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

For External Distribution

Zanmi Lasante

Partners In Health

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 reach out to Sarah Coleman, Mental Health Coordinator, Partners In Health Cross-Site Mental Health Team at scoleman@pih.org.

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 to request any training materials.

Tools:

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

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
CHW Follow-up Form	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
CHW Initial Visit Form	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
CHW Referral Form	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
Clinical Global Impressions Scale (CGI)	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		
Community Education Activity Checklist	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
Community Health Worker Patient Encounter Form	Depression	A flow chart/form for community health workers to use when they encounter a new, suspected case of depression.				x
Depression Checklist	Depression	A checklist to inform the responsibilities around depression identification, treatment and management.	x	x	x	x
Initial Mental Health Evaluation Form	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		
Medication Card for Depression	Depression	A card to reference when prescribing medication.	x	x		
Mental Health Follow-Up Form	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
Nurse Inpatient Encounter Form	Depression	A flow chart/form for nurses working in the inpatient ward to use when they encounter a new, suspected case of depression.			x	

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Nurse Outpatient Encounter Form	Depression	A flow chart/form for nurses working in the outpatient clinic to use when they encounter a new, suspected case of depression.			x	
Physician Patient Encounter Form	Depression	A flow chart/form for physicians to use when they encounter a new, suspected case of depression.	x			
Psychologist/Social Worker Patient Encounter Form	Depression	A flow chart/form for psychologists and social workers to use when they encounter a new, suspected case of depression.		x		
Request for Consultation Form	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	
Safety Plan	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		
Suicidality Screening Instrument**	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		
Suicidality Treatment Guidelines	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		
World Health Organization Disability Assessment Schedule (WHODAS)	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		
ZLDSI	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 to request any training materials.

Tools:

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

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
CHW Follow-up Form	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
CHW Initial Visit Form	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
CHW Referral Form	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
Clinical Global Impressions Scale (CGI)	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		
Community Education Activity Checklist	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
Epilepsy Checklist	Epilepsy	A checklist to inform the responsibilities around epilepsy identification, treatment and management.	x	x	x	x
Epilepsy Education Cards	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
Epilepsy Follow-Up Form	Epilepsy	A form to evaluate and record a patient's epilepsy evolution, for use at each follow-up visit.	x	x		
Initial Evaluation of Epilepsy	Epilepsy	A form to evaluate patients that are suspected of having epilepsy, for use during their initial visit.	x	x		
Guide for Medication Titration in Patients with Epilepsy	Epilepsy	A card to reference when considering an increase or decrease in anti-epileptic medication.	x			
Initial Mental Health Evaluation Form	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		

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Medication Card for Epilepsy	Epilepsy	A card to reference when prescribing medication.	x	x		
Request for Consultation Form	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	
Safety Plan	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		
Stigma Assessment Activity for Epilepsy	Epilepsy	A tool to measure community members' stigma towards people with epilepsy; to be used during community education sessions.				x
Suicidality Screening Instrument**	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		
Suicidality Treatment Guidelines	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		
World Health Organization Disability Assessment Schedule (WHODAS)	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		
ZLDSI	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 to request any training materials.

Tools:

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

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Abnormal Involuntary Movement Scale (AIMS)	Psychosis	A form to record and score the results from the AIMS Examination.	x			
Abnormal Involuntary Movement Scale (AIMS) Examination Procedure	Psychosis	A set of directions to guide physicians in correctly performing the Abnormal Involuntary Movement Scale procedure with a patient.	x			
Agitated Patient Protocol	Psychosis	A protocol outlining the steps to take when confronted with a patient that is agitated, delirious or psychotic.	x	x	x	
Agitation, Delirium and Psychosis Checklist	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
Agitation, Delirium and Psychosis Form	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			
CHW Follow-up Form	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
CHW Initial Visit Form	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
CHW Referral Form	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
Clinical Global Impressions Scale (CGI)	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		
Community Education Activity Checklist	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

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Initial Mental Health Evaluation Form	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		
Medical Evaluation Protocol for Agitation, Delirium and Psychosis	Psychosis	A protocol outlining the medical assessment steps needed to determine if a patient is delirious due to a medical problem or psychosis.	x			
Medication Card for Agitation, Delirium and Psychosis	Psychosis	A card to reference when prescribing medication.	x	x		
Mental Health Follow-Up Form	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
Psychiatric Differential Diagnosis Information Sheet	Psychosis	An outline of DSM IV criteria for severe mental disorders; to be used to assist with diagnosis during clinical sessions with patients.		x		
Psychosis Care Pathway	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
Psychosis Education Cards	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
Request for Consultation Form	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	
Safety Plan	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		
Stigma Assessment Activity for Psychosis	Psychosis	A tool to measure community members' stigma towards people with psychosis; to be used during community education sessions.				x
Suicidality Screening Instrument**	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		

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Suicidality Treatment Guidelines	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		
World Health Organization Disability Assessment Schedule (WHODAS)	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		
ZLDSI	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 to request any training materials.

Tools:

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

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
CES-D	Child & Adolescent Mental Health	A self-assessment to screen for depression; to be administered to adolescents suspected of having depression.		x		
CHW Follow-up Form	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
CHW Initial Visit Form	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
CHW Referral Form	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
Clinical Global Impressions Scale (CGI)	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		
Community Education Activity Checklist	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
Initial Mental Health Evaluation Form	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		
Mental Health Follow-Up Form	Depression; Psychosis; Child & Adolescent Mental Health	A form to evaluate and record a patient's evolution, for use at each follow-up visit.		x		
Request for Consultation Form	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	
Safety Plan	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		

Tool	Disorder Care Pathway that Uses the Tool	Description of Tool	Used by Physicians	Used by Psychologists / Social Workers	Used by Nurses	Used by Community Health Workers
Suicidality Screening Instrument**	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		
Suicidality Treatment Guidelines	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		
World Health Organization Disability Assessment Schedule (WHODAS)	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		
ZLDSI	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	**What did you observe?**
Name:	
Nickname:	
Last Name:	
Sex: ☐ M ☐ F	
Address:	Is it Urgent? ☐ Yes ☐ No
Phone Number:	☐ Seizure ☐ Thinking about suicide ☐ Thinking about harming others
Date of Birth: DD/MM/YYYY	
Age:	

How do you think the patient is feeling?	**What did you do:**
☐ Patient is better now ☐ Patient is doing worse ☐ Patient is the same	☐ Check symptoms ☐ Same day therapy session ☐ Give advice ☐ Relaxation ☐ Ask if patient is out of medication ☐ Yes ☐ No ☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI?**
☐ 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	☐ Bring patient to hospital? ☐ Send patient to hospital? ☐ Encourage the family? ☐ Encourage the patient?	☐ 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	**What did you observe?**
Name:	
Nickname:	
Sex: ☐ M ☐ F	
Address:	Is it a urgent matter that needs immediate attention? ☐ Yes ☐ No
Phone:	☐ Seizure
Date of Birth: DD/MM/YYYY	☐ Thinking about suicide
Age:	☐ Thinking about harming others

Which illness do you think the patient suffers from?	**What did you do:**	
☐ Anxiety	☐ Check symptoms	☐ Ask if patient is out of medication
☐ Psychosis	☐ Same day therapy session	☐ Yes
☐ Epilepsy	☐ Give advice	☐ No
☐ Depression	☐ Relaxation	☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI form?**
☐ Explain the illness to the patient	☐ Bring patient to hospital?	☐ Yes
☐ Give him/her hope	☐ Send patient to hospital?	☐ No
☐ Give him/her the sick role	☐ Encourage the family?	What is the ZLDSI Score: _____ / 39
☐ Encourage the patient to participate in activities that makes him/her happy	☐ Encourage the patient?	

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

☐ Thomonde ☐ Belladère ☐ Boucan Carre
☐ Cange ☐ St Marc ☐ Cerca La Source
☐ Hinche ☐ Petite Rivière ☐ Mirebalais
☐ Lascahobas ☐ 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?

_____

_____

☐ Depression – ZLDSI Score _____
☐ Epilepsy
☐ Seizure
☐ Psychosis

Is the person taking any medications?

☐ Yes ☐ No

If Yes, Specify: _____

Is it Urgent? ☐ Yes ☐ No

☐ Seizure
☐ Thinking about suicide
☐ Thinking about harming others

Who do you refer the patient to:

Zanmi Lasante

☐ Psychologists
☐ Social Worker
☐ Mobile Clinic

Members of the Community

☐ Community Leader
☐ Other Community Health Workers
☐ Others (specify): _____

Date:

_____ / _____ / _____
DD MM YYYY

Remarks

Information on the person who referred the patient:

Name:	Phone:	Address:
Last Name:		
Nickname:		

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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

Partners In Health

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

Partners In Health

Name _____ Age _____ Male / Female (circle one) Town _____

CHW _____ Phone #1 _____ District _____

Patient ID _____ Phone #2 _____ Session # _____

REVIEW KEY SYMPTOMS (circle yes or no)

❶ Suicidal YES NO → ❷ Danger to others YES NO → ❸ Mental Health Crisis YES NO →

ACTION
Depression ZLDSI Scale (see back)
Score _____

ASK
Would you like us to give you treatment?
NO → **ACTION**
Initiate
- ☐ Psycho-education
- ☐ Tracking Symptoms
- ☐ Engagement
- ☐ Relaxation
- ☐ Consult CHW Supervisor

YES →

ACTION
☐ Initiate de-escalation
Depression ZLDSI Scale (see back)
Score _____

ACTION
Same Day Assessment
Date dd/mm/yy
Psychologist / Social Worker
Name _____

No further action

Screening Score
- ☐ 0–12
- ☐ 13–17
- ☐ 18+

ASK
Would you like us to give you treatment?
NO / YES

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 _____

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

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

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?
NO / YES

Seek Consultation from CHW Supervisor

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?
YES NO → Referral to a psychologist/ social worker
YES → Review key symptoms

1.20.16

DEPRESSION CHECKLIST

Partners In Health

Date: _____ **Provider Name:** _____ **Site:** _____

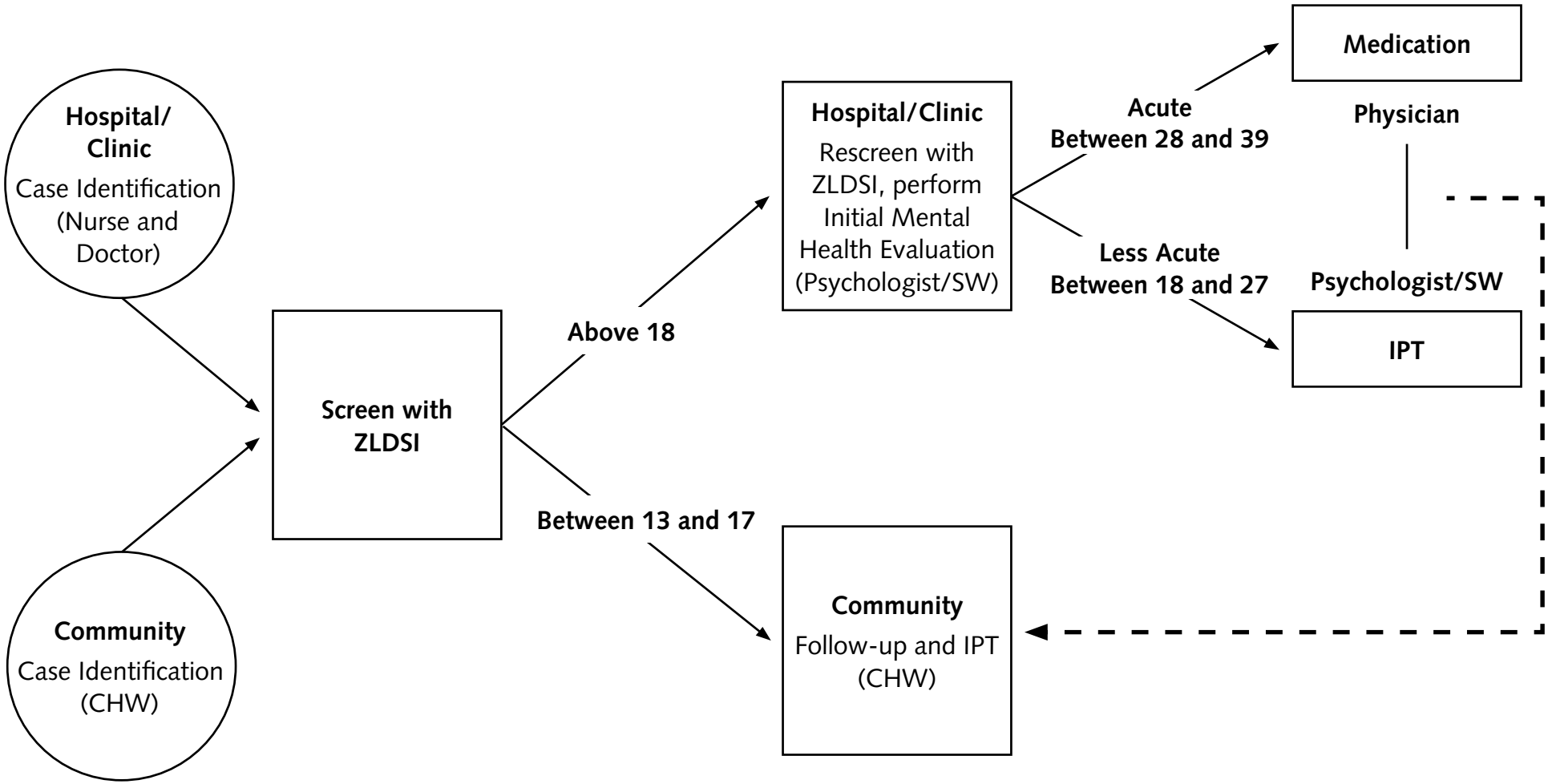
CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Initial Evaluation	**Initial Evaluation**	**Initial Evaluation**	**Initial Evaluation**
☐ Document with Initial Visit Form. ☐ Determine triage/referral ☐ If suicidal, initiate de-escalation, accompany patient to see psychologist immediately. ☐ If ZLDSI>13; or concern for suicidal ideation, psychosis, or epilepsy, refer patient to psychologist. ☐ If ZLDSI<13, manage in community. ☐ Ask patient/family to give psychologist Referral Form. ☐ Begin basic IPT (giving hope, naming and explaining illness). ☐ Provide psychoeducation. ☐ Give ZLDSI and Initial Visit Form to psychologist.	☐ Review Depression Checklist with CHW/nurse to track care. ☐ Document with Initial Mental Health Evaluation form. Use CHW/nurse input. ☐ To diagnose depression, consider ZLDSI score, suicidality, and mania. ☐ Consult physician for suicidal ideation, epilepsy/ other medical problems, psychosis, or severe depression. Accompany patient and present information to physician in person. ☐ Track physician care with Depression Checklist. ☐ Do psychoeducation. Check medication supply. ☐ Determine CHW role: follow up and support/education for moderate/severe depression or transfer to CHW for mild depression. ☐ Schedule proper follow-up (with psychologist, CHW, physician). ☐ Enter patient into registry. File ZLDSI, complete checklist/Patient Encounter Form.	☐ Identify patients at risk for depression and check for depression symptoms in nursing protocol. ☐ Decide referral to physician or psychologist, based on depression symptom score. ☐ Take vital signs and check for headache, abdominal pain, and high blood pressure; contact physician if any are present. ☐ Document in Nurse Inpatient Encounter Form for depression, as well as patient dossier. ☐ Based on referral process, provide psychoeducation and support to patient and family.	☐ Review Initial Mental Health Evaluation with psychologist/SW. ☐ For suicidal patients, work with psychologist/SW to determine risk and to ensure safety plan. ☐ Do medical evaluation separate from mental health evaluation. ☐ Based on ZLDSI score, suicidal ideation, and severity of depression symptoms, decide whether to prescribe. Choose fluoxetine or amitripyline based on symptoms, age, comorbidity. ☐ Provide psychoeducation about medication. ☐ Ensure follow-up with psychologist/SW. ☐ Document evaluation and plan in Initial Mental Health Evaluation.

Partners In Health

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Follow-Up Evaluation	**Follow-Up Evaluation**	**Ongoing Care**	**Follow-Up Evaluation**

☐ Document with Follow-Up Form.
☐ Check for medication compliance and side effects.
☐ Determine triage/referral
  ☐ If suicidal, initiate de-escalation, accompany patient to see psychologist immediately.
  ☐ If ZLDSI>13, medication problem, or concern for suicidal ideation, psychosis, or epilepsy, refer patient to psychologist.
  ☐ If ZLDSI<13, manage in community.
☐ Ask patient/family to give psychologist Referral Form.
☐ Continue IPT (explain illness, give hope, behavioral activation).
☐ Provide psychoeducation.
☐ Give ZLDSI and Initial Visit Form to psychologist.
	☐ Review Depression Checklist with CHW/nurse to track care.
	☐ Document with Mental Health Follow-Up Form.
	☐ Check if depression is improving based on patient report, ZLDSI, mental status exam, CHW/family input. Check medication compliance and side effects.
	☐ Consult physician for suicidal ideation, epilepsy/other medical problems, psychosis, or severe depression. Accompany patient and present information to physician in person.
	☐ Track physician care with Depression Checklist.
	☐ Do psychoeducation, include medication side effects. Check supply of medication.
	☐ Determine CHW role: follow up, support/education for severe depression; transfer to CHW for mild depression.
	☐ Schedule proper follow-up (with psychologist, CHW, physician).
	☐ Enter patient into registry. File ZLDSI, complete checklist/Patient Encounter Form.
		☐ Before discharging patient, provide psychoeducation about treatment and medication. Make sure patient has follow-up appointments with psychologist/SW and physician, if needed.
		☐ If patient has been suicidal during hospitalization, check for suicidal ideation before discharge. If patient is suicidal, contact psychologist immediately.
			☐ Review Initial Mental Health Evaluation with psychologist/SW
			☐ Determine whether patient is improving.
			☐ For suicidal patients, work with psychologist/SW to determine risk and to ensure safety plan.
			☐ Medication: continue or change it based on side effects and response.
			☐ Document evaluation and plan in Mental Health Follow-Up Form.

Partners In Health



*Administer the ZLDSI once every two weeks.

12.4.16

INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services

Partners In Health

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
• Have you felt sad or lost interest in things for a two week period?	• Did you feel very happy for any reason in the last few days?	• Are you a worrier?	• Do you hear things like voices that other people don't hear?
		• What do you worry about?	
			• Do you see things that other people don't see?
• Do you feel like you've lost interest in everything or only in some things?	• Did you get angry more often in the last few days?	• Are you experiencing: ☐ Panic attacks ☐ Fear of crowded places ☐ Sleep problems ☐ Difficulty concentrating ☐ Fatigue ☐ Irritability ☐ Muscle tension ☐ Restlessness	
			• Do you feel that people are conspiring to harm you – even people whom you don't know?
• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39	• Do you: ☐ Have any difficulties of staying attentive? ☐ Speak of things that you shouldn't? ☐ Feel like you're worth more than before? ☐ Have a racing thoughts going through your head? ☐ Have an increase in activities? ☐ Sleep less? ☐ Talk without ceasing?	• Do you often experience any 4 of these problems such as: ☐ increased in heartbeat ☐ breathlessness ☐ sweating ☐ trembling ☐ fear; fear of losing control; fear of becoming crazy; fear of death ☐ feeling dizzy ☐ feel like you're losing consciousness	• Are the voices in your head controlling your thought process?

	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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Present	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐			

If yes, explain: _____

_____

Do you feel safe in your current environment? _____

PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
☐ Are you experiencing pain in your body?	• Is there a change in your: ☐ Weight? ☐ Thirst? ☐ Fever?	☐ Sight problems? ☐ Hearing problems? ☐ Voice change? ☐ Dizziness? ☐ Gum and teeth status? ☐ Difficulty swallowing?	☐ Stiffness of the neck?
BREATHING	**HEART/ARTERIES**	**DIGESTIVE SYSTEM**	**SKIN**
☐ Are you having problems breathing? ☐ Are you coughing? ☐ Do you cough out blood or find blood in your snot?	☐ Do you have an increased heartbeat? ☐ Having chest pain? ☐ Any swelling?	☐ Heart burn? ☐ Gastric Reflux? ☐ Vomiting? ☐ Constipation, diarrhea, gas?	☐ Any changes in your skin?
MUSCLES	**APPENDAGES (HANDS AND FEET)**	**GENITALS/URINATION**	**NEUROLOGICAL**
☐ Are they stiff? ☐ Swollen? ☐ Reddened?	☐ Swollen?	☐ Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often? ☐ Any problems when urinating (pain, amount/ color of urine, blood in urine)?	☐ Any numbness? ☐ Uncontrolled movements?

PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
☐ None	☐ None	☐ 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	☐ well groomed	☐ disheveled	☐ overdressed, elaborate	
Orientation	☐ O x 3	☐ disoriented to time	☐ disoriented to place	☐ disoriented to person
Behavior	☐ WNL ☐ tics	☐ retardation	☐ agitation	☐ tremor
Speech	☐ WNL	☐ slowed	☐ pressured	☐ slurred
Mood	☐ _____			
Affect	☐ euthymic ☐ irritable ☐ congruent with speech content	☐ dysphoric ☐ suspicious ☐ incongruent with speech content	☐ euphoric ☐ labile ☐ other: _____	☐ anxious ☐ flat

MENTAL STATUS EXAM CONTINUED

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

Partners In Health

		FLUOXETINE	AMITRIPTYLINE
		Antidepressant, SSRI: depression, anxiety **Use for: depression, anxiety, post-traumatic stress disorder**	*Tricyclic antidepressant: depression, anxiety, migraine, neuropathic pain* **Use for: depression, anxiety, post-traumatic stress disorder, migraines, neuropathic pain**
DO NOT USE IF		Manic	• Manic, cardiac arrhythmia • Caution in elderly; caution if patient is suicidal as fatal in overdose
MUST CONSULT MENTAL HEALTH TEAM		Prior history of mania, heart condition	Prior history of mania, heart condition
Starting Dose (Adult)		• Dosing Forms: 20 mg capsules • Dosage: Start with 20 mg every morning	• Dosing forms: 25 mg tablets • Dosage: Start with 25 mg at bedtime • Typical maintenance dosage: 50-75 mg daily
"Step" of Uptitration		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.
Maximum Dose		80 mg	300 mg
Toxicities *If rash, stop medication and return to hospital	**Serious**	**Special warning:** serotonin syndrome may occur for 4-6 weeks	**Special warnings:** 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.
	Serotonin Syndrome	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. It can happen when increasing the dose of a single drug, such as fluoxetine. 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. **Treatment:** 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.	
	Common	• Agitation • Transient nausea • Jitters • Restlessness • Drowsiness • Headache • Nausea • Insomnia • Sexual Dysfunction (which can decrease after a few weeks)	• Drowsiness • Dizziness • Sedation • Dry Mouth • Blurred Vision • Constipation • Urinary Retention • Tachycardia • Confusion • Delirium (especially among the elderly)
Tapering/ Discontinuing 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.	
Breastfeeding		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
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____

4. Mental Status Examination

General appearance wnl	☐ Yes	☐ No	Mood disorder	☐ Yes	☐ No	Danger to self, suicidal	☐ Yes	☐ No
Speech wnl	☐ Yes	☐ No	Poor introspection	☐ Yes	☐ No	Danger to others	☐ Yes	☐ No
Behavior wnl	☐ Yes	☐ No	Thought process wnl	☐ Yes	☐ No	Anxiety, phobia	☐ Yes	☐ No
Muscle tone and strength	☐ Yes	☐ No	Thought content wnl	☐ Yes	☐ No	Poor judgement	☐ Yes	☐ No
Cognitive function wnl	☐ Yes	☐ No	Affect wnl	☐ Yes	☐ 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)

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

Partners In Health

Name _____ Age _____ Town _____

Psychologist / SW _____ Male / Female (circle one) District _____

CHW Referrer _____ Phone #1 _____ Session # _____

Patient ID _____ Phone #2 _____ Date received patient info _____

❶ Main Reason for Intake

_____

_____

_____

Other Medical Symptoms

_____

_____

_____

_____

_____

_____

❷ Depression Symptoms	0–1 pts.
Santi kè sere	
Kalkile twòp	
Santi ou kagou, dekouraje ak lavi, oubyenpèdi espwa nèt ale	
Gen difikilte pou dòmi pran ou	
Ou santi lavi-w pase mal oubyen ou santi-wpa alèz ak tèt-w	
Total Depression Score	_____

Depression Score

☐ 0 → **No further action**

☐ 1–2 → ACTION

Same Day Treatment Referral to Psychologist / Social Worker

Date of Treatment Appt.

dd/mm/yy

_____

Psychologist / Social Worker Name

_____

☐ 3–5 → ACTION

Same Day Treatment Referral to Physician (make appt. if physician is not available)

Date of Treatment Appt.

dd/mm/yy

_____

Physician Name

_____

Review course of action treatment with staff and patient

ACTION

Give Form to Physician

Physician received form?

YES → ACTION

Patient / Family Communication

- ☐ Psycho-education
- ☐ Role Give Hope
- ☐ Reassure Family members
- ☐ Assign Patient Role
- ☐ Assign Home Caregiver

NO → **Report to Nurse Supervisor**

1.20.16

NURSE OUTPATIENT ENCOUNTER FORM

Date dd/mm/yy

Partners In Health

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

❶ Take Vital Signs →

❷ Patients Symptoms

- ☐ Headache
- ☐ Abdominal pain
- ☐ High Blood Pressure
- ☐ Other

_____

_____

YES (if any) / NO →

❸ Depression Symptoms	0–1 pts.
Santi kè sere	
Kalkile twòp	
Santi ou kagou, dekouraje ak lavi, oubyenpèdi espwa nèt ale	
Gen difikilte pou dòmi pran ou	
Ou santi lavi-w pase mal oubyen ou santi-wpa alèz ak tèt-w	
Total Depression Score	_____

Depression Score

- ☐ 0 → **No further action**
- ☐ 1–2 → ACTION
  Same Day Treatment Referral to Psychologist / Social Worker
  Date of Treatment Appt.
  dd/mm/yy
  _____
  Psychologist / Social Worker Name
  _____
- ☐ 3–5 → ACTION
  Same Day Treatment Referral to Physician (make appt. if physician is not available)
  Date of Treatment Appt.
  dd/mm/yy
  _____
  Physician Name
  _____

Review course of action treatment with staff and patient →

ACTION
Give Form to Physician
Physician received form?

YES → ACTION
Patient / Family Communication

- ☐ Psycho-education
- ☐ Reassure Family members
- ☐ Assign Home Caregiver
- ☐ Role Give Hope
- ☐ Assign Patient Role

NO → **Report to Nurse Supervisor**

1.20.16

PHYSICIAN PATIENT ENCOUNTER FORM

Date dd/mm/yy

Partners In Health

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

ACTION

Physician received form

- ☐ Yes
- ☐ No

ACTION

- ☐ Mental status exam
- ☐ Physical exam
- ☐ ZL-DSI Score

Score _____

Depression?

NO YES

ACTION

Medication

- ☐ **Fluoxetine** (dosage:_____)
- ☐ **Amitriptyline** (dosage:_____)
- ☐ **Other** (please write)

_____

Psychological treatment needed?

NO YES

ACTION

Same Day Referral to Psychologist / Social Worker

Date dd/mm/yy

Psychologist / Social Worker

Name _____

- ☐ Medical symptoms
- ☐ Epilepsy
- ☐ Psychosis

YES (if any) NO

ACTION

- ☐ **Treat as needed**
- ☐ **Alert mental health team physician and/or psychiatric supervisor**

ACTION

Schedule CHW Meeting

Date of follow up appt.

dd/mm/yy

_____

CHW Name _____

(notes) _____

_____

_____

_____

_____

PSYCH/SOCIAL WORKER PATIENT ENCOUNTER FORM

Date dd/mm/yy

Partners In Health

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

❶ Suicidal YES NO →

❷ Danger to others YES NO →

❸ Mental Health Crisis YES NO →

❹ Prescribed Medication YES NO →

☐ **Perform medical adherence check**

❺ Note observations of:

☐ Medical symptoms
☐ Epilepsy
☐ Psychosis

notes: _____

(if any) YES NO

ACTION

Same Day Treatment Referral to Physician (make appt. if physician is not available)

Date of Treatment Appt.

dd/mm/yy

Physician Name_____

Perform Depression ZLDSI Scale (see back). Score _____

☐ Ensure patient safety from self harm
☐ Speak with person kindly
☐ Offer assurance and hope

ACTION

Give Form to Physician

Physician received form?

NO → **Report to Psychologist / SW Supervisor** explain: _____

YES → **No further action**

ACTION

Discharge patient

☐ Yes
☐ No (explain) _____

ACTION

Alert CHW Coordinator of scoring mismatch

Screening Score

☐ 0–12

ACTION

Same day initiate therapy (main points)

☐ 13–17

☐ Diagnose
☐ Psycho-education
☐ Give hope
☐ Assign patient role
☐ Grief
☐ Interpersonal dispute
☐ Interpersonal deficits

ACTION

Schedule CHW Meeting

Date of Follow up Appt. (within 2 weeks)

dd/mm/yy

CHW Referrer _____

ACTIONS

Depression ZLDSI Scale (see back)

Score _____

☐ Impulsive/bizarre
☐ PTSD

ACTION

Same day initiate therapy (main points)

☐ 18+

☐ Diagnose
☐ Psycho-education
☐ Give hope
☐ Assign patient role
☐ Grief
☐ Interpersonal dispute
☐ Interpersonal deficits

1.20.16

MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM

Partners In Health

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: _____

Reasons/Diagnostic Impressions:	**Services requested:**

• Psychological trauma
• Sexual abuse
• Suicide attempt
• Psychiatric emergency
• Mental confusion
• Psychosis/bipolar disorder
• Behavioral disorders
• Somatoform disorders
• Affective disorders
  • Enuresis
  • Encopresis
• Learning disorder
• Mental retardation
• Addiction
• Epilepsy
• Depression
• Depression and migraines
• Other: _____
	• Psychological Evaluation
	• Psychotherapies
	  • Grief, supportive
	  • Interpersonal therapy
	• Psychotraumatology
	• Counseling
	  • Pre-Operative
	  • Post-Operative
	  • Post-test
	  • Follow-up
	  • Adherence
	  • Pre-HAART
	• Other: _____
	• **IMPORTANT HISTORY:** _____
	_____

Signature of referring provider: _____

Mental health provider that received the referral: _____

Date of receipt: _____ Time: _____

Remarks: _____

Signature: _____

1.20.16

ZANMI LASANTE — MENTAL HEALTH SAFETY PLAN

Zanmi Lasante

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…_____

_____

05.31.16

ZANMI LASANTE — MENTAL HEALTH SUICIDALITY SCREENING INSTRUMENT

Zanmi Lasante

LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
1. Passive	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you have any thoughts of ending your life, even if they are not clear in your mind? **Possible Response:** 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	Description:	
2. Non-Specific Active	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you want to die? Do you often think or talk about death? **Possible Response:** desire/wish to be dead…prefer to be dead…think frequently/talk about death…God would rather have me	Description:	
3. Methods but no Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: If you would do it, how would you do it? **Possible Response:** bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun	Description:	
4. Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you intend to act on these thoughts? **Possible Response:** 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	Description:	
5. Planification	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Have you started planning the details about how you will kill yourself? **Danger Signs:** 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).	Description:	
6. Attempted	☐ No ☐ Yes	☐ No ☐ Yes
Ask: 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? **Danger Signs:** 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.	Description:	
Low: Current = 0 Past = 0 **Medium:** Current = 1–2 yes OR Past = 1 or more yes **High:** Current = 3 or more yes OR Past = 3 or more yes	**Total "yes" in past two weeks**	**Total "yes" in past year**

12.10.15

ZANMI LASANTE — MENTAL HEALTH
SUICIDALITY TREATMENT GUIDELINES

Zanmi Lasante

Provider: _____ Location: _____ Date: ___ / ___ / ___

Last Name: _____ First Name: _____ Nickname: _____ File #: _____

For **ALL** Patients	
Act	1. ☐ Ensure that the environment will be private, safe and non-threatening. 2. ☐ Begin the process of ensuring that the patient will be able to access necessary medication. 3. ☐ Always work with the patient to develop a Safety Plan.
Say	4. ☐ Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. ☐ Start IPT and collect IP inventory. 6. ☐ Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. ☐ Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). *(Write this on the copy of your Safety Plan, on the back side).*
Contact	8. ☐ Always contact at least one person close to the patient to support and monitor them. 9. ☐ Contact as many of the current and potential supports as a patient will permit • ☐ You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients • When involving anyone, ensure that you preserve confidentiality if possible and define these: 1. ☐ Depression, suicidality 2. ☐ The needs of such patients 3. ☐ How others can help 4. ☐ How others can hurt
Team	10. Consult and involve colleagues to help. ☐ Social Worker ☐ Psychologist ☐ Community Health Worker ☐ Doctor ☐ _____
Follow Up	11. If the patient has a **higher** risk level, continue to the guidelines **below**.

For patients with **MEDIUM** risk, include these additional aspects in your care.	
Act	1. ☐ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. ☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur. 3. ☐ Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. ☐ Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. ☐ 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. **Date** _____ **Time** _____ If the patient is **high** risk, continue to the guidelines **below**.
For patients with **HIGH** risk, include these additional aspects in your care.	
Act	1. ☐ Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. 2. ☐ Seek to admit patient to the emergency room or another service with beds for at least 24 hours. 3. ☐ 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. ☐ Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. ☐ Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here). 6. ☐ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. ☐ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). 8. ☐ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. ☐ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). 10. ☐ Frequently re-assess risk level. 11. ☐ 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	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have you been emotionally affected 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	Concentrating on doing something for ten minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5
S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5

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

This concludes our interview. Thank you for participating.

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:

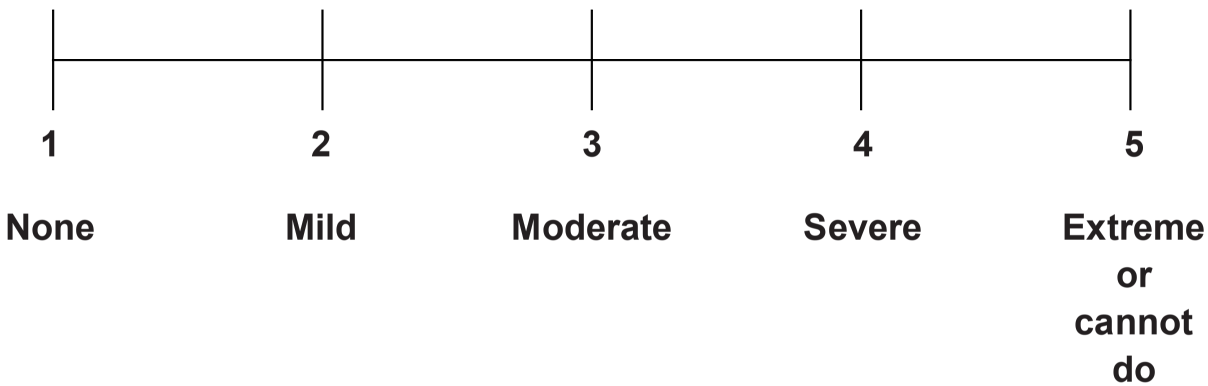
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

Think about the past 30 days only.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

Flashcard 2



ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Partners In Health

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)
1	Santi ou de la la.	0	—	1	2	3
2	Santi kè sere.	0	—	1	2	3
3	Kalkile twòp.	0	—	1	2	3
4	Kriye oubyen anvi kriye	0	—	1	2	3
5	Santi anyen preske pa enterese ou.	0	—	1	2	3
6	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
7	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
8	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
9	Ou pa gen apeti.	0	—	1	2	3
10	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
11	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
12	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
13	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
			Totals	**(+)**	**(+)**	

(=) ZLDSI Score _____

8.4.15

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	**What did you observe?**
Name:	
Nickname:	
Last Name:	
Sex: ☐ M ☐ F	
Address:	Is it Urgent? ☐ Yes ☐ No
Phone Number:	☐ Seizure ☐ Thinking about suicide ☐ Thinking about harming others
Date of Birth: DD/MM/YYYY	
Age:	

How do you think the patient is feeling?	**What did you do:**
☐ Patient is better now ☐ Patient is doing worse ☐ Patient is the same	☐ Check symptoms ☐ Same day therapy session ☐ Give advice ☐ Relaxation ☐ Ask if patient is out of medication ☐ Yes ☐ No ☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI?**
☐ 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	☐ Bring patient to hospital? ☐ Send patient to hospital? ☐ Encourage the family? ☐ Encourage the patient?	☐ 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	**What did you observe?**
Name:	
Nickname:	
Sex: ☐ M ☐ F	
Address:	Is it a urgent matter that needs immediate attention? ☐ Yes ☐ No
Phone:	☐ Seizure
Date of Birth: DD/MM/YYYY	☐ Thinking about suicide
Age:	☐ Thinking about harming others

Which illness do you think the patient suffers from?	**What did you do:**	
☐ Anxiety	☐ Check symptoms	☐ Ask if patient is out of medication
☐ Psychosis	☐ Same day therapy session	☐ Yes
☐ Epilepsy	☐ Give advice	☐ No
☐ Depression	☐ Relaxation	☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI form?**
☐ Explain the illness to the patient	☐ Bring patient to hospital?	☐ Yes
☐ Give him/her hope	☐ Send patient to hospital?	☐ No
☐ Give him/her the sick role	☐ Encourage the family?	What is the ZLDSI Score: _____ / 39
☐ Encourage the patient to participate in activities that makes him/her happy	☐ Encourage the patient?	

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

☐ Thomonde ☐ Belladère ☐ Boucan Carre
☐ Cange ☐ St Marc ☐ Cerca La Source
☐ Hinche ☐ Petite Rivière ☐ Mirebalais
☐ Lascahobas ☐ 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?

_____

_____

☐ Depression – ZLDSI Score _____
☐ Epilepsy
☐ Seizure
☐ Psychosis

Is the person taking any medications?

☐ Yes ☐ No

If Yes, Specify: _____

Is it Urgent? ☐ Yes ☐ No

☐ Seizure
☐ Thinking about suicide
☐ Thinking about harming others

Who do you refer the patient to:

Zanmi Lasante

☐ Psychologists
☐ Social Worker
☐ Mobile Clinic

Members of the Community

☐ Community Leader
☐ Other Community Health Workers
☐ Others (specify): _____

Date:

_____ / _____ / _____
DD MM YYYY

Remarks

Information on the person who referred the patient:

Name:	Phone:	Address:
Last Name:		
Nickname:		

Partners In Health

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

Partners In Health

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

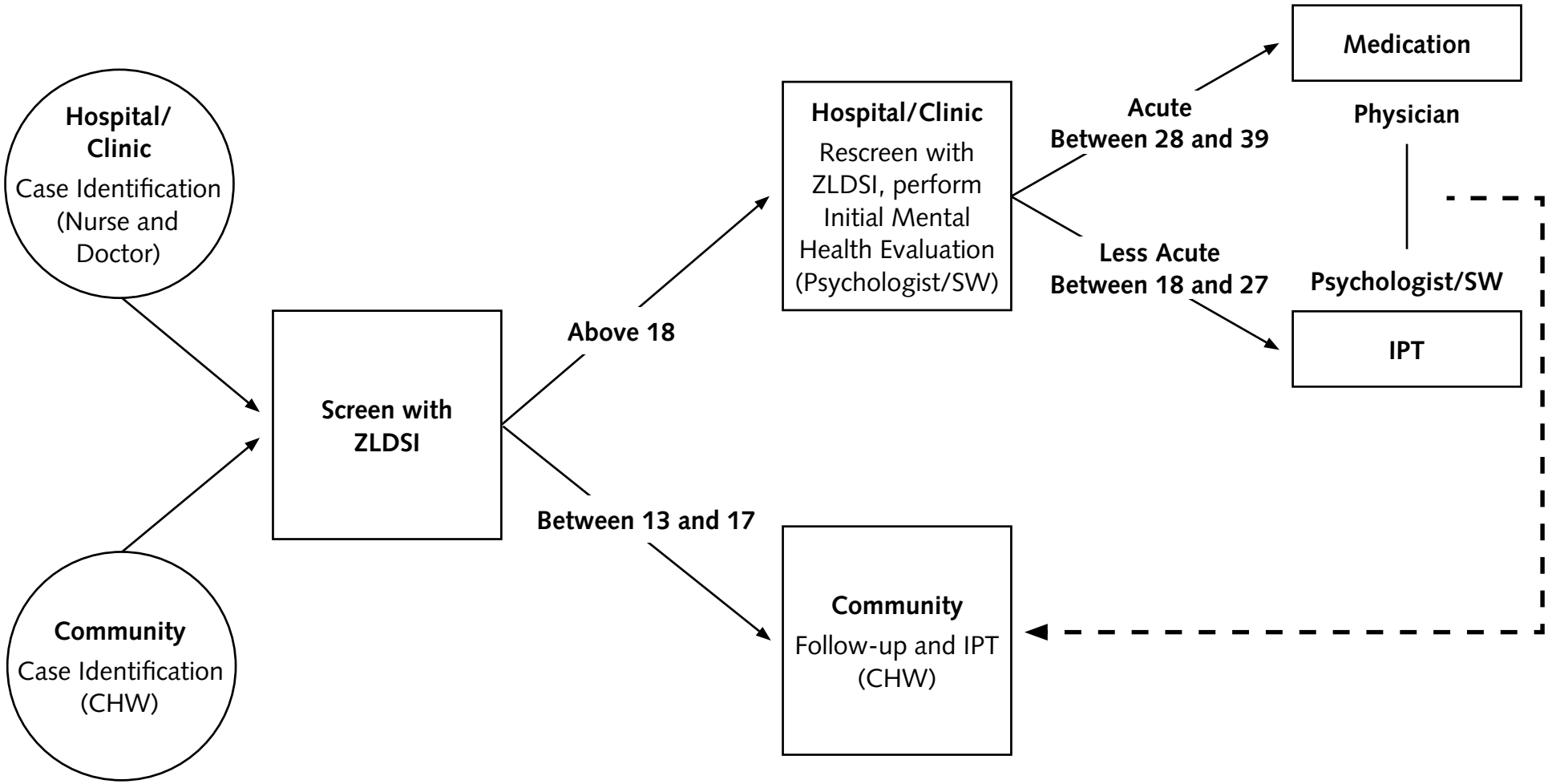
Partners In Health

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Patient Has Not Been Evaluated By Clinician	**Initial Evaluation**	**Initial Evaluation**	**Initial Evaluation**
☐ If emergency (seizure, suicidal ideation), accompany patient to clinic immediately. ☐ Initiate de-escalation for suicidal ideation. ☐ Document with Intial Visit Form. ☐ Do ZLDSI and check for psychological comorbidities. ☐ Ask patient/family to give psychologist Referral Form. ☐ Provide psychoeducation. ☐ Give ZLDSI and Intial Visit Form to psychologist.	☐ Do Epilepsy Checklist with CHW/nurse to track care and get input. ☐ Complete Initial Mental Health Evaluation Form. Do ZLDSI, diagnose mental health comorbidities. ☐ Begin Epilepsy Intake Form. ☐ Schedule follow-up with psychologist/SW and physician within 2 weeks for seizure management. ☐ Accompany patient to see the physician; physicians must see all epilepsy and suicidal cases. ☐ Track physician care with Epilepsy Checklist. ☐ Help physician give psychoeducation to patient and family. ☐ Plan follow-up with CHW. ☐ Enter patient into registry. File ZLDSI, complete checklist.	☐ For seizing/status epilepticus patient, follow emergency protocol. ☐ If no emergency, identify patients who may have epilepsy. ☐ Provide proper nursing care. ☐ Check depression symptoms in nursing protocol. ☐ Refer patient to physician (Epilepsy Intake Form) and psychologist (Initial Mental Health Evaluation Form). Inform psychologist if patient has risk for depression. ☐ Facilitate collaboration between physician and psychologist. ☐ If confirmed seizure, provide psychoeducation. ☐ Prior to discharge, ensure patient has appointments scheduled with psychologist/SW and physician.	☐ For seizing/status epilepticus patients, follow emergency protocol. ☐ Consult with psychologist/SW and review information from Epilepsy Intake Form and Initial Mental Health Evaluation Form. ☐ Document information in Epilepsy Intake and mental health forms. ☐ Do full medical evaluation, including physical exam, neurological exam, and labs. ☐ If epilepsy, choose medication based on type of seizure, gender, and child-bearing status. ☐ Provide enough medication to last until next appointment. ☐ Provide psychoeducation. ☐ Ensure care has been coordinated with psychologist.

EPILEPSY CHECKLIST

CHW	PSYCHOLOGIST/SW	NURSES	PHYSICIANS
Patient Has Been Evaluated By Clinician	**Follow-Up Evaluation**	**Ongoing Care**	**Follow-Up Evaluation**
☐ If emergency (rash, seizure, suicidality), accompany patient to clinic immediately. ☐ Initiate de-escalation for suicidal ideation. ☐ Document with Follow-Up Forms. ☐ Do ZLDSI, check for psychological comorbidities. ☐ Determine whether seizure frequency is decreasing ☐ Check for compliance and side effects, especially rash. ☐ Check to see if patient has enough medication. ☐ Provide psychoeducation. ☐ Ensure patient has follow-up with psychologist. ☐ Give ZLDSI and Follow-Up Form to psychologist.	☐ Document in Epilepsy Follow-Up form. ☐ Do ZLDSI and check for mental health comorbidities. Document in appropriate mental health form. ☐ Check if seizure frequency is decreasing. ☐ Check for medication compliance and side effects, especially rash. ☐ Check if patient has enough medication. ☐ Provide psychoeducation. ☐ Accompany patient to see physician; physicians must see all epilepsy, severe depression and suicidal cases. ☐ Track physician care with epilepsy checklist form. ☐ Plan follow-up with CHW ☐ Enter patient into registry. File ZLDSI, complete checklist.		☐ For status epilepticus patients, follow emergency protocol. ☐ Consult with psychologist/SW, review information from Epilepsy Follow-Up Form and mental health forms. ☐ Document in Epilepsy Follow-Up Form. ☐ Determine whether seizure frequency is decreasing. ☐ Check compliance and side effects to see if patient is tolerating medication. ☐ Perform physical exam and neurological exam. ☐ Adjust medication if necessary. Use Medication Card. ☐ Provide psychoeducation. ☐ Ensure care has been coordinated with psychologist/SW. Return forms to psychologist/SW.

Partners In Health



*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 onro 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 ave 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.

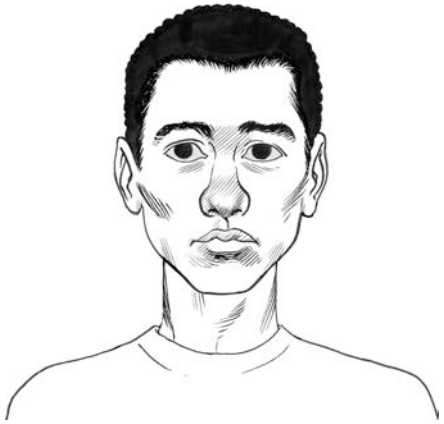
***Note**: Before seeing patients, the psychologist must tell the CHW exactly how patients should be taking medication so the CHW can confirm this. Psychologists are responsible for documenting the drug name, exact dose to take, and how to take it; and must provide this information to the CHW.*

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

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

Some signs and symptoms that may be uncomfortable but are not life-threatening.	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.
• Drowsiness • Slowed thinking • Dizziness • Lack of balance	• Skin changes that begin after starting an epilepsy medication. • Liver problems (eye and skin turns yellow).

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.

Partners In Health

Department of Mental Health & Psychosocial Services

Follow-Up Form – Epilepsy

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?** ☐ Yes ☐ No	☐ Yes	☐ No
Has the patient returned to baseline functioning? Check the boxes: ☐ Work ☐ Family ☐ School ☐ Interpersonal relationships	☐ Yes	☐ No

Medications

Missed dose of medication since last visit? **If yes, why?** ☐ Forgot ☐ Finished medicine ☐ Incomprehension ☐ Demotivation ☐ Drug toxicity ☐ Other	☐ Yes	☐ No

Side effects from anti-epileptic medication? **If yes:** ☐ Jaundice ☐ Vomiting ☐ Difficulties at school ☐ Oversedation ☐ Dizziness ☐ Double vision ☐ Cognitive slowing ☐ Behavioral changes ☐ Rash	☐ Severe/Intolerable	☐ Moderate	☐ None

Current Anti-epileptic Medications	**Morning**	**Noon**	**Night**
☐ Phenobarbital (50 mg)	_____ mg	_____ mg	_____ mg
☐ Phenytoin (100mg)	_____ mg	_____ mg	_____ mg
☐ Valproic Acid (250mg)	_____ mg	_____ mg	_____ mg
☐ Carbamazepine (200mg)	_____ mg	_____ mg	_____ mg
☐ 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:

If female:	Family planning?	☐ Yes	☐ No
	Folic acid?	☐ Yes	☐ No

Other Symptoms			
Depression, psychosis, anxiety, suicidal ideation Which: _____ ZLDSI Score: _____		☐ Yes	☐ No
Follow up with psychologist ?	☐ Yes	☐ No	☐ Referral
Plan			
Change in medication (refer to mhGAP and the medication card)? **If yes:** ☐ Dose increase ☐ Dose decrease ☐ Add medication ☐ Down-titrate medication		☐ Yes	☐ No
New Regimen (if changed)			
New Anti-epileptic Medication	**Morning**	**Noon**	**Night**
☐ Phenobarbital (50 mg)	_____ mg	_____ mg	_____ mg
☐ Phenytoin (100mg)	_____ mg	_____ mg	_____ mg
☐ Valproic Acid (250mg)	_____ mg	_____ mg	_____ mg
☐ Carbamazepine (200mg)	_____ mg	_____ mg	_____ mg
☐ Other: _____	_____ mg	_____ mg	_____ mg
For women of childbearing age or pregnant, folic acid?		☐ Yes	☐ No
Does the patient have enough medication until the next visit?		☐ Yes	☐ 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 of it the number of blood cells or platelets decreases in blood count, stop the medicine to avoid serious toxicity. ☐ **Hepatic panel** ☐ **CBC**			
Psychoeducation: Take medication daily, even if seizures stop. Discontinue medication immediately if skin rash develops. Avoid dangerous activities (bathing/swimming along, working close to fire, driving, etc).			
Next visit: __DD__ / __MM__ / __YYYY__ **Next lab exam:** __DD__ / __MM__ / __YYYY__	_____ **Signature of physician**		

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

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

Answers the call of his name	☐ Yes	☐ No

B. After the episodes...

Is the patient confused or sleepy?	☐ Yes	☐ No
An aura before the crisis (feelings of fear, smells / sounds, confusion)?	☐ Yes	☐ 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?	☐ Yes	☐ No
E. Dizziness, sweating, palpitations, vision loss, feelings of fear, strange smell?	☐ Yes	☐ No

F. Date of last episode: ____ / ____ / ____

G. Normal between episodes?	☐ Yes	☐ No
If not: ☐ cephalalgia ☐ motor weakness ☐ developmental delay		

3. Potential Predisposing Factors

A. Did seizures develop after a major trauma?	Physical	☐ Yes	☐ No
	Emotional	☐ Yes	☐ No
	Sexual	☐ Yes	☐ No

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

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

7. Psychomotor Development

Evaluation			Identified development problems	Is the patient able to work/go to school?	
Gross Motor	☐ normal	☐ not normal		☐ Yes	☐ No
Visual - Fine Motor	☐ normal	☐ not normal		If not, how many days has he been unable to go this past month? _____ days	
Language	☐ normal	☐ not normal			
Socialization/Adaption	☐ normal	☐ 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? Possible etiology _____	☐ Yes	☐ No

Diagnostic:	Epilepsy	Not Epilepsy
	☐ partial seizure or focal ☐ generalized tonic-clonic seizure ☐ secondarily generalized partial seizure ☐ generalized seizures: absence type ☐ other: _____	☐ syncope ☐ non-epileptic psychogenic seizure ☐ unprecise diagnosis

10. Plan (MD ONLY)

Medication Mini-Card	Phenobarbital (PB)	Phenytoin (PHT)	Carbamazepine (CBZ)	Valproic Acid (VPA)
First line	(Broad spectrum)	(Broad spectrum)	• Partial seizures (and including secondarily generalized) • Pregnant women	• Absence seizures in children, and generalized idiopathic epilepsy • Patients with HIV and seizures
Not recommended for	• Pregnant women • Absence seizures	Patients with liver disease	• Absence seizures • Other generalized idiopathic epileptic syndromes	• Pregnant women/ women of child-bearing age • Patients with liver disease

Anti-epileptic medications	Morning	Afternoon	Night
☐ Phenobarbital (50 mg)	_____ mg	_____ mg	_____ mg
☐ Phenytoin (100mg)	_____ mg	_____ mg	_____ mg
☐ Valproic acid (250mg)	_____ mg	_____ mg	_____ mg
☐ Carbamazepine (200mg)	_____ mg	_____ mg	_____ mg

Other medication			
	Interactions with anti-epileptics	☐ Yes	☐ No
	Adjustments to other anti-epileptic medications if necessary	☐ Yes	☐ No

For women 15–45 years old

☐ Begin 4 mg folic acid daily

☐ 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.

☐ Discuss if the patient plans to become pregnant

Lab tests

☐ HIV, RPR (age of onset > 20) ☐ B-HCG ☐ Hepatic function panel ☐ Complete blood count (CBC)

☐ Other _____

Referral

☐ Refer to the CHW, obligatorily Name of CHW _____

☐ Refer to Mental Health if necessary

☐ Refer to EEG if necessary

☐ Refer to head scan if necessary

Psychoeducation: Teach the patient: 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

☐ RDV: ____ / ____ / ____ ☐ Other: _____

Names and signatures of providers

1. Name _____ Discipline _____ Date ____ / ____ / ____

2. Name _____ Discipline _____ Date ____ / ____ / ____

3. Name _____ Discipline _____ Date ____ / ____ / ____

GUIDE FOR MEDICATION TITRATION IN PATIENTS WITH EPILEPSY

Partners In Health

At each meeting with the patient, ask and document:

- Does the patient take the medication every day?
- What is the frequency of seizures?
  - Does the patient have side effects? (vertigo, unsteadiness, drowsiness)?
  - Does the patient need to see a psychologist for psychological/psychiatric problems?

Every woman on antiepileptics must take folic acid (4 mg)

Patient suffers from seizures, NOT on medication

- Determine cause (if possible; e.g. CT scan in adults)
- Begin the medication at the starting dose
- Psychoeducation of patient and family
  - Importance of taking medication every day
  - Discontinue the medication immediately and return to the hospital
  - Help (not bathe/swim alone, not work near fire, no driving, etc).
  - If there is a seizure, the patient should be placed on their side, nothing in their mouth, go to the hospital when finished
- The patient should be seen again a month after starting a new antiepileptic

If the patient does not have a reduction in seizure frequency (or only a minimal decrease), and has no intolerable side effects, and takes medication daily

- Increase dose by a "step"
- Review in a month
- Verify the CBC and LFTs between 6 months to a year, and sodium if taking carbamazepine

Continue titration until seizures are controlled

If untolerable side effects prevent daily functioning of the patient:

AND/OR

No significant reduction in seizure frequency at the maximum dose (or maximum tolerated due to side effects)

- Add a second medication at its starting dose
- Decrease the first medication slowly by steps indicated on the Epilepsy Medication Card.

If patients at the maximum dosage with significant decrease in seizure frequency, but not completely, has no side effects and takes medication daily:

OR

Partial control of seizures but patient cannot tolerate dose increase because of side effects:

- Add a second medication at the starting dose
- Continue the two drugs together
- Follow up in a month

If seizures are well controlled with medication:

- Follow up in three months.
- If still no convulsions, you may see the patient at six month intervals (but earlier if there is a increase in frequency of seizures).
- Verify CBC and LFTs between 6 months and 1 year.

Patient with two medications

If the patient does not have a reduction in seizure frequency (or only a minimal decrease) and no intolerable side effects, and takes both drugs every day:

- Increase the second medication by one "step"
- If the first medication partially decreases the seizures, continue both medications
- If the first medication had no effects on the frequency of seizures, reduce the first medication by steps according to the Epilepsy Medication Card.
- Follow up in a month.

Continue titration of second medication until seizures are under control

If seizures are well controlled with two medications:

- Follow up in three months
- If still no convulsions, you can see patient at 6 months (or if there is a seizure)
- Verify CBC and LFTs between 6 months and 1 year

If still with frequent seizures at maximum dose of two medications and seizures are not controlled:

- Is there a cause that has not been treated (alcoholism, neurocysticercosis)?
- Consider alternative diagnosis to epilepsy
- Consider consultation with a specialist

If seizure-free for two years, you can consider reducing the original drug in stages with the Epilepsy Medication Card – but during the reduction the patient should not drive, etc.

- If seizures return, begin medication (reoccurrence risk: 40% and above at the time of medication termination).

INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services

Partners In Health

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
• Have you felt sad or lost interest in things for a two week period?	• Did you feel very happy for any reason in the last few days?	• Are you a worrier?	• Do you hear things like voices that other people don't hear?
		• What do you worry about?	
			• Do you see things that other people don't see?
• Do you feel like you've lost interest in everything or only in some things?	• Did you get angry more often in the last few days?	• Are you experiencing: ☐ Panic attacks ☐ Fear of crowded places ☐ Sleep problems ☐ Difficulty concentrating ☐ Fatigue ☐ Irritability ☐ Muscle tension ☐ Restlessness	
			• Do you feel that people are conspiring to harm you – even people whom you don't know?
• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39	• Do you: ☐ Have any difficulties of staying attentive? ☐ Speak of things that you shouldn't? ☐ Feel like you're worth more than before? ☐ Have a racing thoughts going through your head? ☐ Have an increase in activities? ☐ Sleep less? ☐ Talk without ceasing?	• Do you often experience any 4 of these problems such as: ☐ increased in heartbeat ☐ breathlessness ☐ sweating ☐ trembling ☐ fear; fear of losing control; fear of becoming crazy; fear of death ☐ feeling dizzy ☐ feel like you're losing consciousness	• Are the voices in your head controlling your thought process?

	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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Present	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐			

If yes, explain: _____

_____

Do you feel safe in your current environment? _____

PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
☐ Are you experiencing pain in your body?	• Is there a change in your: ☐ Weight? ☐ Thirst? ☐ Fever?	☐ Sight problems? ☐ Hearing problems? ☐ Voice change? ☐ Dizziness? ☐ Gum and teeth status? ☐ Difficulty swallowing?	☐ Stiffness of the neck?
BREATHING	**HEART/ARTERIES**	**DIGESTIVE SYSTEM**	**SKIN**
☐ Are you having problems breathing? ☐ Are you coughing? ☐ Do you cough out blood or find blood in your snot?	☐ Do you have an increased heartbeat? ☐ Having chest pain? ☐ Any swelling?	☐ Heart burn? ☐ Gastric Reflux? ☐ Vomiting? ☐ Constipation, diarrhea, gas?	☐ Any changes in your skin?
MUSCLES	**APPENDAGES (HANDS AND FEET)**	**GENITALS/URINATION**	**NEUROLOGICAL**
☐ Are they stiff? ☐ Swollen? ☐ Reddened?	☐ Swollen?	☐ Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often? ☐ Any problems when urinating (pain, amount/ color of urine, blood in urine)?	☐ Any numbness? ☐ Uncontrolled movements?

PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
☐ None	☐ None	☐ 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	☐ well groomed	☐ disheveled	☐ overdressed, elaborate	
Orientation	☐ O x 3	☐ disoriented to time	☐ disoriented to place	☐ disoriented to person
Behavior	☐ WNL ☐ tics	☐ retardation	☐ agitation	☐ tremor
Speech	☐ WNL	☐ slowed	☐ pressured	☐ slurred
Mood	☐ _____			
Affect	☐ euthymic ☐ irritable ☐ congruent with speech content	☐ dysphoric ☐ suspicious ☐ incongruent with speech content	☐ euphoric ☐ labile ☐ other: _____	☐ anxious ☐ flat

MENTAL STATUS EXAM CONTINUED

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

Partners In Health

		PHENOBARBITOL		PHENYTOIN		CARBAMAZEPINE		VALPROATE	
DO NOT USE IF		Women of child-bearing age		Liver disease		Absence seizures		• Women of child-bearing age • Liver disease	
First Line		(Broad spectrum)		(Broad spectrum)		• Partial seizures • Women of child-bearing age		• Absence seizures • Idiopathic generalized epilepsy	
Dosing		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**
Starting Dose		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)
"Step" of Uptitration (Amount to increase total daily dose each month)		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)
						If appears to stop working at 6 weeks, increase dose by one step			
Maximum Dose		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
Toxicities	**Serious**	• **All:** Rash, liver failure, blood count abnormalities *If rash patient must be told to stop medication immediately and return to hospital. • Carbamazepine can also cause hyponatremia.							
	Common	• **All:** Fatigue, dizziness, nausea/vomiting, incoordination, double vision • **Valproate** also causes tremors.							
Monitoring		LFTs, CBC		LFTs, CBC		LFTs, CBC, Sodium		LFTs, CBC	
Tapering **If rash, stop immediately and return to hospital*		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	
Effect on Oral Contraceptives		Decreases efficacy		Decreases efficacy		Decreases efficacy		No effect	
Women of Child-Bearing Age		• Discuss importance of contraceptive use • Folic acid 4 mg daily							
In Pregnancy		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.	
		FOR ALL PREGNANT WOMEN: • If increased seizures during pregnancy, may need higher dose. • Give Vitamin K prior to delivery to prevent hemorrhagic disease of the newborn. • Give folic acid 4 mg daily through pregnancy							
AEDS and ARVs				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

Partners In Health

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: _____

Reasons/Diagnostic Impressions:	**Services requested:**

• Psychological trauma
• Sexual abuse
• Suicide attempt
• Psychiatric emergency
• Mental confusion
• Psychosis/bipolar disorder
• Behavioral disorders
• Somatoform disorders
• Affective disorders
  • Enuresis
  • Encopresis
• Learning disorder
• Mental retardation
• Addiction
• Epilepsy
• Depression
• Depression and migraines
• Other: _____
	• Psychological Evaluation
	• Psychotherapies
	  • Grief, supportive
	  • Interpersonal therapy
	• Psychotraumatology
	• Counseling
	  • Pre-Operative
	  • Post-Operative
	  • Post-test
	  • Follow-up
	  • Adherence
	  • Pre-HAART
	• Other: _____
	• **IMPORTANT HISTORY:** _____
	_____

Signature of referring provider: _____

Mental health provider that received the referral: _____

Date of receipt: _____ Time: _____

Remarks: _____

Signature: _____

1.20.16

ZANMI LASANTE — MENTAL HEALTH SAFETY PLAN

Zanmi Lasante

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…_____

_____

05.31.16

STIGMA ASSESSMENT ACTIVITY

Partners In Health

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

Zanmi Lasante

LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
1. Passive	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you have any thoughts of ending your life, even if they are not clear in your mind? **Possible Response:** 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	Description:	
2. Non-Specific Active	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you want to die? Do you often think or talk about death? **Possible Response:** desire/wish to be dead…prefer to be dead…think frequently/talk about death…God would rather have me	Description:	
3. Methods but no Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: If you would do it, how would you do it? **Possible Response:** bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun	Description:	
4. Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you intend to act on these thoughts? **Possible Response:** 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	Description:	
5. Planification	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Have you started planning the details about how you will kill yourself? **Danger Signs:** 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).	Description:	
6. Attempted	☐ No ☐ Yes	☐ No ☐ Yes
Ask: 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? **Danger Signs:** 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.	Description:	
Low: Current = 0 Past = 0 **Medium:** Current = 1–2 yes OR Past = 1 or more yes **High:** Current = 3 or more yes OR Past = 3 or more yes	**Total "yes" in past two weeks**	**Total "yes" in past year**

12.10.15

ZANMI LASANTE — MENTAL HEALTH
SUICIDALITY TREATMENT GUIDELINES

Zanmi Lasante

Provider: _____ Location: _____ Date: ___ / ___ / ___

Last Name: _____ First Name: _____ Nickname: _____ File #: _____

For **ALL** Patients	
Act	1. ☐ Ensure that the environment will be private, safe and non-threatening. 2. ☐ Begin the process of ensuring that the patient will be able to access necessary medication. 3. ☐ Always work with the patient to develop a Safety Plan.
Say	4. ☐ Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. ☐ Start IPT and collect IP inventory. 6. ☐ Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. ☐ Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). *(Write this on the copy of your Safety Plan, on the back side).*
Contact	8. ☐ Always contact at least one person close to the patient to support and monitor them. 9. ☐ Contact as many of the current and potential supports as a patient will permit • ☐ You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients • When involving anyone, ensure that you preserve confidentiality if possible and define these: 1. ☐ Depression, suicidality 2. ☐ The needs of such patients 3. ☐ How others can help 4. ☐ How others can hurt
Team	10. Consult and involve colleagues to help. ☐ Social Worker ☐ Psychologist ☐ Community Health Worker ☐ Doctor ☐ _____
Follow Up	11. If the patient has a **higher** risk level, continue to the guidelines **below**.

For patients with **MEDIUM** risk, include these additional aspects in your care.	
Act	1. ☐ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. ☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur. 3. ☐ Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. ☐ Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. ☐ 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. **Date** _____ **Time** _____ If the patient is **high** risk, continue to the guidelines **below**.
For patients with **HIGH** risk, include these additional aspects in your care.	
Act	1. ☐ Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. 2. ☐ Seek to admit patient to the emergency room or another service with beds for at least 24 hours. 3. ☐ 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. ☐ Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. ☐ Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here). 6. ☐ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. ☐ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). 8. ☐ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. ☐ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). 10. ☐ Frequently re-assess risk level. 11. ☐ 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	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have you been emotionally affected 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	Concentrating on doing something for ten minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5
S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5

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

This concludes our interview. Thank you for participating.

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:

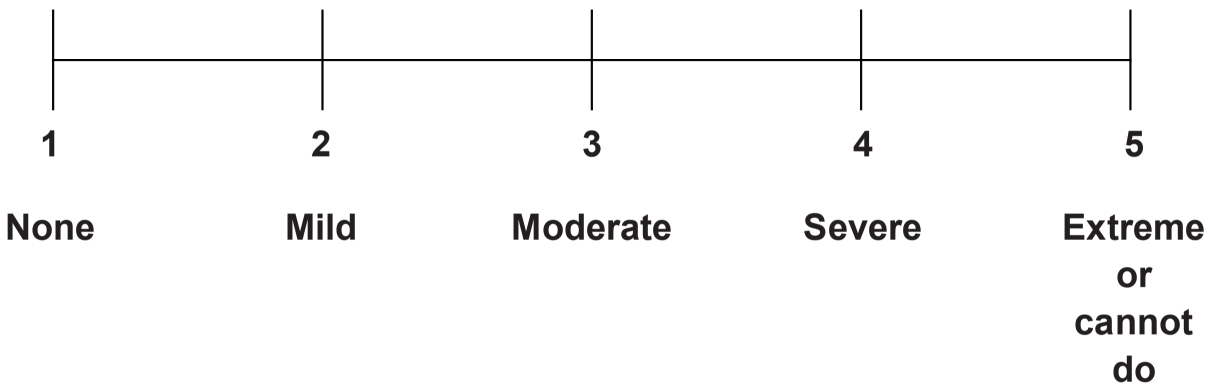
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

Think about the past 30 days only.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

Flashcard 2



ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Partners In Health

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)
1	Santi ou de la la.	0	—	1	2	3
2	Santi kè sere.	0	—	1	2	3
3	Kalkile twòp.	0	—	1	2	3
4	Kriye oubyen anvi kriye	0	—	1	2	3
5	Santi anyen preske pa enterese ou.	0	—	1	2	3
6	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
7	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
8	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
9	Ou pa gen apeti.	0	—	1	2	3
10	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
11	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
12	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
13	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
			Totals	**(+)**	**(+)**	

(=) ZLDSI Score _____

8.4.15

AGITATION, DELIRIUM, AND PSYCHOSIS

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

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Partners In Health

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.

	None, Normal	Minimal (may be extreme normal)	Mild	Moderate	Severe
Facial and Oral Movements					
1. Muscles of Facial Expression e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
2. Lips and Perioral Area e.g., puckering, pouting, smacking	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
3. Jaw e.g., biting, clenching, chewing, mouth opening, lateral movement	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
4. Tongue Rate only increases in movement both in and out of mouth, NOT inability to sustain movement	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Extremity Movements					
5. Upper (arms, wrists, hands, fingers) 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)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
6. Lower (legs, knees, ankles, toes) e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
Trunk Movements					
7. Neck, shoulders, hips e.g., rocking, twisting, squirming, pelvic gyrations	❑ 0	❑ 1	❑ 2	❑ 3	❑ 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.

	No Awareness	Aware, No Distress	Aware, Mild Distress	Aware, Moderate Distress	Aware, Severe Distress
Overall Severity					
8. Severity of abnormal movements	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
9. Incapacitation due to abnormal movements	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
10. Patient's awareness of abnormal movements (rate only patient's report)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4

	Yes	No
Dental Status		
11. Current problems with teeth and/or dentures?	❑ Yes	❑ No
12. Does patient usually wear dentures?	❑ Yes	❑ No

Comments: _____

Examiner's Signature _____ **Next Exam Date** _____

Guy W: ECDEU Assessment Manual for Psychopharmacology - Revised (DHEW Publ No ADM 76-338), US Department of Health, Education, and Welfare; 1976

Partners In Health

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).

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.

AGITATED PATIENT PROTOCOL

Partners In Health

THROUGHOUT VISIT: Assessment

- **REFER** to *Medical Evaluation Protocols for Agitation, Delirium and Psychosis*
- **RECORD** on *Agitation, Delirium and Psychosis Form*

Remember:

- **Safety:** talk first, do not medicate first
- **Medical Health:** vital signs, physical exam, mental status, exam to assess for delirium, labs and studies
- **Mental Health:** take history
- **Follow-Up:** contact psychologist/social worker

STEP 1: Determine level of agitation by observing patient behavior

MILD Agitation

- ❑ wringing/tapping of hands
- ❑ pacing, moving restlessly
- ❑ frequent requests/demands
- ❑ loud or rapid speech
- ❑ low frustration tolerance

MODERATE Agitation

- ❑ verbal threats
- ❑ yelling/cursing
- ❑ does not respond to verbal redirection
- ❑ does not respond to increased staff presence

SEVERE Agitation

- ❑ destroying property
- ❑ physical aggression (e.g., hitting, kicking, biting)
- ❑ self-injurious behavior (e.g., biting hand, head banging)

STEP 2: Manage agitation

1. Manage Behavior/Environment

- ❑ Use calm voice, simple language, soft voice, slow movements
- ❑ Ask "How can I help?" and problem solve with patient; be empathic
- ❑ Remove potentially harmful objects from area
- ❑ Ask about hunger/thirst
- ❑ Decrease stimulation/arrange 1:1
- ❑ Offer verbal support and understanding
- ❑ Allow the patient to show anger/frustration
- ❑ Calm staff
- ❑ If agitation due to delirium, consider Haldol 1– 2 mg PO; not in elderly

1. Manage Behavior/Environment
2. Consider ORAL Medications

- ❑ Offer PO medications first if (Haldol 5 mg + diphenhydramine 50 mg OR Diazepam 10 mg)
- ❑ If patient refuses PO, give IM medications (Haldol 5 mg + diphenhydramine 25 mg OR Diazepam 10 mg)
- ❑ Wait 30 minutes; if patient remains agitated, can give ½ the original dose
- ❑ Use Medication Card to monitor side effects

1. Manage Behavior/Environment
2. Consider ORAL Medications
3. Consider INTRAMUSCULAR Medications

- ❑ Haldol 5 –10 mg IM + diphenhydramine 25 mg IM OR diazepam 10 mg IM
- ❑ Wait 30 minutes; if patient remains agitated, can re-dose with ½ the original dose
- ❑ Use Medication Card to monitor side effects
- ❑ Debrief with staff
- ❑ Consult mental health team if etiology is psychiatric

SAFETY FIRST!

- Do not see the patient alone (ask for security). Remain calm. Remember that patients do not suddenly become violent; their behavior occurs along a spectrum.
- Maintain safe physical distance from patient. Do not allow exit to be blocked. Keep large furniture between you and patient.
- Remove all objects that can be used to harm (needles, sharp objects, other small objects). Check whether patient has a history of violence or substance abuse.
- Talking to patient is safe and effective. Do not yell. Keep your voice calm, quiet, and friendly.
- Make eye contact to show you care about the patient. Show sympathy and empathy ("I understand you are scared, but I am here to help. I will not hurt you.")

☑ AGITATION, DELIRIUM AND PSYCHOSIS CHECKLIST

Date dd/mm/yy

Partners In Health

CHW

AGITATED PATIENT

- ❑ Accompany patient to emergency room immediately

INITIAL EVALUATION (ONCE CALM)

- ❑ If suicidal/violent, accompany patient and family to the clinic immediately
- ❑ Decrease risk and reinforce safety if risk for suicide or violence
- ❑ Complete the Initial Visit Form
- ❑ Use the ZLDSI
- ❑ Do psychoeducation
- ❑ Give the Referral Form and Initial Visit Form to psychologist/SW

FOLLOW-UP

- ❑ If suicidal/violent, accompany patient and family to the clinic immediately
- ❑ Decrease risk and reinforce safety if risk for suicide or violence
- ❑ Document with the Mental Health Follow-Up Form
- ❑ Use the ZLDSI
- ❑ Do psychoeducation
- ❑ Give the Referral Form and Initial Visit Form to psychologist/SW
- ❑ Do follow-up of patient in the community (check patient adherence, side effects, encourage patients to do follow-ups)

PSYCHOLOGIST/SOCIAL WORKER

AGITATED PATIENT

- ❑ Accompany patient to emergency room
- ❑ Refer to the Agitated Patient Protocol; support nurse and physician
- ❑ Collect information from patient and family
- ❑ Arrange 1:1 if needed
- ❑ Remain at bedside until patient is stable
- ❑ Follow patient 2x/day, give phone number to patient's family & nurse/physician
- ❑ Using Agitation, Delirium and Psychosis Checklist, ensure medications given and medical care provided by nurse/MD
- ❑ Give patient/family psychoeducation and support
- ❑ Assess & manage socioeconomic burden of illness
- ❑ Proceed to initial evaluation (once calm)

INITIAL EVALUATION (ONCE CALM)

- ❑ Complete Psychosis Checklist with CHW/nurse
- ❑ Complete ZLDSI
- ❑ Document in Initial Mental Health Evaluation Form
- ❑ Speak with patient and TWO family members & review physician's Agitated Patient Form to complete initial mental health evaluation
- ❑ Ensure vitals, weight, and labs are checked
- ❑ Accompany patient to see physician (sees all psychotic, suicidal, violent cases)
- ❑ Help physician follow checklist
- ❑ Make preliminary diagnosis of delirium/medical illness or mental illness with the physician
- ❑ If patient needs medical care, coordinate with physicians, if patient has psychotic disorder, schedule follow-up within one week
- ❑ Do psychoeducation and support related to medication and psychosis
- ❑ Complete CGI/WHODAS, Registry, Checklist

FOLLOW-UP

- ❑ Use Mental Health Follow-Up Form
- ❑ See whether patient is improving (check mental status exam, functioning, patient and family report)
- ❑ Check medication compliance, side effects
- ❑ Ensure vitals, weight, and labs are checked
- ❑ Accompany patient to see physician; help physician follow Agitation, Delirium and Psychosis Checklist
- ❑ Plan follow-up for 1–2 weeks; coordinate with CHW
- ❑ Do psychoeducation and support for medication and psychosis
- ❑ Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist

NURSES

AGITATED PATIENT

- ❑ Alert either psychologist/social worker
- ❑ Accompany patient to emergency room
- ❑ Refer to Agitated Patient Protocol
- ❑ Manage environment
- ❑ Talk to patient; support family
- ❑ Do vital signs ASAP
- ❑ Prepare oral and IM medications if needed
- ❑ Arrange 1:1 if needed
- ❑ Monitor antipsychotic side effects, report to physician
- ❑ Continue to follow patient closely (at least every 15 min check)
- ❑ Assist doctor in medical evaluation and care (vital signs, lab tests, EKG, fluids)
- ❑ Provide psychoeducation and support to patient and family
- ❑ Document all work in nursing forms

INITIAL EVALUATION (ONCE CALM)

- ❑ Determine whether patient may be psychotic
- ❑ Accompany patient to see psychologist/SW; support collaboration with physician
- ❑ If psychosis is diagnosed, provide psychoeducation and support
- ❑ Before discharge, ensure the patient has a follow-up appt with psychologist/SW

FOLLOW-UP

- ❑ Do vital signs, weight at each visit
- ❑ Check labs when necessary
- ❑ Document in Mental Health Follow-Up Form

PHYSICIAN

AGITATED PATIENT

- ❑ Alert either psychologist/social worker
- ❑ Follow Agitated Patient Protocol to determine level of agitation and to prescribe medication if necessary
- ❑ Continue medical evaluation: physical/neuro exam, vital signs, lab tests
- ❑ Use Medication Card to monitor antipsychotic side effects (consider EKG, fluids)
- ❑ Document in Agitated Patient Form

INITIAL EVALUATION (ONCE CALM)

- ❑ Review Initial Mental Health Evaluation Form with psychologist/SW to diagnose delirium/medical illness or mental disorder
- ❑ Do complete medical evaluation: vital signs, physical/neuro exam, lab tests. Use Medical Evaluation Protocol for Agitation, Delirium and Psychosis
- ❑ If patient has a psychotic disorder or delirium, use Medication Card to dose
- ❑ Do baseline AIMS exam
- ❑ Document everything in Initial Mental Health Evaluation Form
- ❑ Provide medication to last until next appt
- ❑ Do psychoeducation about medication
- ❑ Plan follow-up with psychologist/SW

FOLLOW-UP

- ❑ Review the Mental Health Follow-Up Form with psychologist/SW to see if patient is improving
- ❑ Do physical/neuro exam
- ❑ Check weight/vitals each visit; lab tests and AIMS every 6 months
- ❑ Use Medication Card to check for side effects and to adjust dose as needed
- ❑ Provide medication to last until next appt
- ❑ Discuss discontinuation of antipsychotic with Mental Health team
- ❑ Document properly in Mental Health Follow-Up Form
- ❑ Do psychoeducation about medication
- ❑ Plan follow-up with psychologist/SW

AGITATION, DELIRIUM AND PSYCHOSIS FORM

Partners In Health

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	**What did you observe?**
Name:	
Nickname:	
Last Name:	
Sex: ☐ M ☐ F	
Address:	Is it Urgent? ☐ Yes ☐ No
Phone Number:	☐ Seizure ☐ Thinking about suicide ☐ Thinking about harming others
Date of Birth: DD/MM/YYYY	
Age:	

How do you think the patient is feeling?	**What did you do:**
☐ Patient is better now ☐ Patient is doing worse ☐ Patient is the same	☐ Check symptoms ☐ Same day therapy session ☐ Give advice ☐ Relaxation ☐ Ask if patient is out of medication ☐ Yes ☐ No ☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI?**
☐ 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	☐ Bring patient to hospital? ☐ Send patient to hospital? ☐ Encourage the family? ☐ Encourage the patient?	☐ 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	**What did you observe?**
Name:	
Nickname:	
Sex: ☐ M ☐ F	
Address:	Is it a urgent matter that needs immediate attention? ☐ Yes ☐ No
Phone:	☐ Seizure
Date of Birth: DD/MM/YYYY	☐ Thinking about suicide
Age:	☐ Thinking about harming others

Which illness do you think the patient suffers from?	**What did you do:**	
☐ Anxiety	☐ Check symptoms	☐ Ask if patient is out of medication
☐ Psychosis	☐ Same day therapy session	☐ Yes
☐ Epilepsy	☐ Give advice	☐ No
☐ Depression	☐ Relaxation	☐ Patient is not on medication

Psychoeducation	**Did you:**	**Did you use the ZLDSI form?**
☐ Explain the illness to the patient	☐ Bring patient to hospital?	☐ Yes
☐ Give him/her hope	☐ Send patient to hospital?	☐ No
☐ Give him/her the sick role	☐ Encourage the family?	What is the ZLDSI Score: _____ / 39
☐ Encourage the patient to participate in activities that makes him/her happy	☐ Encourage the patient?	

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

☐ Thomonde ☐ Belladère ☐ Boucan Carre
☐ Cange ☐ St Marc ☐ Cerca La Source
☐ Hinche ☐ Petite Rivière ☐ Mirebalais
☐ Lascahobas ☐ 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?

_____

_____

☐ Depression – ZLDSI Score _____
☐ Epilepsy
☐ Seizure
☐ Psychosis

Is the person taking any medications?

☐ Yes ☐ No

If Yes, Specify: _____

Is it Urgent? ☐ Yes ☐ No

☐ Seizure
☐ Thinking about suicide
☐ Thinking about harming others

Who do you refer the patient to:

Zanmi Lasante

☐ Psychologists
☐ Social Worker
☐ Mobile Clinic

Members of the Community

☐ Community Leader
☐ Other Community Health Workers
☐ Others (specify): _____

Date:

_____ / _____ / _____
DD MM YYYY

Remarks

Information on the person who referred the patient:

Name:	Phone:	Address:
Last Name:		
Nickname:		

Partners In Health

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

Partners In Health

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

Partners In Health

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
• Have you felt sad or lost interest in things for a two week period?	• Did you feel very happy for any reason in the last few days?	• Are you a worrier?	• Do you hear things like voices that other people don't hear?
		• What do you worry about?	
			• Do you see things that other people don't see?
• Do you feel like you've lost interest in everything or only in some things?	• Did you get angry more often in the last few days?	• Are you experiencing: ☐ Panic attacks ☐ Fear of crowded places ☐ Sleep problems ☐ Difficulty concentrating ☐ Fatigue ☐ Irritability ☐ Muscle tension ☐ Restlessness	
			• Do you feel that people are conspiring to harm you – even people whom you don't know?
• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39	• Do you: ☐ Have any difficulties of staying attentive? ☐ Speak of things that you shouldn't? ☐ Feel like you're worth more than before? ☐ Have a racing thoughts going through your head? ☐ Have an increase in activities? ☐ Sleep less? ☐ Talk without ceasing?	• Do you often experience any 4 of these problems such as: ☐ increased in heartbeat ☐ breathlessness ☐ sweating ☐ trembling ☐ fear; fear of losing control; fear of becoming crazy; fear of death ☐ feeling dizzy ☐ feel like you're losing consciousness	• Are the voices in your head controlling your thought process?

	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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Present	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐			

If yes, explain: _____

_____

Do you feel safe in your current environment? _____

PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
☐ Are you experiencing pain in your body?	• Is there a change in your: ☐ Weight? ☐ Thirst? ☐ Fever?	☐ Sight problems? ☐ Hearing problems? ☐ Voice change? ☐ Dizziness? ☐ Gum and teeth status? ☐ Difficulty swallowing?	☐ Stiffness of the neck?
BREATHING	**HEART/ARTERIES**	**DIGESTIVE SYSTEM**	**SKIN**
☐ Are you having problems breathing? ☐ Are you coughing? ☐ Do you cough out blood or find blood in your snot?	☐ Do you have an increased heartbeat? ☐ Having chest pain? ☐ Any swelling?	☐ Heart burn? ☐ Gastric Reflux? ☐ Vomiting? ☐ Constipation, diarrhea, gas?	☐ Any changes in your skin?
MUSCLES	**APPENDAGES (HANDS AND FEET)**	**GENITALS/URINATION**	**NEUROLOGICAL**
☐ Are they stiff? ☐ Swollen? ☐ Reddened?	☐ Swollen?	☐ Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often? ☐ Any problems when urinating (pain, amount/ color of urine, blood in urine)?	☐ Any numbness? ☐ Uncontrolled movements?

PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
☐ None	☐ None	☐ 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	☐ well groomed	☐ disheveled	☐ overdressed, elaborate	
Orientation	☐ O x 3	☐ disoriented to time	☐ disoriented to place	☐ disoriented to person
Behavior	☐ WNL ☐ tics	☐ retardation	☐ agitation	☐ tremor
Speech	☐ WNL	☐ slowed	☐ pressured	☐ slurred
Mood	☐ _____			
Affect	☐ euthymic ☐ irritable ☐ congruent with speech content	☐ dysphoric ☐ suspicious ☐ incongruent with speech content	☐ euphoric ☐ labile ☐ other: _____	☐ anxious ☐ flat

MENTAL STATUS EXAM CONTINUED

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

MEDICAL EVALUATION PROTOCOLS FOR AGITATION, DELIRIUM AND PSYCHOSIS SUMMARY

PROTOCOL IN A CLINIC/HOSPITAL SETTING

Partners In Health

STEP 1a: Is Person Agitated?

Patient is considered agitated if they are any of the following:

- Violent, aggressive
- Yelling, threatening
- Manic, delusional (has untrue, fixed beliefs)
- Hallucinating
- Acutely paranoid
- Wringing of hands, pacing, tapping hand
- Rapid speech, raising voice
- Frequent requests, low frustration tolerance

YES →

STEP 1b: Determine Level of Agitation and Manage

- **Refer to Agitated Patient Protocol to guide agitation management depending on symptoms and severity**
- Use calm voice
- Give verbal support
- Decrease stimuli
- Ask, "How can I help?"
- Alert staff
- Keep yourself safe
- Use WHO mhGAP (p.74) for Self-Harm/Suicide Assessment if necessary

NO ↓

THEN ↓

STEP 2: Perform Medical Assessment

(See Box 1, REFER to and RECORD information on Agitated Patient Form, including):

- **Safety:** talk first, do not medicate first
- **Medical Health:** take vital signs, physical exam, mental status exam to assess for delirium
- **Mental Health:** take history
- **Follow-Up:** contact psychologist

↓

Abnormal mental status exam or meets criteria for delirium **(See Box 2)**

YES →

- Continue evaluation and treatment of underlying medical condition.
- Consider low-dose antipsychotic for delirium (see medication card)
- Consult mental health team/psychologist

NO ↓

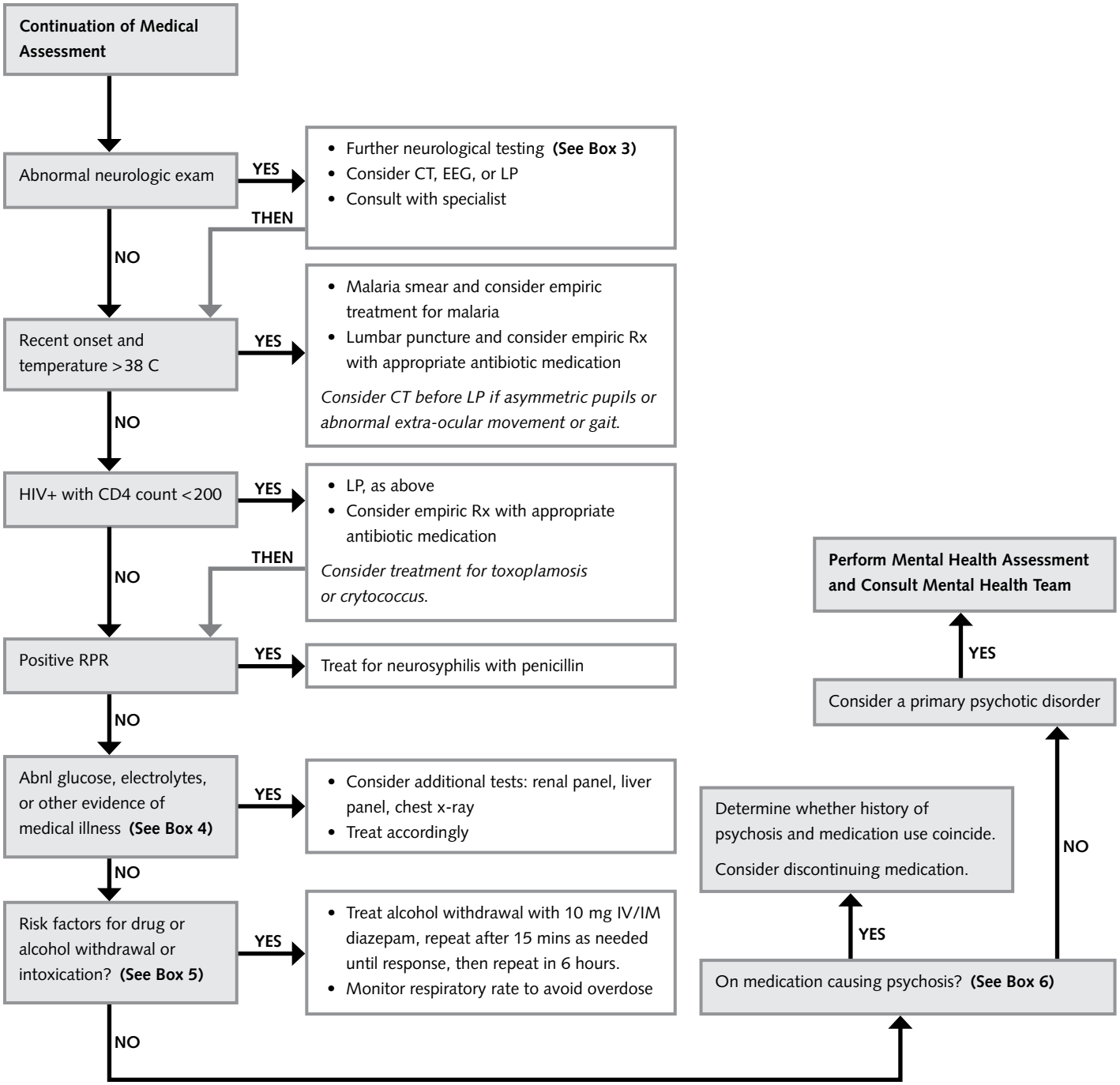
See Page 2 for continuation of Medical Assessment

Box 1: Standard Medical Evaluation for Agitation/Delirium/Psychosis

- Brief History
  - Medical History
  - Alcohol/substance abuse
  - Current medications
  - History of mental illness
- Vital signs, physical exam
- Neurological Exam
- Mental Status Exam
  - Orientation
  - Alertness
  - Confusion

Box 2: Delirium

1. Disturbance of consciousness; reduced ability to focus, sustain or shift attention.
2. A change in cognition or the development of a perceptual disturbance (hallucinations) that is not due to a preexisting, established or evolving dementia.
3. The disturbance develops over a short period of time (usually hours to days) and fluctuates during the day
4. 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.**



Box 3: Neurological Conditions that Cause or Contribute to Psychosis

- Tertiary syphilis
- Encephilitis
- 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

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

MEDICATION CARD FOR AGITATION, DELIRIUM, AND PSYCHOSIS

Partners In Health

	RISPERIDONE	HALOPERIDOL	DIAZEPAM	CARBAMAZEPINE	VALPROATE
	1st Choice: "Atypical" Antipsychotic/Mood stabilizer **Use for: Psychosis (with or without mania)**	*2nd Choice: "Typical" Antipsychotic/Mood stabilizer* **Use for: Aggressive or violent psychosis (with or without mania)**	*Benzodiazepine* **Use for: Alcohol withdrawal, acute agitation with or without anti-psychotic**	*3rd Choice: Mood stabilizer* *Do not prescribe without consulting mental health team* **Use for: Mania without psychosis**	*4th choice: Mood stabilizer* *Do not prescribe without consulting mental health team* **Use for: Mania without psychosis (longstanding aggression or violence in males)**
DO NOT USE IF	• Caution if child/adolescent	• Prior history of dystonia on antipsychotic medication • Children (18 or younger)	• Patient is delirious • Pregnant/breastfeeding women • Children (18 or younger) • Elderly (65 or older)	• Blood disorder • Epilepsy: Absence seizures • Caution if child	• **Women of child-bearing age/pregnant women** • Liver disease • Caution if child
MUST CONSULT MENTAL HEALTH TEAM	• For psychosis due to dementia (increased risk of death) • Children 18 or younger • Pregnant women	• For psychosis due to dementia (increased risk of death) • Pregnant women		• For treatment of all mental illness (excluding epilepsy) • Pregnant or breastfeeding women	• For treatment of all mental illness (excluding epilepsy)
Starting Dose (Adult)	**Take at night due to sedative effects** • Bipolar/Psychosis – 0.5–1 mg • Delirium – 0.25–0.5 mg	**Take at night due to sedative effects** • Bipolar/Psychosis Moderate sxs: 0.5–2.5 mg Severe sxs: 2.5–5 mg • Always prescribe diphenhydramine 25–50 mg daily with haloperidol • Delirium: 0.5–2.5 mg at night (Consider low-dose of risperidone first) • **Aggressive/Violent Patients: See Agitated Patient Protocol**	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
"Step" of uptitration	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
Maximum Dose	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.

		RISPERIDONE	HALOPERIDOL	DIAZEPAM	CARBAMAZEPINE	VALPROATE
Toxicities *If rash, stop medication and return to hospital	**Serious**	**Dystonia** (especially of pharynx, eyes, neck—temporary but potentially fatal), **Tardive Dyskinesia** (permanent), **Akathisia** (restlessness), **Diabetes, Cardiac arrhythmia** leading to torsades des pointes		**Risk of Seizure** if diazepam withdrawn without taper after regular use at higher dose	**Rash, liver failure, decreased white blood count** (Carbamazepine can cause **hyponatremia**) (Valproate can cause **serious birth defects** in pregnancy)	
	Common	• Sedation • Weight Gain • Lactation • Amenorrhea • Enuresis (for boys)	• Sedation • Heavy tongue • Stiffness • Arrhythmia (for patients receiving more than 10 mg daily)	• Sedation • Dependence (should not be given for long periods of time)	Fatigue, dizziness, nausea/vomiting, incoordination, double vision (Carbamazepine decreases efficacy of oral contraceptives; Valproate causes tremor)	
Monitoring		• Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available) • Every visit: weight, vital signs • Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram	• Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available) • Every visit: weight, vital signs • Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram	• Monitor for signs of sedation • Monitor for dependence (need for increased dose to achieve same effect)	LFTs, CBC, Sodium	Weight gain, LFTs, CBC HIV patients receiving valproic acid may require a zidovudine dosage reductin to maintain unchanged serum zidovudine concentrations.
Tapering/ Discontinuing If there is a life-threatening/toxic side effect, stop immediately.		• **Consult with the mental health team before tapering medication. Some patients may need to continue risperidone indefinitely.** • 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.	• **Consult with the mental health team before tapering medication. Some patients may need to continue haloperidol indefinitely.** • 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.	• Only used for the management of agitated/violent patients and alcohol withdrawal. • It should not be continued for more than several days.	Reduce by steps above every 2–4 weeks.	Reduce by steps above every 2–4 weeks.
		• For delirium, stop the medication after medical illness is treated. • 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. • For acute psychosis due to mental illness: consider slowly tapering the medication after patient is symptom-free for 3–6 months.				
Breastfeeding		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		
Manifestation		Muscle rigidity (potentially including: eye muscles, throat, neck, tongue, back) **EMERGENCY**	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 **EMERGENCY**
Treatment		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.
Toxicities	**Serious**	Anaphylaxis, anemia, arrhythmia	Arrhythmia, bronchospasm, Stevens-Johnson syndrome		
	Common	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
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____

4. Mental Status Examination

General appearance wnl	☐ Yes	☐ No	Mood disorder	☐ Yes	☐ No	Danger to self, suicidal	☐ Yes	☐ No
Speech wnl	☐ Yes	☐ No	Poor introspection	☐ Yes	☐ No	Danger to others	☐ Yes	☐ No
Behavior wnl	☐ Yes	☐ No	Thought process wnl	☐ Yes	☐ No	Anxiety, phobia	☐ Yes	☐ No
Muscle tone and strength	☐ Yes	☐ No	Thought content wnl	☐ Yes	☐ No	Poor judgement	☐ Yes	☐ No
Cognitive function wnl	☐ Yes	☐ No	Affect wnl	☐ Yes	☐ 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)

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

Partners In Health

CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
Medical Symptoms or Psychosis Caused by Medical Conditions			
Delirium	New onset abnormal mental status	• Abnormal physical exam, vital signs or laboratory studies • Abnormal mental status examination	• Seek medical source of illness • Follow Medical Evaluation Protocol for Agitation, Delirium and Psychosis
Psychotic Disorder Due to a General Medical Condition	Psychosis is the direct physiological consequence of a medical condition	• Psychotic symptoms • Evidence of a contributing medical illness	
Substance-Induced Psychotic Disorder	Prominent hallucinations or delusions	• Evidence of recent substance intoxication or withdrawal	
Post-Partum Psychosis	New onset psychosis in a female following childbirth	• Recent childbirth	
Mental Health Related Symptoms that are not Psychosis			
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.)	• Common in children and youth	• Ensure safety of patient: assess for self-harm • Seek to understand patient's explanatory model, and to assess internal level of distress • Obtain Biopsychosocial history • Identify potential stressors • Consult traditional healer if currently involved in management
Acute stress, anxiety, and trauma-related problems	Stress and traumatic experiences can result in unusual sensory and perceptual experiences that can mimic psychosis	• Significant trauma history	
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	• Identification of stressor • Poor insight into emotional stressors	
Obsessive-compulsive disorder	Excessive thoughts (obsessions) that can lead to repetitive behaviors (compulsions), with a potential component of disordered thinking	• Specific area of focus	
Autism spectrum disorders	A serious developmental disorder that impairs the ability to communicate and interact	• Longstanding history of unstable interpersonal relationships	
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	• Longstanding history of unstable interpersonal relationships • Poor insight	

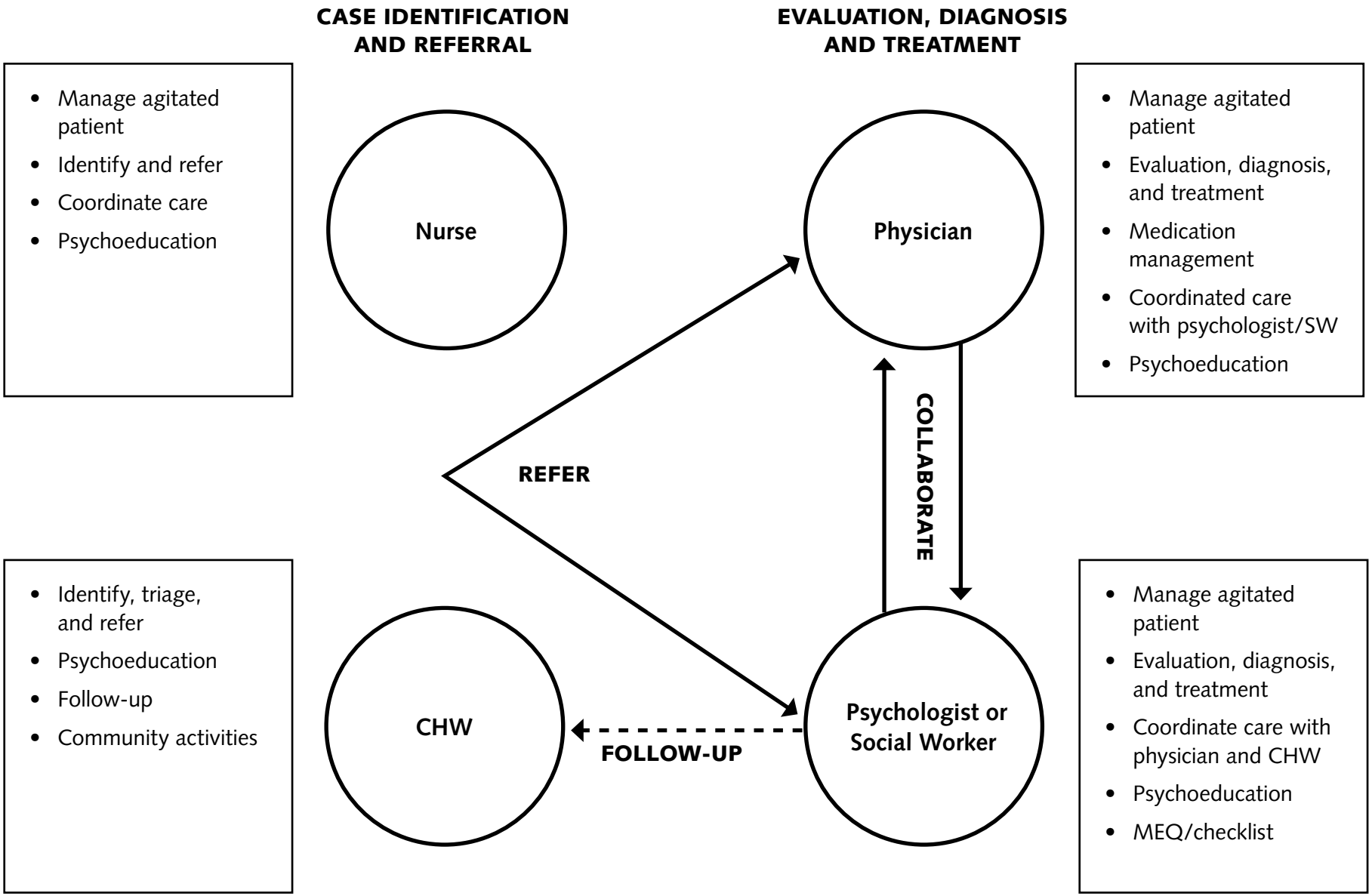
CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
Episodic Psychosis or Mania			
Depression with psychotic features (Mood Disorder, depressed)	A primary depression with psychotic symptoms.	• Depressive symptoms before psychotic symptoms	• Ensure safety of patient: assess for self-harm • Seek to understand patient's explanatory model, and to assess internal level of distress • Obtain Biopsychosocial history • Identify potential stressors • Consult traditional healer if currently involved in management • Consider co-morbid mental health diagnoses. • Both depression and psychosis are treated with distinct medications • Antidepressant medications (fluoxetine, amitryptiline) can cause mania in a person with Bipolar Disorder
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	• Period of mania, or hypomania with depression	
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	• Person returns to functioning	
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	• Do not make diagnosis of Schizophrenia if symptoms are less than 6 months	
Psychosis Not Otherwise Specified (NOS)	Psychotic symptoms about which there is inadequate information to make a diagnosis	• Examples include: psychosis of a few days or weeks duration, post-partum psychosis, and situations in which diagnosis is unclear	

CONDITION	SYMPTOMS	DIAGNOSTIC HINTS	GENERAL MANAGEMENT
	Continous Psychosis		
Schizophrenia (greater than 6 months)	DSM 5 criteria[1] 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): 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly disorganized or catatonic behavior 5. Negative symptoms, i.e., affective flattening, alogia, or avolition **Note:** 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 **Social/occupational dysfunction:** 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. **Duration:** 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. **Exclusions:** • Schizoaffective and mood disorder exclusion • Substance/general medical condition exclusion • 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	• Consider age at onset • Consider prodromal period before onset of initial symptoms	• Ensure safety of patient: assess for self-harm • Seek to understand patient's explanatory model, and to assess internal level of distress • Obtain Biopsychosocial history • Identify potential stressors • Take conservative approach to medication • Consult traditional healer if currently involved in management • Consider co-morbid mental health diagnoses
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	• Delusion is usually realistic	

[1] 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

Partners In Health



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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?

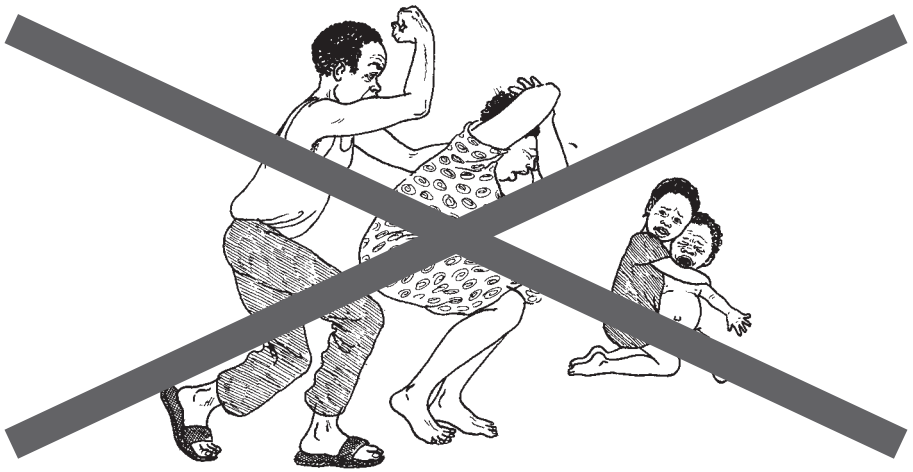
- speaking a lot/speaking too little/speaking to oneself
- hears a voice telling him/her what to do
- sees things that are not there

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.

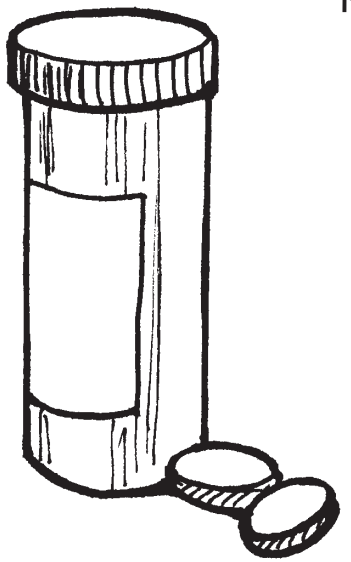
Unconfirmed Case of Psychosis

- 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.

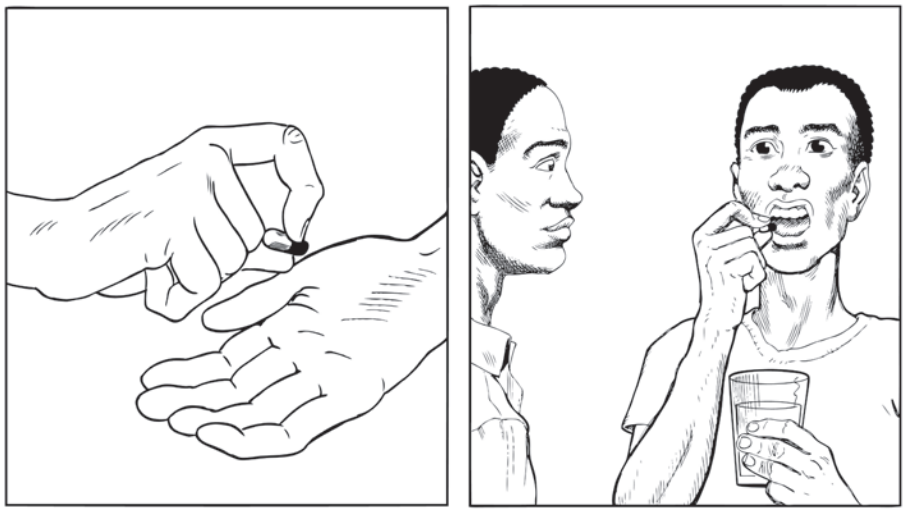


Taking medication is important.

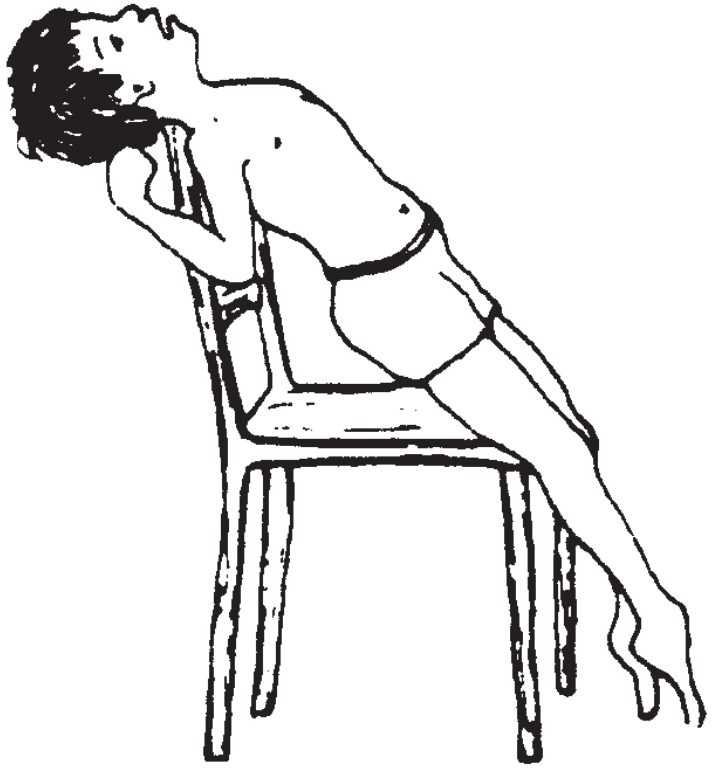
Confirmed Diagnosis of Psychosis (Visit 1)

- 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.

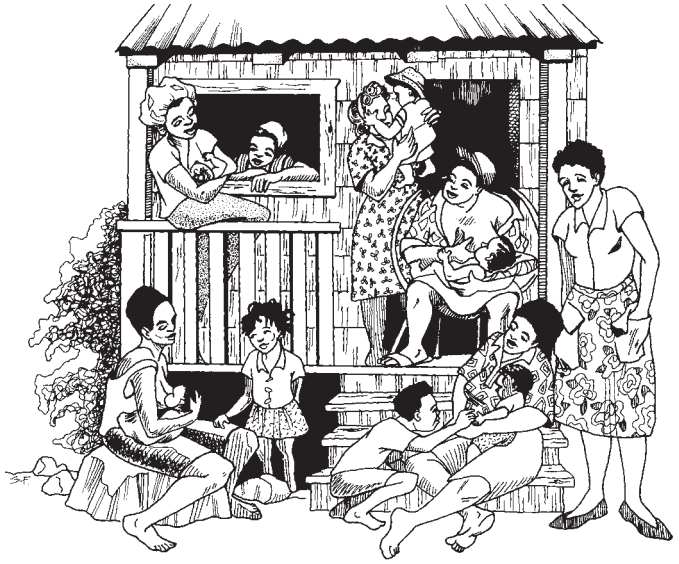
A supportive family environment will help the patient.

It's important to adhere to medication.

Confirmed Diagnosis (Visit 2)

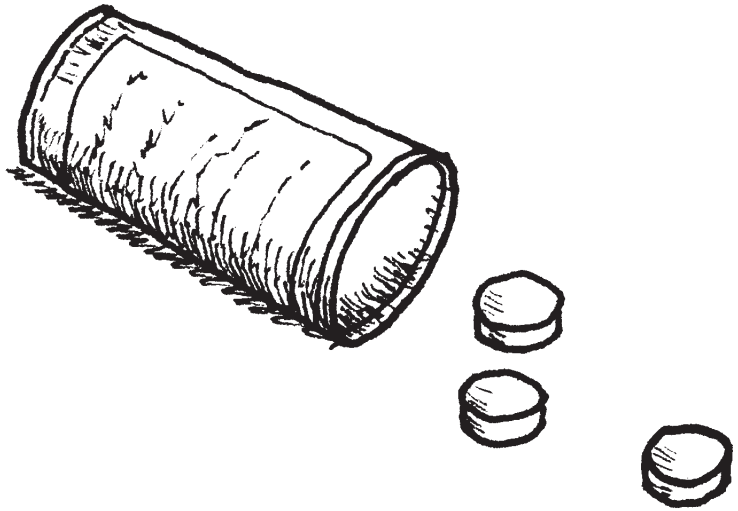
- Check adherence to the medication; check for side effects of medication.
- Check follow-up with psychologist and physician.
- Separate the illness from the person.
- Give hope about the illness.
- Challenge hope and helplessness by explaining to family what they can do to help the patient.
- Discuss 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

Partners In Health

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: _____

Reasons/Diagnostic Impressions:	**Services requested:**

• Psychological trauma
• Sexual abuse
• Suicide attempt
• Psychiatric emergency
• Mental confusion
• Psychosis/bipolar disorder
• Behavioral disorders
• Somatoform disorders
• Affective disorders
  • Enuresis
  • Encopresis
• Learning disorder
• Mental retardation
• Addiction
• Epilepsy
• Depression
• Depression and migraines
• Other: _____
	• Psychological Evaluation
	• Psychotherapies
	  • Grief, supportive
	  • Interpersonal therapy
	• Psychotraumatology
	• Counseling
	  • Pre-Operative
	  • Post-Operative
	  • Post-test
	  • Follow-up
	  • Adherence
	  • Pre-HAART
	• Other: _____
	• **IMPORTANT HISTORY:** _____
	_____

Signature of referring provider: _____

Mental health provider that received the referral: _____

Date of receipt: _____ Time: _____

Remarks: _____

Signature: _____

1.20.16

ZANMI LASANTE — MENTAL HEALTH SAFETY PLAN

Zanmi Lasante

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…_____

_____

05.31.16

STIGMA ASSESSMENT ACTIVITY

Partners In Health

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

Zanmi Lasante

LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
1. Passive	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you have any thoughts of ending your life, even if they are not clear in your mind? **Possible Response:** 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	Description:	
2. Non-Specific Active	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you want to die? Do you often think or talk about death? **Possible Response:** desire/wish to be dead…prefer to be dead…think frequently/talk about death…God would rather have me	Description:	
3. Methods but no Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: If you would do it, how would you do it? **Possible Response:** bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun	Description:	
4. Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you intend to act on these thoughts? **Possible Response:** 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	Description:	
5. Planification	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Have you started planning the details about how you will kill yourself? **Danger Signs:** 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).	Description:	
6. Attempted	☐ No ☐ Yes	☐ No ☐ Yes
Ask: 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? **Danger Signs:** 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.	Description:	
Low: Current = 0 Past = 0 **Medium:** Current = 1–2 yes OR Past = 1 or more yes **High:** Current = 3 or more yes OR Past = 3 or more yes	**Total "yes" in past two weeks**	**Total "yes" in past year**

12.10.15

ZANMI LASANTE — MENTAL HEALTH
SUICIDALITY TREATMENT GUIDELINES

Zanmi Lasante

Provider: _____ Location: _____ Date: ___ / ___ / ___

Last Name: _____ First Name: _____ Nickname: _____ File #: _____

For **ALL** Patients	
Act	1. ☐ Ensure that the environment will be private, safe and non-threatening. 2. ☐ Begin the process of ensuring that the patient will be able to access necessary medication. 3. ☐ Always work with the patient to develop a Safety Plan.
Say	4. ☐ Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. ☐ Start IPT and collect IP inventory. 6. ☐ Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. ☐ Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). *(Write this on the copy of your Safety Plan, on the back side).*
Contact	8. ☐ Always contact at least one person close to the patient to support and monitor them. 9. ☐ Contact as many of the current and potential supports as a patient will permit • ☐ You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients • When involving anyone, ensure that you preserve confidentiality if possible and define these: 1. ☐ Depression, suicidality 2. ☐ The needs of such patients 3. ☐ How others can help 4. ☐ How others can hurt
Team	10. Consult and involve colleagues to help. ☐ Social Worker ☐ Psychologist ☐ Community Health Worker ☐ Doctor ☐ _____
Follow Up	11. If the patient has a **higher** risk level, continue to the guidelines **below**.

For patients with **MEDIUM** risk, include these additional aspects in your care.	
Act	1. ☐ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. ☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur. 3. ☐ Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. ☐ Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. ☐ 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. **Date** _____ **Time** _____ If the patient is **high** risk, continue to the guidelines **below**.
For patients with **HIGH** risk, include these additional aspects in your care.	
Act	1. ☐ Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. 2. ☐ Seek to admit patient to the emergency room or another service with beds for at least 24 hours. 3. ☐ 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. ☐ Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. ☐ Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here). 6. ☐ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. ☐ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). 8. ☐ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. ☐ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). 10. ☐ Frequently re-assess risk level. 11. ☐ 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	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have you been emotionally affected 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	Concentrating on doing something for ten minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5
S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5

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

This concludes our interview. Thank you for participating.

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:

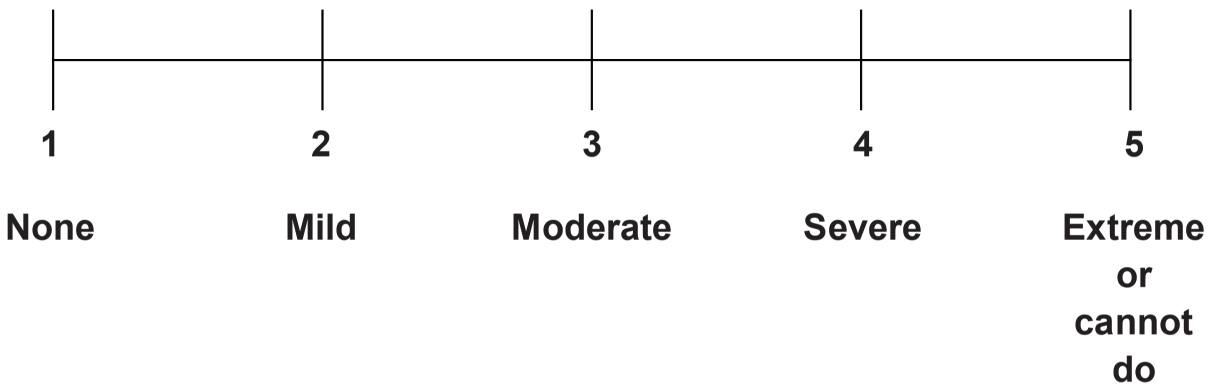
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

Think about the past 30 days only.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

Flashcard 2



ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Partners In Health

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)
1	Santi ou de la la.	0	—	1	2	3
2	Santi kè sere.	0	—	1	2	3
3	Kalkile twòp.	0	—	1	2	3
4	Kriye oubyen anvi kriye	0	—	1	2	3
5	Santi anyen preske pa enterese ou.	0	—	1	2	3
6	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
7	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
8	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
9	Ou pa gen apeti.	0	—	1	2	3
10	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
11	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
12	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
13	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
			Totals	**(+)**	**(+)**	

(=) ZLDSI Score _____

8.4.15

CHILD AND ADOLESCENT MENTAL HEALTH

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

CES-D

Partners In Health

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 ☐	2 ☐	3 ☐	4 ☐	
2. I did not feel like eating; my appetite was poor.	1 ☐	2 ☐	3 ☐	4 ☐	
3. I felt that I could not shake off the blues even with help from my family.	1 ☐	2 ☐	3 ☐	4 ☐	
4. I felt that I was just as good as other people.	4 ☐	3 ☐	2 ☐	1 ☐	
5. I had trouble keeping my mind on what I was doing.	1 ☐	2 ☐	3 ☐	4 ☐	
6. I felt depressed.	1 ☐	2 ☐	3 ☐	4 ☐	
7. I felt that everything I did was an effort.	1 ☐	2 ☐	3 ☐	4 ☐	
8. I felt hopeful about the future.	4 ☐	3 ☐	2 ☐	1 ☐	
9. I thought my life had been a failure.	1 ☐	2 ☐	3 ☐	4 ☐	
10. I felt fearful.	1 ☐	2 ☐	3 ☐	4 ☐	
11. My sleep was restless.	1 ☐	2 ☐	3 ☐	4 ☐	
12. I was happy.	4 ☐	3 ☐	2 ☐	1 ☐	
13. I talked less than usual.	1 ☐	2 ☐	3 ☐	4 ☐	
14. I felt lonely.	1 ☐	2 ☐	3 ☐	4 ☐	
15. People were unfriendly.	1 ☐	2 ☐	3 ☐	4 ☐	
16. I enjoyed life.	4 ☐	3 ☐	2 ☐	1 ☐	
17. I had crying spells.	1 ☐	2 ☐	3 ☐	4 ☐	
18. I felt sad.	1 ☐	2 ☐	3 ☐	4 ☐	
19. I felt that people disliked me.	1 ☐	2 ☐	3 ☐	4 ☐	
20. I could not "get going".	1 ☐	2 ☐	3 ☐	4 ☐	
				Total (out of 80)	

Partners In Health

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)

INITIAL MENTAL HEALTH EVALUATION

Partners In Health Mental Health & Psychosocial Services

Partners In Health

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
• Have you felt sad or lost interest in things for a two week period?	• Did you feel very happy for any reason in the last few days?	• Are you a worrier?	• Do you hear things like voices that other people don't hear?
		• What do you worry about?	
			• Do you see things that other people don't see?
• Do you feel like you've lost interest in everything or only in some things?	• Did you get angry more often in the last few days?	• Are you experiencing: ☐ Panic attacks ☐ Fear of crowded places ☐ Sleep problems ☐ Difficulty concentrating ☐ Fatigue ☐ Irritability ☐ Muscle tension ☐ Restlessness	
			• Do you feel that people are conspiring to harm you – even people whom you don't know?
• Zanmi Lasante Depression Symptom Inventory (ZLDSI): /39	• Do you: ☐ Have any difficulties of staying attentive? ☐ Speak of things that you shouldn't? ☐ Feel like you're worth more than before? ☐ Have a racing thoughts going through your head? ☐ Have an increase in activities? ☐ Sleep less? ☐ Talk without ceasing?	• Do you often experience any 4 of these problems such as: ☐ increased in heartbeat ☐ breathlessness ☐ sweating ☐ trembling ☐ fear; fear of losing control; fear of becoming crazy; fear of death ☐ feeling dizzy ☐ feel like you're losing consciousness	• Are the voices in your head controlling your thought process?

	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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Present	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐	☐
Present	☐	☐	☐			

If yes, explain: _____

_____

Do you feel safe in your current environment? _____

PHYSICAL SYMPTOMS

PAIN	WHOLE BODY	HEAD/EARS/EYES/NOSE/ THROAT	NECK
☐ Are you experiencing pain in your body?	• Is there a change in your: ☐ Weight? ☐ Thirst? ☐ Fever?	☐ Sight problems? ☐ Hearing problems? ☐ Voice change? ☐ Dizziness? ☐ Gum and teeth status? ☐ Difficulty swallowing?	☐ Stiffness of the neck?
BREATHING	**HEART/ARTERIES**	**DIGESTIVE SYSTEM**	**SKIN**
☐ Are you having problems breathing? ☐ Are you coughing? ☐ Do you cough out blood or find blood in your snot?	☐ Do you have an increased heartbeat? ☐ Having chest pain? ☐ Any swelling?	☐ Heart burn? ☐ Gastric Reflux? ☐ Vomiting? ☐ Constipation, diarrhea, gas?	☐ Any changes in your skin?
MUSCLES	**APPENDAGES (HANDS AND FEET)**	**GENITALS/URINATION**	**NEUROLOGICAL**
☐ Are they stiff? ☐ Swollen? ☐ Reddened?	☐ Swollen?	☐ Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often? ☐ Any problems when urinating (pain, amount/ color of urine, blood in urine)?	☐ Any numbness? ☐ Uncontrolled movements?

PAST PSYCHIATRIC HISTORY

NAME OF THE ILLNESS	HOSPITALISATION/ HOME TREATMENT	MEDICATION
☐ None	☐ None	☐ 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	☐ well groomed	☐ disheveled	☐ overdressed, elaborate	
Orientation	☐ O x 3	☐ disoriented to time	☐ disoriented to place	☐ disoriented to person
Behavior	☐ WNL ☐ tics	☐ retardation	☐ agitation	☐ tremor
Speech	☐ WNL	☐ slowed	☐ pressured	☐ slurred
Mood	☐ _____			
Affect	☐ euthymic ☐ irritable ☐ congruent with speech content	☐ dysphoric ☐ suspicious ☐ incongruent with speech content	☐ euphoric ☐ labile ☐ other: _____	☐ anxious ☐ flat

MENTAL STATUS EXAM CONTINUED

Thought Process	☐ linear ☐ tangential ☐ perseverative ☐ illogical ☐ loose associations ☐ _____
Thought Content	☐ WNL ☐ vague ☐ persistent preoccupation with: ☐ suicidal ideation ☐ homicidal ideation Delusions: ☐ none ☐ paranoid ☐ grandiose ☐ other: _____ Perceptual Disturbances/Hallucinations: ☐ none ☐ auditory ☐ visual ☐ olfactory ☐ gustatory ☐ tactile
Insight:	☐ poor ☐ limited ☐ good
Judgment/Impulse Control:	☐ poor ☐ limited ☐ 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
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____
_____		☐ Yes ☐ No ☐ Inc	_____

4. Mental Status Examination

General appearance wnl	☐ Yes	☐ No	Mood disorder	☐ Yes	☐ No	Danger to self, suicidal	☐ Yes	☐ No
Speech wnl	☐ Yes	☐ No	Poor introspection	☐ Yes	☐ No	Danger to others	☐ Yes	☐ No
Behavior wnl	☐ Yes	☐ No	Thought process wnl	☐ Yes	☐ No	Anxiety, phobia	☐ Yes	☐ No
Muscle tone and strength	☐ Yes	☐ No	Thought content wnl	☐ Yes	☐ No	Poor judgement	☐ Yes	☐ No
Cognitive function wnl	☐ Yes	☐ No	Affect wnl	☐ Yes	☐ 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)

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

MENTAL HEALTH AND PSYCHOSOCIAL SERVICES REQUEST FOR CONSULTATION FORM

Partners In Health

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: _____

Reasons/Diagnostic Impressions:	**Services requested:**

• Psychological trauma
• Sexual abuse
• Suicide attempt
• Psychiatric emergency
• Mental confusion
• Psychosis/bipolar disorder
• Behavioral disorders
• Somatoform disorders
• Affective disorders
  • Enuresis
  • Encopresis
• Learning disorder
• Mental retardation
• Addiction
• Epilepsy
• Depression
• Depression and migraines
• Other: _____
	• Psychological Evaluation
	• Psychotherapies
	  • Grief, supportive
	  • Interpersonal therapy
	• Psychotraumatology
	• Counseling
	  • Pre-Operative
	  • Post-Operative
	  • Post-test
	  • Follow-up
	  • Adherence
	  • Pre-HAART
	• Other: _____
	• **IMPORTANT HISTORY:** _____
	_____

Signature of referring provider: _____

Mental health provider that received the referral: _____

Date of receipt: _____ Time: _____

Remarks: _____

Signature: _____

1.20.16

ZANMI LASANTE — MENTAL HEALTH SAFETY PLAN

Zanmi Lasante

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…_____

_____

05.31.16

ZANMI LASANTE — MENTAL HEALTH SUICIDALITY SCREENING INSTRUMENT

Zanmi Lasante

LEVEL REACHED	IN THE PAST TWO WEEKS?	IN THE PAST YEAR?
1. Passive	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you have any thoughts of ending your life, even if they are not clear in your mind? **Possible Response:** 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	Description:	
2. Non-Specific Active	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you want to die? Do you often think or talk about death? **Possible Response:** desire/wish to be dead…prefer to be dead…think frequently/talk about death…God would rather have me	Description:	
3. Methods but no Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: If you would do it, how would you do it? **Possible Response:** bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun	Description:	
4. Intent to Act	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Do you intend to act on these thoughts? **Possible Response:** 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	Description:	
5. Planification	☐ No ☐ Yes	☐ No ☐ Yes
Ask: Have you started planning the details about how you will kill yourself? **Danger Signs:** 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).	Description:	
6. Attempted	☐ No ☐ Yes	☐ No ☐ Yes
Ask: 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? **Danger Signs:** 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.	Description:	
Low: Current = 0 Past = 0 **Medium:** Current = 1–2 yes OR Past = 1 or more yes **High:** Current = 3 or more yes OR Past = 3 or more yes	**Total "yes" in past two weeks**	**Total "yes" in past year**

12.10.15

ZANMI LASANTE — MENTAL HEALTH
SUICIDALITY TREATMENT GUIDELINES

Zanmi Lasante

Provider: _____ Location: _____ Date: ___ / ___ / ___

Last Name: _____ First Name: _____ Nickname: _____ File #: _____

For **ALL** Patients	
Act	1. ☐ Ensure that the environment will be private, safe and non-threatening. 2. ☐ Begin the process of ensuring that the patient will be able to access necessary medication. 3. ☐ Always work with the patient to develop a Safety Plan.
Say	4. ☐ Use the patient's name often, give hope, insist that there are other options, and declare your intent to help. 5. ☐ Start IPT and collect IP inventory. 6. ☐ Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources. 7. ☐ Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). *(Write this on the copy of your Safety Plan, on the back side).*
Contact	8. ☐ Always contact at least one person close to the patient to support and monitor them. 9. ☐ Contact as many of the current and potential supports as a patient will permit • ☐ You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients • When involving anyone, ensure that you preserve confidentiality if possible and define these: 1. ☐ Depression, suicidality 2. ☐ The needs of such patients 3. ☐ How others can help 4. ☐ How others can hurt
Team	10. Consult and involve colleagues to help. ☐ Social Worker ☐ Psychologist ☐ Community Health Worker ☐ Doctor ☐ _____
Follow Up	11. If the patient has a **higher** risk level, continue to the guidelines **below**.

For patients with **MEDIUM** risk, include these additional aspects in your care.	
Act	1. ☐ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.
Say	2. ☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur. 3. ☐ Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.
Contact	4. ☐ Close family should be informed quickly and explicitly of the patient's suicidality.
Team	5. ☐ 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. **Date** _____ **Time** _____ If the patient is **high** risk, continue to the guidelines **below**.
For patients with **HIGH** risk, include these additional aspects in your care.	
Act	1. ☐ Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. 2. ☐ Seek to admit patient to the emergency room or another service with beds for at least 24 hours. 3. ☐ 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. ☐ Despite the potential necessity of negating the patient's autonomy, do as much as possible to preserve dignity.
Contact	5. ☐ Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here). 6. ☐ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).
Team	7. ☐ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). 8. ☐ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.
Follow Up	9. ☐ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). 10. ☐ Frequently re-assess risk level. 11. ☐ 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	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
S5	How much have you been emotionally affected 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	Concentrating on doing something for ten minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5
S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5

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

This concludes our interview. Thank you for participating.

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:

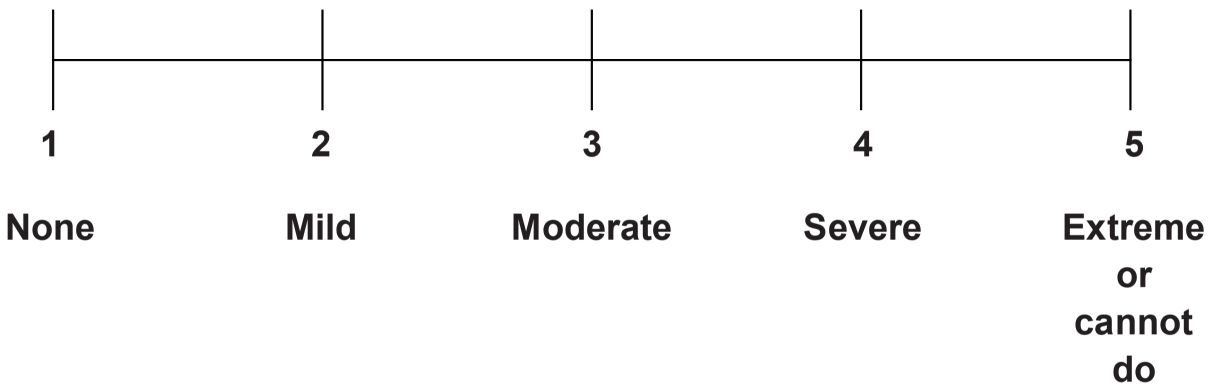
- **Increased effort**
- **Discomfort or pain**
- **Slowness**
- **Changes in the way you do the activity**

Think about the past 30 days only.

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

Flashcard 2



ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)

Partners In Health

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)
1	Santi ou de la la.	0	—	1	2	3
2	Santi kè sere.	0	—	1	2	3
3	Kalkile twòp.	0	—	1	2	3
4	Kriye oubyen anvi kriye	0	—	1	2	3
5	Santi anyen preske pa enterese ou.	0	—	1	2	3
6	Santi ou kagou, dekouraje ak lavi, oubyen pèdi espwa nèt ale.	0	—	1	2	3
7	Gen difikilte pou dòmi pran ou.	0	—	1	2	3
8	Santi ou fatige oubyen ou manke fòs.	0	—	1	2	3
9	Ou pa gen apeti.	0	—	1	2	3
10	Ou santi lavi-w pase mal oubyen ou santi-w pa alèz ak tèt-w.	0	—	1	2	3
11	Fè mouvman oubyen pale tèlman dousman, menm lòt moun wè sa.	0	—	1	2	3
12	Ou di nan tèt ou: Pito-w te mouri, oubyen ou gen lide pou fè tèt-w mal.	0	—	1	2	3
13	Gen difikilte pou rete dòmi jouk li jou.	0	—	1	2	3
			Totals	**(+)**	**(+)**	

(=) ZLDSI Score _____

8.4.15