Partners In Health (PIH) is an independent, non-profit organization founded over twenty years ago in Haiti with a mission to provide the very best medical care in places that had none, to accompany patients through their care and treatment, and to address the root causes of their illness. Today, PIH works in fourteen countries with a comprehensive approach to breaking the cycle of poverty and disease — through direct health-care delivery as well as community-based interventions in agriculture and nutrition, housing, clean water, and income generation.

PIH's work begins with caring for and treating patients, but it extends far beyond to the transformation of communities, health systems, and global health policy. PIH has built and sustained this integrated approach in the midst of tragedies like the devastating earthquake in Haiti. Through collaboration with leading medical and academic institutions like Harvard Medical School and the Brigham & Women's Hospital, PIH works to disseminate this model to others. Through advocacy efforts aimed at global health funders and policymakers, PIH seeks to raise the standard for what is possible in the delivery of health care in the poorest corners of the world.

PIH works in Haiti, Russia, Peru, Rwanda, Sierra Leone, Liberia Lesotho, Malawi, Kazakhstan, Mexico and the United States. For more information about PIH, please visit www.pih.org.

Many PIH and Zanmi Lasante staff members and external partners contributed to the development of this training. We would like to thank Giuseppe Raviola, MD, MPH; Rupinder Legha, MD; Père Eddy Eustache, MA; Tatiana Therosme; Wilder Dubuisson; Ketnie Aristide; Leigh Forbush, MPH; Rami Murali, MA, MPH; Anne Becker, PhD, MD; Mary Kay Smith Fawzi, ScD. and Meg Gerbasi, PhD.


We would like to thank Grand Challenges Canada for their financial and technical support of this curriculum and of our broad mental health systems-building in Haiti.

© Text: Partners In Health, 2015
Photographs: Rebecca E. Rollins/Partners In Health
A young girl traces her finger along the ridges of the giant mosaic at the entrance of the External Clinic at University Hospital in Mirebalais, Haiti. (Photo by Rebecca E. Rollins/Partners In Health)
Design: Elizabeth Martin and Partners In Health
This manual is dedicated to the thousands of health workers whose tireless efforts make our mission a reality and who are the backbone of our programs to save lives and improve livelihoods in poor communities. Every day, they work in health centers, hospitals and visit community members to offer services, education, and support, and they teach all of us that pragmatic solidarity is the most potent remedy for pandemic disease, poverty, and despair.
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### Additional Resources:

mhGAP Intervention Guide English:

mhGAP module – Assessment Management of Conditions
Specifically Related to Stress:
www.who.int/mental_health/emergencies/mhgap_module_management_stress/en/

Diagnostic and Statistical Manual of Mental Disorders (DSM) IV
Introduction to Child & Adolescent Mental Health

INTRODUCTION

Mental disorders are a significant cause of disability in children and adolescents, more prevalent than leukemia, diabetes and AIDS combined. It's estimated that at least 20% of children aged 9–17 have a diagnosable mental disorder with impairment in functioning. Most do not receive care. Mental health services are greatly needed, and there is a paucity of trained specialist providers in most of the world. While culture and local belief systems can inform how mental disorders are manifested, there exists a common set of broad mental health problems and disorders that can present across cultures. Basic skills in spoken communication, evaluation, and psychoeducation can be important interventions for children and families. Psychosocial approaches that include a range of non-pharmacologic interventions that engage the child, adolescent and family in the process of adaptive change should take precedence over a medical or pharmacologic approach. This requires familiarity with the range of local resources, formal (medical systems) and informal (community systems), as well as the variety of therapeutic techniques and their indication in context.

A balanced bio-psycho-social approach to case assessment and formulation is essential. This requires adequate evaluation. Knowing how to recognize normal development based on a child’s age, how to interview family members as well as children, how to ask the right questions in a supportive, empathic way to obtain important information, and how to manage confidentiality, are just some of the issues that arise in the evaluation of children and adolescent mental health concerns. With training, knowledge and experience, a great difference can be made in the lives of children, adolescents and families that are struggling with mental health-related concerns.

In this training, psychologists will receive a broad overview of ethics, normal child development, psychopathology, and evaluation as related to the care of children and adolescents with mental health concerns. Psychologists will leave this training with a further understanding of the important role of both the health system and community in supporting children and youth, including schools and teachers. Ultimately, psychologists will gain greater confidence in assessing children and youth with mental health concerns and will have improved identification, management and treatment skills pertaining to children and adolescent mental health issues.

OBJECTIVES

By the end of this training, participants will be able to:

Session 1:
  a. Describe the purpose of the training.
  b. Establish ground rules that create a respectful and trusting environment.
  c. Demonstrate prior knowledge of the training topic.

Session 2:
  d. Explain the concept of normal development.
  e. Describe the role that genetics and the environment play in child development.
  f. List the stages and domains of child development.
  g. Identify the biological, psychological and social threats to normal child development.

Session 3:
  h. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the infancy development phase.
  i. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the toddlerhood development phase.

Session 4:
  j. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the childhood development phase.
  k. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the adolescence development phase.

Session 5:
  l. Define the four governing ethical principles.
  m. Explain the difference between assent, consent and dissent related to mental health care.
  n. Describe when mental health providers have a legal obligation to breach confidentiality and report certain situations.

Session 6:
  o. Outline the responsibilities of psychologists during an initial mental health evaluation and follow-up evaluation.
  p. Explain when and how to use the HEADDS interview guide questions during an interview with a child/adolescent.
  q. Describe pharmacologic and non-pharmacologic treatment options available for children/adolescents with mental health disorders.
Session 7:
  r. Define Failure to Thrive.
  s. Describe how to evaluate a child who may be experiencing Failure to Thrive.
  t. List psychoeducation messages about Failure to Thrive and treatment options to share with families.

Session 8:
  u. Explain the difference between intellectual disabilities and neurodevelopmental disabilities.
  v. Identify signs and symptoms of intellectual disabilities and neurodevelopmental disabilities.
  w. Utilize mhGAP to assess and manage developmental disorders.

Session 9:
  x. Name common stress-related mental disorders, and their ideal management and treatment in children/adolescents.
  y. Identify at-risk populations for psychological problems after traumatic events.
  z. Describe the physical, psychological, emotional, relational reactions to traumatic events.
  aa. Utilize mhGAP to assess and manage conditions specifically related to stress.

Session 10:
  ab. Identify signs and symptoms of depression in children/adolescents.
  ac. Describe disorders that commonly mimic depression in their presentation.
  ad. Correctly use the ZLDSI and CES-D to screen for depression in children/adolescents.
  ae. Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.
  af. Describe the pharmacologic and non-pharmacologic treatment of depression in children/adolescents.

Session 11:
  ag. Describe how to use the CGI and WHODAS to assess clinical improvement.
  ah. Explain the importance of outcome measures to assess care quality and systems improvement.

Session 12:
  ai. Review all unit objectives.
  aj. Demonstrate learning through a post-test.
  ak. Give feedback on the training.
TIME REQUIRED

3½ days (22 hours and 30 minutes of training sessions)

DAY 1: 6 hours and 15 minutes of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions, Pre-test, Confidentiality</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
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<tr>
<td></td>
<td></td>
<td>• Icebreaker</td>
<td>45 minutes</td>
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<tr>
<td></td>
<td></td>
<td>• Assessment</td>
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</tr>
<tr>
<td>2</td>
<td>Overview of Early Childhood Development</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
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<td></td>
<td></td>
<td>• Small group discussion</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Childhood Development – Infancy through Toddlerhood</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group discussion</td>
<td>15 minutes</td>
</tr>
<tr>
<td>4</td>
<td>Childhood Development – Childhood through Adolescence</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
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<td></td>
<td></td>
<td>• Reflection journey</td>
<td>15 minutes</td>
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<td></td>
<td></td>
<td>• Group discussion</td>
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</table>

DAY 2: 6 hours of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Day 1 Review</td>
<td>• Group presentations</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5</td>
<td>Ethics and Laws of Child and Adolescent Mental Health</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Small group discussion</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Child and Adolescent Assessment and Treatment Options</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
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<tr>
<td></td>
<td></td>
<td>• Mock interviews</td>
<td></td>
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<tr>
<td>7</td>
<td>Child Development and Failure to Thrive</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case study</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Carousel activity</td>
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</tbody>
</table>

DAY 3: 6 hours of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Day 2 Review</td>
<td>• Game</td>
<td>30 minutes</td>
</tr>
<tr>
<td>8</td>
<td>Learning and Developmental Problems</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case study</td>
<td>30 minutes</td>
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<tr>
<td></td>
<td></td>
<td>• Large group presentation</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Trauma and Anxiety</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case study</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Post-it activity</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Depression and Suicide</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case study</td>
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<td></td>
<td></td>
<td>• Role play</td>
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</tbody>
</table>
DAY 4: 4 hours and 15 minutes of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Day 3 Review</td>
<td>Quiz</td>
<td>1 hour</td>
</tr>
<tr>
<td>11</td>
<td>Clinical Outcome Measures: CGI and WHODAS</td>
<td>Facilitator presentation, Case study, Role play</td>
<td>2 hours</td>
</tr>
<tr>
<td>12</td>
<td>Post-test and Feedback</td>
<td>Assessment, Reflection</td>
<td>1 hour 15 minutes</td>
</tr>
</tbody>
</table>

MATERIALS NEEDED

<table>
<thead>
<tr>
<th>Materials</th>
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<tbody>
<tr>
<td>Facilitator Manual — 1 copy/facilitator</td>
</tr>
<tr>
<td>Participant Handbook — 1 copy/participant</td>
</tr>
<tr>
<td>Introduction to Child and Adolescent Mental Health PowerPoint</td>
</tr>
<tr>
<td>Laminated WHODAS Flashcards — 1 set/participant</td>
</tr>
<tr>
<td>DSM IV (participants should bring their own copies)</td>
</tr>
<tr>
<td>mhGAP Intervention Guide</td>
</tr>
<tr>
<td>mhGAP Module — Assessment Management of Conditions Specifically Related to Stress</td>
</tr>
<tr>
<td>Initial Mental Health Evaluation Form — 1 copy/participant</td>
</tr>
<tr>
<td>Suicidality Screening Instrument — 1 copy/participant</td>
</tr>
<tr>
<td>Computer and Projector</td>
</tr>
<tr>
<td>Flip chart</td>
</tr>
<tr>
<td>Markers</td>
</tr>
<tr>
<td>Post-it Notes — estimate 10/participant</td>
</tr>
<tr>
<td>Tape</td>
</tr>
</tbody>
</table>
SESSION 1: Introduction, Pre-test and Confidentiality

Methods: Facilitator presentation, icebreaker, assessment

Time: 1 hour 45 minutes

Materials:
- PowerPoint presentation (Introduction to Child and Adolescent Mental Health slides 1–12)
- Pre-test (1 copy/participant)
- Flip chart or chart paper
- Markers, pens
- Tape
- Post-it Notes

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 1–12.
- Post a blank sheet of paper on the flip chart and title it “Goals & Expectations.”
- Post a blank sheet of paper on the flip chart and title it “Training Rules.”
- Photocopy the pre-test (see appendix).

Objectives:
- a. Describe the purpose of the training.
- b. Establish ground rules that create a respectful and trusting environment.
- c. Demonstrate prior knowledge of the training topic.

NOTE FOR FACILITATOR PREPARATION

General Tips for Presenting PowerPoint (PPT) Slides:
When presenting PPT slides, it is not necessary to read everything on each slide. Instead, summarize the main ideas on the slide and add any supplemental information that will help the audience understand the most important ideas.

Encourage participant feedback during PPT presentations. Some slides have a conversation bubble. Use these conversation prompts to ask the audience questions and hear their feedback before clicking forward to reveal the answers.
STEPS

35 minutes

1. Turn on projector and begin the PowerPoint at Slide 1: Introduction to Child and Adolescent Mental Health. Welcome participants, introduce yourself and this training. Tell the participants that this training is about child and adolescent mental health.

2. Explain to the participants that they have materials and resources that will be referred to throughout the training. The materials and resources will also be a resource to them once the training is over. Tell the participants that the additional materials will be distributed and explained as the training progresses.

3. Have participants turn to the agenda. Tell them that the training is divided into a series of sessions as they can see listed in the agenda.

4. Ask the participants to open their handbooks. Tell the participants that each session has learning objectives associated with it. Tell them that the learning objectives represent what they should learn during each session of the training. The participants should re-visit the learning objectives throughout the training to assure that they are meeting the expectations for the training. Request that the participants ask for clarification or more information if ever they feel like they do not meet a learning objective.

5. Show Slides 1–5.
   Read the objectives on the slide.

   Explain: While culture and local belief systems can inform how mental disorders are manifested, there exists a common set of broad mental health problems and disorders than can present across cultures.

Ask participants: What are some of the devastating consequences for children and youth with untreated mental disorders?

- Worse physical health
- Poor school performance
- Future difficulties finding a good job
- Cause serious suffering for themselves and family
- Can lead to other risky behaviors, such as alcohol or drug use and even suicidal behavior or violence
7. Show slides 8–12.

Explain:
- Zanmi Lasante is supporting the Ministry of Health by piloting a “system of care” for mental health that is integrated into the mental health system of care, using not only psychologists, but other providers including physicians, nurses and community health workers, who are not mental health specialists.
- In 2012, ZL received a grant from Grand Challenges Canada to support this work.
- Given the lack of specialists, a range of people can potentially provide components of psychosocial and/or mental health services (“task sharing”).
- With the support of Grand Challenges Canada, over the next three years ZL will scale up care for priority conditions that include:
  - Depression in Year 1
  - Bipolar disorder, psychosis and epilepsy in Year 2
  - Child and adolescent conditions in Year 3
- Teachers are a key part of child and adolescent mental health. Teachers are often “first responders” to youth who have emotional distress, who are engaging in risky behaviors that are unsafe, or who show signs of mental illness. Teachers also often know students and their home situation well. Because of this, the ZL Mental Health Team is working to train teachers to **recognize** students’ mental health problems, **respond** to them with compassion and support, **refer** youth with problems for treatment and support the **resilience** of students.

8. Turn off the projector (or cover the lens).

40 minutes

9. Pass out one Post-it note to each participant. Ask participants to take a minute and write down one goal or expectation that they have for this training. Then, have all the participants introduce themselves and share their goal. After each person speaks, post their Post-it note to the flip chart entitled “Goals and Expectations.”

10. Assure the participants that many of these goals and expectations will be met during the training. Others will be addressed through monthly meetings and ongoing communication with the participants.

11. Explain that in order to ensure an effective training, the group will follow some ground rules. Invite participants to brainstorm ground rules. Write the ground rules on a sheet of chart paper and keep it posted during the training. Ground rules can include: punctuality; confidentiality; participation in discussions and activities; respect for different opinions; cell phones off.
**Confidentiality**

Confidentiality is one of the most important parts of being a clinician. You must keep everything that family members tell you, and everything you know about their condition, confidential. You should only share such information with other clinicians when needed.

Some of you may reference confidential patient information during the training. You must share or ask in a way that maintains confidentiality. For example, do not use the person’s name, say where she or he lives, or give any other information that would reveal the person’s identity. Also, you must not talk about confidential information outside of this training.

12. Write “parking lot” on a piece of flip chart paper and hang it on the wall. Tell participants that when a question is raised that might not be answerable or relevant at that particular moment, it will go to the “parking lot.” By the end of the training all questions in the parking lot will hopefully be answered, and if not, the facilitators will guide participants to the resources to answer remaining questions.

30 minutes

13. Distribute the pre-test and explain how it should be completed.

14. Collect the completed pre-tests.

15. Explain that the participants will take a post-test at the end of the training in order to measure what they have learned.
SESSION 2: Overview of Early Childhood Development

Methods: Facilitator presentation, small group discussion

Time: 2 hours

Participant Handbook page: 4

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 13–22
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 13–22.

Objectives:
- Explain the concept of normal development.
- Describe the role that genetics and the environment play in child development.
- List the stages and domains of child development.
- Identify the biological, psychological and social threats to normal child development.

STEPS

45 minutes


   Read the objectives and explain to participants that the group will begin to discuss child development. Tell participants:
   - They will spend the next day learning about normal child development. This is important because it is only through understanding what is normal child development that a psychologist can determine who may be experiencing abnormal development or have a mental disorder.
   - Every culture will have its own variation in child development milestones and what is considered “normal.” We will discuss this idea further throughout the day.

2. Show Slide 15.

   Ask participants:
   - Who can tell me what “nature vs. nurture” refers to?

Once a definition has been given by a participant, ask:
- What determines how a child will develop—is it genetics or the environment?
Tell participants that a combination of genetics and environment determines how a child will develop, both before and after birth.

3. Ask participants to think about their skills and beliefs and how they acquired them. Ask students to think about the following:
   - What languages do you speak fluently? How did you learn that language? When did you learn it?
   - Think about something new you learned to do in the past year. (Example: Cook a certain meal? Used a new computer program? Utilized a new type of therapy?). How did you learn it? Do you think it took you longer to learn this skill now than if you had learned it when you were younger?

   Have participants record their thoughts to this activity in their participant handbook.

4. Ask participants to share what they wrote. Discuss the different ways the students have learned things throughout their lives (in school, at home and in the community). During the discussion, talk about the different things (events, places, books/media, peers, parents, teachers, etc.) which have helped to shape their thoughts and actions.

   Ask participants what role time plays in learning and development.

5. Show Slides 16–17.

   Tell participants that certain skills and abilities have a “sensitive period” where the skill is best learned at that time (speaking, walking). A second language, for instance, is more easily learned and mastered at an early age.

   “Critical periods,” on the other hand, are periods in which the child needs to learn that skill, or else it will be extremely difficult (or impossible) to do so afterwards. An example of a critical period is speaking—if a child is never introduced to language until a late stage of childhood, they will almost never be able to master the skill of speaking.

45 minutes


   Explain that both the child and environment (parenting and other risk factors) play a role in determining the course of development. Parents and children influence each other over time: parent behavior affects subsequent child behavior, but parent behavior itself was influenced by previous child behavior.
7. Invite participants to turn to the person sitting next to them and instruct the participants to brainstorm how parents and children influence one another. Suggest that every pair comes up with one concrete example of how a child’s action can influence a parent’s action (or reaction) which, in turn, affects the child’s next action.

8. After giving participants a few minutes to discuss, invite participants to share their examples with the larger group. Stress that positive parent-child relationships are critical to positive child development.

   Read the slide and discuss further the issue of insecurely attached infants.

   Explain that: Insecurely attached infants may appear:
   • Not distressed when the caregiver leaves the room and react to both strangers and the caregiver in a similarly unresponsive fashion. (Avoidant attachment).
   • Hesitant to explore an unfamiliar playroom while the caregiver is present, becoming upset when the caregiver leaves and is angry with the caregiver when she returns, showing some resistance to being comforted. (Resistant attachment).
   • Confused, contradictory or emotionally labile in their behavior, with some of these infants showing signs of disassociation (frozen facial expression and total unresponsiveness). (Disorganized attachment).

10. Show Slides 20–21.
    Explain the basic stages of development and the domains of child development.

    Remind participants that according to the biopsychosocial model, there are three main factors that contribute to developing a mental disorder:
    • Biological factors
    • Psychological factors
    • Social factors

    Tell participants they will now participate in small group discussion to further discuss the risks posed to Haitian children and youth, biologically, psychologically and socially.

    30 minutes

12. Divide participants into groups of 4–5 participants. Ask each group to discuss the biological, social and psychological threats to normal development for children living in Haiti. Encourage participants to fill in the table in their participant handbooks as they discuss these risks.
13. Give participants 10–15 minutes to discuss these risks. After 15 minutes, invite each group to briefly share some of the risks they discussed; record the risks mentioned on a flipchart. Introduce additional risks if not mentioned by participants:

Biological:
• Poor prenatal care, unattended child delivery, birth trauma, infection and low birth weight
• Genetic conditions associated with developmental disabilities
• Family history of mental illness
• Lack of healthcare provider interactions; lack of preparation of healthcare providers
• Malnutrition, and chronic illness of parents

Psychological:
• Poor opportunities for exploration and play for young children
• Maternal depression leads to higher mortality and morbidity rates
• Displacement with loss of support of extended family

Social:
• Poverty, lack of education, unemployment of parents
• Teen pregnancy leads to unprepared, young parents
• Gender inequalities placing women at high risk for difficulties in caring for children
• Families have many children, meaning there is greater risk for neglect

14. Tell participants that in the next section, participants will learn about the various stages of child development: infancy, toddlerhood, childhood and adolescence.
SESSION 3: Childhood Development – Infancy through Toddlerhood

Methods: Facilitator presentation, group discussion

Time: 1 hour 15 minutes

Participant Handbook page: 9

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 23 – 28
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 23 – 28.

Objectives:
- Identify major cognitive/linguistic and social-emotional/behavioral milestones during the infancy development phase.
- Identify major cognitive/linguistic and social-emotional/behavioral milestones during the toddlerhood development phase.

STEPS

25 minutes

   Explain that these next two sessions explore child development, which encompasses the biological and psychological changes that occur in children as they grow.

2. Tell participants they are going to take some time to think about child development and the various phases and milestones that children complete between infancy and adolescence.

3. Ask participants to open their participant handbook to the child development timeline (page 8). Tell participants that they should spend the next five minutes filling in the child development timeline with development milestones that children achieve at different points in their lives.
   Explain that a “milestone” is demonstration of a physical skill or behavior seen in children as they develop. Various stages of development have different milestones.
   Examples of milestones include: talking, learning to crawl or walk, eating solid food etc.
If participants are struggling with the concept of milestones, participants can alternatively come up with descriptions of social/emotional/cognitive/physical changes that happen during each development period.

4. Allow participants to work in pairs or small groups if they prefer. After 10 minutes of filling in their ideas on their timelines, ask for participants to share their thoughts about child development milestones.

5. Tell participants that they will continue to think about milestones through the next two sessions.

6. Start a conversation about infant development by asking participants:
   • Does development of a child just start at birth?

   Allow participants to respond.

   Tell participants that a child’s development is in part determined before a baby is even born. As we just learned, there are both genetic and environmental factors that affect how children develop.

7. Ask:
   • What are some risk factors during pregnancy that could impact a child’s mental health and development?

   Write down participants’ answers on the flip chart.
35 minutes

8. Show Slide 24: Brain Development from Infancy to Adulthood.
   Explain that once a child is born the brain begins to grow quickly. The brain doubles in size in the first year of life, and has reached 80% of its adult volume by age three. Synapses, which are connections between neurons in the brain, are formed very quickly in the first few years of life, as shown on the slide.

   Explain how infancy is characterized from 0–2 years.

   Ask participants if what they are learning about infant milestones is what they originally wrote on their child development timeline.

10. Show Slide 28: Toddlerhood.
    Explain the various milestones of toddlerhood.

    Begin a discussion by asking:
    • How do children learn right from wrong?
    • How are children disciplined in Haiti and what messages do children take away from that method of discipline?

    Connect participants’ answers to toddlerhood and the influence of parents, friends and authority figures in shaping children’s development.
SESSION 4: Childhood Development – Childhood through Adolescence

Methods: Facilitator presentation, Reflection journey, Group discussion

Time: 1 hour 15 minutes

Participant Handbook page: 11

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 29–32
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 29–32.

Objectives:
j. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the childhood development phase.
k. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the adolescence development phase.

STEPS

15 minutes

1. Show Slide 29.
   Explain to participants that they will now learn about the other two phases of child development—childhood and adolescence.

2. Ask the participants to begin by closing their eyes or putting their heads down. Explain that you will take them through a ‘Reflection Journey’—some quiet thinking before a large group discussion.

3. Once the participants are ready, lead them through the following ‘Reflection Journey.’ Be sure to pause for 5–10 seconds after each question to allow the participants to reflect. Keep in mind that you do not need to ask every question (and you may add any questions that might be more relevant).
   When you think about a “good” child:
   • What words come to mind?
   • What images come to mind?
When you think about a “naughty” or “bad” child:
- What words come to mind?
- What images come to mind?

When you think of a child with a mental illness or delayed development:
- What words come to mind?
- What images come to mind?

4. Ask participants to open their eyes. Invite a few participants to share their thoughts (maintaining patient and family confidentiality), and lead a brief discussion during which you discuss how different types of children are viewed in Haiti.

30 minutes

5. Show Slide 30: Childhood.
   Explain the various milestones for children ages 6–11. Compare the milestones to what the participants’ listed in their child development timelines.

   Explain that the last stage in child development is adolescence. Ask the true/false question on the slide.

   Explain:
   - Different parts of the brain mature at different rates.
   - Areas involved in more basic functions mature first: the senses, control of movement.
   - The parts of the brain responsible for controlling impulses and planning ahead—which define adult behavior—are among the last to mature.

7. Facilitate a brief discussion around the continued development of the adolescent brain.
   Ask:
   - What does this mean for how we/parents/teachers treat adolescents?

   Emphasize that adolescents still need guidance from authority figures such as parents and teachers in this phase of development.

30 minutes

   Explain relevant cognitive/linguistic and social/emotional/behavioral milestones. Compare the milestones to what the participants’ listed in their child development timelines.
9. Conclude the discussion by facilitating a discussion around the following question:

- What are different things that parents/teachers/community members can do to help children develop during infancy, toddlerhood, childhood and adolescence?

Write down participants answers on a flip chart (whether in 4 boxes on the same page, or a separate page for each development stage).
DAY 1 REVIEW: Participant Presentations

Methods: Group Presentations

Time: 30 minutes

Materials:
- Flip chart
- Markers

STEPS

30 minutes

1. Explain to the participants that they will be reviewing yesterday’s sessions by participating in group presentations.

2. Tell the participants that they will be divided into small groups and will be assigned a session from yesterday. The groups will have 10 minutes to create a three to five minute presentation summarizing the most important information from their assigned session. Each group will be given a piece of flip chart paper and markers—participants are free to draw, create a map, or write an outline to present their information to the audience.

3. Divide the participants into three groups. Distribute the flip chart paper and markers. Assign one of the following sessions to each group (if there are more than five participants in each group, participants should be divided into further groups. You can assign the same session to more than one group):
   - Session 2: Overview of Early Childhood Development
   - Session 3: Childhood Development – Infancy through Toddlerhood
   - Session 4: Childhood Development – Childhood through Adolescence

4. Read the following questions aloud to the participants to guide their work:
   - What were some of the key points raised during the session?
   - What ideas and suggestions are you taking away from this training?

5. After 10 minutes, invite each group to the front of the room to present. (If you have more than three groups, just invite one group per assigned session to present). Instruct the timer to time each group so that no group goes over the five minute time limit. Thank each group after they have presented.
SESSION 5: Ethics & Laws of Child and Adolescent Mental Health

Methods: Facilitator presentation, Small group discussion

Time: 2 hours

Participant Handbook page: 12

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 33–47
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 33–47.

Objectives:
- Define the four governing ethical principles.
- Explain the difference between assent, consent and dissent related to mental health care.
- Describe when mental health providers have a legal obligation to breach confidentiality and report certain situations.

STEPS

30 minutes

1. Show Slide 33.
   Ask participants:
   - By a show of hands, who believes that all children should have the same rights? (Hands should go up).
   Ask:
   - Who believes that all children receive the same rights, in reality? (Hands should go down).

2. Show Slides 34–35.
   Tell participants that the United Nations believes that all children should have the same rights, just as we do at Zamni Lasante. It doesn’t always happen though, which is why the United Nations has created various declarations advocating for children and people with disabilities.
3. Show Slide 36.
   Tell participants they will now discuss the following question in pairs:
   - What groups of children/adolescents in Haiti are particularly vulnerable?

4. Have participants stand up and find someone in the room they haven’t yet spoken to during the training. Participants will have 2 minutes to discuss the discussion question with this partner, standing.

5. After two minutes, announce that each person will now find a new partner to discuss the question with. After two minutes, invite participants to sit down. Call on individuals to share what they discussed with their partner.

Highlight vulnerable the following populations (if not mentioned by participants):
- Orphans or children separated from their families
- Restavecs
- Children who are not attending school
- Victims of violence or abuse
- Teen parents
- Girls (raised to be quiet, demure, kept close to home). Boys, by contrast, are given much more freedom and latitude.

30 minutes

   Tell participants that these are important ethical principles that all health providers should abide by.

   Ask participants how to define assent, consent and dissent. Write their definitions on a piece of flip chart paper. Give these definitions if participants do not correctly define the terms.
   - Assent – to openly agree
   - Consent – failure to object (but not an affirmative agreement)
   - Dissent – to disagree

   Ask participants why understanding these different words are important:
   - When we are treating children, who do we need consent from?
     - Answer: Parents/guardian
• When we are treating children over 16, what should we ensure we have from the adolescent, consent or assent? What about the parent?
  – Answer: Assent from adolescent, consent from parent

Further discuss what to do if an adolescent dissents but the family consents to treatment for the child.

7. Show Slides 40–42.
   Review the laws around reporting and confidentiality.

8. Show Slides 43–46.
   Discuss laws around suicide, substance abuse, neglect and physical/sexual abuse.

1 hour

9. Tell participants they will now be working in small groups to brainstorm screening questions for child and adolescent patients around some of these sensitive issues.

10. Divide participants into four groups, assigning each group one of the following topics:
    • Sexual assault/rape/sexual abuse
    • Physical abuse or neglect
    • Substance abuse
    • Threat of harm to self or threat of harm to others

11. Give each group a piece of flip chart paper and markers. Ask participants in their groups to discuss the following for 15 minutes:
    • What questions would you ask the child/adolescent to learn if they have experienced the issue?
    • What signs/symptoms could indicate that the child/adolescent patient has experience that issue?

12. Encourage participants to write down their team’s ideas on the flip chart paper. After 15 minutes, invite each group to the front of the room to give a 3–5 minute overview of their screening questions and a patient’s potential signs/symptoms of the issue they were assigned.

13. Show Slide 47.

Conclude by telling participants that oftentimes, child/adolescent patients who have had a traumatic experience (sexual abuse, suicidal ideation, neglect) are stigmatized. Stigma can lead to discrimination and further trauma for the child, which makes the psychologist’s role in improving the mental health and self-esteem of children and adolescents crucial.
SESSION 6: Child and Adolescent Assessment & Treatment Options

Methods: Facilitator presentation, mock interviews

Time: 2 hours

Participant Handbook page: 14

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 48–61
- Initial Mental Health Evaluation Form (1 copy/participant)

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 48–61.

Objectives:
- Outline the responsibilities of psychologists during an initial mental health evaluation and follow-up evaluation.
- Explain when and how to use the HEADDS interview guide questions during an interview with a child/adolescent.
- Describe pharmacologic and non-pharmacologic treatment options available for children/adolescents with mental health disorders.

STEPS

30 minutes

1. Show Slide 48–49.
   Tell participants that a mental health assessment of a child or adolescent is very similar to that done with an adult.

2. Show Slides 50–51.
   Before animating the text, ask participants:
   - What are the various steps involved in an initial mental health evaluation and follow-up evaluation?
   - What forms do you complete?
   - What other health providers and family members do you include in the patient’s care?
   Once participants have responded, animate the slides and go over anything the participants didn’t mention.
3. Show Slide 52.

Explain to participants that a specific assessment for children that can be used is the Attachment Informed Assessment. This is an assessment where you obtain the history of the child's attachments:

- Chronological account of the significant attachment figures available to the child since birth
- Disruptions in care, abandonment or losses, alternate caregivers, neglect of care and abuse
- Availability of the current primary carer and contact with other

During this Attachment Informed Assessment you also want to observe the infant/child's current behavior:

- Help or comfort-seeking behavior
- Quality of interaction and ability to use caregiver or another adult for comfort


Go over the key points on the slides.

Explain that participants will now practice using these sample interview questions and interview structure to get comfortable.

5. Pass out the Initial Mental Health Evaluation Form to each participant.

45 minutes

6. Activity instructions:

- Tell participants that they will spend the next 15 minutes practicing child/adolescent mental health interview questions with the person sitting next to them. One participant will begin by being the interviewer, while the other participant is the interviewee. Participants will spend 15 minutes interviewing their partner using the Initial Mental Health Evaluation Form.

- Participants should adapt their interview with the Initial Mental Health Evaluation Form as if they were assessing a child. Participants should use some of the sample questions just covered in the lecture, and should be sure to explain the purpose of the interview and confidentiality.

- Participants should think about how they can make the interview child-friendly to ensure they are obtaining correct information from both the child and the caregiver.
7. Begin the activity. After 15 minutes, have participants switch roles. After 30 minutes, bring participants back together. Facilitate a discussion about any difficulties that participants encountered during the practice activity or further questions about interviewing children/adolescents.

45 minutes


Emphasize that nonpharmacologic approaches should be taken if a child is diagnosed with a mental disorder. However, if needed, medication is available. Physicians need to work extremely closely with the patient, family and psychologist to ensure a high level of treatment and continued care.
SESSION 7: Child Development and Failure to Thrive

**Methods**: Facilitator presentation, case study, carousel activity

**Time**: 1 hour 30 minutes

**Participant Handbook page**: 18

**Materials**:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 62–71
- Flip chart
- Markers
- Tape

**Preparation**:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 62–71.
- Write the following titles on separate flip chart pages:
  1. Medical Assessment of Infant
  2. Psychological Assessment of Mother
  3. Treatment for Infant
  4. Psychoeducation for Mother/Family
  5. Psychological Treatment for Mother

**Objectives**:
- Define Failure to Thrive.
- Describe how to evaluate a child who may be experiencing Failure to Thrive.
- List psychoeducation messages about Failure to Thrive and treatment options to share with families.

**STEPS**

**30 minutes**

1. Show Slide 62 which introduces the session.

2. Show Slide 63.
   Ask a participant to read the case study aloud, which is also found in the participant handbook.
3. Show Slide 64.
   Spark a discussion around what is happening in this case, as introduced through the discussion questions.

4. Show Slide 65.
   Ask a participant to continue reading the case study.

5. Show Slide 66.
   Before animating the text, ask participants if anyone can define “failure to thrive.”
   Once participants respond, animate the text. Ask:
   • Has anyone ever seen a baby they would consider “failing to thrive”?
   • What did the child look like?
   • Why did you think the child was failing to thrive?

   Explain some common reasons for failure to thrive, specifically related to eating and nutrition.

   30 minutes

7. Show slide 69.
   Tell participants they will now spend some time brainstorming how they would do an evaluation of and provide treatment for this case (woman and her baby). Explain that assessment and treatment skills are an important competency of psychologists, and so the participants will spend this next activity “thinking on their feet.”

8. Hang up the five already-labeled flip chart pages around the room. Explain the following instructions to participants, and tell participants to wait to move until after all instructions are given.
   • Participants will be broken up into five groups, and each group will be placed at a flipchart. Participants should remember which number flipchart they have been placed at (1–5).
   • The participants will be given markers and will have 2–3 minutes at their flipchart to discuss and write down their ideas related to the title of the flip chart. Participants should consider:
     – What forms should be utilized
     – What other providers should be involved
     – The correct method of assessment or treatment
• After two minutes, the facilitator will call out “move,” and all groups will finish writing, and travel in their groups to the next flip chart paper to the right. All groups will move to the next flip chart at the same time, (group at flip chart 1 will move to flip chart 2, flip chart group 2 will move to flip chart 3, and so forth).

• Once at the new flip chart, the groups will have the opportunity to read what has been written, and add any additional ideas (if a group agrees with an idea that has already been written, they can put the “+” sign to signal agreement next to the specific points).

• After two to three minutes, have participants move again in their groups to the next flip chart to the right, and continue the process until all flip charts have been visited by all the groups.

9. Divide participants into groups and send each group to their starting poster.

10. Have participants begin the activity.

11. After 2–3 minutes, call for all groups to rotate to the poster to their right. Continue to rotate every 2–3 minutes, until groups have traveled to all posters.

12. Once all groups have visited each flip chart, have all participants sit down. The facilitator should collect all the flip charts and bring them to the front of the room.

30 minutes

13. Spend the next 20 minutes reviewing and summarizing the information aloud on the collected flip charts.

   Add or correct additional information as necessary. Highlight the correct evaluation and treatment techniques if clarity is needed.
DAY 2 REVIEW: Ball Toss

**Methods:** Game

**Time:** 30 minutes

**Materials:**
- Ball (about 1 for every 7–10 participants)

**STEPS**

1. Explain to the participants that they will be reviewing yesterday’s sessions by participating in a game.

2. Open the game by reviewing the titles of the three sessions covered the day before.
   - Session 5: Ethics and Laws of Child and Adolescent Mental Health
   - Session 6: Child and Adolescent Assessment and Treatment Options
   - Session 7: Child Development and Failure to Thrive

3. Invite participants to take 5–10 minutes to look over their notes and participant handbook chapters on these sessions, reviewing quietly some of the most salient points or new pieces of information learned.

4. After 5–10 minutes, ask for participants to come stand in one large circle or make multiple circles depending on class size (7–10 people is ideal for a circle; if there are more than 10 people, create another circle with a separate ball and facilitator).

5. Give the following directions to the participants (each facilitator should give each circle the same set of instructions):
   
The facilitator in the circle will begin the game by announcing which session to review (5, 6 or 7). The facilitator will begin by holding the ball and sharing a fact or new piece of knowledge from yesterday. Then, once the facilitator has stated his fact, he will throw the ball to a participant in the circle, who will then have to say another, different fact learned yesterday from that session. Once a participant has received the ball and has contributed a fact, they should put their hands behind their back, to signal they have participated. This participant now throws the ball to a third person in the circle, who will have to share another new fact. Ask participants to not repeat the same piece of information that another participant has already mentioned.
6. The ball should ultimately be thrown to each person in the group once, so everyone has an opportunity to contribute.

7. Once everyone has shared one fact for the chosen session, begin the game again, this time focusing on a different session. Continue until all participants have spoken about all sessions.
SESSION 8: Learning and Developmental Problems

Methods: Facilitator presentation, Case study, Large group discussion

Time: 1 hour 30 minutes

Participant Handbook page: 20

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 72–86
- mhGAP Intervention Guide

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 72–86.

Objectives:
- Explain the difference between intellectual disabilities and neurodevelopmental disabilities.
- Identify signs and symptoms of intellectual disabilities and neurodevelopmental disabilities.
- Utilize mhGAP to assess and manage developmental disorders.

Steps

45 minutes

1. Show Slide 72 which introduces the session.

2. Show Slide 73.
   Ask a participant to read the case study aloud, which is also found in the participant handbook.

3. Show slide 74.
   Spark a discussion around what is happening in this case, as introduced through the discussion questions.

4. Show slide 75.
   Ask a participant to continue reading the case study.

5. Show slide 76.
   Ask the discussion question listed on the slide.
6. Show Slide 77.
Animate the diagram and explain (comparing intellectual disability with learning disability on flip chart if needed):

- The main difference between an intellectual disability (formally known as mental retardation) and a learning disability is that an intellectual disability refers to ability, whereas a learning disability is associated with achievement.
- Those with an intellectual disability have a limit on the level of intelligence—they will perform lower on an IQ test.
- A learning disability does not affect a person’s intelligence, but it affects the brain’s ability to process, store, and respond to certain information. Specific learning disabilities can be in areas such as reading, math, or writing.

7. Show Slide 78.
Tell participants that clinical manifestations of intellectual disabilities include: basic adaptive functioning, basic cognitive functioning, basic social functioning, reading, spelling and writing, nonacademic problems.

8. Show slides 79–81.
Mention that examples of neurodevelopmental disorders include:

- Autism
- Fetal Alcohol Syndrome
- ADHD

Learning disorder perinatal risk factors include:

- Very low birthweight
- Severe intrauterine growth restriction
- Perinatal hypoxia
- Prenatal exposure to alcohol and drugs
Other factors include:
- Environmental toxins such as lead
- Drugs such as cocaine
- Infections such as meningitis and HIV
- Brain injury and head trauma

9. Show Slide 82.
Read the points on the slide. Mention that many of these interventions for learning problems are not possible for most youth (unless there is a special school in the area).

45 minutes

10. Tell participants to open their mhGAP to the section on developmental disorders.

11. Show slides 83–86.
Go through the mhGAP chapter on Developmental Disorders, highlighting the assessment and intervention portions.

After reviewing slide 86, begin a discussion on psychoeducation messages through asking the following questions:
- How do parents view children with developmental problems?
- What psychoeducation messages would you give to the mother in the case study?
- How can you work with teachers and schools to assist children with developmental disorders?

12. Conclude the session by noting that learning and development disorders are some of the least identified issues, although merit great attention because they affect great numbers of children.
SESSION 9: Trauma and Anxiety

**Methods:** Facilitator presentation, Case study, Post-it activity

**Time:** 2 hours  
**Participant Handbook page:** 22

**Materials:**  
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 87–111  
- Flip chart  
- Markers  
- mhGAP module – Assessment Management of Conditions Specifically Related to Stress  
- Post-its (2/participant)

**Preparation:**  
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 87–111.  
- On two flip chart pages, write the following (one title on each page):  
  - Anxiety Screening Questions  
  - Anxiety Management and Treatment

**Objectives:**  
- Name common stress-related mental disorders, and their ideal management and treatment in children/adolescents.  
- Identify at-risk populations for psychological problems after traumatic events.  
- Describe the physical, psychological, emotional, relational reactions to traumatic events.  
- Utilize mhGAP to assess and manage conditions specifically related to stress.

**STEPS**

1. Show Slide 87 which introduces the session.

2. Show Slide 88.  
   Ask a participant to read the case study aloud, which is also found in the participant handbook.

3. Show Slide 89.  
   Spark a discussion around what is happening in this case, as introduced through the discussion questions.

4. Show Slide 90.  
   Read the slide.
5. Show Slide 91.

Before animating the text, ask participants:

- What are additional risk factors that make some people more prone to developing psychological problems after traumatic events?
- What populations are most affected after traumatic events?
- What might some coping mechanisms be?

Once participants have responded, animate the text.

6. Explain that people who experience traumatic events often have physical, psychological and emotional reactions. Draw four columns (or boxes) on a piece of flip chart paper, and label the top of each column, “physical,” “psychological,” “emotional” and “relational.” Ask participants what these different reactions might look like. Record participant’s answers on the flip chart page.

Then, animate Slides 92–95.

7. Show Slides 96–98.

Before animating the text, ask participant:

- What is PTSD?
- How should it be treated?
- What can be done in the community when a traumatic event has occurred in the community (and thus affected many people)?

Once participants have responded, animate the text.


Before animating the text, ask participants about their experience with diagnosing anxiety. Ask:

- What symptoms did your patient with anxiety have?
- How might these symptoms manifest in children/adolescents?

After taking responses from the participants, animate the text.

Tell participants that anxiety disorders include: Generalized Anxiety Disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, Separation Anxiety Disorder, Panic/agoraphobia, Selective Mutism.

9. Tell participants they will now brainstorm screening questions and treatment/management methods for anxiety. Hang up the two previously prepared flip chart pages on the wall. Distribute two Post-it notes to each participant.
10. Tell participants that on one Post-it note, they will write 1–2 anxiety screening questions, while on the other Post-it note they will write 1–2 methods of managing/treating anxiety.

11. Allow participants a few minutes to think and write down their ideas. Once participants have written on their Post-its, encourage them to post.

12. Once all participants have posted their ideas, look over the ideas briefly and summarizing common anxiety screening questions and anxiety management/treatment methods.

   Then, show slides 101–102.

13. Ask participants if there are any questions.

14. Tell participants that the mhGAP Intervention Guide does a good job of outlining assessment and management of conditions related to stress. Ask participants to open their mhGAP to the chapter “Conditions Specifically Related to Stress.”

15. Show slides 103–111.

   Go through the nine pages of “Conditions Specifically Related to Stress,” alternating between participants reading the key sections aloud, and outlining the other information provided in those pages yourself.

16. Conclude by encouraging participants to refer to the mhGAP to guide assessment and treatment of stress-related conditions in children and adolescents, such as PTSD and other forms of trauma.
SESSION 10: Depression and Suicide

Methods: Facilitator presentation, Case study, Role play

Time: 2 hours

Participant Handbook page: 26

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 112–142
- Make copies of the ZLDSI and CES-D (1 copy/participant)
- Make copies of Suicidality Screening Instrument (1 copy/participant)

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 112–142.

Objectives:
- ab. Identify signs and symptoms of depression in children/adolescents.
- ac. Describe disorders that commonly mimic depression in their presentation.
- ad. Correctly use the ZLDSI and CES-D to screen for depression in children/adolescents.
- ae. Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.
- af. Describe the pharmacologic and non-pharmacologic treatment of depression in children/adolescents.

STEPS

30 minutes

1. Show Slide 112 which introduces the session.

2. Show Slide 113.
   Ask a participant to read the case study aloud, which is also found in the participant handbook.
CASE STUDY

A 16-year-old boy comes to the clinic accompanied by a teacher. The teacher had met with the boy that morning and had noted that the boy looked withdrawn. The teacher gave the boy a CES-D to fill out, and the boy had a score of 30. The teacher asked the boy about having thoughts to harm himself, and the boy stated that he was not sure that life was living anymore because the family had recently lost its major source of income, and he would have to leave school to find work.

   Spark a discussion around what is happening in this case, as introduced through the discussion questions.

   Review the basics of depression with participants.

5. Show Slides 120–123.
   Tell participants that they will use the ZLDSI with children to screen for depression. Go over the basics of the ZLDSI with the participants as a review.

   Psychologists will also have their child/adolescent patients complete the CES-D, which is a depression-self assessment.

   Take 5 minutes to go over the CES-D with the participants. Invite participants to open to the annex, where the CES-D is located. Go over every question, explaining how to interpret the patient’s answers.

6. Ask participants if there are any other screening questions they might ask their child patients to assist with depression diagnosis.
   Mention the following screening questions if not mentioned by participants:
   
   • “Would you say that you have been getting satisfaction from school and your friendships and the things you do every day? Have you been enjoying your favorite activities?”
   
   • “Would you say that you are very hard on yourself? Have you ever felt hopeless, as though life was not worth living anymore? Do you have plans for the future?”
   
   • “Have you felt sad, hopeless or empty for several days or weeks at a time? Have you felt irritable or tired most of the time for hardly any reason at all?”
   
   • “How long do these feelings last? What is the longest they have lasted?”
7. Show Slide 124.
   Explain that depending on the results of the ZLDSI and CES-D, the psychologist will diagnose a child with depression.

8. Show Slides 125–129.
   Explain the other symptoms that are typically confused with depression. Ask if there are any questions.

   Explain to the participants that psychologists have the responsibility within the system of care to evaluate and properly screen patients for suicidality. Child/adolescent patients who have a high score on the ZLDSI, CES-D, have a diagnosed mental illness express, or have acute emotional distress should be screened by the psychologist using the Suicidality Screening Instrument.

   In addition to the Suicidality Screening Instrument, additional self-harm/safety and violence questions to employ include:
   - “I now want to ask you some questions about your safety. The most important thing we want to do here today is make sure that you feel safe here, and at home.”
   - “Have things ever been so difficult/Have there been other times in your life that you wanted to die? Thought about taking your own life? Do you currently feel at risk in any way of harming yourself? Have you ever tried to harm yourself? When and how?”
   - “Has there been a time when you have thought about hurting someone else? How about currently?”
   - “Do you currently feel safe at home? Are people nice to each other at home? Are there arguments? Do they ever turn into fights, with yelling or hitting?”
   - “Are there any guns or other weapons at home?”
   - “Have you ever been threatened or hurt physically by either a family member or someone else close to you? Does anyone ever say things to you at home or at school that hurt your feelings? Have you experienced any bullying at school? Either at home or at school, has anyone ever touched you inappropriately against your will?
     - If yes: I am so sorry to hear that that happened. Do you know who it was? Do you know where they are now? Do you feel safe from them? Is there anything we can do here today, right now, to help with this?”
10. Show Slide 133.

Have the participants open their participant handbook to the Suicidality Screening Instrument. Explain that psychologists will use the Suicidality Screening Instrument to determine the severity of suicidal ideation depending on the answers of the patient. Give the participants one to two minutes to read over the screening instrument.

11. Tell the participants that they will ask the six questions on the Suicidality Screening Instrument in order, and for each question the psychologist will inquire whether the patient had those thoughts in the past two weeks and/or in the past year. The psychologist will check the answer that the patient gives for each question (yes or no). If the patient gives details or information during the screening, it should be written down in the appropriate “description” space. If a patient says no to a question in both columns, the interview ends there and should not continue (because each question builds on the one before it, assuming “yes” was indicated).

12. Explain when the psychologist has finished asking the questions (or has received a no for both columns, ending the interview), the psychologist will add up the number of “yes” in each column and write the total number of “yes” for each column on the scoring line. Then, the participants will look at the scoring criteria below and determine the risk depending on the scores for the current column and the past column.

13. Distribute the Suicidality Screening Instrument handout to each participant.

14. Tell the participants they will now have the opportunity to practice screening for suicidality through two guided role plays (refer to Facilitator Notes). Ask the participants to turn to the role plays in their participant handbook. Explain:

• Participants will be split into pairs, and one person will play the psychologist while the other will play the patient.

• The participants will have three minutes to complete Role Play #1, following the script in the participant handbook.

• Once the role play is complete, the participant in the psychologist role will have the responsibility of scoring the interview on the Suicidality Screening Instrument.

• Once the interview is finished and scored, participants should switch roles and continue to Role Play #2.

• Once the Role Play #2 interview is complete, the participant in the psychologist should score the interview on their Suicidality Screening Instrument.

15. Divide the participants up into pairs, have each pair choose who will play each role, and have all pairs begin Role Play #1. After the participants have finished the role play (it should take no more than three minutes), remind the psychologist role to record his score on the sample screening instrument handout.
16. Tell the participants to continue to Role Play #2.

17. After the participants have finished the role plays, bring all the participants back together.

18. Show Slide 134.

Animate the title. Ask the participants who were the psychologists in Role Play #1 what score they determined. Take a few answers from the participants. Animate the slide text. Tell them the correct scoring is:

- Now/In Past 2 Weeks = 0
- In Past Year = 2

Go over any questions if participants determined a different score.

Ask the participants who were the psychologists in Role Play #2 what score they determined. Take a few answers from participants. Animate the slide text. Tell them the correct scoring is:

- Now/In Past 2 Weeks = 3
- In Past Year = 3

Go over any questions if participants determined a different score.

19. Tell the participants that once they have a score from the Suicidality Screening Instrument, they will determine a category of risk. As the participants see, there are different categories of risk that span from low risk to high risk. The level of risk takes into account both the scoring from the questions “now or in the past two weeks” and “in the past year.”

20. Ask the participants to use the scores for the past two role plays to determine the level of risk of each of those patients.

Ask:

- What would the participants label “Emmanuel” (Role Play #1 patient)?

Wait for participants to give answers. Confirm that he would be “medium risk.”

Ask:

- What would the participants label “Katrina” (Role Play #2 patient)?

Wait for participants to give answers. Confirm that she would be probably “high risk” because she has a current score of three, a past score of three, and indicated she might act on her suicidal thoughts.

Explain that once a level of risk is determined, psychologists will use the Suicidality Treatment Guidelines to treat the patient accordingly. Have the participants look at the Suicidality Treatment Guidelines in their participant workbook. Explain that the chart walks the participants through the things they should do, say, refer to, record and follow up with in terms of treatment for the patient. All patients, including the patients with low risk, should receive the treatment in the first box, “for all patients.” If a patient has a medium or high risk, they should pass to the second box, “for patients with medium and high risk” which has additional treatment aspects. If a patient is high risk, they should also receive treatment in the third box, “for patients with high risk.”

22. Tell participants to look at the first box on the Treatment Guidelines under “for all patients” that says “act.” The participants will see that point number three refers to developing a safety plan. Tell participants that all patients who are screened for suicidality, whether low risk or high risk, need a safety plan. A safety plan is a plan, collaboratively developed by the patient and psychologist, which assists patients to decrease their risk of suicide. Have the participants turn to the Safety Plan in the annex of their participant handbook.

23. Show Slides 136–137.

Explain that psychologists will go through creating a plan with the patient that will outline how the patient will recognize when they are in a crisis, and how to prevent suicide through five distinct steps (if one step fails to decrease the level of suicide risk, the next consecutive step is followed).

24. Have a participant read through the steps on the slide that outline the components of a safety plan. Remind the participants that their role as psychologist is to support patients in creating this plan (the psychologists is not creating this plan for the patients!).

Emphasize that the most important aspect of the safety plan is its accessibility and ease of use. A safety plan will not be helpful if there are obstacles in the plan that the patient cannot overcome. The psychologist’s role is to discuss feasibility of the plan’s steps with the patient so the patient is prepared.


Review treatment options and psychoeducation around depression. Emphasize that non-pharmacologic treatment is to be used for all cases of depression — whether or not the patient is on medication.
ROLE PLAY 1

**Psychologist:** Hello Emmanuel.

**Patient:** Hello.

**Psychologist:** I’d like to ask you a few additional questions to be sure that you are safe. Part of my job here in the health facility is to help people feel safe, and to help all of the physicians and nurses to ensure the safety of people we see here. Please know that you can trust me, and that I would like to be helpful to you.

**Patient:** OK.

**Psychologist:** Sometimes, when things are particularly difficult, some people have thoughts of not wanting to live. Have you ever wished you were dead in the past two weeks?

**Patient:** No.

**Psychologist:** Have you ever wished you were dead in the past year?

**Patient:** Yes.

*Interview continues because patient said yes.*

**Psychologist:** Have you had any thoughts of killing yourself in the past two weeks?

**Patient:** No.

**Psychologist:** Have you had any thoughts of killing yourself in the past year?

**Patient:** Yes. Things were just so hard!

*Interview continues because patient said yes.*

**Psychologist:** Have you been thinking of ways to do this in the past two weeks?

**Patient:** No.

**Psychologist:** Have you been thinking of ways to do this in the past year?

**Patient:** No. I never decided to do anything.

*Interview ends because patient said no to each column of a question.*
ROLE PLAY 2

Psychologist: Hello Katrina.

Patient: Hello.

Psychologist: I’d like to ask you a few additional questions to be sure that you are safe. Part of my job here in the hospital/clinic is to help people feel safe, and to help all of the physicians and nurses to ensure the safety of people we see here. Please know that you can trust me, and that I would like to be helpful to you.

Patient: OK.

Psychologist: Have you ever wished you were dead in the past two weeks?

Patient: Yes.

Psychologist: Have you ever wished you were dead in the past year?

Patient: Yes.

*Interview continues because patient said yes.*

Psychologist: Have you had any thoughts of killing yourself in the past two weeks?

Patient: Yes. I don’t want to live anymore, but I know my family would feel so bad.

Psychologist: Have you had any thoughts of killing yourself in the past 12 months?

Patient: (Nods).

*Interview continues because patient said yes.*

Psychologist: Have you been thinking of ways to do this, now or in the past two weeks?

Patient: Yes, I think a lot about it.

Psychologist: Have you been thinking of ways to do this, in the past year?

Patient: Yes, I guess I’ve been thinking about it for a long time.

*Interview continues because patient said yes.*

Psychologist: Do you have any intention to act on these thoughts?

Patient: I’m not sure…

Psychologist: We are here to help you, you are not alone. I would like to work with you to develop a plan to support you given that things are so difficult currently.

*Interview ends as clinician develops a plan to support the patient based on the rest of the history obtained.*
**DAY 3 REVIEW: Team Quiz Questions**

- **Methods:** Game
- **Time:** 1 hour
- **Materials:**
  - Post-it Notes (7/group)

**STEPS**

1. Explain to the participants that they will be reviewing yesterday’s sessions by creating quiz questions and then participating in a game.

2. Divide participants up into groups of 6–8 participants. Before allowing participants to move into their groups, give them the following instructions:
   - Each group will have the task of reviewing the content from the three sessions from yesterday (learning and developmental problems; trauma and anxiety; depression and suicide) and creating seven strong quiz questions that relate to the main points of the session.
   - The quiz questions can be true/false or open-ended (there should not be multiple choice questions created, as these take a lot of time to administer).
   - The groups will write each quiz question they formulate on a different Post-it; in total, each group will present 7 Post-it notes with a quiz question.
   - Participants will have 15 minutes in their groups to brainstorm their quiz questions.
   - After 15 minutes, a leader from each group will come to the front to administer their quiz questions to the audience.
   - Participants should not answer questions they created.

3. Divide the participants into their groups and begin the review activity.

4. After 15 minutes, invite a leader from Group #1 to come to the front of the room and administer their questions to the audience.

5. Now, invite a leader from Group #2 to the front to administer their quiz questions. Continue, inviting each group to present their questions until all groups have presented.
SESSION 11: Clinical Outcome Measures: CGI and WHODAS

Methods: Facilitator presentation, case study, role play

Time: 2 hours

Participant Handbook page: 32

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 143–155
- Make copies of the CGI (1 copy/participant)
- Make copies of the WHODAS (1 copy/participant)

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 143–155.
- Prepare the WHODAS role play with co-facilitator.

Objectives:
- Describe how to use the CGI and WHODAS to assess clinical improvement.
- Explain the importance of outcome measures to assess care quality and systems improvement.

STEPS

20 minutes

1. Show Slide 143.
   
   Tell the participants that effective care is that which has been shown to improve functioning and quality of life. Effective care may be based on several different types and levels of evidence, and it reflects the best care a system can offer at any given point. To measure effective care, the Zamni Lasante system of care will use the Clinical Global Impressions Scale (known as “CGI”) and the World Health Organization Disability Assessment Schedule (known as “WHODAS”).

2. Remind participants that many of them have already been introduced to the CGI and WHODAS.
   
   Ask participants: Who can tell me about the CGI and/or WHODAS? What is it? When do we use it?
3. Show Slide 144.

Explain that the Clinical Global Impressions Scale (CGI) is an easily adopted tool that measures the effect of treatment over time. It is a global assessment of current symptoms, behavior, and the impact of illness on functioning. Its goal is to allow the clinician to rate the severity of illness (CGI-S), change over time (CGI-I), and efficacy of medication.

4. Remind participants that they will complete the CGI when they first meet with a patient, then every time they meet with a patient (but not more frequently than once per week). Have the participants open their participant handbook to the annex where they can find the CGI Scale.

Explain that there are three different measures on the CGI:

- **Severity scale** – which assesses a patient’s symptom severity over the past 7 days.
- **Improvement scale** – which measures the overall clinical change of the patient using the baseline assessment as the reference point.
- **Side-effects scale** – which analyzes the side-effects of the medication.

Allow the participants to read over the CGI scale.

5. Show Slide 145.

Explain that psychologists will determine the CGI Severity by assessing how ill the patient is at the time of interview relative to the psychologist’s past experience with patients who have the same diagnosis. The psychologist will judge the level of mental illness that the child/adolescent has experienced over the past 7 days.

### CGI SEVERITY TIPS

- Err on the side of a more severe rating if in doubt between two values
- Always use the same time period (past seven days)
- Do not compare the patient to a superior functioning person: compare “relative to your past experience with patients who have the same diagnosis…considering your total clinical experience with this population.”

6. Tell the participants they will now have an opportunity to practice scoring the CGI-S through a case study. Read aloud Case 1 (which they will recognize as Case 3 from earlier in the training) and begin a discussion about the patient’s level of severity.
CASE 1

A young girl of 14 is brought to the clinic by her sister. The girl is quiet but her sister states that she has been reporting hearing voices and seeing things at night, and has not been sleeping. The patient has been feeling so tired that she frequently falls asleep in class. The girls live with their aunt, as their father left home, and their mother died two years ago in a car accident. The sister reports that one week earlier the girl had been sexually assaulted by a boy from school. The patient has not gone back to school since the incident. The patient denies suicidal ideation and has no previous psychiatric history. She reports additional symptoms of being unable to “feel deeply” and is having trouble concentrating.

7. Ask participants what rating they might give the patient in the case, and why. Once you have taken several ideas from the participants, explain that a suggested CGI-S score for this case is a 5 (markedly ill). Explain the following rationale to the participants. Answer questions as they arise.

RATIONALÉ

This patient has symptoms that are consistent with PTSD and are beginning to affect her functioning. These elements both suggest a score no less than a 5 (markedly ill). The patient’s functioning at school is affected at this point; she falls asleep in class and now no longer goes to school. Her illness has caused a distinct impairment of occupational function justifying the score to a 5 (markedly ill).

8. Show Slide 146.

Tell the participants that the next part of the CGI focuses on improvement. When completing the CGI Improvement (CGI-I) section, the participants need to first indicate whether this is an initial evaluation using the CGI, or a follow-up appointment. Explain the following:

• **At Initial Evaluation:** If the patient has been in treatment previously, rate CGI-I based on the history and compared to the patient’s condition prior to treatment. Otherwise, select 0, “not assessed.”

• **Follow-Up Appointment:** Rate CGI-I 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.

9. Tell the participants they will now have an opportunity to practice scoring the CGI-I through a case study. Read aloud Case 2 and begin a discussion about the patient’s level of severity.
CASE 2

The 14 year old girl you saw earlier and diagnosed with PTSD has returned for a follow-up visit. You have seen her every two weeks for the past two months. You have engaged her with individual counseling, and some family counseling with her aunt and sister. During this appointment the patient reports that she is sleeping through the night most nights, and is no longer seeing things. She occasionally has nightmares and wakes up. The patient has begun attending school again and has not fallen asleep in class the past week. The patient still reports trouble concentrating at school, especially when she sees the boy who sexually assaulted her.

10. Ask the participants what rating they might give the patient in the case, and why. Once you have taken several ideas from the participants, tell the participants that a suggested CGI-I Score for this case is a 2 (much improved). Explain the following rationale to the participants. Answer questions as they arise.

RATIONALE

The patient's clinical status has clearly changed in the direction of improvement. For a CGI-I score of 3 (minimally improved), the level of change would not be sufficient to make an appreciable difference to the patient's clinical status, level of distress, or functioning. This patient is now experiencing a significant nightly improvement in sleep, and is therefore sleeping less in class. The patient is no longer seeing or hearing things at night. Nonetheless, the patient is still symptomatic; she has problems concentrating and experiences nightmares. Consequently, a rating of 2, much improved, rather than 1, very much improved, best captures this patient's improvement relative to her baseline state.

11. Show Slide 147.

Explain that the side-effects scale scores a patient's level of side-effects from medication on a scale of 0–3. The closer the number is to zero, the better. Remind the participants that medication side-effects will be monitored by physicians using the Abnormal Involuntary Movements Scale (AIMS). The psychologist's role is not to actively check or identify side-effects. Rather, the CGI Side-Effects scale is simply used to serve as an additional tracking tool, and to double-check what the physician has found in his AIMS evaluation.

12. Explain to the participants that the CGI Side-Effects scale is only used after a patient has begun medication. If a patient is not actively taking medication, then the psychologist does not need to fill in the side-effects scale. Tell the participants that they will be tracking their patients’ ratings for severity, improvement and side-effects (if relevant) over time, and will be recording this information in a place where they can get a snapshot of the progress of the patient.

Tell the participants that another tool that psychologists will use to track patients’ progress over time is the WHODAS. There are six domains of functioning in the WHODAS that will be discussed with the patient and then recorded. Tell the participants that they will complete the WHODAS when they first meet with a patient, then every three months.

14. Have the participants turn to the WHODAS 12-Item Version in their participant handbook annex. Tell the participants that there are several sections of the WHODAS, but the main sections that psychologists will be training on today is Section 3–4.

15. Ask the participants to read over Section 3 silently. Tell the participants that this section tells the psychologist how to introduce the WHODAS interview to the patient. The words in blue are what the psychologist should say to the patient.

16. Show Slide 149.

Tell the participants that there are two flashcards that the psychologist can use to help the patient communicate their answers. The purpose of the flashcards is to provide a visual cue or reminder to the patient about important pieces of information while answering questions. Show the participants the laminated flashcards they have been provided.

Flashcard 1 provides information about how “health conditions” and “having difficulty” are defined, and reminds the respondent that the timeframe for evaluation is the past 30 days. The information on this card provides the respondent with useful reminders throughout the interview. Flashcard 2 is the second card to be used in the interview. It provides the response scale to be used for most questions. When introducing this scale to a patient, the psychologist should read aloud the number and the corresponding word. Explain these cards may or may not be useful depending on the literacy level of the patient.

17. Show Slides 150–151.

Ask for a participant to read Section 3 aloud, just reading the blue words. Ask if there are any questions about this introductory language, and if everyone understands why the flashcards are shown to the patient.

Explain to the participants that when the psychologist asks a question, they will prompt the patient to give an answer listed on the scale: none, mild, moderate, severe, extreme or cannot do. The psychologist will then circle the correct answer on the WHODAS, and will continue to the next question. The last few questions in Section 4 asks for the patient to quantify the number of days they were experiencing difficulty with various activities. Ask for a participant to read Section 4 aloud.

19. Tell the participants that occasionally a question will appear that is not applicable to the patient. Maybe the patient doesn’t ever perform the task that the question is asking about, so the patient doesn’t have an answer to give about the level of difficulty doing it. If a patient says a question is not applicable to them, the psychologist should with: “Can you tell me why this question does not apply to you?” If the question truly does not apply to the patient, the psychologist should write “not applicable” next to the question on the WHODAS recording form.


Read the slide, emphasizing these are important points to administering the WHODAS correctly.

30 minutes

21. Tell participants they will now observe a role play using the WHODAS. Participants should follow along using their copy of the WHODAS and should record the patient’s answers on their WHODAS.

DIRECTIONS FOR FACILITATORS

Have the two facilitators who are performing the role play come to the front of the room and sit in seats facing the audience. One facilitator will introduce himself as the patient, and the other facilitator will introduce himself as the psychologist. The facilitator playing the psychologist should begin the role play, administering the WHODAS. The patient should respond accordingly, improvising.

22. Once the role play has finished, ask the participants what they recorded for each question on their WHODAS. Answer any remaining questions about the WHODAS and its scoring.
SESSION 12: Post-Test and Feedback

Methods: Assessment, evaluation

Time: 1 hour 15 minutes

Materials:
- PowerPoint (Introduction to Child and Adolescent Mental Health), slides 156–157
- Flip chart
- Markers
- Post-it Notes
- Post-test Answer Key (downloaded on the computer to be projected)
- Training Evaluation Forms (1 copy/participant)
- Post-test (1 copy/participant)

Preparation:
- Review PowerPoint (Introduction to Child and Adolescent Mental Health), slides 156–157.
- Photocopy post-tests and training evaluation forms
- Create three flip chart pages, each individually titled:
  1. How will you share what you’ve learned?
  2. What strategies will you use to ensure collaboration with other team members?
  3. When I’m unsure or struggling I will…

Objectives:
- ai. Review all unit objectives.
- aj. Demonstrate learning through a post-test.
- ak. Give feedback on the training.

STEPS

Post-test:

45 minutes

1. Show Slide 156.

Tell participants they have come to the end of the training and will now demonstrate their new-found knowledge through a post-test.

2. Administer the post-test to the participants. Allow them 30 minutes to complete the post-test.

3. Once the post-test has finished, and all tests have been collected, project the post-test answer key. Go over each question and the correct answer. Answer any questions that arise from the participants.
Reflection:

15 minutes

4. Hang up the three pre-written flip chart pages on three separate walls in the training space.

5. Show Slide 157.

Tell the participants they will spend a few minutes reflecting on this training. Pass out three Post-it notes to each participant. Instruct them to reflect and write down an answer for each of the three questions (listed on the slide) on a different Post-it note. There is no need for them to put their name on the Post-it notes, as this is an anonymous activity.

6. Once they have finished writing their three Post-it notes, they should go and post their Post-it notes on the corresponding flip chart page. Once the participants have posted their Post-it notes, all the participants should circulate between the three flip chart pages to view what others have written.

7. After all the participants have had a few minutes to circulate and read others’ reflections, ask them to sit down.

8. Conclude by taking down the pages and reading all answers aloud to the group. Highlight similar answers and unique ideas.

Evaluation:

15 minutes

9. Explain that you would like to gather the participants’ comments and feedback on this training, in order to revise and improve future trainings if needed.

10. Give each participant an evaluation form. As the participants work, circulate and help as needed.

11. Once all the participants have finished their evaluations, collect the written evaluation forms.

12. Congratulate the participants on having completed this training. Thank them for their participation. Distribute certificates as appropriate.
Annex
**PRE-TEST**

Name: ___________________________ Date: ___________________________

Site: ___________________________ Supervisor: _________________________

1. Which group of disorders is most frequent in children? (Choose one) ( __ / 1 point)
   a. Mood disorders
   b. Behavioral disorders
   c. Anxiety disorders
   d. Substance abuse disorders

2. What is a sensitive period? (Choose one) ( __ / 1 point)
   a. The period in which children cry to get their needs fulfilled.
   b. A time during a child’s life when a child is more sensitive to environmental influences and experiences have a greater impact on brain development.
   c. A time during pregnancy when the mother needs to eat more to nourish the baby.
   d. A period during adolescence when self-esteem is particularly fragile.

3. The Transactional Model of Development promotes the idea that: (Choose one) ( __ / 1 point)
   a. Both children and parents play a role in determining the course of a child’s development.
   b. Children and parents influence each other over time.
   c. Children need to be ignored when they start crying.
   d. A and B

4. What are the four domains of child development? (Choose one) ( __ / 1 point)
   a. Physical, social, biological, emotional
   b. Language, motor, behavior, temperament
   c. Infancy, toddlerhood, childhood, adolescence
   d. Cognitive, linguistic, social-emotional, behavioral

5. What are the four main stages of child development? (Choose one) ( __ / 1 point)
   a. Infancy, toddlerhood, childhood, adolescence
   b. Neonate, child, teenager, adult
   c. Fetus, baby, child, young adult
   d. 0–5 years old, 5–10 years old, 10–15 years old, 15–20 years old
6. Normal child development includes which milestones for 2-year-olds? (Choose one) ( __ / 1 point)
   a. Literacy skills
   b. Make-believe play
   c. Combining two or more words
   d. Development of first friendships
   e. B and C
   f. All of the above

7. Normal child development includes which milestones for 5-year-olds? (Choose one) ( __ / 1 point)
   a. Feeding and toileting
   b. Growth of child’s vocabulary to 2,000 words
   c. Emergence of moral beliefs
   d. Numeracy skills
   e. All of the above

8. Normal child development includes which milestones for 11-year-olds? (Choose one) ( __ / 1 point)
   a. Development of first friendships
   b. Sexual and/or romantic interests may begin
   c. Risky behaviors
   d. Awareness of gender stereotypes
   e. B and D

9. Normal child development includes which milestones for 18-year-olds? (Choose one) ( __ / 1 point)
   a. Peer victimization
   b. Fluctuation in self-esteem and emotional experiences
   c. Vocabulary growth to over 40,000 words
   d. Difficulty in rational decision making
   e. All of the above
10. What do “beneficence” and “autonomy” mean in the context of ethical principles? *(Choose one)*

a. Beneficence means there are benefits for the psychologists; autonomy means that psychologists can do what they want.

b. Beneficence means the duty to not “do bad”; autonomy means the psychologist should be free to give the treatment they think is best.

c. Beneficence means the duty to do good; autonomy means that the psychologist respects the patient’s right to independence and personal decision-making.

d. Beneficence means to treat all people equally; autonomy means the patient is free to seek treatment anywhere they want.

11. When do psychologists have a right to breach confidentiality with a child/adolescent patient? *(Choose one)*

a. When there is a threat of harm to self (including suicide)

b. When there is a threat of harm to other(s)

c. When there is evidence of physical or sexual abuse or neglect

d. When a sexual assault or rape has occurred

e. All of the above

12. Functional impairment can be assessed by inquiring about a patient’s symptoms and functioning in major life domains. What domains does the HEADSS interview guide ask about? *(Choose one)*

a. Home, Education, Activities, Drugs, Sexuality, Suicide/Depression

b. Headaches, Endocrine disorders, ADHD, Diabetes, Sexually transmitted diseases

c. Home, Family, Support systems, School

d. Friendships, Hobbies, Family relationships, Medical history

13. “Failure to Thrive” is defined as: *(Choose one)*

a. Babies between 0–2 that cry constantly and have attachment problems

b. Children who experience delayed development due to neurodevelopmental problems

c. Children under five who have low height or weight, due to inadequate caloric intake

d. Children under five who have been placed with other relatives because the mother cannot care for the baby
14. What is the difference between an intellectual disability and a learning disability? (Choose one) ( __ / 1 point)
   a. Intellectual disabilities are genetic in nature whereas learning disabilities stem from behavioral issues.
   b. Intellectual disabilities limit the level of intelligence of a person; learning disabilities do not affect intelligence but do affect the brain’s ability to process and respond to certain information.
   c. Intellectual disabilities are treatable whereas learning disabilities are not.
   d. There is no difference between them.

15. Psychological problems after traumatic events are more likely to develop in which populations? (Choose one) ( __ / 1 point)
   a. Children
   b. People with past histories of mental illness
   c. Women and girls
   d. People with low socioeconomic status/living in poverty
   e. All of the above

16. Post-traumatic stress disorder is typically manifested through which of the following symptoms: (Choose one) ( __ / 1 point)
   a. Problems with eye contact, pointing and other gestures
   b. Hyperarousal, re-experiencing, detachment from others
   c. Delusions and thoughts that someone is controlling the patient
   d. Feelings of worthlessness, lack of interest in engaging in pleasurable activities

17. A safety plan is... (Choose one) ( __ / 1 point)
   a. A document completed by both the psychologist and patient outlining how the patient will recognize when they are in a crisis, and how to prevent suicide through five distinct steps.
   b. A plan in which the CHW calls the psychologist if they think one of their patients is in danger.
   c. A plan created by a psychologist that a patient would use when they run out of medication.
   d. A two-step plan that prevents patient suicide through contacting family members and mental health professionals.
18. Which of the following suggests severe depression: *(Choose one)* ( ___ / 1 point)
   a. ZLDSI score of 18 or more
   b. CES-D score of 25 or more
   c. Expression of suicidal ideation
   d. Presence of psychosis
   e. All of the above

19. True or False: Physicians can consider giving children/youth antidepressants if they have consulted with the Mental Health Team. Medication should be initiated at 50% usual starting dose. *(Choose one)* ( ___ / 1 point)
   a. True
   b. False

20. When is the CGI used with child and adolescent patients? *(Choose one)* ( ___ / 1 point)
   a. Every 6 months
   b. Only when the child/adolescent has expressed suicidal ideation
   c. Every appointment with the child/adolescent
   d. Only after 3 mental health appointments
## PRE-TEST AND POST-TEST ANSWER KEY

Name: ___________________________  Date: ___________________________

Site: ___________________________  Supervisor: ___________________________

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<tr>
<td><strong>1.</strong> Which group of disorders is most frequent in children? <em>(Choose one)</em></td>
<td>( __ / 1 point)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Mood disorders</td>
<td></td>
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<tr>
<td></td>
<td>b. Behavioral disorders</td>
<td></td>
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<tr>
<td></td>
<td>c. Anxiety disorders</td>
<td></td>
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<td></td>
<td>d. Substance abuse disorders</td>
<td></td>
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</tbody>
</table>

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</thead>
<tbody>
<tr>
<td><strong>2.</strong> What is a sensitive period? <em>(Choose one)</em></td>
<td>( __ / 1 point)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. The period in which children cry to get their needs fulfilled.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>b. A time during a child’s life when a child is more sensitive to environmental influences and experiences have a greater impact on brain development.</td>
<td></td>
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<tr>
<td></td>
<td>c. A time during pregnancy when the mother needs to eat more to nourish the baby.</td>
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<td></td>
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<tr>
<td></td>
<td>d. A period during adolescence when self-esteem is particularly fragile.</td>
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</thead>
<tbody>
<tr>
<td><strong>3.</strong> The Transactional Model of Development promotes the idea that: <em>(Choose one)</em></td>
<td>( __ / 1 point)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a. Both children and parents play a role in determining the course of a child’s development.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>b. Children and parents influence each other over time.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>c. Children need to be ignored when they start crying.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>d. A and B</td>
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</tbody>
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</thead>
<tbody>
<tr>
<td><strong>4.</strong> What are the four domains of child development? <em>(Choose one)</em></td>
<td>( __ / 1 point)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Physical, social, biological, emotional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Language, motor, behavior, temperament</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Infancy, toddlerhood, childhood, adolescence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Cognitive, linguistic, social-emotional, behavioral</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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<table>
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</thead>
<tbody>
<tr>
<td><strong>5.</strong> What are the four main stages of child development? <em>(Choose one)</em></td>
<td>( __ / 1 point)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Infancy, toddlerhood, childhood, adolescence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Neonate, child, teenager, adult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Fetus, baby, child, young adult</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>d. 0–5 years old, 5–10 years old, 10–15 years old, 15–20 years old</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Normal child development includes which milestones for 2-year-olds? (Choose one) ( _ / 1 point)
   a. Literacy skills
   b. Make-believe play
   c. Combining two or more words
   d. Development of first friendships
   e. B and C
   f. All of the above

7. Normal child development includes which milestones for 5-year-olds? (Choose one) ( _ / 1 point)
   a. Feeding and toileting
   b. Growth of child’s vocabulary to 2,000 words
   c. Emergence of moral beliefs
   d. Numeracy skills
   e. All of the above

8. Normal child development includes which milestones for 11-year-olds? (Choose one) ( _ / 1 point)
   a. Development of first friendships
   b. Sexual and/or romantic interests may begin
   c. Risky behaviors
   d. Awareness of gender stereotypes
   e. B and D

9. Normal child development includes which milestones for 18-year-olds (Choose one) ( _ / 1 point)
   a. Peer victimization
   b. Fluctuation in self-esteem and emotional experiences
   c. Vocabulary growth to over 40,000 words
   d. Difficulty in rational decision making
   e. All of the above
10. What do “beneficence” and “autonomy” mean in the context of ethical principles? (Choose one) (___ / 1 point)

a. Beneficence means there are benefits for the psychologists; autonomy means that psychologists can do what they want.

b. Beneficence means the duty to not “do bad”; autonomy means the psychologist should be free to give the treatment they think is best.

c. **Beneficence means the duty to do good; autonomy means that the psychologist respects the patient’s right to independence and personal decision-making.**

d. Beneficence means to treat all people equally; autonomy means the patient is free to seek treatment anywhere they want.

11. When do psychologists have a right to breach confidentiality with a child/adolescent patient? (Choose one) (___ / 1 point)

a. When there is a threat of harm to self (including suicide)

b. When there is a threat of harm to other(s)

c. When there is evidence of physical or sexual abuse or neglect

d. When a sexual assault or rape has occurred

e. **All of the above**

12. Functional impairment can be assessed by inquiring about a patient’s symptoms and functioning in major life domains. What domains does the HEADSS interview guide ask about? (Choose one) (___ / 1 point)

a. **Home, Education, Activities, Drugs, Sexuality, Suicide/Depression**

b. Headaches, Endocrine disorders, ADHD, Diabetes, Sexually transmitted diseases

c. Home, Family, Support systems, School

d. Friendships, Hobbies, Family relationships, Medical history

13. “Failure to Thrive” is defined as: (Choose one) (___ / 1 point)

a. Babies between 0–2 that cry constantly and have attachment problems

b. Children who experience delayed development due to neurodevelopmental problems

c. **Children under five who have low height or weight, due to inadequate caloric intake**

d. Children under five who have been placed with other relatives because the mother cannot care for the baby
14. What is the difference between an intellectual disability and a learning disability? (Choose one) ( _ / 1 point)
   a. Intellectual disabilities are genetic in nature whereas learning disabilities stem from behavioral issues.
   b. Intellectual disabilities limit the level of intelligence of a person; learning disabilities do not affect intelligence but do affect the brain's ability to process and respond to certain information.
   c. Intellectual disabilities are treatable whereas learning disabilities are not.
   d. There is no difference between them.

15. Psychological problems after traumatic events are more likely to develop in which populations? (Choose one) ( _ / 1 point)
   a. Children
   b. People with past histories of mental illness
   c. Women and girls
   d. People with low socioeconomic status/living in poverty
   e. All of the above

16. Post-traumatic stress disorder is typically manifested through which of the following symptoms: (Choose one) ( _ / 1 point)
   a. Problems with eye contact, pointing and other gestures
   b. Hyperarousal, re-experiencing, detachment from others
   c. Delusions and thoughts that someone is controlling the patient
   d. Feelings of worthlessness, lack of interest in engaging in pleasurable activities

17. A safety plan is... (Choose one) ( _ / 1 point)
   a. A document completed by both the psychologist and patient outlining how the patient will recognize when they are in a crisis, and how to prevent suicide through five distinct steps.
   b. A plan in which the CHW calls the psychologist if they think one of their patients is in danger.
   c. A plan created by a psychologist that a patient would use when they run out of medication.
   d. A two-step plan that prevents patient suicide through contacting family members and mental health professionals.
18. Which of the following suggests severe depression: *(Choose one)* *( __ / 1 point)*
   a. ZLDSI score of 18 or more
   b. CES-D score of 25 or more
   c. Expression of suicidal ideation
   d. Presence of psychosis
   e. All of the above

19. True or False: Physicians can consider giving children/youth antidepressants if they have consulted with the Mental Health Team. Medication should be initiated at 50% usual starting dose. *(Choose one)* *( __ / 1 point)*
   a. True
   b. False

20. When is the CGI used with child and adolescent patients? *(Choose one)* *( __ / 1 point)*
   a. Every 6 months
   b. Only when the child/adolescent has expressed suicidal ideation
   c. Every appointment with the child/adolescent
   d. Only after 3 mental health appointments
PARTNERS IN HEALTH MENTAL HEALTH & PSYCHOSOCIAL SERVICES
ADULT MENTAL HEALTH EVALUATION

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

<table>
<thead>
<tr>
<th>Depression</th>
<th>Mania</th>
<th>Anxiety</th>
<th>Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have you felt sad or lost interest in things for a two week period?</td>
<td>• Did you feel very happy for any reason in the last few days?</td>
<td>• Are you a worrier?</td>
<td>• Do you hear things like voices that other people don’t hear?</td>
</tr>
<tr>
<td>• Do you feel like you’ve lost interest in everything or only in some things?</td>
<td>• Did you get angry more often in the last few days?</td>
<td>• What do you worry about?</td>
<td>• Do you see things that other people don’t see?</td>
</tr>
<tr>
<td>• Zanmi Lasante Depression Symptom Inventory (ZLDSI): 1/39</td>
<td>• Do you:</td>
<td>• Are you experiencing:</td>
<td>• Do you feel that people are conspiring to harm you – even people whom you don’t know?</td>
</tr>
<tr>
<td></td>
<td>• Have any difficulties of staying attentive?</td>
<td>□ Panic attacks</td>
<td>• Are the voices in your head controlling your thought process?</td>
</tr>
<tr>
<td></td>
<td>□ Speak of things that you shouldn’t?</td>
<td>□ Fear of crowded places</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Feel like you’re worth more than before?</td>
<td>□ Sleep problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Have a racing thoughts going through your head?</td>
<td>□ Difficulty concentrating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Have an increase in activities?</td>
<td>□ Fatigue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Sleep less?</td>
<td>□ Irritability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Talk without ceasing?</td>
<td>□ Muscle tension</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Restlessness</td>
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</tbody>
</table>
**SUICIDE**

Have you ever thought of causing harm to yourself or committing suicide in the past? What about now?

<table>
<thead>
<tr>
<th>Ideation</th>
<th>Attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Present</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?

<table>
<thead>
<tr>
<th>Ideation</th>
<th>Acts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Present</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Beer</th>
<th>Home Brew</th>
<th>Liquor</th>
<th>Tobacco</th>
<th>Marijuana</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Present</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Physical</th>
<th>Emotional</th>
<th>Sexual</th>
<th>Re-experiencing</th>
<th>Hyperarousal</th>
<th>Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Present</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

If yes, explain: ________________

Do you feel safe in your current environment? ________________
# Physical Symptoms

<table>
<thead>
<tr>
<th>Pain</th>
<th>Whole Body</th>
<th>Head/Ears/Eyes/Nose/Throat</th>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you experiencing pain in your body?</td>
<td>• Is there a change in your:</td>
<td>□ Sight problems?</td>
<td>□ Stiffness of the neck?</td>
</tr>
<tr>
<td></td>
<td>□ Weight?</td>
<td>□ Hearing problems?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Thirst?</td>
<td>□ Voice change?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Fever?</td>
<td>□ Dizziness?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Gum and teeth status?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Difficulty swallowing?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breathing</th>
<th>Heart/Arteries</th>
<th>Digestive System</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having problems breathing?</td>
<td>□ Do you have an increased heartbeat?</td>
<td>□ Heart burn?</td>
<td>□ Any changes in your skin?</td>
</tr>
<tr>
<td></td>
<td>□ Having chest pain?</td>
<td>□ Gastric Reflux?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Any swelling?</td>
<td>□ Vomiting?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Constipation, diarrhea, gas?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Muscles</th>
<th>Appendages (Hands and Feet)</th>
<th>Genitals/Urinaition</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are they stiff?</td>
<td>□ Swollen?</td>
<td>□ Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?</td>
<td>□ Any numbness?</td>
</tr>
<tr>
<td></td>
<td>□ Swollen?</td>
<td></td>
<td>□ Uncontrolled movements?</td>
</tr>
<tr>
<td></td>
<td>□ Reddened?</td>
<td></td>
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</tr>
</tbody>
</table>


# PAST PSYCHIATRIC HISTORY

<table>
<thead>
<tr>
<th>NAME OF THE ILLNESS</th>
<th>HOSPITALISATION/ HOME TREATMENT</th>
<th>MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Psychiatric Family History:

---

**Past Medical History and Active Medical Problems**

- Head Injury:

- Loss Of Consciousness:

- Last Date Of Menstruation: ___ / ___ / ___

- 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 ________________________________
<table>
<thead>
<tr>
<th>General Appearance</th>
<th>□ well groomed □ disheveled □ overdressed, elaborate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>□ O x 3 □ disoriented to time □ disoriented to place □ disoriented to person</td>
</tr>
<tr>
<td>Behavior</td>
<td>□ WNL □ tics □ retardation □ agitation □ tremor</td>
</tr>
<tr>
<td>Speech</td>
<td>□ WNL □ slowed □ pressured □ slurred</td>
</tr>
<tr>
<td>Mood</td>
<td>□--------------------------------------------------</td>
</tr>
<tr>
<td>Affect</td>
<td>□ euthymic □ dysphoric □ euphoric □ anxious □ irritable □ suspicious □ labile □ flat □ congruent with speech content □ incongruent with speech content □ other: ____________________</td>
</tr>
<tr>
<td>Thought Process</td>
<td>□ linear □ tangential □ perseverative □ illogical □ loose associations □ ____________________</td>
</tr>
<tr>
<td>Thought Content</td>
<td>□ WNL □ vague □ WNL □ suicidal ideation □ homicidal ideation □ none □ paranoid □ grandiose □ other: ____________________ □ auditory □ visual □ olfactory □ gustatory □ tactile</td>
</tr>
<tr>
<td>Insight:</td>
<td>□ poor □ limited □ good</td>
</tr>
<tr>
<td>Judgment/Impulse Control:</td>
<td>□ poor □ limited □ good</td>
</tr>
</tbody>
</table>

General Impressions: ____________________

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

Axis I: ___________________________________________________________________

Axis II: ___________________________________________________________________

Axis III: ___________________________________________________________________

Axis IV: ___________________________________________________________________

PLAN/AVAILABILITY:

Next Visit: __________________________________________________________________

Follow Up:

☐ Reevaluation using the ZLDSI: When? ________________

☐ CHW: When? ________________ Name of CHW: ___________________________ ☐ Contacted

☐ Psychotherapy: When? ________________ Name of psychologist/social worker: ___________________________ ☐ Contacted

☐ Hospitalization: When? ________________

☐ Medical Evaluation: When? ________________ ☐ Referral Complete ☐ at ___________________________

Necessary Intervention:

Safety: ___________________________________________________________________

Psychoeducation: ___________________________________________________________________

Medication (including name, dose, frequency, quantity, date of refill): ___________________________________________________________________

Other: ___________________________________________________________________

___________________________________________________________________________

Signature of Evaluating Clinician ___________________________ Date ________________

Print Name of Evaluating Clinician ___________________________ Discipline (Psychiatry, Psychology, Social Work, Primary Care)
**ZANMI LASANTE DEPRESSION SYMPTOM INVENTORY (ZLDSI)**

Date ____________

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

**Totals**

<table>
<thead>
<tr>
<th></th>
<th>(+)</th>
<th>(+)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(=) ZLDSI Score
**CES-D**

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

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

Total (out of 60)
### ZANMI LASANTE — MENTAL HEALTH

#### SUICIDALITY SCREENING INSTRUMENT

<table>
<thead>
<tr>
<th>LEVEL REACHED</th>
<th>IN THE PAST TWO WEEKS?</th>
<th>IN THE PAST YEAR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Passive</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> Do you have any thoughts of ending your life, even if they are not clear in your mind?</td>
<td><strong>Possible Response:</strong> I think about it from time to time, but I have never acted upon it...I would make my family feel too bad...God would not forgive me</td>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>2. Non-Specific Active</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> Do you want to die? Do you often think or talk about death?</td>
<td><strong>Possible Response:</strong> desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me</td>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>3. Methods but no Intent to Act</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> If you would do it, how would you do it?</td>
<td><strong>Possible Response:</strong> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</td>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>4. Intent to Act</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> Do you intend to act on these thoughts?</td>
<td><strong>Possible Response:</strong> 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</td>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>5. Planification</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> Have you started planning the details about how you will kill yourself?</td>
<td><strong>Danger Signs:</strong> 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).</td>
<td><strong>Description:</strong></td>
</tr>
<tr>
<td>6. Attempted</td>
<td>No  Yes</td>
<td>No  Yes</td>
</tr>
<tr>
<td><strong>Ask:</strong> 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?</td>
<td><strong>Danger Signs:</strong> 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.</td>
<td><strong>Description:</strong></td>
</tr>
</tbody>
</table>

**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
### For ALL Patients

<table>
<thead>
<tr>
<th>Act</th>
<th>1. Ensure that the environment will be private, safe and non-threatening.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Begin the process of ensuring that the patient will be able to access necessary medication.</td>
<td></td>
</tr>
<tr>
<td>3. Always work with the patient to develop a Safety Plan.</td>
<td></td>
</tr>
<tr>
<td>Say</td>
<td>4. Use the patient’s name often, give hope, insist that there are other options, and declare your intent to help.</td>
</tr>
<tr>
<td>5. Start IPT and collect IP inventory.</td>
<td></td>
</tr>
<tr>
<td>6. Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources.</td>
<td></td>
</tr>
<tr>
<td>7. Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy). <em>(Write this on the copy of your Safety Plan, on the back side).</em></td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>8. Always contact at least one person close to the patient to support and monitor them.</td>
</tr>
<tr>
<td>9. Contact as many of the current and potential supports as a patient will permit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You should utilize the clergy early and heavily for supporting, home visiting, and monitoring patients</td>
</tr>
<tr>
<td></td>
<td>• When involving anyone, ensure that you preserve confidentiality if possible and define these:</td>
</tr>
<tr>
<td></td>
<td>1. Depression, suicidality</td>
</tr>
<tr>
<td></td>
<td>2. The needs of such patients</td>
</tr>
<tr>
<td></td>
<td>3. How others can help</td>
</tr>
<tr>
<td></td>
<td>4. How others can hurt</td>
</tr>
<tr>
<td>Team</td>
<td>10. Consult and involve colleagues to help.</td>
</tr>
<tr>
<td></td>
<td>Social Worker ☐ Psychologist ☐ Community Health Worker ☐ Doctor ☐</td>
</tr>
<tr>
<td>Follow Up</td>
<td>11. If the patient has a <strong>higher</strong> risk level, continue to the guidelines <strong>below</strong>.</td>
</tr>
</tbody>
</table>
### 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. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Say</td>
<td>2.</td>
<td>☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td>☐ Seek agreement or at least acceptance that individuals in that patient's milieu may need to be notified explicitly.</td>
</tr>
<tr>
<td>Contact</td>
<td>4.</td>
<td>☐ Close family should be informed quickly and explicitly of the patient's suicidality.</td>
</tr>
<tr>
<td>Team</td>
<td>5.</td>
<td>☐ At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.</td>
</tr>
</tbody>
</table>
| 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 ____________ |
| 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. |
ZANMI LASANTE — MENTAL HEALTH
SAFETY PLAN

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 and social environments that offer distractions and support:
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... ___________________________
## Clinical Global Impressions Scale

**Date:** __________________________

**Name:** __________________________  **Psychologist / SW:** __________________________

**Patient ID:** ______________________  **Age:** __________________________

**Male/ Female (circle one)**  **Phone #1:** __________________________

**Town:** __________________________  **Phone #2:** __________________________

**District:** ________________________  **Session#:** __________________________

**Date received patient info:** __________________________

### I. Severity of Illness

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

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

0 = Not assessed

1 = Normal, not at all ill.
Symptoms of disorder have not been present in the past seven days.

2 = Borderline mentally ill.
Subtle or suspected symptoms within the past seven days. No definable impact on behavior or function.

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

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

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

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

7 = Among the most extremely ill patients.
Pathology drastically interferes in many life functions. Patient may need to be hospitalized.

**Rating**
(Number 0–7)
II. Improvement

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

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

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

0 = Not assessed
1 = Very much improved.
   Nearly all better; good level of functioning; minimal symptoms; represents a very substantial change.
2 = Much improved.
   Notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain.
3 = Minimally improved.
   Slightly better with little or no clinically meaningful reduction of symptoms. May represent very little change in basic clinical status, level of care, or functional capacity.
4 = No change.
   Symptoms remain essentially unchanged.
5 = Minimally worse.
   Slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity.
6 = Much worse.
   Clinically significant increase in symptoms and diminished functioning.
7 = Very much worse.
   Severe exacerbation of symptoms and loss of functioning.

Rating
(Number 0–7)

III. Side Effects

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

0 = None
1 = Do not significantly interfere with patient’s functioning.
2 = Significantly interfere with patient’s functioning.
3 = Outweighs therapeutic effects with patient’s functioning.

Rating
(Number 0–3)
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**

<table>
<thead>
<tr>
<th>In the past 30 days, how much difficulty did you have in:</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme or cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1  Standing for long periods such as 30 minutes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>S2  Taking care of your household responsibilities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>S3  Learning a new task, for example, learning how to get to a new place?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>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?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>S5  How much have you been emotionally affected by your health problems?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

| 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 Health Organization Disability Assessment Schedule 2.0

Flashcard 2

1. None
2. Mild
3. Moderate
4. Severe
5. Extreme or cannot do
EVALUATION FORM

What training activity did you like the most? Why?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What training activity did you like the least? Why?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What did you learn that was valuable and that you will use in your work?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Was there anything you did not understand? Give specific examples.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What are your recommendations to improve this training? What would you change? (For example, what activities, illustrations, etc. would you change?)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________


Do you have any recommendations for the facilitators of this training?

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

What questions do you still have for the facilitators of this training?

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Were there any questions during the training which the facilitators did not answer?

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

What additional comments do you have?

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Thank you for completing this evaluation.