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 illnesses. 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 Tatiana Therosme; Père Eddy Eustache, MA; Reginald Fils-Aime, MD; Jennifer Sévère, MD; Giuseppe Raviola, MD, MPH; Jenny Lee Utech; Helen Verdeli, PhD; Gary Belkin, MD, PhD, MPH; Dave Grelotti, MD; Shin Daimyo, MPH; Seiya Fukuda; Andrew Rasmussen, PhD; Helen Knight; Kate Boyd, MPH; Leigh Forbush, MPH; Ketnie Aristide; Wilder Dubuission. We would also like to thank Virginia Allread who compiled and edited the final version of the Facilitator Manual and PowerPoint slide sets.


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

© Text: Partners In Health, 2015
Photographs: Partners In Health
Design: Elizabeth Martin and Partners In Health, 2015
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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mhGAP Intervention Guide English:
Introduction to Mental Health and Depression

INTRODUCTION

According to the World Health Organization, untreated mental disorders account for 13% of the total global burden of disease. Unipolar depressive disorder is the third leading cause of disease burden, however current predictions suggest that by 2030, depression will be the leading cause of disease burden globally. The gap between the need for treatment for mental disorders and its provision is wide all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem in low and middle-income countries.¹

Disability due to depressive disorder and the lack of mental health services is acutely felt in Haiti. The devastating 2010 Haiti earthquake highlighted a lack of formal biomedical mental health services. For Partners In Health and Zamni Lasante, the earthquake became a catalyst for the integration of mental health into Zanmi Lasante’s system of care. This new mental health system of care is a model that is framed within the Haitian cultural context, underpinned by evidence-based biopsychosocial approaches.²

This curriculum marks a major step in Partners In Health/Zamni Lasante’s efforts to meet the need for mental health services in Haiti by training non-specialist health providers. It is the front line healthcare providers who have played an important role in helping us recognize the need for mental health and will play an instrumental role in scaling up services: community health workers, nurses, psychologists and social workers, and physicians. Through this curriculum, healthcare providers will possess the technical knowledge and skills to identify, manage and treat major depressive disorder and act as advocates for the rights of patients with mental illness. By the end of this training, physicians will understand how to work hand-in-hand with community health workers, nurses, psychologists and social workers to provide high-quality, humane medical and mental health care for patients suffering from depression.

¹. WHO Secretariat. Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. 1 December 2011. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf
OBJECTIVES

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

Session 1:
   a. Describe the purpose of the training.
   b. Demonstrate prior knowledge of the training topic.
   c. Establish ground rules that create a respectful and trusting environment.
   d. Identify the need for mental health services.

Session 2:
   e. Describe the epidemiology of depression.
   f. List the responsibilities of the physician in the depression care pathway.
   g. Describe the importance of mental health care within a human rights context.
   h. Identify stigma surrounding mental illness and its impact on patient care and outcomes.

Session 3:
   i. Apply the biopsychosocial approach to depression diagnosis and care.
   j. List the four sign and symptom areas (ABCDs) of depression.
   k. Describe differential diagnoses of illnesses related to depression.
   l. Explain how to approach and evaluate suicidal patients.

Session 4:
   m. Identify the importance of performing a medical evaluation before a mental health evaluation.
   n. Define delirium.
   o. Identify the most common medical conditions and mental illnesses that can present with depression-like symptoms.
   p. Correctly complete the Patient Encounter Form.

Session 5:
   q. Model appropriate interviewing skills.
   r. Correctly complete the physician sections of the Initial Mental Health Evaluation.

Session 6:
   s. Conduct the Zanmi Lasante Depression Screening Inventory.
   t. Explain the collaboration between the physician and psychologist in evaluating patients with symptoms of depression.
Session 7:
   u. Describe the non-pharmacologic and pharmacologic treatment options for depression.
   v. Provide psychoeducation messages about medication use to patients.
   w. List the indications, dosage, mechanism of action, and adverse effects of depression medications amitriptyline and fluoxetine.

Session 8:
   x. Explain the process of follow up for people living with depression.
   y. Correctly complete the physician sections of the Follow Up Form.

Session 9:
   z. Describe how to use mhGAP for the management of depression.
   aa. Describe how to use mhGAP for the management of self-harm/suicide.

Session 10:
   ab. Review all unit objectives.
   ac. Demonstrate learning through a post-test.
   ad. Give feedback on the training.
### TIME REQUIRED

3 days (17 hours and 20 minutes of training sessions, including optional Session 9)

## DAY 1: 5 hours 20 minutes of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
</table>
| 1       | Introductions, Pre-test and Confidentiality | • Introductions  
• Pre-test  
• Facilitator presentation | 2 hours |
| 2       | Epidemiology of Depression and Stigma | • Facilitator presentation  
• Large and small group discussions | 1 hour 35 minutes |
| 3       | Diagnosis of Depression | • Facilitator presentation  
• Case studies | 1 hour 45 minutes |

## DAY 2: 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>Review</td>
<td>Day 1 Review</td>
<td>• Group presentations</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
| 4       | Medical Evaluation and Management of Depression | • Facilitator presentation  
• Small group work | 1 hour 15 minutes |
| 5       | Initial Mental Health Evaluation | • Facilitator presentation  
• Role plays | 1 hour 40 minutes |
| 6       | The ZLDSI | • Facilitator presentation  
• Role play  
• Case studies | 1 hour 20 minutes |
| 7       | Medication Management and Other Treatments for Depression | • Facilitator presentation  
• Case studies | 1 hour 30 minutes |

## DAY 3: 4 hours 15 minutes of training sessions

(with the optional session, 5 hours and 45 minutes)

<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>• Bingo</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
| 8       | Follow-Up and Documentation | • Facilitator presentation  
• Case study | 1 hour 15 minutes |
| 9       | Advanced Practice—Depression and mhGAP (optional) | • Facilitator presentation  
• Role play | 1 hour 30 minutes |
| 10      | Review, Post-Test and Feedback | • Facilitator presentation  
• Case studies  
• Assessment  
• Evaluation | 2 hours 30 minutes |
## MATERIALS NEEDED

<table>
<thead>
<tr>
<th>Materials</th>
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</thead>
<tbody>
<tr>
<td>Facilitator Manuals—one copy/facilitator</td>
<td></td>
</tr>
<tr>
<td>Participant Handbooks—one copy/participant</td>
<td></td>
</tr>
<tr>
<td>Depression PowerPoint presentation</td>
<td></td>
</tr>
<tr>
<td>Pre-/post-test (two copies/participant)</td>
<td></td>
</tr>
<tr>
<td>Flip chart</td>
<td></td>
</tr>
<tr>
<td>Markers, pens</td>
<td></td>
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<tr>
<td>Tape</td>
<td></td>
</tr>
<tr>
<td>Post-it notes (estimate five/participant)</td>
<td></td>
</tr>
<tr>
<td>mhGAP—one copy/participant (for optional Session 9)</td>
<td></td>
</tr>
<tr>
<td>Computer and projector</td>
<td></td>
</tr>
<tr>
<td>Laminated Depression Medication Card—one copy/participant</td>
<td></td>
</tr>
<tr>
<td>Participant bingo cards—one card/participant. (There are 10 different cards in the Annex; if there are 20 participants, make two copies of each card)</td>
<td></td>
</tr>
<tr>
<td>Small prizes for winners of Bingo game (ex. sweets)</td>
<td></td>
</tr>
</tbody>
</table>
SESSION 1: Introduction, Pre-Test and Confidentiality

Methods: Introductions, pre-test, facilitator presentation

Time: 2 hours

Materials:
- PowerPoint presentation
- Pre-test (one copy/participant)
- Flip chart
- Markers, pens
- Tape
- Post-it notes (one or two/participant)

Preparation:
- 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 Ground Rules.”
- Photocopy the pre-test.

Objectives:
Participants will be able to:
- a. Describe the purpose of the training.
- b. Demonstrate prior knowledge of the training topic.
- c. Establish ground rules that create a respectful and trusting environment.
- d. Identify the need for mental health services.

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, use the slides as an “aide mémoire”, i.e., notes to guide the trainer in his/her explanation and exploration of the topic.

Some slides have a conversation bubble. Use the bubble prompts to ask the audience questions and hear their feedback before clicking forward to reveal the answers. Other slides have discussion questions that appear in the Facilitator Manual (rather than on the slides). There are a number of reasons to use these prompts: to engage participants; to support them to learn from each other as well as from you, the trainer; to encourage participants to recognize that they know more about this topic than they might currently recognize; and for you to gauge their current knowledge level.
**STEPS**

**45 minutes**

1. Turn on the projector before the training and show Slide 1: Introduction to Mental Health Care for Depression as participants enter the room. Start the training by welcoming participants.

2. Introduce yourself, giving a one minute overview of your expertise in this field.

3. Explain that the purpose of this training is to prepare physicians to address problems related to mental disorders, specifically related to depression. This training will provide physicians with the tools to diagnose and address mental disorders. Mental disorders are common, however, treatment is available and effective.

4. Introductions: Pass out one Post-it note to each participant. Ask the participants to take a minute and write down one goal or expectation that they have for this training. Then ask participants to introduce themselves by stating, in turn, their:
   - Name
   - Place of employment
   - One goal or expectation that they have for this training

   After each person speaks, place their Post-it note on the flip chart entitled ‘Goals and Expectations’.

5. Summarize introductions by telling participants that many of their goals and expectations will be met during this training. Expectations not met today will be addressed in some other way, either with individual follow-up, monthly meetings, ongoing communication or in future trainings.

   *Be sure to save the flip chart with Post-it notes, you will need it on the last day of training!*

6. Introduce participant handbooks: 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 has finished, such as when they are seeing patients or need clarification on the topics covered in the training.

7. Ask participants to turn to the agenda. Tell them that the training is divided into a series of sessions as they can see listed in the agenda.
8. Ask the participants to turn to their participant handbooks. Tell them 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 ensure that they are meeting the expectations for the training. Request that participants ask for clarification or more information if ever they feel like they cannot meet a learning objective.

9. Turn on the projector.


Explain that each session has training objectives. Provide an overview of the training, reading the objectives of the training as they appear on the slides. Note that the objectives also appear in their participant handbooks.

11. Remind the participants that they are responsible for their own learning. As such, encourage them to ask questions throughout the training, especially if they do not feel like they are able to fulfill the training objectives.

12. Designate someone as the ‘time keeper’. The role of the time keeper is to keep the training running smoothly by being aware of time, and to signal to the facilitator when there is five minutes left in a session. The time keeper should have a watch or cell phone.

13. Turn off the projector.

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

15. Collect the completed pre-tests.

16. Explain that the participants will take a post-test at the end of the training to measure what they have learned.

17. 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 flip chart paper and keep them in view during the training. Ground rules can include punctuality, confidentiality, participation in discussions and activities, respect for different opinions and cell phones being switched off.
CONFIDENTIALITY

Confidentiality is one of the most important parts of being a clinician. All providers, from physicians to the reception and janitorial staff, must keep confidential everything learned about a patient and his/her family as well as anything learned about a patient’s condition. A health provider may only share such information with other clinicians when needed in the care or treatment of that patient.

When sharing patient cases within this training or outside of the training, ensure that patient confidentiality is maintained: do not use the person’s name, do not state where she or he lives, and do not give any other information that would reveal the individual’s identity.

Additionally, do not share information about your fellow participants learned during this training. If, for example, a colleague admitted during the training that he feels uncomfortable screening for depression, that acknowledgement stays in this classroom. Adults tend to be most comfortable learning and sharing in environments where they will be treated nonjudgmentally, and where their fellow participants are trustworthy.

18. Write ‘parking lot’ on a sheet 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. When there is a lull in the training, or at the end of each day the facilitator can take the time to address some of the questions in the parking lot. By the end of the training all questions in the parking lot will hopefully be answered, and if not, the facilitators should guide the participants to the resources to answer any remaining questions.

30 minutes

19. Show Slide 8: Mental Illness.

Explain each bullet point in turn. The following background information is provided as context.

- Mental illness is a public health crisis. According to the World Health Organization (WHO), 14% of the global burden of disease is attributed to mental, neurological, and substance use disorders. These disorders are common in all regions of the world, affecting every community and age group across all income countries.

- One in every four (25%) people experience a mental illness during their life. Depression, like so many other mental illnesses, can affect anyone and it is one of the most widespread illnesses, often co-existing with other serious illnesses. According to the World Health Organization, depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move into the first place by 2030.

- If depression is diagnosed, it can be treated. One of the biggest barriers to treatment, other than cost, is stigma.

Explain that this photograph was taken one month after the earthquake. The earthquake highlighted and exacerbated the significant need for mental health services in Haiti. Encourage discussion about this photograph.

Ask:
- What is your response to the image of the man seated on the ground?

Ask follow up questions as needed to focus the discussion on the lack of access to services and the need for a mental health system of care.


Explain that, for many reasons, there is a significant need for mental health services in Haiti. This need is underscored by the fact that there are less than 20 psychiatrists, and one neurologist in Haiti.


Explain that Zanmi Lasante and Partners In Health responded to the earthquake by developing the human resource capacity to deliver such services, and mounting a mental health response both in the Internally Displaced Persons (IDP) settlements in Port-au-Prince, and in building a system of care in the Central Plateau.

23. Show Slide 12: Mental Health Priority Areas for PIH/ZL.

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 and social workers, but other providers including physicians, nurses and community health workers, who are not mental health specialists.


Explain that guided by this commitment the ZL Mental Health team has developed a number of initiatives in mental health care.


Explain that in 2012, ZL received a grant from Grand Challenges Canada to support this work.

26. Show Slide 15: Long-term Response and Developing a “System of Care”.

This diagram shows the skills needed within the system of care to provide comprehensive mental health care.

27. Show Slide 16: Assigning tasks to provider roles.
Given the lack of specialists, a range of people can potentially provide components of psychosocial and/or mental health services (“task sharing”):

- Community members (leaders, religious figures, teachers)
- Community health workers
- Nurses
- Social workers
- Psychologists
- Physicians

Additional components include:

- Psychosocial assistance (such as financial, nutritional, and housing support or establishing a safe environment)
- Psychoeducation
- Screening
- Triage and referral
- Psychotherapeutic treatments
- Psychopharmacologic treatments

Each level of provider and staff fulfill different roles in this system of care. This is what is meant by “task shifting” in mental health care.

28. Show Slide 17: Over the next three years:

- (CLICK 4 times) Zanmi Lasante will scale up comprehensive, community-based mental health services integrating CHWs in Haiti’s Central Plateau.
- (CLICK 2 times) Zanmi Lasante will support the strengthening of national institutions such as the schools of medicine and nursing so that the methods learned can be integrated with training and early professional development of generalist providers. If the pilot is proven successful then the government will take the materials created with the potential to scale up services (CLICK) more broadly to both governmental and nongovernmental entities who ideally should be sharing methods and practices.
- (CLICK) This will require coordinated communication and collaboration—focused on mental health—among a range of diverse stakeholders. This work provides a very real chance for Haiti to develop a sustainable, community-based mental health system for the long-term.

29. Show Slide 18: Psychologists and Social Workers.

While psychologists and social workers are a critical component of the system of care, they cannot do the work alone. The psychologists are the mental health specialists in the system, and should be seeing the most acute cases. Both psychologists and social workers are currently being trained to deliver evidence-based psychotherapy for patients.
Physicians (such as Dr. Reginald Fils-Aime) have an important role to play, which includes:
- Completing a basic mental health evaluation
- Recognizing basic categories of mental disorders
- Working collaboratively with psychologists and social workers in providing care
- Managing the prescription of medications for mental disorders, which psychologists cannot do. Medications provide an essential element of effective care for many patients.

31. Show Slide 20: Nurses.
Often, medical problems present with mental health problems. People with significant mental illness who are vulnerable deserve to have the same care as those with other medical conditions, despite the complexity of their illness and prevailing undercurrent of stigma.

As the only specialized mental health centers in the country are in Port-au-Prince, healthcare providers, particularly nurses, at health centers throughout the country have a vital role to play in the care of people with mental illness. Zanmi Lasante mental health trainings will prepare nurses to safely and humanely serve people with mental disorders in hospital and clinic settings.

32. Show Slide 21: Community Health Workers.
Community health workers have critical roles in the delivery of mental health services:
- Screening: Zanmi Lasante has developed screening tools for CHWs to identify people with mental health problems and refer them to the clinic for further evaluation by psychologists and social workers.
- Follow up: CHWs are being trained in basic support skills to follow up with patients with mental health problems in the community.

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

These efforts will include the integration of multiple components: integration of training and curriculum, monitoring and evaluation, IT and electronic medical records.

34. Show Slide 23: This is long-term...
Read the slide and conclude the session.

35. Ask participants if they have any questions on this session.
SESSION 2: Epidemiology of Depression and Stigma

Methods: Facilitator presentation, large and small group discussions

Time: 1 hour 35 minutes

Participant Handbook page: 3

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:

Objectives:
Participants will be able to:

- Describe the epidemiology of depression.
- List the responsibilities of the physician in the depression care pathway.
- Describe the importance of mental health care within a human rights context.
- Identify stigma surrounding mental illness and its impact on patient care and outcomes.

STEPS

20 minutes

1. Show Slide 24: Session 2: Epidemiology of Depression and Stigma
   Introduce this session by reading the objectives.

   Explain that mental illness is common:
   - Noncommunicable diseases now account for nearly half of the global burden of disease, and almost 45% of the adult burden in low-and middle-income countries.
   - The distribution of noncommunicable diseases is illustrated in this slide. The bar charts show the age-standardized DALYs (disability-adjusted life year) for noncommunicable diseases by major cause group, sex, and country income group in 2004. Notice that the distribution of neuropsychiatric conditions (medium orange color) makes up a notable percentage, and a fairly consistent percentage of the DALYS across both genders and all country income groups.3

• One DALY is, for all practical purposes, a lost year of “healthy” life. DALYs are the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences. DALYs represent the burden of disease as well as the gap between current health status and an ideal health situation.4

3. Show and read Slide 26: Treatment Gap.


   Note that Unipolar depressive disorders was the third leading cause of burden of disease globally in 2004 (point out the yellow highlighted text in the left column). But, it is expected to be the leading cause of burden of disease globally by 2030 (point out yellow highlighted text in column to right), causing 44% MORE DALY’s in 2030 than in 2004.

5. Show and read Slide 28: Epidemiology of Depression.


7. Show and read Slide 30: Distribution of Depression.

8. Show Slide 31: Mental Illness and Health.

   Ask participants the first question on the slide, give them about three to five minutes to respond. Then ask the second question, giving them another five minutes to respond.


   Show the slide and read the definitions. Note that Zanmi Lasante’s goal in treating mental illness is mental health. Explain that during this training, participants will learn about mental health and their role in helping people to achieve good mental health and get help for mental disorders.

   Explain to participants that:

   • Good mental health is part of good health. If someone does not have good mental health, that person is considered to have a mental health disorder or mental health problem. There are a number of mental disorders, some of which will be discussed during this training.

   • This training focuses on how physicians can provide safe, effective, evidence-based and culturally sound care for people suffering from depression and other mental disorders. There are a number of skills participants will learn in this training. Given the lack of specialists such as psychiatrists, and the shortage of psychologists, as well as the fact that good treatment for mental disorders requires a collaborative approach, participants will be expected to take responsibility for the care of people with depression and other mental disorders in collaboration with other providers.

4. For more information, see WHO. “Health statistics and information systems” at: http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/
• Animate the speech bubble. Ask participants: What do you think are the responsibilities of physicians in ensuring optimal health for their patients?

10. Show Slide 33: Depression Checklist.
    Refer participants to the Depression Checklist in the annex. Animate the arrows (two clicks) to point out the columns that list the doctor/physician roles. Give them a couple of minutes to review the physician role as well as that of the CHW, psychologist/social worker and nurse. Ask participants:
    • How do you see the role of the physician fitting in with the roles of other healthcare workers?
    • What advantages do you see with this distribution of roles?
    • What disadvantages?
    • How can we minimize the disadvantages?

11. Ask participants:
    • What does the physician do in the initial evaluation?
    • How about in the follow-up evaluation?
    Record responses on a sheet of flip chart paper.

    Add any roles and responsibilities that participants may have missed.

13. Show Slide 36: Physicians Must Also Understand …
    Note that the diagnosis, care and treatment of those with mental illness requires a full understanding of the cultural context, patient rights, the roles and responsibilities of other care providers.
    Explain to participants that:
    • We will now focus on mental health in the context of stigma, culture and religion. We will do this while also considering mental health and human rights.
    • This training will also explore the developing “system of care” for mental health, and your role as physicians in that system of care.

  30 minutes

    Explain to participants that the next few slides will explore the concept of human rights, including the roles and responsibilities of physicians in helping patients and their families. Read the slide aloud.
15. Facilitate the Human Rights exercise:
   Post a blank sheet of flip chart paper.
   • Animate the speech bubble. Ask participants the following question and write their responses on the sheet:
     – What are some examples of human rights? In other words, what are some examples of things or conditions that all people need in order to live freely and with dignity?
   If participants have trouble naming examples, invite them to think about the rights that they, their friends and family have come to expect or currently enjoy. If need be, offer one or two examples to start the brainstorming.
   When participants have named all the examples they can think of, read the flip chart paper list aloud. If your list does not include the rights included in the box below, add these to the list participants compiled on flip chart paper.

   **ALL PEOPLE HAVE THE RIGHT TO:**
   • Live freely and be safe from harm
   • Not be treated cruelly
   • Not be enslaved
   • Choose their religion
   • Think and express themselves freely
   • Participate in their government [voting, etc.]
   • Marry and have a family
   • Own property
   • Work and be paid and treated fairly
   • Have a standard of living adequate for the health and well-being of oneself and of one’s family, including the right to access to food, clothing, housing, medical care, and necessary social services
   • Get an education
   • Participants may name other examples

   Explain that in 1948 (after World War II), representatives from over 48 countries joined together to create a document called the Universal Declaration of Human Rights. The Declaration names all the rights that human beings must have to live freely and with dignity. The Declaration states, “All human beings are born free and equal in dignity and rights.” The Universal Declaration of Human Rights names many rights, including the ones named during the brainstorm. Among the rights named are the right to health care and a good standard of living. The Declaration also states that governments, communities, and individuals are all responsible for upholding and protecting human rights.
   Read articles 1, 3, and 5 aloud.
Read Article 25 aloud and explain that the Universal Declaration of Human Rights says that all people are born free and equal in dignity and rights. All people have the right to life, liberty, and security of person. No one should be treated cruelly or degradingly. All people have the right to good food, clothing, housing, and medical care. This includes people with mental health problems. Not having good food, clothing, housing, and medical care can, in turn, affect physical and mental health. Mental health care is part of medical care, and all people—men, women and children—have a right to care for mental disorders.

Ask participants to answer both questions on the slide, drawing from their experiences as physicians. Take four or five minutes to discuss the first question, then another four or five minutes to discuss the second.

45 minutes

Read the slide aloud. Animate the speech bubble. Then ask and encourage a brief discussion by asking: “What are the factors that contribute to the discrimination against people with mental illness?”

If appropriate, recall the discussion of the photo taken after the earthquake (Slide 9).

Ask participants:
• What are some of the words that you have heard used to describe people with problems related to mental health?

Record their responses on a sheet of flip chart paper. Once there are 5–10 responses (in addition to the words on the slide), ask participants:
• How many of these terms are derogatory (vs. complimentary or neutral)?
• Given these stereotypes about mental health, what does that mean in terms of our job diagnosing and treating mental health disorders?
• What do providers say or believe about people with mental disorders?
• What do community members say or believe about people with mental disorders? Why?
• How are people with mental health disorders treated in the healthcare system? Why?
• How are people with mental disorders treated in their communities? Why?
21. Show Slide 43: Stigma can Lead to Discrimination.

Note that stigma can:
• Deter people with mental illness from seeking help
• Make it difficult to find a job or establish healthy relationships

22. Show Slide 44: Questions for Discussion.

Ask participants to get into groups of three. In their small groups, invite participants to discuss the three questions on this slide (the questions also appear below). One person should act as group reporter.
• What beliefs or practices have you had in the past about people with mental disorders?
• How have you dealt with people with mental disorders?
• How can you work to change your own beliefs and practices?

While the groups are discussing, prepare two sheets of flip chart paper: the first should have the title “Past beliefs/practices”. The second should be titled “Action points for change”.

After 10 to 15 minutes, ask the group to reconvene as one large group. Ask if any of the groups would like to volunteer to summarize the group discussion. Take notes on the prepared sheets of flip chart paper; separate out the agreed action point onto the second sheet of flip chart paper.

Invite the remaining groups to add any key points that they discussed not reported by the first group.

23. Show Slide 45: Care Pathway: Depression.

Explain to participants that after a qualitative assessment in 2011 indicated that depression was a major concern, Zanmi Lasante prioritized the development of the care pathway for depression. Zanmi Lasante developed a locally validated, easy-to-use screening tool for depression. The care pathway includes screening for depression by CHWs with this screening tool to obtain a numerical score:
• Those with a lower level of depression are followed up by a CHW. This is a 3-session intervention adapted from Interpersonal Therapy (IPT).
• Those with a higher depression score are referred for re-evaluation by a psychologist or social worker, who refers the person for IPT.
• Those with the highest scores are referred to a physician for evaluation to start medication.
SESSION 3: Diagnosis of Depression

Methods: Facilitator presentation, case studies

Time: 1 hour 45 minutes

Participant Handbook page: 5

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:

Objectives:
Participants will be able to:

i. Apply the biopsychosocial approach to depression diagnosis and care.

j. List the four sign and symptom areas (ABCDs) of depression.

k. Describe differential diagnoses of illnesses related to depression.

l. Explain how to approach and evaluate suicidal patients.

STEPS

45 minutes

   Introduce this session by reading the objectives.

2. Show Slide 47: Biopsychosocial Approach.
   Explain to participants that Zanmi Lasante’s approach to the diagnosis, care and treatment of mental illness is from a wider perspective than is often used in conventional medicine. This approach can be thought of as the biopsychosocial approach.

   The biopsychosocial model is a broader and integrated approach to human behavior and disease in comparison to the more traditional biomedical model. The biopsychosocial approach can be applied to any condition or illness. It suggests that psychosocial factors affect the onset and course of almost all chronic physical and mental disorders and, as such, the behavioral and emotional aspects of a patient should be considered when making decisions about treatment and support.
A balanced biopsychosocial approach to diagnosis, evaluation, care and treatment is essential.

Ask participants:

- What biological factors do you think might affect a patient’s vulnerability to mental health problems? (Record responses on flip chart paper.)
- What social factors do you think contribute to risk of mental health problems? (Record responses on flip chart paper.)
- What psychological factors might make an individual more prone to mental health problems? (Record responses on flip chart paper.)

3. Divide participants into small groups of three or four participants per group. Refer participants to the case study in their participant handbooks.

4. Give groups 15 minutes to read and discuss the case and then respond to the case questions.

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**CASE: THE BIOPSYCHOSOCIAL APPROACH**

Leila is a 16 year-old female recently admitted to the hospital because of active suicidal ideations. Leila was found holding a 2 liter-size jug of pesticide up to her mouth at home. Leila has a history of suicidal ideation and has tried to cut herself in the past, but reported that the knife would not penetrate her skin. She said that she would not be able to stop herself again.

Leila reported depression for the past 2 years and thoughts of death for the last 18 months. Leila is an overweight female who appeared sad, making poor eye contact and demonstrating poor social skills. She says that she has no friends at school; her affect was flat and apathetic. Leila reported difficulty sleeping, decreased energy, irritable mood and trouble with her appetite. She also reported significant feelings of worthlessness, helplessness and hopelessness.

Leila related that her depression had worsened in the past two weeks because her sister was living at home again. Her sister is abusive towards her (she started choking Leila for borrowing her clothing last week), and Leila believes her mother does not punish her sister appropriately.

Leila’s parents divorced when she was 10 years old. Her mother is a victim of domestic violence, and her father is an alcoholic. Leila denies any substance abuse history.

**CASE QUESTIONS:**

1. From a biopsychosocial perspective, what is going on in this case? What are the possible biological, psychological, and social factors involved?
CASE: THE BIOPSYCHOSOCIAL APPROACH (continued)

ANSWER:
Biological: Given that Leila’s father is an alcoholic, and her mother tolerated years of domestic violence, it is quite possible that both parents are depressed. Much of this may have been precipitated by the onset of puberty, which often exacerbates mental health issues. Leila also might be vulnerable to alcoholism.

Social: Leila is growing up in a dysfunctional home, made worse by an abusive sister over whom the parents have no control.

Psychological factors: Leila may feel that she does not fit in either at home or at school, alienating her and creating a situation that makes one more vulnerable to mental illness.

2. What other issues must be considered or explored in this case?

ANSWER:
Does Leila have a medical illness that needs to be ruled out?
Does she have evidence of mania? Anxiety? Psychosis?
Is there a history of violence in the house?
Is there a history of sexual violence against Leila? Any other trauma?
Has she received any care or treatment for her mental illness?
How is Leila doing in school? What do people at school think of her?
What is the contribution of poverty to these difficulties?
How do the remaining family members understand her illness?


5. When groups have finished answering the case questions, ask each group to report on one answer or aspect of the case. Encourage discussion.

   Compare participant discussion to the case study with those on this slide.

   Explain that the participants will now take a closer look at some of the biological factors affecting depression. Review the bullet points on the slide.

   Direct participants to the images of the neuron and the close-up image of the synapse, pre- and post-synaptic receptors, and neurotransmitters in their participant handbooks.
   Explain the bullet points on the slide.

10. Show and read Slide 52: Biology: Neurochemistry.

   Discuss the role of genetics in individual vulnerability to depression.

1 hour

12. Show Slide 54: ABCDs of Major Depressive Disorder (1). 
   Tell the participants that they are going to transition now from discussing the 
   biopsychosocial model to the signs and symptoms of mental illness. Explain that 
   generally, when considering how to think about and describe symptoms and signs of 
   depression, four symptom areas should be considered: the ABCDs.

   Describe the As and Bs: Affect and mood, and Behavior. Animate the speech bubble 
   and ask participants to give examples of both affect/mood and behavior, drawing from 
   their experience.

13. Show Slide 55: ABCDs of Major Depressive Disorder (2). 
   Explain the Cs and Ds: Cognition and perception, and Development. As a point of 
   clarification, cognition includes attention, remembering, producing and understanding 
   language, solving problems, and making decisions.

   Animate the speech bubble and ask participants to give examples of cognition/perception. 
   Animate the second speech bubble and ask participants for examples of development, 
   drawing from their experience. Then ask participants:
   • What affect/mood might you expect a depressed patient to display?
   • What behavior would you expect in a typical depressed patient?
   • How would you expect a depressed patient to describe his/her cognition/perception?
   • How would you expect a depressed patient to describe his/her development?

14. Show Slide 56: The Signs and Symptoms of Major Depressive Disorder. 
   Compare participant responses from the previous discussion questions with those 
   on the slide.

15. Show Slide 57: Diagnosing Severe Depression. 
   Review the key points on the slide. Explain that ZLDSI score will be discussed in later 
   sessions. Note that:
• As long as a medical issue is not the cause of depression, these patients will improve over time with psychotherapy.

• Medications (amitriptyline or fluoxetine) can help, but only if patient is severely depressed (as defined by ZLDSI score and suicidal ideation).

• When screening for suicide, enquire about symptoms over the past two weeks.

16. Show Slide 58: Explaining Other Symptoms.
   Read the key points on the slide.

17. Show Slide 59: Dysthymia.
   Explain to the participants that:
   • Dysthymia is also called neurotic depression, dysthymic disorder or chronic depression.
   • It is a mood disorder similar to depression, but with less severe but longer lasting symptoms (by definition, at least two years for adults, one year for children and adolescents).
   • People with dysthymia may believe that depression is part of their character, so may not think to discuss their symptoms with doctors.
   • As the treatment is different from depression, it should be differentiated from such.

   Review content. Explain to participants that depression can be “unipolar”, that is indicative of a depressed mood over time, it can be “bipolar”, meaning that mood fluctuates between depression and hypomania or mania, and depression can also be accompanied by psychosis in certain instances. It is important to differentiate between unipolar and bipolar depression, as the treatment is different.

   Review content. Ask participants if they have any related comments, questions or stories that they would like to share about any of their patients.

   Explain to participants that in the DSM-IV, somatoform disorders comprise the disorders also called “psychosomatic”. Somatization and conversion are two types of somatization disorders.

   Review the bullet points. Explain to participants that somatization disorder is more common in women, but it occurs in men as well. Somatization disorders are understood as a call for help. Animate the speech bubble and ask participants:

Animate the speech bubble and ask participants: What are some common somatic symptoms for Haitians?

Animate the rest of the slide and read the bullet points. Explain to participants that most often, somatic symptoms represent some underlying depression and anxiety. But somatic symptoms can also be indicative of other problems.

Tell participants that when the chief complaint is headache, there is often depression; whether headache is a somatic symptom of depression or part of a comorbid headache syndrome is difficult to determine.

22. Show Slide 64: Conversion Disorder.

Explain to participants that conversion disorder is a loss or change in sensory or motor function that is suggestive of a physical disorder but caused by psychological factors. Review bullet points. Add additional information as necessary:

- With a conversion disorder, the symptoms are not under voluntary control, although the patient may be able to control their severity. Symptoms are not intentionally produced or feigned.
- Those with depression might be predisposed to developing somatoform disorders. It is important to note that patients with somatic symptoms that are not depressed require care and treatment that is different from that for depression.
- The focus of treatment for somatoform disorders is improving daily functioning, not on managing symptoms. Stress reduction is often an important part of getting better. Counseling for family and friends may also be useful.

23. Show Slide 65: Depression, Other Differential Diagnoses.

There are other diagnoses that can appear similar to depression, but less often. These include:

- Panic Disorder, which causes discrete episodes of intense fear or discomfort in which anxiety symptoms began abruptly and peak within about ten minutes and are accompanied by a panic attack: dizziness, palpitations, chest pain, sweating, chills, trembling, numbness or tingling, shortness of breath, choking, nausea, feelings of unreality, fear of losing control, fear of dying.
- Generalized anxiety disorder, which is characterized by excessive worry and anxiety, more days than not, for six months. People with generalized anxiety disorder have trouble controlling these anxieties or worries.
• Post-traumatic stress disorder, which is characterized by:
  – Re-experience of a traumatic event that was witnessed or experienced. The traumatic event would have been intensely horrifying.
  – PTSD patients often feel socially detached or emotionally numb. They may display symptoms of hyperarousal; symptoms can cause significant distress or interference with school, relationships, important activities.

• Epilepsy: Epilepsy is a chronic condition, characterized by recurrent unprovoked seizures. It has several causes; it may be genetic or may occur in people who have a past history of birth trauma, brain infections or head injury. In some cases, no specific cause can be identified.
  – The two major forms of seizures are convulsive and non-convulsive.
  – Non-convulsive epilepsy has features such as change in awareness, behavior, emotions or senses (such as taste, smell, vision or hearing) similar to mental health conditions, so may be confused with them.
  – Convulsive epilepsy has features such as sudden muscle contraction, causing the person to fall and lie rigidly, followed by the muscles alternating between relaxation and rigidity, with or without loss of bowel or bladder control. This type is associated with greater stigma and higher morbidity and mortality.

   Explain to participants that, in some cases, during screening or in other situations, you will encounter people with mental disorders who are suffering from very serious, acute conditions. These conditions are referred to as mental health crises. A mental health crises can be symptoms of severe depression.

   Probably the most extreme and dramatic mental health crises is the patient who is considering or attempting suicide. Suicidal ideation should be considered a sign of severe depression.

   Define self-harm and suicide. Then ask participants:
   • Raise your hand if you have encountered a patient who has committed an act of self-harm or has attempted suicide.
   • Would anyone like to share their experiences in handling those patients?
   • What steps did you take, as a physician, when you learned about the patient’s act of self-harm or suicidal ideation?
26. Show Slide 68: Evaluating Patients for Suicide: True or False?
   Click once to show the statement, than ask participants if the statement is true or false. Click again to show the answer, and then a third time to show the explanation.

27. Show Slide 69: Asking about Self-Harm/Suicide.
   Use this slide to stress the importance of screening for suicide. Review the points on the slide. The next few slides provide a brief overview of the assessment of suicide.

28. Show Slide 70: Suicide Screening Questions.
   Review the three suicide screening questions, which enquire about wishing to die, wanting to commit suicide, or wanting to self-harm. Ask participants:
   • Have you screened for suicide ideation?
   • What questions have you used?
   • What was the outcome?
   Allow 5–10 minutes for this discussion.

29. Show Slide 71: If Suicidal... and Slide 72: If Patient is a Danger to Others...
   Explain that to ensure the safety of a person who is suffering from a mental health crisis and the safety of other people around that person, healthcare providers must take special steps and precautions.
DAY 1: Review

Methods: Group presentations

Time: 30 minutes

Materials:
- Flip chart or laptop computers
- Tape
- Markers

Objectives:
Participants will be able to:
- Recall key points taught in Sessions 1, 2, and 3.

30 minutes

1. Explain to 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 down an outline to present their information to the audience. Encourage the groups to draw information from their participant handbooks. If they prefer, they can create a PowerPoint presentation rather than using flip chart paper.

3. Divide 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, divide participants into further groups and assign the same session to more than one group):
   - Session 1: Introductions, Pre-Test and Confidentiality
   - Session 2: Epidemiology of Depression and Stigma
   - Session 3: Diagnosis of Depression

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. 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 4: Medical Evaluation and Management of Depression

Methods: Facilitator presentation, small group work

Time: 1 hour 15 minutes

Participant Handbook page: 12

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:
- Review the Patient Encounter Form and the Initial Mental Health Evaluation Form.

Objectives:
Participants will be able to:

m. Identify the importance of a performing a medical evaluation before a mental health evaluation.

n. Define delirium.

o. Identify the most common medical conditions and mental illnesses that can present with depression-like symptoms.

p. Correctly complete the Patient Encounter Form.

STEPS

45 minutes

   Introduce this session by reading the objectives.

   Explain to participants that:
   - As physicians, it is your essential responsibility to assist in the proper medical evaluation of patients.
   - Patients die because a medical problem is misunderstood to be a psychiatric one, and as a result the person does not receive an adequate medical evaluation.
   - Similarly, patients with mental disorders are often not evaluated for co-morbid medical conditions, leaving these patients at risk from potentially preventable illness.
3. Show Slide 75: Key Points Before Considering a Patient “Psychiatric”.
   Review each of the bullet points.

4. Show Slide 76: Delirium.
   Mention the differences between delirium and psychosis (which are often confused):
   • Hallucinations, most often auditory, “hearing voices”
   • Seeing hallucinations that are not transient
   • Usually develops more slowly; family has often noticed problems for a long time
   • Symptoms usually change over weeks to months

5. Show and read Slide 77: Medical delirium is not a psychiatric problem!

6. Invite participants to break into groups of three. Assign one set of questions to each of
   the groups (if there are more than three groups, assign sets of questions to more than one
   group). Give participants ten minutes to discuss their answers to the questions assigned to
   their group.

   **Group 1:**
   • What are the symptoms of alcohol withdrawal?
   • Who do you think is at risk of alcohol withdrawal? Why do you say this?
   • How would you differentiate between a patient with depression and a patient with
     alcohol withdrawal?

   **Group 2:**
   • What drugs and poisons can cause psychiatric symptoms if ingested?
   • Who do you think is at risk of drug or poison ingestion/overdose? Why do you say this?
   • How would you differentiate between a patient with depression and a patient
     experiencing a drug overdose/poisoning?

   **Group 3:**
   • What medical conditions, unrelated to alcohol and drugs, can mimic a
     psychiatric illness?
   • Who do you think is at risk of these medical conditions? Why do you say this?
   • How would you differentiate between a patient with each of these medical conditions
     and a patient with depression?

7. Wander from group to group and provide support as needed. After ten minutes, ask
   the groups to reconvene, invite the groups that discussed the first set of questions to
   present their answers to each of the questions. Do the same for the second and third set
   of questions.
8. Show Slide 78–79: Medical Condition.
   Then compare participant answers to those on the slide.

   Read slide and compare participants’ answers.

10. Show Slide 81: Medical Conditions Can Cause Depression.
    Read slide and compare participants’ answers.

    Read slide and compare participants’ answers.

30 minutes

12. Show Slide 83: Do a Physical Examination First!

13. Show slide 84: Components of the Physical Examination.
    List the components of the Physical Examination section of the Initial Mental Health Evaluation Form, which can be found in the annex of their participant handbooks.

    The physical exam includes the neurologic exam.

15. Show Slide 87: Patient Encounter Form.
    The Patient Encounter Form guides the physician at first contact. Refer participants to this form in the annex of their participant handbooks. Suggest they follow along as this form is reviewed.

    The first step is to fill in the date and patient demographic information at the top of the form.

    The first box on the Patient Encounter Form asks if the “Physician received form”. Check either “yes” or “no”.

    The second action box asks the physician to check off the following boxes when these activities are completed and fill in the ZLDSI Score:
    • Mental status exam
    • Physical exam
    • ZLDSI Score
The mental status exam can be done during the physical exam, both of which are discussed further in the next session. The physician must complete the physical exam; it is important that all mental health patients undergo a complete physical before they are referred to the psychologist. Once the mental status, physical exams and ZLDSI scores are complete, these boxes can be checked off. The ZLDSI form is explained further in the next sessions.

17. Show Slide 89: Depression Not Diagnosed.
   If, based on the mental status, physical exams and the ZLDSI score, the physician does not think that the patient has depression, then the physician reviews medical symptoms for physical illness, and if found provides treatment as needed. The mental health team should be alerted. (Epilepsy and psychosis are further described in a separate training.)

   If the patient does not have depression and does not have any physical illness, s/he is referred to meet with a community health worker and is given a follow up appointment.

   If depression is diagnosed, then the physician decides whether and what to prescribe.

   The physician then decides if psychological treatment is needed. If not, then the patient will meet with a CHW and be given a follow up appointment; if so then a referral to the psychologist/social worker will be made on the same day.

   Ask participants what questions they have on the Patient Encounter Form.
SESSION 5: Initial Mental Health Evaluation

Methods: Facilitator presentation, role plays

Time: 1 hour 40 minutes

Participant Handbook page: 14

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:
- Review the role plays, Facilitator Manual, PowerPoint slides 93–100.
- Review the Initial Mental Health Evaluation.

Objectives:
Participants will be able to:
q. Model appropriate interviewing skills.
r. Correctly complete the physician sections of the Initial Mental Health Evaluation.

STEPS

30 minutes

1. Show Slide 93: Session 5: Mental Health Evaluation.
   Introduce this session by reading the objectives.

2. Show Slide 94: Expectation.
   Explain to participants that the expectation is that you will be able to conduct the complete mental health evaluation, as described on the slide.

   Throughout this session and the next, emphasize the importance of working collaboratively with the psychologist, social workers, nurses and community health workers at their sites. A multidisciplinary, integrative approach is essential to the success of this work.

   Review each bullet point. Ask participants:
   - Would you like to add anything to this list?
   - Are there any principles that would be difficult to adhere to?
4. Ask participants:
   - If a patient thought that you were judging them, what do you think they would do? (Ensure the group recognizes that patients who feel uncomfortable in a clinic setting tend to drop out of care.)
   - What other interview skills are important when discussing sensitive health information with a patient? Record participant responses on a sheet of flip chart paper.

5. Show Slide 96: Basic Interview Skills.
   Compare participant responses with the skills listed on the slide. Stress that these are essential skills not only for doing a mental health evaluation, but for all patient interactions. These skills are helpful in personal communication as well!

For the following skills, ask participants to come to the front of the room and give examples of how this is done. Elicit as many examples as possible, one skill at a time:
   - Show empathy
   - Active listening
   - Ask open-ended questions

50 minutes

6. Ask a volunteer to come forward and assist with a role play. Ask the volunteer to play the physician while you play the role of the patient in the case study below.

INTerview role play 1: josie

Background information to inform role play:
Josie is a 52-year old woman who has come to your clinic. She says that “she has no interest in anything.” Her physical symptoms include low energy, shaking and trembling throughout her body, irregular menstrual flows, and insomnia. When asked about her family, Josie admits that she resents her mother and father (who have now passed away): her father married multiple times. He was also verbally and physically abusive to her. Josie’s mother, because she was divorced from Josie’s father when she was six years old, moved to Port-au-Prince. Because money was tight, Josie’s mother dealt with the stresses of life by becoming angry and violent with her and her siblings (Josie was the oldest child).

Josie left home at 17, married at 25 and eventually had four children. This episode of depression was triggered when her oldest daughter, who is now 26, did not meet her expectations. Josie found herself reacting angrily to her daughter, as her mother had done to her so many years ago. Josie’s communication with her husband is very poor.
**INTERVIEW ROLE PLAY 1: JOSIE** *(continued)*

**SCRIPT:**

Physician: Could you please tell me a bit about the problem that led to your coming here for treatment?

Patient: responds according to the story

Physician: Can you tell me a little bit more about (problem/symptom/illness)? (explore chronology of events)

Patient: responds according to the story

Physician: Are you currently treated for this (problem/symptom/illness)? How? Are you taking any medications for this? Have you ever taken any medication for this?

Patient: responds according to the story

Physician: Over the past two weeks how often have you felt little interest or pleasure in doing things?

Patient: responds according to the story

Physician: Over the past two weeks how often have you been feeling down, depressed, or hopeless?

Patient: responds according to the story

Physician: OK. I’m going to ask a few questions about your medical history now… (role play ends).

Adapted from: Flower Essence Society, Journey out of Depression. Available at: http://www.flowersociety.org/journey.htm

Role play for a few minutes, until the volunteer has had a chance to model all three skills.

7. **Lead a brief discussion with the whole group, asking participants:**
   - How did the physician show empathy?
   - How did he/she show he/she was listening actively?
   - What open-ended questions did he/she ask?

8. **Divide participants into pairs. Each pair should choose a role play from the box below to practice the following skills:**
   - Show empathy
   - Use active listening
   - Ask open-ended questions that will help you to understand the problems that the person is having in her or his life
9. After five minutes participants should switch roles; they may switch role plays as well if they want. As pairs practice, circulate, observe/listen, and support.

10. Ask one pair to come forward and perform their role play for the whole group. Lead a brief discussion on the pair’s performance.

<table>
<thead>
<tr>
<th>INTERVIEW ROLE PLAY 2: CATHELINE</th>
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<tbody>
<tr>
<td>Your patient, Catheline, is a 45-year old woman whose daughter died during childbirth about two months ago. People have gone back to their usual routine and the expectation is that she, too, will return to normal. In reality, Catheline has just begun to grieve. She is depressed, confused, questioning, looking for answers, and angry with the recently deceased daughter, who (in the days before her death two months ago) refused to go to the maternity ward when she started bleeding.</td>
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<tr>
<th>INTERVIEW ROLE PLAY 3: EMMANUEL</th>
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<tr>
<td>The CHW brings Emmanuel to the clinic, Emmanuel is 35 years old. Emmanuel hardly speaks and when he does, it is monosyllabic. There are long silences. Sentences are started and stopped midway through. Thoughts are not completed. The man seems somewhat distracted. It seems that his wife left him and he feels this indicates a real failure, a personal disgrace, and a humiliation.</td>
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<tr>
<th>INTERVIEW ROLE PLAY 4: GABY</th>
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<tbody>
<tr>
<td>Despite earning good grades in secondary school, your patient, Gaby—a 19-year old woman, was not accepted to university to study medicine. Her life had been totally centered on this goal and now it feels as if the world has come crashing in around her. Complaints are somatic, i.e., unable to sleep, loss of appetite, weight loss, sadness, without energy.</td>
</tr>
</tbody>
</table>

11. Discuss the remaining skills briefly one at a time (whole story, energy level, follow the patient’s lead regarding religion or spirituality), asking for examples how each is done.\(^5\)

20 minutes


Explain to participants that the interview skills that they have just learned are important for any patient consultation, but certainly for the initial consultation. These skills set the tone for all future consultations, determine level of trust between provider and patient, affect whether the patient will return for follow-up care, and determine—at least in part—the successfulness of your overall intervention.

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5. Lena Verdeli
Tell participants that we are now going to transition from interview skills to the application of these skills in the initial mental health evaluation.

Invite participants to turn to the Initial Mental Health Evaluation in the annex of their participant handbooks. This form should be used to guide the mental health evaluation and can be used to ensure that the evaluation is thorough. It is critical for generalist physicians to understand how to conduct, and document, a basic mental health evaluation. This form was introduced in the last session, it will be discussed in more depth now.

Give participants about five minutes to read the form.

**USE THE INITIAL MENTAL HEALTH EVALUATION FORM**

Use the evaluation form (rather than the slides) to guide your presentation of the patient evaluation procedure.

Looking at Page 1 of the Initial Mental Health Evaluation, explain that the psychologist/social worker would typically complete the:

- Chief complaint
- History of present illness
- Psychiatric review of systems

On page 2, the psychologist/social worker would complete the:

- Suicide/homicide screening
- Substance abuse and trauma questions
- Past psychiatric history
- Past medical history
- Active medical problems

The physician would complete the section called the medical review of systems, at the bottom of the 2nd page. Take a moment to quickly list the observations that need to be made to fill in this section.


Explain that the psychologist/social worker would complete the following sections:

- Psychiatric family and medical histories
- Social/cultural history
- Medications
The physician would then be responsible for completing the next two sections:

- Physical Exam
- Mental Status Exam


The Mental Status Exam continues on the fourth page.

15. Show Slide 100: Mental Status Exam.

Ask participants to follow along in their copy of the Initial Mental Health Evaluation. The Mental Status Exam includes:

- General appearance: describe patient appearance; for example does s/he appear her/his age, does the patient make good eye contact, is he/she dressed appropriately, etc.
- Orientation: Alert and oriented to time (day of week), place (where patient is) and person (can say who he/she is). Impairment can suggest dementia or delirium.
- Behavior
- Speech
- Mood: euthymic (normal), sad, depressed, irritable, angry—use patient’s own words
- Affect: consistent with mood, anxious, etc.
- Thought process: racing thoughts/manic, poverty of thought (lack of thought)
- Thought content; auditory hallucinations, visual hallucinations, delusions, paranoid, suicidal thoughts, thoughts to harm others
- Insight: Good, fair, poor
- Judgment: Good, fair, poor

Upon completion, the physician returns the form to the psychologist/social worker, who then completes the last sections on the last page, including:

- Biopsychosocial formulation
- Diagnosis
- Plan
- Signature

16. Ask participants what questions they have on the Initial Mental Health Evaluation.
SESSION 6: The ZLDSI

Methods: Facilitator presentation, role play, case studies

Time: 1 hour 20 minutes

Participant Handbook page: 17

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:
- Review the Zanmi Lasante Depression Screening Inventory.

Objectives:
Participants will be able to:
- Conduct the Zanmi Lasante Depression Screening Inventory.
- Explain the collaboration between the physician and psychologist in evaluating patients with symptoms of depression.

STEPS

60 minutes

1. Show Slide 101: Session 6: The ZLDSI.
   Introduce this session by reading the objectives.

2. Show Slide 102: Care Pathway: Depression.
   Explain to participants that they will remember the depression care pathway from Session 2, when it was introduced as a screening/referral as well as a tracking tool and to guide care. The pathway relies on ZLDSI scores to guide the treatment plan.

3. Show Slide 103: ZLDSI.
   Refer participants to the ZLDSI in their participant handbooks. The depression screening tool, called the Zanmi Lasante Depression Screening Inventory, has 13 items and was developed so that it could be used by any level of healthcare provider: CHW, nurses, social workers, psychologists and physicians.
Tell participants that today, we will learn how to use the ZLDSI:

- The intention of the ZLDSI is to provide not only a numerical score that can guide assessment and referral, but also a score that can guide treatment over time, and as a measure of clinical improvement.

- It is intended to be a simple and quick tool to use. However, there are certain steps which will make its use easier. One of those steps is preparing the patient to respond to the format of the questions; the questions may confuse patients unless properly introduced. The healthcare providers should also be sure to take his/her time when eliciting patient responses, and not rush through the questions.

4. Show Slides 104–105: How to Use the ZLDSI.

   Review the bullet points on the slides.

5. Then explain that the group will now practice using the ZLDSI. Ask your co-facilitator or an experienced participant to come to the front of the room to role play with you, to model how the ZLDSI should be used. Play the role of the physician, and ask your colleague to play the role of David (see box below).

### ZLDSI ROLE PLAY 1

**BACKGROUND INFORMATION**

David is a 28 year-old married male. He has a very demanding, high stress job in the Ministry of Health. David has always been a high achiever. He graduated with top honors and still has very high standards for himself and can be very self-critical when he fails to meet them. Lately, he has struggled with significant feelings of worthlessness and shame due to his inability to perform as well as he always has in the past.

For the past few weeks David has felt unusually fatigued and found it increasingly difficult to concentrate at work. His coworkers have noticed that he is often irritable and withdrawn, which is quite different from his typically upbeat and friendly disposition. He has called in sick on several occasions, which is completely unlike him. On those days he stays in bed all day, watching TV or sleeping.

At home, David’s wife has noticed changes as well. He’s shown little interest in sex and has had difficulties falling asleep at night. His insomnia has been keeping her awake as he tosses and turns for an hour or two after they go to bed. She’s overheard him having frequent sad-sounding phone conversations with a brother, which has her worried. When she tries to get him to open up about what’s bothering him, he pushes her away with an abrupt “everything’s fine”.

Although he hasn’t ever considered suicide, David has found himself increasingly dissatisfied with his life. He gets frustrated with himself because he feels like he has every reason to be happy, yet can’t seem to shake the sense of doom and gloom that has been clouding each day as of late.
ZLDSI ROLE PLAY 1  

(continued)

ROLE PLAY INSTRUCTIONS
The physician should use the ZLDSI to screen for depression.

The patient should respond according to the information given in the background section.


6. Ask participants to observe carefully, and to mark their copies of the ZLDSI as the patient responds.

7. When the role play has concluded, ask participants for their observations and comments about how you handled the ZLDSI, and discuss as needed. Then, for each ZLDSI question, ask the group how they answered and discuss as needed.

8. Finally, ask participants:
   - If David was a poor village farmer (and not an MOH employee in a high stress job), whose answers to the screening questions were the same, but less articulately voiced, would you have scored him the same way?
   - How do you think the farmer’s symptoms might present in contrast with those of David’s?

9. Return to Slide 103: Care Pathway: Depression.
   Place this patient’s score on the pathway. Ask participants: given his score what should be done next?

10. Show Slide 106: When in doubt about a diagnosis.
    Emphasize with participants that it is critical that as general practitioners they learn to do a basic mental health evaluation. Explain to participant that:
    - If you find yourself in doubt about a diagnosis, or have a question about a case you are seeing, then you should consult with the mental health team at your hospital.
    - You can do this by calling the mental health team members at your hospital, and completing the Request for Consultation Form, which can be found in the annex.

20 minutes

11. Divide participants into small groups of three or four participants each, refer them to the case below.

12. Give groups 10 minutes to discuss the case and answer the questions that follow each one.
ZLDSI CASE STUDY

CASE QUESTIONS

1. You see a young man at the clinic. You perform an evaluation, as you have been trained to do. He reports some potential depression symptoms. You find that he has a ZLDSI score of 13. What is your course of action?

   ANSWER: Refer patient to the local CHW that can perform follow up and IPT in the community.

2. A 35 year old woman who has had difficulty participating in her regular activities for the past six months is screened for depression by a CHW using the ZLDSI. This woman has a score of 32 so she is referred to you. You perform an evaluation, as you have been trained to do. You determine that it is most likely that the woman is depressed. What is your course of action?

   ANSWER: Refer to psychologist. Discuss providing medication. Ensure she is supported in the community by the CHW.

13. When groups have finished working, ask each group to report on one answer or aspect of the case. Encourage discussion as needed.

14. Ask participants what questions they have on the ZLDSI.
SESSION 7: Medication Management and Other Treatments for Depression

Methods: Facilitator presentation, case studies

Time: 1 hour 30 minutes

Participant Handbook page: 19

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:

Objectives:
Participants will be able to:
1. Describe the non-pharmacologic and pharmacologic treatment options for depression.
2. Provide psychoeducation messages about medication use to patients.
3. List the indications, dosage, mechanism of action, and adverse effects of depression medications amitriptyline and fluoxetine.

STEPS

45 minutes

   Introduce this session by reading the objectives.

   Explain to participants that treatment options for depression include not only medications (fluoxetine, amitriptyline), but also counseling provided by CHWs, psychologists/social workers, which might include:
   - Psychoeducation
   - Family and social support
   - Vocational training
   - Addressing stressors
   - Relaxation techniques
   - Problem solving
   - Encouraging activities
   Initiate the discussion about psychoeducation by asking the questions on the slide and eliciting answers from the group.

   Tell participants that psychoeducation involves letting the person know that she or he may have a mental health problem or disorder (naming the problem), and explaining to the person and family members (if the patient consents) what that means in context.

   Reinforce the importance of targeting messages to the patient’s level of understanding and level of interest (“meet your patient where he/she is”). The best way to gauge their level of understanding and interest is to ask questions and listen to their responses.

   Review the points on the slide, linking them to the answers just mentioned.

5. Show Slide 111: Psychotherapy.
   Explain:
   - Supportive psychotherapy: Aims to minimize levels of emotional distress. It can include the provision of support by giving the person and family hope, assigning the person the sick role if appropriate, and helping the person and the family to mobilize social supports.
   - Interpersonal therapy: Also effective for depression. Addresses relationships in the “here and now,” with a focus on four areas: grief; role transitions; role disputes; and interpersonal deficits.
   - 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.
   - 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.

   Review the classes of medications as listed. SSRI = Selective serotonin re-uptake inhibitors or serotonin-specific reuptake inhibitors.

7. Show Slide 113: Medication Actions on Neurotransmitters in Depression.
   Explain the action of depression drugs on serotonin and noradrenaline.
8. Show Slide 114: Mechanism of Action of SSRIs.

Depression is associated with reduced levels of the monoamines in the brain, such as 5-HT. The selective 5-HT re-uptake inhibitors (SSRIs) are thought to restore the levels of 5-HT in the synaptic cleft by binding at the 5-HT re-uptake transporter preventing the re-uptake and subsequent degradation of 5-HT. This re-uptake blockade leads to the accumulation of 5-HT in the synaptic cleft and the concentration of 5-HT returns to within the normal range.6


Tricyclic antidepressants (TCAs) are a group of drugs used to treat mood disorders including depression. TCAs bind to 5-HT and noradrenaline re-uptake transporters, which prevents the re-uptake of the monoamines from the synaptic cleft and their subsequent degradation. This leads to the accumulation of 5-HT and noradrenaline in the synaptic cleft and the concentration returns to within the normal range.6

10. Show Slide 116: Prescribing: Key Definitions.

Review the bullet points on the slide. Animate the speech bubble, then ask participants:

• What are the key factors that go into a decision of whether to prescribe and what to prescribe?
• Record responses on flip chart paper.

11. Show Slide 117: True or False.

CLICK and ask question. Once participants have had an opportunity to respond to the question, CLICK again for the answer.


Review the bullet points on the slides and compare with participant responses on flip chart paper.


Note that there are a range of medications across several types/classes used in the treatment of depression and other types of mental illness.

Tell participants that today we will discuss primarily fluoxetine and amitriptyline.


Review the key points. Let participants know that more detailed monitoring instructions can be found in mhGAP.

6. Description and corresponding slide are adapted from: CNS Forum, Image Bank. Available at: https://www.cnsforum.com/educationalresources/imagebank/antidepressants/drug_ssr1_2
15. Show Slide 122: Fluoxetine, Adverse Effects.
Review the adverse effects.

Provide an overview of this topic.

Distribute copies of the laminated Medication Card for Depression. Explain to participants that they also have copies of the same card, but not laminated, in the annex of their participant handbook. They will see that the key points on fluoxetine are summarized on the Medication Card, as are the key points for amitriptyline, which will be discussed next. Give participants a minute or two to review the column on fluoxetine. Ask if there are any questions about this drug.

Review the key points. Again, let participants know that more detailed monitoring instructions can be found in the mhGAP.

Refer participants to the Medication Card for Depression, where they will find key points on amitriptyline. Give participants a minute or two to review the column on fluoxetine. Ask if there are any questions about this drug.

20. Tell participants that other than fluoxetine and amitriptyline, drugs that are commonly prescribed for mental illnesses other than depression include:

- **Diazepam**, which is indicated for anxiety disorders, catatonia, insomnia, seizures (status epilepticus), alcohol withdrawal. Side effects: sedation, anterograde amnesia and confusion (with high doses). The elderly are more prone to adverse effects of diazepam such as confusion, amnesia, ataxia and hangover effects as well as falls.

- **Lorazepam**, which is indicated for anxiety disorders, catatonia, insomnia, seizures (status epilepticus), alcohol withdrawal. Side effects are similar to diazepam.

- **Haloperidol**, which is indicated for schizophrenia, schizoaffective disorder, bipolar disorder in pregnant women, agitation in delirium. Side effects include extrapyramidal symptoms (EPS), Tardive Dyskinesia (TD), neuroleptic malignant syndrome (NMS), dry mouth, lethargy, tremors, and weight-gain; QT prolongation.

- **Risperidone**, which is indicated for treatment of schizophrenia, schizoaffective disorder, bipolar disorder, irritability in autism. Side effects include weight gain, metabolic side effects, sedation, hypersalivation, hyperprolactinemia, EPS, TD, NMS.
- **Valproic Acid**, which is indicated in the treatment of seizures and bipolar disorder. Side effects include tremor, hair loss, pancreatitis, hepatotoxicity, thrombocytopenia, aplastic anemia, hyperammonemia, sedation. It is considered the most teratogenic of all antiepileptics, use **carbamazepine** for women who are pregnant.

   Review the bullet points in turn.

22. Show Slide 128: Geriatric Depression.
   Review the bullet points in turn.

23. Show Slide 129: Pediatric Depression.
   Review the bullet points in turn. Ask participants what experience they have had with caring for pregnant, geriatric or pediatric patients with depression. Were they treated? What were the outcomes?

   Note that giving amitriptyline to suicidal patients is risky because they can overdose on it. Consider, instead, contacting the mental health team for guidance.

25. Show Slide 131: Medication Psychoeducation (1).
   Patient education is incredibly important around medication. The healthcare provider should be guided by the patient’s questions and his/her presentation. The provider may have to repeat or say things in a different way so that the patient understands. Use this slide to discuss common side effects of amitriptyline.

   Discuss the side effects of fluoxetine.

27. Divide participants into small groups of three or four participants per group. Refer participants to the case studies in their participant handbooks.

28. Give the groups 15 minutes (or more) to discuss all four cases and respond to the question(s) that follow each case.
**MEDICATION CASE STUDIES**

**CASE 1:** A 68 year old male who is agitated and complains of appetite loss and low mood over the previous two months. During the examination he is visibly sad, complains of inability to sleep, and loss of interest in farming and visiting children and grandchildren. He states that he always used to go to the field to work six days a week, but lately he just can’t get the energy to tend to the fields. The patient denies any suicidal thoughts. Physical examination and other investigations are normal, and the diagnosis of major depression is made by the psychologist/social worker.

1. If you would prescribe, what medication would you prescribe as a first choice and why? What is the starting dose?
   
   **ANSWER:** Fluoxetine, it’s the first choice medication for depression. Start with 20 mg.

**CASE 2:** An 18-year old female presents who has been crying every day for the past month, and scores 25 on the ZLDSI. After an evaluation you believe that she is experiencing an episode of depression.

2. What medication would you prescribe as a first choice and why?
   
   **ANSWER:** Fluoxetine, it’s the first choice medication for depression.

**CASE 3:** A 45-year old female presents with symptoms of a severe headache. After an evaluation you believe that she is experiencing headaches due to migraines.

3. What medication would you prescribe for the migraine? What else should you check for?
   
   **ANSWER:** Amitriptyline for headache, check for co-morbid medical condition.

**CASE 4:** You see a 30 year-old mother of four children who has been married for eight years. She lives with her husband and in-laws in a small village. She gave birth to her fourth child three months ago. Her pregnancy and labor had been uneventful, and an untrained midwife helped conduct the home delivery. She received no antenatal or postnatal care. For a month after the birth, the patient felt normal, but then she began to exhibit unusual behavior. She became reclusive and stopped speaking to anyone at home, losing interest in her daily activities and ceasing to care for her children. She has been seen talking to herself and reports hearing voices. One day, when all of her family members had gone to the fields to work, she attempted to kill herself with the neighbor’s gun. Some neighboring men saw her, stopped her, and one of them ran to get her family from the fields. They called a friend to take her to the clinic, where she now sits in front of you.

4. Considering that this patient is still breastfeeding her three month old infant, would you prescribe for this case? Why or why not?
   
   **ANSWER:** Yes. There is a low risk that antipsychotic medication is passed through breastmilk. It is very important to have the woman’s psychosis controlled.
5. If you would prescribe, what medication would you give her as a first choice and why? What is the starting dose?

**ANSWER:** Haloperidol, 5 mg. Haloperidol does not have significant side effects related to breastfeeding, whereas risperidone can cause prolactemia.

6. How would you answer this question if the patient was four months pregnant rather than breastfeeding?

**ANSWER:** The answer would be the same; Haloperidol, 5 mg.

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**Case 1:** Adapted from National Prescribing Service Limited, Case Study 10: Depression (September 2000). Available at: [http://www.nps.org.au/__data/assets/pdf_file/0006/35367/Case_10_results.pdf](http://www.nps.org.au/__data/assets/pdf_file/0006/35367/Case_10_results.pdf)

**Case 4:** Adapted from: Gard, BS. The Network, “Case Study: Postpartum Depression, Sheela’s Story. Available at: [http://www.the-networktufh.org/sites/default/files/attachments/basic_pages/Postpartum%20Depression-Case%20Study.pdf](http://www.the-networktufh.org/sites/default/files/attachments/basic_pages/Postpartum%20Depression-Case%20Study.pdf)

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29. When groups have finished discussing the cases, ask each group to report on one or two of the cases. Encourage discussion, particularly on the last case regarding depression and psychosis during pregnant and breastfeeding.
DAY 2: Review

Methods: Game

Time: 30 minutes

Materials:
- Markers, pens
- Small prizes for winners of Bingo game (ex., sweets)

Preparation:
- Review the 37 bingo question on the Bingo Questions Sheet in the annex.
- Cut out the bingo cards in the annex so that there is one bingo card per participant. There are 10 different cards. If you have 20 participants, make two copies of each card, shuffle and distribute randomly, one to each participant.

Objectives:
Participants will be able to:
- Recall key points taught in Sessions 4, 5, 6 and 7.

STEPS

1. Distribute the prepared bingo cards to participants. Explain that the participants will now review day two’s training content using a game called Depression Bingo.

2. Explain to participants that you [the facilitator] will read a question from your question cards. Read the questions in random order (do not read them in order from 1–37!). Check off each question as you read it so that it is not read more than once. Do not reveal the answer.

3. After a question is read, participants should think of the answer, and then look for the answer to that question on their Bingo cards. Note: there are 37 questions and each card has only 24 answers, so there’s a 35% chance that the correct answer is NOT on their card!

4. Participants who think they have the correct answer on their Bingo card should quickly raise their hand (or stand up). The facilitator should choose one person to answer the question. If that person is correct, all participants with that particular answer on their Bingo card may cross off the corresponding box on their Bingo card. If the participant provides an incorrect answer, the next person may venture a guess (continue until the question is answered correctly). Ensure that everyone has a chance to answer at least one question.
5. The first player to mark five squares across, up/down, or diagonally should yell “BINGO”. If someone has yelled bingo, the facilitator should ask that participant to read the answers that were marked to verify that there were no errors. If all answers are correct, then play to see who gets 2nd and 3rd place or stop the play.

6. When the game is over, review all remaining questions by reading the questions to the group and then asking someone (a different participant each time) to provide the correct answer.

7. During this game, questions about the training content often arise. Use the game to clarify information and answer questions that the participants may have.

8. Reward the winners at the end of the game!
SESSION 8: Follow Up and Documentation

Methods: Facilitator presentation, case studies

Time: 1 hour 15 minutes

Participant Handbook page: 24

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape

Preparation:
- Review the case study, Facilitator Manual, PowerPoint slides 133–143.
- Review the Mental Health Follow-Up Form.

Objectives:
Participants will be able to:
- Explain the process of follow up for people living with depression.
- Correctly complete the physician sections of the Follow-Up Form.

STEPS

30 minutes

1. Show Slide 133: Session 8: Follow Up and Documentation.

Introduce this session by reading the objectives. Start by asking participants:
   - Why is follow up important?
   - Why is follow up important for patients who are depressed?

Key concepts that arise from the discussion should center on the importance of ensuring continuity of care as patients with chronic illnesses require a lot of provider time at initial visit and follow up.


Explain to participants that this list is from the Depression Checklist, which is in the annex of the participant handbook. Refer participants to this document to also review the follow-up responsibilities of the psychologist, nurse and CHW. Ask participants:
   - In the follow-up evaluation, who do you think the physician works most closely with? (Answer: the psychologist)
   - How will your evaluation benefit from feedback of the other cadres (nurse and CHW)?

When a new medication is started, the physician should see the patient within 2–4 weeks. As the patient becomes stable on the medication, appointments can be reduced to monthly, then every two months, then every three months (depending on the patient and their situation). If a patient is depressed, but not on medication, the CHW and psychologist/social worker will be working with the patient and will refer to the physician if needed.


Read slide.

5. Show Slide 137: Determine if Patient is Improving.

Read slide.


Stress the importance of:

- Continuing to work with the psychologist to determine if the patient is improving.
- Changes in medication dosage are based on patient progress and side effects.

Tell participants that a patient who has already experienced an episode of depression is at high risk of relapse. The patient who has experienced two episodes of depression is at an ever higher risk of relapse.

7. Show Slide 139: Continuing or Stopping Amitriptyline and Fluoxetine.

Review each bullet point. Ask participants what questions they have.


Review all points on the slide.

Refer participants to the Mental Health Follow-Up Form in the annex of their participant handbooks. Give them three or four minutes to review this form.

9. Show Slides 141–142: Mental Health Follow-Up Form.

Highlight the parts of the Follow-Up Form that need to be completed by the physician. This is the form on which the physician records his/her patient observations during the follow-up visit and records and changes in medication or medication dosage.

Ask if there are any questions about filling in this form. Note that this form is initiated and completed by the psychologist/social worker, to whom it should be returned upon completion of the physician sections.
45 minutes

10. Divide participants into small groups of three or four participants per group. Refer participants to the case study in their participant handbooks.

11. Give the groups 15 minutes (or more) to discuss the case and respond to the question(s) that follow.

FOLLOW UP CASE STUDY

Chief Complaint:
A 25 year old woman you saw initially four months ago for depression returns to the clinic. She continues to be depressed. She tells you that she’s tired, has a headache and still feels terrible.

History of Present Illness:
Initially she presented with fatigue, difficulty concentrating, weight gain and suicidal thoughts. She now reports little change in her symptoms since starting an antidepressant. She spends most of the day sleeping in bed and finds that she does not enjoy any of the activities she used to enjoy such as being with friends and attending church.

Physical Examination:
Vital Signs: Bradycardia (HR 56), hypotension (BP 80/40)

Skin is course and dry. Diminished reflexes throughout. On Mental Status Exam speech is slowed with deep voice. She can recall only one of three objects after five minutes and has difficulty counting backwards by sevens. She has completed high school education and is a student at university.

Laboratory Studies:
Electrolytes and CBC: normal
RPR nonreactive
HIV negative

You send her for thyroid testing and find an increased TSH and low total T4.

CASE QUESTIONS AND ANSWERS

1. Discuss the differential diagnosis for this case.

   ANSWER: Depression can be caused by a medical condition if an underlying disorder tends to cause depression by a known physiologic mechanism. Common examples include hypothyroidism, cerebrovascular disease, multiple sclerosis, cancer (especially pancreatic and CNS), Cushing’s disease, SLE, viral illness, Addison’s disease, medications (beta-blockers, reserpine), sleep apnea, and Parkinson’s Disease.
2. What treatment would you follow in this case?

   **ANSWER:** Treatment of the underlying medical condition should take priority; concurrent antidepressant therapy may be indicated if the depression is severe and slow to respond. In this case, treat hypothyroidism with thyroxine.

Adapted from:

12. When groups have finished discussing the cases, ask each group to report their findings. Encourage discussion. Ask participants if they have any lessons learned from follow-up visits that they would like to share.


   Mention that a critical component of the integration of mental health services into the healthcare system, is the use of monitoring and evaluation, and quality improvement practices.

14. Ask participants what questions they have about the follow up care of patients who have depression.
SESSION 9: Advanced Practice—Depression and mhGAP

Methods: Facilitator presentation, role play

Time: 1 hour 30 minutes

Participant Handbook page: 27

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape
- Copies (1/participant) of WHO mhGAP Intervention Guide.

Preparation:
- Review the mhGAP Intervention Guide.

Objectives:
Participants will be able to:
- Describe how to use mhGAP for the management of depression.
- Describe how to use mhGAP for the management of self-harm/suicide.

NOTE FOR FACILITATOR:

Session 9 is an optional session that should be taught after the participants have thoroughly understood and mastered Sessions 1–8. The review questions and pre-/post-test questions do not cover this session.

STEPS

45 minutes

1. Show Slide 144: Session 9: Advanced Practice—Depression and mhGAP.

   Introduce this session by reading the objectives. Tell participants that in this next session they will learn about mhGAP and how it connects to their work with patients who are depressed.
2. **Show Slide 145: mhGAP Intervention Guide.**

   Explain to participants that in 2011 the World Health Organization developed the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings.

   Distribute the mhGAP copies to each participant.

   Explain to participants that the mhGAP has been developed for use in non-specialized health-care settings, particularly non-mental health providers such as physicians, nurses, psychologists/social workers at first- and second-level facilities (local clinics as well as district hospitals).

   Ask the participants if anyone has referenced mhGAP in their work. If so, ask for the participant to describe the experience of using mhGAP.

3. **Show Slide 146: Table of Contents.**

   This slide illustrates the spectrum of conditions included in this document.

4. **Show Slide 147: Master Chart (page 8).**

   Ask participants to turn to page 8 in their mhGAP guides as you explain the next slides.

   (CLICK twice) Specifically, this year, in Year 1 of the scale-up process, Zanmi Lasante will focus on depression care. Depression includes (read on left side, Depression chapter description).

5. **Show Slide 148: Master Chart (page 9).**

   (CLICK TWICE) Also in Year 1 Zanmi Lasante will focus on Self-harm/Suicide. A recent study indicated that 6% of people in the Plateau Central have suicidal ideation.

6. **Show Slide 149: Depression, Assessment and Management Guide (page 10).**

   Ask participants to open their mhGAP to page 10. Explain to participants that the mhGAP Intervention Guide is useful in thinking about how to assess for depression. Focus on the left side of the page, which describes what should be considered in assessing someone for depression.

   Choose a participant to read out Step 1 in the Depression Assessment and Management Guide (DEP1). Mention that participants have already learned about the listed symptoms of depression. Notice that the patient would need to answer “yes” to all three boxes of questions before moderate-severe depression is considered likely. If moderate-severe depression is likely the flowchart then directs the reader to the appropriate paragraphs on pages 13–16 to guide their consultation.
Ask participants to take a minute and silently read the end boxes on page 10 that describe the actions for a patient with moderate-severe depression, other complaints or bereavement. Recommend that they turn to sections DEP 2 and DEP 3 on pages 13–16.

Ask participants: What resource will you use to determine what medication to prescribe a patient? Take responses. (Correct answer: Medication Card for Depression.)

7. Show Slide 150: Depression, Assessment and Management Guide (page 11).
Have the participants turn to the next page in mhGAP (page 11), which guides the user through the differential diagnoses of bipolar depression, depression with psychotic features and concurrent conditions. Allow the participants to read this page silently for a few minutes. Mention the fact that it is common that patients may be suffering from multiple mental or physical health conditions at once. Conditions should be treated as necessary.

Explain to participants that mention of self-harm refers the reader to the “Master Chart”, on pages 8 and 9. However, the self-harm/suicide flowcharts start on page 73. Tell participants that we will return to self-harm/suicide shortly.

Have participant turn to page 12 in their mhGAP guide, which guides the user through specific special populations: women of child-bearing age and children/adolescents. Give participants a few minutes to read this page silently and flip to the various sections to which the boxes on the right half of the page refer.

Have the participants continue to the next page in mhGAP (page 13).
- Section 2.1: Psychoeducation: Mention that one of the most useful tools that mhGAP offers is psychoeducation messages. The messages on this page are depression-specific. Allow participants to read over the psychoeducation materials in their mhGAP.
- Invite participants to peruse the remaining four sections—Section 2.2: Addressing current psychosocial stressors, Section 2.3: Reactivate social networks, Section 2.4: Structured physical activity programme, and Section 2.5 Offer regular follow-up. Ask if there are any comments or questions.

Invite participants to skim through section 3 on pages 14 to 16, which provides guidance on initiating medication, special populations, monitoring patients on medication, and terminating medication.

11. Show Slide 154: Is there Imminent Risk?
Ask the question. Once you have a number of responses, CLICK to show the answer.

Refer participants to pages 74–76 and invite them to read through these pages. They should use the case on the previous slide to move from the box on the left (answer would be “NO” to the lower box on the right). They should feel free to flip ahead to sections SUI 2.1, 2.2 and 2.4. Animate the speech bubble and ask participants:

- To whom should you immediately refer a patient that is at risk of self-harm or suicide? (Answer: the psychologist/social worker!)

Emphasize the importance of immediate follow-up by a psychologist/social worker if the patient is at imminent risk for self-harm/suicide. Tell participants that self-harm and suicide can be attempted by anyone who might have mental health issues, including depression, epilepsy, psychosis and bipolar disorder.

Emphasize that no matter the condition of the patient, it is important not to leave the patient alone.

- Ask: What does “offer and activate psychosocial support” (bottom of page 74) mean? (Answer is on page 77.)

Participants will also notice that the self-harm/suicide section recognizes that there can be concurrent conditions, including complex emotional or pain symptoms.

They will see that the flow charts progress through attempted medically serious act of self-harm, to imminent risk of suicide, concurrent disorders, chronic pain and (number 5 on page 76) emotional symptoms severe enough to warrant clinical management.


Ask them to refer to their own mhGAP documents and read through these pages. Ask if there are comments or questions.


Review the points on the slide and explain to participants that often, depression can be accompanied by significant anxiety. At other times, anxiety can be predominant, without depression. In addition, “depression” is a concept that has been developed in the Western context. In different cultures, people have different ways of describing how emotional distress manifests both physically and psychologically. The way that the mhGAP Intervention Guide manages this is by describing “Significant Emotional or Medically Unexplained Symptoms.” These are symptoms that represent some combination of depression, anxiety and medically unexplained symptoms. When emotional distress manifests physically, the symptoms are referred to as “somatic” (of the body).
15. Show Slide 159: Other Significant Emotional or Medically Unexplained Complaints (pages 80–81).

Repeat the process as you did before, inviting participants to read through these two pages and then flip back to DEP 2.2, DEP 2.3 and DEP 2.4 to re-review the sections to which the final box on the right side lists.


Refer participants to pages 82 and 83 in their mhGAP documents. Invite them to take five minutes to read through the advanced psychosocial interventions, many of which have been mentioned previously in this training.

17. Show Slide 161: DSM.

There are places in which the mhGAP refers to certain other conditions. The DSM-4 will be used to describe these conditions. While the Diagnostic and Statistical Manual of Mental Disorders (DSM 4, 1994) represents the official classification system of psychiatric conditions in the United States, it should be used with caution in other contexts and cultures. WHO endorses the International Statistical Classification of Diseases and Related Health Problems (ICD). In some circumstances, neither of these may capture particular clinical presentations in local context. The protocols have been adapted carefully from the DSM, based on the experience of ZL clinicians and with attention to local context.

45 minutes

18. Tell participants that they will now practice using mhGAP through a role play. Ask for three volunteers: one to play the role of the physician, the other the patient, and the third the patient’s wife. The volunteers should come to the front of the room to conduct their 10 minute role play in front of the group.

The role play appears in the box below.

<table>
<thead>
<tr>
<th>MHGAP CASE STUDY</th>
</tr>
</thead>
</table>

**BACKGROUND**

Today a 30 year old, married, male patient has been referred to you; he and his wife were accompanied to the clinic by the CHW. The CHW brought him to the clinic as his depression screening by the CHW was positive: he mentioned to the CHW that he feels so tired lately, and he just doesn’t feel like working (he is a clothing vendor in the local market). He has missed work every day for the last week and, to make it worse, he feels so guilty about it, especially because he has a wife and two children to support. He is not sleeping well, and doesn’t have an appetite.

This man does not have any episodes of manic symptoms nor does he exhibit any psychotic features or other concurrent conditions. The physician should go through the screening questions on pages 10 and 11 of the mhGAP guide.
The physician is covering for the psychologist who is currently dealing with an emergency. The physician should turn to page 10 of the depression mhGAP guide and initiate the interview as if this man were a new patient.

**SCRIPT**

**The physician:** Good afternoon, how may I help you today?

**The patient:** Greets physician. Reluctantly tells physician about his ZLDSI screening with the community health worker.

**The wife:** Fills in additional information that the patient didn't mention.

**The physician:**
- Over the last two weeks, how often have you felt down, depressed, or hopeless?
- Over the last two weeks, how often have you felt little interest or pleasure in doing things?
- Over the last two weeks how often have you had trouble falling or staying asleep or sleeping too much?
- Over the last two weeks how often have you felt like you were tired or had little energy?
- How has your appetite been over the past two weeks? (screen for overeating as well as poor appetite)
- Over the past two weeks how often have you felt bad about yourself, feeling like you were a failure or as if you had let yourself or your family down?
- Over the past two weeks have you had trouble concentrating on things, such as reading or your daily chores?
- Over the past two weeks have you or anyone else mentioned that you are moving or speaking slowly or, the opposite, been fidgety or restless?

**The patient:** Responds according to background history.

**The physician:** Screens for bipolar depression, psychotic features and concurrent conditions as per page 11 of the mhGAP Guide.

Once the role play had been completed, the facilitator should then lead a debriefing by asking:

- What did the physician ask that enabled him/her to get an answer to questions 1 on page 10 (DEP1)? (The questions at the top of that page reads: “Does the person have moderate-severe depression”?)
- How did the patient respond in terms of the core depression symptoms (top/left white box)?
• How did the patient respond in reference to the other features of depression (middle/left white box)?

• Does this patient have “difficulties carrying out usual work, school, domestic, or social activities” (third from top white box on left)?

• How did the mhGAP assessment and management guide lead the clinician from there?

• Moving to the second page of DEP1 (page 11 in the mhGAP guide), did the physician screen for bipolar depression? What question did the physician ask? What was the outcome?

• Had this patient answered “yes” to the question about prior manic episodes, which algorithm should have been followed?

• Had this patient answered “no” to the question about prior manic episodes, but “yes” to the question about hallucinations, which algorithm should have then been followed?

• If this man said something that indicated he was at risk of suicide, what should have been done?

19. Ask participants what questions they have on the mhGAP guide.
SESSION 10: Review, Post-Test and Feedback

Methods: Facilitator presentation, case studies, assessment, evaluation

Time: 2 hours 30 minutes

Participant Handbook page: 29

Materials:
- PowerPoint presentation
- Flip chart
- Markers, pens
- Tape
- Post-it notes
- Post-test (1/participant)
- Post-test answer key (on a computer to be projected)
- Training Evaluation Form
- Flip chart sheet with Post-it notes listing participants’ goals and expectations as articulated during introductions (Session 1)

Preparation:
- Photocopy the pre-test and training evaluation form.
- Create three flip chart pages, each individually titled:
  - How will you share what you’ve learned?
  - What strategies will you use to ensure collaboration with other team members?
  - When I’m unsure or struggling I will...

Objectives:
Participants will be able to:
- Review all unit objectives.
- Demonstrate learning through a post-test.
- Give feedback on the training.

STEPS

60 minutes

   Introduce this session by reading the objectives.
   Explain that we will discuss case studies as a way to review the management of patients with depression and to become more familiar with the forms and tools that are available to help with patient management.
2. Divide the participants into small groups of three or four people. Ask participants to turn to the case studies in their participant handbook. Tell the participants that they should read the first part of the case, respond accordingly, and then continue on to the next question.

3. Tell participants that they will have 45 minutes to complete the case study questions in their groups. Remind the participants to reference the tools and forms with which they have been provided. Encourage them to think about the system of care more broadly and their roles within the system. Ask the participants to consider how they should best work with community health workers, nurses, social workers and psychologists, and other members of the care team.

4. After 45 minutes, ask everyone to join the larger group again. Review the case studies by asking a different group to present each case and their answers. Use the questions included in the case studies to guide the conversation.

5. Answer any questions that arise.

### CASE STUDY 1 MARIE-FLOR

Use the Depression Checklist to determine how to manage this case.

The psychologist presents this case to you using the Initial Mental Health Evaluation Form and the ZLDSI: Marie-Flor is a 24-year-old woman whose mother died one year ago, leaving her to care for her seven brothers and sisters. She finished her primary education and wishes to go to university, but all of her money must be spent on her siblings. She has no family member helping her take care of her siblings. Her ZLDSI score is 30, she is not sleeping nor eating well, and she has lost weight.

### CASE STUDY QUESTIONS AND ANSWERS

1. What are your core clinical responsibilities for this patient the first time you meet her?

   **ANSWER:**

   **Core Clinical Responsibilities**
   
   • Assessing patient for suicide
   • Medical evaluation
   • Deciding whether to prescribe medication; choosing what medication to prescribe
   • Psychoeducation about medication
CASE STUDY 1 MARIE-FLOR (continued)

2. Which forms will you use?

   ANSWER:
   Tools
   • mhGAP
   • Depression Checklist
   • Patient Encounter Form
   • Depression Medication Card

3. The psychologist/social worker diagnoses Marie-Flor with severe depression because her functioning is impaired (she is not sleeping or eating), and her ZLDSI score is high. You also learn that she sometimes thinks about dying. Do you prescribe a medication? Which medication do you prescribe? Which dose should you begin with?

   ANSWERS:
   Prescribing medication: You should check to make sure Marie-Flor is not pregnant. If she is pregnant, do not prescribe medication. You must also complete a full medical evaluation to ensure a medical problem is not causing her depression. If there are no contraindications, you should prescribe a medication for Marie-Flor because she is very impaired and severely depressed.

   Which medication do you prescribe? Amitriptyline is the better choice. You should start with 25 mg or 12.5 mg if Marie-Flor is very thin. If she is suicidal, only give her seven days worth.

4. What messages would you give to Marie-Flor about her medication? Explain to her how to take the medication properly and what the side effects are.

   ANSWERS:
   Explain common and adverse side effects, as well as how to respond to both.

   For amitriptyline, explain that the most common side effects are sedation, lightheadedness/dizziness (from orthostatic hypotension), constipation/difficulty urinating, dry mouth, blurred vision.

   Advise the patient to drink a lot of water to offset these side effects.

   Explain to the patient that if she has any symptoms suggestive of a cardiac problem (like palpitations), she must stop the medication immediately.

   Sometimes young people ages 18–25 become suicidal after starting an antidepressant. People who have bipolar can develop manic symptoms after starting an antidepressant. For both problems, the patient must stop the medication and come to the clinic/hospital immediately.
CASE STUDY 2 JEAN

Use the Depression Checklist to determine how to manage this case.

Jean is a 20-year-old male who comes to the mental health clinic accompanied by his parents and a community health worker, who report that he has recently been very excitable, is up all night and is eager to talk to everyone. During the initial evaluation, the psychologist/social worker learns that Jean has been sleeping poorly and has grandiose thoughts. During the evaluation, Jean says that everything is just fine, and he leaves the session. The psychologist/social worker stops the evaluation and comes to you concerned that he is bipolar.

CASE STUDY QUESTIONS AND ANSWERS

1. What is your next step? Does Jean have bipolar disorder?

   **ANSWER:**
   At this point, the psychologist/social worker cannot make a diagnosis of bipolar disorder because the evaluation has not been complete.

   The next best step is to see if you can collaborate with the psychologist to do a complete evaluation of the patient.

2. When you gather information from the community health worker, you learn that Jean recently failed his baccalaureate exam. As the eldest son in a family of eight children, he had hoped to score well on the exam, go to university, and then find a good job to support his brothers, sisters, and parents. As the community health worker shares this history, you see that Jean has returned. He is now sitting on a bench not far from the clinic. What is your next step? Use the depression checklist.

   **ANSWER:**
   The next step is for the psychologist/social worker to do a complete Initial Mental Health Evaluation Form, which includes doing a ZLDSI.

3. The psychologist/social worker completes the Initial Mental Health Evaluation Form with Jean. Jean has a score of 30. He demonstrates some manic symptoms (euphoria, decreased sleep), all of which developed following his baccalaureate exam. The psychologist has recommended he receive medication. What is your next step?

   **ANSWER:**
   According to the depression checklist, your first responsibility is to review the Initial Mental Health Evaluation form with the psychologist to better understand the history.

   A mental health diagnosis cannot be made until Jean has had a comprehensive mental health evaluation AND a medical evaluation to make sure that a medical problem is not causing the mental health symptoms. This is why the depression checklist asks physicians to do a complete medical evaluation separate from the mental health evaluation.

   Assuming that Jean’s medical exam is totally normal: his ZLDSI score raises concern for depression, and the physician should consider prescribing medication.
CASE STUDY 3 YVELINE

Chief Complaint:
You are asked to see a 72 year old woman, name Yveline, with weight loss, fatigue and insomnia for the past 2 months. When you meet her and ask how she is doing, she responds, “I am very tired…”

History of Present Illness:
Yveline says that she has not felt the same since she moved from her home to live with her daughter. She feels that she is burdening her daughter, but has failing health and has no other choice. Her friends have all passed away, and she says that she doesn’t have anything to live for and thinks about death frequently. She denies any suicidal plan but feels that she’d be better off dead. She also reports poor concentration and trouble remembering things. She no longer enjoys the things that she used to do and often feels worthless.

Physical Examination:
Vital Signs: normal

Mental Status Exam significant for depressed mood, psychomotor retardation, impaired short term memory, and difficulty attending to the interview

Laboratory Studies:
Electrolytes and CBC: normal
RPR nonreactive
HIV negative

CASE STUDY QUESTIONS AND ANSWERS
1. What ABCD’s of major depressive order are present in this case?

   ANSWER:
   Affect and mood: Yveline has not felt like herself since she moved in with her daughter, she seems to feel a sense of guilt for relying on her daughter, she does not feel good about herself and her role.

   Behavior: the fact that she has lost weight, assuming there has been no physical illness, suggests that she may be depressed; she admits to fatigue and insomnia; she takes little joy from daily activities.

   Cognition and perception: Yveline seems to lack the will to live; she is also experiencing poor concentration, trouble remembering things.

   Development: Yveline is 72 and experiencing a number of normal changes for someone her age; however, many of these changes are difficult, particularly the loss of friends and partner and the loss of good health.
CASE STUDY 3 YVELINE

2. What are the possible psychological and social risk factors in this case (the bio-psycho-social model)?

**ANSWER:**
Biological factors: age, failing health, probably chronic health problems, possibly a disposition to depression.

Social Factors: many of her friends have passed away, although she is living with her daughter, this does not appear to be helpful, possibly poverty.

Psychological Factors: feeling like a burden on her daughter.

3. If you suspect depression, what should your next steps be?

**ANSWER:**
Administer the ZLDSI, contact the psychologist.
Complete a safety evaluation of the patient with regard to risk of harming herself as part of the evaluation and follow-up.

4. If the ZLDSI score is high enough, what medication could be provided?

**ANSWER:**
For a higher ZLDSI score, medication for depression is also indicated in addition to psychosocial and psychological support.

Begin with fluoxetine unless there is a reason to start with amitriptyline. Keep in mind that she is an elderly patient who has lost weight, so you need to consider starting dosage carefully.

5. What should you communicate to Yveline?

**ANSWER:**
Psychoeducation: medication side effects, how to take the medication, follow-up plan.

Communicate with associated providers such as the psychologist. The psychologist will also work with her to: address current psychosocial stressors, reactivate social networks.

Adapted from:
**Post-test:**

40 minutes

6. After the case study discussions have finished, administer the post-test to the participants. Allow them 30 minutes to complete the post-test. Participants may not use their notes or participant handbooks during the test.

7. Once the post-test is 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.

**Reflection:**

30 minutes

8. Ask participants to recall the first day of training, when each participant introduced him/herself. At that point in time everyone was asked to state their:
   - Name
   - Place of employment
   - One goal or expectation that they have for this training

Go back to the flip chart entitled “Goals and Expectations” where you posted participants Post-it notes on the first day of training. Read each one out loud and ask if this goal/expectation was achieved (no need to read duplicates). Where there are goals or expectations that have not been met, provide a plan for meeting it in the future (maybe this goal will be met in a different training, or through one-on-one mentoring), if not mentioned previously.


Ask participant to break into groups of three or four people per group. In their groups they should spend five minutes brainstorming each of the following questions:
   - How will you share what you’ve learned?
   - What strategies will you use to ensure collaboration with other team members?
   - When I’m unsure or struggling I will...

10. Post the flip chart sheets that were prepared in advance. After 15 minutes ask the groups to reconvene. Ask the first group how they responded to the first question, ask other groups if they’d like to add anything. Then ask the second group to respond to the next question, repeating the process until all three questions have been discussed. Take notes on the pre-prepared flip chart sheets.
Evaluation

20 minutes

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

12. Invite participants fill in the evaluation. As they fill in the evaluation, circulate and help as needed.

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

14. Congratulate the participants on having completed this training. Thank them for their participation. Distribute certificates as appropriate.
Annex
Circle the most correct response. All questions have just ONE correct response.

1. Approximately what percentage of people world-wide experience a mental illness during their life? (___ / 1 point)
   a. 1%
   b. 15%
   c. 25%
   d. 50%

2. Of the leading causes of burden of disease globally in 2004, unipolar depressive disorder ranked how high? (___ / 1 point)
   a. First
   b. Third
   c. Eighth
   d. Tenth
   e. Fifteenth

3. As per the depression checklist, what is the responsibility of the physician in the initial evaluation? (___ / 1 point)
   a. For suicidal patients, work with psychologist to determine risk and to ensure safety plan.
   b. Identify patients at risk for depression and check for depression symptoms in the nursing protocol.
   c. Based on ZLDSI score, suicidal ideation, and severity of depression symptoms, decide whether to prescribe.
   d. All the above
   e. A and C
4. To have moderate-severe depression, according to mhGAP, a patient would have had at least 2 of the CORE depression symptoms, what are the CORE depression symptoms?
   a. Depressed mood (feeling sad)
   b. Ideas or acts of self-harm or suicide
   c. Loss of interest or pleasure in activities that one usually enjoyed
   d. Decreased energy or easily fatigued
   e. All the above
   f. A, C, and D only
   g. A, B, and C only

5. To have moderate-severe depression, according to mhGAP, a patient would have had at least three OTHER FEATURES of depression, what are these OTHER FEATURES?
   a. Reduced concentration and attention
   b. Withdrawal, agitation, disorganized behavior
   c. Delusions
   d. Ideas of guilt and unworthiness
   e. All the above
   f. A and D only

6. To have major depressive disorder, a patient must have symptoms most of the day nearly every day for how long?
   a. 2 weeks
   b. 3 weeks
   c. 5 weeks
   d. 8 weeks

7. Before starting treatment for major depressive disorder, you would want to ask about symptoms of or a history of which two psychiatric conditions:
   a. Epilepsy and bipolar depression
   b. Dementia and Epilepsy
   c. Dementia and substance use disorders
   d. Psychosis and dementia
   e. Bipolar disorder and psychosis
8. A patient is at risk of self-harm or suicide if these conditions are present:  
   a. Has current or past thoughts or a plan to commit suicide or self-harm  
   b. Has tried to kill her/himself  
   c. Has access to weapons or other means to commit suicide or self-harm  
   d. Had been diagnosed as having severe-moderate depression  
   e. All the above  
   f. A, B and C  

9. The ZLDSI is used to screen for depression. If a patient’s score on the ZLDSI is  
   16, what should happen?  
   a. The patient does not require further assessment for depression but should  
      be provided with community follow-up, IPT, and assessment for other  
      problems through the chief complaint  
   b. No mental health follow up is necessary, this person is not depressed  
   c. Consider antidepressants  
   d. Immediate referral to a health facility  
   e. A and C  

10. If a patient’s score on the ZLDSI is between 18 and 27, what should happen?  
    a. The patient does not require further assessment for depression but should  
       be assessed for other problems through the chief complaint, history of  
       present illness, and social history  
    b. Referral to the community health worker  
    c. Referral to the psychologist/social worker and community health worker for  
       IPT  
    d. Immediate referral to a health facility  
    e. All of the above  

11. For which of the following medical conditions is a differential diagnosis NOT  
    typically necessary (because its symptoms are not typically confused with those  
    of depression)?  
    a. Multiple sclerosis  
    b. Typhoid Fever  
    c. Stroke  
    d. Hypothyroidism  
    e. HIV  
    f. Addison’s disease  
    g. Epilepsy
12. Which of the following is **NOT** evaluated during the mental status exam? (___ / 1 point)
   a. General appearance
   b. Orientation
   c. Mood
   d. Thought content
   e. Medical history
   f. Insight

13. To screen for possible psychosis, which of the following question would you ask? (___ / 1 point)
   a. How is your sleep?
   b. Did you experience a trauma, such as physical, sexual or emotional abuse?
   c. Have you ever lost consciousness?
   d. Do you see things that other people do not see?
   e. Do you experience heart palpitations?

14. Amitriptyline belongs to which class of drugs? (___ / 1 point)
   a. Tricyclic antidepressants (TCAs)
   b. Selective serotonin reuptake inhibitors (SSRIs)
   c. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
   d. Norepinephrine reuptake inhibitors (NRIs)

15. Fluoxetine belongs to which class of drugs? (___ / 1 point)
   a. Tricyclic antidepressants (TCAs)
   b. Selective serotonin reuptake inhibitors (SSRIs)
   c. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
   d. Norepinephrine reuptake inhibitors (NRIs)

16. If a patient taking fluoxetine reports agitation, ataxia, diaphoresis, diarrhea, hyperreflexia, mental status changes, myoclonus, shivering, tremor, and/or hyperthermia, what are you most worried about: (___ / 1 point)
   a. Serious cardiac arrhythmias
   b. Serotonin syndrome
   c. Neuroleptic malignant syndrome
   d. Tricyclic antidepressant syndrome
   e. Monoamine oxidase inhibitor (MAOI) interaction
17. Which of the following is/are common side effect(s) of amitriptyline? (___ / 1 point)
   a. Induction of mania in patients with Bipolar disorder
   b. Sexual dysfunction
   c. Serious cardiac arrhythmias
   d. Ringing in the ears
   e. Frequent urination
   f. All the above
   g. A and C only
   h. A and B only

18. Which of the following is/are common side effect(s) of fluoxetine? (___ / 1 point)
   a. Induction of mania in patients with bipolar disorder
   b. Sexual dysfunction
   c. Serious cardiac arrhythmias
   d. Ringing in the ears
   e. Frequent urination
   f. All the above
   g. A and C only
   h. A and B only

19. Amitriptyline should be avoided in patients with the following conditions EXCEPT: (___ / 1 point)
   a. Serious heart arrhythmias
   b. Recent heart attack
   c. Bleeding from stomach, esophagus or duodenum
   d. Suicidal thoughts

20. In the follow up visit, if a patient presents with antidepressant side effects, what are your options? (___ / 1 point)
   a. Decreasing the dosage
   b. Changing antidepressant
   c. Discontinuing medication
   d. Continue the medication until remission of symptoms of depression
   e. All the above
   f. A, B, and C
PRE-TEST AND POST-TEST ANSWER KEY

Name: ___________________________ Date: ___________________________
Site: ___________________________ Supervisor: ___________________________

Circle the most correct response. All questions have just ONE correct response.

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   b. 15%
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   a. First
   b. Third
   c. Eighth
   d. Tenth
   e. Fifteenth

3. As per the depression checklist, what is the responsibility of the physician in the initial evaluation? ( ____ / 1 point)
   a. For suicidal patients, work with psychologist to determine risk and to ensure safety plan.
   b. Identify patients at risk for depression and check for depression symptoms in the nursing protocol.
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   b. Dementia and Epilepsy
   c. Dementia and substance use disorders
   d. Psychosis and dementia
   e. Bipolar disorder and psychosis
8. A patient is at risk of self-harm or suicide if these conditions are present: (___ / 1 point)
   a. Has current or past thoughts or a plan to commit suicide or self-harm
   b. Has tried to kill her/himself
   c. Has access to weapons or other means to commit suicide or self-harm
   d. Had been diagnosed as having severe-moderate depression
   e. All the above
   f. A, B and C

9. The ZLDSI is used to screen for depression. If a patient's score on the ZLDSI is 16, what should happen? (___ / 1 point)
   a. The patient does not require further assessment for depression but should be provided with community follow-up, IPT, and assessment for other problems through the chief complaint
   b. No mental health follow up is necessary, this person is not depressed
   c. Consider antidepressants
   d. Immediate referral to a health facility
   e. A and C

10. If a patient's score on the ZLDSI is between 18 and 27, what should happen? (___ / 1 point)
    a. The patient does not require further assessment for depression but should be assessed for other problems through the chief complaint, history of present illness, and social history
    b. Referral to the community health worker
    c. Referral to the psychologist/social worker and community health worker for IPT
    d. Immediate referral to a health facility
    e. All of the above

11. For which of the following medical conditions is a differential diagnosis NOT typically necessary (because its symptoms are not typically confused with those of depression)? (___ / 1 point)
    a. Multiple sclerosis
    b. Typhoid Fever
    c. Stroke
    d. Hypothyroidism
    e. HIV
    f. Addison’s disease
    g. Epilepsy
12. Which of the following is NOT evaluated during the mental status exam? (___ / 1 point)
   a. General appearance
   b. Orientation
   c. Mood
   d. Thought content
   e. Medical history
   f. Insight

13. To screen for possible psychosis, which of the following question would you ask? (___ / 1 point)
   a. How is your sleep?
   b. Did you experience a trauma, such as physical, sexual or emotional abuse?
   c. Have you ever loss consciousness?
   d. Do you see things that other people do not see?
   e. Do you experience heart palpitations?

14. Amitriptyline belongs to which class of drugs? (___ / 1 point)
   a. Tricyclic antidepressants (TCAs)
   b. Selective serotonin reuptake inhibitors (SSRIs)
   c. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
   d. Norepinephrine reuptake inhibitors (NRIs)

15. Fluoxetine belongs to which class of drugs? (___ / 1 point)
   a. Tricyclic antidepressants (TCAs)
   b. Selective serotonin reuptake inhibitors (SSRIs)
   c. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
   d. Norepinephrine reuptake inhibitors (NRIs)

16. If a patient taking fluoxetine reports agitation, ataxia, diaphoresis, diarrhea, hyperreflexia, mental status changes, myoclonus, shivering, tremor, and/or hyperthermia, what are you most worried about? (___ / 1 point)
   a. Serious cardiac arrhythmias
   b. Serotonin syndrome
   c. Neuroleptic malignant syndrome
   d. Tricyclic antidepressant syndrome
   e. Monoamine oxidase inhibitor (MAOI) interaction
17. Which of the following is/are common side effect(s) of amitriptyline?  
   a. Induction of mania in patients with Bipolar disorder  
   b. Sexual dysfunction  
   c. Serious cardiac arrhythmias  
   d. Ringing in the ears  
   e. Frequent urination  
   f. All the above  
   g. A and C only  
   h. A and B only

18. Which of the following is/are common side effect(s) of fluoxetine?  
   a. Induction of mania in patients with bipolar disorder  
   b. Sexual dysfunction  
   c. Serious cardiac arrhythmias  
   d. Ringing in the ears  
   e. Frequent urination  
   f. All the above  
   g. A and C only  
   h. A and B only

19. Amitriptyline should be avoided in patients with the following conditions **EXCEPT:**  
   a. Serious heart arrhythmias  
   b. Recent heart attack  
   c. **Bleeding from stomach, esophagus or duodenum**  
   d. Suicidal thoughts

20. In the follow up visit, if a patient presents with antidepressant side effects, what are your options?  
   a. Decreasing the dosage  
   b. Changing antidepressant  
   c. Discontinuing medication  
   d. Continue the medication until remission of symptoms of depression  
   e. All the above  
   f. A, B, and C
**DEPRESSION BINGO REVIEW GAME—QUESTION & ANSWER SHEET**

<table>
<thead>
<tr>
<th>ASK QUESTIONS IN RANDOM ORDER</th>
<th>Mark off each question after it has been asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the name of the form that guides the physician at first patient contact?</td>
<td>![ ]</td>
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<tr>
<td>Answer: Patient Encounter Form</td>
<td>![ ]</td>
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<tr>
<td>2. Severe alcohol withdrawal can cause what?</td>
<td>![ ]</td>
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<tr>
<td>Answer: Delirium Tremens</td>
<td>![ ]</td>
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<tr>
<td>3. If a patient had a ZLDSI score of 30, what would be the correct course of action?</td>
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<tr>
<td>Answer: Refer to physician to consider medication</td>
<td>![ ]</td>
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<td>4. How long does it take for amitriptyline and fluoxetine to reach full effect?</td>
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<tr>
<td>Answer: 4–6 weeks</td>
<td>![ ]</td>
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<td>5. What percentage of women suffer from depression or anxiety during pregnancy?</td>
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<tr>
<td>Answer: 20%</td>
<td>![ ]</td>
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<td>6. What is the definition of delirium?</td>
<td>![ ]</td>
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<tr>
<td>Answer: Disturbance of consciousness, reduced awareness with cognitive deficit</td>
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<td>7. What population is considered at increased risk for depression because of isolation,</td>
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<td>losses and medical illness?</td>
<td>![ ]</td>
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<td>Answer: Elderly</td>
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<td>8. What disorder requires a history of at least one manic or hypomanic episode?</td>
<td>![ ]</td>
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<tr>
<td>Answer: Bipolar disorder</td>
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<tr>
<td>9. Name a neurologic disease that can present as delirium.</td>
<td>![ ]</td>
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<tr>
<td>Answer: Stroke or severe hypertension</td>
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<tr>
<td>10. Name an endocrine disorder that can present as delirium.</td>
<td>![ ]</td>
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<tr>
<td>Answer: Thyroid or glucose dysregulation</td>
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<td>11. Which exam includes a review of cranial nerves, motor, sensory, reflexes, and</td>
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<td>coordination/gait?</td>
<td>![ ]</td>
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<tr>
<td>Answer: Neurological Exam</td>
<td>![ ]</td>
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<td>12. Which develops over a period of days (rather than weeks or months), delirium</td>
<td>![ ]</td>
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<td>or psychosis?</td>
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<tr>
<td>Answer: Delirium</td>
<td>![ ]</td>
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<td>Question</td>
<td>Answer</td>
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<tr>
<td>13. Name two neurologic conditions that can present as a psychiatric problem:</td>
<td>Vitamin B 12 deficiency, Cancer: brain tumor</td>
</tr>
<tr>
<td>14. When discontinuing amitriptyline or fluoxetine, it should be tapered over what period of time?</td>
<td>Over 2 weeks or more</td>
</tr>
<tr>
<td>15. What is the name of the form that guides the patient’s first mental health and physical health assessment after intake?</td>
<td>Initial Mental Health Evaluation Form</td>
</tr>
<tr>
<td>16. What is one of the essential interview skills for all patient interactions?</td>
<td>Ask open-ended questions</td>
</tr>
<tr>
<td>17. Which parts of the Initial Mental Health Evaluation Form does the physician fill out?</td>
<td>Medical review of systems, Physical Exam, Mental Status Exam</td>
</tr>
<tr>
<td>18. Which exam includes a review of speech, mood, affect, thought process, thought content, insight, and judgment?</td>
<td>Mental Status Exam</td>
</tr>
<tr>
<td>19. If a patient had a ZLDSI score of 20, what would be the correct course of action?</td>
<td>Refer to psychologist/SW for IPT</td>
</tr>
<tr>
<td>20. What is the name of the depression screening tool that provides a score that guides the provider through the Depression Care Pathway for a patient?</td>
<td>ZLDSI</td>
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<tr>
<td>21. How many “items” are on the ZLDSI depression screening tool?</td>
<td>13</td>
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<td>22. Name one important psychoeducation messages for patients.</td>
<td>Minimize alcohol use</td>
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<td>23. Mild depressive symptoms can often be treated with what?</td>
<td>Psychotherapy and psychosocial interventions alone</td>
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<tr>
<td>24. Amitriptyline is in what class of medication?</td>
<td>Tricyclic antidepressant</td>
</tr>
<tr>
<td>25. Fluoxetine is in what class of medications?</td>
<td>SSRI</td>
</tr>
</tbody>
</table>
26. What is most often due to simultaneous use of two serotonergic substances and can occur with dose increase of an SSRI?  
*Answer: Serotonin Syndrome*

27. What is the normal starting dose for fluoxetine?  
*Answer: 10–20 mg/day*

28. At what time of day should fluoxetine be taken?  
*Answer: Mornings*

29. What is the typical dose of fluoxetine?  
*Answer: 40 mg/day*

30. What is the maximum dose of fluoxetine?  
*Answer: 80mg/day*

31. Because amitriptyline can cause side effects that include constipation, urinary difficulties, and dry mouth, patients taking it should be advised to do what?  
*Answer: Drink lots of water*

32. What is the normal starting dose for amitriptyline?  
*Answer: 25 mg/day*

33. At what time of day should amitriptyline be taken?  
*Answer: At bedtime*

34. What is the typical dose of amitriptyline?  
*Answer: 50–75 mg/day*

35. What is the maximum dose of amitriptyline?  
*Answer: 200mg*

36. Two of the severe side effects of fluoxetine and amitriptyline can include manic symptoms and suicidal ideation. If this happens, what should you do?  
*Answer: Stop the drug immediately*

37. The care of youth with depression is important for a number of reasons, particularly their risk of suicide. What percentage of depressed adolescents attempt suicide?  
*Answer: 30%*
DEPRESSION BINGO REVIEW GAME—CARDS FOR PARTICIPANTS

Print/photocopy two copies of each card (or enough so that each participant has one). There are ten cards in this annex; each is slightly different.

<table>
<thead>
<tr>
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<tr>
<td><strong>Delirium Tremens</strong></td>
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<tr>
<td>Mental Status Exam</td>
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<tr>
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<tr>
<td>20%</td>
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<tr>
<td>Disturbance of Consciousness, Reduced Awareness with Cognitive Deficit</td>
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## BINGO

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<thead>
<tr>
<th>Mornings</th>
<th>Stroke or Severe Hypertension</th>
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<th>SSRI</th>
<th>At Bedtime</th>
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<td>Refer to Physician to Consider Medication</td>
<td>Neurological Exam</td>
<td>30%</td>
<td>10–20 mg/day</td>
<td>Bipolar Disorder</td>
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<td>Drink Lots of Water</td>
<td>Delirium</td>
<td><strong>FREE</strong></td>
<td>Tricyclic Antidepressants</td>
<td>Stop the Drug Immediately</td>
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<tr>
<td>200 mg</td>
<td>Vitamin B12 Deficiency and Cancer: Brain Tumor</td>
<td>Over 2 weeks or More</td>
<td>40 mg/day</td>
<td>Refer to Psychologist/SW for IPT</td>
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<td>20%</td>
<td>13</td>
<td>Minimize Alcohol Use</td>
<td>80 mg/day</td>
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<th>Ask Open-ended Questions</th>
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<th>40 mg/day</th>
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<td>20%</td>
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</tr>
<tr>
<td>Tricyclic Antidepressants</td>
<td></td>
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</tr>
<tr>
<td>13</td>
<td></td>
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</tr>
<tr>
<td>40 mg/day</td>
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<tr>
<td>30%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Serotonin Syndrome</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Thyroid or Glucose Dysregulation</td>
<td></td>
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</tr>
<tr>
<td>Mental Status Exam</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Vitamin B12 Deficiency and Cancer: Brain Tumor</td>
<td></td>
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<tr>
<td>Delirium Tremens</td>
<td></td>
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</tr>
<tr>
<td>Bipolar Disorder</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ask Open-ended Questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FREE</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25 mg/day</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Refer to Psychologist/SW for IPT</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Drink Lots of Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delirium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 2 weeks or More</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mornings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4–6 Weeks</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Disturbance of Consciousness, Reduced Awareness with Cognitive Deficit</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ZLDSI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimize Alcohol Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 mg/day</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10–20 mg/day</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## BINGO

<table>
<thead>
<tr>
<th>Serotonin Syndrome</th>
<th>Stroke or Severe Hypertension</th>
<th>Medical Review of Systems, Physical Exam &amp; Mental Status Exam</th>
<th>SSRI</th>
<th>At Bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid or Glucose Dysregulation</td>
<td>Delirium</td>
<td>ZLDSI</td>
<td>Mornings</td>
<td>4–6 weeks</td>
</tr>
<tr>
<td>Same Day</td>
<td>Ask Open-ended Questions</td>
<td>FREE</td>
<td>25 mg/day</td>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>Over 2 Weeks or More</td>
<td>Request for Consultation Form</td>
<td>Psychotherapy and Psychosocial Interventions Alone</td>
<td>Stop the Drug Immediately</td>
<td>Drink Lots of Water</td>
</tr>
<tr>
<td>Disturbance of Consciousness, Reduced Awareness with Cognitive Deficit</td>
<td>Elderly</td>
<td>Minimize Alcohol Use</td>
<td>80 mg/day</td>
<td>Patient Encounter Form</td>
</tr>
</tbody>
</table>
### DEPRESSION CHECKLIST

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

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

Initial Visit
Follow-Up Visit

Date: __________________________
Patient Name: __________________
Patient DOB: ________________
CHW/Nurse Name: ______________
Psychologist/SW Name: __________
Physician Name: _______________  

INSTRUCTIONS:
1. This form is to document the patient’s care experience. It is for quality assurance and monitoring/evaluation. The psychologist is responsible for helping other clinicians complete it.
2. Use of this form is required by Zanmi Lasante. Failure to use this form will result in professional consequences.
3. Make sure you mark the patient’s name and DOB and the date
4. For the diagram on this page, document which role providers were involved in the patient’s care by marking the box next to the role provider.
5. Document whether this is an initial or follow-up visit by marking the correct box.
6. The psychologist must mark the checklist on the other side when completing their work and when collaborating with CHWs and physicians. The checklist ensures complete, quality care.

THANK YOU
<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>2</td>
<td>Santi kè sere.</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Kalkile twòp.</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Kriye oubyen anvi kriye</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</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>
</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>
</tr>
<tr>
<td>7</td>
<td>Gen difikilte pou dòmi pran ou.</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</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>
</tr>
<tr>
<td>9</td>
<td>Ou pa gen apeti.</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</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>
</tr>
<tr>
<td>11</td>
<td>Fè mouvman oubyen pale tèlman dousman, menm lòt moun we sa.</td>
<td>0</td>
<td>—</td>
<td>1</td>
<td>2</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>
</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>
</tr>
</tbody>
</table>

**Totals**

(+) (+) (+)

(=) **ZLDSI Score** _______
PARTNERS IN HEALTH –
MENTAL HEALTH AND PSYCHOSOCIAL SERVICES
REQUEST FOR CONSULTATION FORM

Date: ___________ Referring Provider: ____________________________ Recipient (Provider): ____________________________
Recipient’s telephone: ____________________________

Patient Information
First Name: ____________________________ Nickname: ____________________________ Last Name: ____________________________
Dossier Number: ____________________________ Date of Birth: ____________________________ Sex: ____________________________
Telephone: ____________________________
Address: ____________________________

Principal Symptoms: ____________________________

<table>
<thead>
<tr>
<th>Reasons/Diagnostic Impressions:</th>
<th>Services requested:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Psychological trauma</td>
<td>• Psychological Evaluation</td>
</tr>
<tr>
<td>• Sexual abuse</td>
<td>• Psychotherapies</td>
</tr>
<tr>
<td>• Suicide attempt</td>
<td>• Grief, supportive</td>
</tr>
<tr>
<td>• Psychiatric emergency</td>
<td>• Interpersonal therapy</td>
</tr>
<tr>
<td>• Mental confusion</td>
<td>• Psychotraumatology</td>
</tr>
<tr>
<td>• Psychosis/bipolar disorder</td>
<td>• Counseling</td>
</tr>
<tr>
<td>• Behavioral disorders</td>
<td>• Pre-Operative</td>
</tr>
<tr>
<td>• Somatoform disorders</td>
<td>• Post-Operative</td>
</tr>
<tr>
<td>• Affective disorders</td>
<td>• Post-test</td>
</tr>
<tr>
<td>• Enuresis</td>
<td>• Follow-up</td>
</tr>
<tr>
<td>• Encopresis</td>
<td>• Adherence</td>
</tr>
<tr>
<td>• Learning disorder</td>
<td>• Pre-HAART</td>
</tr>
<tr>
<td>• Mental retardation</td>
<td>• Other: ____________</td>
</tr>
<tr>
<td>• Addiction</td>
<td>• IMPORTANT HISTORY: ____________________________</td>
</tr>
<tr>
<td>• Epilepsy</td>
<td>____________________________</td>
</tr>
<tr>
<td>• Depression</td>
<td>____________________________</td>
</tr>
<tr>
<td>• Depression and migraines</td>
<td>____________________________</td>
</tr>
<tr>
<td>• Other: ____________</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

Signature of referring provider: ____________________________

Mental health provider that received the referral: ____________________________

Date of receipt: ____________________________ Time: ____________________________

Remarks: ____________________________

Signature: ____________________________
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>• Did you feel very happy for any reason in the last few days?</td>
<td>• What do you worry about?</td>
<td></td>
<td>• Do you see things that other people don’t see?</td>
</tr>
<tr>
<td>• Do you feel like you’ve lost interest in everything or only in some things?</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>
<td></td>
</tr>
<tr>
<td>• Do you:</td>
<td>◯ Panic attacks</td>
<td></td>
<td>• Do you feel dizzy</td>
</tr>
<tr>
<td>◯ Have any difficulties of staying attentive?</td>
<td>◯ Fear of crowded places</td>
<td></td>
<td>◯ feeling dizzy</td>
</tr>
<tr>
<td>◯ Speak of things that you shouldn’t?</td>
<td>◯ Sleep problems</td>
<td></td>
<td>◯ feel like you’re losing consciousness</td>
</tr>
<tr>
<td>◯ Feel like you’re worth more than before?</td>
<td>◯ Difficulty concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◯ Have a racing thoughts going through your head?</td>
<td>◯ Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◯ Have an increase in activities?</td>
<td>◯ Irritability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◯ Sleep less?</td>
<td>◯ Muscle tension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>◯ Talk without ceasing?</td>
<td>◯ Restlessness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Zanmi Lasante Depression Symptom Inventory (ZLDSI):**

| • Do you often experience any 4 of these problems such as: | |
| ◯ increased in heartbeat | |
| ◯ breathlessness | |
| ◯ sweating | |
| ◯ trembling | |
| ◯ fear; fear of losing control; fear of becoming crazy; fear of death | |
| ◯ feeling dizzy | |
| ◯ feel like you’re losing consciousness | |

• Are you a worrier?
• What do you worry about?
SUBSTANCE ABUSE

Do you use any of the following?

<table>
<thead>
<tr>
<th></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>Past</td>
<td></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>
<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></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>Past</td>
<td>□</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>
<td>□</td>
</tr>
</tbody>
</table>

If yes, explain:

Do you feel safe in your current environment? ______________________________

SUICIDE

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

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

VIOLENCE/HOMICIDE

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></th>
<th>Ideation</th>
<th>Acts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Present</td>
<td>□ Yes</td>
<td>□ 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
### 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></td>
<td></td>
<td>• Is there a change in your:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Weight?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Thirst?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fever?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Are you experiencing pain in your body?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sight problems?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hearing problems?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Voice change?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></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>☐</td>
<td>Are you having problems breathing?</td>
<td>• Do you have an increased heartbeat?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Are you coughing?</td>
<td>• Having chest pain?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Do you cough out blood or find blood in your snot?</td>
<td>• Any swelling?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Any changes in your skin?</td>
<td>• Heart burn?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Gastric Reflux?</td>
<td>• Vomiting?</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Constipation, diarrhea, gas?</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/URINATION</th>
<th>NEUROLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Are they stiff?</td>
<td>• Swollen?</td>
<td>• Any numbness?</td>
</tr>
<tr>
<td>☐</td>
<td>Swollen?</td>
<td>• Do you have any STDs causing discharge (more than usual) in your genitals? How much? How often?</td>
<td>• Uncontrolled movements?</td>
</tr>
<tr>
<td>☐</td>
<td>Reddened?</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  

---

**Partners In Health | FACILITATOR MANUAL | ANNEX**
## 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>
</tbody>
</table>

| Affect             | euthymic | dysphoric | euphoric | anxious |
|                   | irritable | suspicious | labile | flat |
|                   | congruent with speech content | incongruent with speech content | other: | |

| Thought Process    | linear | tangential | perseverative | illogical |
|                   | loose associations | | |

| Thought Content    | WNL | vague |              |          |
|                   | | | | |
|                   | persistent preoccupation with: | | |
|                   | | suicidal ideation | | |
|                   | | homicidal ideation | | |
|                   | Delusions: | | |
|                   | | none | paranoid | grandiose | other: |
|                   | Perceptual Disturbances/Hallucinations: | | |
|                   | | none | auditory | visual | olfactory | gustatory |
|                   | | tactile | | |

| Insight:           | poor | limited | good | |

| Judgment/Impulse Control: | poor | limited | good |

General Impressions: ________________________________

BIOPSYCHOSOCIAL FORMULATION (including patient’s strengths and coping strategies): ________________________________
DIAGNOSIS:

Axis I: ____________________________________________________________

Axis II: ___________________________________________________________

Axis III: __________________________________________________________

Axis IV: __________________________________________________________

PLAN/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)
## FLUOXETINE

**Antidepressant, SSRI: depression, anxiety**

Use for: depression, anxiety, post-traumatic stress disorder

**DO NOT USE IF**
- Manic
- Manic, cardiac arrhythmia
- Caution in elderly; caution if patient is suicidal as fatal in overdose

**MUST CONSULT MENTAL HEALTH TEAM**
- Prior history of mania, heart condition

**Starting Dose (Adult)**
- Dosing Forms: 20 mg capsules
- Dosage: Start with 20 mg every morning
- Typical maintenance dosage: 50-75 mg daily

**“Step” of Uptitration**
- If necessary, increase by 20 mg increments each month until a maximum of 80 mg daily.

**Maximum Dose**
- 80 mg

**Toxicities**
- *If rash, stop medication and return to hospital*
- Serious: Special warning: serotonin syndrome may occur for 4-6 weeks

**Serotonin Syndrome**
- Mostly this is because of the use of two serotonin drugs simultaneously eg. SSRI’s such as fluoxetine, carbamazepine, tramadol, amitriptyline, pentazocine, lithium or cocaine.
- It can happen when increasing the dose of a single drug, such as fluoxetine.
- Symptoms may include at least three of the following: restlessness, ataxia, diaphoresis, diarrhea, hyperreflexia, change in mental state, mydriasis, tremor, or hyperthermia. Need to distinguish between the serotonin syndrome and neuroleptic malignant syndrome that is characterized by rigidity and slowed movements.
- **Treatment:** to stop serotonin medications, use ice, antipyretic drugs, fans in case of fever, and rehydration if the patient is dehydrated. Treat other vital sign abnormalities as needed.

**Common**
- Agitation
- Transient nausea
- Jitters
- Restlessness
- Drowsiness
- Headache
- Nausea
- Insomnia
- Sexual Dysfunction (which can decrease after a few weeks)

**Tapering/Discontinuing**
- Taper gradually over 2 or more weeks.
- Antidepressant withdrawal syndrome can include insomnia, anxiety, irritability, nausea, headache.

**Breastfeeding**
- Safety unknown; caution advised.

## AMITRIPTYLINE

**Tricyclic antidepressant: depression, anxiety, migraine, neuropathic pain**

Use for: depression, anxiety, post-traumatic stress disorder, migraines, neuropathic pain

**DO NOT USE IF**
- • Manic, cardiac arrhythmia
- • Caution in elderly; caution if patient is suicidal as fatal in overdose

**MUST CONSULT MENTAL HEALTH TEAM**
- Prior history of mania, heart condition

**Starting Dose (Adult)**
- Dosing forms: 25 mg tablets
- Dosage: Start with 25 mg at bedtime
- Typical maintenance dosage: 50-75 mg daily

**“Step” of Uptitration**
- If necessary, increase by 25 mg increments every two weeks until a maximum of 200 mg daily.

**Maximum Dose**
- 300 mg

**Special warnings:** less well tolerated than Fluoxetine. Risk of death in overdose. High risk of arrhythmias and sudden death due to prolonged QT interval and also high risk of myocardial infarction. For patients over 40 years, we must obtain the history of symptoms of arrhythmia, disorders of the cardiac conduction system, diseases of the coronary arteries and make an electrocardiac examination before starting treatment.

**Common**
- Agitation
- Transient nausea
- Jitters
- Restlessness
- Drowsiness
- Dizziness
- Sedation
- Dry Mouth
- Blurred Vision
- Constipation
- Urinary Retention
- Tachycardia
- Confusion
- Delirium (especially among the elderly)

**Tapering/Discontinuing**
- If there is a life-threatening/toxic side effect, stop immediately.

**Breastfeeding**
- Probably safe; caution advised.
## Mental Health Follow-Up Form

**File Number:**

**EMR Number:**

**Location:**

**Date:**

**DD/MM/YYYY**

<table>
<thead>
<tr>
<th>File Number:</th>
<th>EMR Number:</th>
<th>Location:</th>
<th>Date:</th>
</tr>
</thead>
</table>

### 1. Initial Diagnosis

**Initial Diagnosis:**

Contacts since the last visit:

- Patient
- Parent
- Family
- Medication
- CHW
- Other

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

### 3. Ongoing psychotherapy (Progress)

**ZLDSI score for depression (if present):**

**Date of last menstrual period:**

**DD/MM/YYYY**

**Current medications**

- Yes
- No

<table>
<thead>
<tr>
<th>Medication/s</th>
<th>Dose/Freq</th>
<th>Side Effects</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

- Yes
- No
- Inc
## 4. Mental Status Examination

<table>
<thead>
<tr>
<th>General appearance wnl</th>
<th>Yes</th>
<th>No</th>
<th>Mood disorder</th>
<th>Yes</th>
<th>No</th>
<th>Danger to self, suicidal</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech wnl</td>
<td>Yes</td>
<td>No</td>
<td>Poor introspection</td>
<td>Yes</td>
<td>No</td>
<td>Danger to others</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Behavior wnl</td>
<td>Yes</td>
<td>No</td>
<td>Thought process wnl</td>
<td>Yes</td>
<td>No</td>
<td>Anxiety, phobia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscle tone and strength</td>
<td>Yes</td>
<td>No</td>
<td>Thought content wnl</td>
<td>Yes</td>
<td>No</td>
<td>Poor judgement</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cognitive function wnl</td>
<td>Yes</td>
<td>No</td>
<td>Affect wnl</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Observations from the mental health examination:

## 5. Positive results from the physical examination/labs:


## 6. Diagnosis (DSM-IV):


## 7. Response to recent interventions:


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

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

## 9. Other recommendations (if necessary)


10. Plan

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

Name of the person completing the evaluation: ___________________________  Date: ___________________________
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.