PARTICIPANT MANUAL

Introduction to Child & Adolescent Mental Health

Curriculum for Psychologists
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 Dubuission; Ketnie Aristide; Leigh Forbush, MPH; Rami Murali, MA, MPH; Anne Becker, PhD, MD; Mary Kay Smith Fawzi, ScD. and Meg Gerbasi, PhD.


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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

Mental disorders are a significant cause of disability in children and adolescents, more prevalent than leukemia, diabetes and AIDS combined.\(^1\) 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

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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, you will be able to:**

a. Explain the concept of normal development.
b. Describe the role that genetics and the environment play in child development.
c. List the stages and domains of child development.
d. Identify the biological, psychological and social threats to normal child development.
e. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the infancy development phase.
f. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the toddlerhood development phase.
g. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the childhood development phase.
h. Identify major cognitive/linguistic and social-emotional/behavioral milestones during the adolescence development phase.
i. Define the four governing ethical principles.
j. Explain the difference between assent, consent and dissent related to mental health care.
k. Describe when mental health providers have a legal obligation to breach confidentiality and report certain situations.
l. Outline the responsibilities of psychologists during an initial mental health evaluation and follow-up evaluation.
m. Explain when and how to use the HEADDS interview guide questions during an interview with a child/adolescent.
n. Describe pharmacologic and non-pharmacologic treatment options available for children/adolescents with mental health disorders.
o. Define Failure to Thrive.
p. Describe how to evaluate a child who may be experiencing Failure to Thrive.
q. List psychoeducation messages about Failure to Thrive and treatment options to share with families.
r. Explain the difference between intellectual disabilities and neurodevelopmental disabilities.
s. Identify signs and symptoms of intellectual disabilities and neurodevelopmental disabilities.
t. Utilize mhGAP to assess and manage developmental disorders.
u. Name common stress-related mental disorders, and their ideal management and treatment in children/adolescents.

v. Identify at-risk populations for psychological problems after traumatic events.

w. Describe the physical, psychological, emotional, relational reactions to traumatic events.

x. Utilize mhGAP to assess and manage conditions specifically related to stress.

y. Identify signs and symptoms of depression in children/adolescents.

z. Describe disorders that commonly mimic depression in their presentation.

aa. Correctly use the ZLDSI and CES-D to screen for depression in children/adolescents.

ab. Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.

ac. Describe the pharmacologic and non-pharmacologic treatment of depression in children/adolescents.

ad. Describe how to use the CGI and WHODAS to assess clinical improvement.

ae. Explain the importance of outcome measures to assess care quality and systems improvement.
Overview of Early Childhood Development

Normal development refers to average or “on-time” growth based on milestones across specific stages (physical, cognitive, linguistic, social-emotional, and behavioral). Every culture will have its own variation in child development milestones and what is considered “normal.”

Development principles:

- Development is similar for each individual.
- Development builds upon earlier learning.
- Development proceeds at an individual rate.
- The different areas of development are interrelated.
- Development is a lifelong process.

Nature vs. Nuture

A combination of genetics and environment determines how a child will develop, both before and after birth.

<table>
<thead>
<tr>
<th>REFLECTION</th>
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<tbody>
<tr>
<td>Think about something new you learned to do in the past year. (Example: Cooked a certain meal? Used a new computer program? Utilized a new type of therapy?)</td>
</tr>
</tbody>
</table>

1. How did you learn it?

2. Do you think it took you longer to learn this skill now than if you had learned it when you were younger?
Sensitive Period

- A time during an organism’s life when it is more sensitive to environmental influences and experiences have a greater impact on brain development
- Optimal times for certain capacities to be developed

Critical Period

- If the organism does not receive the appropriate stimulus during a “critical period” to learn a given skill or trait, it may be difficult or impossible to develop some functions later in life
- Typically, things cannot be changed after a critical period

Transactional Model of Development

Both child and environment (parenting and other risk factors) play a role in determining the course of development.

Attachment

An enduring emotional bond characterized by a tendency to seek and maintain proximity to a specific figure or figures, particularly when under stress. Disruptions in the infant-caregiver bond can result in insecurely attached infants.

Insecurely attached infants may appear:
- Not distressed when the caregiver leaves the room and reacts 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).
Stages and Domains of Child Development

Stages of Child Development

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age Range</th>
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<tbody>
<tr>
<td>Infancy</td>
<td>From 0–2 Years</td>
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<tr>
<td>Toddlerhood</td>
<td>From 3–5 Years</td>
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<tr>
<td>Children</td>
<td>From 6–11 Years</td>
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<tr>
<td>Adolescence</td>
<td>From 12–18 Years</td>
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</table>

Domains of Child Development

- Cognitive
- Behavioral
- Linguistic
- Social-emotional
Risks to Early Childhood Development

<table>
<thead>
<tr>
<th>BIOLOGICAL THREATS TO NORMAL CHILD DEVELOPMENT</th>
<th>PSYCHOLOGICAL THREATS TO NORMAL CHILD DEVELOPMENT</th>
<th>SOCIAL THREATS TO NORMAL CHILD DEVELOPMENT</th>
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<tr>
<td>AGE</td>
<td>CHILD DEVELOPMENT TIMELINE</td>
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<td>INFANCY (0–2 YEARS)</td>
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<td>18</td>
<td>TODDLERHOOD (3–5 YEARS)</td>
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<td>CHILDHOOD (6–11 YEARS)</td>
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<td>18</td>
<td>ADOLESCENCE (12–18 YEARS)</td>
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# Childhood Development – Infancy through Toddlerhood

## Brain Development

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.

## Infancy Milestones (0–2 Years Old)

Infancy can be divided into:

- Birth to 6 months
- 7 months to 1 year
- 13 months to 18 months
- 19 months to 2 years

<table>
<thead>
<tr>
<th>0–6 months</th>
<th>COGNITIVE/LINGUISTIC</th>
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<tbody>
<tr>
<td></td>
<td>Recognition of facial expression</td>
</tr>
<tr>
<td></td>
<td>Preference for familiar people, stimuli and face-to-face interactions</td>
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<tr>
<td></td>
<td>Improvement of memory and attention</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7 months–1 year</th>
<th>COGNITIVE/LINGUISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Object permanence (8 months)</td>
</tr>
<tr>
<td></td>
<td>Emergent language skills</td>
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<tr>
<td></td>
<td>Can point to object (e.g., a toy) around one year</td>
</tr>
<tr>
<td></td>
<td>Learn and respond to own name</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>13–18 months</th>
<th>COGNITIVE/LINGUISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Object permanence</td>
</tr>
<tr>
<td></td>
<td>Memory and retrieval</td>
</tr>
<tr>
<td></td>
<td>Vocabulary grows to about 200 words</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19 months–2 years</th>
<th>COGNITIVE/LINGUISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development and execution of action plans</td>
</tr>
<tr>
<td></td>
<td>Pretend or make-believe play (20 months) and daily life play themes</td>
</tr>
<tr>
<td></td>
<td>Combining two or more words</td>
</tr>
<tr>
<td></td>
<td>Vocabulary growth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0–6 months</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Self-regulation based on routines</td>
</tr>
<tr>
<td></td>
<td>Sleep cycles become more predictable by 8 weeks</td>
</tr>
<tr>
<td></td>
<td>Social smile</td>
</tr>
<tr>
<td></td>
<td>Multiple displays of emotions by age 6 months</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7 months–1 year</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Development of attachment relationships</td>
</tr>
<tr>
<td></td>
<td>Separation anxiety</td>
</tr>
<tr>
<td></td>
<td>Social referencing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13–18 months</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-awareness</td>
</tr>
<tr>
<td></td>
<td>Empathy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>19 months–2 years</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Growing awareness of others</td>
</tr>
<tr>
<td></td>
<td>Complex emotions</td>
</tr>
<tr>
<td></td>
<td>Lower intensity of separation anxiety</td>
</tr>
<tr>
<td></td>
<td>Self-control</td>
</tr>
<tr>
<td></td>
<td>Play</td>
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</tbody>
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### Toddlerhood Milestones (3–5 Years Old)

<table>
<thead>
<tr>
<th></th>
<th>COGNITIVE/LINGUISTIC</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–5 years</td>
<td>• Sociodramatic play (by age 3): mental representations</td>
<td>• Normative temper tantrums</td>
</tr>
<tr>
<td></td>
<td>• Continuously searches for logical explanations and cause/effect relationships</td>
<td>• Development of first friendships</td>
</tr>
<tr>
<td></td>
<td>(“why” period)</td>
<td>• Emergence of moral beliefs</td>
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<tr>
<td></td>
<td>• Early literacy and numeracy skills</td>
<td>• Capacity to describe mental states and characteristics of others</td>
</tr>
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<td></td>
<td>• Grammatically complex sentences by age 4</td>
<td>• Physical maturation: Feeding and toileting</td>
</tr>
<tr>
<td></td>
<td>• Growth of child’s vocabulary to about 2,000 words by age 5</td>
<td>• Sexual curiosity and self-exploration</td>
</tr>
</tbody>
</table>

[Partners In Health | Participant Handbook](#)
# Childhood Development – Childhood through Adolescence

## Childhood Milestones (6–11 Years Old)

<table>
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<tr>
<th>COGNITIVE/LINGUISTIC</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
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</thead>
<tbody>
<tr>
<td>6–11 years</td>
<td></td>
</tr>
<tr>
<td>• Self-control and use of divided, focused, and selective attention</td>
<td>• Self-esteem or beliefs about self-worth</td>
</tr>
<tr>
<td>• Time and spatial orientation and organization: right from left</td>
<td>• Awareness of gender stereotypes and roles</td>
</tr>
<tr>
<td>• Categorization of objects</td>
<td>• Empathy and moral development</td>
</tr>
<tr>
<td>• Processing auditory and visual information</td>
<td>• Friendships</td>
</tr>
<tr>
<td>• Sophisticated literacy and numeric skills</td>
<td>• Peer victimization</td>
</tr>
<tr>
<td>• Vocabulary growth: Up to 10,000 words</td>
<td>• Sexual and/or romantic interests may begin</td>
</tr>
<tr>
<td>• Advances in conversational skills</td>
<td></td>
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</tbody>
</table>

## Adolescence Milestones (12–18 Years Old)

The last stage in child development is adolescence. 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.

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<thead>
<tr>
<th>COGNITIVE/LINGUISTIC</th>
<th>SOCIAL-EMOTIONAL/BEHAVIORAL</th>
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</thead>
<tbody>
<tr>
<td>12–18 years</td>
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<tr>
<td>• Growth in self-consciousness and cognitive distortions</td>
<td>• Fluctuation in self-esteem and emotional experiences linked to hormonal changes</td>
</tr>
<tr>
<td>• Imaginary audience</td>
<td>• Mild to moderate variations in mood and behavior</td>
</tr>
<tr>
<td>• Difficulty with rational decision-making and impulsivity</td>
<td>• Peer group</td>
</tr>
<tr>
<td>• Vocabulary growth (over 40,000 words by age 18)</td>
<td>• Risky behaviors</td>
</tr>
<tr>
<td>• Conversational skills</td>
<td>• Peer victimization</td>
</tr>
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<td></td>
<td>• Greater understanding of their own moral beliefs</td>
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</tbody>
</table>
Ethics & Laws of Child and Adolescent Mental Health

Children and Human Rights

The Universal Declaration of Human Rights:

Article 25

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children...shall enjoy the same social protection.

United Nations Convention on the Rights of the Child

1989: Established the rights of children to survival, development, protection and participation, including the rights to voice their views freely, be given commensurate deference, and live with their families.

United Nations Convention on the Rights of Person with Disabilities

2006: Emphasized that respect and dignity are to be accorded to disabled individuals of all ages, including children.

Governing Ethical Principles

1. Beneficence – the duty to do good
2. Nonmaleficence – the duty to not “do bad”
3. Autonomy – respect for the patient’s right to independence and personal decision-making
4. Justice – to treat all people equally and equitably

Assent and Dissent

Assent: ____________________________

Consent: ____________________________

Dissent: ____________________________

Age of consent: Children are considered adults at 18 years of age (medical treatment in general, specifically for both mental health treatment and reproductive health treatment, and for sexual intercourse). For youth under 18 years of age, parents must give consent to their child seeing a health professional.
Legal Obligations to Breach Confidentiality

Psychologists have a legal obligation to report or act upon certain situations, and in these cases confidentiality may be breached:

- Threat of harm to self (including suicide)
- Threat of harm to other(s)
- Evidence of physical or sexual abuse or neglect
- Sexual assault or rape
  - Haitian law protects confidentiality of this information. Psychologists should obtain the victim’s permission if they decide it is important to report it.

ACTIVITY: DISCUSSION

- 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 experienced that issue?
Child and Adolescent Assessment & Treatment Options

Guiding Principles for Assessment

• Do
  – Assess for risk
  – Evaluate vulnerabilities and strengths

• Use
  – Biopsychosocial framework
  – Developmental context
  – A relational approach

• Assume
  – Parents want the best for their children

Essential Components of an Assessment

• Medical history
• Family history and current supports
• History of trauma, losses and displacements
• Assessment of risk (suicide, violence, sexual history drugs and alcohol)
• Knowledge of areas of strength
• Collateral contact with family members or others close to the child/adolescent in the community

Interview Structure

Under ideal circumstances, using a bio-psycho-socio-cultural approach, information is obtained about:

1. The current problem
   – How do family members understand and describe what is concerning them?
   – Has this happened before?
   – Was there a precipitant?
   – Why have they sought help now?
   – What have they tried and what has been helpful?
   – What made them decide to seek help from you and your service?
   – What do they want help with? What are their priorities?
2. The background and developmental history of
   – Child (development since birth)
   – Parents and family (relationships; conception, pregnancy and delivery)

3. Current supports and stressors

**HEADSS: Asking About Functioning**

**Home**
- “How do you get along with your parents/family?”

**Education**
- “Do you go to school? If no, why not?”
- “How do you like school and your teachers?”
- “How well do you do in school?”

**Activities**
- “What do you like to do?”
- “Do you have a best friend or group of good friends?”

**Drugs**
- “Have you ever used alcohol or drugs?”

**Sexuality**
- “Are there any issues regarding sexuality or sexual activity that are of concern to you?”

**Suicide/depression**
- “Everyone feels sad or angry some of the time. How about you?”
- “Did you ever feel so upset that you wished you were not alive or so angry you wanted to hurt someone else badly?”

**Attachment Informed Assessment**

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

**Treatment**

Non-pharmacologic 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.

**Psychotherapy**

Psychotherapy in children can be effective in reducing symptomatology. Psychotherapy involves a series of discrete steps including: assessment; deciding upon treatment with the patient; obtaining treatment assent and consent; a monitoring plan; and implementing treatment. Psychotherapeutic interventions will be used for cognitive, emotional, and/or behavioral symptoms. **The quality of the therapist-patient alliance is the strongest predictor of treatment outcome.** Psychotherapeutic approaches in rank order of comparative effectiveness include:

- **Cognitive-behavioral therapy:** First-line treatment for anxiety and mild depression. Based on the theory that antecedent events stimulate thoughts and beliefs that cause emotional consequences. Problem-oriented.
- **Interpersonal therapy:** Also effective for depression. Addressed relationships in the “here and now,” with a focus on four areas: grief; role transitions; role disputes; and interpersonal deficits.
- **Family therapy:** Problems exist in family interactions and not just in individuals. Solutions involve improving communication, reframing of behaviors and giving directives to disrupt dysfunctional patterns.
- **Psychodynamic psychotherapy:** Based on the belief that much of one’s mental activity, including internal conflicts, occurs outside one’s awareness.
- **Supportive psychotherapy:** Aims to minimize levels of emotional distress.
- **Narrative therapy:** Based on the principle that self-stories organize, interpret and assign meaning to events in a person’s life.
Medication

- Only for severe presentations of illness, when clearly indicated, sustainable and with adequate follow up possible.
- Identification and assessment of clear target symptoms agreed upon with the child/adolescent and family.
- Search for medical factors that may be causing or exacerbating target symptoms.
- Completion of medical tests that have a bearing on treatment course.
- Establishment of a plan for monitoring of effects.
- Consideration of withdrawal of medication after 6–12 months to determine if still needed.
Child Development and Failure to Thrive

CASE STUDY 1

A 30-year-old woman presents to the clinic brought by her mother. She carries with her a baby of 2 years, who is thin and listless. The grandmother reports, with great concern, that the baby is not doing well, and does not seem to be thriving like other babies of the same age. You note that the woman is quiet and somewhat withdrawn.

The baby has refused to eat since the first few months of life. The grandmother explains that the mother has been lying in bed, with difficulty getting up in the morning. There is no father in the home. The boy is apathetic when presented with food and turns his head away. His development appears a bit delayed. He is walking well but only saying a few words. When weighed he is below the 2nd percentile for height and weight. There is adequate food in the home.

Failure to Thrive

Failure to thrive = children under age 5 who have low height or weight, due to inadequate caloric intake.

May be due to:

- Inadequate food supply
- Physical causes in child such as chronic infection, food allergies, and failure to absorb food
- Temperamental characteristics in child such as restlessness
- Poor social conditions and lack of sanitation, overcrowding and financial hardship
- Inadequate parenting due to depression, apathy, irritability and insensitivity to the needs of the child

Feeding Problems: First 3 Months of Life

- Too early introduction of complementary feeding (should be exclusively breastfeeding for 6 months)
- Illness in the child (neonatal tetanus, pertussis, other congenital abnormality)

Where the food supply is adequate:

- Anatomical abnormality or illness of baby
- Anatomical abnormality of mother
- Anxiety or depression
- Problems with feeding technique
- Problems in mother-baby and feeding relationship
Feeding Problems: 3 Months to 3 Years

Where the food supply is adequate:

- Finicky eating habits
- Overeating
- Putting things that are not food in mouth
- Vomiting

Evaluation

<table>
<thead>
<tr>
<th>INFANT</th>
<th>MOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Growth chart</td>
<td>• Assess mother for physical and mental fitness</td>
</tr>
<tr>
<td>• Physical examination</td>
<td>• Ask about:</td>
</tr>
<tr>
<td>• Look for evidence of infection</td>
<td>– Details of feeding problem</td>
</tr>
<tr>
<td>• Ask about food availability</td>
<td>– Food child is given</td>
</tr>
<tr>
<td></td>
<td>– Other things that have been tried</td>
</tr>
<tr>
<td></td>
<td>– History of mental health problems in parent</td>
</tr>
</tbody>
</table>

Treatment

Infant:

- Provide food, ensure access to resources as possible
- Feed child three meals per day and three snacks
- Multivitamin if available
- Follow growth weekly to monthly, if failure to respond within 2–3 months, re-evaluate

Mother/Family:

- As possible, address any contributing parental disorder to problem
- Instruct parents in high-calorie/high-protein diet
- Discuss optimal feeding interactions with all caregivers
Learning and Developmental Problems

CASE STUDY 2

A mother comes to the clinic with her 9-year-old son. She reports that her child is not doing well at school, and is falling behind because he is unable to read. She expresses that the family is spending their money sending him to school and he is not taking advantage of the opportunity. The boy’s father has been calling him lazy, and has beat him several times recently. The boy’s mother asks for your help and advice.

The mother reports that at age 5 the boy’s skills were like those of a boy half his age. His language was like that of a 2-year-old, and he was still wetting himself. He had been able to walk by 18 months. No one else in the family had been slow to learn. He generally had been an obedient, rather passive boy.

Learning and Development

Intellectual Disability

• A group of disorders that have in common deficits of adaptive and intellectual function and an age of onset before maturity is reached—deficits in functioning and social interaction.

• A prenatal biologic/genetic cause can be identified in more than 75% of cases.

• Clinical manifestations of intellectual disabilities include: basic adaptive functioning, basic cognitive functioning, basic social functioning, reading, spelling and writing, nonacademic problems.

Neurodevelopmental Disorders

• Pervasive Developmental Disorder & Autism Spectrum Disorder
  – Persistent impairment in reciprocal social communication and interaction and restricted, repetitive patterns of behavior and interest.
  – Social challenges can include problems in spoken language, responding to others, interaction with others, eye contact, pointing and other gestures, reduced imagination, or unusual or restricted interests and/or rigid and repetitive behaviors.

• Learning Disorder
  – Neurodevelopmental dysfunction can place a child at risk for developmental, cognitive, emotional, behavioral, psychosocial and adaptive challenges
  – Reading, writing, language, spelling, mathematics
  – Pre-/peri-natal, genetic, medical, psychologic-environmental and sociocultural influences
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.

Interventions for Learning Problems

- School accommodations
- Curriculum modifications
- Remediation of skills
- Strengthening of strengths
- Individual and family counseling
- Medications (when appropriate)
Trauma and Anxiety

CASE STUDY 3

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 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.

Common Mental Disorders After Traumatic Events

• Post-traumatic Stress Disorder
• Depression
• Anxiety Disorders
• Psychosomatic Disorders
• Psychosis

Risk Factors for Psychological Problems After Traumatic Events

Risk Factors:

• Low socioeconomic status/poverty
• Past traumatic life events
• Past history of mental illness

Populations:

• Women and girls are more affected
• Children are affected more than adults
• Men more likely to abuse alcohol
### Physical Reactions

- Poor sleep (increase, decrease, broken)
- Nightmares
- Change in appetite (increase, decrease)
- Dizziness
- Headaches or body pain
- Upset Stomach
- Fatigue, malaise

### Psychological Reactions

- Problems concentrating
- Forgetfulness
- Difficulty making decisions
- Losing track of time
- Feeling as if you can’t control your thoughts
- Confusion
- Restless

### Emotional Reactions

- Helplessness
- Powerless
- Numb or unable to feel deeply
- Depression
- Guilt

### Relational Reactions

- Hard to trust others
- Not wanting to see people you don't know
- Wanting to be alone
- Feeling that others don’t understand you
- Problems with spouse or family members
- Increased resilience and altruistic behavior

### Post-Traumatic Stress Disorder

- Re-experiencing (intrusive distressing memories, nightmares, flashback/reliving the event, nightmares, hallucinations)
- Hyperarousal (insomnia, irritability, angry outbursts, exaggerated startle response)
- Avoidance of stimuli associated with the trauma, detachment and estrangement from others, foreshortened sense

### Treatment

- Strengthen individual functioning
- Psychopharmacology for significant, longstanding symptoms
- Individual counseling
- Family counseling
- Rehabilitation (mentally ill, brain injury, physical injury, developmental delay)

### Community-Based Promotion

- Promote strengths, healthy coping
- Support to families, family reunification
- Group interventions
- Gender-based violence programs
Introduction to Child & Adolescent Mental Health  

Curriculum for Psychologists

- Healing rituals
- Strengthen cultural mechanisms
- Normalize environment
- Peace building to human rights education
- Skills development
- Economic opportunities, e.g. income generating programs

**Anxiety**

- Epidemiology: Prevalence approximately 5–18%.\(^3\)
  - Genetic susceptibility, psychosocial factors, often co-morbid with depression and other disorders.

- Clinical presentation (DSM-based criteria):
  - Always consider anxiety and/or depression when meeting children or adolescents with new or unusual physiologic, perceptual or behavioral symptoms, somatic complaints, irritability and social withdrawal.
  - Younger children may be less able to verbalize feeling states. Older children with anxiety may present with psychotic or melancholic symptoms or suicidal behavior.

**Differential Diagnosis**

- Normal anxiety
- Anxiety due to a general medical condition
- Adjustment disorder
- Substance-induced
- Pervasive Developmental Disorder (PDD)
- School refusal related to conduct disorder
- Delusional or psychotic disorder (rare)

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Screening Questions

- “Are there things that you are afraid of?”
- “Do you often feel nervous? Are there things that bring this on?”
- “Do you have thoughts that you can’t get out of your head, even though they really bother you? What are they?”
- “Are there things that you feel you must do to help you feel less anxious—like washing your hands, checking on something, or counting things?”

Management

- Support coping and relaxation
- Refer for psychotherapy by specialist if available
- Support coping skills
  - “Identify situations that make you feel stressed”
  - “Imagine how your friends would respond to these situations”
  - “List as many ways as you can think of to make these situations less stressful”
  - “Imagine yourself doing these things”
  - “Rehearse a situation before you face it”
  - “Share your stress with others, such as friends, family or teachers”
  - “Do not be embarrassed to see a counselor”

- Relaxation and breathing exercises
Depression and Suicide

CASE STUDY 4

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 worth living anymore because the family had recently lost its major source of income, and he would have to leave school to find work.

Depression

Causes

- Depression is a bio-psycho-social disorder
- Evidence demonstrates altered brain structure and function in depression
- It is not clear if these changes cause depression or whether they are caused by depression
- Genetics plays a role in causing depression, but so do life events including trauma, poverty, abuse and losses

Signs and Symptoms of Major Depressive Disorder

- Affect and mood: Look sad, feel sad, feelings of worthlessness
- Behavior: Psychomotor slowing, lack of interest in engaging in pleasurable activities, lack of energy, insomnia or hypersomnia
- Cognition and perception: Difficulty concentrating, persistent guilty ruminations, thoughts of suicide
- Development: Difficulties carrying out usual work, school, domestic or other areas of functioning

Depression Screening Questions

- “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?”
Diagnosing Severe Depression

- When diagnosing moderate-severe depression, assess:
  - If the patient has had symptoms over the past two weeks
  - If, over the past two weeks, the patient has had difficulties in day-to-day functioning due to the symptoms
- The following suggests severe depression:
  - ZLDSI > 18 OR
  - Suicidal Ideation OR
  - CES-D > 25 OR
  - Alters operation (unable to work/go to school, inability to maintain social relationships/family, inability to take charge) OR
  - Presence of psychosis

Other Symptoms

- Dysthymia:
  - Depression symptoms lasting at least two years and
  - Do not meet the full criteria for major depressive disorder
- Bipolar disorder:
  - Requires a history of at least one manic or hypomanic episode
- Adjustment disorder with depressed mood:
  - May be diagnosed when there is an identifiable psychosocial stressor and the symptoms do not meet full criteria for major depressive disorder

Treatment

- Mild depressive symptoms can often be treated with psychotherapy and psychosocial interventions alone.
- Moderate and severe depression are best treated with a combination of medication, psychotherapy and social support.
Evidence-Based Therapies:

- Interpersonal Psychotherapy (IPT)
- Supportive
- Cognitive Behavioral Therapy (CBT)
- Behavioral Activation (BA)
- Breathing/muscle relaxation techniques, stress management
- Group therapy
- Family and couple therapy
- School-based mental health and psychosocial interventions

Medication:

- Antidepressants should be used with caution with children, initiated at 50% usual starting dose (children may respond to lower doses, and have side effects to lower doses; however, they may also need higher doses given high metabolism)
- Choose medications with side effects in mind (for example, to help sleep)
- Fluoxetine
  - Indications: Depression; anxiety disorders including PTSD
  - Consider stopping when: No or minimal depressive symptoms for 9–12 months and able to carry out routine activities for that time

Psychoeducation Key Messages:

- Depression is a very common problem
- Treatment is available and effective
- Adherence to prescribed treatment is important
- It is important for you to continue activities that used to be interesting or give pleasure
- Maintain a regular sleep schedule
- Minimize alcohol use
- It is important to recognize thoughts of self-harm or suicide and seek help if those occur

**Suicide**

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.
Suicide Screening Questions

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?”

Safety Plan

Plan’s six essential components:

1. Recognize warning signs of a suicidal crisis about to happen

2. Identify and employ internal coping strategies without needing to contact another person

3. Utilize contacts with people as a means of distraction from suicidal thoughts and urges

4. Contact friends or family members who can help resolve a crisis and with whom suicidality can be discussed

5. Contact mental health professionals or agencies

6. Reduce potential use of lethal means
### Role Plays

<table>
<thead>
<tr>
<th>ROLE PLAY 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychologist:</strong> Hello Emmanuel.</td>
</tr>
<tr>
<td><strong>Patient:</strong> Hello.</td>
</tr>
<tr>
<td><strong>Psychologist:</strong> 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.</td>
</tr>
<tr>
<td><strong>Patient:</strong> OK.</td>
</tr>
<tr>
<td><strong>Psychologist:</strong> 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?</td>
</tr>
<tr>
<td><strong>Patient:</strong> No.</td>
</tr>
<tr>
<td><strong>Psychologist:</strong> Have you ever wished you were dead in the past year?</td>
</tr>
<tr>
<td><strong>Patient:</strong> Yes. <em>Interview continues because patient said yes.</em></td>
</tr>
<tr>
<td><strong>Psychologist:</strong> Have you had any thoughts of killing yourself in the past two weeks?</td>
</tr>
<tr>
<td><strong>Patient:</strong> No.</td>
</tr>
<tr>
<td><strong>Psychologist:</strong> Have you had any thoughts of killing yourself in the past year?</td>
</tr>
<tr>
<td><strong>Patient:</strong> Yes. Things were just so hard! <em>Interview continues because patient said yes.</em></td>
</tr>
<tr>
<td><strong>Psychologist:</strong> Have you been thinking of ways to do this in the past two weeks?</td>
</tr>
<tr>
<td><strong>Patient:</strong> No.</td>
</tr>
<tr>
<td><strong>Psychologist:</strong> Have you been thinking of ways to do this in the past year?</td>
</tr>
<tr>
<td><strong>Patient:</strong> No. I never decided to do anything. <em>Interview ends because patient said no to each column of a question.</em></td>
</tr>
</tbody>
</table>
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.
Clinical Outcome Measures – CGI and WHODAS

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”).

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.

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.

**CGI Severity**

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”
**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.

**CGI Improvement**

- **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.

**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.

**CGI Side Effects**

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. 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. 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.
World Health Organization Disability Assessment Schedule (WHODAS)

There are six domains of functioning in the WHODAS that will be discussed with the patient and then recorded:

• Cognition – understanding and communicating
• Mobility – moving and getting around
• Self-care – hygiene, dressing, eating and staying alone
• Getting along – interacting with other people
• Life activities – domestic responsibilities, leisure, work and school
• Participation – joining in community activities

Tips for Using the WHODAS

• Read the entire question before allowing the patient to respond
• Repeat the question if necessary
• If you do not understand the patient’s response, ask probing follow-up questions.
  – Can you tell me what you mean by that?
  – Can you tell me more about that?
  – Can you give me your best guess?
  – Can you provide one overall rating?
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):</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>
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<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>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do you often experience any 4 of these problems such as:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Increased in heartbeat</td>
<td></td>
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<td></td>
<td></td>
<td>□ breathlessness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ sweating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ trembling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ fear; fear of losing control; fear of becoming crazy; fear of death</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ feeling dizzy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ feel like you’re losing consciousness</td>
<td></td>
</tr>
</tbody>
</table>
### SUBSTANCE ABUSE

<table>
<thead>
<tr>
<th>Do you use any of the following?</th>
<th>Beer</th>
<th>Home Brew</th>
<th>Liquor</th>
<th>Tobacco</th>
<th>Marijuana</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>Present</strong></td>
<td>☐</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? ☐ Yes ☐ No 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></th>
<th>Physical</th>
<th>Emotional</th>
<th>Sexual</th>
<th>Re-experiencing</th>
<th>Hyperarousal</th>
<th>Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>Present</strong></td>
<td>☐</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? _________________________________
<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Whole Body</th>
<th>Head/Ears/Eyes/Nose/Throat</th>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td>- Are you experiencing pain in your body?</td>
<td>- Is there a change in your:</td>
<td>- Sight problems?</td>
</tr>
<tr>
<td></td>
<td>- Weight?</td>
<td>- Hearing problems?</td>
<td>- Stiffness of the neck?</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>
<tr>
<td><strong>Breathing</strong></td>
<td>- Are you having problems breathing?</td>
<td>- Do you have an increased heartbeat?</td>
<td>- Heart burn?</td>
</tr>
<tr>
<td></td>
<td>- Are you coughing?</td>
<td>- Having chest pain?</td>
<td>- Gastric Reflux?</td>
</tr>
<tr>
<td></td>
<td>- Do you cough out blood or find blood in your snot?</td>
<td>- Any swelling?</td>
<td>- Vomiting?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Constipation, diarrhea, gas?</td>
</tr>
<tr>
<td><strong>Muscles</strong></td>
<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>
</tr>
<tr>
<td></td>
<td>- Swollen?</td>
<td></td>
<td>- Any numbness?</td>
</tr>
<tr>
<td></td>
<td>- Reddened?</td>
<td></td>
<td>- Uncontrolled movements?</td>
</tr>
<tr>
<td><strong>Appendages</strong></td>
<td></td>
<td>- Any problems when urinating (pain, amount/color of urine, blood in urine)?</td>
<td></td>
</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: Last Date Of Menstruation: ____ / ____ / ____
- □ Loss Of Consciousness: Other Things:

### Medication/Allergies/Side Effects:

### Medical Family History:

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

### Legal Problems:
PHYSICAL EXAM (PHYSICIAN)

Vital Signs: __________________________________________________________

HEENT: __________________________________________________________

Chest/Lungs: _______________________________________________________

Cardio-vascular: ____________________________________________________

Abdomen: _________________________________________________________

Genitals: __________________________________________________________

Extremities: ________________________________________________________

Skin: ______________________________________________________________

Lymph nodes: ______________________________________________________

NEUROLOGIC EXAM (PHYSICIAN)

Cranial nerves II to XII Intact □ If impaired, specify __________________________

Motor: _____________________________________________________________

Pronator drift: ______________________________________________________

Sensory: ___________________________________________________________

Vibration: __________________________________________ Position: ___________

Reflexes: DTR __________________ Clonus __________________ Babinsky _______________

Coordination and Gait: Rapid alternating movements __________________ Nose finger test _______________

Romberg __________________________ Gait __________________________ Heel toe walk test _______________
### MENTAL STATUS EXAM

<table>
<thead>
<tr>
<th>General Appearance</th>
<th>□ well groomed</th>
<th>□ disheveled</th>
<th>□ overdressed, elaborate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>□ O x 3</td>
<td>□ disoriented to time</td>
<td>□ disoriented to place</td>
</tr>
<tr>
<td>Behavior</td>
<td>□ WNL</td>
<td>□ retardation</td>
<td>□ agitation</td>
</tr>
<tr>
<td>Speech</td>
<td>□ WNL</td>
<td>□ slowed</td>
<td>□ pressured</td>
</tr>
<tr>
<td>Mood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affect</td>
<td>□ euthymic</td>
<td>□ dysphoric</td>
<td>□ euphoric</td>
</tr>
<tr>
<td></td>
<td>□ irritable</td>
<td>□ suspicious</td>
<td>□ labile</td>
</tr>
<tr>
<td></td>
<td>□ congruent with speech content</td>
<td>□ incongruent with speech content</td>
<td>□ other:</td>
</tr>
<tr>
<td>Thought Process</td>
<td>□ linear</td>
<td>□ tangential</td>
<td>□ perseverative</td>
</tr>
<tr>
<td></td>
<td>□ loose associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought Content</td>
<td>□ WNL</td>
<td>□ vague</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ persistent preoccupation with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ suicidal ideation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ homicidal ideation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions:</td>
<td>□ none</td>
<td>□ paranoid</td>
<td>□ grandiose</td>
</tr>
<tr>
<td>Perceptual Disturbances/Hallucinations:</td>
<td>□ none</td>
<td>□ auditory</td>
<td>□ visual</td>
</tr>
<tr>
<td></td>
<td>□ tactile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight:</td>
<td>□ poor</td>
<td>□ limited</td>
<td>□ good</td>
</tr>
<tr>
<td>Judgment/Impulse Control:</td>
<td>□ poor</td>
<td>□ limited</td>
<td>□ 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**: dd/mm/yy

<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**

(+

(=) **ZLDSI Score**
**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>1</td>
<td>2</td>
<td>3</td>
<td>4</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>1</td>
<td>2</td>
<td>3</td>
<td>4</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><strong>1. Passive</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<td><strong>Possible Response:</strong> I think about it from time to time, but I’ve never acted upon it...I would make my family feel too bad...God would not forgive me</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Non-Specific Active</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td><strong>3. Methods but no Intent to Act</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<td><strong>Possible Response:</strong> bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Intent to Act</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td><strong>5. Planification</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td><strong>6. Attempted</strong></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></td>
<td>Description:</td>
</tr>
<tr>
<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></td>
<td></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**
# Zanmi Lasante — Mental Health

## Suicidality Treatment Guidelines

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

<table>
<thead>
<tr>
<th>Act</th>
<th>1.</th>
<th>□ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.</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>
<tr>
<td>Follow Up</td>
<td>6.</td>
<td>□ If the patient is medium risk, schedule follow-up within 7 days. <strong>Date</strong> __________ <strong>Time</strong> __________ If the patient is high risk, continue to the guidelines below.</td>
</tr>
</tbody>
</table>

### For patients with HIGH risk, include these additional aspects in your care.

| Act | 1. | □ Ensure safety and calm. Remove potential weapons. Obtain help and apply physical/chemical restraint if necessary. |
|     | 2. | □ Seek to admit patient to the emergency room or another service with beds for at least 24 hours. |
|     | 3. | □ Determine who will be available to watch the patient and when so that they are not left unattended. |
|     |     | Name __________ Time __________ Name __________ Time __________ |
|     |     | Name __________ Time __________ Name __________ Time __________ |
|     |     | Name __________ Time __________ Name __________ Time __________ |
| Say | 4. | □ Despite the potential necessity of negating the patient’s autonomy, do as much as possible to preserve dignity. |
| Contact | 5. | □ Any and all accessible individuals from the patient’s milieu (you are justified in breaching confidentiality here). |
|     | 6. | □ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason). |
| Team | 7. | □ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain). |
|     | 8. | □ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well. |
| Follow Up | 9. | □ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr). |
|     | 10. | □ Frequently re-assess risk level. |
|     | 11. | □ If the patient leaves or can’t be kept, follow through with continued intensive psychosocial activation. |
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>
<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**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
</tbody>
</table>

Flashcard 2