

# Tools for use in an integrated, community-based mental health system of care: *An Introduction and Reference Guide*

*For External Distribution*



## CONTACT

Please note that these tools are only one part of planning and implementing an integrated mental health program. If you want to learn more about Partners in Health's community-based mental health work, are interested in training materials, or wish to adapt a specific tool, please contact the Partners In Health Cross-Site Mental Health Team at [xsitementalhealth@pih.org](mailto:xsitementalhealth@pih.org).

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# OVERVIEW

## Mental Health System of Care at Zanmi Lasante

Zanmi Lasante (ZL) has worked in Haiti for over 25 years and is the largest nongovernment health care provider in the country, serving an area of 1.3 million people with a staff of more than 5,200. Zanmi Lasante operates clinics and hospitals at 11 sites in the Central Plateau and Lower Artibonite valley, and began providing initial mental health services in 2005 to patients with HIV and tuberculosis. When Haiti was struck by a devastating earthquake in 2010, ZL became involved in building a system for mental health care. In 2012, ZL/PIH received a \$1,497,095 CAD grant from Grand Challenges Canada (GCC) to develop a mental health system of care that would be integrated into existing services across all 11 facilities.

Between 2013 and 2015, ZL iteratively created and piloted training curricula, job aids, and clinical tools across different disorder care pathways tailored to various providers (physicians, nurses, psychologists/social workers, and community health workers). These materials build on the World Health Organization's mhGAP Intervention Guide and provide a replicable set of implementation steps that can be adapted to settings lacking formal mental health services.

In the ZL mental health system of care, care is given through a task-sharing model in which providers collaborate across the continuum of care. In conjunction with this work, the ZL Mental Health Team has developed a system of sustained clinical supervision for providers and an MEQ system for mental health data collection and quality improvement. ZL has made enormous gains in developing local capacity to deliver safe, effective, and culturally sound mental health services. Providers across the ZL catchment area are now able to screen and provide treatments for depression, epilepsy, psychotic disorders and child and adolescent mental health problems. With the continued support of Grand Challenges Canada, work to strengthen this system and expand services is ongoing.

## What's In This Document?

This document outlines the tools that were created during the development of Zanmi Lasante's community-based mental health care system. These evidence-based tools have been created for the Haitian context, and are currently available in both English and French/Haitian Creole at this time.

We have created this document to outline the tools for other audiences, both at Zanmi Lasante partner sites and other organizations, who may be interested in creating their own community-based system of mental health care. After a thoughtful and iterative development process, we believe that the same basic service package and tools outlined here can be utilized, with appropriate adaptation, in other locations and contexts.

## How Should I Use this Document?

The Table of Contents organizes the tools by disorder care pathway:

1. Depression
2. Epilepsy
3. Agitation, Delirium and Psychosis
4. Child and Adolescent Mental Health

You can refer to each section to find a list of the tools used by ZL providers to screen, manage and treat patients with that disorder. The page numbers in the list indicate which page the tools are found within the online PDF (please note that there are no page numbers on the forms themselves). Please click the page number to go directly to the form. Note that some tools are listed in multiple sections, as some clinical tools are used across disorders.

Each section also contains a chart that gives a brief description of each tool and indicates which provider should use that tool. Following the list of all tools and charts, you will find the tools themselves. The tools are separated out by disorder.

Please note that:

1. Each tool description reflects its current use in Haiti, and that a tool's use elsewhere or by a different provider will require adaptation to that context and that provider.
2. Because there are some tools that are used across several disorder care pathways, you will see the same tool repeated under different disorder sections.
3. The tools found in this document are similar to the tools found in the annex of the disorder and provider-specific training manuals, which are available via Dropbox. If you do not have access to these training manuals, they are available upon request from Sarah Coleman (scoleman@pih.org). **However, this document contains the most up-to-date tools.** The tools in the curricula and training manuals have not been updated since their publication and printing, while some of the tools in this document have been updated. Please refer to the tools in this document for adaptation and use, as they represent the tools being used at Zanmi Lasante at this time.

# MENTAL HEALTH TOOLS: TABLE OF CONTENTS

## DEPRESSION

### Training Materials:

*Facilitator and participant manuals and PowerPoint slides were created to train each of the following cadres on Depression: Physicians, Nurses, Psychologists/ Social Workers, and Community Health Workers. These manuals and slides are not included in this document but are available via Dropbox. If you do not have access to these materials through Dropbox, please contact Sarah Coleman at [scoleman@pih.org](mailto:scoleman@pih.org) to request any training materials.*

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• World Health Organization Disability Assessment Schedule (WHODAS) - 12 Item Version*	49
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*\*While this tool is not found in the training materials for Depression, it is recommended for use for this disorder.*

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>CHW Follow-up Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the each follow-up visit with a community member diagnosed with a mental disorder.				x
<b>CHW Initial Visit Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the first visit with a patient diagnosed with a mental disorder.				x
<b>CHW Referral Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete when referring a patient suspected of having a mental disorder to a psychologist at their local health center.				x
<b>Clinical Global Impressions Scale (CGI)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to determine the severity, level of improvement, and medication side effects of a patient's mental illness; to be completed each patient visit. Can be administered every 1 week.		x		
<b>Community Education Activity Checklist</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A checklist to assist community health workers in identifying the elements that contribute to a successful community education activity.				x
<b>Community Health Worker Patient Encounter Form</b>	Depression	A flow chart/form for community health workers to use when they encounter a new, suspected case of depression.				x
<b>Depression Checklist</b>	Depression	A checklist to inform the responsibilities around depression identification, treatment and management.	x	x	x	x
<b>Initial Mental Health Evaluation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to evaluate patients that are suspected of having a mental health problem, for use during their first visit.	x	x		
<b>Medication Card for Depression</b>	Depression	A card to reference when prescribing medication.	x	x		
<b>Mental Health Follow-Up Form</b>	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
<b>Nurse Inpatient Encounter Form</b>	Depression	A flow chart/form for nurses working in the inpatient ward to use when they encounter a new, suspected case of depression.			x	

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Nurse Outpatient Encounter Form</b>	Depression	A flow chart/form for nurses working in the outpatient clinic to use when they encounter a new, suspected case of depression.			x	
<b>Physician Patient Encounter Form</b>	Depression	A flow chart/form for physicians to use when they encounter a new, suspected case of depression.	x			
<b>Psychologist/Social Worker Patient Encounter Form</b>	Depression	A flow chart/form for psychologists and social workers to use when they encounter a new, suspected case of depression.		x		
<b>Request for Consultation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A referral form for internal hospital use, from a non-mental health provider to a mental health provider.	x	x	x	
<b>Safety Plan</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A worksheet outlining a safety plan for a suicidal patient; to be completed collaboratively by a psychologist/social worker and the patient.		x		
<b>Suicidality Screening Instrument**</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	An instrument for providers to screen patients for active or passive suicidal ideation, if patient is determined to be at risk.		x		
<b>Suicidality Treatment Guidelines</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to guide providers in their treatment of a patient with active or passive suicidal ideation, depending on level of risk as determined by the Suicidality Screening Instrument.		x		
<b>World Health Organization Disability Assessment Schedule (WHODAS)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to measure the level of functionality of a person with mental health problems. Can be completed every month.		x		
<b>ZLDSI</b>	Depression; Epilepsy; Psychosis; Child and Adolescent Mental Health	ZLDSI: Zanmi Lasante Depression Screening Identification tool; used to screen patients for depression in Haitian Creole. Can be administered every two weeks.	x	x	x	x

**\*\* This tool may be considered for use by other providers, too.**

# EPILEPSY

## Training Materials:

Facilitator and participant manuals and PowerPoint slides were created to train each of the following cadres on Epilepsy: Physicians, Nurses, Psychologists/ Social Workers, and Community Health Workers. These manuals and slides are not included in this document but are available via Dropbox. If you do not have access to these materials through Dropbox, please contact Sarah Coleman at [scoleman@pih.org](mailto:scoleman@pih.org) to request any training materials.

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*\*While this tool is not found in the training materials for Epilepsy, it is recommended for use for this disorder.*



<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>CHW Follow-up Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the each follow-up visit with a community member diagnosed with a mental disorder.				X
<b>CHW Initial Visit Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the first visit with a patient diagnosed with a mental disorder.				X
<b>CHW Referral Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete when referring a patient suspected of having a mental disorder to a psychologist at their local health center.				X
<b>Clinical Global Impressions Scale (CGI)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to determine the severity, level of improvement, and medication side effects of a patient's mental illness; to be completed each patient visit. Can be administered every 1 week.		X		
<b>Community Education Activity Checklist</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A checklist to assist community health workers in identifying the elements that contribute to a successful community education activity.				X
<b>Epilepsy Checklist</b>	Epilepsy	A checklist to inform the responsibilities around epilepsy identification, treatment and management.	X	X	X	X
<b>Epilepsy Education Cards</b>	Epilepsy	Cards that use images and text to describe the cause, prognosis and treatment of epilepsy; to be used during community education sessions and home visits.				X
<b>Epilepsy Follow-Up Form</b>	Epilepsy	A form to evaluate and record a patient's epilepsy evolution, for use at each follow-up visit.	X	X		
<b>Initial Evaluation of Epilepsy</b>	Epilepsy	A form to evaluate patients that are suspected of having epilepsy, for use during their initial visit.	X	X		
<b>Guide for Medication Titration in Patients with Epilepsy</b>	Epilepsy	A card to reference when considering an increase or decrease in anti-epileptic medication.	X			
<b>Initial Mental Health Evaluation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to evaluate patients that are suspected of having a mental health problem, for use during their first visit.	X	X		

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Medication Card for Epilepsy</b>	Epilepsy	A card to reference when prescribing medication.	x	x		
<b>Request for Consultation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A referral form for internal hospital use, from a non-mental health provider to a mental health provider.	x	x	x	
<b>Safety Plan</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A worksheet outlining a safety plan for a suicidal patient; to be completed collaboratively by a psychologist/social worker and the patient.		x		
<b>Stigma Assessment Activity for Epilepsy</b>	Epilepsy	A tool to measure community members' stigma towards people with epilepsy; to be used during community education sessions.				x
<b>Suicidality Screening Instrument**</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	An instrument for providers to screen patients for active or passive suicidal ideation, if patient is determined to be at risk.		x		
<b>Suicidality Treatment Guidelines</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to guide providers in their treatment of a patient with active or passive suicidal ideation, depending on level of risk as determined by the Suicidality Screening Instrument.		x		
<b>World Health Organization Disability Assessment Schedule (WHODAS)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to measure the level of functionality of a person with mental health problems. Can be completed every month.		x		
<b>ZLDSI</b>	Depression; Epilepsy; Psychosis; Child and Adolescent Mental Health	ZLDSI: Zanmi Lasante Depression Screening Identification tool; used to screen patients for depression in Haitian Creole. Can be administered every two weeks.	x	x	x	x

**\*\* This tool may be considered for use by other providers, too.**

# AGITATION, DELIRIUM AND PSYCHOSIS

## Training Materials:

Facilitator and participant manuals and PowerPoint slides were created to train each of the following cadres on Agitation, Delirium, and Psychosis: Physicians, Nurses, Psychologists/ Social Workers, and Community Health Workers. These manuals and slides are not included in this document but are available via Dropbox. If you do not have access to these materials through Dropbox, please contact Sarah Coleman at [scoleman@pih.org](mailto:scoleman@pih.org) to request any training materials.

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• Suicidality Screening Instrument	151
• Suicidality Treatment Guidelines	152
• World Health Organization Disability Assessment Schedule (WHODAS) - 12 Item Version	154
• ZLDSI*	158

*\*While this tool is not found in the training materials for Agitation, Delirium and Psychosis, it is recommended for use for this disorder.*

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Abnormal Involuntary Movement Scale (AIMS)</b>	Psychosis	A form to record and score the results from the AIMS Examination.	x			
<b>Abnormal Involuntary Movement Scale (AIMS) Examination Procedure</b>	Psychosis	A set of directions to guide physicians in correctly performing the Abnormal Involuntary Movement Scale procedure with a patient.	x			
<b>Agitated Patient Protocol</b>	Psychosis	A protocol outlining the steps to take when confronted with a patient that is agitated, delirious or psychotic.	x	x	x	
<b>Agitation, Delirium and Psychosis Checklist</b>	Psychosis	A checklist to inform the responsibilities around psychosis identification, treatment and management for physicians, nurses, psychologists/social workers, and community health workers.	x	x	x	x
<b>Agitation, Delirium and Psychosis Form</b>	Psychosis	A form to complete when evaluating an agitated patient; this form helps determine if the cause of agitation is a medical problem, or potential mental health problem.	x			
<b>CHW Follow-up Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the each follow-up visit with a community member diagnosed with a mental disorder.				x
<b>CHW Initial Visit Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the first visit with a patient diagnosed with a mental disorder.				x
<b>CHW Referral Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete when referring a patient suspected of having a mental disorder to a psychologist at their local health center.				x
<b>Clinical Global Impressions Scale (CGI)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to determine the severity, level of improvement, and medication side effects of a patient's mental illness; to be completed each patient visit. Can be administered every 1 week.		x		
<b>Community Education Activity Checklist</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A checklist to assist community health workers in identifying the elements that contribute to a successful community education activity.				x

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Initial Mental Health Evaluation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to evaluate patients that are suspected of having a mental health problem, for use during their first visit.	x	x		
<b>Medical Evaluation Protocol for Agitation, Delirium and Psychosis</b>	Psychosis	A protocol outlining the medical assessment steps needed to determine if a patient is delirious due to a medical problem or psychosis.	x			
<b>Medication Card for Agitation, Delirium and Psychosis</b>	Psychosis	A card to reference when prescribing medication.	x	x		
<b>Mental Health Follow-Up Form</b>	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
<b>Psychiatric Differential Diagnosis Information Sheet</b>	Psychosis	An outline of DSM IV criteria for severe mental disorders; to be used to assist with diagnosis during clinical sessions with patients.		x		
<b>Psychosis Care Pathway</b>	Psychosis	A diagram demonstrating the collaboration between the four cadres of healthcare providers when working with a patient that is agitated, delirious or psychotic.	x	x	x	x
<b>Psychosis Education Cards</b>	Psychosis	Cards that use images and text to describe the cause, prognosis and treatment of psychosis; to be used during community education sessions and home visits.				x
<b>Request for Consultation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A referral form for internal hospital use, from a non-mental health provider to a mental health provider.	x	x	x	
<b>Safety Plan</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A worksheet outlining a safety plan for a suicidal patient; to be completed collaboratively by a psychologist/social worker and the patient.		x		
<b>Stigma Assessment Activity for Psychosis</b>	Psychosis	A tool to measure community members' stigma towards people with psychosis; to be used during community education sessions.				x
<b>Suicidality Screening Instrument**</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	An instrument for providers to screen patients for active or passive suicidal ideation, if patient is determined to be at risk.		x		

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Suicidality Treatment Guidelines</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to guide providers in their treatment of a patient with active or passive suicidal ideation, depending on level of risk as determined by the Suicidality Screening Instrument.		x		
<b>World Health Organization Disability Assessment Schedule (WHODAS)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to measure the level of functionality of a person with mental health problems. Can be completed every month.		x		
<b>ZLDSI</b>	Depression; Epilepsy; Psychosis; Child and Adolescent Mental Health	ZLDSI: Zanmi Lasante Depression Screening Identification tool; used to screen patients for depression in Haitian Creole. Can be administered every two weeks.	x	x	x	x

*\*\* This tool may be considered for use by other providers, too.*

# CHILD AND ADOLESCENT MENTAL HEALTH

## Training Materials:

Facilitator and participant manuals and PowerPoint slides were created to train Psychologists on Child and Adolescent Mental Health. These manuals and slides are not included in this document but are available via Dropbox. If you do not have access to these materials through Dropbox, please contact Sarah Coleman at [scoleman@pih.org](mailto:scoleman@pih.org) to request any training materials.

## Tools:

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• Suicidality Treatment Guidelines	176
• World Health Organization Disability Assessment Schedule (WHODAS) - 12 Item Version	178
• ZLDSI	182

*\*While this tool is not found in the training materials for Child & Adolescent Mental Health, it is recommended for use for this disorder.*

<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>CES-D</b>	Child & Adolescent Mental Health	A self-assessment to screen for depression; to be administered to adolescents suspected of having depression.		x		
<b>CHW Follow-up Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the each follow-up visit with a community member diagnosed with a mental disorder.				x
<b>CHW Initial Visit Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete during the first visit with a patient diagnosed with a mental disorder.				x
<b>CHW Referral Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form that community health workers complete when referring a patient suspected of having a mental disorder to a psychologist at their local health center.				x
<b>Clinical Global Impressions Scale (CGI)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to determine the severity, level of improvement, and medication side effects of a patient's mental illness; to be completed each patient visit. Can be administered every 1 week.		x		
<b>Community Education Activity Checklist</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A checklist to assist community health workers in identifying the elements that contribute to a successful community education activity.				x
<b>Initial Mental Health Evaluation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to evaluate patients that are suspected of having a mental health problem, for use during their first visit.	x	x		
<b>Mental Health Follow-Up Form</b>	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
<b>Request for Consultation Form</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A referral form for internal hospital use, from a non-mental health provider to a mental health provider.	x	x	x	
<b>Safety Plan</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A worksheet outlining a safety plan for a suicidal patient; to be completed collaboratively by a psychologist/social worker and the patient.		x		



<b>Tool</b>	<b>Disorder Care Pathway that Uses the Tool</b>	<b>Description of Tool</b>	<b>Used by Physicians</b>	<b>Used by Psychologists / Social Workers</b>	<b>Used by Nurses</b>	<b>Used by Community Health Workers</b>
<b>Suicidality Screening Instrument**</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	An instrument for providers to screen patients for active or passive suicidal ideation, if patient is determined to be at risk.		x		
<b>Suicidality Treatment Guidelines</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A form to guide providers in their treatment of a patient with active or passive suicidal ideation, depending on level of risk as determined by the Suicidality Screening Instrument.		x		
<b>World Health Organization Disability Assessment Schedule (WHODAS)</b>	Depression; Epilepsy; Psychosis; Child & Adolescent Mental Health	A tool to measure the level of functionality of a person with mental health problems. Can be completed every month.		x		
<b>ZLDSI</b>	Depression; Epilepsy; Psychosis; Child and Adolescent Mental Health	ZLDSI: Zanmi Lasante Depression Screening Identification tool; used to screen patients for depression in Haitian Creole. Can be administered every two weeks.	x	x	x	x

*\*\* This tool may be considered for use by other providers, too.*

# **DEPRESSION**

Tools for use in an integrated, community-based mental health system of care



# Partners In Health

Department of Mental Health & Psychosocial Services  
Patient Follow-up Form – Community Health Workers

Visit Date:  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:  
\_\_\_\_\_  
Visit Number:  
\_\_\_\_\_

### Patients' Demographic Data

Name:  
Nickname:  
Last Name:  
Sex:  M  F

Address:  
Phone Number:  
Date of Birth: DD/MM/YYYY  
Age:

### What did you observe?

Is it Urgent?  Yes  No  
 Seizure  
 Thinking about suicide  
 Thinking about harming others

### How do you think the patient is feeling?

Patient is better now  
 Patient is doing worse  
 Patient is the same

### What did you do:

Check symptoms  
 Same day therapy session  
 Give advice  
 Relaxation  
 Ask if patient is out of medication  
 Yes  
 No  
 Patient is not on medication

### Psychoeducation

Explain the illness to the patient  
 Give him/her hope  
 Give him/her the sick role  
 Encourage the patient to participate in activities that makes him/her happy

### Did you:

Bring patient to hospital?  
 Send patient to hospital?  
 Encourage the family?  
 Encourage the patient?

### Did you use the ZLDSI?

Yes  
 No  
What is the ZLDSI Score:  
\_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Name of CHW

\_\_\_\_\_  
\_\_\_\_\_



# Partners In Health

Department of Mental Health & Psychosocial Services  
Initial Visit Patient Form – Community Health Workers

Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:

\_\_\_\_\_

### Patients' Demographic Data

Name:

Nickname:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### What did you observe?

Is it a urgent matter that needs immediate attention?  Yes  No

Seizure

Thinking about suicide

Thinking about harming others

### Which illness do you think the patient suffers from?

Anxiety

Psychosis

Epilepsy

Depression

### What did you do:

Check symptoms

Same day therapy session

Give advice

Relaxation

Ask if patient is out of medication

Yes

No

Patient is not on medication

### Psychoeducation

Explain the illness to the patient

Give him/her hope

Give him/her the sick role

Encourage the patient to participate in activities that makes him/her happy

### Did you:

Bring patient to hospital?

Send patient to hospital?

Encourage the family?

Encourage the patient?

### Did you use the ZLDSI form?

Yes

No

What is the ZLDSI Score: \_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

### Name of CHW



# Partners In Health

Department of Mental Health &  
Psychosocial Services

## Referral Form – Community Health Workers

### Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Thomonde   | <input type="checkbox"/> Belladère      | <input type="checkbox"/> Boucan Carre    |
| <input type="checkbox"/> Cange      | <input type="checkbox"/> St Marc        | <input type="checkbox"/> Cerca La Source |
| <input type="checkbox"/> Hinche     | <input type="checkbox"/> Petite Rivière | <input type="checkbox"/> Mirebalais      |
| <input type="checkbox"/> Lascahobas | <input type="checkbox"/> Verrettes      |  |

### Patients' Demographic Data

Name:

Nickname:

Last Name:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### Reason for the Referral

Why are you referring the patient?

Is it Urgent?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

- Seizure
- Thinking about suicide
- Thinking about harming others

Depression – ZLDSI Score \_\_\_\_\_

Epilepsy

Seizure

Psychosis

Is the person taking any medications?

Yes  No

If Yes, Specify: \_\_\_\_\_

### Who do you refer the patient to:

Zanmi Lasante

Members of the Community

Psychologists

Community Leader

Social Worker

Other Community Health Workers

Mobile Clinic

Others (specify): \_\_\_\_\_

Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

### Remarks

### Information on the person who referred the patient:

Name:

Phone:

Address:

Last Name:

Nickname:

**CLINICAL GLOBAL IMPRESSIONS SCALE**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Psychologist / SW: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Age: \_\_\_\_\_

Male/ Female (circle one)

Phone #1: \_\_\_\_\_

Town: \_\_\_\_\_

Phone #2: \_\_\_\_\_

District: \_\_\_\_\_

Session#: \_\_\_\_\_

Date received patient info: \_\_\_\_\_

**I. Severity of Illness**

Considering your total clinical experience with this particular population, how mentally ill has the patient been over the past 7 days?

**Tip:** Compare relative to your past experience with patients who have the same diagnosis considering your total clinical experience with this population.

**0 = Not assessed****1 = Normal, not at all ill.**

Symptoms of disorder have not been present in the past seven days.

**2 = Borderline mentally ill.**

Subtle or suspected symptoms within the past seven days. No definable impact on behavior or function.

**3 = Mildly ill.**

Clearly established symptoms causing minimal, if any, distress or difficulty in social or occupational function.

**4 = Moderately ill.**

Overt symptoms causing noticeable, but modest, functional impairment or distress. There is evidence of functional interference in multiple settings. Some symptoms may warrant medication.

**5 = Markedly ill.**

Intrusive symptoms that distinctly impair social or occupational function or cause intrusive levels of distress. Functional interference due to symptoms is obvious to others.

**6 = Severely ill.**

Disruptive pathology; behavior and function are frequently influenced by symptoms. Dysfunction may require assistance from others.

**7 = Among the most extremely ill patients.**

Pathology drastically interferes in many life functions. Patient may need to be hospitalized.

**Rating**  
(Number 0–7)

## II. Improvement

Compared to the patient's baseline condition before treatment, how much has the patient changed?

### Tips:

For initial evaluation: if the patient has been in treatment previously, rate CGI Improvement based on the history and compared to the patient's condition prior to treatment. Otherwise, leave blank.

Progress Notes: Rate improvement by comparing the current condition to the patient's condition at the initiation of the current treatment plan. Assess how much the patient's illness has changed relative to a baseline state at the beginning of the treatment plan based on the first evaluation. Rate total improvement whether or not in your judgment it is due to treatment.

**0 = Not assessed**

**1 = Very much improved.**

Nearly all better; good level of functioning; minimal symptoms; represents a very substantial change.

**2 = Much improved.**

Notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain.

**3 = Minimally improved.**

Slightly better with little or no clinically meaningful reduction of symptoms. May represent very little change in basic clinical status, level of care, or functional capacity.

**4 = No change.**

Symptoms remain essentially unchanged.

**5 = Minimally worse.**

Slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity.

**6 = Much worse.**

Clinically significant increase in symptoms and diminished functioning.

**7 = Very much worse.**

Severe exacerbation of symptoms and loss of functioning.

**Rating**  
(Number 0–7)

## III. Side Effects

Select the terms that best describe the degree of side effects of medication treatment.

**0 = None**

**1 = Do not significantly interfere with patient's functioning.**

**2 = Significantly interfere with patient's functioning.**

**3 = Outweighs therapeutic effects with patient's functioning.**

**Rating**  
(Number 0–3)

## COMMUNITY EDUCATION ACTIVITY (CEA) CHECKLIST

### Guidelines:

- CHWs conduct CEAs once a month.
- CEAs are approximately 1–3 hours long.
- Local leaders will announce the sessions on the appropriate day; CHWs will conduct sessions at a place where people are gathered (church, school, etc.).
- CHWs will record information about the CEAs on the Stigma Reduction Form and attendance sheet.
- CHWs should arrange water, snacks and soda for participants.
- CHWs should use visuals such as Community Education Cards and the participant handbook as much as possible during the sessions.

### Steps:

- Introduce yourself to the group.
- Explain the goal of the meeting and introduce the main subject.
- Assess the baseline knowledge of the subject (through asking the audience general questions).
- Use Community Education Cards and the participant handbook to provide key information about the main subject.
  - Define the disease.
  - Explain symptoms with concrete examples.
  - Explain how the disease develops, if it is contagious, prevention methods, where and how to be treated, and recovery.
- Assess community members' understanding of stigma and discrimination through the Stigma Assessment Activity before giving information, and again after.
- Explain the damage that stigma and discrimination can cause to families and communities.
- Allow participants to ask questions throughout the presentation.
- Continuously ask questions to assess understanding. Give a small incentive to participants who answer correctly.
- Remind participants that if they or anyone they know are facing any of the topics being discussed, they should speak to the CHW. The CHW can give a referral to the hospital or other experts.
- Distribute the snack, such as soda or cookies.
- If time allows, practice a specific skill:
  - Practice doing a consultation, completing the referral form, using the ZLDSI, etc.





# CHW PATIENT ENCOUNTER FORM

Date dd/mm/yy



Name \_\_\_\_\_ Age \_\_\_\_\_ Male / Female (circle one) Town \_\_\_\_\_  
 CHW \_\_\_\_\_ Phone #1 \_\_\_\_\_ District \_\_\_\_\_  
 Patient ID \_\_\_\_\_ Phone #2 \_\_\_\_\_ Session # \_\_\_\_\_

## REVIEW KEY SYMPTOMS (circle yes or no)

**1 Suicidal**  
 YES NO →

**2 Danger to others**  
 YES NO →

**3 Mental Health Crisis**  
 YES NO →

**ACTION**  
 Depression ZLDSI Scale (see back)  
 Score \_\_\_\_\_

**ASK**  
 Would you like us to give you treatment?

**ACTION**  
**Initiate**  
 Psycho-education  
 Tracking Symptoms  
 Engagement  
 Relaxation  
 Consult CHW Supervisor

**ACTION**  
 Initiate de-escalation  
 Depression ZLDSI Scale (see back)  
 Score \_\_\_\_\_

**ACTION**  
**Same Day Assessment**  
 Date dd/mm/yy  
 Psychologist / Social Worker Name \_\_\_\_\_

## FOLLOW UP after Psych/SW/Physician Appointment

**Psych medication prescribed?**  
 YES NO → Review key symptoms  
 Missed doses in last 2 weeks?  
 YES NO → Patient agrees to continue medication?  
 Review key symptoms ← YES NO → Referral to a psychologist/ social worker

**Screening Score**  
 0-12     13-17     18+

**ASK**  
 Would you like us to give you treatment?

**ACTION**  
**CHW follow-up appointment within one week**  
dd/mm/yy  
 Date \_\_\_\_\_

**ACTION**  
 Psycho-education  
 Tracking Symptoms  
 Engagement  
 Relaxation

**ASK**  
 Would you like us to give you treatment?

**ACTION**  
**Same day first therapy session**  
 List main points:  
 Diagnose  
 Psycho-education  
 Give hope  
 Assign patient role

**ASK**  
 Would you like us to give you treatment?

**ASK**  
**Seek Consultation from CHW Supervisor**

**ACTION**  
**Confirm Assessment Appointment**  
 Date Psych / SW sent patient info dd/mm/yy  
 Method of contact (circle one)  
 Text / Phone / In person  
 Appointment Date (within 3 days) dd/mm/yy  
 Psychologist / SW Name \_\_\_\_\_

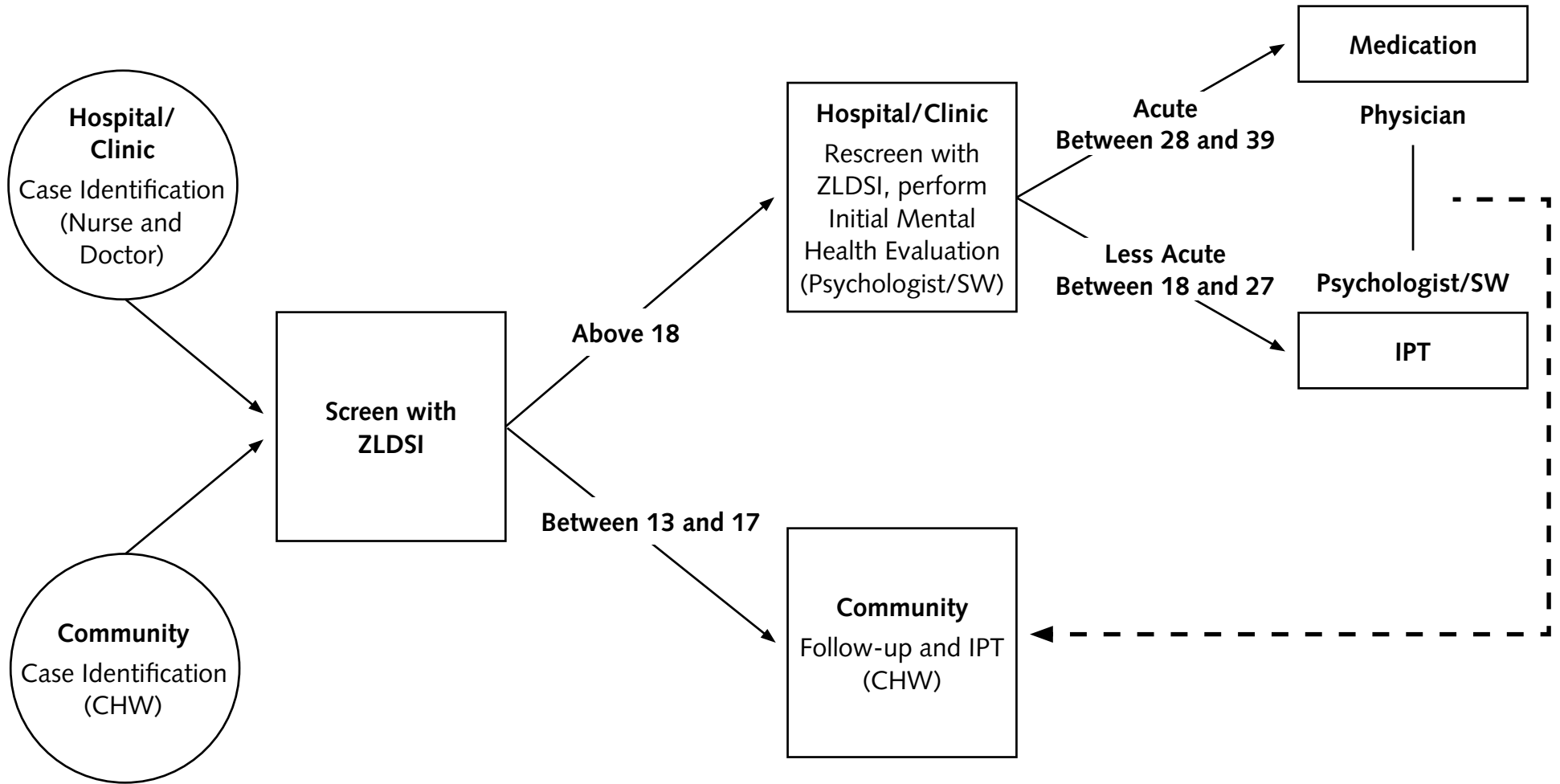
# DEPRESSION CHECKLIST

Date: \_\_\_\_\_ Provider Name: \_\_\_\_\_ Site: \_\_\_\_\_

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Initial Evaluation	Initial Evaluation	Initial Evaluation	Initial Evaluation
<ul style="list-style-type: none"> <li><input type="checkbox"/> Document with Initial Visit Form.</li> <li><input type="checkbox"/> Determine triage/referral                             <ul style="list-style-type: none"> <li><input type="checkbox"/> If suicidal, initiate de-escalation, accompany patient to see psychologist immediately.</li> <li><input type="checkbox"/> If ZLDSI&gt;13; or concern for suicidal ideation, psychosis, or epilepsy, refer patient to psychologist.</li> <li><input type="checkbox"/> If ZLDSI&lt;13, manage in community.</li> </ul> </li> <li><input type="checkbox"/> Ask patient/family to give psychologist Referral Form.</li> <li><input type="checkbox"/> Begin basic IPT (giving hope, naming and explaining illness).</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Give ZLDSI and Initial Visit Form to psychologist.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Depression Checklist with CHW/nurse to track care.</li> <li><input type="checkbox"/> Document with Initial Mental Health Evaluation form. Use CHW/nurse input.</li> <li><input type="checkbox"/> To diagnose depression, consider ZLDSI score, suicidality, and mania.</li> <li><input type="checkbox"/> Consult physician for suicidal ideation, epilepsy/ other medical problems, psychosis, or severe depression. Accompany patient and present information to physician in person.</li> <li><input type="checkbox"/> Track physician care with Depression Checklist.</li> <li><input type="checkbox"/> Do psychoeducation. Check medication supply.</li> <li><input type="checkbox"/> Determine CHW role: follow up and support/education for moderate/severe depression or transfer to CHW for mild depression.</li> <li><input type="checkbox"/> Schedule proper follow-up (with psychologist, CHW, physician).</li> <li><input type="checkbox"/> Enter patient into registry. File ZLDSI, complete checklist/Patient Encounter Form.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify patients at risk for depression and check for depression symptoms in nursing protocol.</li> <li><input type="checkbox"/> Decide referral to physician or psychologist, based on depression symptom score.</li> <li><input type="checkbox"/> Take vital signs and check for headache, abdominal pain, and high blood pressure; contact physician if any are present.</li> <li><input type="checkbox"/> Document in Nurse Inpatient Encounter Form for depression, as well as patient dossier.</li> <li><input type="checkbox"/> Based on referral process, provide psychoeducation and support to patient and family.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Initial Mental Health Evaluation with psychologist/SW.</li> <li><input type="checkbox"/> For suicidal patients, work with psychologist/SW to determine risk and to ensure safety plan.</li> <li><input type="checkbox"/> Do medical evaluation separate from mental health evaluation.</li> <li><input type="checkbox"/> Based on ZLDSI score, suicidal ideation, and severity of depression symptoms, decide whether to prescribe. Choose fluoxetine or amitripyline based on symptoms, age, comorbidity.</li> <li><input type="checkbox"/> Provide psychoeducation about medication.</li> <li><input type="checkbox"/> Ensure follow-up with psychologist/SW.</li> <li><input type="checkbox"/> Document evaluation and plan in Initial Mental Health Evaluation.</li> </ul>

# DEPRESSION CHECKLIST

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Follow-Up Evaluation	Follow-Up Evaluation	Ongoing Care	Follow-Up Evaluation
<ul style="list-style-type: none"> <li><input type="checkbox"/> Document with Follow-Up Form.</li> <li><input type="checkbox"/> Check for medication compliance and side effects.</li> <li><input type="checkbox"/> Determine triage/referral                             <ul style="list-style-type: none"> <li><input type="checkbox"/> If suicidal, initiate de-escalation, accompany patient to see psychologist immediately.</li> <li><input type="checkbox"/> If ZLDSI&gt;13, medication problem, or concern for suicidal ideation, psychosis, or epilepsy, refer patient to psychologist.</li> <li><input type="checkbox"/> If ZLDSI&lt;13, manage in community.</li> </ul> </li> <li><input type="checkbox"/> Ask patient/family to give psychologist Referral Form.</li> <li><input type="checkbox"/> Continue IPT (explain illness, give hope, behavioral activation).</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Give ZLDSI and Initial Visit Form to psychologist.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Depression Checklist with CHW/nurse to track care.</li> <li><input type="checkbox"/> Document with Mental Health Follow-Up Form.</li> <li><input type="checkbox"/> Check if depression is improving based on patient report, ZLDSI, mental status exam, CHW/family input. Check medication compliance and side effects.</li> <li><input type="checkbox"/> Consult physician for suicidal ideation, epilepsy/other medical problems, psychosis, or severe depression. Accompany patient and present information to physician in person.</li> <li><input type="checkbox"/> Track physician care with Depression Checklist.</li> <li><input type="checkbox"/> Do psychoeducation, include medication side effects. Check supply of medication.</li> <li><input type="checkbox"/> Determine CHW role: follow up, support/education for severe depression; transfer to CHW for mild depression.</li> <li><input type="checkbox"/> Schedule proper follow-up (with psychologist, CHW, physician).</li> <li><input type="checkbox"/> Enter patient into registry. File ZLDSI, complete checklist/Patient Encounter Form.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Before discharging patient, provide psychoeducation about treatment and medication. Make sure patient has follow-up appointments with psychologist/SW and physician, if needed.</li> <li><input type="checkbox"/> If patient has been suicidal during hospitalization, check for suicidal ideation before discharge. If patient is suicidal, contact psychologist immediately.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Initial Mental Health Evaluation with psychologist/SW</li> <li><input type="checkbox"/> Determine whether patient is improving.</li> <li><input type="checkbox"/> For suicidal patients, work with psychologist/SW to determine risk and to ensure safety plan.</li> <li><input type="checkbox"/> Medication: continue or change it based on side effects and response.</li> <li><input type="checkbox"/> Document evaluation and plan in Mental Health Follow-Up Form.</li> </ul>



\*Administer the ZLDSI once every two weeks.

# INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services



Record Number: \_\_\_\_\_ EMR Number: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Site : \_\_\_\_\_

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex:  M  F Date of Birth (Day/Month/Year): \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Commune: \_\_\_\_\_ Profession: \_\_\_\_\_ Telephone: \_\_\_\_\_

Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of Community Health Worker/Telephone: \_\_\_\_\_

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**Chief Complaint** (in the patient's own words):

**History of Present Illness** (Date of symptom onset, precipitants, course, any prior treatment):

## PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION	MANIA	ANXIETY	PSYCHOSIS
<ul style="list-style-type: none"> <li>• Have you felt sad or lost interest in things for a two week period?</li> <li>• Do you feel like you've lost interest in everything or only in some things?</li> <li>• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39</li> </ul>	<ul style="list-style-type: none"> <li>• Did you feel very happy for any reason in the last few days?</li> <li>• Did you get angry more often in the last few days?</li> <li>• Do you:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Have any difficulties of staying attentive?</li> <li><input type="checkbox"/> Speak of things that you shouldn't?</li> <li><input type="checkbox"/> Feel like you're worth more than before?</li> <li><input type="checkbox"/> Have a racing thoughts going through your head?</li> <li><input type="checkbox"/> Have an increase in activities?</li> <li><input type="checkbox"/> Sleep less?</li> <li><input type="checkbox"/> Talk without ceasing?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Are you a worrier?</li> <li>• What do you worry about?</li> <li>• Are you experiencing:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Fear of crowded places</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Muscle tension</li> <li><input type="checkbox"/> Restlessness</li> </ul> </li> <li>• Do you often experience any 4 of these problems such as:               <ul style="list-style-type: none"> <li><input type="checkbox"/> increased in heartbeat</li> <li><input type="checkbox"/> breathlessness</li> <li><input type="checkbox"/> sweating</li> <li><input type="checkbox"/> trembling</li> <li><input type="checkbox"/> fear; fear of losing control; fear of becoming crazy; fear of death</li> <li><input type="checkbox"/> feeling dizzy</li> <li><input type="checkbox"/> feel like you're losing consciousness</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Do you hear things like voices that other people don't hear?</li> <li>• Do you see things that other people don't see?</li> <li>• Do you feel that people are conspiring to harm you – even people whom you don't know?</li> <li>• Are the voices in your head controlling your thought process?</li> </ul>

	SUICIDE		VIOLENCE/HOMICIDE	
	Have you ever thought of causing harm to yourself or committing suicide in the past? What about now?		Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?	
	Ideation	Attempts	Ideation	Acts
Past	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain \_\_\_\_\_

Do you have a plan?  Yes  No      Are there guns or other weapons in the household?  Yes  No

SUBSTANCE ABUSE						
Do you use any of the following?						
	Beer	Home Brew	Liquor	Tobacco	Marijuana	Cocaine
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain quantity, first use, last use: \_\_\_\_\_

Need to cut down?       Annoyed or angered by others who comment on your use?       Guilty about using?   
 In order to function properly, do you need to take that substance before starting your day?

TRAUMA						
Did you ever experience a trauma, such as physical, sexual, or emotional abuse, that is impacting your current functioning?						
	Physical	Emotional	Sexual	Re-experiencing	Hyperarousal	Avoidance
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: \_\_\_\_\_

Do you feel safe in your current environment? \_\_\_\_\_

## PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
<input type="checkbox"/> Are you experiencing pain in your body?	<ul style="list-style-type: none"> <li>• Is there a change in your:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight?</li> <li><input type="checkbox"/> Thirst?</li> <li><input type="checkbox"/> Fever?</li> </ul> </li> </ul>	<input type="checkbox"/> Sight problems?  <input type="checkbox"/> Hearing problems?  <input type="checkbox"/> Voice change?  <input type="checkbox"/> Dizziness?  <input type="checkbox"/> Gum and teeth status?  <input type="checkbox"/> Difficulty swallowing?	<input type="checkbox"/> Stiffness of the neck?
BREATHING	HEART/ARTERIES	DIGESTIVE SYSTEM	SKIN
<input type="checkbox"/> Are you having problems breathing?  <input type="checkbox"/> Are you coughing?  <input type="checkbox"/> Do you cough out blood or find blood in your snot?	<input type="checkbox"/> Do you have an increased heartbeat?  <input type="checkbox"/> Having chest pain?  <input type="checkbox"/> Any swelling?	<input type="checkbox"/> Heart burn?  <input type="checkbox"/> Gastric Reflux?  <input type="checkbox"/> Vomiting?  <input type="checkbox"/> Constipation, diarrhea, gas?	<input type="checkbox"/> Any changes in your skin?
MUSCLES	APPENDAGES (HANDS AND FEET)	GENITALS/URINATION	NEUROLOGICAL
<input type="checkbox"/> Are they stiff?  <input type="checkbox"/> Swollen?  <input type="checkbox"/> Reddened?	<input type="checkbox"/> Swollen?	<input type="checkbox"/> Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?  <input type="checkbox"/> Any problems when urinating (pain, amount/ color of urine, blood in urine)?	<input type="checkbox"/> Any numbness?  <input type="checkbox"/> Uncontrolled movements?



## PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

### Psychiatric Family History:

---

### Past Medical History and Active Medical Problems

Head Injury:

Last Date Of Menstruation: \_\_\_ / \_\_\_ / \_\_\_

Loss Of Consciousness:

Other Things:

---

### Medication/Allergies/Side Effects:

---

### Medical Family History:

---

**Social/Cultural History** (include childhood family configuration, urban or rural setting, level of education, romantic relationships, and occupation or other means of financial support):

### Legal Problems:

## PHYSICAL EXAM (PHYSICIAN)

Vital Signs: \_\_\_\_\_

HEENT: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Cardio-vascular: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitals: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_

## NEUROLOGIC EXAM (PHYSICIAN)

Cranial nerves II to XII Intact  If impaired, specify \_\_\_\_\_

Motor: \_\_\_\_\_

Pronator drift: \_\_\_\_\_

Sensory: \_\_\_\_\_

Vibration: \_\_\_\_\_ Position: \_\_\_\_\_

Reflexes: DTR \_\_\_\_\_ Clonus \_\_\_\_\_ Babinsky \_\_\_\_\_

Coordination and Gait: Rapid alternating movements \_\_\_\_\_ Nose finger test \_\_\_\_\_

Romberg \_\_\_\_\_ Gait \_\_\_\_\_ Heel toe walk test \_\_\_\_\_

## MENTAL STATUS EXAM

General Appearance	<input type="checkbox"/> well groomed	<input type="checkbox"/> disheveled	<input type="checkbox"/> overdressed, elaborate
Orientation	<input type="checkbox"/> O x 3	<input type="checkbox"/> disoriented to time	<input type="checkbox"/> disoriented to place <input type="checkbox"/> disoriented to person
Behavior	<input type="checkbox"/> WNL <input type="checkbox"/> tics	<input type="checkbox"/> retardation	<input type="checkbox"/> agitation <input type="checkbox"/> tremor
Speech	<input type="checkbox"/> WNL	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured <input type="checkbox"/> slurred
Mood	<input type="checkbox"/> _____		
Affect	<input type="checkbox"/> euthymic <input type="checkbox"/> irritable <input type="checkbox"/> congruent with speech content	<input type="checkbox"/> dysphoric <input type="checkbox"/> suspicious <input type="checkbox"/> incongruent with speech content	<input type="checkbox"/> euphoric <input type="checkbox"/> labile <input type="checkbox"/> other: _____ <input type="checkbox"/> anxious <input type="checkbox"/> flat

## MENTAL STATUS EXAM CONTINUED

Thought Process	<input type="checkbox"/> linear <input type="checkbox"/> tangential <input type="checkbox"/> perseverative <input type="checkbox"/> illogical <input type="checkbox"/> loose associations <input type="checkbox"/> _____
Thought Content	<input type="checkbox"/> WNL <input type="checkbox"/> vague <input type="checkbox"/> persistent preoccupation with: <input type="checkbox"/> suicidal ideation <input type="checkbox"/> homicidal ideation Delusions: <input type="checkbox"/> none <input type="checkbox"/> paranoid <input type="checkbox"/> grandiose <input type="checkbox"/> other: _____ Perceptual Disturbances/Hallucinations: <input type="checkbox"/> none <input type="checkbox"/> auditory <input type="checkbox"/> visual <input type="checkbox"/> olfactory <input type="checkbox"/> gustatory <input type="checkbox"/> tactile
Insight:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good
Judgment/Impulse Control:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good

**General Impressions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### BIOPSYCHOSOCIAL FORMULATION (including patient's strengths and coping strategies):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DIAGNOSIS:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

### PLAN:

#### Psychological Treatment Plan

##### Treatment Goals

1. Goal: \_\_\_\_\_

2. Goal: \_\_\_\_\_

3. Goal: \_\_\_\_\_

**Intervention**

- Interpersonal Psychotherapy (IPT)
- Medication
- Behavioral Activation
- Psychoeducation
- Parent/Family Supportive Therapy
- Other \_\_\_\_\_
- Relaxation Training
- Supportive Psychotherapy
- Grief Support
- Parent Skills Training

**Frequency**

- Once per week
- Bi-weekly
- Once per month

**Number of Sessions:**

- 4–6 sessions
- 6–8 sessions
- 8–10 sessions
- 10–12 sessions

Primary Clinician: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

**Referrals**

**CHW**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Social Worker**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Other Plan: (follow-up with family, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

**FOLLOW-UP**

**Psychiatric Medication**

Medication	Dose	Frequency	Quantity	Refill Date
Risperidone				
Haloperidol				
Diazepam				
Carbamazepine				
Valporic Acid				
Other: _____				

**Hospitalization:**

Date of Admission: \_\_\_ / \_\_\_ / \_\_\_

Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_

# MEDICATION CARD FOR DEPRESSION

		FLUOXETINE	AMITRIPTYLINE
		<p><i>Antidepressant, SSRI: depression, anxiety</i></p> <p><b>Use for: depression, anxiety, post-traumatic stress disorder</b></p>	<p><i>Tricyclic antidepressant: depression, anxiety, migraine, neuropathic pain</i></p> <p><b>Use for: depression, anxiety, post-traumatic stress disorder, migraines, neuropathic pain</b></p>
<b>DO NOT USE IF</b>		Manic	<ul style="list-style-type: none"> <li>• Manic, cardiac arrhythmia</li> <li>• Caution in elderly; caution if patient is suicidal as fatal in overdose</li> </ul>
<b>MUST CONSULT MENTAL HEALTH TEAM</b>		Prior history of mania, heart condition	Prior history of mania, heart condition
<b>Starting Dose (Adult)</b>		<ul style="list-style-type: none"> <li>• Dosing Forms: 20 mg capsules</li> <li>• Dosage: Start with 20 mg every morning</li> </ul>	<ul style="list-style-type: none"> <li>• Dosing forms: 25 mg tablets</li> <li>• Dosage: Start with 25 mg at bedtime</li> <li>• Typical maintenance dosage: 50-75 mg daily</li> </ul>
<b>“Step” of Uptitration</b>		If necessary, increase by 20 mg increments each month until a maximum of 80 mg daily.	If necessary, increase by 25 mg increments every two weeks until a maximum of 200 mg daily.
<b>Maximum Dose</b>		80 mg	300 mg
<b>Toxicities</b> *If rash, stop medication and return to hospital	<b>Serious</b>	<p><b>Special warning:</b> serotonin syndrome may occur for 4-6 weeks</p>	<p><b>Special warnings:</b> less well tolerated than Fluoxetine. Risk of death in overdose. High risk of arrhythmias and sudden death due to prolonged QT interval and also high risk of myocardial infarction. For patients over 40 years, we must obtain the history of symptoms of arrhythmia, disorders of the cardiac conduction system, diseases of the coronary arteries and make an electrocardiac examination before starting treatment.</p>
	<b>Serotonin Syndrome</b>	<p>Mostly this is because of the use of two serotonin drugs simultaneously eg. SSRI's such as fluoxetine, carbamazepine, tramadol, amitriptyline, pentazocine, lithium or cocaine.</p> <p>It can happen when increasing the dose of a single drug, such as fluoxetine.</p> <p>Symptoms may include at least three of the following: restlessness, ataxia, diaphoresis, diarrhea, hyperreflexia, change in mental state, myoclonus, tremor, or hyperthermia. Need to distinguish between the serotonin syndrome and neuroleptic malignant syndrome that is characterized by rigidity and slowed movements.</p> <p><b>Treatment:</b> to stop serotonin medications, use ice, antipyretic drugs, fans in case of fever, and rehydration if the patient is dehydrated. Treat other vital sign abnormalities as needed.</p>	
	<b>Common</b>	<ul style="list-style-type: none"> <li>• Agitation</li> <li>• Transient nausea</li> <li>• Jitters</li> <li>• Restlessness</li> <li>• Drowsiness</li> <li>• Headache</li> <li>• Nausea</li> <li>• Insomnia</li> <li>• Sexual Dysfunction (which can decrease after a few weeks)</li> </ul>	<ul style="list-style-type: none"> <li>• Drowsiness</li> <li>• Dizziness</li> <li>• Sedation</li> <li>• Dry Mouth</li> <li>• Blurred Vision</li> <li>• Constipation</li> <li>• Urinary Retention</li> <li>• Tachycardia</li> <li>• Confusion</li> <li>• Delirium (especially among the elderly)</li> </ul>
<b>Tapering/ Discontinuing</b> If there is a life-threatening/toxic side effect, stop immediately.		Taper gradually over 2 or more weeks. Antidepressant withdrawal syndrome can include insomnia, anxiety, irritability, nausea, headache.	
<b>Breastfeeding</b>		Safety unknown; caution advised.	Probably safe; caution advised.



# Partners In Health

Department of Mental Health & Psychosocial Services

## Mental Health Follow-Up Form

File Number:

\_\_\_\_\_

EMR Number:

\_\_\_\_\_

Location:

\_\_\_\_\_

Date:

\_\_\_ / \_\_\_ / \_\_\_

Name of CHW: \_\_\_\_\_ Number of visits: \_\_\_\_\_ Date of last visit: \_\_\_ / \_\_\_ / \_\_\_

### Patients' Demographic Data

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Last Name: \_\_\_\_\_

Sex:  M  F

Address: \_\_\_\_\_

Change in phone number:  Yes  No

Date of Birth: DD/MM/YYYY

Age: \_\_\_\_\_

### 1. Initial Diagnosis

Initial Diagnosis: \_\_\_\_\_

Contacts since the last visit:

Patient  Parent  Family  Medication  CHW  Other \_\_\_\_\_

### 2. Evolution: (Comment on symptoms, aggravation and improvement, location, quality, severity, duration, schedule, context, modifying factors, and coping strategies):

### 3. Ongoing psychotherapy (Progress)

ZLDSI score for depression (if present): \_\_\_\_\_

Date of last menstrual period: DD/MM/YYYY \_\_\_\_\_

Current medications  Yes  No

Medication/s	Dose/Freq	Side Effects	Comments
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____

### 4. Mental Status Examination

General appearance wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to self, suicidal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor introspection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to others	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought process wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety, phobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle tone and strength	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought content wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor judgement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive function wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Affect wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Observations from the mental health examination:

\_\_\_\_\_

**5. Positive results from the physical examination/labs (PHYSICIANS):**

**6. Diagnosis (DSM-IV):**

**7. Response to recent interventions:**

**8. Interventions in the current session (I), Future treatment plan (P)**

<input type="checkbox"/> Interpersonal therapy, session # _____ <input type="checkbox"/> Active listening <input type="checkbox"/> Reinforcement of alliance <input type="checkbox"/> Encouragement/support <input type="checkbox"/> Psychoeducation <input type="checkbox"/> Identify/express feelings <input type="checkbox"/> Discuss issues of protection <input type="checkbox"/> Evaluation/Safety planning <input type="checkbox"/> Relaxation <input type="checkbox"/> Acupuncture	<input type="checkbox"/> Discuss medication <input type="checkbox"/> Review social activities <input type="checkbox"/> Identify family roles <input type="checkbox"/> Work on communication <input type="checkbox"/> Explore conflicts <input type="checkbox"/> Work on resources <input type="checkbox"/> Work on a plan of change <input type="checkbox"/> Therapeutic plan/social activities <input type="checkbox"/> Cognitive behavioral therapy <input type="checkbox"/> Anger management	<input type="checkbox"/> Controlling motivations <input type="checkbox"/> Emotional regulation <input type="checkbox"/> Behavioral regulation <input type="checkbox"/> Training for self-control <input type="checkbox"/> Develop a behavior plan <input type="checkbox"/> Cognitive intervention <input type="checkbox"/> Sensory response <input type="checkbox"/> Plan/review progress <input type="checkbox"/> Collaborate with other clinicians <input type="checkbox"/> Other _____ _____ _____
---	--	--

**9. Intervention of Social Worker**

**10. Other recommendations (if necessary)**

**11. Plan**

Plan discussed with patient and he (she) approves:  Yes If  No, explain:

Name of the person completing the evaluation: \_\_\_\_\_ Date: \_\_\_\_\_

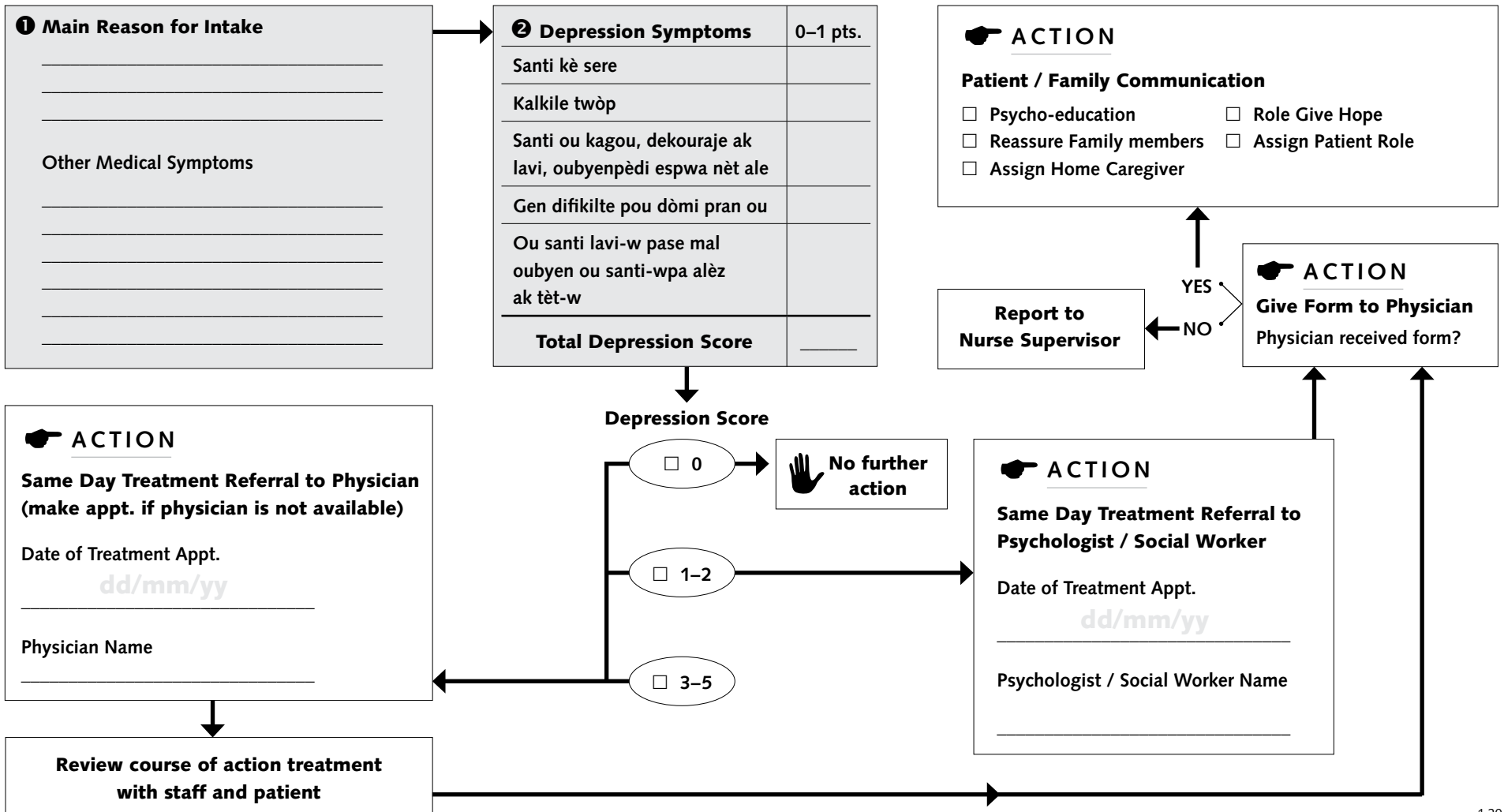


# NURSE INPATIENT ENCOUNTER FORM

Date dd/mm/yy



Name _____	Age _____	Town _____
Psychologist / SW _____	Male / Female (circle one)	District _____
CHW Referrer _____	Phone #1 _____	Session # _____
Patient ID _____	Phone #2 _____	Date received patient info _____





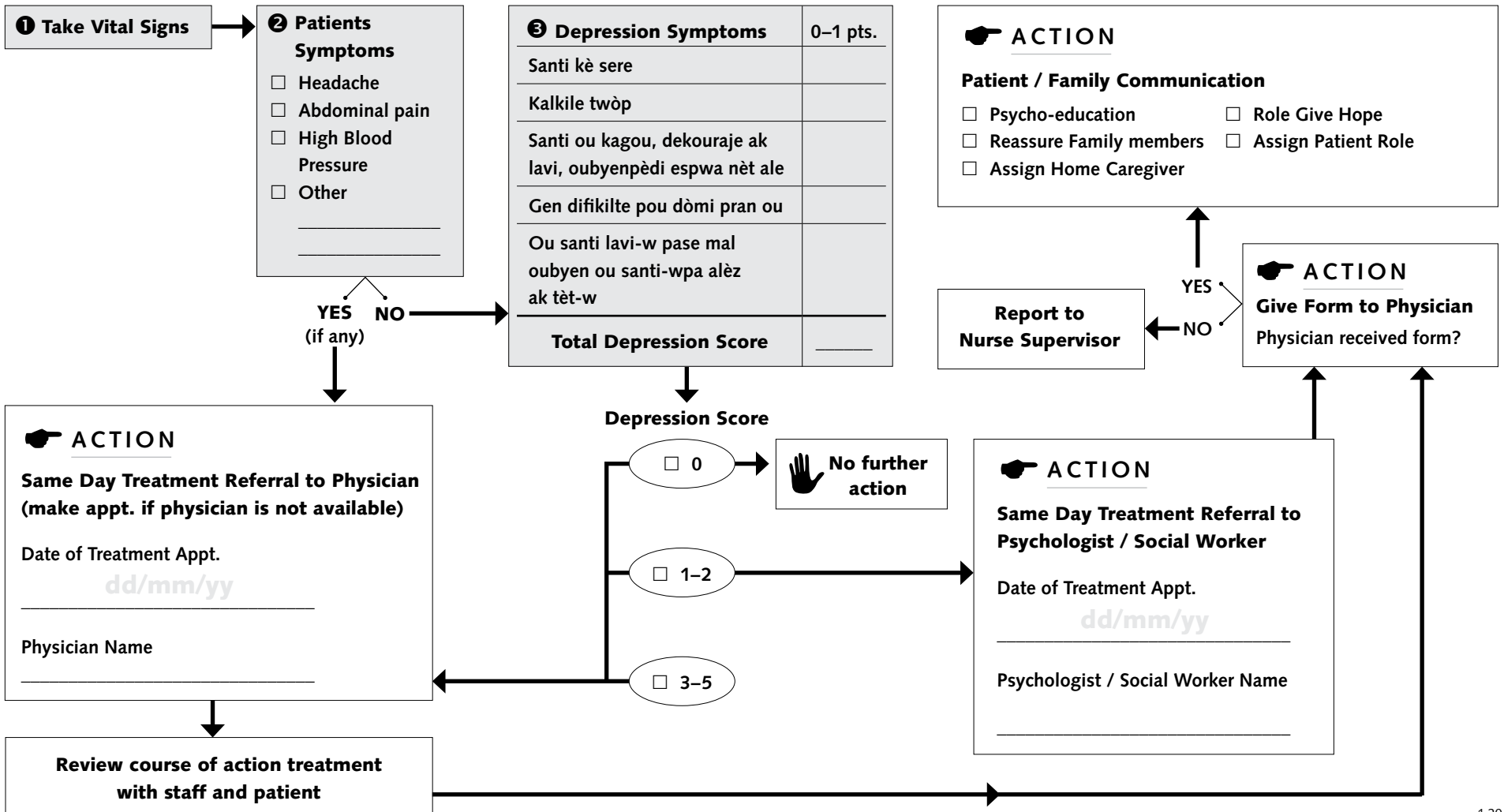


# NURSE OUTPATIENT ENCOUNTER FORM

Date dd/mm/yy



Name _____	Age _____	Town _____
Psychologist / SW _____	Male / Female (circle one)	District _____
CHW Referrer _____	Phone #1 _____	Session # _____
Patient ID _____	Phone #2 _____	Date received patient info _____



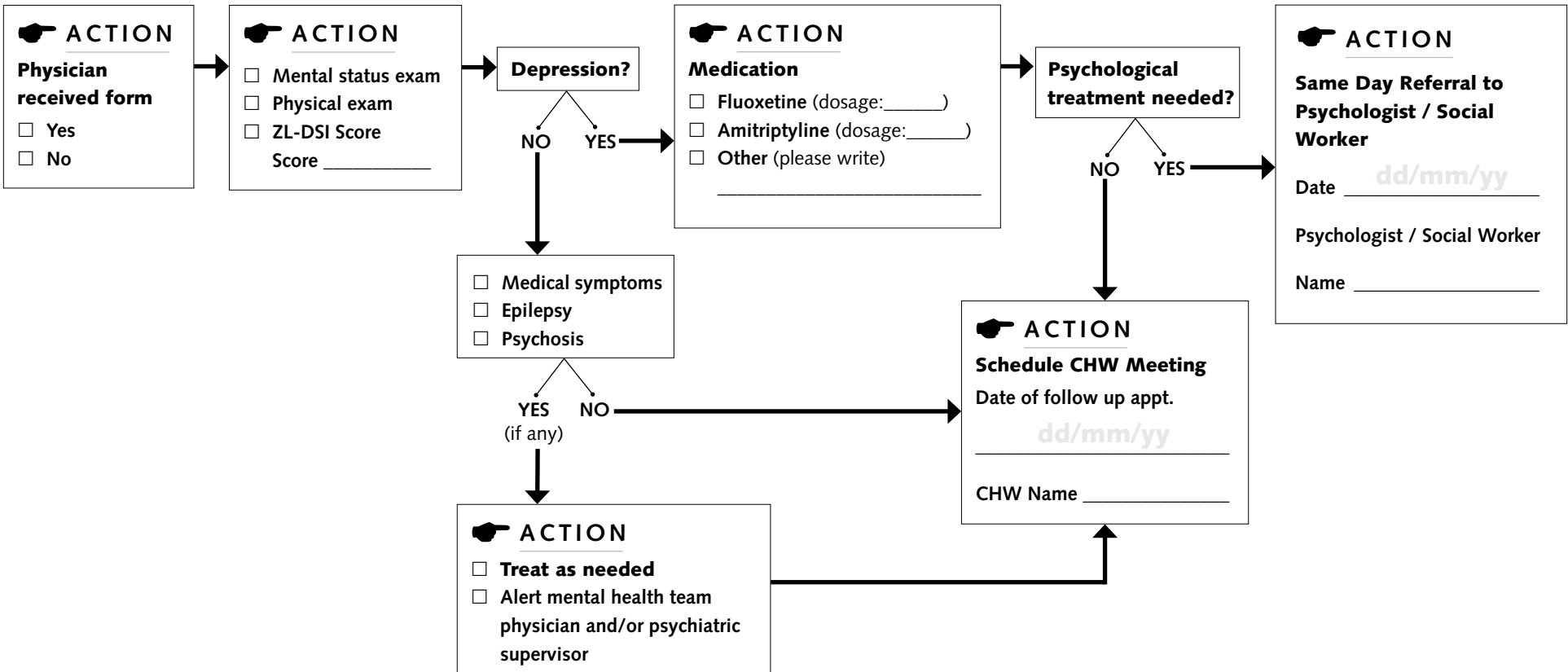


# PHYSICIAN PATIENT ENCOUNTER FORM

Date dd/mm/yy



Name _____	Age _____	Town _____
Psychologist / SW _____	Male / Female (circle one)	District _____
CHW Referrer _____	Phone #1 _____	Session # _____
Patient ID _____	Phone #2 _____	Date received patient info _____



(notes) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



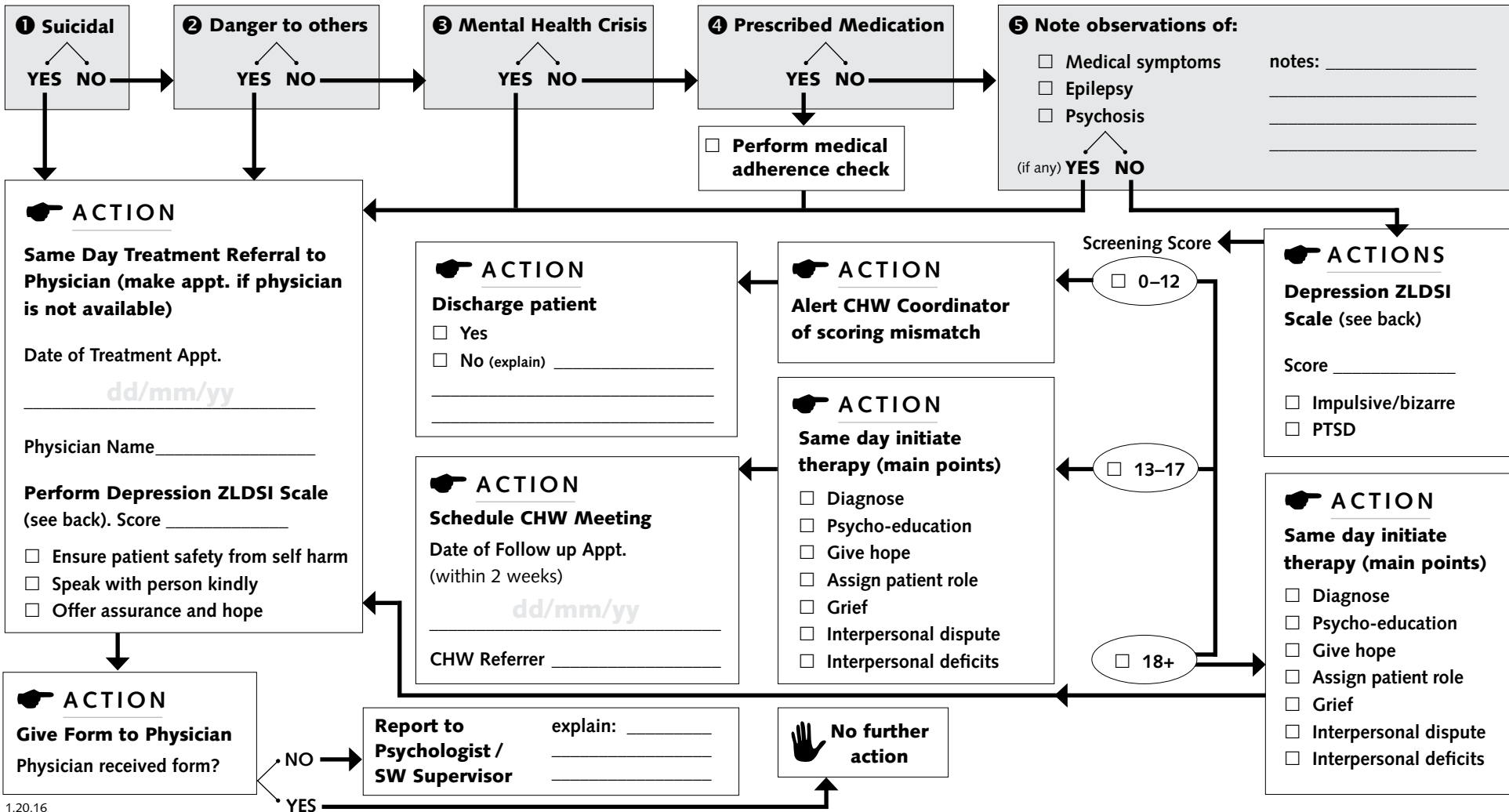
# PSYCH/SOCIAL WORKER PATIENT ENCOUNTER FORM

Date dd/mm/yy



Name _____	Age _____	Town _____
Psychologist / SW _____	Male / Female (circle one)	District _____
CHW Referrer _____	Phone #1 _____	Session # _____
Patient ID _____	Phone #2 _____	Date received patient info _____

## REVIEW KEY SYMPTOMS



# MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM



Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Recipient (Provider): \_\_\_\_\_

Recipient's telephone: \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Last Name: \_\_\_\_\_

Dossier Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Principal Symptoms: \_\_\_\_\_

<b>Reasons/Diagnostic Impressions:</b> <ul style="list-style-type: none"><li>• Psychological trauma</li><li>• Sexual abuse</li><li>• Suicide attempt</li><li>• Psychiatric emergency</li><li>• Mental confusion</li><li>• Psychosis/bipolar disorder</li><li>• Behavioral disorders</li><li>• Somatoform disorders</li><li>• Affective disorders<ul style="list-style-type: none"><li>• Enuresis</li><li>• Encopresis</li></ul></li><li>• Learning disorder</li><li>• Mental retardation</li><li>• Addiction</li><li>• Epilepsy</li><li>• Depression</li><li>• Depression and migraines</li><li>• Other: _____</li></ul>	<b>Services requested:</b> <ul style="list-style-type: none"><li>• Psychological Evaluation</li><li>• Psychotherapies<ul style="list-style-type: none"><li>• Grief, supportive</li><li>• Interpersonal therapy</li></ul></li><li>• Psychotraumatology</li><li>• Counseling<ul style="list-style-type: none"><li>• Pre-Operative</li><li>• Post-Operative</li><li>• Post-test</li><li>• Follow-up</li><li>• Adherence</li><li>• Pre-HAART</li></ul></li><li>• Other: _____</li><li>• <b>IMPORTANT HISTORY:</b> _____ _____</li></ul>
--	---

Signature of referring provider: \_\_\_\_\_

Mental health provider that received the referral: \_\_\_\_\_

Date of receipt: \_\_\_\_\_ Time: \_\_\_\_\_

Remarks: \_\_\_\_\_

Signature: \_\_\_\_\_

**STEP 1** Warning signs that a crisis is developing (such as thoughts, images, moods, situations, behavior):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 2** Internal coping strategies – activities that I can do without others to distract myself from my problems, such as relaxation techniques:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 3** People and social environments that offer distractions and support:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Where \_\_\_\_\_ Where \_\_\_\_\_

**Step 4** People I can ask to help me:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 5** Professionals and agencies I can contact during a crisis:

- Community Health Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Ajan Sante \_\_\_\_\_ Telephone \_\_\_\_\_
- Social Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Psychologist \_\_\_\_\_ Telephone \_\_\_\_\_
- Doctor \_\_\_\_\_ Telephone \_\_\_\_\_
- Spiritual Healer \_\_\_\_\_ Telephone \_\_\_\_\_
- Emergency Room/Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 6** Making the environment safe:

\_\_\_\_\_  
\_\_\_\_\_

*I, \_\_\_\_\_, will follow the steps when I'm in a crisis,  
and one thing more important to me than anything else that will help me live is... \_\_\_\_\_*

**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY SCREENING INSTRUMENT**



LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
<b>1. Passive</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you have any thoughts of ending your life, even if they are not clear in your mind?</p> <p><b>Possible Response:</b> I think about it from time to time, but I've never acted upon it...I would make my family feel too bad...God would not forgive me</p>	Description:	
<b>2. Non-Specific Active</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you want to die? Do you often think or talk about death?</p> <p><b>Possible Response:</b> desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me</p>	Description:	
<b>3. Methods but no Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> If you would do it, how would you do it?</p> <p><b>Possible Response:</b> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</p>	Description:	
<b>4. Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you intend to act on these thoughts?</p> <p><b>Possible Response:</b> I will kill myself but I do not know when... I do not think I can do so now...but it's too much for me, I cannot yet</p>	Description:	
<b>5. Planification</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you started planning the details about how you will kill yourself?</p> <p><b>Danger Signs:</b> there is a sudden change in attitude, withdraws from everything; not interested in anything; say: "when I am not here anymore"; seeks to implement the plan, write a note (on paper).</p>	Description:	
<b>6. Attempted</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you tried to do something that could hasten the end of your life? Have you stopped preserving your life, like not eating and not taking medication?</p> <p><b>Danger Signs:</b> Realized did not want to die after the attempt failed, but it often gets worse again after a few days; might have some injuries or marks.</p>	Description:	
<p>Low: Current = 0 Past = 0</p> <p>Medium: Current = 1–2 yes OR Past = 1 or more yes</p> <p>High: Current = 3 or more yes OR Past = 3 or more yes</p>	<p>Total "yes" in past two weeks</p> <input type="checkbox"/>	<p>Total "yes" in past year</p> <input type="checkbox"/>

Provider: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ File #: \_\_\_\_\_

For ALL Patients	
Act	1. <input type="checkbox"/> Ensure that the environment will be private, safe and non-threatening. 2. <input type="checkbox"/> Begin the process of ensuring that the patient will be able to access necessary medication. 3. <input type="checkbox"/> Always work with the patient to develop a Safety Plan.
Say	4. <input type="checkbox"/> Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. <input type="checkbox"/> Start IPT and collect IP inventory. 6. <input type="checkbox"/> Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. <input type="checkbox"/> Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). <i>(Write this on the copy of your Safety Plan, on the back side).</i>
Contact	8. <input type="checkbox"/> Always contact at least one person close to the patient to support and monitor them. 9. <input type="checkbox"/> Contact as many of the current and potential supports as a patient will permit <ul style="list-style-type: none"> <li>• <input type="checkbox"/> You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients</li> <li>• When involving anyone, ensure that you preserve confidentiality if possible and define these:                             <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Depression, suicidality</li> <li>2. <input type="checkbox"/> The needs of such patients</li> <li>3. <input type="checkbox"/> How others can help</li> <li>4. <input type="checkbox"/> How others can hurt</li> </ol> </li> </ul>
Team	10. Consult and involve colleagues to help. <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Doctor <input type="checkbox"/> _____
Follow Up	11. If the patient has a <b>higher</b> risk level, continue to the guidelines <b>below</b> .

ZANMI LASANTE — MENTAL HEALTH  
 SUICIDALITY TREATMENT GUIDELINES

For patients with <b>MEDIUM</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. <input type="checkbox"/> Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur.
	3. <input type="checkbox"/> Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. <input type="checkbox"/> Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. <input type="checkbox"/> At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.
Follow Up	6. If the patient is medium risk, schedule follow-up within 7 days. <b>Date</b> _____ <b>Time</b> _____ If the patient is <b>high</b> risk, continue to the guidelines <b>below</b> .
For patients with <b>HIGH</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary.
	2. <input type="checkbox"/> Seek to admit patient to the emergency room or another service with beds for at least 24 hours.
	3. <input type="checkbox"/> Determine who will be available to watch the patient and when so that they are not left unattended. Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____
Say	4. <input type="checkbox"/> Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. <input type="checkbox"/> Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here).
	6. <input type="checkbox"/> Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. <input type="checkbox"/> MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain).
	8. <input type="checkbox"/> Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. <input type="checkbox"/> Keep the patient admitted and under continuous monitoring (e.g. 4x/hr).
	10. <input type="checkbox"/> Frequently re-assess risk level.
	11. <input type="checkbox"/> If the patient leaves or can't be kept, follow through with continued intensive psychosocial activation.





## Section 3 Preamble

### **Say to respondent:**

The interview is about difficulties people have because of health conditions.

### **Hand flashcard #1 to respondent**

By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

### **Point to flashcard #1**

- Increased effort
- Discomfort or pain
- Slowness
- Changes in the way you do the activity.

When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

### **Hand flashcard #2 to respondent**

Use this scale when responding.

### **Read scale aloud:**

None, mild, moderate, severe, extreme or cannot do.

**Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview**

**Please continue to next page...**



## Section 4 Core questions

### Show flashcard #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S1	<a href="#">Standing for long periods</a> such as <a href="#">30 minutes</a> ?	1	2	3	4	5
S2	Taking care of your <a href="#">household responsibilities</a> ?	1	2	3	4	5
S3	<a href="#">Learning a new task</a> , for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have <a href="#">joining in community activities</a> (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have <a href="#">you</a> been <a href="#">emotionally affected</a> by your health problems?	1	2	3	4	5

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S6	<a href="#">Concentrating</a> on doing something for <a href="#">ten minutes</a> ?	1	2	3	4	5
S7	<a href="#">Walking a long distance</a> such as a <a href="#">kilometre</a> [or equivalent]?	1	2	3	4	5
S8	<a href="#">Washing your whole body</a> ?	1	2	3	4	5
S9	Getting <a href="#">dressed</a> ?	1	2	3	4	5
S10	<a href="#">Dealing with people you do not know</a> ?	1	2	3	4	5
S11	<a href="#">Maintaining a friendship</a> ?	1	2	3	4	5
S12	Your day-to-day <a href="#">work/school</a> ?	1	2	3	4	5

H1	Overall, in the past 30 days, <a href="#">how many days</a> were these difficulties present?	<i>Record number of days</i> ____
H2	In the past 30 days, for how many days were you <a href="#">totally unable</a> to carry out your usual activities or work because of any health condition?	<i>Record number of days</i> ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <a href="#">cut back</a> or <a href="#">reduce</a> your usual activities or work because of any health condition?	<i>Record number of days</i> ____

This concludes our interview. Thank you for participating.



# **WHODAS 2.0**

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 1*

## **Health conditions:**

- **Diseases, illnesses or other health problems**
- **Injuries**
- **Mental or emotional problems**
- **Problems with alcohol**
- **Problems with drugs**

## **Having difficulty with an activity means:**

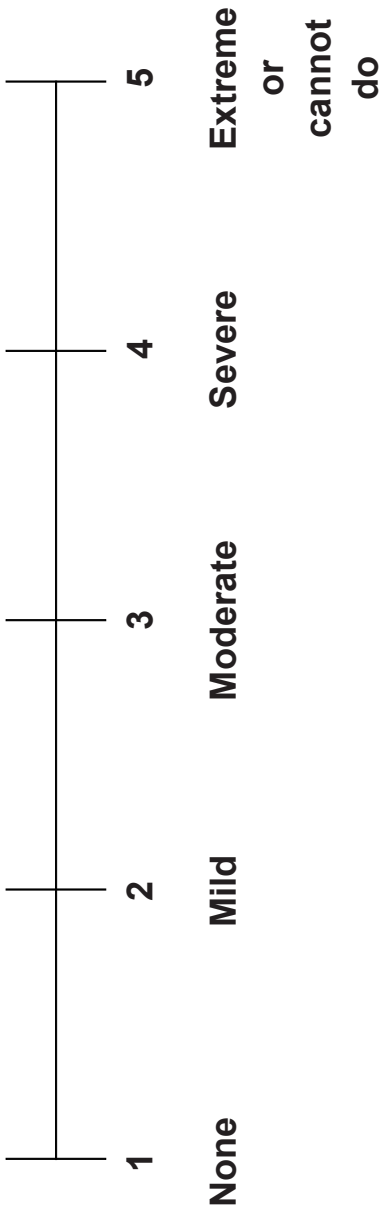
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

**Think about the past 30 days only.**

# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

## Flashcard 2



# ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Date dd/mm/yy

	Pandan 15 jou ki sòt pase la yo, konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Di tou	Konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Pandan kèk jou (1–5 jou)	Plis pase yon semèn (6–9 jou)	Preske chak jou (10–15 jou)
<b>1</b>	Santi ou de la la.	0	—	1	2	3
<b>2</b>	Santi kè sere.	0	—	1	2	3
<b>3</b>	Kalkile twòp.	0	—	1	2	3
<b>4</b>	Kriye oubyen anvri kriye	0	—	1	2	3
<b>5</b>	Santi anyen preske pa enterese ou.	0	—	1	2	3
<b>6</b>	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
<b>7</b>	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
<b>8</b>	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
<b>9</b>	Ou pa gen apeti.	0	—	1	2	3
<b>10</b>	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
<b>11</b>	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
<b>12</b>	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
<b>13</b>	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
<b>Totals</b>				<b>(+)</b>	<b>(+)</b>	

**(=) ZLDSI Score** \_\_\_\_\_

# **EPILEPSY**

Tools for use in an integrated, community-based mental health system of care



# Partners In Health

Department of Mental Health & Psychosocial Services  
Patient Follow-up Form – Community Health Workers

Visit Date:  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:  
\_\_\_\_\_  
Visit Number:  
\_\_\_\_\_

### Patients' Demographic Data

Name:

Nickname:

Last Name:

Sex:  M  F

Address:

Phone Number:

Date of Birth: DD/MM/YYYY

Age:

### What did you observe?

Is it Urgent?  Yes  No

- Seizure
- Thinking about suicide
- Thinking about harming others

### How do you think the patient is feeling?

- Patient is better now
- Patient is doing worse
- Patient is the same

### What did you do:

- Check symptoms
- Same day therapy session
- Give advice
- Relaxation
- Ask if patient is out of medication
  - Yes
  - No
  - Patient is not on medication

### Psychoeducation

- Explain the illness to the patient
- Give him/her hope
- Give him/her the sick role
- Encourage the patient to participate in activities that makes him/her happy

### Did you:

- Bring patient to hospital?
- Send patient to hospital?
- Encourage the family?
- Encourage the patient?

### Did you use the ZLDSI?

Yes  
 No  
 What is the ZLDSI Score:  
 \_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

### Name of CHW



# Partners In Health

Department of Mental Health & Psychosocial Services  
Initial Visit Patient Form – Community Health Workers

Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:

\_\_\_\_\_

### Patients' Demographic Data

Name:

Nickname:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### What did you observe?

Is it a urgent matter that needs immediate attention?  Yes  No

Seizure

Thinking about suicide

Thinking about harming others

### Which illness do you think the patient suffers from?

Anxiety

Psychosis

Epilepsy

Depression

### What did you do:

Check symptoms

Same day therapy session

Give advice

Relaxation

Ask if patient is out of medication

Yes

No

Patient is not on medication

### Psychoeducation

Explain the illness to the patient

Give him/her hope

Give him/her the sick role

Encourage the patient to participate in activities that makes him/her happy

### Did you:

Bring patient to hospital?

Send patient to hospital?

Encourage the family?

Encourage the patient?

### Did you use the ZLDSI form?

Yes

No

What is the ZLDSI Score: \_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

### Name of CHW





# Partners In Health

Department of Mental Health &  
Psychosocial Services

## Referral Form – Community Health Workers

### Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Thomonde   | <input type="checkbox"/> Belladère      | <input type="checkbox"/> Boucan Carre    |
| <input type="checkbox"/> Cange      | <input type="checkbox"/> St Marc        | <input type="checkbox"/> Cerca La Source |
| <input type="checkbox"/> Hinche     | <input type="checkbox"/> Petite Rivière | <input type="checkbox"/> Mirebalais      |
| <input type="checkbox"/> Lascahobas | <input type="checkbox"/> Verrettes      |  |

### Patients' Demographic Data

Name:

Nickname:

Last Name:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### Reason for the Referral

Why are you referring the patient?

Is it Urgent?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

- Seizure
- Thinking about suicide
- Thinking about harming others

Depression – ZLDSI Score \_\_\_\_\_

Epilepsy

Seizure

Psychosis

Is the person taking any medications?

Yes  No

If Yes, Specify: \_\_\_\_\_

### Who do you refer the patient to:

Zanmi Lasante

Members of the Community

Psychologists

Community Leader

Social Worker

Other Community Health Workers

Mobile Clinic

Others (specify): \_\_\_\_\_

Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

### Remarks

### Information on the person who referred the patient:

Name:

Phone:

Address:

Last Name:

Nickname:

**CLINICAL GLOBAL IMPRESSIONS SCALE**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Psychologist / SW: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Age: \_\_\_\_\_

Male/ Female (circle one)

Phone #1: \_\_\_\_\_

Town: \_\_\_\_\_

Phone #2: \_\_\_\_\_

District: \_\_\_\_\_

Session#: \_\_\_\_\_

Date recieved patient info: \_\_\_\_\_

**I. Severity of Illness**

Considering your total clinical experience with this particular population, how mentally ill has the patient been over the past 7 days?

**Tip:** Compare relative to your past experience with patients who have the same diagnosis considering your total clinical experience with this population.

**0 = Not assessed****1 = Normal, not at all ill.**

Symptoms of disorder have not been present in the past seven days.

**2 = Borderline mentally ill.**

Subtle or suspected symptoms within the past seven days. No definable impact on behavior or function.

**3 = Mildly ill.**

Clearly established symptoms causing minimal, if any, distress or difficulty in social or occupational function.

**4 = Moderately ill.**

Overt symptoms causing noticeable, but modest, functional impairment or distress. There is evidence of functional interference in multiple settings. Some symptoms may warrant medication.

**5 = Markedly ill.**

Intrusive symptoms that distinctly impair social or occupational function or cause intrusive levels of distress. Functional interference due to symptoms is obvious to others.

**6 = Severely ill.**

Disruptive pathology; behavior and function are frequently influenced by symptoms. Dysfunction may require assistance from others.

**7 = Among the most extremely ill patients.**

Pathology drastically interferes in many life functions. Patient may need to be hospitalized.

**Rating**  
(Number 0–7)

## II. Improvement

Compared to the patient's baseline condition before treatment, how much has the patient changed?

### Tips:

For initial evaluation: if the patient has been in treatment previously, rate CGI Improvement based on the history and compared to the patient's condition prior to treatment. Otherwise, leave blank.

Progress Notes: Rate improvement by comparing the current condition to the patient's condition at the initiation of the current treatment plan. Assess how much the patient's illness has changed relative to a baseline state at the beginning of the treatment plan based on the first evaluation. Rate total improvement whether or not in your judgment it is due to treatment.

**0 = Not assessed**

**1 = Very much improved.**

Nearly all better; good level of functioning; minimal symptoms; represents a very substantial change.

**2 = Much improved.**

Notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain.

**3 = Minimally improved.**

Slightly better with little or no clinically meaningful reduction of symptoms. May represent very little change in basic clinical status, level of care, or functional capacity.

**4 = No change.**

Symptoms remain essentially unchanged.

**5 = Minimally worse.**

Slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity.

**6 = Much worse.**

Clinically significant increase in symptoms and diminished functioning.

**7 = Very much worse.**

Severe exacerbation of symptoms and loss of functioning.

**Rating**  
(Number 0–7)

## III. Side Effects

Select the terms that best describe the degree of side effects of medication treatment.

**0 = None**

**1 = Do not significantly interfere with patient's functioning.**

**2 = Significantly interfere with patient's functioning.**

**3 = Outweighs therapeutic effects with patient's functioning.**

**Rating**  
(Number 0–3)

## COMMUNITY EDUCATION ACTIVITY (CEA) CHECKLIST

### Guidelines:

- CHWs conduct CEAs once a month.
- CEAs are approximately 1–3 hours long.
- Local leaders will announce the sessions on the appropriate day; CHWs will conduct sessions at a place where people are gathered (church, school, etc.).
- CHWs will record information about the CEAs on the Stigma Reduction Form and attendance sheet.
- CHWs should arrange water, snacks and soda for participants.
- CHWs should use visuals such as Community Education Cards and the participant handbook as much as possible during the sessions.

### Steps:

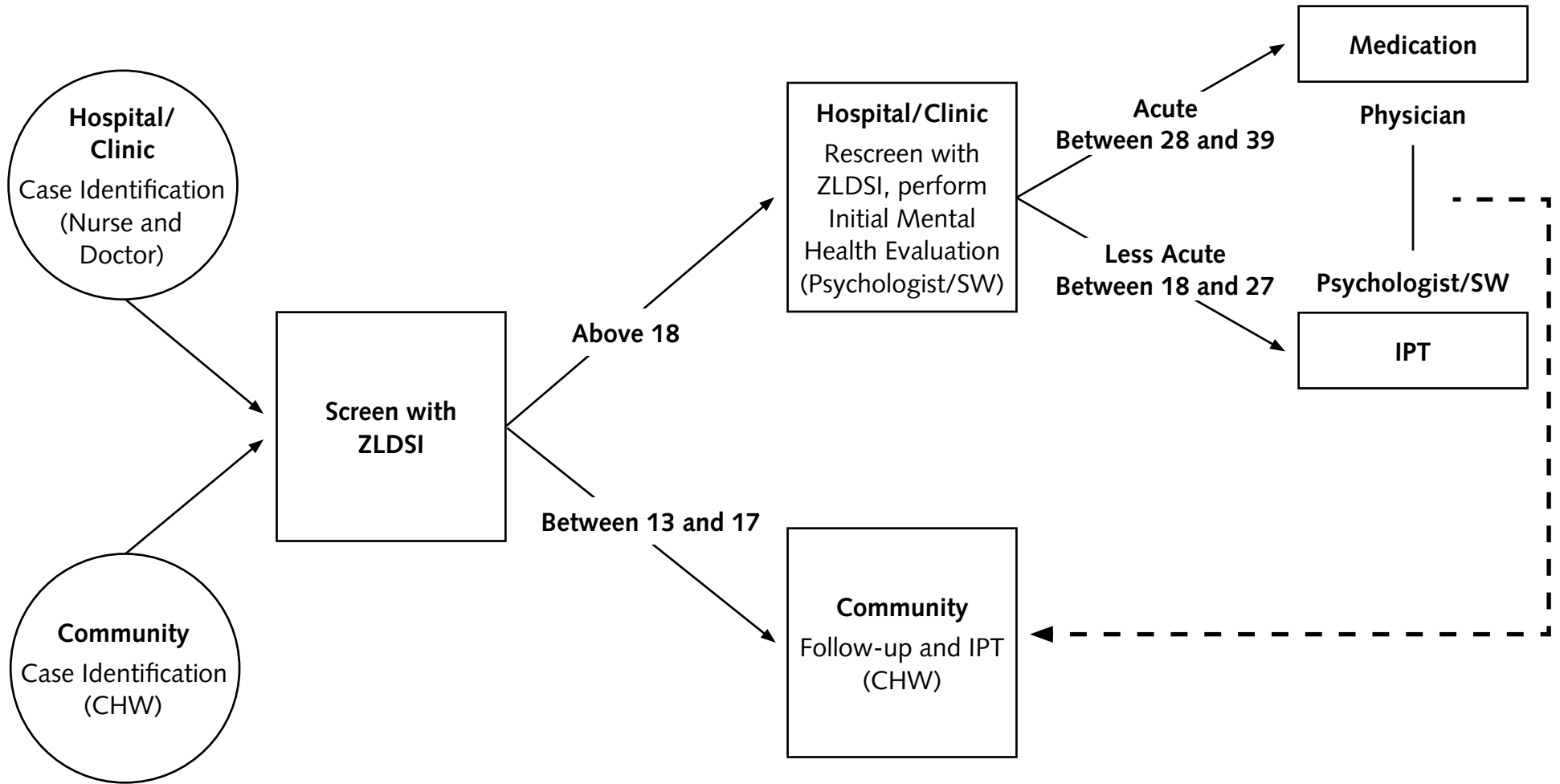
- Introduce yourself to the group.
- Explain the goal of the meeting and introduce the main subject.
- Assess the baseline knowledge of the subject (through asking the audience general questions).
- Use Community Education Cards and the participant handbook to provide key information about the main subject.
  - Define the disease.
  - Explain symptoms with concrete examples.
  - Explain how the disease develops, if it is contagious, prevention methods, where and how to be treated, and recovery.
- Assess community members' understanding of stigma and discrimination through the Stigma Assessment Activity before giving information, and again after.
- Explain the damage that stigma and discrimination can cause to families and communities.
- Allow participants to ask questions throughout the presentation.
- Continuously ask questions to assess understanding. Give a small incentive to participants who answer correctly.
- Remind participants that if they or anyone they know are facing any of the topics being discussed, they should speak to the CHW. The CHW can give a referral to the hospital or other experts.
- Distribute the snack, such as soda or cookies.
- If time allows, practice a specific skill:
  - Practice doing a consultation, completing the referral form, using the ZLDSI, etc.

# EPILEPSY CHECKLIST

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
<b>Patient Has Not Been Evaluated By Clinician</b>	<b>Initial Evaluation</b>	<b>Initial Evaluation</b>	<b>Initial Evaluation</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> If emergency (seizure, suicidal ideation), accompany patient to clinic immediately.</li> <li><input type="checkbox"/> Initiate de-escalation for suicidal ideation.</li> <li><input type="checkbox"/> Document with Intial Visit Form.</li> <li><input type="checkbox"/> Do ZLDSI and check for psychological comorbidities.</li> <li><input type="checkbox"/> Ask patient/family to give psychologist Referral Form.</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Give ZLDSI and Intial Visit Form to psychologist.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Do Epilepsy Checklist with CHW/nurse to track care and get input.</li> <li><input type="checkbox"/> Complete Initial Mental Health Evaluation Form. Do ZLDSI, diagnose mental health comorbidities.</li> <li><input type="checkbox"/> Begin Epilepsy Intake Form.</li> <li><input type="checkbox"/> Schedule follow-up with psychologist/SW and physician within 2 weeks for seizure management.</li> <li><input type="checkbox"/> Accompany patient to see the physician; physicians must see all epilepsy and suicidal cases.</li> <li><input type="checkbox"/> Track physician care with Epilepsy Checklist.</li> <li><input type="checkbox"/> Help physician give psychoeducation to patient and family.</li> <li><input type="checkbox"/> Plan follow-up with CHW.</li> <li><input type="checkbox"/> Enter patient into registry. File ZLDSI, complete checklist.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> For seizing/status epilepticus patient, follow emergency protocol.</li> <li><input type="checkbox"/> If no emergency, identify patients who may have epilepsy.</li> <li><input type="checkbox"/> Provide proper nursing care.</li> <li><input type="checkbox"/> Check depression symptoms in nursing protocol.</li> <li><input type="checkbox"/> Refer patient to physician (Epilepsy Intake Form) and psychologist (Initial Mental Health Evaluation Form). Inform psychologist if patient has risk for depression.</li> <li><input type="checkbox"/> Facilitate collaboration between physician and psychologist.</li> <li><input type="checkbox"/> If confirmed seizure, provide psychoeducation.</li> <li><input type="checkbox"/> Prior to discharge, ensure patient has appointments scheduled with psychologist/SW and physician.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> For seizing/status epilepticus patients, follow emergency protocol.</li> <li><input type="checkbox"/> Consult with psychologist/SW and review information from Epilepsy Intake Form and Initial Mental Health Evaluation Form.</li> <li><input type="checkbox"/> Document information in Epilepsy Intake and mental health forms.</li> <li><input type="checkbox"/> Do full medical evaluation, including physical exam, neurological exam, and labs.</li> <li><input type="checkbox"/> If epilepsy, choose medication based on type of seizure, gender, and child-bearing status.</li> <li><input type="checkbox"/> Provide enough medication to last until next appointment.</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Ensure care has been coordinated with psychologist.</li> </ul>

## EPILEPSY CHECKLIST

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Patient Has Been Evaluated By Clinician	Follow-Up Evaluation	Ongoing Care	Follow-Up Evaluation
<ul style="list-style-type: none"> <li><input type="checkbox"/> If emergency (rash, seizure, suicidality), accompany patient to clinic immediately.</li> <li><input type="checkbox"/> Initiate de-escalation for suicidal ideation.</li> <li><input type="checkbox"/> Document with Follow-Up Forms.</li> <li><input type="checkbox"/> Do ZLDSI, check for psychological comorbidities.</li> <li><input type="checkbox"/> Determine whether seizure frequency is decreasing</li> <li><input type="checkbox"/> Check for compliance and side effects, especially rash.</li> <li><input type="checkbox"/> Check to see if patient has enough medication.</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Ensure patient has follow-up with psychologist.</li> <li><input type="checkbox"/> Give ZLDSI and Follow-Up Form to psychologist.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Document in Epilepsy Follow-Up form.</li> <li><input type="checkbox"/> Do ZLDSI and check for mental health comorbidities. Document in appropriate mental health form.</li> <li><input type="checkbox"/> Check if seizure frequency is decreasing.</li> <li><input type="checkbox"/> Check for medication compliance and side effects, especially rash.</li> <li><input type="checkbox"/> Check if patient has enough medication.</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Accompany patient to see physician; physicians must see all epilepsy, severe depression and suicidal cases.</li> <li><input type="checkbox"/> Track physician care with epilepsy checklist form.</li> <li><input type="checkbox"/> Plan follow-up with CHW</li> <li><input type="checkbox"/> Enter patient into registry. File ZLDSI, complete checklist.</li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> For status epilepticus patients, follow emergency protocol.</li> <li><input type="checkbox"/> Consult with psychologist/SW, review information from Epilepsy Follow-Up Form and mental health forms.</li> <li><input type="checkbox"/> Document in Epilepsy Follow-Up Form.</li> <li><input type="checkbox"/> Determine whether seizure frequency is decreasing.</li> <li><input type="checkbox"/> Check compliance and side effects to see if patient is tolerating medication.</li> <li><input type="checkbox"/> Perform physical exam and neurological exam.</li> <li><input type="checkbox"/> Adjust medication if necessary. Use Medication Card.</li> <li><input type="checkbox"/> Provide psychoeducation.</li> <li><input type="checkbox"/> Ensure care has been coordinated with psychologist/SW. Return forms to psychologist/SW.</li> </ul>



\*Administer the ZLDSI once every two weeks.

# Card #1: What to do when someone is having a seizure





## **Card #1: What to do when someone is having a seizure**

If you see someone you suspect is having a seizure:

- Turn them onto their side
- Do not put anything in their mouth
- Remove any nearby objects that could be dangerous
- Put something soft under their head

In addition, do this:

- Do not leave the person alone.
- Patients must visit the clinic / hospital immediately if it is the first time they have had a seizure. A person's first seizure can be a life-threatening illness. Please refer to Session 3 for more information about how to evaluate the case and prioritize severity.
- Find family or close neighbors to help.
- Always treat people with kindness and tenderness.

## Card #2: Key Epilepsy Messages



## Card #2: Key Epilepsy Messages

- **People suffering from epilepsy can live a full and healthy life** by following proper treatment recommended by psychologists and physicians.
- It is important to follow the proper treatment to control seizures.
  - Ask people with epilepsy, "How did the doctor tell you to take medication?" Encourage patients to take their medication as the doctors say.
  - Remind patients to keep appointments so they can have enough medicine without running out.
  - Patients should see a doctor or psychologist if the seizures worsen or if the medication produces side effects (see Card 4).
- **Epilepsy is not a punishment.** People have it when the brain does not work as it should, and it is a disease like any other disease. There are treatments for it, as there are for other diseases like hypertension.

***Note:** Before seeing patients, the psychologist must tell the CHW exactly how patients should be taking medication so the CHW can confirm this. Psychologists are responsible for documenting the drug name, exact dose to take, and how to take it; and must provide this information to the CHW.*

### Card #3: Activities that Patients Suffering from Epilepsy Should Avoid



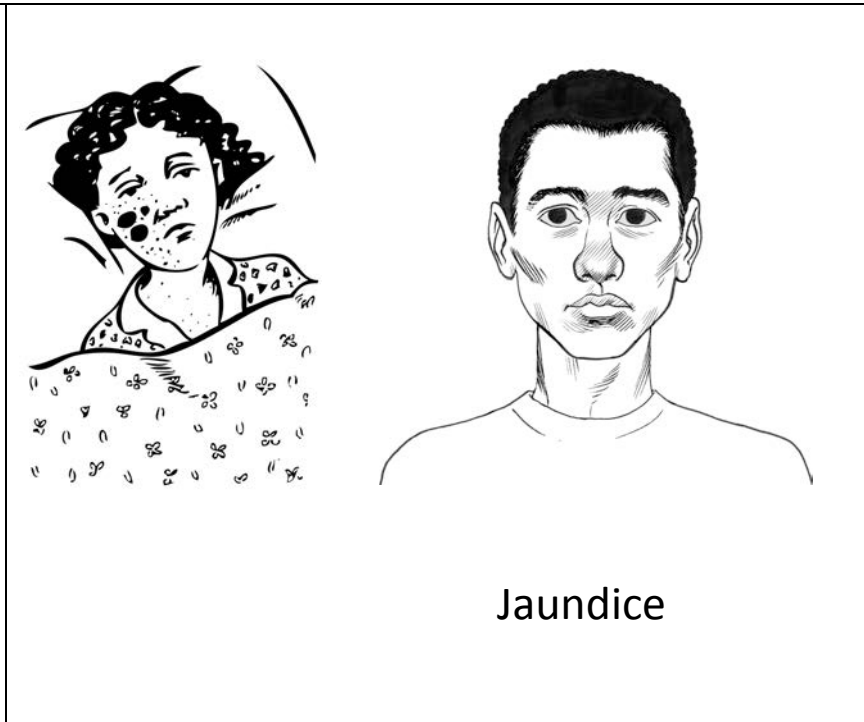
### **Card #3: Activities that Patients Suffering from Epilepsy Should Avoid**

- People with epilepsy **should not participate in activities by themselves** before being seizure-free for 6 months – 1 year. If they participate in these activities during a period of uncontrolled seizures, this can be dangerous. Explain that doctors will tell them when it safe to participate in such activities again:
  - Driving
  - Swimming / bathing by themselves
  - Being near a fire
  - Work or playing in high places

## Card #4: Medication Side Effects



Some signs and symptoms that are uncomfortable but not life-threatening.



Jaundice

Life threatening signs and symptoms. If you have these signs and symptoms, notify your CHW, stop taking your epilepsy medication and go to the hospital immediately.

## Card #4: Medication Side Effects

<p>Some signs and symptoms that may be uncomfortable but are not life-threatening.</p>	<p>Life threatening signs and symptoms. If you have these signs and symptoms, notify your CHW, stop taking your epilepsy medication and go to the hospital immediately.</p>
<ul style="list-style-type: none"><li>• Drowsiness</li><li>• Slowed thinking</li><li>• Dizziness</li><li>• Lack of balance</li></ul>	<ul style="list-style-type: none"><li>• Skin changes that begin after starting an epilepsy medication.</li><li>• Liver problems (eye and skin turns yellow).</li></ul>

## Card #5: Epilepsy During Pregnancy





## **Card #5: Epilepsy During Pregnancy**

It is very dangerous for a woman to have a seizure during pregnancy.

- Women suffering from epilepsy who plan to become pregnant should talk with a doctor to determine the type of medication and dose to take.
- Women who have epilepsy and become pregnant should continue taking medication for their epilepsy.
- Pregnant women with epilepsy are likely to have pre-eclampsia (high blood pressure) during the third trimester of pregnancy and should go to the hospital immediately.

## Card #6: Psychoeducation for *Unconfirmed* Epilepsy Cases



## **Card #6: Psychoeducation for *Unconfirmed* Epilepsy Cases**

(discuss these key points with community members who may have epilepsy, but has not yet been confirmed by a physician)

- I do not know if you have epilepsy or not. But I work with many people who have epilepsy, and after receiving treatment and medication, they have made great progress. They feel better and their life has improved.
- Sometimes people might think that spirits make people sick. But I have seen many people who work with a psychologist and a physician and have improved.
- Maybe you went to a traditional healer or have already sought treatment for this disease. But maybe if you visit a psychologist and a physician, you will get better.
- I do not know if you have epilepsy. But it is important to go to the hospital because this disease can get worse if you do not receive treatment.
- I'm here to support and help you. I'm here to help you meet with a psychologist and a physician. After you meet with them, I am here to support you.

ZL ID: \_\_\_\_\_  
 Date: DD / MM / YYYY  
 Contact: \_\_\_\_\_  
 Last name: \_\_\_\_\_  
 Nickname: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Zone: \_\_\_\_\_  
 Sex:  M  F Age: \_\_\_\_\_

Provider Name: \_\_\_\_\_  
 \_\_\_\_\_  
 Visit Number: \_\_\_\_\_

**Patient History**

How many times in the past month has the patient had seizures?  None  \_\_\_\_\_ /month  
 Date of last seizure: DD / MM / YYYY

Hospitalized since the last seizure? If yes, was it due to a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

Has the patient returned to baseline functioning? Check the boxes: <input type="checkbox"/> Work <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Interpersonal relationships	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**Medications**

Missed dose of medication since last visit? If yes, why? <input type="checkbox"/> Forgot <input type="checkbox"/> Finished medicine <input type="checkbox"/> Incomprehension <input type="checkbox"/> Demotivation <input type="checkbox"/> Drug toxicity <input type="checkbox"/> Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

Side effects from anti-epileptic medication? If yes: <input type="checkbox"/> Jaundice <input type="checkbox"/> Vomiting <input type="checkbox"/> Difficulties at school <input type="checkbox"/> Oversedation <input type="checkbox"/> Dizziness <input type="checkbox"/> Double vision <input type="checkbox"/> Cognitive slowing <input type="checkbox"/> Behavioral changes <input type="checkbox"/> Rash	<input type="checkbox"/> Severe/intolerable	<input type="checkbox"/> Moderate	<input type="checkbox"/> None
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Current Anti-epileptic Medications	Morning	Noon	Night
<input type="checkbox"/> Phenobarbital (50 mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Phenytoin (100mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Valproic Acid (250mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Carbamazepine (200mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Other: _____	_____ mg	_____ mg	_____ mg

**Current Other Medications**  
 Other non anti-epileptic medications?  Yes  No List: \_\_\_\_\_  
 Interactions with anti-epileptic medications?  Yes  No List: \_\_\_\_\_

**Previous History**

Comorbidities: \_\_\_\_\_  
 Symptoms: \_\_\_\_\_  
 Changes in physical exam: \_\_\_\_\_  
 Changes in neurological exam: \_\_\_\_\_

<b>If female:</b>	Family planning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Folic acid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Symptoms			
Depression, psychosis, anxiety, suicidal ideation Which: _____ ZLDSI Score: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Follow up with psychologist ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Referral
Plan			
Change in medication (refer to mhGAP and the medication card)? If yes: <input type="checkbox"/> Dose increase <input type="checkbox"/> Dose decrease <input type="checkbox"/> Add medication <input type="checkbox"/> Down-titrate medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
New Regimen (if changed)			
New Anti-epileptic Medication	Morning	Noon	Night
<input type="checkbox"/> Phenobarbital (50 mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Phenytoin (100mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Valproic Acid (250mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Carbamazepine (200mg)	_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Other: _____	_____ mg	_____ mg	_____ mg
For women of childbearing age or pregnant, folic acid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the patient have enough medication until the next visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Labs at baseline and three months.			
If stable at three months, test in six months. If lab results remain stable, test annually. If hepatic balance increases significantly or if the number of blood cells or platelets decreases in blood count, stop the medicine to avoid serious toxicity. <input type="checkbox"/> Hepatic panel <input type="checkbox"/> CBC			
<b>Psychoeducation:</b> Take medication daily, even if seizures stop. Discontinue medication immediately if skin rash develops. Avoid dangerous activities (bathing/swimming alone, working close to fire, driving, etc).			
Next visit: <u>  DD  </u> / <u>  MM  </u> / <u>  YYYY  </u>	Signature of physician		
Next lab exam: <u>  DD  </u> / <u>  MM  </u> / <u>  YYYY  </u>			



# Partners In Health

Mental Health Clinic

## Initial Evaluation of Epilepsy

ZL ID: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Contact: \_\_\_\_\_

Last Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

First Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_

Name of provider: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Patient referred by:  primary care  hospital  other clinic  other \_\_\_\_\_  CHW \_\_\_\_\_

### 1. Episode Characteristics

A. During an episode, does the patient:

Fall	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lose consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Been incontinent (urine or stool)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injuries during the event	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bite tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stare off and is unresponsive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have lip smacking, mumbling, picking at clothes or other automatisms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rigidity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shake	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes:</b> Is the shaking only on, or start on, one side?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(Circle One) Eyes closed    Eyes open    **If open:**  Deviates to one side     Rolls backward     Straight ahead

Answers the call of his name	<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	------------------------------	-----------------------------

B. After the episodes...

Is the patient confused or sleepy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
An aura before the crisis (feelings of fear, smells / sounds, confusion)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

C. How long are typical episodes? \_\_\_\_ min \_\_\_\_ sec

### 2. History of the Episode

A. Age at first episode: \_\_\_\_\_ years

B. How many times during the past month has the patient had an episode? \_\_\_\_\_ episodes  
If rare (once or less than once a year), number of total episodes in lifetime: \_\_\_\_\_

C. Trigger:  Alcohol  Fever  Emotional  None

D. Does the patient present alarm sign(s) before an episode?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

E. Dizziness, sweating, palpitations, vision loss, feelings of fear, strange smell?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

F. Date of last episode: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

G. Normal between episodes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If not:</b> <input type="checkbox"/> cephalalgia <input type="checkbox"/> motor weakness <input type="checkbox"/> developmental delay		

### 3. Potential Predisposing Factors

A. Did seizures develop after a major trauma?	Physical	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Emotional	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sexual	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>B. Before the episodes occurred, the patient had:</b> Infection of the nervous system (meningitis, cerebral malaria)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sickle cell anemia		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Trauma/head surgery		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Toxic products (pesticides, insecticides)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Taking a new medication Which new medication? _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>C. Is the patient consuming alcohol or other drugs?</b> If yes: <input type="checkbox"/> homebrew ____ liters/day <input type="checkbox"/> beer/rum ____ bottles/day <input type="checkbox"/> other: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> In the past
<b>4. Medical History</b>			
<b>A. Has the patient been treated for tuberculosis?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>B. Has the patient been treated for diabetes?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>C. Has the patient been treated for heart disease?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>D. Children: birth history</b>		Spontaneous cry at birth <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Premature <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Birth trauma <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family history of epilepsy or convulsions?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric disorders:		Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____		Psychotrauma <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>E. If the patient is a woman between 15 and 45 years: Does she use a contraception method?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Is she pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>F. HIV status</b> Date of last test: ____ / ____ / ____ If positive: last CD4 date ____ / ____ / ____		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Unknown
		Is the patient in the ZL HIV program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5. Medication</b>			
<b>A. Has the patient taken epilepsy medication?</b> If yes, which? <input type="checkbox"/> phenobarbital <input type="checkbox"/> phenytoin <input type="checkbox"/> carbamazepine <input type="checkbox"/> valproic acid <input type="checkbox"/> other _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>B. Is the patient currently taking medication for epilepsy?</b> If yes, dose: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>C. Are there any side effects?</b> If yes, explain: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>D. Allergies to medication</b> If yes, explain: _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>6. Physical Exam (MD ONLY)</b>			
Vital Signs BP: _____ Pulse: _____ Temperature: _____ Weight: _____ kg Height: _____ cm Children < 3 years, head circumference: _____ cm			

Normal		Abnormal
<b>General</b>	<input type="checkbox"/> good appearance	<input type="checkbox"/> wasting <input type="checkbox"/> distressed <input type="checkbox"/> birth defects <b>If so, what:</b> _____
<b>Neuro</b>	<input type="checkbox"/> normal mental state <input type="checkbox"/> normal eye movements <input type="checkbox"/> normal strength in face, arms and legs <input type="checkbox"/> normal and symmetric reflexes <input type="checkbox"/> normal coordination <input type="checkbox"/> normal gait	<input type="checkbox"/> mental retardation <input type="checkbox"/> confusion <input type="checkbox"/> abnormal speaking <input type="checkbox"/> abnormal ocular movements <input type="checkbox"/> weak arms/legs <b>If weakness:</b> <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> abnormal reflex <b>If abnormal:</b> <input type="checkbox"/> asymmetric <input type="checkbox"/> hypertonic <input type="checkbox"/> hypotonic <input type="checkbox"/> poor coordination <input type="checkbox"/> abnormal gait <input type="checkbox"/> other _____
<b>Heart</b>	<input type="checkbox"/> steady pace <input type="checkbox"/> steady breathing	<input type="checkbox"/> breathless <input type="checkbox"/> tachycardia
<b>Other</b>		

### 7. Psychomotor Development

Evaluation			Identified development problems	Is the patient able to work/go to school?	
Gross Motor	<input type="checkbox"/> normal	<input type="checkbox"/> not normal			<input type="checkbox"/> Yes
Visual - Fine Motor	<input type="checkbox"/> normal	<input type="checkbox"/> not normal	If not, how many days has he been unable to go this past month? _____ days		
Language	<input type="checkbox"/> normal	<input type="checkbox"/> not normal			
Socialization/Adaption	<input type="checkbox"/> normal	<input type="checkbox"/> not normal			

### 8. Has the patient previously been tested?

	Date	Results			
Blood test	___ / ___ / ___	NFS:	VS:	Blood Sugar:	Others:
Liver/renal function tests	___ / ___ / ___				
Ionogram	___ / ___ / ___				
EEG	___ / ___ / ___				
CT scan	___ / ___ / ___				
Other	___ / ___ / ___				

### 9. Clinical Impressions

Summary

Are the symptoms typical of epilepsy?

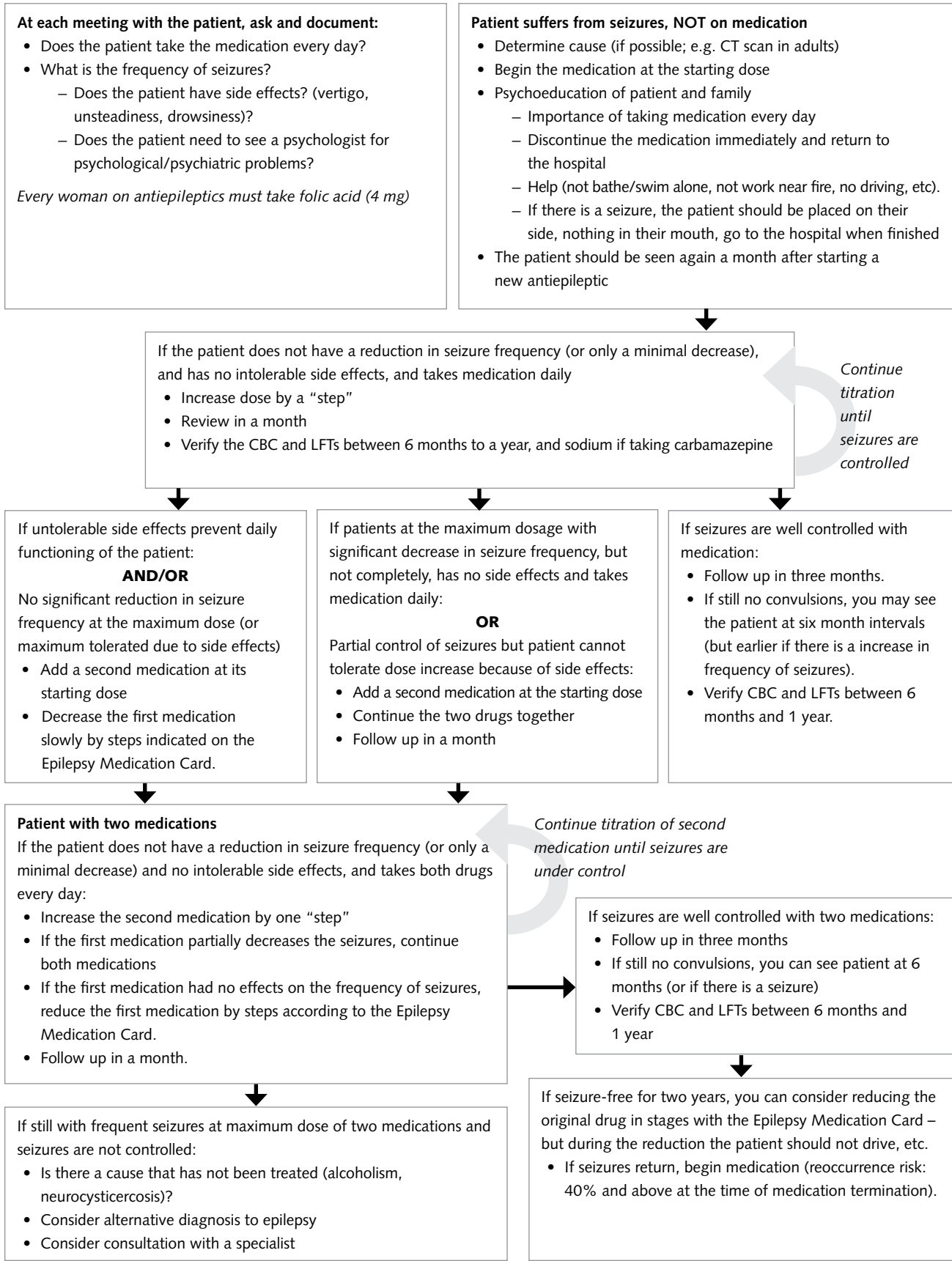
Yes  No

Possible etiology \_\_\_\_\_

Diagnostic:	Epilepsy	Not Epilepsy
	<input type="checkbox"/> partial seizure or focal <input type="checkbox"/> generalized tonic-clonic seizure <input type="checkbox"/> secondarily generalized partial seizure <input type="checkbox"/> generalized seizures: absence type <input type="checkbox"/> other: _____	<input type="checkbox"/> syncope <input type="checkbox"/> non-epileptic psychogenic seizure <input type="checkbox"/> unprecise diagnosis



10. Plan (MD ONLY)				
Medication Mini-Card	Phenobarbital (PB)	Phenytoin (PHT)	Carbamazepine (CBZ)	Valproic Acid (VPA)
First line	(Broad spectrum)	(Broad spectrum)	<ul style="list-style-type: none"> <li>Partial seizures (and including secondarily generalized)</li> <li>Pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>Absence seizures in children, and generalized idiopathic epilepsy</li> <li>Patients with HIV and seizures</li> </ul>
Not recommended for	<ul style="list-style-type: none"> <li>Pregnant women</li> <li>Absence seizures</li> </ul>	Patients with liver disease	<ul style="list-style-type: none"> <li>Absence seizures</li> <li>Other generalized idiopathic epileptic syndromes</li> </ul>	<ul style="list-style-type: none"> <li>Pregnant women/women of child-bearing age</li> <li>Patients with liver disease</li> </ul>
<b>Anti-epileptic medications</b>		<b>Morning</b>	<b>Afternoon</b>	<b>Night</b>
<input type="checkbox"/> Phenobarbital (50 mg)		_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Phenytoin (100mg)		_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Valproic acid (250mg)		_____ mg	_____ mg	_____ mg
<input type="checkbox"/> Carbamazepine (200mg)		_____ mg	_____ mg	_____ mg
<b>Other medication</b>			Interactions with anti-epileptics	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adjustments to other anti-epileptic medications if necessary			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>For women 15–45 years old</b>				
<input type="checkbox"/> Begin 4 mg folic acid daily				
<input type="checkbox"/> Talk about contraception with the patient. If the patient is interested in contraception, prescribe contraception. PB/PHT/CBZ decreases the effectiveness of oral contraceptive; barrier method is necessary to prevent it.				
<input type="checkbox"/> Discuss if the patient plans to become pregnant				
<b>Lab tests</b>				
<input type="checkbox"/> HIV, RPR (age of onset > 20) <input type="checkbox"/> B-HCG <input type="checkbox"/> Hepatic function panel <input type="checkbox"/> Complete blood count (CBC)				
<input type="checkbox"/> Other _____				
<b>Referral</b>				
<input type="checkbox"/> Refer to the CHW, obligatorily    Name of CHW _____				
<input type="checkbox"/> Refer to Mental Health if necessary				
<input type="checkbox"/> Refer to EEG if necessary				
<input type="checkbox"/> Refer to head scan if necessary				
<b>Psychoeducation: Teach the patient:</b> Take medication every day, even if seizures continue. Stop medication immediately if a rash develops. Avoid hazardous activities (swimming/swimming alone, working near a fire, driving, etc.)				
Date of appointment ____ / ____ / ____    Other: _____				
11. Disposition				
<input type="checkbox"/> RDV: ____ / ____ / ____ <input type="checkbox"/> Other: _____				
<b>Names and signatures of providers</b>				
1. Name _____ Discipline _____ Date ____ / ____ / ____				
2. Name _____ Discipline _____ Date ____ / ____ / ____				
3. Name _____ Discipline _____ Date ____ / ____ / ____				



# INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services



Record Number: \_\_\_\_\_ EMR Number: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Site : \_\_\_\_\_

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex:  M  F Date of Birth (Day/Month/Year): \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Commune: \_\_\_\_\_ Profession: \_\_\_\_\_ Telephone: \_\_\_\_\_

Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of Community Health Worker/Telephone: \_\_\_\_\_

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**Chief Complaint** (in the patient's own words):

**History of Present Illness** (Date of symptom onset, precipitants, course, any prior treatment):

## PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION	MANIA	ANXIETY	PSYCHOSIS
<ul style="list-style-type: none"> <li>• Have you felt sad or lost interest in things for a two week period?</li> <li>• Do you feel like you've lost interest in everything or only in some things?</li> <li>• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39</li> </ul>	<ul style="list-style-type: none"> <li>• Did you feel very happy for any reason in the last few days?</li> <li>• Did you get angry more often in the last few days?</li> <li>• Do you:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Have any difficulties of staying attentive?</li> <li><input type="checkbox"/> Speak of things that you shouldn't?</li> <li><input type="checkbox"/> Feel like you're worth more than before?</li> <li><input type="checkbox"/> Have a racing thoughts going through your head?</li> <li><input type="checkbox"/> Have an increase in activities?</li> <li><input type="checkbox"/> Sleep less?</li> <li><input type="checkbox"/> Talk without ceasing?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Are you a worrier?</li> <li>• What do you worry about?</li> <li>• Are you experiencing:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Fear of crowded places</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Muscle tension</li> <li><input type="checkbox"/> Restlessness</li> </ul> </li> <li>• Do you often experience any 4 of these problems such as:               <ul style="list-style-type: none"> <li><input type="checkbox"/> increased in heartbeat</li> <li><input type="checkbox"/> breathlessness</li> <li><input type="checkbox"/> sweating</li> <li><input type="checkbox"/> trembling</li> <li><input type="checkbox"/> fear; fear of losing control; fear of becoming crazy; fear of death</li> <li><input type="checkbox"/> feeling dizzy</li> <li><input type="checkbox"/> feel like you're losing consciousness</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Do you hear things like voices that other people don't hear?</li> <li>• Do you see things that other people don't see?</li> <li>• Do you feel that people are conspiring to harm you – even people whom you don't know?</li> <li>• Are the voices in your head controlling your thought process?</li> </ul>

	SUICIDE		VIOLENCE/HOMICIDE	
	Have you ever thought of causing harm to yourself or committing suicide in the past? What about now?		Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?	
	Ideation	Attempts	Ideation	Acts
Past	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain \_\_\_\_\_

Do you have a plan?  Yes  No      Are there guns or other weapons in the household?  Yes  No

SUBSTANCE ABUSE						
Do you use any of the following?						
	Beer	Home Brew	Liquor	Tobacco	Marijuana	Cocaine
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain quantity, first use, last use: \_\_\_\_\_

Need to cut down?       Annoyed or angered by others who comment on your use?       Guilty about using?   
 In order to function properly, do you need to take that substance before starting your day?

TRAUMA						
Did you ever experience a trauma, such as physical, sexual, or emotional abuse, that is impacting your current functioning?						
	Physical	Emotional	Sexual	Re-experiencing	Hyperarousal	Avoidance
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: \_\_\_\_\_

Do you feel safe in your current environment? \_\_\_\_\_

## PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
<input type="checkbox"/> Are you experiencing pain in your body?	<ul style="list-style-type: none"> <li>• Is there a change in your:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight?</li> <li><input type="checkbox"/> Thirst?</li> <li><input type="checkbox"/> Fever?</li> </ul> </li> </ul>	<input type="checkbox"/> Sight problems?  <input type="checkbox"/> Hearing problems?  <input type="checkbox"/> Voice change?  <input type="checkbox"/> Dizziness?  <input type="checkbox"/> Gum and teeth status?  <input type="checkbox"/> Difficulty swallowing?	<input type="checkbox"/> Stiffness of the neck?
BREATHING	HEART/ARTERIES	DIGESTIVE SYSTEM	SKIN
<input type="checkbox"/> Are you having problems breathing?  <input type="checkbox"/> Are you coughing?  <input type="checkbox"/> Do you cough out blood or find blood in your snot?	<input type="checkbox"/> Do you have an increased heartbeat?  <input type="checkbox"/> Having chest pain?  <input type="checkbox"/> Any swelling?	<input type="checkbox"/> Heart burn?  <input type="checkbox"/> Gastric Reflux?  <input type="checkbox"/> Vomiting?  <input type="checkbox"/> Constipation, diarrhea, gas?	<input type="checkbox"/> Any changes in your skin?
MUSCLES	APPENDAGES (HANDS AND FEET)	GENITALS/URINATION	NEUROLOGICAL
<input type="checkbox"/> Are they stiff?  <input type="checkbox"/> Swollen?  <input type="checkbox"/> Reddened?	<input type="checkbox"/> Swollen?	<input type="checkbox"/> Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?  <input type="checkbox"/> Any problems when urinating (pain, amount/ color of urine, blood in urine)?	<input type="checkbox"/> Any numbness?  <input type="checkbox"/> Uncontrolled movements?

## PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

### Psychiatric Family History:

---

### Past Medical History and Active Medical Problems

Head Injury:

Last Date Of Menstruation: \_\_\_ / \_\_\_ / \_\_\_

Loss Of Consciousness:

Other Things:

---

### Medication/Allergies/Side Effects:

---

### Medical Family History:

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**Social/Cultural History** (include childhood family configuration, urban or rural setting, level of education, romantic relationships, and occupation or other means of financial support):

### Legal Problems:

## PHYSICAL EXAM (PHYSICIAN)

Vital Signs: \_\_\_\_\_

HEENT: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Cardio-vascular: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitals: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_

## NEUROLOGIC EXAM (PHYSICIAN)

Cranial nerves II to XII Intact  If impaired, specify \_\_\_\_\_

Motor: \_\_\_\_\_

Pronator drift: \_\_\_\_\_

Sensory: \_\_\_\_\_

Vibration: \_\_\_\_\_ Position: \_\_\_\_\_

Reflexes: DTR \_\_\_\_\_ Clonus \_\_\_\_\_ Babinsky \_\_\_\_\_

Coordination and Gait: Rapid alternating movements \_\_\_\_\_ Nose finger test \_\_\_\_\_

Romberg \_\_\_\_\_ Gait \_\_\_\_\_ Heel toe walk test \_\_\_\_\_

## MENTAL STATUS EXAM

General Appearance	<input type="checkbox"/> well groomed	<input type="checkbox"/> disheveled	<input type="checkbox"/> overdressed, elaborate
Orientation	<input type="checkbox"/> O x 3	<input type="checkbox"/> disoriented to time	<input type="checkbox"/> disoriented to place <input type="checkbox"/> disoriented to person
Behavior	<input type="checkbox"/> WNL <input type="checkbox"/> tics	<input type="checkbox"/> retardation	<input type="checkbox"/> agitation <input type="checkbox"/> tremor
Speech	<input type="checkbox"/> WNL	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured <input type="checkbox"/> slurred
Mood	<input type="checkbox"/> _____		
Affect	<input type="checkbox"/> euthymic <input type="checkbox"/> irritable <input type="checkbox"/> congruent with speech content	<input type="checkbox"/> dysphoric <input type="checkbox"/> suspicious <input type="checkbox"/> incongruent with speech content	<input type="checkbox"/> euphoric <input type="checkbox"/> labile <input type="checkbox"/> other: _____ <input type="checkbox"/> anxious <input type="checkbox"/> flat



## MENTAL STATUS EXAM CONTINUED

Thought Process	<input type="checkbox"/> linear <input type="checkbox"/> tangential <input type="checkbox"/> perseverative <input type="checkbox"/> illogical <input type="checkbox"/> loose associations <input type="checkbox"/> _____
Thought Content	<input type="checkbox"/> WNL <input type="checkbox"/> vague <input type="checkbox"/> persistent preoccupation with: <input type="checkbox"/> suicidal ideation <input type="checkbox"/> homicidal ideation Delusions: <input type="checkbox"/> none <input type="checkbox"/> paranoid <input type="checkbox"/> grandiose <input type="checkbox"/> other: _____ Perceptual Disturbances/Hallucinations: <input type="checkbox"/> none <input type="checkbox"/> auditory <input type="checkbox"/> visual <input type="checkbox"/> olfactory <input type="checkbox"/> gustatory <input type="checkbox"/> tactile
Insight:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good
Judgment/Impulse Control:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good

General Impressions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### BIOPSYCHOSOCIAL FORMULATION (including patient's strengths and coping strategies):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DIAGNOSIS:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

### PLAN:

#### Psychological Treatment Plan

##### Treatment Goals

1. Goal: \_\_\_\_\_

2. Goal: \_\_\_\_\_

3. Goal: \_\_\_\_\_

**Intervention**

- Interpersonal Psychotherapy (IPT)
- Medication
- Behavioral Activation
- Psychoeducation
- Parent/Family Supportive Therapy
- Other \_\_\_\_\_
- Relaxation Training
- Supportive Psychotherapy
- Grief Support
- Parent Skills Training

**Frequency**

- Once per week
- Bi-weekly
- Once per month

**Number of Sessions:**

- 4–6 sessions
- 6–8 sessions
- 8–10 sessions
- 10–12 sessions

Primary Clinician: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

**Referrals**

**CHW**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Social Worker**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Other Plan: (follow-up with family, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

**FOLLOW-UP**

**Psychiatric Medication**

Medication	Dose	Frequency	Quantity	Refill Date
Risperidone				
Haloperidol				
Diazepam				
Carbamazepine				
Valporic Acid				
Other: _____				

**Hospitalization:**

Date of Admission: \_\_\_ / \_\_\_ / \_\_\_

Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_

# MEDICATION CARD FOR EPILEPSY

		PHENOBARBITOL		PHENYTOIN		CARBAMAZEPINE		VALPROATE	
<b>DO NOT USE IF</b>		Women of child-bearing age		Liver disease		Absence seizures		<ul style="list-style-type: none"> <li>• Women of child-bearing age</li> <li>• Liver disease</li> </ul>	
<b>First Line</b>		(Broad spectrum)		(Broad spectrum)		<ul style="list-style-type: none"> <li>• Partial seizures</li> <li>• Women of child-bearing age</li> </ul>		<ul style="list-style-type: none"> <li>• Absence seizures</li> <li>• Idiopathic generalized epilepsy</li> </ul>	
<b>Dosing</b>		Once daily (best at night due to sedative effects)		Once daily (best at night due to sedative effects)		Twice to three times daily		Twice daily	
		Adult	Child	Adult	Child	Adult	Child	Adult	Child
<b>Starting Dose</b>		60 mg daily	3 mg/kg daily	300 mg daily	5 mg/kg daily	200 mg twice daily	5 mg/kg (divided: 2.5mg/kg twice daily)	200–250 mg twice daily	15mg/kg/day (divided: 7.5 mg/kg twice daily)
<b>“Step” of Uptitration (Amount to increase total daily dose each month)</b>		30 mg daily	2 mg/kg daily	50 mg daily	2–5 mg/kg daily	200 mg total daily	5–10 mg/kg (total) daily	250–500mg (total) daily (as needed/as tolerated)	5–15 mg/kg daily (total)
		<b>If appears to stop working at 6 weeks, increase dose by one step</b>							
<b>Maximum Dose</b>		180 mg daily	6–8 mg/kg daily	400–600 mg daily	8–10 mg/kg/day (max: 300 mg/day)	1400–1600 mg daily (total; divided into 3 doses/day)	10–30 mg/kg (divided: 15 mg/kg daily)	2000–2500 mg (total) daily (divided into 2 doses/day)	60 mg/kg/day
<b>Toxicities</b>		<b>Serious</b>							
		<ul style="list-style-type: none"> <li>• <b>All:</b> Rash, liver failure, blood count abnormalities *If rash patient must be told to stop medication immediately and return to hospital.</li> <li>• Carbamazepine can also cause hyponatremia.</li> </ul>							
		<b>Common</b>							
		<ul style="list-style-type: none"> <li>• <b>All:</b> Fatigue, dizziness, nausea/vomiting, incoordination, double vision</li> <li>• <b>Valproate</b> also causes tremors.</li> </ul>							
<b>Monitoring</b>		LFTs, CBC		LFTs, CBC		LFTs, CBC, Sodium		LFTs, CBC	
<b>Tapering</b> <i>*If rash, stop immediately and return to hospital</i>		Reduce by steps above every 4 weeks		Reduce by steps above every 2–4 weeks		Reduce by steps above every 2–4 weeks		Reduce by steps above every 2–4 weeks	
<b>Effect on Oral Contraceptives</b>		Decreases efficacy		Decreases efficacy		Decreases efficacy		No effect	
<b>Women of Child-Bearing Age</b>		<ul style="list-style-type: none"> <li>• Discuss importance of contraceptive use</li> <li>• Folic acid 4 mg daily</li> </ul>							
<b>In Pregnancy</b>		Do not initiate. If patient already taking, make sure on folic acid 4 mg daily; If increased seizures, may need higher dose.		Second choice if patient does not respond to carbamazepine, cannot tolerate it, or is not available.		First choice		Do not initiate. If patient already taking, make sure on folic acid 4mg daily; If increased seizures, may need higher dose.	
		<b>FOR ALL PREGNANT WOMEN:</b> <ul style="list-style-type: none"> <li>• If increased seizures during pregnancy, may need higher dose.</li> <li>• Give Vitamin K prior to delivery to prevent hemorrhagic disease of the newborn.</li> <li>• Give folic acid 4 mg daily through pregnancy</li> </ul>							
<b>AEDS and ARVs</b>				Patients receiving phenytoin may require a lopinavir/ritonavir dosage increase of about 50% to maintain unchanged serum concentrations				Patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations	

# MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM



Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Recipient (Provider): \_\_\_\_\_

Recipient's telephone: \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Last Name: \_\_\_\_\_

Dossier Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Principal Symptoms: \_\_\_\_\_

<b>Reasons/Diagnostic Impressions:</b> <ul style="list-style-type: none"><li>• Psychological trauma</li><li>• Sexual abuse</li><li>• Suicide attempt</li><li>• Psychiatric emergency</li><li>• Mental confusion</li><li>• Psychosis/bipolar disorder</li><li>• Behavioral disorders</li><li>• Somatoform disorders</li><li>• Affective disorders<ul style="list-style-type: none"><li>• Enuresis</li><li>• Encopresis</li></ul></li><li>• Learning disorder</li><li>• Mental retardation</li><li>• Addiction</li><li>• Epilepsy</li><li>• Depression</li><li>• Depression and migraines</li><li>• Other: _____</li></ul>	<b>Services requested:</b> <ul style="list-style-type: none"><li>• Psychological Evaluation</li><li>• Psychotherapies<ul style="list-style-type: none"><li>• Grief, supportive</li><li>• Interpersonal therapy</li></ul></li><li>• Psychotraumatology</li><li>• Counseling<ul style="list-style-type: none"><li>• Pre-Operative</li><li>• Post-Operative</li><li>• Post-test</li><li>• Follow-up</li><li>• Adherence</li><li>• Pre-HAART</li></ul></li><li>• Other: _____</li><li>• <b>IMPORTANT HISTORY:</b> _____</li></ul>
--	---

Signature of referring provider: \_\_\_\_\_

Mental health provider that received the referral: \_\_\_\_\_

Date of receipt: \_\_\_\_\_ Time: \_\_\_\_\_

Remarks: \_\_\_\_\_

Signature: \_\_\_\_\_

**STEP 1** Warning signs that a crisis is developing (such as thoughts, images, moods, situations, behavior):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 2** Internal coping strategies – activities that I can do without others to distract myself from my problems, such as relaxation techniques:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 3** People and social environments that offer distractions and support:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Where \_\_\_\_\_ Where \_\_\_\_\_

**Step 4** People I can ask to help me:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 5** Professionals and agencies I can contact during a crisis:

- Community Health Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Ajan Sante \_\_\_\_\_ Telephone \_\_\_\_\_
- Social Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Psychologist \_\_\_\_\_ Telephone \_\_\_\_\_
- Doctor \_\_\_\_\_ Telephone \_\_\_\_\_
- Spiritual Healer \_\_\_\_\_ Telephone \_\_\_\_\_
- Emergency Room/Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 6** Making the environment safe:

\_\_\_\_\_  
\_\_\_\_\_

*I, \_\_\_\_\_, will follow the steps when I'm in a crisis,  
and one thing more important to me than anything else that will help me live is... \_\_\_\_\_*

## STIGMA ASSESSMENT ACTIVITY

Sadrak is eight years old. Sometimes he falls and his body becomes stiff. After that, his entire body shakes for a minute or so. He forgets what happens and wants to sleep. Since he was two years old, he has experienced these types of events intermittently.

PART 1			
	Disagree	Neither agree nor disagree	Agree
People choose to live like this and can change if they want			
The problem is that he has a weak mind or little brain			
This problem is not really a medical problem			
This person is dangerous			
It is best to avoid people with problems like this so you can avoid having the same problem			
You never can tell what a person acting like this will do			
If I had a problem like this, I wouldn't tell anyone			
I would not like to work with someone with this problem			
I would not choose this person as a leader			

PART 2		
	Yes	No
Would you like to be the neighbor of this person?		
Would you like to spend time with or date this person?		
Would you like to develop a friendship with this person?		
Would like to work closely with this person?		
Would you like it if someone like that married a member of your family?		

**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY SCREENING INSTRUMENT**



LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
<b>1. Passive</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you have any thoughts of ending your life, even if they are not clear in your mind?</p> <p><b>Possible Response:</b> I think about it from time to time, but I've never acted upon it...I would make my family feel too bad...God would not forgive me</p>	Description:	
<b>2. Non-Specific Active</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you want to die? Do you often think or talk about death?</p> <p><b>Possible Response:</b> desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me</p>	Description:	
<b>3. Methods but no Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> If you would do it, how would you do it?</p> <p><b>Possible Response:</b> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</p>	Description:	
<b>4. Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you intend to act on these thoughts?</p> <p><b>Possible Response:</b> I will kill myself but I do not know when... I do not think I can do so now...but it's too much for me, I cannot yet</p>	Description:	
<b>5. Planification</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you started planning the details about how you will kill yourself?</p> <p><b>Danger Signs:</b> there is a sudden change in attitude, withdraws from everything; not interested in anything; say: "when I am not here anymore"; seeks to implement the plan, write a note (on paper).</p>	Description:	
<b>6. Attempted</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you tried to do something that could hasten the end of your life? Have you stopped preserving your life, like not eating and not taking medication?</p> <p><b>Danger Signs:</b> Realized did not want to die after the attempt failed, but it often gets worse again after a few days; might have some injuries or marks.</p>	Description:	
<p>Low: Current = 0 Past = 0</p> <p>Medium: Current = 1–2 yes OR Past = 1 or more yes</p> <p>High: Current = 3 or more yes OR Past = 3 or more yes</p>	<p>Total "yes" in past two weeks</p> <input type="checkbox"/>	<p>Total "yes" in past year</p> <input type="checkbox"/>

Provider: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ File #: \_\_\_\_\_

For ALL Patients	
Act	1. <input type="checkbox"/> Ensure that the environment will be private, safe and non-threatening. 2. <input type="checkbox"/> Begin the process of ensuring that the patient will be able to access necessary medication. 3. <input type="checkbox"/> Always work with the patient to develop a Safety Plan.
Say	4. <input type="checkbox"/> Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. <input type="checkbox"/> Start IPT and collect IP inventory. 6. <input type="checkbox"/> Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. <input type="checkbox"/> Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). <i>(Write this on the copy of your Safety Plan, on the back side).</i>
Contact	8. <input type="checkbox"/> Always contact at least one person close to the patient to support and monitor them. 9. <input type="checkbox"/> Contact as many of the current and potential supports as a patient will permit <ul style="list-style-type: none"> <li>• <input type="checkbox"/> You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients</li> <li>• When involving anyone, ensure that you preserve confidentiality if possible and define these:                             <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Depression, suicidality</li> <li>2. <input type="checkbox"/> The needs of such patients</li> <li>3. <input type="checkbox"/> How others can help</li> <li>4. <input type="checkbox"/> How others can hurt</li> </ol> </li> </ul>
Team	10. Consult and involve colleagues to help. <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Doctor <input type="checkbox"/> _____
Follow Up	11. If the patient has a <b>higher</b> risk level, continue to the guidelines <b>below</b> .



**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY TREATMENT GUIDELINES**

For patients with <b>MEDIUM</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. <input type="checkbox"/> Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur.
	3. <input type="checkbox"/> Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. <input type="checkbox"/> Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. <input type="checkbox"/> At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.
Follow Up	6. If the patient is medium risk, schedule follow-up within 7 days. <b>Date</b> _____ <b>Time</b> _____ If the patient is <b>high</b> risk, continue to the guidelines <b>below</b> .
For patients with <b>HIGH</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary.
	2. <input type="checkbox"/> Seek to admit patient to the emergency room or another service with beds for at least 24 hours.
	3. <input type="checkbox"/> Determine who will be available to watch the patient and when so that they are not left unattended. Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____
Say	4. <input type="checkbox"/> Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. <input type="checkbox"/> Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here).
	6. <input type="checkbox"/> Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. <input type="checkbox"/> MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain).
	8. <input type="checkbox"/> Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. <input type="checkbox"/> Keep the patient admitted and under continuous monitoring (e.g. 4x/hr).
	10. <input type="checkbox"/> Frequently re-assess risk level.
	11. <input type="checkbox"/> If the patient leaves or can't be kept, follow through with continued intensive psychosocial activation.



## Section 3 Preamble

### **Say to respondent:**

The interview is about difficulties people have because of health conditions.

### **Hand flashcard #1 to respondent**

By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

### **Point to flashcard #1**

- Increased effort
- Discomfort or pain
- Slowness
- Changes in the way you do the activity.

When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

### **Hand flashcard #2 to respondent**

Use this scale when responding.

### **Read scale aloud:**

None, mild, moderate, severe, extreme or cannot do.

**Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview**

**Please continue to next page...**



## Section 4 Core questions

### Show flashcard #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S1	<a href="#">Standing for long periods</a> such as <a href="#">30 minutes</a> ?	1	2	3	4	5
S2	Taking care of your <a href="#">household responsibilities</a> ?	1	2	3	4	5
S3	<a href="#">Learning a new task</a> , for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have <a href="#">joining in community activities</a> (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have <a href="#">you</a> been <a href="#">emotionally affected</a> by your health problems?	1	2	3	4	5

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S6	<a href="#">Concentrating</a> on doing something for <a href="#">ten minutes</a> ?	1	2	3	4	5
S7	<a href="#">Walking a long distance</a> such as a <a href="#">kilometre</a> [or equivalent]?	1	2	3	4	5
S8	<a href="#">Washing your whole body</a> ?	1	2	3	4	5
S9	Getting <a href="#">dressed</a> ?	1	2	3	4	5
S10	<a href="#">Dealing with people you do not know</a> ?	1	2	3	4	5
S11	<a href="#">Maintaining a friendship</a> ?	1	2	3	4	5
S12	Your day-to-day <a href="#">work/school</a> ?	1	2	3	4	5

H1	Overall, in the past 30 days, <a href="#">how many days</a> were these difficulties present?	<i>Record number of days</i> ____
H2	In the past 30 days, for how many days were you <a href="#">totally unable</a> to carry out your usual activities or work because of any health condition?	<i>Record number of days</i> ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <a href="#">cut back</a> or <a href="#">reduce</a> your usual activities or work because of any health condition?	<i>Record number of days</i> ____

This concludes our interview. Thank you for participating.



# **WHODAS 2.0**

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 1*

## **Health conditions:**

- **Diseases, illnesses or other health problems**
- **Injuries**
- **Mental or emotional problems**
- **Problems with alcohol**
- **Problems with drugs**

## **Having difficulty with an activity means:**

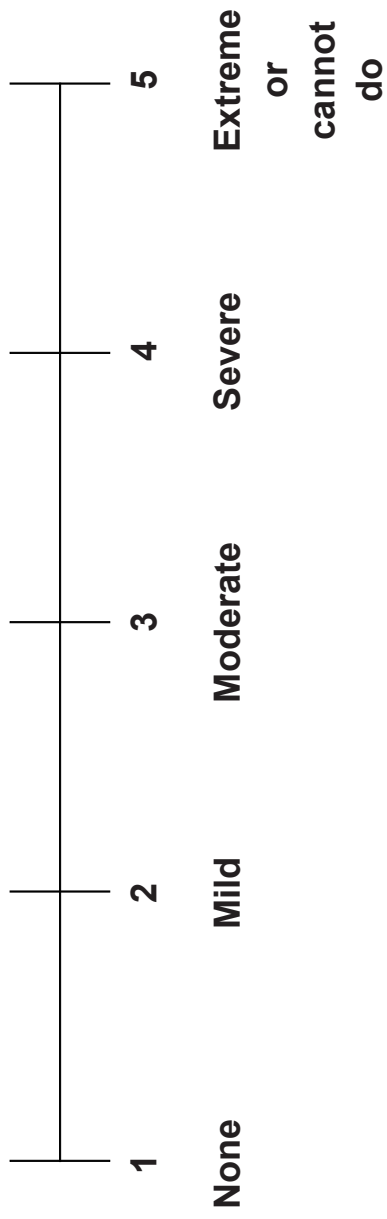
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

**Think about the past 30 days only.**

# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 2*




**ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)**

 Date     dd/mm/yy    

	Pandan 15 jou ki sòt pase la yo, konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Di tou	Konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Pandan kèk jou (1–5 jou)	Plis pase yon semèn (6–9 jou)	Preske chak jou (10–15 jou)
<b>1</b>	Santi ou de la la.	0	—	1	2	3
<b>2</b>	Santi kè sere.	0	—	1	2	3
<b>3</b>	Kalkile twòp.	0	—	1	2	3
<b>4</b>	Kriye oubyen anvi kriye	0	—	1	2	3
<b>5</b>	Santi anyen preske pa enterese ou.	0	—	1	2	3
<b>6</b>	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
<b>7</b>	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
<b>8</b>	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
<b>9</b>	Ou pa gen apeti.	0	—	1	2	3
<b>10</b>	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
<b>11</b>	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
<b>12</b>	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
<b>13</b>	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
<b>Totals</b>				<b>(+)</b>	<b>(+)</b>	

**(=) ZLDSI Score**

# **AGITATION, DELIRIUM, AND PSYCHOSIS**

Tools for use in an integrated, community-based mental health system of care



# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)



Patient's Name: \_\_\_\_\_ Date: dd/mm/yy \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### CURRENT MEDICATIONS AND TOTAL MG/DAY

Medication #1: \_\_\_\_\_ Total mg/Day: \_\_\_\_\_ Medication #2: \_\_\_\_\_ Total mg/Day: \_\_\_\_\_

**INSTRUCTIONS: COMPLETE THE EXAMINATION PROCEDURE BEFORE ENTERING THESE RATINGS.**

### Facial and Oral Movements

- |   | None, Normal               | Minimal (may be extreme normal) | Mild                       | Moderate                   | Severe                     |
|---|----------------------------|---------------------------------|----------------------------|----------------------------|----------------------------|
| <b>1.</b> Muscles of Facial Expression<br>e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing | <input type="checkbox"/> 0 | <input type="checkbox"/> 1      | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>2.</b> Lips and Perioral Area<br>e.g., puckering, pouting, smacking  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1      | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>3.</b> Jaw<br>e.g., biting, clenching, chewing, mouth opening, lateral movement  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1      | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>4.</b> Tongue<br>Rate only increases in movement both in and out of mouth, NOT inability to sustain movement   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1      | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

### Extremity Movements

- |  |                            |                            |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>5.</b> Upper (arms, wrists, hands, fingers)<br>Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous); athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT include tremor (i.e., repetitive, regular, rhythmic) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>6.</b> Lower (legs, knees, ankles, toes)<br>e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

### Trunk Movements

- |   |                            |                            |                            |                            |                            |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>7.</b> Neck, shoulders, hips<br>e.g., rocking, twisting, squirming, pelvic gyrations | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

### SCORING:

- Score the highest amplitude or frequency in a movement on the 0–4 scale, not the average;
- A POSITIVE AIMS EXAMINATION IS A SCORE OF 2 IN TWO OR MORE MOVEMENTS or a SCORE OF 3 OR 4 IN A SINGLE MOVEMENT
- Do not sum the scores: e.g. a patient who has scores 1 in four movements DOES NOT have a positive AIMS score of 4.

### Overall Severity

- |   |                            |                            |                            |                            |                            |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>8.</b> Severity of abnormal movements  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>9.</b> Incapacitation due to abnormal movements                                | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| <b>10.</b> Patient's awareness of abnormal movements (rate only patient's report) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

### Dental Status

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>11.</b> Current problems with teeth and/or dentures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12.</b> Does patient usually wear dentures?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Next Exam Date \_\_\_\_\_



## AIMS EXAMINATION PROCEDURE

### SHOULD BE COMPLETED BEFORE ENTERING THE RATINGS ON THE AIMS FORM

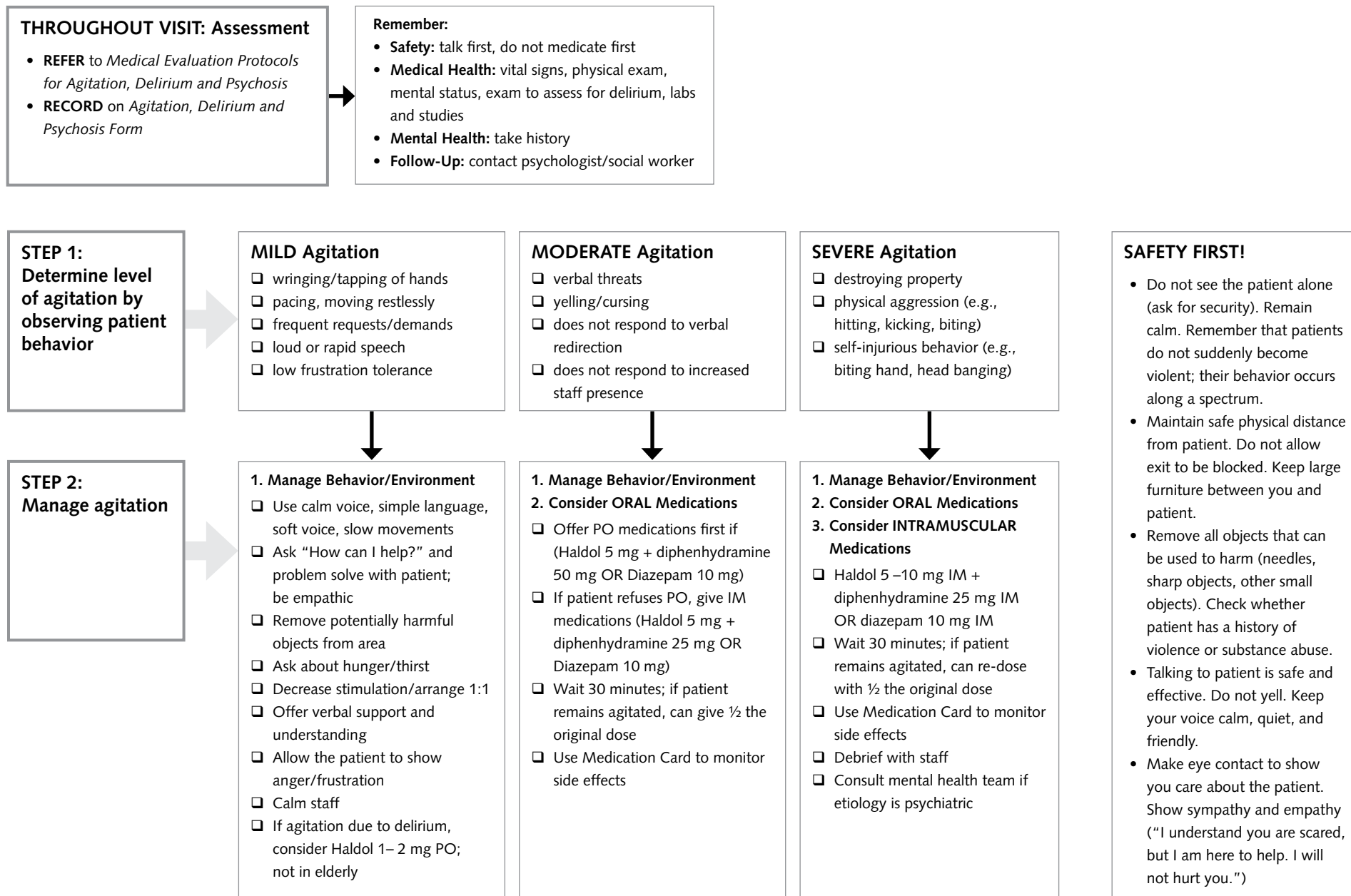
Either before or after completing the Examination Procedure, observe the patient unobtrusively at rest (e.g. in waiting room).

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**The chair to be used in this examination should be a hard, firm one without arms.**

1. Ask patient whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is, to remove it.
2. Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient now?
3. Ask patient whether he/she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.
4. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position).
5. Ask patient to sit with hands hanging unsupported. If male, between legs, if female, and wearing a dress, hanging over knees. (Observe hands and other body areas.)
6. Ask patient to open mouth. (Observe tongue at rest within mouth.) Do this twice.
7. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.)
8. \*Ask patient to tap thumb, with each finger, as rapidly as possible for 10–15 seconds: separately with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend patient's left and right arms, one at a time. (Note any rigidity and rate it.)
10. Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
11. \*Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)
12. \*Have patient walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

\*Activated movements.



# ✓ AGITATION, DELIRIUM AND PSYCHOSIS CHECKLIST

Date dd/mm/yy



CHW	PSYCHOLOGIST/SOCIAL WORKER	NURSES	PHYSICIAN
<b>AGITATED PATIENT</b>	<b>AGITATED PATIENT</b>	<b>AGITATED PATIENT</b>	<b>AGITATED PATIENT</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Accompany patient to emergency room immediately</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Accompany patient to emergency room</li> <li><input type="checkbox"/> Refer to the Agitated Patient Protocol; support nurse and physician</li> <li><input type="checkbox"/> Collect information from patient and family</li> <li><input type="checkbox"/> Arrange 1:1 if needed</li> <li><input type="checkbox"/> Remain at bedside until patient is stable</li> <li><input type="checkbox"/> Follow patient 2x/day, give phone number to patient's family &amp; nurse/physician</li> <li><input type="checkbox"/> Using Agitation, Delirium and Psychosis Checklist, ensure medications given and medical care provided by nurse/MD</li> <li><input type="checkbox"/> Give patient/family psychoeducation and support</li> <li><input type="checkbox"/> Assess &amp; manage socioeconomic burden of illness</li> <li><input type="checkbox"/> Proceed to initial evaluation (once calm)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Alert either psychologist/social worker</li> <li><input type="checkbox"/> Accompany patient to emergency room</li> <li><input type="checkbox"/> Refer to Agitated Patient Protocol</li> <li><input type="checkbox"/> Manage environment</li> <li><input type="checkbox"/> Talk to patient; support family</li> <li><input type="checkbox"/> Do vital signs ASAP</li> <li><input type="checkbox"/> Prepare oral and IM medications if needed</li> <li><input type="checkbox"/> Arrange 1:1 if needed</li> <li><input type="checkbox"/> Monitor antipsychotic side effects, report to physician</li> <li><input type="checkbox"/> Continue to follow patient closely (at least every 15 min check)</li> <li><input type="checkbox"/> Assist doctor in medical evaluation and care (vital signs, lab tests, EKG, fluids)</li> <li><input type="checkbox"/> Provide psychoeducation and support to patient and family</li> <li><input type="checkbox"/> Document all work in nursing forms</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Alert either psychologist/social worker</li> <li><input type="checkbox"/> Follow Agitated Patient Protocol to determine level of agitation and to prescribe medication if necessary</li> <li><input type="checkbox"/> Continue medical evaluation: physical/neuro exam, vital signs, lab tests</li> <li><input type="checkbox"/> Use Medication Card to monitor antipsychotic side effects (consider EKG, fluids)</li> <li><input type="checkbox"/> Document in Agitated Patient Form</li> </ul>
<b>INITIAL EVALUATION (ONCE CALM)</b>	<b>INITIAL EVALUATION (ONCE CALM)</b>	<b>INITIAL EVALUATION (ONCE CALM)</b>	<b>INITIAL EVALUATION (ONCE CALM)</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> If suicidal/violent, accompany patient and family to the clinic immediately</li> <li><input type="checkbox"/> Decrease risk and reinforce safety if risk for suicide or violence</li> <li><input type="checkbox"/> Complete the Initial Visit Form</li> <li><input type="checkbox"/> Use the ZLDSI</li> <li><input type="checkbox"/> Do psychoeducation</li> <li><input type="checkbox"/> Give the Referral Form and Initial Visit Form to psychologist/SW</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Complete Psychosis Checklist with CHW/nurse</li> <li><input type="checkbox"/> Complete ZLDSI</li> <li><input type="checkbox"/> Document in Initial Mental Health Evaluation Form</li> <li><input type="checkbox"/> Speak with patient and TWO family members &amp; review physician's Agitated Patient Form to complete initial mental health evaluation</li> <li><input type="checkbox"/> Ensure vitals, weight, and labs are checked</li> <li><input type="checkbox"/> Accompany patient to see physician (sees all psychotic, suicidal, violent cases)</li> <li><input type="checkbox"/> Help physician follow checklist</li> <li><input type="checkbox"/> Make preliminary diagnosis of delirium/medical illness or mental illness with the physician</li> <li><input type="checkbox"/> If patient needs medical care, coordinate with physicians, if patient has psychotic disorder, schedule follow-up within one week</li> <li><input type="checkbox"/> Do psychoeducation and support related to medication and psychosis</li> <li><input type="checkbox"/> Complete CGI/WHODAS, Registry, Checklist</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Determine whether patient may be psychotic</li> <li><input type="checkbox"/> Accompany patient to see psychologist/SW; support collaboration with physician</li> <li><input type="checkbox"/> If psychosis is diagnosed, provide psychoeducation and support</li> <li><input type="checkbox"/> Before discharge, ensure the patient has a follow-up appt with psychologist/SW</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review Initial Mental Health Evaluation Form with psychologist/SW to diagnose delirium/medical illness or mental disorder</li> <li><input type="checkbox"/> Do complete medical evaluation: vital signs, physical/neuro exam, lab tests. Use Medical Evaluation Protocol for Agitation, Delirium and Psychosis</li> <li><input type="checkbox"/> If patient has a psychotic disorder or delirium, use Medication Card to dose</li> <li><input type="checkbox"/> Do baseline AIMS exam</li> <li><input type="checkbox"/> Document everything in Initial Mental Health Evaluation Form</li> <li><input type="checkbox"/> Provide medication to last until next appt</li> <li><input type="checkbox"/> Do psychoeducation about medication</li> <li><input type="checkbox"/> Plan follow-up with psychologist/SW</li> </ul>
<b>FOLLOW-UP</b>	<b>FOLLOW-UP</b>	<b>FOLLOW-UP</b>	<b>FOLLOW-UP</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> If suicidal/violent, accompany patient and family to the clinic immediately</li> <li><input type="checkbox"/> Decrease risk and reinforce safety if risk for suicide or violence</li> <li><input type="checkbox"/> Document with the Mental Health Follow-Up Form</li> <li><input type="checkbox"/> Use the ZLDSI</li> <li><input type="checkbox"/> Do psychoeducation</li> <li><input type="checkbox"/> Give the Referral Form and Initial Visit Form to psychologist/SW</li> <li><input type="checkbox"/> Do follow-up of patient in the community (check patient adherence, side effects, encourage patients to do follow-ups)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use Mental Health Follow-Up Form</li> <li><input type="checkbox"/> See whether patient is improving (check mental status exam, functioning, patient and family report)</li> <li><input type="checkbox"/> Check medication compliance, side effects</li> <li><input type="checkbox"/> Ensure vitals, weight, and labs are checked</li> <li><input type="checkbox"/> Accompany patient to see physician; help physician follow Agitation, Delirium and Psychosis Checklist</li> <li><input type="checkbox"/> Plan follow-up for 1-2 weeks; coordinate with CHW</li> <li><input type="checkbox"/> Do psychoeducation and support for medication and psychosis</li> <li><input type="checkbox"/> Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Do vital signs, weight at each visit</li> <li><input type="checkbox"/> Check labs when necessary</li> <li><input type="checkbox"/> Document in Mental Health Follow-Up Form</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review the Mental Health Follow-Up Form with psychologist/SW to see if patient is improving</li> <li><input type="checkbox"/> Do physical/neuro exam</li> <li><input type="checkbox"/> Check weight/vitals each visit; lab tests and AIMS every 6 months</li> <li><input type="checkbox"/> Use Medication Card to check for side effects and to adjust dose as needed</li> <li><input type="checkbox"/> Provide medication to last until next appt</li> <li><input type="checkbox"/> Discuss discontinuation of antipsychotic with Mental Health team</li> <li><input type="checkbox"/> Document properly in Mental Health Follow-Up Form</li> <li><input type="checkbox"/> Do psychoeducation about medication</li> <li><input type="checkbox"/> Plan follow-up with psychologist/SW</li> </ul>



# AGITATION, DELIRIUM AND PSYCHOSIS FORM



Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone: \_\_\_\_\_ Provider: \_\_\_\_\_ Date: dd/mm/yy

## 1. SAFETY (USE AGITATED PATIENT PROTOCOL)

Patient is:  Not Agitated (But appears psychotic)  Agitated (Mild)  Aggressive (Moderate)  Violent (Severe)

History of Violence:  No  Yes: Describe violent behavior \_\_\_\_\_  
When did it take place: \_\_\_\_\_

Manage Behavior/Environment Completed Does patient need a 1:1?  No  Yes: \_\_\_\_\_

## 2. MEDICAL HEALTH (USE MEDICAL EVALUATION PROTOCOL)

Vital Signs: Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ RR: \_\_\_\_\_ O2: \_\_\_\_\_ Weight: \_\_\_\_\_

### Physical Exam

HEENT:  Normal  Abnormal: \_\_\_\_\_  
Cardiac:  Normal  Abnormal: \_\_\_\_\_  
Pulmonary:  Normal  Abnormal: \_\_\_\_\_  
Abdominal:  Normal  Abnormal: \_\_\_\_\_  
Skin/Extremities:  Normal  Abnormal: \_\_\_\_\_

### Neurological Exam

Cranial Nerves:  Normal  Abnormal: \_\_\_\_\_  
Motor Strength:  Normal  Abnormal: \_\_\_\_\_  
Sensory:  Normal  Abnormal: \_\_\_\_\_  
Reflexes:  Normal  Abnormal: \_\_\_\_\_  
Gait/Coordination:  Normal  Abnormal: \_\_\_\_\_

### Mental Status Exam

Alert  Sleepy  Unable to Arouse  
Thought Process:  Normal  Confused: \_\_\_\_\_  
Can Follow Simple Commands:  No  Yes  
Hallucinations:  No  Yes: \_\_\_\_\_  
Orientation: Person  No  Yes  
Place  No  Yes  
Time/Date  No  Yes  
Friend/Family Member  No  Yes

### Laboratory Tests Ordered

Hemogram  CD4  Hepatic Panel  
 RPR  TB  Renal Panel  
 HIV  Urinalysis  Malaria

Family History of Mental Illness:  No  Yes

Medical History:  HIV/AIDS (CD4: \_\_\_\_\_)  TB  
 HTN  Head Injury (with loss of consciousness)  
 Epilepsy  Dementia  Other: \_\_\_\_\_

Alcohol Use:  No  Yes:  Daily?

Drug Use:  No  Yes: \_\_\_\_\_

Current medications (names and doses): \_\_\_\_\_

### Delirium

- Disturbance of consciousness with reduced ability to focus, sustain or shift attention.
  - A change in cognition or the development of a perceptual disturbance (hallucinations) that is not better accounted for by a preexisting, established or evolving dementia.
  - The disturbance develops over a short period of time (usually hours to days) and fluctuates during the day
  - There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.
- No  Yes (Patient must meet all four criteria above to make diagnosis)

## 3. MENTAL HEALTH

History of mental illness:  No  Yes: \_\_\_\_\_

Has the patient gone to M&K/Beudet/other psych facility?  No  Yes: \_\_\_\_\_

Is this the first episode of agitation?  No  Yes: \_\_\_\_\_ History of suicide attempt:  No  Yes: \_\_\_\_\_

Post-Ictal Psychosis:  No  Yes (episodes of agitation/psychosis only take place after epileptic seizure)

Antipsychotic Medication (Use Agitated Patient Protocol; give dose and indicate whether PO/IM):

Risperidone: \_\_\_\_\_  Haloperidol: \_\_\_\_\_  Other: Diphenhydramine: \_\_\_\_\_

## 4. FOLLOWUP

Psychologist contacted about patient

Presumed Etiology of Agitation/Psychosis:  Medical Problem/Delirium: \_\_\_\_\_  Mental Health Problem: \_\_\_\_\_

Has Haloperidol been given?:  No  Yes  Fluids ordered/given  EKG ordered/done

Notes: \_\_\_\_\_



# Partners In Health

Department of Mental Health & Psychosocial Services  
Patient Follow-up Form – Community Health Workers

Visit Date:  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:  
\_\_\_\_\_  
Visit Number:  
\_\_\_\_\_

### Patients' Demographic Data

Name:

Nickname:

Last Name:

Sex:  M  F

Address:

Phone Number:

Date of Birth: DD/MM/YYYY

Age:

### What did you observe?

Is it Urgent?  Yes  No

- Seizure
- Thinking about suicide
- Thinking about harming others

### How do you think the patient is feeling?

- Patient is better now
- Patient is doing worse
- Patient is the same

### What did you do:

- Check symptoms
- Same day therapy session
- Give advice
- Relaxation
- Ask if patient is out of medication
  - Yes
  - No
  - Patient is not on medication

### Psychoeducation

- Explain the illness to the patient
- Give him/her hope
- Give him/her the sick role
- Encourage the patient to participate in activities that makes him/her happy

### Did you:

- Bring patient to hospital?
- Send patient to hospital?
- Encourage the family?
- Encourage the patient?

### Did you use the ZLDSI?

Yes  
 No  
What is the ZLDSI Score:  
\_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

### Name of CHW



# Partners In Health

Department of Mental Health & Psychosocial Services  
Initial Visit Patient Form – Community Health Workers

Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

Chart Number:

\_\_\_\_\_

### Patients' Demographic Data

Name:

Nickname:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### What did you observe?

Is it a urgent matter that needs immediate attention?  Yes  No

Seizure

Thinking about suicide

Thinking about harming others

### Which illness do you think the patient suffers from?

Anxiety

Psychosis

Epilepsy

Depression

### What did you do:

Check symptoms

Same day therapy session

Give advice

Relaxation

Ask if patient is out of medication

Yes

No

Patient is not  
on medication

### Psychoeducation

Explain the illness to the patient

Give him/her hope

Give him/her the sick role

Encourage the patient to participate in activities that makes  
him/her happy

### Did you:

Bring patient to hospital?

Send patient to hospital?

Encourage the family?

Encourage the patient?

### Did you use the ZLDSI form?

Yes

No

What is the ZLDSI Score: \_\_\_\_ / 39

### What are some other problems that the patients' family say he/she have?

### Name of CHW



# Partners In Health

Department of Mental Health &  
Psychosocial Services

## Referral Form – Community Health Workers

### Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Thomonde   | <input type="checkbox"/> Belladère      | <input type="checkbox"/> Boucan Carre    |
| <input type="checkbox"/> Cange      | <input type="checkbox"/> St Marc        | <input type="checkbox"/> Cerca La Source |
| <input type="checkbox"/> Hinche     | <input type="checkbox"/> Petite Rivière | <input type="checkbox"/> Mirebalais      |
| <input type="checkbox"/> Lascahobas | <input type="checkbox"/> Verrettes      |  |

### Patients' Demographic Data

Name:

Nickname:

Last Name:

Sex:  M  F

Address:

Phone:

Date of Birth: DD/MM/YYYY

Age:

### Reason for the Referral

Why are you referring the patient?

Is it Urgent?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

- Seizure
- Thinking about suicide
- Thinking about harming others

Depression – ZLDSI Score \_\_\_\_\_

Epilepsy

Seizure

Psychosis

Is the person taking any medications?

Yes  No

If Yes, Specify: \_\_\_\_\_

### Who do you refer the patient to:

Zanmi Lasante

Members of the Community

Psychologists

Community Leader

Social Worker

Other Community Health Workers

Mobile Clinic

Others (specify): \_\_\_\_\_

Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DD MM YYYY

### Remarks

### Information on the person who referred the patient:

Name:

Phone:

Address:

Last Name:

Nickname:

## CLINICAL GLOBAL IMPRESSIONS SCALE

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Psychologist / SW: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Age: \_\_\_\_\_

Male/ Female (circle one)

Phone #1: \_\_\_\_\_

Town: \_\_\_\_\_

Phone #2: \_\_\_\_\_

District: \_\_\_\_\_

Session#: \_\_\_\_\_

Date recieved patient info: \_\_\_\_\_

### I. Severity of Illness

**Considering your total clinical experience with this particular population, how mentally ill has the patient been over the past 7 days?**

**Tip:** Compare relative to your past experience with patients who have the same diagnosis considering your total clinical experience with this population.

**0 = Not assessed**

**1 = Normal, not at all ill.**

Symptoms of disorder have not been present in the past seven days.

**2 = Borderline mentally ill.**

Subtle or suspected symptoms within the past seven days. No definable impact on behavior or function.

**3 = Mildly ill.**

Clearly established symptoms causing minimal, if any, distress or difficulty in social or occupational function.

**4 = Moderately ill.**

Overt symptoms causing noticeable, but modest, functional impairment or distress. There is evidence of functional interference in multiple settings. Some symptoms may warrant medication.

**5 = Markedly ill.**

Intrusive symptoms that distinctly impair social or occupational function or cause intrusive levels of distress. Functional interference due to symptoms is obvious to others.

**6 = Severely ill.**

Disruptive pathology; behavior and function are frequently influenced by symptoms. Dysfunction may require assistance from others.

**7 = Among the most extremely ill patients.**

Pathology drastically interferes in many life functions. Patient may need to be hospitalized.

**Rating**  
(Number 0–7)



## II. Improvement

Compared to the patient's baseline condition before treatment, how much has the patient changed?

### Tips:

For initial evaluation: if the patient has been in treatment previously, rate CGI Improvement based on the history and compared to the patient's condition prior to treatment. Otherwise, leave blank.

Progress Notes: Rate improvement by comparing the current condition to the patient's condition at the initiation of the current treatment plan. Assess how much the patient's illness has changed relative to a baseline state at the beginning of the treatment plan based on the first evaluation. Rate total improvement whether or not in your judgment it is due to treatment.

**0 = Not assessed**

**1 = Very much improved.**

Nearly all better; good level of functioning; minimal symptoms; represents a very substantial change.

**2 = Much improved.**

Notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain.

**3 = Minimally improved.**

Slightly better with little or no clinically meaningful reduction of symptoms. May represent very little change in basic clinical status, level of care, or functional capacity.

**4 = No change.**

Symptoms remain essentially unchanged.

**5 = Minimally worse.**

Slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity.

**6 = Much worse.**

Clinically significant increase in symptoms and diminished functioning.

**7 = Very much worse.**

Severe exacerbation of symptoms and loss of functioning.

**Rating**  
(Number 0–7)

## III. Side Effects

Select the terms that best describe the degree of side effects of medication treatment.

**0 = None**

**1 = Do not significantly interfere with patient's functioning.**

**2 = Significantly interfere with patient's functioning.**

**3 = Outweighs therapeutic effects with patient's functioning.**

**Rating**  
(Number 0–3)

## COMMUNITY EDUCATION ACTIVITY (CEA) CHECKLIST

### Guidelines:

- CHWs conduct CEAs once a month.
- CEAs are approximately 1–3 hours long.
- Local leaders will announce the sessions on the appropriate day; CHWs will conduct sessions at a place where people are gathered (church, school, etc.).
- CHWs will record information about the CEAs on the Stigma Reduction Form and attendance sheet.
- CHWs should arrange water, snacks and soda for participants.
- CHWs should use visuals such as Community Education Cards and the participant handbook as much as possible during the sessions.

### Steps:

- Introduce yourself to the group.
- Explain the goal of the meeting and introduce the main subject.
- Assess the baseline knowledge of the subject (through asking the audience general questions).
- Use Community Education Cards and the participant handbook to provide key information about the main subject.
  - Define the disease.
  - Explain symptoms with concrete examples.
  - Explain how the disease develops, if it is contagious, prevention methods, where and how to be treated, and recovery.
- Assess community members' understanding of stigma and discrimination through the Stigma Assessment Activity before giving information, and again after.
- Explain the damage that stigma and discrimination can cause to families and communities.
- Allow participants to ask questions throughout the presentation.
- Continuously ask questions to assess understanding. Give a small incentive to participants who answer correctly.
- Remind participants that if they or anyone they know are facing any of the topics being discussed, they should speak to the CHW. The CHW can give a referral to the hospital or other experts.
- Distribute the snack, such as soda or cookies.
- If time allows, practice a specific skill:
  - Practice doing a consultation, completing the referral form, using the ZLDSI, etc.

# INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services



Record Number: \_\_\_\_\_ EMR Number: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Site : \_\_\_\_\_

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex:  M  F Date of Birth (Day/Month/Year): \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Commune: \_\_\_\_\_ Profession: \_\_\_\_\_ Telephone: \_\_\_\_\_

Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of Community Health Worker/Telephone: \_\_\_\_\_

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**Chief Complaint** (in the patient's own words):

**History of Present Illness** (Date of symptom onset, precipitants, course, any prior treatment):

**PSYCHIATRIC REVIEW OF SYSTEMS**

DEPRESSION	MANIA	ANXIETY	PSYCHOSIS
<ul style="list-style-type: none"> <li>• Have you felt sad or lost interest in things for a two week period?</li> <li>• Do you feel like you've lost interest in everything or only in some things?</li> <li>• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39</li> </ul>	<ul style="list-style-type: none"> <li>• Did you feel very happy for any reason in the last few days?</li> <li>• Did you get angry more often in the last few days?</li> <li>• Do you:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Have any difficulties of staying attentive?</li> <li><input type="checkbox"/> Speak of things that you shouldn't?</li> <li><input type="checkbox"/> Feel like you're worth more than before?</li> <li><input type="checkbox"/> Have a racing thoughts going through your head?</li> <li><input type="checkbox"/> Have an increase in activities?</li> <li><input type="checkbox"/> Sleep less?</li> <li><input type="checkbox"/> Talk without ceasing?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Are you a worrier?</li> <li>• What do you worry about?</li> <li>• Are you experiencing:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Fear of crowded places</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Muscle tension</li> <li><input type="checkbox"/> Restlessness</li> </ul> </li> <li>• Do you often experience any 4 of these problems such as:               <ul style="list-style-type: none"> <li><input type="checkbox"/> increased in heartbeat</li> <li><input type="checkbox"/> breathlessness</li> <li><input type="checkbox"/> sweating</li> <li><input type="checkbox"/> trembling</li> <li><input type="checkbox"/> fear; fear of losing control; fear of becoming crazy; fear of death</li> <li><input type="checkbox"/> feeling dizzy</li> <li><input type="checkbox"/> feel like you're losing consciousness</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Do you hear things like voices that other people don't hear?</li> <li>• Do you see things that other people don't see?</li> <li>• Do you feel that people are conspiring to harm you – even people whom you don't know?</li> <li>• Are the voices in your head controlling your thought process?</li> </ul>

	SUICIDE		VIOLENCE/HOMICIDE	
	Have you ever thought of causing harm to yourself or committing suicide in the past? What about now?		Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?	
	Ideation	Attempts	Ideation	Acts
Past	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain \_\_\_\_\_

Do you have a plan?  Yes  No      Are there guns or other weapons in the household?  Yes  No

SUBSTANCE ABUSE						
Do you use any of the following?						
	Beer	Home Brew	Liquor	Tobacco	Marijuana	Cocaine
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain quantity, first use, last use: \_\_\_\_\_

Need to cut down?       Annoyed or angered by others who comment on your use?       Guilty about using?   
 In order to function properly, do you need to take that substance before starting your day?

TRAUMA						
Did you ever experience a trauma, such as physical, sexual, or emotional abuse, that is impacting your current functioning?						
	Physical	Emotional	Sexual	Re-experiencing	Hyperarousal	Avoidance
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: \_\_\_\_\_

Do you feel safe in your current environment? \_\_\_\_\_

## PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
<input type="checkbox"/> Are you experiencing pain in your body?	<ul style="list-style-type: none"> <li>• Is there a change in your:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight?</li> <li><input type="checkbox"/> Thirst?</li> <li><input type="checkbox"/> Fever?</li> </ul> </li> </ul>	<input type="checkbox"/> Sight problems?  <input type="checkbox"/> Hearing problems?  <input type="checkbox"/> Voice change?  <input type="checkbox"/> Dizziness?  <input type="checkbox"/> Gum and teeth status?  <input type="checkbox"/> Difficulty swallowing?	<input type="checkbox"/> Stiffness of the neck?
BREATHING	HEART/ARTERIES	DIGESTIVE SYSTEM	SKIN
<input type="checkbox"/> Are you having problems breathing?  <input type="checkbox"/> Are you coughing?  <input type="checkbox"/> Do you cough out blood or find blood in your snot?	<input type="checkbox"/> Do you have an increased heartbeat?  <input type="checkbox"/> Having chest pain?  <input type="checkbox"/> Any swelling?	<input type="checkbox"/> Heart burn?  <input type="checkbox"/> Gastric Reflux?  <input type="checkbox"/> Vomiting?  <input type="checkbox"/> Constipation, diarrhea, gas?	<input type="checkbox"/> Any changes in your skin?
MUSCLES	APPENDAGES (HANDS AND FEET)	GENITALS/URINATION	NEUROLOGICAL
<input type="checkbox"/> Are they stiff?  <input type="checkbox"/> Swollen?  <input type="checkbox"/> Reddened?	<input type="checkbox"/> Swollen?	<input type="checkbox"/> Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?  <input type="checkbox"/> Any problems when urinating (pain, amount/ color of urine, blood in urine)?	<input type="checkbox"/> Any numbness?  <input type="checkbox"/> Uncontrolled movements?

## PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

### Psychiatric Family History:

---

### Past Medical History and Active Medical Problems

Head Injury:

Last Date Of Menstruation: \_\_\_ / \_\_\_ / \_\_\_

Loss Of Consciousness:

Other Things:

---

### Medication/Allergies/Side Effects:

---

### Medical Family History:

---

**Social/Cultural History** (include childhood family configuration, urban or rural setting, level of education, romantic relationships, and occupation or other means of financial support):

### Legal Problems:

## PHYSICAL EXAM (PHYSICIAN)

Vital Signs: \_\_\_\_\_

HEENT: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Cardio-vascular: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitals: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_

## NEUROLOGIC EXAM (PHYSICIAN)

Cranial nerves II to XII Intact  If impaired, specify \_\_\_\_\_

Motor: \_\_\_\_\_

Pronator drift: \_\_\_\_\_

Sensory: \_\_\_\_\_

Vibration: \_\_\_\_\_ Position: \_\_\_\_\_

Reflexes: DTR \_\_\_\_\_ Clonus \_\_\_\_\_ Babinsky \_\_\_\_\_

Coordination and Gait: Rapid alternating movements \_\_\_\_\_ Nose finger test \_\_\_\_\_

Romberg \_\_\_\_\_ Gait \_\_\_\_\_ Heel toe walk test \_\_\_\_\_

## MENTAL STATUS EXAM

General Appearance	<input type="checkbox"/> well groomed	<input type="checkbox"/> disheveled	<input type="checkbox"/> overdressed, elaborate
Orientation	<input type="checkbox"/> O x 3	<input type="checkbox"/> disoriented to time	<input type="checkbox"/> disoriented to place <input type="checkbox"/> disoriented to person
Behavior	<input type="checkbox"/> WNL <input type="checkbox"/> tics	<input type="checkbox"/> retardation	<input type="checkbox"/> agitation <input type="checkbox"/> tremor
Speech	<input type="checkbox"/> WNL	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured <input type="checkbox"/> slurred
Mood	<input type="checkbox"/> _____		
Affect	<input type="checkbox"/> euthymic <input type="checkbox"/> irritable <input type="checkbox"/> congruent with speech content	<input type="checkbox"/> dysphoric <input type="checkbox"/> suspicious <input type="checkbox"/> incongruent with speech content	<input type="checkbox"/> euphoric <input type="checkbox"/> labile <input type="checkbox"/> other: _____ <input type="checkbox"/> anxious <input type="checkbox"/> flat



## MENTAL STATUS EXAM CONTINUED

Thought Process	<input type="checkbox"/> linear <input type="checkbox"/> tangential <input type="checkbox"/> perseverative <input type="checkbox"/> illogical <input type="checkbox"/> loose associations <input type="checkbox"/> _____
Thought Content	<input type="checkbox"/> WNL <input type="checkbox"/> vague <input type="checkbox"/> persistent preoccupation with: <input type="checkbox"/> suicidal ideation <input type="checkbox"/> homicidal ideation Delusions: <input type="checkbox"/> none <input type="checkbox"/> paranoid <input type="checkbox"/> grandiose <input type="checkbox"/> other: _____ Perceptual Disturbances/Hallucinations: <input type="checkbox"/> none <input type="checkbox"/> auditory <input type="checkbox"/> visual <input type="checkbox"/> olfactory <input type="checkbox"/> gustatory <input type="checkbox"/> tactile
Insight:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good
Judgment/Impulse Control:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good

**General Impressions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**BIOPSYCHOSOCIAL FORMULATION** (including patient's strengths and coping strategies):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DIAGNOSIS:

Axis I: \_\_\_\_\_  
 Axis II: \_\_\_\_\_  
 Axis III: \_\_\_\_\_  
 Axis IV: \_\_\_\_\_

### PLAN:

#### Psychological Treatment Plan

##### Treatment Goals

1. Goal: \_\_\_\_\_
2. Goal: \_\_\_\_\_
3. Goal: \_\_\_\_\_

**Intervention**

- Interpersonal Psychotherapy (IPT)
- Medication
- Behavioral Activation
- Psychoeducation
- Parent/Family Supportive Therapy
- Other \_\_\_\_\_
- Relaxation Training
- Supportive Psychotherapy
- Grief Support
- Parent Skills Training

**Frequency**

- Once per week
- Bi-weekly
- Once per month

**Number of Sessions:**

- 4–6 sessions
- 6–8 sessions
- 8–10 sessions
- 10–12 sessions

Primary Clinician: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

**Referrals**

**CHW**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Social Worker**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Other Plan: (follow-up with family, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

**FOLLOW-UP**

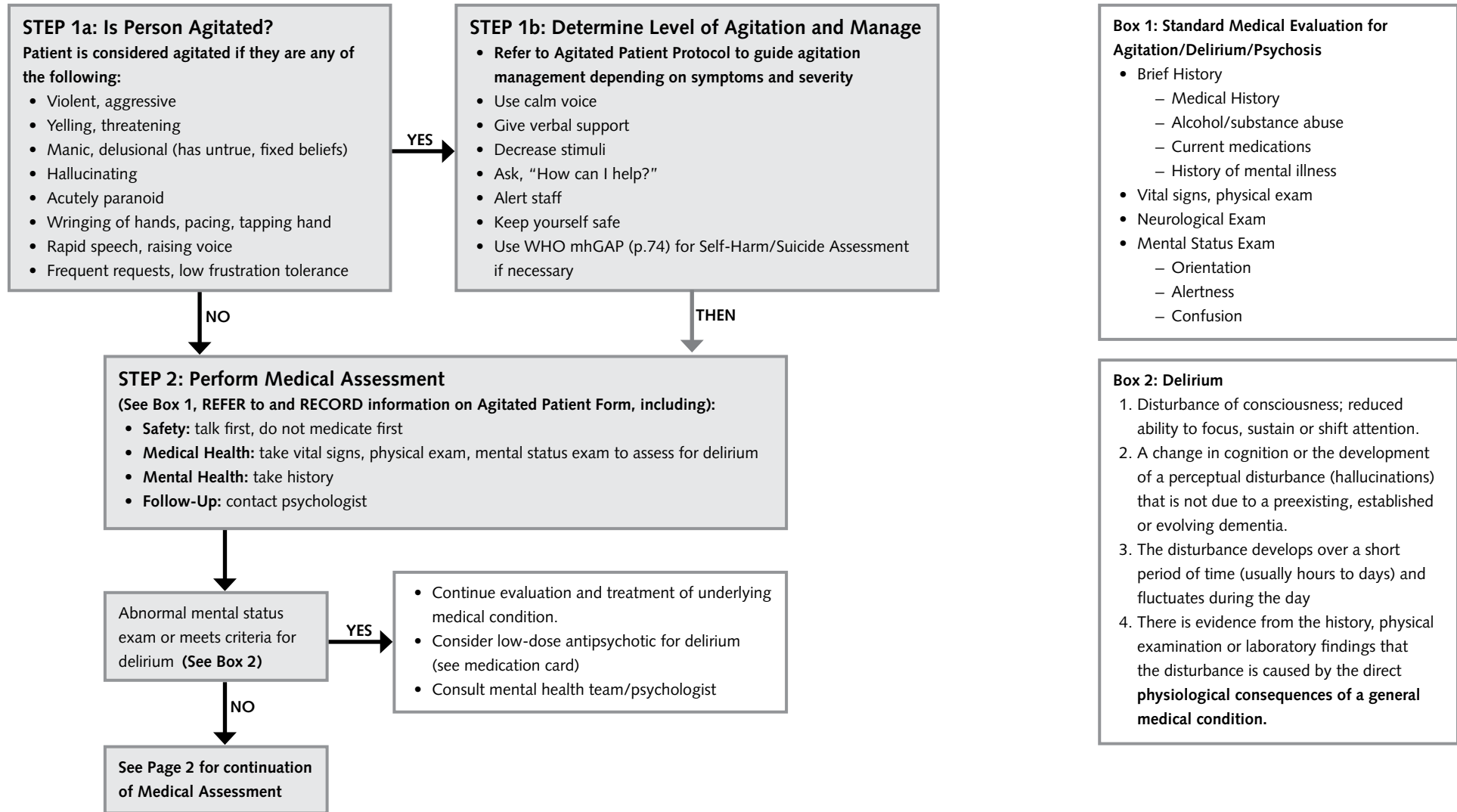
**Psychiatric Medication**

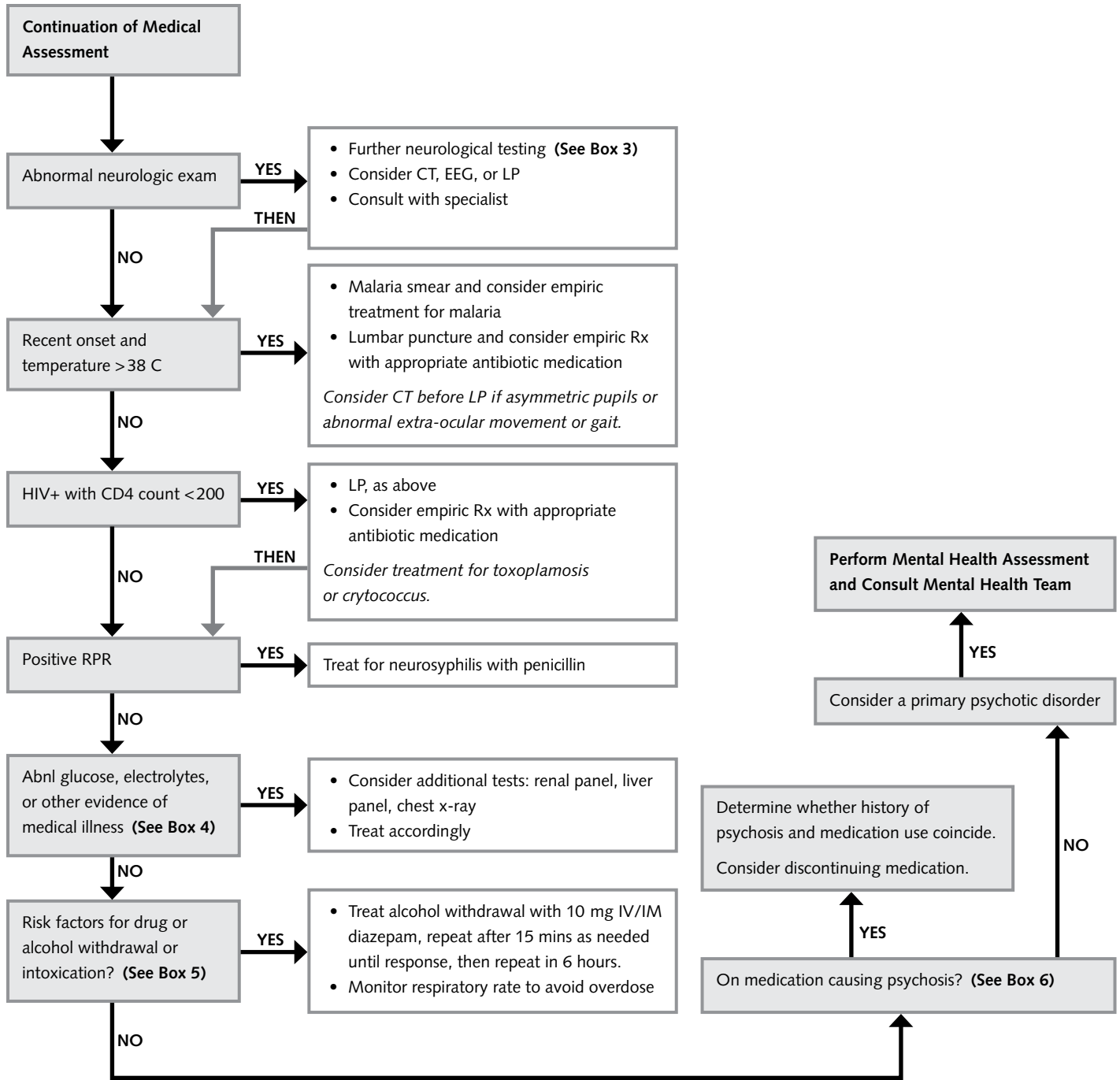
Medication	Dose	Frequency	Quantity	Refill Date
Risperidone				
Haloperidol				
Diazepam				
Carbamazepine				
Valporic Acid				
Other: _____				

**Hospitalization:**

Date of Admission: \_\_\_ / \_\_\_ / \_\_\_

Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_





**Box 3: Neurological Conditions that Cause or Contribute to Psychosis**

- Tertiary syphilis
- Encephalitis
- Dementia (HIV, Alzheimers)
- Parkinsons
- Brain tumors or other mass lesions (TB, lymphoma, toxoplasmosis)

**Box 4: Common Systemic Conditions that can Cause/Contribute to Psychosis**

- Malaria
- Electrolyte abnormalities (sodium, calcium)
- Malnutrition, thiamine deficiency
- Thyroid disease
- Alcohol withdrawal
- Hypoxia

**Box 5: Alcohol Withdrawal**

- History of heavy alcohol use (last drink 24–28 hours prior to symptoms)
- Severe alcohol withdrawal:
  - Within a few hours: withdrawal tremors, nausea, vomiting, sweating, anxiety
  - Within a few days: hallucinations, seizures, fever, disorientation, hypertension

**Box 6: Medications that can Cause/Contribute to Psychosis**

- Corticosteroids
- Cycloserine
- Isoniazid, Efavirenz
- Corticosteroids
- Phenobarbital
- High doses of anti-cholinergic medication

# MEDICATION CARD FOR AGITATION, DELIRIUM, AND PSYCHOSIS

	RISPERIDONE	HALOPERIDOL	DIAZEPAM	CARBAMAZEPINE	VALPROATE
	<p><i>1st Choice: "Atypical"</i> Antipsychotic/Mood stabilizer</p> <p><b>Use for: Psychosis (with or without mania)</b></p>	<p><i>2nd Choice: "Typical"</i> Antipsychotic/Mood stabilizer</p> <p><b>Use for: Aggressive or violent psychosis (with or without mania)</b></p>	<p><i>Benzodiazepine</i></p> <p><b>Use for: Alcohol withdrawal, acute agitation with or without anti-psychotic</b></p>	<p><i>3rd Choice: Mood stabilizer</i> <u>Do not prescribe without consulting mental health team</u></p> <p><b>Use for: Mania without psychosis</b></p>	<p><i>4th choice: Mood stabilizer</i> <u>Do not prescribe without consulting mental health team</u></p> <p><b>Use for: Mania without psychosis (longstanding aggression or violence in males)</b></p>
<b>DO NOT USE IF</b>	<ul style="list-style-type: none"> <li>Caution if child/adolescent</li> </ul>	<ul style="list-style-type: none"> <li>Prior history of dystonia on antipsychotic medication</li> <li>Children (18 or younger)</li> </ul>	<ul style="list-style-type: none"> <li>Patient is delirious</li> <li>Pregnant/breastfeeding women</li> <li>Children (18 or younger)</li> <li>Elderly (65 or older)</li> </ul>	<ul style="list-style-type: none"> <li>Blood disorder</li> <li>Epilepsy: Absence seizures</li> <li>Caution if child</li> </ul>	<ul style="list-style-type: none"> <li><b>Women of child-bearing age/pregnant women</b></li> <li>Liver disease</li> <li>Caution if child</li> </ul>
<b>MUST CONSULT MENTAL HEALTH TEAM</b>	<ul style="list-style-type: none"> <li>For psychosis due to dementia (increased risk of death)</li> <li>Children 18 or younger</li> <li>Pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>For psychosis due to dementia (increased risk of death)</li> <li>Pregnant women</li> </ul>		<ul style="list-style-type: none"> <li>For treatment of all mental illness (excluding epilepsy)</li> <li>Pregnant or breastfeeding women</li> </ul>	<ul style="list-style-type: none"> <li>For treatment of all mental illness (excluding epilepsy)</li> </ul>
<b>Starting Dose (Adult)</b>	<p><b>Take at night due to sedative effects</b></p> <ul style="list-style-type: none"> <li>Bipolar/Psychosis – 0.5–1 mg</li> <li>Delirium – 0.25–0.5 mg</li> </ul>	<p><b>Take at night due to sedative effects</b></p> <ul style="list-style-type: none"> <li>Bipolar/Psychosis Moderate sx: 0.5–2.5 mg Severe sx: 2.5–5 mg</li> <li>Always prescribe diphenhydramine 25–50 mg daily with haloperidol</li> <li>Delirium: 0.5–2.5 mg at night (Consider low-dose of risperidone first)</li> <li><b>Aggressive/Violent Patients: See Agitated Patient Protocol</b></li> </ul>	See Agitated Patient Protocol for guidelines regarding use.	200 mg twice daily	200–250 mg twice daily  *Patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations
<b>"Step" of up titration</b>	Antipsychotics require 4–6 weeks to reach full effect. If there are safety concerns, physicians can increase doses more quickly (every 3–7 days) by 0.5 mg increments. Delirium: increase by 0.25 mg increments.	Antipsychotics require 4–6 weeks to reach full effect. If there are safety concerns, physicians can increase doses more quickly (every 3–7 days) by 2.5 mg increments.	See Agitated Patient Protocol for guidelines regarding use.	200 mg total daily	250–500 mg total daily
<b>Maximum Dose</b>	2 mg Doses above 2 mg daily must be reviewed with the mental health team.	10 mg Doses above 10 mg daily must be reviewed with the mental health team.	10 mg Doses above 10 mg daily must be reviewed with the mental health team.	800 mg (for mental illness) Doses above 800 mg must be reviewed with the mental health team.	1000 mg (for mental illness) Doses above 1000 mg must be reviewed with the mental health team.

Medication Card for Agitation, Delirium, and Psychosis (continued)

		RISPERIDONE	HALOPERIDOL	DIAZEPAM	CARBAMAZEPINE	VALPROATE
<b>Toxicities</b> *If rash, stop medication and return to hospital	<b>Serious</b>	<b>Dystonia</b> (especially of pharynx, eyes, neck—temporary but potentially fatal), <b>Tardive Dyskinesia</b> (permanent), <b>Akathisia</b> (restlessness), <b>Diabetes</b> , <b>Cardiac arrhythmia</b> leading to torsades des pointes		<b>Risk of Seizure</b> if diazepam withdrawn without taper after regular use at higher dose	<b>Rash, liver failure, decreased white blood count</b> (Carbamazepine can cause <b>hyponatremia</b> ) (Valproate can cause <b>serious birth defects</b> in pregnancy)	
	<b>Common</b>	<ul style="list-style-type: none"> <li>Sedation</li> <li>Weight Gain</li> <li>Lactation</li> <li>Amenorrhea</li> <li>Enuresis (for boys)</li> </ul>	<ul style="list-style-type: none"> <li>Sedation</li> <li>Heavy tongue</li> <li>Stiffness</li> <li>Arrhythmia (for patients receiving more than 10 mg daily)</li> </ul>	<ul style="list-style-type: none"> <li>Sedation</li> <li>Dependence (should not be given for long periods of time)</li> </ul>	Fatigue, dizziness, nausea/vomiting, incoordination, double vision  (Carbamazepine decreases efficacy of oral contraceptives; Valproate causes tremor)	
<b>Monitoring</b>		<ul style="list-style-type: none"> <li>Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available)</li> <li>Every visit: weight, vital signs</li> <li>Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram</li> </ul>	<ul style="list-style-type: none"> <li>Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available)</li> <li>Every visit: weight, vital signs</li> <li>Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram</li> </ul>	<ul style="list-style-type: none"> <li>Monitor for signs of sedation</li> <li>Monitor for dependence (need for increased dose to achieve same effect)</li> </ul>	LFTs, CBC, Sodium	Weight gain, LFTs, CBC  HIV patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations.
<b>Tapering/ Discontinuing</b> If there is a life-threatening/toxic side effect, stop immediately.		<ul style="list-style-type: none"> <li><b>Consult with the mental health team before tapering medication. Some patients may need to continue risperidone indefinitely.</b></li> <li>If the patient has other significant side effects, consider decreasing the dose slowly (by 0.25–0.5 mg increments) and monitoring closely. Can also consider changing to haloperidol.</li> </ul>	<ul style="list-style-type: none"> <li><b>Consult with the mental health team before tapering medication. Some patients may need to continue haloperidol indefinitely.</b></li> <li>If the patient has other significant side effects, consider decreasing the dose slowly (by 2.5 mg increments) and monitoring closely. Can also consider changing to risperidone.</li> </ul>	<ul style="list-style-type: none"> <li>Only used for the management of agitated/violent patients and alcohol withdrawal.</li> <li>It should not be continued for more than several days.</li> </ul>	Reduce by steps above every 2–4 weeks.	Reduce by steps above every 2–4 weeks.
		<ul style="list-style-type: none"> <li>For delirium, stop the medication after medical illness is treated.</li> <li>For chronic psychosis due to mental illness: if the patient is showing improvement in symptoms and has no major side effects, do not stop the medication.</li> <li>For acute psychosis due to mental illness: consider slowly tapering the medication after patient is symptom-free for 3–6 months.</li> </ul>				
<b>Breastfeeding</b>		Do not prescribe to pregnant or breastfeeding patients without consulting with the mental health team; give folic acid 4 mg QD through pregnancy.	Do not prescribe to pregnant or breastfeeding patients without consulting with the mental health team; give folic acid 4 mg QD through pregnancy.	Contraindicated	Do not prescribe (for mental illness) to pregnant or breastfeeding patients without consulting the mental health team; give folic acid 4 mg QD through pregnancy.	Do not initiate. If already on, make sure taking 4 mg folic acid QD.

## TREATMENT FOR ANTIPSYCHOTIC MEDICATION SIDE EFFECTS

		ESP (EXTRAPYRAMIDAL SYMTOMS)		TARDIVE DYSKINESIA	NEUROLEPTIC MALIGNANT SYNDROME (NMS)
		ACUTE DYSTONIA	AKATHISIA		
<b>Manifestation</b>		Muscle rigidity (potentially including: eye muscles, throat, neck, tongue, back)  <b>EMERGENCY</b>	Psychomotor restlessness	Involuntary orofacial movements (may be permanent)	Confusion, delirium, stiffness (like a lead pipe), sweating, hyperpyrexia, autonomic instability, drooling, elevated WBC, elevated CPK, death  <b>EMERGENCY</b>
<b>Treatment</b>		Diphenhydramine 50–75 mg IM or PO daily  Several liters of IV or PO fluids daily	Propranolol 10–20 mg TID  Can also decrease the dose of medication	Discontinue neuroleptic or lower dose  Consider Vitamin C (500–1000 mg/d) + Vitamin E (1200–1600 IU/d)	1. Discontinue offending medication. 2. Medical evaluation and support (consider IV fluids) 3. Hospitalize 4. Consider dopamine agonists or dantrolene to improve outcome.
<b>Toxicities</b>	<b>Serious</b>	Anaphylaxis, anemia, arrhythmia	Arrhythmia, bronchospasm, Stevens-Johnson syndrome		
	<b>Common</b>	Drowsiness, dizziness, headache, dry mouth, tachycardia, constipation, blurred vision	Fatigue, dizziness, nausea, depression, insomnia		



# Partners In Health

Department of Mental Health & Psychosocial Services

## Mental Health Follow-Up Form

File Number:

\_\_\_\_\_

EMR Number:

\_\_\_\_\_

Location:

\_\_\_\_\_

Date:

\_\_\_ / \_\_\_ / \_\_\_

Name of CHW: \_\_\_\_\_ Number of visits: \_\_\_\_\_ Date of last visit: \_\_\_ / \_\_\_ / \_\_\_

### Patients' Demographic Data

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Last Name: \_\_\_\_\_

Sex:  M  F

Address: \_\_\_\_\_

Change in phone number:  Yes  No

Date of Birth: DD/MM/YYYY

Age: \_\_\_\_\_

### 1. Initial Diagnosis

Initial Diagnosis: \_\_\_\_\_

Contacts since the last visit:

Patient  Parent  Family  Medication  CHW  Other \_\_\_\_\_

### 2. Evolution: (Comment on symptoms, aggravation and improvement, location, quality, severity, duration, schedule, context, modifying factors, and coping strategies):

### 3. Ongoing psychotherapy (Progress)

ZLDSI score for depression (if present): \_\_\_\_\_

Date of last menstrual period: DD/MM/YYYY \_\_\_\_\_

Current medications  Yes  No

Medication/s	Dose/Freq	Side Effects	Comments
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____

### 4. Mental Status Examination

General appearance wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to self, suicidal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor introspection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to others	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought process wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety, phobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle tone and strength	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought content wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor judgement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive function wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Affect wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Observations from the mental health examination:



**5. Positive results from the physical examination/labs (PHYSICIANS):**

**6. Diagnosis (DSM-IV):**

**7. Response to recent interventions:**

**8. Interventions in the current session (I), Future treatment plan (P)**

<input type="checkbox"/> Interpersonal therapy, session # _____ <input type="checkbox"/> Active listening <input type="checkbox"/> Reinforcement of alliance <input type="checkbox"/> Encouragement/support <input type="checkbox"/> Psychoeducation <input type="checkbox"/> Identify/express feelings <input type="checkbox"/> Discuss issues of protection <input type="checkbox"/> Evaluation/Safety planning <input type="checkbox"/> Relaxation <input type="checkbox"/> Acupuncture	<input type="checkbox"/> Discuss medication <input type="checkbox"/> Review social activities <input type="checkbox"/> Identify family roles <input type="checkbox"/> Work on communication <input type="checkbox"/> Explore conflicts <input type="checkbox"/> Work on resources <input type="checkbox"/> Work on a plan of change <input type="checkbox"/> Therapeutic plan/social activities <input type="checkbox"/> Cognitive behavioral therapy <input type="checkbox"/> Anger management	<input type="checkbox"/> Controlling motivations <input type="checkbox"/> Emotional regulation <input type="checkbox"/> Behavioral regulation <input type="checkbox"/> Training for self-control <input type="checkbox"/> Develop a behavior plan <input type="checkbox"/> Cognitive intervention <input type="checkbox"/> Sensory response <input type="checkbox"/> Plan/review progress <input type="checkbox"/> Collaborate with other clinicians <input type="checkbox"/> Other _____ _____ _____
---	--	--

**9. Intervention of Social Worker**

**10. Other recommendations (if necessary)**

**11. Plan**

Plan discussed with patient and he (she) approves:  Yes If  No, explain:

Name of the person completing the evaluation: \_\_\_\_\_ Date: \_\_\_\_\_

**DIFFERENTIAL DIAGNOSIS INFORMATION SHEET  
FOR SEVERE MENTAL DISORDERS**



CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
<b>Medical Symptoms or Psychosis Caused by Medical Conditions</b>			
Delirium	New onset abnormal mental status	<ul style="list-style-type: none"> <li>Abnormal physical exam, vital signs or laboratory studies</li> <li>Abnormal mental status examination</li> </ul>	<ul style="list-style-type: none"> <li>Seek medical source of illness</li> <li>Follow Medical Evaluation Protocol for Agitation, Delirium and Psychosis</li> </ul>
Psychotic Disorder Due to a General Medical Condition	Psychosis is the direct physiological consequence of a medical condition	<ul style="list-style-type: none"> <li>Psychotic symptoms</li> <li>Evidence of a contributing medical illness</li> </ul>	
Substance-Induced Psychotic Disorder	Prominent hallucinations or delusions	<ul style="list-style-type: none"> <li>Evidence of recent substance intoxication or withdrawal</li> </ul>	
Post-Partum Psychosis	New onset psychosis in a female following childbirth	<ul style="list-style-type: none"> <li>Recent childbirth</li> </ul>	
<b>Mental Health Related Symptoms that are not Psychosis</b>			
Transient hallucinations	Anomalous experiences, may occur in a person in a state of good mental and physical health, even in the apparent absence of a trigger (stress, fatigue, intoxication, etc.)	<ul style="list-style-type: none"> <li>Common in children and youth</li> </ul>	<ul style="list-style-type: none"> <li>Ensure safety of patient: assess for self-harm</li> <li>Seek to understand patient's explanatory model, and to assess internal level of distress</li> <li>Obtain Biopsychosocial history</li> <li>Identify potential stressors</li> <li>Consult traditional healer if currently involved in management</li> </ul>
Acute stress, anxiety, and trauma-related problems	Stress and traumatic experiences can result in unusual sensory and perceptual experiences that can mimic psychosis	<ul style="list-style-type: none"> <li>Significant trauma history</li> </ul>	
Conversion Disorder	Usually in response to stress, a person can develop blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation	<ul style="list-style-type: none"> <li>Identification of stressor</li> <li>Poor insight into emotional stressors</li> </ul>	
Obsessive-compulsive disorder	Excessive thoughts (obsessions) that can lead to repetitive behaviors (compulsions), with a potential component of disordered thinking	<ul style="list-style-type: none"> <li>Specific area of focus</li> </ul>	
Autism spectrum disorders	A serious developmental disorder that impairs the ability to communicate and interact	<ul style="list-style-type: none"> <li>Longstanding history of unstable interpersonal relationships</li> </ul>	
Personality Disorder	A deeply ingrained and maladaptive pattern of behavior of a specified kind, typically manifest by the time one reaches adolescence and causing long-term difficulties in personal relationships or in functioning in society	<ul style="list-style-type: none"> <li>Longstanding history of unstable interpersonal relationships</li> <li>Poor insight</li> </ul>	

Differential Diagnosis Information Sheet For Severe Mental Disorders (Continued)

CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
<b>Episodic Psychosis or Mania</b>			
Depression with psychotic features (Mood Disorder, depressed)	A primary depression with psychotic symptoms.	<ul style="list-style-type: none"> <li>• Depressive symptoms before psychotic symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure safety of patient: assess for self-harm</li> <li>• Seek to understand patient's explanatory model, and to assess internal level of distress</li> <li>• Obtain Biopsychosocial history</li> <li>• Identify potential stressors</li> <li>• Consult traditional healer if currently involved in management</li> <li>• Consider co-morbid mental health diagnoses.</li> <li>• Both depression and psychosis are treated with distinct medications</li> <li>• Antidepressant medications (fluoxetine, amitriptyline) can cause mania in a person with Bipolar Disorder</li> </ul>
Bipolar Disorder (Mood Disorder, manic or depressed)	Marked by alternating periods of elation and depression; some develop mania without depression, others can develop hypomania with depression	<ul style="list-style-type: none"> <li>• Period of mania, or hypomania with depression</li> </ul>	
Brief psychotic disorder (less than one month)	A sudden, short-term episode of psychotic thinking and behavior which occurs with a stressful event; can be informed by social and cultural factors	<ul style="list-style-type: none"> <li>• Person returns to functioning</li> </ul>	
Schizophreniform Disorder (Schizophrenia symptoms 1-6 months)	Symptoms of schizophrenia are present for a significant portion of the time within a 1-month period, but signs of disruption are not present for the full six months required for the diagnosis of schizophrenia	<ul style="list-style-type: none"> <li>• Do not make diagnosis of Schizophrenia if symptoms are less than 6 months</li> </ul>	
Psychosis Not Otherwise Specified (NOS)	Psychotic symptoms about which there is inadequate information to make a diagnosis	<ul style="list-style-type: none"> <li>• Examples include: psychosis of a few days or weeks duration, post-partum psychosis, and situations in which diagnosis is unclear</li> </ul>	

Differential Diagnosis Information Sheet For Severe Mental Disorders (Continued)

CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
<b>Continous Psychosis</b>			
Schizophrenia (greater than 6 months)	<p>DSM 5 criteria<sup>1</sup></p> <p>Two (or more) of the following, each present for a significant portion of time during a 1-month period. At least one of these must be (1), (2), or (3):</p> <ol style="list-style-type: none"> <li>1. Delusions</li> <li>2. Hallucinations</li> <li>3. Disorganized speech</li> <li>4. Grossly disorganized or catatonic behavior</li> <li>5. Negative symptoms, i.e., affective flattening, alogia, or avolition</li> </ol> <p><b>Note:</b> Only one of the above symptoms is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts or two or more voices are conversing with each other</p> <p><b>Social/occupational dysfunction:</b> For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved before the onset.</p> <p><b>Duration:</b> Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms and may include periods of prodromal or residual symptoms.</p> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Schizoaffective and mood disorder exclusion</li> <li>• Substance/general medical condition exclusion</li> <li>• Pervasive developmental disorder- the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least a month</li> </ul>	<ul style="list-style-type: none"> <li>• Consider age at onset</li> <li>• Consider prodromal period before onset of initial symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure safety of patient: assess for self-harm</li> <li>• Seek to understand patient's explanatory model, and to assess internal level of distress</li> <li>• Obtain Biopsychosocial history</li> <li>• Identify potential stressors</li> <li>• Take conservative approach to medication</li> <li>• Consult traditional healer if currently involved in management</li> <li>• Consider co-morbid mental health diagnoses</li> </ul>
Delusional disorder (plausible, circumscribed delusions)	Associated with one or more nonbizarre delusions of thinking such as expressing beliefs that can occur in real life, provided no other symptoms of schizophrenia are present	<ul style="list-style-type: none"> <li>• Delusion is usually realistic</li> </ul>	

<sup>1</sup> DSM-5 Diagnostic criteria for schizophrenia. American Psychiatric Association: *Diagnostic and statistical manual of mental disorders, fifth edition*, Washington, DC, 2013, American Psychiatric Association.

# PSYCHOSIS CARE PATHWAY

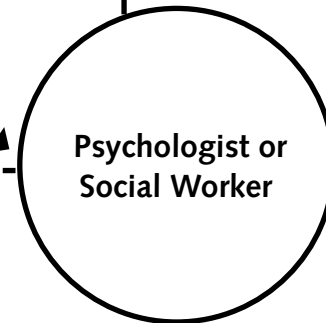
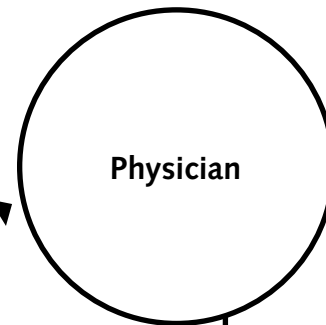
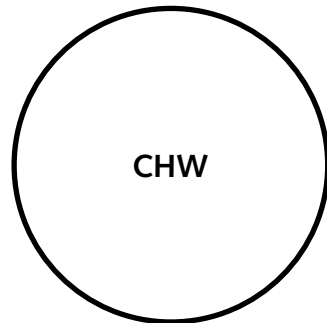
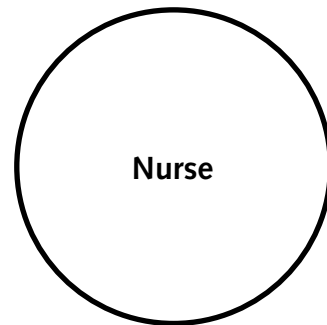


## CASE IDENTIFICATION AND REFERRAL

## EVALUATION, DIAGNOSIS AND TREATMENT

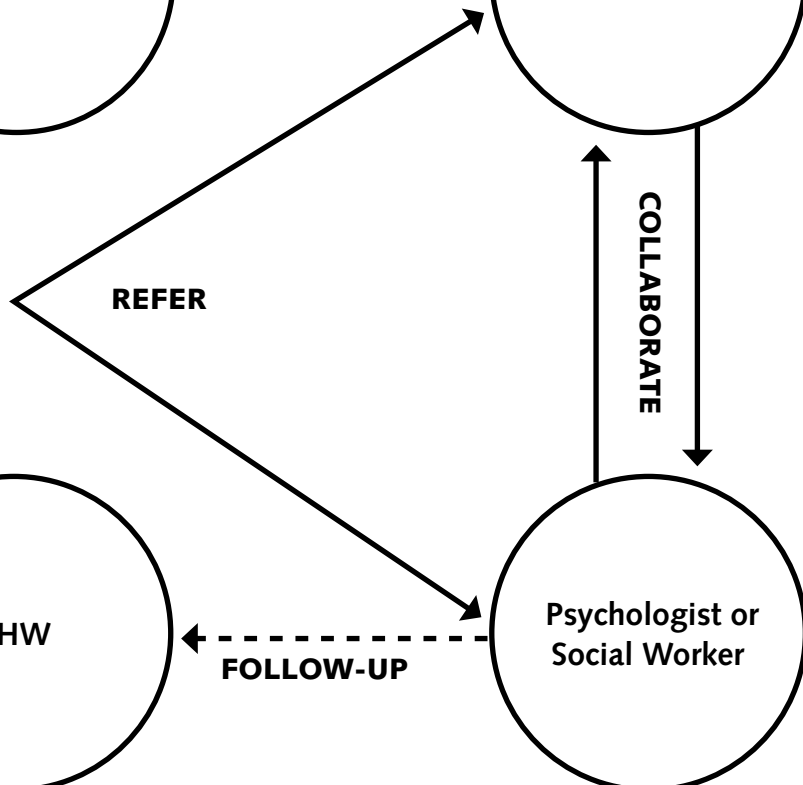
- Manage agitated patient
- Identify and refer
- Coordinate care
- Psychoeducation

- Identify, triage, and refer
- Psychoeducation
- Follow-up
- Community activities



- Manage agitated patient
- Evaluation, diagnosis, and treatment
- Medication management
- Coordinated care with psychologist/SW
- Psychoeducation

- Manage agitated patient
- Evaluation, diagnosis, and treatment
- Coordinate care with physician and CHW
- Psychoeducation
- MEQ/checklist



# What does psychosis look like?



Seeing things that are not there



Hearing voices



Speaking to oneself



Not taking care of self

# Identification of Psychosis

What are the thinking signs of psychosis?

- strange thoughts about people harming him/her, about having great powers
- thinks that mind is being controlled
- cannot think well
- thinking/speaking does not make sense

What are the other signs of psychosis?

- speaking a lot/speaking too little/speaking to oneself
- hears a voice telling him/her what to do
- sees things that are not there

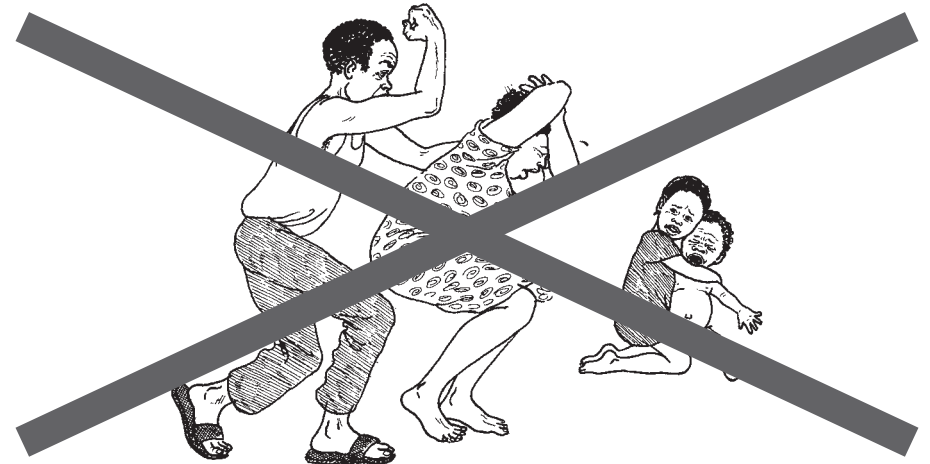
What are the functioning signs of psychosis?

- unable to go to school/work
- does not take care of self (bathing, eating)
- does not take care of children/family
- does not do other activities (go to church, work the land)
- isolated from family
- being alone

# What is psychosis?



Psychosis is not a punishment, a curse, or spirit possession – it is a medical emergency!



Do not tie up, beat, or burn someone who might have psychosis.



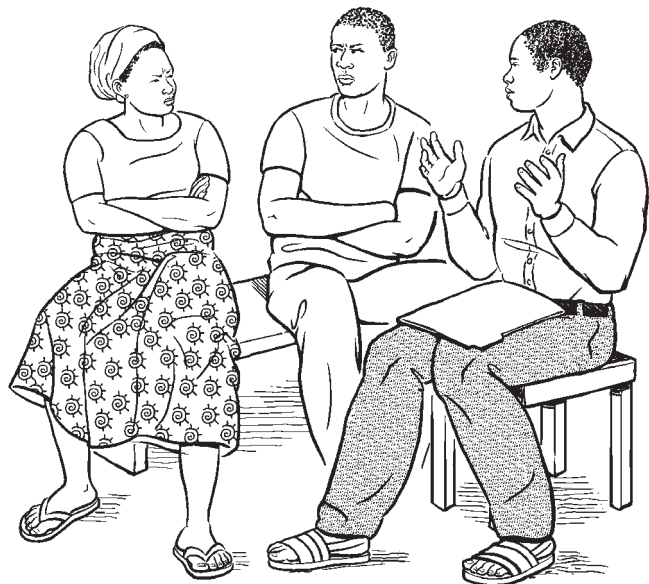
Find friends and neighbors to help.



# Unconfirmed Case of Psychosis

- Psychosis is not a punishment, a curse, or spirit possession.
- It is not contagious.
- Psychosis/agitation is a medical emergency that must be treated immediately.
- Do not blame the person. Do not challenge the person.
- Treat the individual kindly and with respect.
- Do not tie up, beat, or burn the person.
- Avoid crowds/noise.
- **SAFETY:** Never leave the person alone or with children/other vulnerable individuals. Remove dangerous objects.
- Find family members and neighbors who can help.

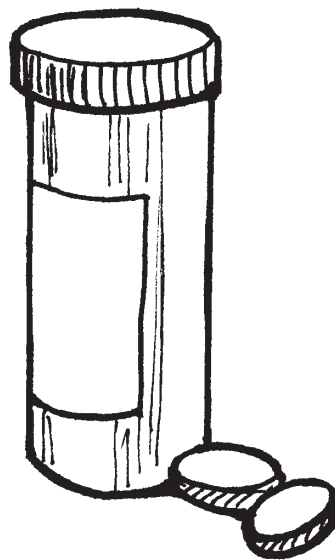
# How to care for someone with psychosis



Psychosis affects the whole family.



Share information with the psychologist/social worker.

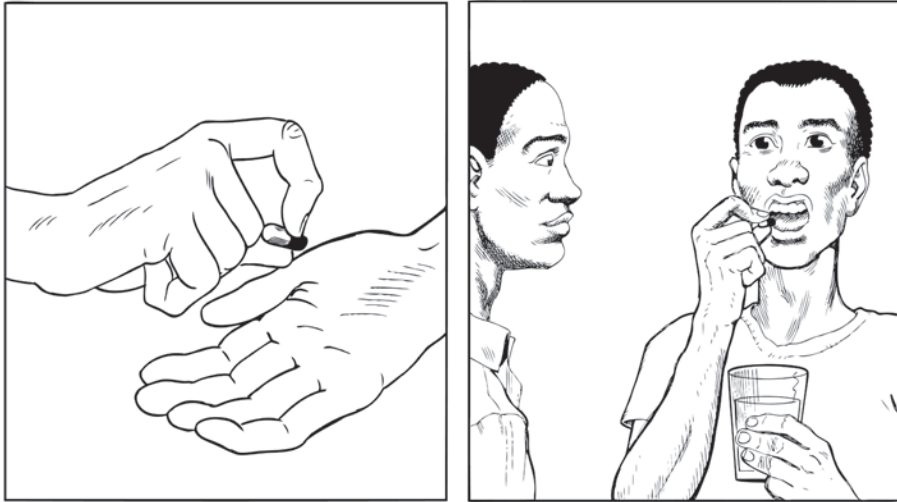


Taking medication is important.

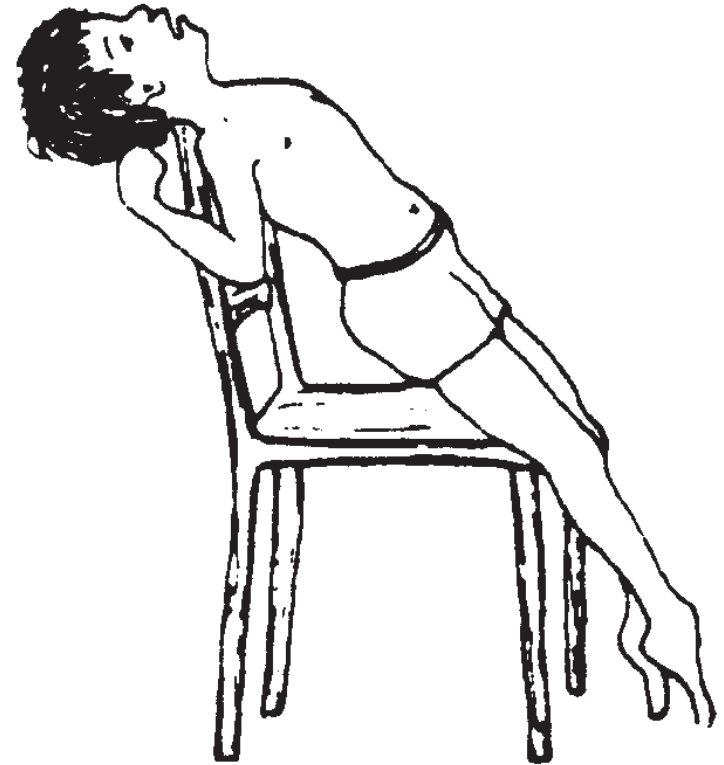
# Confirmed Diagnosis of Psychosis (Visit 1)

- Give psychoeducation messages about medication.
- Check adherence to the medication; check for side effects of medication.
- Check follow-up with psychologist/social worker and physician.
- Ask families to share all information with psychologist/social worker.
- Check the impact of the illness on the family.
- If there is enough time, proceed to the psychoeducation messages for Visit 2.

# Taking medication and potential side effects



The medication that the patient is taking for psychosis can have secondary effects.



Medication can have dangerous side effects.

# Medication

- Patients must take medications everyday, exactly as the doctor prescribed.
- Families must choose one person in the family to be responsible for keeping medication and for giving it to the patient.
- A family member must watch the patient take the pill and swallow it.
- If the patient refuses medication, the family must take the patient to see the psychologist and physician.
- Medications for psychosis can take weeks, even months to work.
- If the family member becomes pregnant or is breastfeeding, take her to the psychologist/doctor immediately but do not stop the medication.
- Families should tell the psychologist and physician about side effects.
- Dangerous side effects include:
  - Muscle rigidity (potentially including: eye muscles, throat, neck, tongue, back).
  - Confusion, delirium, stiffness (rigidity), sweating, hyperpyrexia, autonomic instability, drooling; death.
  - Rashes, jaundice.

# Continue adherence and follow up



There is treatment for people with mental illness.



A supportive family environment will help the patient.



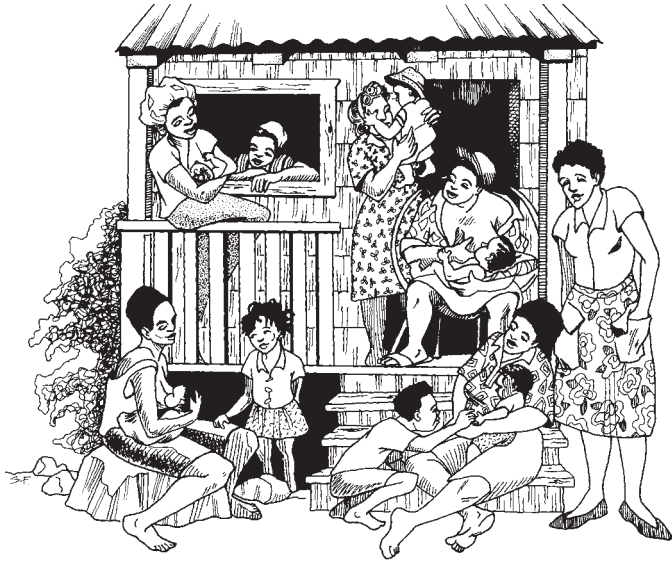
It's important to adhere to medication.

# Confirmed Diagnosis (Visit 2)

- Check adherence to the medication; check for side effects of medication.
- Check follow-up with psychologist and physician.
- Separate the illness from the person.
- Give hope about the illness.
- Challenge hope and helplessness by explaining to family what they can do to help the patient.
- Discuss with the family how to create a supportive environment.
- Discuss the role of the family in supporting the patient's treatment (medication, appointment, activities, daily schedule).



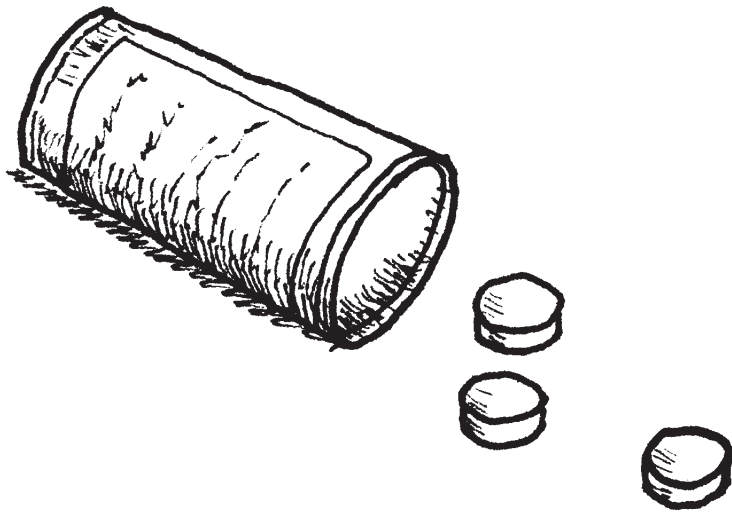
# Continuous support of patient and family



Continue a supportive environment.



Follow up with physician and psychologist/social worker.



Continue supporting the patient's treatment.



Identify family/neighbors who can help.



# Stable or Improved

- Check adherence to the medication; check for side effects of medication.
- Check follow-up with psychologist and physician.
- Check whether family has identified other family/neighbors who can help.
- Check whether family has created a supportive environment at home.
- Check whether the family is supporting the patient's treatment.
- Plan relapse prevention drill.

# Relapse prevention drill

Prevent Relapse:



Suicide



Psychosis



Depression

# Relapse Prevention Drill

## RELAPSE PREVENTION DRILL

1. Name four things family can do to prevent illness:

- a.
- b.
- c.
- d.

2. List four signs your family member may be getting sick again:

- a.
- b.
- c.
- d.

3. What is your plan if the patient stops taking medication?

4. What is your plan if the patient becomes agitated/violent?

5. Which people will help you with this plan?

Take the patient to the clinic/hospital \_\_\_\_\_

Take care of the children \_\_\_\_\_

Other people who will help:

- a.
- b.

# MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM



Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Recipient (Provider): \_\_\_\_\_

Recipient's telephone: \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Last Name: \_\_\_\_\_

Dossier Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Principal Symptoms: \_\_\_\_\_

<b>Reasons/Diagnostic Impressions:</b> <ul style="list-style-type: none"><li>• Psychological trauma</li><li>• Sexual abuse</li><li>• Suicide attempt</li><li>• Psychiatric emergency</li><li>• Mental confusion</li><li>• Psychosis/bipolar disorder</li><li>• Behavioral disorders</li><li>• Somatoform disorders</li><li>• Affective disorders<ul style="list-style-type: none"><li>• Enuresis</li><li>• Encopresis</li></ul></li><li>• Learning disorder</li><li>• Mental retardation</li><li>• Addiction</li><li>• Epilepsy</li><li>• Depression</li><li>• Depression and migraines</li><li>• Other: _____</li></ul>	<b>Services requested:</b> <ul style="list-style-type: none"><li>• Psychological Evaluation</li><li>• Psychotherapies<ul style="list-style-type: none"><li>• Grief, supportive</li><li>• Interpersonal therapy</li></ul></li><li>• Psychotraumatology</li><li>• Counseling<ul style="list-style-type: none"><li>• Pre-Operative</li><li>• Post-Operative</li><li>• Post-test</li><li>• Follow-up</li><li>• Adherence</li><li>• Pre-HAART</li></ul></li><li>• Other: _____</li><li>• <b>IMPORTANT HISTORY:</b> _____ _____</li></ul>
--	---

Signature of referring provider: \_\_\_\_\_

Mental health provider that received the referral: \_\_\_\_\_

Date of receipt: \_\_\_\_\_ Time: \_\_\_\_\_

Remarks: \_\_\_\_\_

Signature: \_\_\_\_\_

**STEP 1** Warning signs that a crisis is developing (such as thoughts, images, moods, situations, behavior):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 2** Internal coping strategies – activities that I can do without others to distract myself from my problems, such as relaxation techniques:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 3** People and social environments that offer distractions and support:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Where \_\_\_\_\_ Where \_\_\_\_\_

**Step 4** People I can ask to help me:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 5** Professionals and agencies I can contact during a crisis:

- Community Health Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Ajan Sante \_\_\_\_\_ Telephone \_\_\_\_\_
- Social Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Psychologist \_\_\_\_\_ Telephone \_\_\_\_\_
- Doctor \_\_\_\_\_ Telephone \_\_\_\_\_
- Spiritual Healer \_\_\_\_\_ Telephone \_\_\_\_\_
- Emergency Room/Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 6** Making the environment safe:

\_\_\_\_\_  
\_\_\_\_\_

*I, \_\_\_\_\_, will follow the steps when I'm in a crisis,  
and one thing more important to me than anything else that will help me live is... \_\_\_\_\_*

## STIGMA ASSESSMENT ACTIVITY

Sadrak is a 22 year old man. He is terrified of the dark and refuses to sleep alone at night. He believes that someone is coming to get him the minute that he shuts his eyes and because of that Sadrak always sleeps with a knife under his pillow. Ever since the age of 17 Sadrak has shown signs of a mental illness. He often sees and hears things that are not present and spends majority of his day talking to himself or throwing rocks at people. Because of that, Sadrak doesn't have any friends and everyone in the community is afraid of him.

PART 1			
	Disagree	Neither agree nor disagree	Agree
People choose to live like this and can change if they want			
The problem is that he has a weak mind or little brain			
This problem is not really a medical problem			
This person is dangerous			
It is best to avoid people with problems like this so you can avoid having the same problem			
You never can tell what a person acting like this will do			
If I had a problem like this, I wouldn't tell anyone			
I would not like to work with someone with this problem			
I would not choose this person as a leader			

PART 2		
	Yes	No
Would you like to be the neighbor of this person?		
Would you like to spend time with or date this person?		
Would you like to develop a friendship with this person?		
Would like to work closely with this person?		
Would you like it if someone like that married a member of your family?		

**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY SCREENING INSTRUMENT**



LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
<b>1. Passive</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you have any thoughts of ending your life, even if they are not clear in your mind?</p> <p><b>Possible Response:</b> I think about it from time to time, but I've never acted upon it...I would make my family feel too bad...God would not forgive me</p>	Description:	
<b>2. Non-Specific Active</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you want to die? Do you often think or talk about death?</p> <p><b>Possible Response:</b> desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me</p>	Description:	
<b>3. Methods but no Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> If you would do it, how would you do it?</p> <p><b>Possible Response:</b> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</p>	Description:	
<b>4. Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you intend to act on these thoughts?</p> <p><b>Possible Response:</b> I will kill myself but I do not know when... I do not think I can do so now...but it's too much for me, I cannot yet</p>	Description:	
<b>5. Planification</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you started planning the details about how you will kill yourself?</p> <p><b>Danger Signs:</b> there is a sudden change in attitude, withdraws from everything; not interested in anything; say: "when I am not here anymore"; seeks to implement the plan, write a note (on paper).</p>	Description:	
<b>6. Attempted</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you tried to do something that could hasten the end of your life? Have you stopped preserving your life, like not eating and not taking medication?</p> <p><b>Danger Signs:</b> Realized did not want to die after the attempt failed, but it often gets worse again after a few days; might have some injuries or marks.</p>	Description:	
<p>Low: Current = 0 Past = 0</p> <p>Medium: Current = 1–2 yes OR Past = 1 or more yes</p> <p>High: Current = 3 or more yes OR Past = 3 or more yes</p>	<p>Total "yes" in past two weeks</p> <input type="checkbox"/>	<p>Total "yes" in past year</p> <input type="checkbox"/>

Provider: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ File #: \_\_\_\_\_

For ALL Patients	
Act	1. <input type="checkbox"/> Ensure that the environment will be private, safe and non-threatening. 2. <input type="checkbox"/> Begin the process of ensuring that the patient will be able to access necessary medication. 3. <input type="checkbox"/> Always work with the patient to develop a Safety Plan.
Say	4. <input type="checkbox"/> Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. <input type="checkbox"/> Start IPT and collect IP inventory. 6. <input type="checkbox"/> Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. <input type="checkbox"/> Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). <i>(Write this on the copy of your Safety Plan, on the back side).</i>
Contact	8. <input type="checkbox"/> Always contact at least one person close to the patient to support and monitor them. 9. <input type="checkbox"/> Contact as many of the current and potential supports as a patient will permit <ul style="list-style-type: none"> <li>• <input type="checkbox"/> You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients</li> <li>• When involving anyone, ensure that you preserve confidentiality if possible and define these:                             <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Depression, suicidality</li> <li>2. <input type="checkbox"/> The needs of such patients</li> <li>3. <input type="checkbox"/> How others can help</li> <li>4. <input type="checkbox"/> How others can hurt</li> </ol> </li> </ul>
Team	10. Consult and involve colleagues to help. <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Doctor <input type="checkbox"/> _____
Follow Up	11. If the patient has a <b>higher</b> risk level, continue to the guidelines <b>below</b> .



**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY TREATMENT GUIDELINES**

For patients with <b>MEDIUM</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. <input type="checkbox"/> Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur. 3. <input type="checkbox"/> Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. <input type="checkbox"/> Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. <input type="checkbox"/> At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.
Follow Up	6. If the patient is medium risk, schedule follow-up within 7 days. <b>Date</b> _____ <b>Time</b> _____ If the patient is <b>high</b> risk, continue to the guidelines <b>below</b> .
For patients with <b>HIGH</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. 2. <input type="checkbox"/> Seek to admit patient to the emergency room or another service with beds for at least 24 hours. 3. <input type="checkbox"/> Determine who will be available to watch the patient and when so that they are not left unattended. Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____
Say	4. <input type="checkbox"/> Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. <input type="checkbox"/> Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here). 6. <input type="checkbox"/> Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. <input type="checkbox"/> MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). 8. <input type="checkbox"/> Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. <input type="checkbox"/> Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). 10. <input type="checkbox"/> Frequently re-assess risk level. 11. <input type="checkbox"/> If the patient leaves or can't be kept, follow through with continued intensive psychosocial activation.



## Section 3 Preamble

### **Say to respondent:**

The interview is about difficulties people have because of health conditions.

### **Hand flashcard #1 to respondent**

By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

### **Point to flashcard #1**

- Increased effort
- Discomfort or pain
- Slowness
- Changes in the way you do the activity.

When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

### **Hand flashcard #2 to respondent**

Use this scale when responding.

### **Read scale aloud:**

None, mild, moderate, severe, extreme or cannot do.

**Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview**

**Please continue to next page...**



## Section 4 Core questions

### Show flashcard #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S1	<a href="#">Standing for long periods</a> such as <a href="#">30 minutes</a> ?	1	2	3	4	5
S2	Taking care of your <a href="#">household responsibilities</a> ?	1	2	3	4	5
S3	<a href="#">Learning a new task</a> , for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have <a href="#">joining in community activities</a> (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have <a href="#">you</a> been <a href="#">emotionally affected</a> by your health problems?	1	2	3	4	5

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S6	<a href="#">Concentrating</a> on doing something for <a href="#">ten minutes</a> ?	1	2	3	4	5
S7	<a href="#">Walking a long distance</a> such as a <a href="#">kilometre</a> [or equivalent]?	1	2	3	4	5
S8	<a href="#">Washing your whole body</a> ?	1	2	3	4	5
S9	Getting <a href="#">dressed</a> ?	1	2	3	4	5
S10	<a href="#">Dealing with people you do not know</a> ?	1	2	3	4	5
S11	<a href="#">Maintaining a friendship</a> ?	1	2	3	4	5
S12	Your day-to-day <a href="#">work/school</a> ?	1	2	3	4	5

H1	Overall, in the past 30 days, <a href="#">how many days</a> were these difficulties present?	<i>Record number of days</i> ____
H2	In the past 30 days, for how many days were you <a href="#">totally unable</a> to carry out your usual activities or work because of any health condition?	<i>Record number of days</i> ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <a href="#">cut back</a> or <a href="#">reduce</a> your usual activities or work because of any health condition?	<i>Record number of days</i> ____

This concludes our interview. Thank you for participating.



# **WHODAS 2.0**

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 1*

## **Health conditions:**

- **Diseases, illnesses or other health problems**
- **Injuries**
- **Mental or emotional problems**
- **Problems with alcohol**
- **Problems with drugs**

## **Having difficulty with an activity means:**

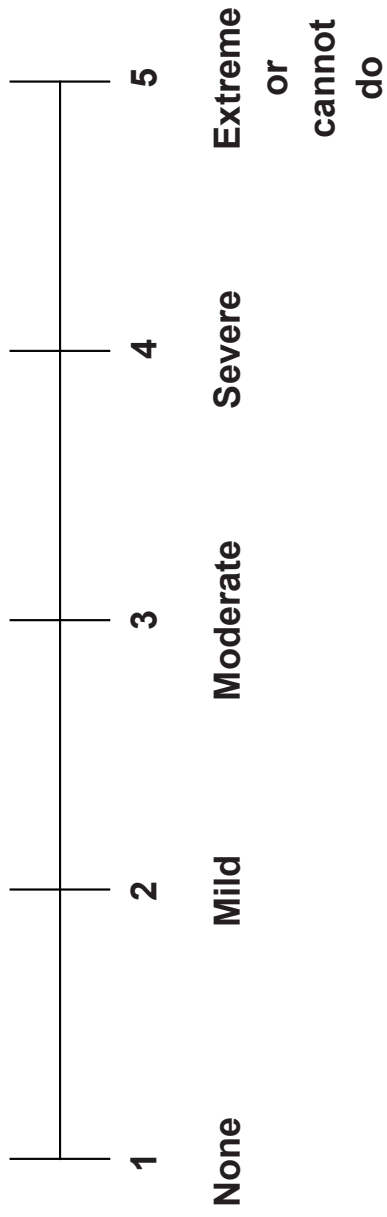
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

**Think about the past 30 days only.**

# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 2*



# ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Date dd/mm/yy

	Pandan 15 jou ki sòt pase la yo, konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Di tou	Konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Pandan kèk jou (1–5 jou)	Plis pase yon semèn (6–9 jou)	Preske chak jou (10–15 jou)
<b>1</b>	Santi ou de la la.	0	—	1	2	3
<b>2</b>	Santi kè sere.	0	—	1	2	3
<b>3</b>	Kalkile twòp.	0	—	1	2	3
<b>4</b>	Kriye oubyen anvi kriye	0	—	1	2	3
<b>5</b>	Santi anyen preske pa enterese ou.	0	—	1	2	3
<b>6</b>	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
<b>7</b>	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
<b>8</b>	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
<b>9</b>	Ou pa gen apeti.	0	—	1	2	3
<b>10</b>	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
<b>11</b>	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
<b>12</b>	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
<b>13</b>	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
<b>Totals</b>				<b>(+)</b>	<b>(+)</b>	

**(=) ZLDSI Score** \_\_\_\_\_

# **CHILD AND ADOLESCENT MENTAL HEALTH**

Tools for use in an integrated, community-based mental health system of care

# CES-D

**INSTRUCTIONS:** Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week: (check one box on each line).

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1 – 2 days)	Occasionally or a moderate amount of time (3 – 4 days)	All of the time (5 – 7 days)	Score – Adult Use Only (1 – 4)
1. I was bothered by things that usually don't bother me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
2. I did not feel like eating; my appetite was poor.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
3. I felt that I could not shake off the blues even with help from my family.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
4. I felt that I was just as good as other people.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
5. I had trouble keeping my mind on what I was doing.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
6. I felt depressed.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
7. I felt that everything I did was an effort.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
8. I felt hopeful about the future.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
9. I thought my life had been a failure.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
10. I felt fearful.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
11. My sleep was restless.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
12. I was happy.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
13. I talked less than usual.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
14. I felt lonely.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
15. People were unfriendly.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
16. I enjoyed life.	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
17. I had crying spells.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
18. I felt sad.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
19. I felt that people disliked me.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
20. I could not "get going".	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
<b>Total (out of 80)</b>					



**CLINICAL GLOBAL IMPRESSIONS SCALE**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Psychologist / SW: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Age: \_\_\_\_\_

Male/ Female (circle one)

Phone #1: \_\_\_\_\_

Town: \_\_\_\_\_

Phone #2: \_\_\_\_\_

District: \_\_\_\_\_

Session#: \_\_\_\_\_

Date received patient info: \_\_\_\_\_

**I. Severity of Illness**

Considering your total clinical experience with this particular population, how mentally ill has the patient been over the past 7 days?

**Tip:** Compare relative to your past experience with patients who have the same diagnosis considering your total clinical experience with this population.

**0 = Not assessed****1 = Normal, not at all ill.**

Symptoms of disorder have not been present in the past seven days.

**2 = Borderline mentally ill.**

Subtle or suspected symptoms within the past seven days. No definable impact on behavior or function.

**3 = Mildly ill.**

Clearly established symptoms causing minimal, if any, distress or difficulty in social or occupational function.

**4 = Moderately ill.**

Overt symptoms causing noticeable, but modest, functional impairment or distress. There is evidence of functional interference in multiple settings. Some symptoms may warrant medication.

**5 = Markedly ill.**

Intrusive symptoms that distinctly impair social or occupational function or cause intrusive levels of distress. Functional interference due to symptoms is obvious to others.

**6 = Severely ill.**

Disruptive pathology; behavior and function are frequently influenced by symptoms. Dysfunction may require assistance from others.

**7 = Among the most extremely ill patients.**

Pathology drastically interferes in many life functions. Patient may need to be hospitalized.

**Rating**  
(Number 0–7)

## II. Improvement

Compared to the patient's baseline condition before treatment, how much has the patient changed?

### Tips:

For initial evaluation: if the patient has been in treatment previously, rate CGI Improvement based on the history and compared to the patient's condition prior to treatment. Otherwise, leave blank.

Progress Notes: Rate improvement by comparing the current condition to the patient's condition at the initiation of the current treatment plan. Assess how much the patient's illness has changed relative to a baseline state at the beginning of the treatment plan based on the first evaluation. Rate total improvement whether or not in your judgment it is due to treatment.

**0 = Not assessed**

**1 = Very much improved.**

Nearly all better; good level of functioning; minimal symptoms; represents a very substantial change.

**2 = Much improved.**

Notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain.

**3 = Minimally improved.**

Slightly better with little or no clinically meaningful reduction of symptoms. May represent very little change in basic clinical status, level of care, or functional capacity.

**4 = No change.**

Symptoms remain essentially unchanged.

**5 = Minimally worse.**

Slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity.

**6 = Much worse.**

Clinically significant increase in symptoms and diminished functioning.

**7 = Very much worse.**

Severe exacerbation of symptoms and loss of functioning.

**Rating**  
(Number 0–7)

## III. Side Effects

Select the terms that best describe the degree of side effects of medication treatment.

**0 = None**

**1 = Do not significantly interfere with patient's functioning.**

**2 = Significantly interfere with patient's functioning.**

**3 = Outweighs therapeutic effects with patient's functioning.**

**Rating**  
(Number 0–3)

# INITIAL MENTAL HEALTH EVALUATION

*Partners In Health Mental Health & Psychosocial Services*



Record Number: \_\_\_\_\_ EMR Number: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Site : \_\_\_\_\_

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Sex:  M  F Date of Birth (Day/Month/Year): \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Commune: \_\_\_\_\_ Profession: \_\_\_\_\_ Telephone: \_\_\_\_\_

Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Name of Community Health Worker/Telephone: \_\_\_\_\_

---

**Chief Complaint** (in the patient's own words):

**History of Present Illness** (Date of symptom onset, precipitants, course, any prior treatment):

## PSYCHIATRIC REVIEW OF SYSTEMS

DEPRESSION	MANIA	ANXIETY	PSYCHOSIS
<ul style="list-style-type: none"> <li>• Have you felt sad or lost interest in things for a two week period?</li> <li>• Do you feel like you've lost interest in everything or only in some things?</li> <li>• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39</li> </ul>	<ul style="list-style-type: none"> <li>• Did you feel very happy for any reason in the last few days?</li> <li>• Did you get angry more often in the last few days?</li> <li>• Do you:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Have any difficulties of staying attentive?</li> <li><input type="checkbox"/> Speak of things that you shouldn't?</li> <li><input type="checkbox"/> Feel like you're worth more than before?</li> <li><input type="checkbox"/> Have a racing thoughts going through your head?</li> <li><input type="checkbox"/> Have an increase in activities?</li> <li><input type="checkbox"/> Sleep less?</li> <li><input type="checkbox"/> Talk without ceasing?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Are you a worrier?</li> <li>• What do you worry about?</li> <li>• Are you experiencing:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Fear of crowded places</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Muscle tension</li> <li><input type="checkbox"/> Restlessness</li> </ul> </li> <li>• Do you often experience any 4 of these problems such as:               <ul style="list-style-type: none"> <li><input type="checkbox"/> increased in heartbeat</li> <li><input type="checkbox"/> breathlessness</li> <li><input type="checkbox"/> sweating</li> <li><input type="checkbox"/> trembling</li> <li><input type="checkbox"/> fear; fear of losing control; fear of becoming crazy; fear of death</li> <li><input type="checkbox"/> feeling dizzy</li> <li><input type="checkbox"/> feel like you're losing consciousness</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Do you hear things like voices that other people don't hear?</li> <li>• Do you see things that other people don't see?</li> <li>• Do you feel that people are conspiring to harm you – even people whom you don't know?</li> <li>• Are the voices in your head controlling your thought process?</li> </ul>

	SUICIDE		VIOLENCE/HOMICIDE	
	Have you ever thought of causing harm to yourself or committing suicide in the past? What about now?		Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?	
	Ideation	Attempts	Ideation	Acts
Past	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, explain \_\_\_\_\_

Do you have a plan?  Yes  No      Are there guns or other weapons in the household?  Yes  No

SUBSTANCE ABUSE						
Do you use any of the following?						
	Beer	Home Brew	Liquor	Tobacco	Marijuana	Cocaine
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, explain quantity, first use, last use: \_\_\_\_\_

Need to cut down?       Annoyed or angered by others who comment on your use?       Guilty about using?   
 In order to function properly, do you need to take that substance before starting your day?

TRAUMA						
Did you ever experience a trauma, such as physical, sexual, or emotional abuse, that is impacting your current functioning?						
	Physical	Emotional	Sexual	Re-experiencing	Hyperarousal	Avoidance
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: \_\_\_\_\_

Do you feel safe in your current environment? \_\_\_\_\_

## PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
<input type="checkbox"/> Are you experiencing pain in your body?	<ul style="list-style-type: none"> <li>• Is there a change in your:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight?</li> <li><input type="checkbox"/> Thirst?</li> <li><input type="checkbox"/> Fever?</li> </ul> </li> </ul>	<input type="checkbox"/> Sight problems?  <input type="checkbox"/> Hearing problems?  <input type="checkbox"/> Voice change?  <input type="checkbox"/> Dizziness?  <input type="checkbox"/> Gum and teeth status?  <input type="checkbox"/> Difficulty swallowing?	<input type="checkbox"/> Stiffness of the neck?
BREATHING	HEART/ARTERIES	DIGESTIVE SYSTEM	SKIN
<input type="checkbox"/> Are you having problems breathing?  <input type="checkbox"/> Are you coughing?  <input type="checkbox"/> Do you cough out blood or find blood in your snot?	<input type="checkbox"/> Do you have an increased heartbeat?  <input type="checkbox"/> Having chest pain?  <input type="checkbox"/> Any swelling?	<input type="checkbox"/> Heart burn?  <input type="checkbox"/> Gastric Reflux?  <input type="checkbox"/> Vomiting?  <input type="checkbox"/> Constipation, diarrhea, gas?	<input type="checkbox"/> Any changes in your skin?
MUSCLES	APPENDAGES (HANDS AND FEET)	GENITALS/URINATION	NEUROLOGICAL
<input type="checkbox"/> Are they stiff?  <input type="checkbox"/> Swollen?  <input type="checkbox"/> Reddened?	<input type="checkbox"/> Swollen?	<input type="checkbox"/> Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?  <input type="checkbox"/> Any problems when urinating (pain, amount/ color of urine, blood in urine)?	<input type="checkbox"/> Any numbness?  <input type="checkbox"/> Uncontrolled movements?

## PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

### Psychiatric Family History:

---

### Past Medical History and Active Medical Problems

Head Injury:

Last Date Of Menstruation: \_\_\_ / \_\_\_ / \_\_\_

Loss Of Consciousness:

Other Things:

---

### Medication/Allergies/Side Effects:

---

### Medical Family History:

---

**Social/Cultural History** (include childhood family configuration, urban or rural setting, level of education, romantic relationships, and occupation or other means of financial support):

### Legal Problems:

## PHYSICAL EXAM (PHYSICIAN)

Vital Signs: \_\_\_\_\_

HEENT: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Cardio-vascular: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitals: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_

## NEUROLOGIC EXAM (PHYSICIAN)

Cranial nerves II to XII Intact  If impaired, specify \_\_\_\_\_

Motor: \_\_\_\_\_

Pronator drift: \_\_\_\_\_

Sensory: \_\_\_\_\_

Vibration: \_\_\_\_\_ Position: \_\_\_\_\_

Reflexes: DTR \_\_\_\_\_ Clonus \_\_\_\_\_ Babinsky \_\_\_\_\_

Coordination and Gait: Rapid alternating movements \_\_\_\_\_ Nose finger test \_\_\_\_\_

Romberg \_\_\_\_\_ Gait \_\_\_\_\_ Heel toe walk test \_\_\_\_\_

## MENTAL STATUS EXAM

General Appearance	<input type="checkbox"/> well groomed	<input type="checkbox"/> disheveled	<input type="checkbox"/> overdressed, elaborate
Orientation	<input type="checkbox"/> O x 3	<input type="checkbox"/> disoriented to time	<input type="checkbox"/> disoriented to place <input type="checkbox"/> disoriented to person
Behavior	<input type="checkbox"/> WNL <input type="checkbox"/> tics	<input type="checkbox"/> retardation	<input type="checkbox"/> agitation <input type="checkbox"/> tremor
Speech	<input type="checkbox"/> WNL	<input type="checkbox"/> slowed	<input type="checkbox"/> pressured <input type="checkbox"/> slurred
Mood	<input type="checkbox"/> _____		
Affect	<input type="checkbox"/> euthymic <input type="checkbox"/> irritable <input type="checkbox"/> congruent with speech content	<input type="checkbox"/> dysphoric <input type="checkbox"/> suspicious <input type="checkbox"/> incongruent with speech content	<input type="checkbox"/> euphoric <input type="checkbox"/> labile <input type="checkbox"/> other: _____ <input type="checkbox"/> anxious <input type="checkbox"/> flat



## MENTAL STATUS EXAM CONTINUED

Thought Process	<input type="checkbox"/> linear <input type="checkbox"/> tangential <input type="checkbox"/> perseverative <input type="checkbox"/> illogical <input type="checkbox"/> loose associations <input type="checkbox"/> _____
Thought Content	<input type="checkbox"/> WNL <input type="checkbox"/> vague <input type="checkbox"/> persistent preoccupation with: <input type="checkbox"/> suicidal ideation <input type="checkbox"/> homicidal ideation Delusions: <input type="checkbox"/> none <input type="checkbox"/> paranoid <input type="checkbox"/> grandiose <input type="checkbox"/> other: _____ Perceptual Disturbances/Hallucinations: <input type="checkbox"/> none <input type="checkbox"/> auditory <input type="checkbox"/> visual <input type="checkbox"/> olfactory <input type="checkbox"/> gustatory <input type="checkbox"/> tactile
Insight:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good
Judgment/Impulse Control:	<input type="checkbox"/> poor <input type="checkbox"/> limited <input type="checkbox"/> good

**General Impressions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### BIOPSYCHOSOCIAL FORMULATION (including patient's strengths and coping strategies):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DIAGNOSIS:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

### PLAN:

#### Psychological Treatment Plan

##### Treatment Goals

1. Goal: \_\_\_\_\_

2. Goal: \_\_\_\_\_

3. Goal: \_\_\_\_\_

**Intervention**

- Interpersonal Psychotherapy (IPT)
- Medication
- Behavioral Activation
- Psychoeducation
- Parent/Family Supportive Therapy
- Other \_\_\_\_\_
- Relaxation Training
- Supportive Psychotherapy
- Grief Support
- Parent Skills Training

**Frequency**

- Once per week
- Bi-weekly
- Once per month

**Number of Sessions:**

- 4–6 sessions
- 6–8 sessions
- 8–10 sessions
- 10–12 sessions

Primary Clinician: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

**Referrals**

**CHW**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Social Worker**

Name: \_\_\_\_\_ Appointment Date: \_\_\_ / \_\_\_ / \_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

**Other Plan: (follow-up with family, etc.)**

\_\_\_\_\_  
\_\_\_\_\_

**FOLLOW-UP**

**Psychiatric Medication**

Medication	Dose	Frequency	Quantity	Refill Date
Risperidone				
Haloperidol				
Diazepam				
Carbamazepine				
Valporic Acid				
Other: _____				

**Hospitalization:**

Date of Admission: \_\_\_ / \_\_\_ / \_\_\_

Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_



# Partners In Health

Department of Mental Health & Psychosocial Services

## Mental Health Follow-Up Form

File Number:

\_\_\_\_\_

EMR Number:

\_\_\_\_\_

Location:

\_\_\_\_\_

Date:

\_\_\_ / \_\_\_ / \_\_\_

Name of CHW: \_\_\_\_\_ Number of visits: \_\_\_\_\_ Date of last visit: \_\_\_ / \_\_\_ / \_\_\_

### Patients' Demographic Data

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Last Name: \_\_\_\_\_

Sex:  M  F

Address: \_\_\_\_\_

Change in phone number:  Yes  No

Date of Birth: DD/MM/YYYY

Age: \_\_\_\_\_

### 1. Initial Diagnosis

Initial Diagnosis: \_\_\_\_\_

Contacts since the last visit:

Patient  Parent  Family  Medication  CHW  Other \_\_\_\_\_

### 2. Evolution: (Comment on symptoms, aggravation and improvement, location, quality, severity, duration, schedule, context, modifying factors, and coping strategies):

### 3. Ongoing psychotherapy (Progress)

ZLDSI score for depression (if present): \_\_\_\_\_

Date of last menstrual period: DD/MM/YYYY \_\_\_\_\_

Current medications  Yes  No

Medication/s	Dose/Freq	Side Effects	Comments
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Inc	_____

### 4. Mental Status Examination

General appearance wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to self, suicidal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor introspection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Danger to others	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought process wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety, phobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle tone and strength	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thought content wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor judgement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive function wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Affect wnl	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Observations from the mental health examination:

\_\_\_\_\_

**5. Positive results from the physical examination/labs (PHYSICIANS):**

**6. Diagnosis (DSM-IV):**

**7. Response to recent interventions:**

**8. Interventions in the current session (I), Future treatment plan (P)**

<input type="checkbox"/> Interpersonal therapy, session # _____ <input type="checkbox"/> Active listening <input type="checkbox"/> Reinforcement of alliance <input type="checkbox"/> Encouragement/support <input type="checkbox"/> Psychoeducation <input type="checkbox"/> Identify/express feelings <input type="checkbox"/> Discuss issues of protection <input type="checkbox"/> Evaluation/Safety planning <input type="checkbox"/> Relaxation <input type="checkbox"/> Acupuncture	<input type="checkbox"/> Discuss medication <input type="checkbox"/> Review social activities <input type="checkbox"/> Identify family roles <input type="checkbox"/> Work on communication <input type="checkbox"/> Explore conflicts <input type="checkbox"/> Work on resources <input type="checkbox"/> Work on a plan of change <input type="checkbox"/> Therapeutic plan/social activities <input type="checkbox"/> Cognitive behavioral therapy <input type="checkbox"/> Anger management	<input type="checkbox"/> Controlling motivations <input type="checkbox"/> Emotional regulation <input type="checkbox"/> Behavioral regulation <input type="checkbox"/> Training for self-control <input type="checkbox"/> Develop a behavior plan <input type="checkbox"/> Cognitive intervention <input type="checkbox"/> Sensory response <input type="checkbox"/> Plan/review progress <input type="checkbox"/> Collaborate with other clinicians <input type="checkbox"/> Other _____ _____ _____
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**9. Intervention of Social Worker**

**10. Other recommendations (if necessary)**

**11. Plan**

Plan discussed with patient and he (she) approves:  Yes If  No, explain:

Name of the person completing the evaluation: \_\_\_\_\_ Date: \_\_\_\_\_

# MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM



Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Recipient (Provider): \_\_\_\_\_

Recipient's telephone: \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Last Name: \_\_\_\_\_

Dossier Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Principal Symptoms: \_\_\_\_\_

<b>Reasons/Diagnostic Impressions:</b> <ul style="list-style-type: none"><li>• Psychological trauma</li><li>• Sexual abuse</li><li>• Suicide attempt</li><li>• Psychiatric emergency</li><li>• Mental confusion</li><li>• Psychosis/bipolar disorder</li><li>• Behavioral disorders</li><li>• Somatoform disorders</li><li>• Affective disorders<ul style="list-style-type: none"><li>• Enuresis</li><li>• Encopresis</li></ul></li><li>• Learning disorder</li><li>• Mental retardation</li><li>• Addiction</li><li>• Epilepsy</li><li>• Depression</li><li>• Depression and migraines</li><li>• Other: _____</li></ul>	<b>Services requested:</b> <ul style="list-style-type: none"><li>• Psychological Evaluation</li><li>• Psychotherapies<ul style="list-style-type: none"><li>• Grief, supportive</li><li>• Interpersonal therapy</li></ul></li><li>• Psychotraumatology</li><li>• Counseling<ul style="list-style-type: none"><li>• Pre-Operative</li><li>• Post-Operative</li><li>• Post-test</li><li>• Follow-up</li><li>• Adherence</li><li>• Pre-HAART</li></ul></li><li>• Other: _____</li><li>• <b>IMPORTANT HISTORY:</b> _____ _____</li></ul>
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Signature of referring provider: \_\_\_\_\_

Mental health provider that received the referral: \_\_\_\_\_

Date of receipt: \_\_\_\_\_ Time: \_\_\_\_\_

Remarks: \_\_\_\_\_

Signature: \_\_\_\_\_

**STEP 1** Warning signs that a crisis is developing (such as thoughts, images, moods, situations, behavior):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 2** Internal coping strategies – activities that I can do without others to distract myself from my problems, such as relaxation techniques:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

**STEP 3** People and social environments that offer distractions and support:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Where \_\_\_\_\_ Where \_\_\_\_\_

**Step 4** People I can ask to help me:

- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_
- Name \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 5** Professionals and agencies I can contact during a crisis:

- Community Health Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Ajan Sante \_\_\_\_\_ Telephone \_\_\_\_\_
- Social Worker \_\_\_\_\_ Telephone \_\_\_\_\_
- Psychologist \_\_\_\_\_ Telephone \_\_\_\_\_
- Doctor \_\_\_\_\_ Telephone \_\_\_\_\_
- Spiritual Healer \_\_\_\_\_ Telephone \_\_\_\_\_
- Emergency Room/Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

**STEP 6** Making the environment safe:

\_\_\_\_\_  
\_\_\_\_\_

*I, \_\_\_\_\_, will follow the steps when I'm in a crisis,  
and one thing more important to me than anything else that will help me live is... \_\_\_\_\_*

**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY SCREENING INSTRUMENT**



LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
<b>1. Passive</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you have any thoughts of ending your life, even if they are not clear in your mind?</p> <p><b>Possible Response:</b> I think about it from time to time, but I've never acted upon it...I would make my family feel too bad...God would not forgive me</p>	Description:	
<b>2. Non-Specific Active</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you want to die? Do you often think or talk about death?</p> <p><b>Possible Response:</b> desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me</p>	Description:	
<b>3. Methods but no Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> If you would do it, how would you do it?</p> <p><b>Possible Response:</b> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</p>	Description:	
<b>4. Intent to Act</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Do you intend to act on these thoughts?</p> <p><b>Possible Response:</b> I will kill myself but I do not know when... I do not think I can do so now...but it's too much for me, I cannot yet</p>	Description:	
<b>5. Planification</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you started planning the details about how you will kill yourself?</p> <p><b>Danger Signs:</b> there is a sudden change in attitude, withdraws from everything; not interested in anything; say: "when I am not here anymore"; seeks to implement the plan, write a note (on paper).</p>	Description:	
<b>6. Attempted</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p><b>Ask:</b> Have you tried to do something that could hasten the end of your life? Have you stopped preserving your life, like not eating and not taking medication?</p> <p><b>Danger Signs:</b> Realized did not want to die after the attempt failed, but it often gets worse again after a few days; might have some injuries or marks.</p>	Description:	
<p>Low: Current = 0 Past = 0</p> <p>Medium: Current = 1–2 yes OR Past = 1 or more yes</p> <p>High: Current = 3 or more yes OR Past = 3 or more yes</p>	<p>Total "yes" in past two weeks</p> <input type="checkbox"/>	<p>Total "yes" in past year</p> <input type="checkbox"/>

Provider: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ File #: \_\_\_\_\_

For ALL Patients	
Act	1. <input type="checkbox"/> Ensure that the environment will be private, safe and non-threatening. 2. <input type="checkbox"/> Begin the process of ensuring that the patient will be able to access necessary medication. 3. <input type="checkbox"/> Always work with the patient to develop a Safety Plan.
Say	4. <input type="checkbox"/> Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. <input type="checkbox"/> Start IPT and collect IP inventory. 6. <input type="checkbox"/> Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. <input type="checkbox"/> Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). <i>(Write this on the copy of your Safety Plan, on the back side).</i>
Contact	8. <input type="checkbox"/> Always contact at least one person close to the patient to support and monitor them. 9. <input type="checkbox"/> Contact as many of the current and potential supports as a patient will permit <ul style="list-style-type: none"> <li>• <input type="checkbox"/> You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients</li> <li>• When involving anyone, ensure that you preserve confidentiality if possible and define these:               <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Depression, suicidality</li> <li>2. <input type="checkbox"/> The needs of such patients</li> <li>3. <input type="checkbox"/> How others can help</li> <li>4. <input type="checkbox"/> How others can hurt</li> </ol> </li> </ul>
Team	10. Consult and involve colleagues to help. <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Doctor <input type="checkbox"/> _____
Follow Up	11. If the patient has a <b>higher</b> risk level, continue to the guidelines <b>below</b> .



**ZANMI LASANTE — MENTAL HEALTH  
SUICIDALITY TREATMENT GUIDELINES**

For patients with <b>MEDIUM</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. <input type="checkbox"/> Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur.
	3. <input type="checkbox"/> Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. <input type="checkbox"/> Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. <input type="checkbox"/> At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.
Follow Up	6. If the patient is medium risk, schedule follow-up within 7 days. <b>Date</b> _____ <b>Time</b> _____ If the patient is <b>high</b> risk, continue to the guidelines <b>below</b> .
For patients with <b>HIGH</b> risk, include these additional aspects in your care.	
Act	1. <input type="checkbox"/> Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary.
	2. <input type="checkbox"/> Seek to admit patient to the emergency room or another service with beds for at least 24 hours.
	3. <input type="checkbox"/> Determine who will be available to watch the patient and when so that they are not left unattended. Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____ Name _____ Time _____      Name _____ Time _____
Say	4. <input type="checkbox"/> Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. <input type="checkbox"/> Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here).
	6. <input type="checkbox"/> Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. <input type="checkbox"/> MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain).
	8. <input type="checkbox"/> Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. <input type="checkbox"/> Keep the patient admitted and under continuous monitoring (e.g. 4x/hr).
	10. <input type="checkbox"/> Frequently re-assess risk level.
	11. <input type="checkbox"/> If the patient leaves or can't be kept, follow through with continued intensive psychosocial activation.



## Section 3 Preamble

### **Say to respondent:**

The interview is about difficulties people have because of health conditions.

### **Hand flashcard #1 to respondent**

By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

### **Point to flashcard #1**

- Increased effort
- Discomfort or pain
- Slowness
- Changes in the way you do the activity.

When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

### **Hand flashcard #2 to respondent**

Use this scale when responding.

### **Read scale aloud:**

None, mild, moderate, severe, extreme or cannot do.

**Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview**

**Please continue to next page...**



## Section 4 Core questions

### Show flashcard #2

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S1	<a href="#">Standing for long periods</a> such as <a href="#">30 minutes</a> ?	1	2	3	4	5
S2	Taking care of your <a href="#">household responsibilities</a> ?	1	2	3	4	5
S3	<a href="#">Learning a new task</a> , for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have <a href="#">joining in community activities</a> (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have <a href="#">you</a> been <a href="#">emotionally affected</a> by your health problems?	1	2	3	4	5

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
S6	<a href="#">Concentrating</a> on doing something for <a href="#">ten minutes</a> ?	1	2	3	4	5
S7	<a href="#">Walking a long distance</a> such as a <a href="#">kilometre</a> [or equivalent]?	1	2	3	4	5
S8	<a href="#">Washing your whole body</a> ?	1	2	3	4	5
S9	Getting <a href="#">dressed</a> ?	1	2	3	4	5
S10	<a href="#">Dealing with people you do not know</a> ?	1	2	3	4	5
S11	<a href="#">Maintaining a friendship</a> ?	1	2	3	4	5
S12	Your day-to-day <a href="#">work/school</a> ?	1	2	3	4	5

H1	Overall, in the past 30 days, <a href="#">how many days</a> were these difficulties present?	<i>Record number of days</i> ____
H2	In the past 30 days, for how many days were you <a href="#">totally unable</a> to carry out your usual activities or work because of any health condition?	<i>Record number of days</i> ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <a href="#">cut back</a> or <a href="#">reduce</a> your usual activities or work because of any health condition?	<i>Record number of days</i> ____

This concludes our interview. Thank you for participating.



# **WHODAS 2.0**

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 1*

## **Health conditions:**

- **Diseases, illnesses or other health problems**
- **Injuries**
- **Mental or emotional problems**
- **Problems with alcohol**
- **Problems with drugs**

## **Having difficulty with an activity means:**

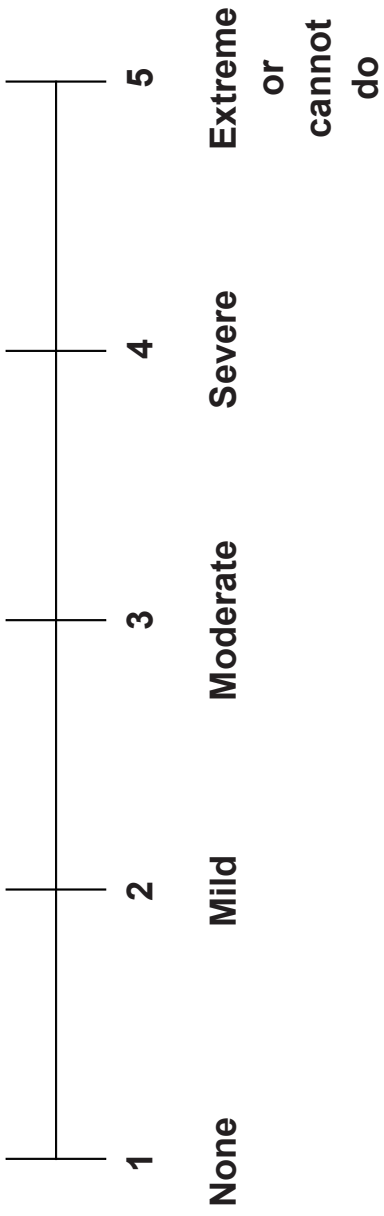
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

**Think about the past 30 days only.**

# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

*Flashcard 2*




**ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)**

 Date     dd/mm/yy    

	Pandan 15 jou ki sòt pase la yo, konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Di tou	Konbyen fwa yon nan pwoblèm sa yo te fatige ou ?	Pandan kèk jou (1–5 jou)	Plis pase yon semèn (6–9 jou)	Preske chak jou (10–15 jou)
<b>1</b>	Santi ou de la la.	0	—	1	2	3
<b>2</b>	Santi kè sere.	0	—	1	2	3
<b>3</b>	Kalkile twòp.	0	—	1	2	3
<b>4</b>	Kriye oubyen anvi kriye	0	—	1	2	3
<b>5</b>	Santi anyen preske pa enterese ou.	0	—	1	2	3
<b>6</b>	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
<b>7</b>	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
<b>8</b>	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
<b>9</b>	Ou pa gen apeti.	0	—	1	2	3
<b>10</b>	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
<b>11</b>	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
<b>12</b>	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
<b>13</b>	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
<b>Totals</b>				<b>(+)</b>	<b>(+)</b>	

**(=) ZLDSI Score**