal benefit should not obscure the distinction between an established service and a study designed to answer an unresolved question.

Patients should also be cautious about borrowing medical credibility from unrelated uses. A device used for one neurological condition is not automatically an effective treatment for all psychiatric difficulties. Each proposed indication needs evidence and appropriate oversight. The existence of sophisticated engineering does not settle clinical value. The person deserves a complete care pathway, not simply access to a machine or an operation.

Rapid acting medicines are not instant cures

Newer medicines can offer additional possibilities for some people with depression that has not responded adequately to previous treatment. Esketamine is one example. The FDA approved the use of the product for treatment-resistant depression among adults as a single therapy or in combination

with an oral antidepressant in the US prescribing information due to the significant safety concerns involved (US FDA, 2025). This approval constitutes a regulatory indication in a certain jurisdiction. It does not establish approval, availability or suitability in every African country. A clinician must consider the applicable local framework, the person's history and the service's ability to deliver the treatment safely.

Rapid improvement, where it occurs, still needs evaluation over time. Relief during an early phase does not demonstrate that the condition has been permanently removed. Continuing care, review and management of other needs remain important. Patients should understand the intended course, follow-up expectations and practical costs.

It is also important to distinguish esketamine from other ketamine formulations and treatment settings. Similar names do not make products or delivery arrangements interchangeable. The relevant evidence and safety requirements must match what is actually being offered. A person seeking relief should not have to rely on a seller's assurance that all versions are equivalent. Specialist explanation can preserve hope while preventing a promising development from being expanded into claims the evidence does not support.

Supervision is part of the medicine

The setting in which a treatment is delivered can be central to its safety. A product that requires observation cannot be evaluated as though it were simply a tablet to collect and use independently. Staff, monitoring, emergency readiness and post-treatment advice are part of the intervention.

For esketamine, US prescribing information describes risks including sedation, dissociation, respiratory depression, and abuse and misuse, with monitoring requirements (FDA, 2025). These requirements should be understood through the treating service and current local guidance. They are not details that can be replaced by a reassuring message from a remote seller.

An African service considering such treatment needs to examine the whole pathway. Can people travel safely afterwards? Who reviews physical health concerns? What happens if an adverse event occurs? Can follow-up be sustained without unaffordable repeated travel? The answers may determine whether a service is ready to offer the intervention responsibly.

Patients should ask for a clear account of fees and arrangements. Low advertised prices can exclude essential assessment or observation, while high prices do not prove quality. The central issue is whether the treatment is delivered according to an appropriate standard. Innovation becomes clinically meaningful

through the system around it. Removing safeguards to make a treatment appear cheaper or more convenient can change the very conditions under which its benefits and risks were evaluated.

New mechanisms widen choices without ending uncertainty

Progress in psychiatric medicines includes attempts to work through different biological pathways. In September 2024, the FDA approved xanomeline and trospium chloride, marketed as Cobenfy, for schizophrenia in adults. The agency described it as a new mechanism of action involving cholinergic rather than the usual dopamine-receptor targeting approach (FDA, 2024).

Such a development matters because patients differ in treatment response and tolerance. However, a new mechanism does not establish that every patient should switch, that side effects have disappeared or that long-term questions have all been answered. The FDA's announcement also describes adverse effects and contraindications that require clinical attention.

The appropriate conversation connects the development with the individual's needs. What problem would a change address? What alternatives are available? How would response and safety be monitored? The prescriber must consider the complete treatment history rather than choosing solely on novelty.

Access also depends on local approval, supply, affordability and clinical capacity. This chapter does not assume that an approval

in the United States creates availability across Africa. A responsible health system can evaluate new options while improving access to existing effective care. Patients should not be made to feel that their current treatment is worthless because another medicine has appeared. Progress expands informed choices; it does not remove the need for careful prescribing and shared decisions.

Genetic information has a limited but developing role

Pharmacogenetics examines how genetic differences can affect aspects of medicine response, including drug metabolism. The FDA maintains a table of gene–drug associations and cautions that inclusion does not necessarily mean testing is recommended before prescribing a medicine (FDA, n.d.). A genetic association is therefore not the same as a universal instruction to test.

Patients may encounter offers to identify the perfect psychiatric medicine through a sample of saliva or blood. Such promises need scrutiny. The person can ask which genes are examined, what decisions the test can inform and what the report cannot predict. Clinical response also depends on factors that a genetic report does not capture completely.

Interpretation should involve a qualified professional familiar with the relevant evidence. A result should not prompt an unsupervised change to a prescription. The report may require

consideration alongside other medicines, physical health, previous treatment and the patient's priorities. A colour-coded recommendation is still information to interpret, not a substitute for clinical judgement.

Cost and privacy also matter. Who stores the sample and genetic data? Can the information be reused or shared? Does the expected clinical benefit justify the expense in this case? These questions are particularly important where the same household is struggling to fund ordinary care. Personalised treatment should mean care fitted to a person, not simply the purchase of a personalised-looking report.

Promising research is different from a commercial promise

Interest in psychedelic and dissociative drugs has expanded research into possible mental health applications. NIDA describes both potential therapeutic research and important health risks associated with these substances (National Institute on Drug Abuse [NIDA], n.d.). Scientific interest deserves serious examination, but it does not validate every retreat, product or practitioner using the same vocabulary.

A research intervention may involve careful selection, a defined preparation, trained staff and extensive follow-up. Those conditions may differ greatly from an informal or commercial experience. Findings should not be transferred automatically between substances, doses, populations or settings.

A person should know whether an offer is lawful clinical care, a regulated study or something else. The provider should explain the evidence, uncertainties, exclusions and response to complications. Testimonials about a profound experience do not establish lasting clinical benefit or suitability for another person.

For a public-facing African mental health book, the appropriate stance is neither dismissal of all investigation nor encouragement of self-experimentation. Such people require professional evaluation because the lack of regulation may lead to potential dangers that the ad does not mention. It is clear why the desire for a life-transforming experience is there, considering all of the pain that has been experienced. What should follow then is a provision of honest information and proper care. Scientific progress depends on the successful application of research conclusions.

Telemedicine can bring expertise closer

Remote consultation can connect a patient or local clinician with a professional who is not physically nearby. It may reduce some travel and widen opportunities for follow-up, consultation or psychological care. The WHO telemedicine implementation guide sees telemedicine as a service that requires planning, implementation, and maintenance, rather than just accessing a video app (WHO, 2022).

The suitability will depend on the individual and the task at hand. Some assessments need physical examination, investigations or immediate in-person support. A remote professional should explain what can be addressed through the consultation and when another form of care is needed. The patient should understand who is responsible for prescribing, referrals and follow-up.

An illustrative district service might arrange a specialist consultation with a local clinician present, where appropriate and agreed. That arrangement could help connect expertise with local examination and practical support. It would still need clear responsibilities and a reliable route for urgent concerns.

Privacy, language, technological ability and connection quality become important for remote independent sessions. The person should know what happens if the call fails. Cross-border care also requires verification of relevant professional and legal requirements. A clinician's online availability does not automatically establish permission to practise everywhere. Good telemedicine reduces distance while preserving the standards of explanation, confidentiality and accountability expected in any other consultation.

Digital access is not evenly distributed

A smartphone can create an opportunity for care while leaving important barriers intact. A person may share the device, lack

reliable data or have nowhere private to speak. Disability, language and literacy can also affect whether a digital service is usable. An appointment link is not evidence that access has been achieved.

WHO's guideline on digital interventions considers benefits, harms, feasibility, resources and equity within health-system strengthening (WHO, 2019). That perspective is particularly useful when services are tempted to count enrolment as success. The relevant question is whether people receive appropriate help under conditions they can sustain.

An illustrative woman using a shared household phone may prefer a clinic visit because messages could expose her care to someone who controls the device. Another person may value remote sessions because travel is expensive. The service should explore these preferences rather than assume one format is universally more accessible.

Alternatives need to remain available where possible. A digital pathway should not quietly exclude people who cannot use it, and a failed connection should not automatically be recorded as unwillingness to engage. Local planning can include low-bandwidth options, accessible materials and clear arrangements for in-person referral. Technology improves equity when its design responds to barriers. It can deepen inequality when the

people least able to use it are treated as responsible for being left behind.

Apps need evidence beyond popularity

Mental health applications can offer education, exercises, reminders or ways to record experience. NIMH identifies potential benefits alongside concerns about effectiveness, privacy and the limited guidance available for choosing among products (NIMH, n.d.-b). Popularity, a professional-looking interface and favourable reviews do not establish clinical value. The person should ask what the app is intended to do. Is it a general wellbeing tool, a way to communicate with a clinician or a specific therapeutic intervention? Evidence should match that purpose and the actual version being offered. A claim that one digital programme helped a research group does not establish that every app using similar language will help.

The practical burden also matters. Frequent prompts may feel supportive to one person and intrusive to another. A symptom diary can be useful when someone reviews it with the user, but become a source of worry if every fluctuation produces an alarming interpretation. The person should retain control over participation where appropriate.

An app should not be the only route to help during a serious deterioration. Clear information about service limits and urgent support is essential. Users also need to know whether messages

reach a human professional and when a response can be expected. A tool is more credible when its function and boundaries are explicit than when it implies constant care that no one is actually providing.

Data protection belongs inside care

Mental health information can be deeply sensitive. A digital record may include experiences that a person has not shared with a spouse, employer or community leader. Genetic information, location data and recordings can add further concerns. The decision to collect such information should have a clear purpose.

Patients should receive an understandable explanation of who can access data, where they are stored and how they may be used. Consent should not be reduced to a long screen of unreadable terms. Services must also establish the applicable legal requirements rather than assume that a commercial platform's default settings are sufficient.

NIMH highlights privacy as a central issue in mental health technology (NIMH, n.d.-b). In practice, this means asking whether information is necessary, whether access is restricted and what happens if a device is lost or an account is shared. Removing a name may not always remove the possibility of identifying someone through other details.

Professionals need clear organisational arrangements for records and communication. Personal convenience should not determine where clinical information is copied. Patients should have a route to raise concerns and obtain explanations. Trust depends on more than a claim that data are secure. It also depends on restraint: collecting only what is justified, sharing appropriately and refusing uses that serve commercial interests at the expense of the person's dignity or safety.

AI can assist while still being wrong

Artificial intelligence can support tasks such as organising information, drafting material or identifying patterns for professional review. The guidelines of WHO regarding the usage of multimodal large-scale models also caution against inaccurate results, bias, privacy issues, and over-reliance (WHO, 2024). Fluency should not be mistaken for clinical understanding.

A system may produce a confident answer from incomplete information. It may miss a relevant physical condition, misunderstand an expression of distress or invent a reference. These possibilities are especially important when users are frightened, seeking certainty or unable to verify the response. The presence of medical vocabulary does not establish that a safe assessment has occurred.

For clinicians, assistance should preserve responsibility. Generated notes and suggestions need checking against the actual consultation and appropriate evidence. A professional should not allow a system's apparent confidence to override information from the patient or concerns that require examination. Responsibility remains with the service and qualified practitioners using the tool.

For the public, AI may be useful for preparing questions or understanding general concepts, provided the information is checked where clinical decisions are involved. It should not be presented as an independent prescriber or emergency service. A reliable system must state its limits, and a responsible service must make human care reachable. Automation has value when it supports judgement rather than obscuring who is answerable for the result.

Language and local evaluation matter

A tool developed elsewhere may perform differently when used with another language, population or service setting. Translation alone cannot establish that a symptom question, risk classification or treatment suggestion retains its meaning. African linguistic and social diversity makes local evaluation especially important.

An expression of spiritual distress, a respectful indirect answer or a description of bodily discomfort may be misinterpreted if

the tool assumes one narrow way of presenting symptoms. Professionals can also make these mistakes; technology does not remove the need for cultural humility. The difference is that an automated error may be reproduced across many encounters before it is noticed.

The WHO guidelines on AI also emphasise the need for governance and stakeholder participation in the development and implementation process (WHO, 2024). In the case of services, this entails testing by the right users and monitoring the service's performance, in addition to a means of contesting the decision made.

Local evaluation should examine who benefits, who is missed and whether errors cause harm. Average performance can hide important differences between groups. A tool should not be treated as appropriate for all African settings because it was tested in one city or language. Responsible adaptation preserves the possibility of declining or revising a technology when its assumptions do not fit the people it is meant to serve.

Wearable numbers need a human interpretation

Devices that record activity, sleep-related signals or other measurements can help some people notice patterns. Their outputs should be interpreted according to what the device actually measures and how reliably it does so. A consumer score

is not automatically a diagnosis, and a change in a graph does not by itself establish relapse.

A person might find a simple record helpful when discussing fatigue or routine with a clinician. Another might become preoccupied with achieving an ideal number. The service should ask whether the information improves understanding and action or adds anxiety without benefit. More data do not always mean more clarity.

The response pathway matters. If a device issues an alert, who reviews it and what should the person do? If no qualified person is monitoring the information, the user should not be left with the impression of continuous clinical supervision. That misunderstanding can delay help when symptoms require assessment.

Privacy and affordability remain relevant, including whether the device must be replaced or linked to a paid service. A low-technology diary may sometimes answer the clinical question adequately. The choice should follow the person’s needs rather than the appeal of constant measurement. Technology becomes useful when it produces information that someone can interpret responsibly and use to improve care. Counting and classifying a life should never substitute for understanding it.

Buying equipment is different from building a service

A hospital can obtain a device before it has the workforce and systems to use it consistently. A digital platform can launch before referral arrangements exist. These gaps matter because the treatment or service is the complete pathway, including staffing, supplies, maintenance, consent, monitoring and follow-up.

African institutions should therefore examine the continuing costs of an innovation. What training is required? Who maintains equipment? What happens during a power interruption or supply shortage? Can individuals fulfil the required programme? How are problems solved? A donation can cut down the cost of initial buying, but many duties will remain undone.

WHO's digital health guideline places interventions within health-system strengthening rather than treating technology as a substitute for functioning services (WHO, 2019). The same practical reasoning applies to physical equipment. An advanced treatment should be supported without allowing essential care to become unavailable to everyone else.

This is a matter of sequencing and balance. Investment can expand specialist options while also protecting access to assessment, medicines, psychological interventions and community support. Services should evaluate actual patient

outcomes and operating reliability after implementation. A machine that is rarely functional or a platform that repeatedly loses contact may produce impressive publicity without dependable care. Modernisation should be visible in the patient's experience of continuity, safety and useful treatment, not only in photographs of new equipment.

Asking better questions protects hope

Before deciding about a treatment, ask why it was proposed, what evidence supports it, which alternatives exist and what to do if it does not help. Include risks, costs and the practical demands of follow-up.

A research finding, a regulatory authorisation and local availability answer different questions. Practitioners can help families understand how each applies to their situation and explain where evidence remains uncertain.

Brain stimulation, newer medicines and digital care can widen the options for selected needs. Their value depends on assessment, safe delivery and follow-up.

Access to suitable advances should extend to people who face financial or geographic barriers. The next chapter considers the stigma and rights issues that can also determine whether someone obtains care with dignity.

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Chapter 9

Ending Stigma and Protecting Rights

Dignity should not depend on a diagnosis

A person attends a clinic for help and returns home with a new fear: what will happen if others find out? The concern may involve employment, marriage, friendship, religious membership or the right to be heard within the family. Symptoms are already difficult. Anticipated rejection adds another burden to seeking care.

In this fictional example, disclosure carries a risk. Services and communities can reduce that risk by protecting privacy and making it possible to seek care and continue ordinary activities without discrimination.

Rights and dignity apply throughout illness, treatment and recovery. Continuing support should help people exercise their preferences and receive fair treatment.

Families, services, schools, workplaces, faith communities, media and governments can change practices that sustain stigma. International standards inform this work, and legal procedures depend on the country.

Seeing the different parts of stigma

Stigma can involve stereotypes about a group, prejudice towards its members and discriminatory behaviour. The American Psychiatric Association also distinguishes public,

self-directed and institutional forms of stigma (American Psychiatric Association, n.d.). These distinctions help explain why a friendly awareness message may leave significant barriers untouched.

A stereotype might suggest that everyone with a psychiatric diagnosis is unreliable. Prejudice can turn that assumption into fear or contempt. Discrimination occurs when a person is excluded from an opportunity because of such assumptions. Institutional arrangements can reproduce exclusion even when individual staff members believe they are being neutral.

An illustrative employer may speak warmly about mental health while automatically rejecting applicants who disclose previous treatment. The reassuring language does not remove the discriminatory practice. Similarly, a clinic may display a rights poster while speaking to relatives instead of the patient. The problem lies in what happens, not only in what people say they value.

Effective action therefore needs a specific target. Are people afraid to seek help? Are staff making unsupported assumptions? Does an application form demand unnecessary health information? Is a complaint process inaccessible? These are different problems requiring different responses. Naming the mechanism makes change more achievable. It also allows evaluation to move beyond counting campaign participants

towards examining whether people are treated more fairly in the settings that shape their lives.

The comparison with physical illness needs care

Comparing mental health care with the treatment of physical illness can expose an unfair double standard. Someone may accept spectacles or blood pressure medicine while mocking psychiatric treatment. The comparison can help a community recognise that needing care should not make a person an object of ridicule.

However, physical illness is not universally free from stigma. People can experience rejection around HIV, epilepsy, visible disability and other health conditions. Saying that nobody stigmatises physical illness overlooks these experiences and may unintentionally divide people who need the same protections.

The stronger principle is that no health condition justifies humiliation or exclusion. Mental and physical health both deserve competent care, and a person can experience difficulties in both areas. Respect should not depend on proving that one illness resembles another closely enough to qualify for compassion.

A diagnosis can help explain a need without defining the whole person. Someone who wears glasses remains a colleague, parent, friend or student; the same breadth of identity belongs

to someone receiving mental health treatment. Yet the argument should go further than normalising treatment. Even a person who has no diagnosis, declines public disclosure or has not reached care deserves dignity. The goal is equal membership in society, supported by fair opportunities and appropriate assistance. Comparisons can open the conversation, but rights should rest on personhood rather than on the persuasive power of an analogy.

Language can open or close a door

Words influence how a person is received. Mocking labels, jokes and casual diagnostic insults can make a household or workplace feel unsafe. Describing a person entirely through a condition can also narrow attention to symptoms while obscuring skills, responsibilities and preferences.

Respectful language should remain understandable. The aim is not to replace every familiar expression with difficult terminology or shame someone who asks an honest question. A useful correction explains why a term hurts and offers a clearer way to describe the concern. Local language discussions should involve people who use the language and people who have experienced its effects.

Preferences differ. Some people welcome person-first wording; others prefer a particular identity term. Asking how someone wishes to be described is often more respectful than imposing

one formula. The description should also be relevant. A diagnosis does not belong in every introduction or account of a person's behaviour.

Services can begin with their own records. Notes should distinguish observation from judgement. "Missed two appointments because transport was unaffordable" communicates more than a label suggesting that the person is uncooperative. Accurate language improves clinical understanding as well as dignity. The broader purpose is to make it easier to tell the truth about distress and care. People should be able to discuss serious difficulties without inheriting a vocabulary that turns those difficulties into evidence of personal inferiority.

Self-stigma grows in a social world

A person repeatedly exposed to negative messages may begin applying them inwardly. They may expect rejection, underestimate their abilities or feel ashamed of needing help. Recognising this pattern should not become another reason to blame the person for lacking confidence. Their expectations may have been shaped by actual mistreatment.

An illustrative graduate may stop applying for work after hearing that people with mental health histories cannot be trusted. Psychological support can help examine the conclusion and rebuild options. Yet the employer's practices also need

attention. Asking the applicant to become more resilient while leaving discrimination unchanged is an incomplete response.

Support can reconnect the person with identities and achievements beyond illness. This might include learning, family roles, friendship, creative activity or participation in a group they choose. Progress should not be measured only through public declarations of confidence. Someone may take an important step privately and still feel uncertain.

Peer contact can also provide alternative accounts of living with a condition, provided no single recovery story becomes a standard everyone must meet. People deserve dignity whether their symptoms resolve quickly, recur or require continuing care. Reducing self-stigma involves both personal support and a social environment that offers credible reasons to expect fair treatment. Confidence becomes easier to rebuild when opportunities are real, relationships are respectful and asking for help does not repeatedly produce humiliation.

Disclosure must remain a choice

Public discussion can challenge stereotypes, but disclosure carries different consequences for different people. A professional with secure employment may face fewer risks than a student dependent on relatives or a worker without contractual protection. Encouraging openness should include an honest discussion of these differences.

A person can consider what they want to share, with whom, for what purpose and at what time. Disclosure to a clinician is different from a workplace announcement or an online testimony. Information shared for one purpose should not automatically circulate for another. The person may also choose to share a practical need without revealing every clinical detail. An illustrative employee seeking time for appointments might discuss scheduling with an authorised manager through an appropriate process. That does not mean colleagues need access to therapy notes. Relevant legal requirements and organisational procedures should be established in the specific setting rather than assumed.

No one owes the public a personal account in order to advance a campaign. People who choose advocacy should have support, control over their story and a way to set limits. Those who remain private should receive the same respect. Ending stigma means making disclosure safer while protecting the right not to disclose unnecessarily. It should expand the person's options rather than replacing a culture of enforced silence with a new expectation of compulsory public honesty.

Confidentiality is visible in small decisions

A service can breach trust without publishing a formal report. Speaking loudly in a queue, leaving a record on a desk or sending a detailed message to a shared phone can expose

sensitive information. Privacy needs attention throughout the care pathway, including reception, consultation, records and follow-up.

The person should understand who may receive information and why. Where disclosure is required by applicable law or necessary under relevant professional duties, the explanation should be clear and proportionate. Staff should not promise absolute secrecy without explaining recognised limits. Equally, vague appeals to family concern should not justify unrestricted sharing.

A relative paying for treatment is not automatically entitled to everything discussed. A community leader's influence does not confer a clinical role. Information should be shared on an appropriate basis, with consent where required and with attention to the minimum relevant detail. Complex situations need proper professional guidance.

Institutions can make privacy practical through staff training, suitable spaces, access controls and clear communication arrangements. Patients should have a route to question an apparent breach without fearing loss of care. A confidentiality policy becomes credible through ordinary conduct. When people see that their information is handled carefully, they have stronger reasons to seek help and report concerns honestly.

Protecting privacy therefore supports both rights and the quality of the care itself.

Health services must examine their own assumptions

Stigma can enter the very services intended to provide help. A professional may dismiss a physical complaint because a psychiatric diagnosis is already recorded. Staff may assume that a person cannot understand an explanation, or speak to accompanying relatives as though the patient were absent. These practices can damage trust and clinical accuracy.

Every complaint still needs an appropriate assessment. A history of anxiety does not establish that new chest discomfort has the same explanation. A diagnosis of psychosis does not remove the possibility of infection, pain or another physical condition. The clinical task is to investigate proportionately rather than let the label decide the answer in advance.

WHO's guidance on physical health in adults with severe mental disorders supports recognition and management of coexisting conditions and health risks (World Health Organization [WHO], 2018). Respectful care must therefore include access to ordinary physical health assessment as well as psychiatric treatment.

Services can review how patients experience reception, waiting, examination and explanation. Staff also need working conditions that support careful practice, including supervision

and realistic workloads. Overload can contribute to poor encounters, but it should not become an excuse for routine humiliation. Improvement requires both professional accountability and institutional support. A person seeking care should encounter a clinical question about their current need, not a set of assumptions attached permanently to a previous diagnosis.

Risk assessment should not become a stereotype

Some situations require careful assessment of immediate risk. That need does not justify treating everyone with a mental health condition as dangerous. A diagnosis alone cannot provide a complete account of a person's current behaviour, circumstances or support needs.

An assessment should focus on relevant information: what is happening now, what has changed, what the person reports and which protective or concerning factors are present. The response should fit the situation and be reviewed as it changes. People should understand the purpose of questions where possible, rather than feel that any admission of distress will automatically lead to punishment.

The same care applies to public discussion after a violent event. Speculation about an offender's diagnosis can turn uncertainty into a story about an entire group. Journalists and leaders should distinguish established information from assumption and avoid

using a psychiatric label as a convenient explanation for conduct that has not been assessed.

Safety and dignity need to be pursued together. Professionals should seek appropriate urgent assistance when necessary while avoiding degrading treatment or unsupported restrictions. Families need clear routes to help so that fear does not become the only guide to action. Responsible risk work concerns an individual situation; stigma turns that work into a general judgement about people who share a label. Keeping the distinction clear protects the quality of assessment as well as the people being assessed.

Consent begins with an understandable explanation

Consent requires information a person can understand and a genuine opportunity to participate. The professional should explain the proposed intervention, expected benefits, significant risks and reasonable alternatives. Questions and disagreement deserve attention rather than being treated as evidence of disloyalty or illness.

Support might involve the use of an interpreter, accessible information, extra time, or someone trusted by the patient. The right approach will depend on the individual. Signing a form does not prove the explanation was adequate, especially if the person felt unable to ask questions.

The joint guidance issued by WHO and OHCHR emphasises free and informed consent and a move toward rights-based mental health care (World Health Organization & Office of the United Nations High Commissioner for Human Rights, 2023). Alternative approaches to coercion are also recommended. This guidance serves as a framework for reform, and it is not a statement about each country's laws being sufficient now.

Healthcare providers have to be aware of the legal and professional guidelines relevant to their case, especially if it is complicated or urgent. Decision-making support and available safeguards need to be provided. The conversation needs to go on while the intervention takes place, since the person's preferences, benefits, and adverse effects can shift. It should be experienced as participation in care, not as a document used to silence later discussion.

Support for decisions should protect the person's voice

A person may need assistance to understand information, communicate preferences or navigate a service. Needing help does not mean that every decision should be transferred permanently to someone else. Support should be tailored to the task and the person's circumstances.

Article 12 of the Convention on the Rights of Persons with Disabilities recognises equal recognition before the law and access to support in exercising legal capacity (United Nations,

2006). The Convention provides an international rights framework. Its implementation and the applicable procedures need examination within the relevant national setting.

A supporter can help the person compare options, remember questions or express a preference. Safeguards are needed where the supporter has a conflicting financial or personal interest. Assistance should not become an opportunity to replace the person's wishes with the family's preferred outcome.

An illustrative adult may want help reading a treatment explanation while remaining clear about which option they prefer. Another may need several discussions and different communication methods. Services should consider such adjustments before assuming that participation is impossible. Where complex decisions arise, appropriate professional and legal processes are necessary. The practical aim is to preserve as much meaningful involvement as possible and prevent a diagnosis from becoming a blanket denial of agency. Respect includes taking seriously a choice that differs from what a relative or practitioner would choose for themselves.

Crisis care must remain accountable

A crisis can create urgency, fear and pressure to act. It also creates conditions in which a person's preferences may be overlooked and restrictive responses normalised. Preparation

and effective de-escalation and clinical service provision may assist the services in making a better decision.

The recommendations set out by WHO and OHCHR include cessation of coercive measures and the establishment of alternative strategies. That direction requires investment in services, training and safeguards, alongside legal reform. It should not be reduced to a slogan that leaves an unprepared family alone during a serious emergency.

When immediate help is needed, professionals must use the relevant emergency pathway and understand current legal duties. They should explain actions where possible, document decisions and provide access to appropriate review. A diagnosis should never function as automatic permission for humiliation, arbitrary punishment or disregard of basic needs.

After the event, the person's experience deserves attention. What felt helpful or frightening? Would previous support have stopped the escalation? Was communication poor, or was availability lacking? Reflection will help make adjustments for the future plan and help the team recover from the encounter.

Accountability is compatible with acknowledging difficult decisions. It requires that urgency does not place professional conduct beyond examination. A humane system learns from crises rather than treating repeated distress as proof that the person deserves fewer rights.

Rights extend beyond the clinic

Health care is only one setting in which discrimination operates. People may encounter barriers in housing, education, employment, financial decisions and community participation. Clinical improvement cannot by itself remove these barriers, particularly when exclusion is embedded in routine rules.

The Convention on the Rights of Persons with Disabilities addresses community inclusion, education, health and work, among other rights (United Nations, 2006, Articles 19, 24, 25 and 27). Applying these principles requires attention to the relevant legal framework and the actual obstacles people face. All psychological disorders do not have the same legal consequences, and it is wrong to assume entitlements without verification.

It is possible for an organisation to review whether the imposition of such restrictions would be in proportion to its purpose or would only reflect the stereotypical image. Is there any discrimination against the individual based on his diagnosis in the past? Does the institution ask for undue information?

People may need accessible advice or advocacy to pursue concerns. Services can help identify appropriate organisations without promising a legal outcome. Structural reform should also reduce the need for individuals to challenge every barrier alone. The goal is a society in which membership and

opportunity do not disappear when someone seeks treatment. Rights protection should follow the person into ordinary life, where recovery must become practically possible.

Fairness at work needs more than a wellbeing poster

A workplace can promote mental health awareness while maintaining conditions that discourage disclosure and help-seeking. Staff may fear gossip, blocked promotion or automatic dismissal. The poster will not be able to address these issues if the organisational decisions send out a different message.

The World Health Organization (WHO)'s guidelines on mental health in the workplace call for organisational interventions, accommodations, and support for participation and return to work (WHO, 2022). Such interventions could involve scheduling adjustments or modifications in job duties based on the nature of the occupation and individual needs.

This conversation should centre on functioning and support, not on access to personal information. A manager may need to understand an agreed adjustment without knowing the details of psychotherapy. Confidentiality responsibilities should be explicit, including who holds information and how it is used.

Informal workers also need attention. Formal complaint procedures may not be available to traders, housemaids, or casual labourers. Advocacy that addresses only salaried employment misses important realities across African settings.

Community organisations, professional bodies and public services can explore practical protection and support. Fairness involves how work is allocated, how difficulties are reviewed and whether people can obtain care without avoidable loss of livelihood. A workplace becomes more credible when respectful procedures continue after the awareness event has ended.

Schools can protect learning and belonging

A student experiencing mental health difficulties needs appropriate support while remaining a member of the learning community. Gossip, ridicule and unsupported assumptions about ability can create barriers beyond the condition itself. School responses should consider learning, safety and privacy together.

A teacher does not need to diagnose a student to notice a change and arrange an appropriate referral. The conversation should be respectful and linked to an established support pathway. A student should not be required to recount personal experiences publicly as proof of need. Applicable safeguards and parent involvement provisions are contingent upon age and specific situations. Possible accommodations can be made based on attendance, workloads, or assessments using proper procedures. They should be reviewed and explained to the student. Support should preserve educational opportunity rather than quietly

lowering expectations without discussion or excluding the learner from ordinary activities.

Peers also shape belonging. Schools can respond to bullying, challenge diagnostic insults and teach how to seek help without turning a particular student into a classroom example. Staff need training and accessible consultation for concerns that exceed their competence. The aim is neither to treat every difficulty as illness nor to demand that serious distress remain invisible. An inclusive school makes it possible to receive help and continue learning with dignity. Its response can influence whether a young person sees future institutions as places of support or places where disclosure is dangerous.

Family reputation should not outweigh a person's welfare

Families may conceal illness because they fear damage to marriage prospects, social standing or relationships. These fears can reflect actual prejudice in the community. Understanding them does not justify withholding necessary care, denying the person's experience or forcing secrecy that increases isolation.

The family can distinguish privacy from shame. Privacy protects a person's control over information. Shame treats the condition as evidence that the household is inferior. A person may reasonably choose a small circle of disclosure while still being free to attend treatment and obtain support.

Relatives may also face stigma by association. They can need information, peer contact and opportunities to discuss their own concerns. Supporting them should not require the patient to become responsible for repairing the family's reputation. Each person's needs deserve attention in an appropriate setting.

An illustrative parent may worry that neighbours will notice clinic visits. A useful conversation can explore confidential arrangements and challenge the belief that receiving care is a disgrace. Community change remains necessary so that families have fewer reasons to anticipate rejection. The household should not have to solve society's prejudice alone. It can, however, refuse to pass that prejudice inward through ridicule, threats or unnecessary restrictions. Protecting a relative's welfare should include listening to what they want rather than deciding solely on what will look respectable to outsiders.

Faith leaders can challenge shame without claiming certainty

Religious language can be comforting and unifying, but it can also stigmatise by linking distress to sin or moral weakness. A leader can support spiritual meaning while encouraging competent assessment and treatment. These contributions need not compete.

A person should be free to seek prayer without being pressured to abandon prescribed care. They should also be free to decline

prayer or public testimony without losing practical assistance. Spiritual care should preserve choice, confidentiality and dignity rather than make acceptance depend on a particular account of illness.

Leadership encompasses aspects that enable individuals to observe and appreciate the celebrations within the community. In the event that only complete recovery stories are valued, those who continue suffering from the aftermath may discover themselves forced to hide what they are going through. We should view this situation as a reminder that healing is an ongoing process.

Referrals can offer leaders ways to address areas beyond their expertise.

They should know where to direct someone and how to assist without disclosing information unnecessarily. Education within worship settings can use general examples rather than identifying a member. The aim is a community in which people can belong throughout difficulty. Challenging shame becomes practical when compassion shapes announcements, visits, financial assistance and the way members speak about people who are absent as well as those present.

Media stories can widen or narrow understanding

News, entertainment and social media influence what people expect from mental health care. Repeated images of violence,

helplessness or bizarre behaviour can make a narrow picture appear universal. Stories of recovery can help, but they also need room for continuing difficulty and support.

Journalists must differentiate between verified facts and speculation, particularly following an incident of crime or crisis. A diagnosis should not be inserted simply to make a story more dramatic. Photographs, recordings and identifying details require careful consideration of consent, privacy and possible harm. Someone visibly distressed may not be in a position to make an informed decision about permanent public exposure.

Institutions should apply the same discipline to their own publicity. A clinic's success story, a fundraising appeal or a faith testimony should not reveal a person's history merely because the organisation believes the story will inspire others. Consent needs a clear explanation of audience, format and likely circulation.

An illustrative campaign could invite a participant to review the proposed account, set boundaries and decline particular questions. Once material is online, complete withdrawal may be difficult, and that limit should be explained beforehand. Responsible communication portrays people as more than symptoms or lessons. It can describe barriers, useful care and social responsibilities while preserving the person's right to an ordinary life beyond the story.

Lived experience should influence decisions

People who use mental health services have knowledge about what care feels like and where systems fail. That knowledge should shape planning, delivery and evaluation rather than appear only as a brief testimony at a launch. Participation becomes meaningful when it can change a decision.

The Mosaic approach by WHO recognises that the leadership or co-leadership of people who have experience with stigma, social engagement, and inclusive partnerships is one of the key guiding principles in tackling stigmatisation (WHO Regional Office for Europe, 2024).

A practical partnership should agree roles, support and fair recognition. Participants may need transport costs, accessible documents, interpretation or payment for substantial work. Invitations should not repeatedly favour only people whose recovery stories are comfortable for professionals. Critical feedback and experiences of continuing illness are also important.

No individual can represent every diagnosis, language, generation or community. Programmes should seek varied perspectives while respecting the choice not to participate. People should retain control over personal disclosure and should not be expected to tolerate intrusive questions as the price of influence. Lived experience leadership is strongest

when it is supported by transparent authority and accountability. It can help institutions recognise problems that are invisible from a managerial position and design responses that make sense to the people expected to use them.

Social contact needs a thoughtful setting

Anti-stigma work can bring people into meaningful contact with others who have experienced mental health difficulties. The purpose is to challenge generalisations through human interaction, not to display a person as an educational object. Preparation and shared control matter.

A discussion can focus on ordinary life, barriers, treatment experiences and practical inclusion. Participants should know the purpose and ground rules. A facilitator can redirect intrusive questions and respond to stereotypes without asking the person with lived experience to carry every difficult moment alone.

Mosaic also advises on using a systematic approach where goals are defined, preparation and learning take place (WHO Regional Office for Europe, 2024). Its principles should not be treated as a guarantee that one event will transform a community. The audience, setting and follow-up influence what can reasonably be expected.

An illustrative association might invite a co-designed discussion and then review its membership rules and complaint process. The discussion creates an opening; institutional action

determines whether the opening leads somewhere useful. Social contact should therefore connect with opportunities for behavioural change. Organisers can ask what participants will do differently and whether the people most affected notice a change. Respectful contact is valuable, but ending discrimination also requires decisions about access, treatment, employment and belonging after the meeting closes.

Kenyan evidence offers promise with limits

Research in Kilifi, Kenya, evaluated participatory video combined with face-to-face interaction involving people with mental, neurological and substance use disorders. Among the target population, an improvement in knowledge, attitude, and behaviour measures was observed following the intervention and during the four-month follow-up period (Bitta et al., 2023). The study design must be interpreted cautiously because it involved comparing participant scores over time and not through a randomised control group. The findings support the feasibility and promise of the approach in the setting studied, but cannot establish that every observed change was caused by the intervention alone. Intended behaviour also differs from verified changes in everyday discrimination.

These distinctions do not diminish the value of African research. They help identify the next questions. Which elements of the programme mattered? Were changes sustained? Did

people using services experience better treatment? Would the approach work similarly in another language, audience or setting?

A responsible programme can draw inspiration from the study while planning its own evaluation. Local adaptation should involve the people represented and the intended audience. Evidence becomes more useful when it guides realistic expectations rather than provides a slogan that an intervention has been proven everywhere. The goal is cumulative learning: identify a promising approach, test it carefully, examine whose lives change and improve the work in response to what remains unresolved.

Institutions need a way to hear complaints

A right is difficult to exercise when the only complaint route leads back to the person responsible for the harm. People may fear retaliation, loss of treatment or public exposure. Institutions need accessible channels through which concerns can be raised and reviewed fairly.

WHO's QualityRights toolkit provides tools for assessing and improving quality and human rights in mental health and social care facilities (WHO, 2012). Such assessment can support institutional change, but a completed form does not establish that patients feel safe speaking. Private feedback and independent perspectives remain important.

The complaints procedure should describe how the complaint is made, what will happen after that, timelines involved, and options for review. Needs for accommodation regarding communication and disability should be met. The relevant organisations from outside the institution would depend on the country and issue but could include regulatory boards, human rights organisations, or legal services.

Institutions should search for both patterns and individual occurrences. If there are several complaints related to privacy, humiliation, or lack of access, there may be a systemic problem. Staff also need a safe way to raise concerns about practices they witness. Accountability should produce appropriate investigation, remedy and learning, not merely a defensive response. When people see that concerns can lead to change without punishment for speaking, trust has a stronger foundation than any promise that the institution always acts respectfully.

Measuring change in treatment and opportunity

Anti-stigma campaigns need to determine what success looks like before they begin. Knowledge assessments are beneficial, but knowledge is not the same as fair treatment. Someone might know the right answer while still excluding a co-worker or ignoring the needs of a patient.

Assessment could look at many different areas. Have attitudes shifted? Have practices been changed? Do those receiving services experience more respect? Is it easier for applicants to have access to resources? Measures need to be appropriate to the goals of the campaign and maintain confidentiality. Documented incidents of discrimination present obligations for follow-up.

In an anti-stigma workplace campaign, assessment could include looking at the process for accommodation requests A clinic might assess privacy during registration and whether explanations are understood. A community programme might ask whether participants feel more welcome in ordinary activities. These are illustrative possibilities, not one compulsory measurement package.

Results need honest interpretation. A short follow-up cannot establish permanent change. Positive average does not necessarily mean positive individual experiences. The rise in complaints could also be an indication of increasing confidence in the process of reporting. Evaluation should therefore combine suitable measures with careful listening. The purpose is to improve protection and opportunity, not to produce impressive publicity. A programme succeeds more credibly when people affected by stigma can describe concrete changes

and when the organisation remains willing to address findings that are uncomfortable.

Turning rights into daily responsibilities

Put rights into practice through staff training, accessible services, independent oversight and ways to challenge mistreatment.

Governments and organisations can review whether funding and procedures meet those duties. Community agencies need workable referral information, and people receiving care need accessible information and a role in service improvement.

The WHO and OHCHR (2023) guidance sets out principles for dignity, participation and community inclusion. Check the applicable national procedures when helping someone exercise a particular right.

Progress is visible when someone can report a side effect without humiliation, make a complaint that receives a response or return to work with fair consideration. The final chapter connects these responsibilities to the design of services across Africa.

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Chapter 10

Building a Coordinated African Mental Health Response

The person should not have to hold the system together

A person seeking mental health care may move between a general clinic, a specialist, a counsellor, a pharmacy and community sources of support. Each encounter can be helpful. Yet the person may still be left carrying instructions that do not fit together, repeating a painful history and searching for someone who will address an unresolved concern.

Coordination means making these contributions work as a coherent response. The patient should understand the plan, the professionals should know their responsibilities and referrals should connect people with actual care. Families and communities should receive appropriate guidance without being expected to replace unavailable services. Government should provide the policy, financing and accountability that make continuity possible.

This final chapter brings the book’s arguments into that practical task. It proposes ways to organise assessment, treatment, everyday support and public responsibility. The proposals need local adaptation; they are not a tested programme with a guaranteed outcome. Africa’s countries, districts and communities have different resources, languages and legal arrangements.

The central commitment remains the same across these differences: see the person, investigate carefully, offer appropriate treatment, take adverse effects seriously and protect dignity. A coordinated system does more than calm a crisis. It helps people regain functioning, relationships and opportunities, while remaining available when continuing care is needed. The goal is a dependable pathway through difficulty rather than a collection of services that the patient must somehow assemble alone.

Begin with a shared direction

A mental health strategy should explain what improvement it seeks and who is responsible for delivering it. Broad promises about awareness or excellence need to become decisions about access, quality, continuity and protection from harm. Otherwise, organisations may pursue separate projects while important needs remain unattended.

WHO's Comprehensive Mental Health Action Plan 2013–2030 identifies leadership and governance, integrated community-based services, promotion and prevention, and stronger information and research as major objectives (World Health Organization [WHO], 2021a). These areas provide a useful organising direction. They should guide practical work rather than remain headings in an unread policy.

A local planning group can ask what a person should be able to expect when seeking help. Where can they start? What assessment is available? How are specialist needs recognised? Can they obtain medicines and psychological care when indicated? What happens after discharge or a missed appointment? The answers should be understandable to service users as well as planners.

A shared direction also needs boundaries. No profession can responsibly promise to manage every condition independently, and no community partner should be assigned clinical tasks beyond its competence. Cooperation does not require identical roles. It requires agreement about how different roles connect. The plan becomes credible when a person can follow those connections and find assistance at the next step without relying on personal influence or repeated explanations of why their need matters.

Read regional progress without flattening Africa

Regional evidence can identify priorities, but its geography and limitations must remain visible. The WHO African Region is an administrative region and does not include every country on the African continent. Findings about its Member States should not automatically be described as statistics for all Africa.

The WHO Regional Office for Africa (2025) reports gaps in financing, staffing, integration with primary care and

information systems. Its findings draw on preliminary Mental Health Atlas data with incomplete survey participation, which limits comparisons across countries.

The report supports a practical conclusion: commitments need resources, implementation and reliable reporting. It does not establish that every district has the same gaps or that countries can be ranked responsibly from one isolated indicator. A policy document may exist while delivery remains weak; another setting may have useful local work that national reporting captures poorly.

Planning should therefore combine regional direction with current national and local assessment. Ask what services function, who reaches them and where care is interrupted. Include rural areas, informal settlements and groups whose needs may be missed by routine attendance records. Data should help identify action rather than provide a dramatic opening statistic that obscures uncertainty. Respect for African diversity is compatible with regional cooperation when evidence is used at the level it can actually support.

Map the journey before adding another programme

A service map should begin with the patient's journey rather than an organisational chart. People may first approach a general practitioner, community worker, faith leader, teacher or

emergency department. Each entry point needs an appropriate response and a realistic route onward.

Mapping can identify where people lose contact with care. An appointment may be available but unaffordable to reach. A specialist referral may require paperwork that nobody explains. A person may receive a prescription while the medicine is unavailable locally. These are different interruptions and require different solutions.

An illustrative district planning exercise could follow several common pathways from first concern to follow-up. Participants would include service users, frontline workers and relevant community partners. They would examine waiting, costs, communication, clinical responsibility and what happens when the expected service is unavailable. The exercise should protect individual confidentiality.

The result need not be a complicated diagram. It should identify the next useful change, who will make it and how the effect will be checked. Adding a new programme before understanding existing pathways can create another disconnected doorway. Coordination often begins by repairing a transition: ensuring that a referral is received, clarifying contact arrangements or making instructions understandable. Such changes may appear modest, but they address the point at which a person otherwise

returns home without the help that the original consultation intended.

Make primary care a supported entry point

Primary care can make mental health assessment and treatment more reachable, particularly where specialist services are concentrated elsewhere. Integration needs more than asking already busy workers to add another responsibility. It requires preparation, tools, medicines, supervision and referral arrangements.

WHO's mhGAP guidelines advocate for evidence-based treatment of mental disorders, neurological disorders, and substance use disorders, even in places where there is a shortage of specialists (WHO, 2023). Its use should involve trained practitioners and a functioning service context. A manual cannot substitute for demonstrated competence or make every complex decision straightforward.

The entry point should remain broad enough to consider physical health, substances, medicines and social circumstances. A patient presenting with sleep difficulty, pain or poor concentration should receive appropriate assessment rather than an automatic mental health label. Conversely, a mental health concern should not be ignored because the person arrived through a general clinic.

The service should explain what it can provide and where additional care is available. Specialist consultation can support local workers without transferring every patient to a distant hospital. Clear escalation arrangements are essential when needs exceed local capacity. Integration succeeds when people receive useful care closer to home and can move to additional expertise when necessary. It fails when the word integration simply conceals unsupported task expansion or a referral route that exists only on paper.

An assessment should remain open to revision

A coordinated response depends on a working understanding that can change with new information. Diagnosis guides care, but a label should not prevent reconsideration when symptoms, treatment response or the history raise new questions. Review is part of competent practice rather than an admission that all earlier care was worthless.

The assessment should consider the person's account, functioning, physical health, medicines, substance use and relevant circumstances. Investigations should answer a clinical question. Specialist medical judgement determines when imaging, laboratory tests or neurological assessment are indicated; the presence or absence of a scan does not by itself settle a psychiatric diagnosis.

A counsellor who notices a possible medical concern should communicate it through an appropriate referral rather than independently replace the medical assessment. A prescriber who identifies relational or psychological needs should connect the person with suitable support. Each contribution can improve the shared understanding without erasing professional boundaries.

The patient should know what remains uncertain and why a proposed next step is useful. This is particularly important after years of treatment, when disappointment may make certainty especially attractive. A responsible service can acknowledge uncertainty while still offering a clear plan. Its strength lies in following evidence, explaining decisions and responding when the person’s course does not fit expectations. Coordination makes reconsideration easier by allowing relevant information to reach someone able to act on it.

Give every plan a clear clinical connection

People need to know whom to contact when the plan becomes difficult. A service may assign a suitable coordinating professional or team, depending on its resources and the person’s needs. This role should have defined responsibilities and realistic availability. It should not promise continuous access that nobody can deliver.

The coordinator can help ensure that agreed assessments, referrals and reviews are connected. Clinical decisions remain with appropriately qualified practitioners. The role is especially useful where several services are involved or where a person struggles to navigate appointments and information.

The plan should record what the patient understands and wants to achieve. A clinical goal might concern symptoms; a personal goal might involve returning to trading, caring for children or resuming study. Connecting them gives follow-up a clearer purpose. The person should also know what to do when the designated contact is unavailable.

Coordination must respect confidentiality. Relevant information can be shared on an appropriate basis without distributing an entire personal history to every partner. The service should explain these arrangements and revisit them when circumstances change. A named connection cannot repair an underfunded system alone, but it can reduce avoidable confusion. The patient should encounter someone who can help locate the next step, rather than a sequence of professionals who each regard the unresolved difficulty as another service's responsibility.

Medicines require access and review

An appropriate prescription is useful only if the person can obtain and use the medicine safely. Procurement, affordability

and reliable supply therefore belong within mental health planning. Shortages can interrupt treatment even when the patient and prescriber have agreed on the plan.

Review should include benefit, adverse effects, physical health and the person's concerns. WHO's guidance on physical health in adults with severe mental disorders supports attention to coexisting illness and health risks (WHO, 2018). Sedation, weight change or other difficulties should prompt assessment and appropriate action rather than automatic criticism of the patient's habits.

The service needs a route for questions between routine visits. The patient should know whom to contact about troublesome effects and should receive clear advice on treatment changes from the prescriber. Pharmacists can contribute information about safe use, supply and possible interactions within their professional role.

System planning should also consider what happens when a medicine becomes unavailable. Substitution and changes in dosing require appropriate clinical decisions, not improvised instructions from unqualified staff or relatives. Reliable treatment involves stock management and communication as well as prescribing expertise. A coordinated response treats the patient's report as important evidence, supports informed participation and protects continuity. Adherence becomes more

realistic when care is understandable, tolerable and actually available, rather than presented as a duty the person must fulfil despite obstacles the system has left unresolved.

Psychological care needs a place in the service

Psychological interventions should be planned as a service component, with appropriate staff, time, supervision and referral criteria. They should not depend entirely on whether an individual prescriber remembers a particular counsellor or the patient can locate private care independently.

The manual for implementing by WHO provides practical guidance on evidence-based psychological interventions, including planning, contextualisation, workforce capacity building, and assessment and evaluation. The relevance extends beyond selecting a named therapy. The organisation must be able to deliver the intervention competently and sustain it.

Treatment choice should follow the condition, evidence, severity, preference and available resources. Some people may benefit from a psychological intervention alone; others need medication, specialist procedures, social assistance or combined care. A universal claim that neither medicine nor psychotherapy can ever work alone would misrepresent this variety.

Services should explain what is available, likely waiting times and alternatives where suitable. Generic supportive

conversation should not be marketed as a specialist treatment without the relevant preparation. At the same time, ordinary humane support remains valuable and should not be dismissed because it is not psychotherapy. A coordinated system can distinguish these contributions clearly. The practical goal is to make appropriate psychological work reachable and connected with the rest of care, while giving patients an honest explanation of its purpose and limits.

Share tasks with support and accountability

Task sharing can extend access by preparing workers to deliver defined activities within a supported system. It requires clarity about what each worker can do, how competence is assessed and when additional expertise is needed. It should not transfer unlimited responsibility to people with the least training or authority.

Training should include observed practice, feedback and ongoing supervision where appropriate. A worker may understand a method in a classroom while still needing help applying it to complex situations. Supervisors must have protected time and an appropriate workload, rather than just being listed in the proposal without time for participation.

The WHO manual for implementing psychological interventions includes workforce training as part of the broader process of service delivery and evaluation (WHO, 2024). Local

projects, therefore, need to plan in advance for supervision, referrals, and workforce supports. Counting the number of trained individuals alone will not demonstrate that patients are receiving appropriate services.

Established boundaries protect the workforce and the public. Educators in the community can identify problems and refer people to evaluation without making a diagnosis. The counsellors must operate within the bounds of their competence and regulations. Specific tasks, like prescribing and specific procedures, require particular competencies.

A patient should not have to infer a provider's capabilities from a confident title. The service should make roles understandable and provide a way to address concerns about quality or conduct.

Protect the workforce that provides the care

An overwhelmed professional can remain dedicated while lacking enough time to meet every need. Recognising this pressure should lead to better working conditions and service design. It should not excuse avoidable harm or encourage the belief that patients must accept poor treatment because staff are busy.

Workforce planning needs attention to recruitment, retention, distribution and everyday support. A district may need a reliable consultation arrangement as urgently as another short training course. Staff may require protected supervision, safer premises,

administrative assistance or a more realistic allocation of tasks. The appropriate priorities should follow local assessment.

WHO's guidance on mental health in the workplace encourages organisational steps towards tackling workplace conditions that support participation (WHO, 2022a). Health services should apply that concern to their own employees. Telling exhausted workers to practise self-care cannot replace attention to workload, bullying, insecure employment or inadequate resources.

Professional development should also include respectful communication and the ability to seek help. Staff should be able to discuss uncertainty, errors and difficult encounters through appropriate channels. A punitive culture can encourage concealment; a culture without accountability can leave harmful practice unchanged. Services need both support and standards. Patients benefit when workers have the skills, time and institutional backing to assess carefully, explain clearly and maintain continuity. Protecting the workforce is therefore a practical part of protecting the people who use its services.

Include families without transferring the whole burden

Families can provide essential practical support, but their contribution should be negotiated. The person receiving care should help decide who is involved and what information can

be shared. The family should understand the plan and have opportunities to describe its own limits.

A coordinated service can ask who manages transport, meals, childcare and appointments. It can identify whether one person is becoming exhausted or whether a child has assumed responsibilities beyond their age. Practical support may need to come from social services or other organisations rather than another appeal to family duty.

Community mental health recommendations by the WHO emphasise person-centred and rights-based care within larger health and social systems (WHO, 2021b). Applying that orientation means keeping the patient's voice central while recognising that supporters also need information, rest and assistance. Household involvement should not become a substitute for professional follow-up.

Families may disagree about the meaning of symptoms or the usefulness of treatment. Appropriate education and skilled conversations can help, while violence or coercion may require a different safety response. A joint meeting is not automatically suitable for every household. The goal is a sustainable arrangement that supports dignity and care. The service remains responsible for the work it has agreed to provide, and relatives should know where to turn when a concern exceeds what they can safely manage at home.

Connect social needs with actual assistance

Mental health care often identifies difficulties involving food, income, housing, education or protection. Recording them is important, but a note that someone has social problems does not create support. Coordination should connect identified needs with relevant assistance wherever it is available.

The referral should be specific. Which organisation can help, what does it provide and how does the person reach it? Eligibility, costs and waiting times may affect whether the referral is usable. A service should avoid promising benefits it has not verified or directing someone repeatedly towards an organisation that cannot respond.

The person should help set priorities. A practitioner may focus on an employment programme while the patient is worried about sleeping safely that night. Short-term requirements and long-term objectives call for distinct approaches. Assistance should also respect privacy and avoid requiring unnecessary public disclosure.

Not every social difficulty has an available solution. The service can acknowledge the gap, explore realistic options and use aggregated information to support advocacy. Honesty is preferable to describing an impossible referral as completed care. A coordinated system recognises that coping skills and clinical treatment cannot by themselves remove every external

pressure. It seeks practical improvements while making unmet needs visible to those responsible for resources and policy. Patients should not be blamed when their recovery is constrained by conditions that require public or institutional action.

Work with community and faith partners responsibly

Community organisations and faith leaders can provide support, education and routes towards care. Partnerships should begin with a clear understanding of each contribution and an agreement about referral, consent and protection from harm. Popularity or local influence does not establish clinical competence.

Partners can help people recognise concerns, obtain transport or remain included in community life. They should not be expected to manage complex clinical conditions independently. A referral relationship should make it easier to seek qualified assessment when needed, including when the person's preferred explanation differs from that of a health professional.

Accountability applies across settings. Prayer, cultural practice or community authority should not justify abuse, exploitation or denial of necessary care. At the same time, professionals should engage respectfully and learn how people understand suffering and help-seeking. The practical aim is to create trustworthy

connections without endorsing every practice associated with a partner.

Agreements should be reviewed through the patient's experience. Are people reaching suitable services? Is private information protected? Can a person decline an activity without losing support? Can concerns be raised safely? A partnership becomes meaningful when these questions have credible answers. Cooperation should expand options and make responsibilities clearer. It should not create a closed network in which organisations protect one another's reputation while the person receiving care has no independent route to challenge harmful conduct.

Plan for emergencies before they arrive

A mental health system needs a realistic route for urgent assessment and assistance. A clinic that offers routine appointments should know how to respond when a person's needs cannot safely wait. Community partners and families need clear information about the same pathway.

Planning includes recognising concerns, arranging contact, transport where relevant and continuity after the immediate event. The route should reflect services that actually operate locally. A directory that is not maintained can create dangerous confusion. Staff should know what to do when the preferred receiving service is unavailable.

Patients can participate in advance discussions about familiar warning signs, helpful responses and contact preferences. The plan should be understandable and revisable. It must also recognise that a serious new problem may not follow the person's usual pattern and may require fresh assessment.

Emergency response must maintain dignity and meet professional and legal standards. Rights must be apparent under duress, including the rights to explanation, documentation, and review. After the crisis, the system should examine what happened and what might prevent another avoidable escalation. The goal is more than repeated rescue. Reliable follow-up, timely review and access to continuing treatment can address problems that otherwise accumulate until only an emergency response remains. Crisis planning is therefore connected to the quality of ordinary care throughout the year.

Prevention belongs across the life course

A coordinated response should include promotion and prevention alongside treatment. These activities address different needs and should not be treated as interchangeable. General education may support wellbeing without being adequate care for an established condition; clinical services may treat illness while broader risks remain unchanged.

The WHO's strategy encompasses promotion and prevention as part of the role of mental health systems and partners (WHO,

2021a). Local-level work might include schools, workplaces, families, and public institutions, depending on priorities that are evidence- and need-based. Programmes should explain what they aim to prevent and how the effect will be evaluated.

Examples might include safer school environments, support for parents, responses to violence or measures addressing harmful substance use. Each requires an appropriate design and competent implementation. A general claim that one workshop prevents all mental illness would be indefensible. The aim is to reduce relevant risks and strengthen protection without promising complete control over outcomes.

Prevention should also avoid patient blame. People can develop conditions despite supportive environments and careful habits. Likewise, seeking early help should not lead automatically to unnecessary diagnosis or treatment. A balanced system makes information and assessment available while respecting variation in experience. Its commitment is to reduce avoidable harm and improve access to help, recognising that neither individuals nor institutions can guarantee that all suffering will be prevented.

Finance the whole pathway

A mental health policy requires predictable resources. Funding needs to cover assessment, treatment, psychological care, supervision, medicines, information systems and connections with community support. An initial project grant may create an

opportunity, but it does not establish that care will continue when the project ends.

As per WHO's 2025 report on progress in the region of Africa, there is a need to allocate budgetary lines and funding towards implementation and further incorporation into primary care (WHO Regional Office for Africa, 2025). Therefore, it is prudent to consider the findings of this report in light of this regional context.

A local budget should identify recurrent costs and the responsibilities of each organisation. Transport, interpretation and outreach may be important for access even when they are less visible than equipment. Costs carried by families and unpaid workers also need attention. A service is not inexpensive simply because its burden has been shifted away from the institution.

Funding decisions should be transparent enough to examine. What activities are supported? Who can use them? Which groups remain excluded? New technologies and specialist options can have value while essential services also require protection. The objective is a coherent investment that improves access and quality across a pathway. Patients should not have to abandon indicated care because the budget funded a launch, a building or a training event without funding the work that follows.

Make rights part of service design

Rights protection should be built into routine arrangements rather than added after a complaint. Services need accessible information, privacy, support for decisions and fair ways to raise concerns. They need to know how all of this relates to what they do themselves.

The WHO and OHCHR (2023) guidance calls for person-centred services and action on discrimination and coercion. Service managers should identify the applicable national duties and procedures when designing local care.

A care service can consider if the patient is addressed directly, if records are being handled properly, and if costs and options are being explained. People should have an opportunity to provide feedback privately even if their opinion contradicts a relative's opinion. A complaint should not automatically threaten access to care.

Independent perspectives and lived-experience participation can help identify gaps that internal reports miss. Changes should be followed through and evaluated rather than recorded only as recommendations. Rights and clinical quality support one another: a person who can speak honestly about adverse effects, fear or disagreement gives the team information needed for better decisions. Protecting dignity therefore contributes to useful care while remaining an obligation even when treatment

is difficult or the person does not improve as everyone had hoped.

Use technology to strengthen continuity

Digital systems can assist with records, consultation, appointment arrangements and communication. Their value depends on whether they solve a real service problem and can be used safely. A new platform should not become another barrier for people who share devices, lack data or need in-person support.

A WHO guideline for digital interventions considers technology in terms of health systems strengthening, such as the viability of the use of technology, its equity and resource implications (WHO, 2019). This perspective enables us to evaluate whether the technology enhances the care delivery process rather than simply increasing digital activity.

The service will also determine how to share information and what the follow-up will be. An automated message is not a consultation, and an app must not create a false impression of constant professional monitoring unless there is actually a service to do so. Sensitive data also requires appropriate safeguards, including secure contact arrangements on shared devices.

Decision support software, artificial intelligence and others will also require appropriate oversight and evaluation. A clinician

remains accountable for decisions made within their role. Technology can help information reach the right person at the right time, but coordination still depends on someone understanding it and acting. A system that transmits concerns rapidly while leaving nobody responsible for responding has digitised a gap rather than repaired it.

Measure what matters to people

Routine information should include access and service activity, but these are not enough. A clinic can report many consultations while patients remain unable to obtain treatment or understand the plan. Evaluation should examine benefit, functioning, safety, experience and continuity alongside attendance.

The person's priorities deserve a place. Has sleep improved? Can they resume an important activity? Are side effects being addressed? Do they feel respected? Supporters may also need assessment of their own circumstances, without assuming that patient improvement automatically removes caregiver strain.

Actions in WHO's strategy include improvements in information systems and research, while the regional status update mentions reporting as an ongoing challenge (WHO, 2021a; WHO Regional Office for Africa, 2025). Indicators at the local level should be manageable and relevant, not excessive in number to the point of documentation becoming more important than patient care.

Careful interpretation is needed. An increase in hospital admissions can either signal increased social support services or difficulty in accessing hospitals. An increase in reports can mean a deterioration in the quality of services or increased confidence in reporting. A favourable average can conceal exclusion of a smaller group. Evaluation should therefore combine appropriate measures with contextual understanding. The purpose is to identify what should change and whether that change benefits people. Data become valuable when they influence decisions, not merely when they appear in an annual report.

Grow African evidence through careful local work

African services need research that addresses relevant conditions, settings and practical decisions. Evidence from elsewhere can inform care while leaving questions about language, resources, delivery and acceptability. Local research should complement international knowledge rather than assume either that all imported evidence fits or that none can be useful. Studies need clear questions, appropriate ethics review and transparent methods. Service users must have a voice in setting priorities and determining important outcomes. Participation in research must be clearly different from normal service provision, with informed consent and protections. Community

members must be provided with a proper accounting of what has been learned.

Findings from both promising and disappointing studies need to be published. A well-designed study that fails to demonstrate added value will significantly contribute to waste reduction and guide future directions. Labelling every pilot project as a success is one way of failing to learn what works where.

The World Mental Health Report calls for transformation within mental health systems and settings (WHO, 2022b). Research can contribute to transformation by investigating implementation, cost, quality, and social aspects, in addition to clinical aspects. The aim is cumulative knowledge that improves decisions. African diversity should shape sampling and interpretation, and conclusions should remain proportionate to the participants, setting and follow-up. Respect for context strengthens scientific enquiry; it does not excuse claims that cannot be examined or independently verified.

Begin with an achievable year of improvement

A practical implementation proposal can start with a defined area and a small set of service problems. The following approach is a planning suggestion for local adaptation, not a validated model. Its purpose is to turn broad commitments into work that can be reviewed.

During an initial preparation period, the responsible organisations can map services, hear patient and worker experiences and agree priority gaps. They can identify who has authority to act, what resources exist and which changes require additional support. The resulting plan should specify responsibilities and realistic review points.

Implementation can then focus on a few connected improvements, such as a dependable referral arrangement, a route for medication concerns and access to a defined psychological intervention. Each change needs suitable preparation, resources and feedback. Trying to transform every service simultaneously can make it difficult to understand why progress stalls.

Later review should examine both outcomes and unintended burdens. Did access improve? Were workers supported? Did costs shift onto families? Are confidentiality and rights protected? The programme can revise its approach before wider expansion. A year is a useful administrative horizon, not a promise that system change will be completed within twelve months. The value lies in making improvement visible, accountable and sustainable. A modest change that continues to help people is more valuable than a large announcement whose services disappear after the launch.

Keep recovery claims precise and hopeful

The book began with concern about prolonged suffering, treatment effects, overlooked contributors and lives restricted by stigma. These concerns call for better care and careful language. The wish to heal should not produce a universal explanation of illness or a promise that one intervention can remove every cause.

Reducing a factor that worsens symptoms can help. Treating an identified contributor can sometimes produce substantial recovery. The outcome still depends on the condition, the person, the intervention and the period of observation. Some people recover from an episode; others experience recurrence or need continuing management. Meaningful lives remain possible across different courses.

Statistics should therefore identify the population, outcome and follow-up. Remission, functioning, recovery and cure should not be used as interchangeable terms. A study in one setting cannot establish the percentage of all Africans who will be permanently healed. Honesty about these distinctions protects patients from false expectations and professionals from indefensible claims.

Hope can rest on more solid ground: competent assessment, appropriate treatment, attention to daily conditions and a system that responds when needs change. A person should not be

blamed because improvement is slower than expected. The team can review the formulation, barriers and care plan while preserving dignity. Scientific humility leaves room for further discovery and for the individual whose experience differs from the average. It supports persistence without pretending that every outcome is controllable.

A shared commitment to restoring lives

The response proposed in this book connects clinical care with the circumstances in which people live. It includes investigation and treatment where indicated, attention to side effects and support for daily life.

People receiving care bring knowledge of their own circumstances and priorities. Families can offer practical help and companionship. Practitioners, services and governments are responsible for providing care that people can reach and use. Coordination is visible in a referral that leads to care, a side effect that receives serious attention, a safe return home or a fair opportunity to resume learning or work.

Across Africa, this work takes place in clinics, households, neighbourhoods and public institutions. Its measure is whether people can obtain suitable help, exercise their rights and take part in a life they value.

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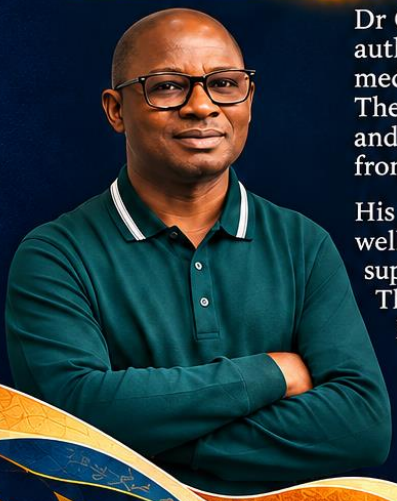
About the Book

Mental health care should help people reclaim their lives, relationships and aspirations. What does it take to make that possible?

Restoring Minds, Rebuilding Lives examines mental health care and recovery across Africa's diverse communities. It brings together evidence on medication, psychotherapy, everyday living and emerging treatments, while addressing side effects, stigma, cultural context and patients' rights.

Written for individuals experiencing mental health difficulties, their families, counselling students, practitioners, faith leaders and policymakers, this book advocates compassionate, coordinated care. It offers hope grounded in evidence, recognising that recovery takes different forms and that every person deserves dignity, appropriate treatment and opportunities to participate in life.

About the Author



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ISBN: 978-99977-0-830-4

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