Introduction to Mental Health and Depression
Curriculum for Psychologists and Social Workers
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 Dubuisson. 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.

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Design: Mara Seibert 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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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 to 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, psychologists and social workers will understand how to work hand-in-hand with community health workers, nurses, and physicians 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/ebwha/pdf_files/EB130/B130_9-en.pdf
OBJECTIVES

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

a. Describe the epidemiology of depression
b. List the responsibilities of the psychologist/social worker in the depression care pathway
c. Describe the importance of mental health care within a human rights context
d. Identify stigma surrounding mental illness and its impact on patient care and outcomes
e. Apply the biopsychosocial approach to depression diagnosis and care
f. List the four sign and symptom areas (ABCDs) of depression
g. Describe differential diagnoses of illnesses related to depression
h. Explain how to approach and evaluate suicidal patients
i. Identify the importance of performing a medical evaluation before a mental health evaluation
j. Define delirium
k. Identify the most common medical conditions and mental illnesses that can present with depression-like symptoms
l. Correctly complete the Patient Encounter Form
m. Model appropriate interviewing skills
n. Correctly complete the psychologist/social worker sections of the Initial Mental Health Evaluation
o. Conduct the Zanmi Lasante Depression Screening Inventory
p. Explain the collaboration between the physician and psychologist/social worker in evaluating patients with symptoms of depression
q. Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.
r. Provide an overview of the general principles of Interpersonal Psychotherapy (IPT)
s. Outline the key steps in each of the three phases of IPT
t. Discuss the strategies used during IPT to help patients deal with depression and prevent future episodes of depression
u. Facilitate initial, middle and termination phase IPT sessions
v. Describe the non-pharmacologic and pharmacologic treatment options for depression
w. Provide psychoeducation messages about medication use to patients
x. List the indications, dosage, mechanism of action, and adverse effects of depression medications amitriptyline and fluoxetine
y. List the key psychoeducation messages for patients with depression
z. Explain the process of follow up for people living with depression
aa. Correctly complete the psychologist/social worker sections of the Follow Up Form
ab. Describe how to use mhGAP for the management of depression.
ac. Describe how to use mhGAP for the management of self-harm/suicide.
Epidemiology of Depression and Stigma

Mental Illness and Health

Health is defined by the WHO as “a state of complete physical, mental and social well-being”. Good mental health is part of good health. More than just an absence of mental disorders, mental health is a state of well-being whereby individuals recognize their abilities, are able to cope with normal stresses of life, work productively and fruitfully, and make a contribution to their communities.

If someone does not have good mental health, that person is considered to have a mental health disorder or mental health problem.

Depression—Leading Cause of Disease

Depression is common worldwide, in all countries and cultures. Unipolar depressive disorders was the third leading cause of burden of disease globally in 2004. But, it is expected to be the leading cause of burden of disease globally by 2030.3

Psychosocial risk factors include:

• Poor social supports

• Early parental loss

• Introversion

• Female gender

• Recent stressor (especially medical illness)

Treatment Gap

The gap between the need for treatment and treatment provision is wide.

• Low- and middle-income countries: between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem.

• High-income countries: between 35% and 50% receive no treatment.4


Universal Declaration of Human Rights

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 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.

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

Discussion Questions

• How do you think the concept of human rights is applied (or not applied) to people living with mental disorders in Haiti?

• How do you think that you could make things better?

Stigma and Discrimination

Many Haitian families are denied their basic human rights. People with mental health problems are particularly vulnerable to denial of their rights, health, and well-being.

Community members, health providers, and sometimes even religious leaders sometimes stigmatize people with mental disorders. In some cases, stigma can cause these people to discriminate against people with mental disorders. Discrimination can lead to neglect, physical abuse, denial of health care, and other abuses.

Discussion Questions

• 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?
Diagnosis of Depression

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.

Basic Risk Factors for Mental Health Problems

- Biological factors:
  - Chronic health problems (example: HIV)
  - Brain damage/head trauma
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 2 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?
2. What other issues must be considered or explored in this case?

Adapted from: Sekhar, Deepa. 2000. Major Depressive Disorder in Adolescence: a case study. Available at: www.brown.edu/Courses/BI.../Deepa%20Sekhar.doc

### Biology: Causes

Depression involves abnormal functioning of neurotransmitters, including:
- Monoamines (serotonin, norepinephrine, and dopamine)
- Gamma-aminobutyric acid (GABA)
- Glutamate

Genes contribute vulnerability toward depression:
- More prevalent in first degree relatives
- Concordance is greater in monozygotic than dizygotic twins
- Increased prevalence of alcohol dependence in relatives

Depression typically requires additional non-genetic factors to produce the disorder.

### ABCDs of Major Depressive Disorder

Generally, when considering how to think about and describe symptoms and signs of depression, four symptom areas should be considered: the ABCDs.

**A**ffect and mood
- Affect: facial, vocal, or gestural indicators of feeling or emotion
- Mood: the patient’s emotional state (ex: happy, sad, irritable, angry)

**B**ehavior
- The actions and mannerisms of the patient interacting with the environment
Cognition and perception
- Cognition: processing of information, applying knowledge, and changing preferences
- Perception: process of attaining awareness or understanding of the environment by organizing and interpreting sensory information

Development:
- Normal milestones are unmet
- Life events or circumstances can precipitate mental health crises
- Mental illness can cause impairment in functioning

The Signs and Symptoms of Major Depressive Disorder
Affect and mood: Look sad, feel sad, feelings of worthlessness.

Behavior: Psychomotor slowing, lack of interest in engaging in pleasurable activities, lack of energy, insomnia or hypersomnia

Cognition and perception: Difficulty concentrating, persistent guilty ruminations, thoughts of suicide

Development: Difficulties carrying out usual work, school, domestic or other areas of functioning

Diagnosing Severe Depression
When diagnosing moderate-severe depression, assess:
- If the patient has had symptoms over the past two weeks
- If, over the past two weeks, the patient has had difficulties in day-to-day functioning due to the symptoms

The following suggests severe depression:
- ZLDSI > 18 OR
- Suicidal Ideation OR
- Alters operation (unable to work/go to school, inability to maintain social relationships/family, inability to take charge) OR
- Presence of psychosis

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.
Other Disorders

Dysthymia
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.

Bipolar Disorder
Requires a history of at least one manic or hypomanic episode. Mood fluctuates between depression and hypomania or mania, and depression can also be accompanied by psychosis in certain instances.

Adjustment Disorder with Depressed Mood
May be diagnosed when there is an identifiable psychosocial stressor and the symptoms do not meet full criteria for major depressive disorder.

Somatization Disorder
A chronic syndrome of: recurring multiple somatic complaints not explained medically. Across cultures, the majority of patients with depression present only with somatic symptoms, half of these with multiple unexplained symptoms

- Associated with psychological distress
- Associated with medical help-seeking behaviors
- Tends to occur more in poor, rural populations
Inquire about childhood histories of missing or disaffected parents, or of sexual or physical abuse.

Conversion Disorder
Conversion disorder is a loss or change in sensory or motor function that is suggestive of a physical disorder but caused by psychological factors.

Common symptoms: paralysis, aphonia, non-epileptic seizures, disturbances of gait and coordination, blindness, tunnel vision, and anesthesia

Evidence of a psychological cause:

- Temporal relationship between symptom onset and environmental precipitants or stressors
Panic Disorder

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

Characterized by excessive worry and anxiety, more days than not, for six months. Person has trouble controlling these anxieties or worries.

Post-Traumatic Stress Disorder

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.
Medical Evaluation and Management of Depression

Key Points Before Considering a Patient “Psychiatric”

- We must have all of the medical information we can possibly have before making a psychiatric diagnosis
- Exclude delirium and other medical and neurologic causes before diagnosing a psychiatric illness
- Never treat a psychiatric problem until you know what the problem is

Delirium

A disturbance of consciousness, or a reduced awareness of the environment that develops over a period of days and often fluctuates throughout the day. This disturbance is accompanied by cognitive deficits, or problems in thinking. Delirium may be substance-induced, or due to a medical condition, including cardiac, neoplastic and infectious illness.

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

Activity

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<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
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<td>1. What are the symptoms of alcohol withdrawal?</td>
<td>1. What drugs and poisons can cause psychiatric symptoms if ingested?</td>
<td>1. What medical conditions, unrelated to alcohol and drugs, can mimic a psychiatric illness?</td>
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<td>2. Who do you think is at risk of alcohol withdrawal? Why do you say this?</td>
<td>2. Who do you think is at risk of drug or poison ingestion/overdose? Why do you say this?</td>
<td>2. Who do you think is at risk of these medical conditions? Why do you say this?</td>
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<tr>
<td>3. How would you differentiate between the patient with depression and the patient with alcohol withdrawal?</td>
<td>3. How would you differentiate between the patient with depression and the patient experiencing a drug overdose/poisoning?</td>
<td>3. How would you differentiate between the patient with each of these medical conditions and a patient with depression?</td>
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**Do a Physical Examination First!**

- The patient must be referred to the physician for a complete physical exam and to check other medical symptoms

- The physician will evaluate the medical causes of depression (hypothyroidism, anemia, drugs, HIV) and comorbidities through the case history, physical examination, laboratory examination

- The physician will document findings in the Initial Mental Health Evaluation Form

- The mental health team should be alert to need for rapid medical attention

**Components of the Physical Examination**

- Vital signs (temperature, heart rate, pulse)

- HEENT (head, eyes, ears, nose, and throat)

- Chest/Lungs

- Cardio-vascular

- Abdomen

- Genital

- Extremities

- Skin

- Lymph nodes

- Neurological examination

**Activity—Patient Encounter Form**

A. Patient 1 is homicidal, trace her pathway on the patient encounter form.

B. Patient 2 has just been diagnosed by the physician as having epilepsy, trace his pathway on the patient encounter form.

C. Patient 3 is suicidal, trace his pathway on the patient encounter form.
Initial Mental Health Evaluation

As a psychologist/social worker you should know how to work with the physician to ensure that all sections of the initial mental health evaluation form are completed. This includes chief complaint, history of present illness, psychiatric review of systems, past psychiatric and medical histories, physical exam/mental status exam, biopsychosocial formulation, diagnosis and treatment plan.

Mental Health Care: General Principles

• Do no harm
• Protect the autonomy, and the safety of the patient
• Maintain therapeutic boundaries with the patient
• Obtain a good history of the presenting problem
• Before psychiatric diagnosis, adequate medical evaluation is necessary
• Protect patient confidentiality
• Prioritize, where possible the least restrictive means for providing treatment
• Provide the patient and family with clear information about diagnosis, recommended treatments, and treatment alternatives
• Be aware of your own reactions to a patient. Protect the patient from your own emotional states. Do not let the patient feel judged.
• Before psychiatric diagnosis, adequate medical evaluation is necessary

Basic Interview Skills

• Speak with the person in a place that promotes confidentiality and makes the person feel safe
• Be sensitive; respect the person’s emotional vulnerability
• Be aware of your own reactions to a patient. Protect the patient from your own emotional states.
• Do not let the patient feel judged.
• 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
• Learn the person’s whole story
• Meet the person at her or his energy level
• Follow the person’s lead about religion and spirituality

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.

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

Patient: responds according to the story

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

Patient: responds according to the story

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

Patient: responds according to the story
INTERVIEW ROLE PLAY 1: JOSIE

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

Patient: responds according to the story

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

Patient: responds according to the story

Psychologist: 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

INTERVIEW ROLE PLAY 2: CATHELINE

Your patient, Catheline, is a 45-year old woman whose daughter died giving birth 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.

INTERVIEW ROLE PLAY 3: EMMANUEL

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.

INTERVIEW ROLE PLAY 4: GABY

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.
Initial Mental Health Evaluation Form

The psychologist/social worker would typically complete everything on the Initial Mental Health Evaluation Form with the exception of the sections completed by the physician, which are:

- Medical review of systems
- Physical Exam
- Mental Status Exam

The goal of taking a thorough history is to obtain a range of information by moving from the open-ended to the specific. The evaluation form contains specific questions to assist you in obtaining specific information related to a range of possible mental disorders.

Eliciting the history of present illness:

- Could you briefly describe the events or circumstances that led to your coming to the hospital?
- What is your understanding of why these things have happened/what the problem is? Why do you think these things are happening?
- Can you tell me a little bit more about (problem/symptom/illness)? (explore chronology of events)
- Are you currently treated for this (problem/symptom/illness)? How? Are you taking any medications for this? Have you even taken any medication for this?

Summary, Formulation and Decision Making

- Who is this person?
- Why is he/she seeking help now?
- Who are the significant people in his/her life?
- What BIOLOGICAL, SOCIAL and PSYCHOLOGICAL factors are playing a role in the patient’s illness?
- What are their strengths and protective factors?
- Has he/she received any treatment in the past, and what were the outcomes?

The biopsychosocial formulation and diagnosis sections of the evaluation form may be completed after the patient leaves the office. The biopsychosocial section should include the psychologist/social workers overall assessment of the patients strengths and coping strategies. The psychologist/social worker should record here key observations that will assist with the therapy, psychoeducation including medication adherence support or any other part of the plan.
The ZLDSI

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. 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 provider should also be sure to take his/her time when eliciting patient responses, and not rush through the questions.

How to Use the ZLDSI

- Find a quiet, discrete place to ask the questions
- Begin by saying: “I am now going to ask you some questions about how you have been feeling in a number of ways. In responding to the questions I’d like you to think about the past few weeks.”
- Begin at the top left of the ZLDSI, ask the first question, followed by item 1
- Let the patient respond
- Circle the number of the response provided
- Re-prompt the four descriptors after each question
- When done with the questions, add the numbers to obtain a numerical score

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.
### 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.

#### 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.

Available at: http://www.psyweb.com/Casestudies/CaseStudies.jsp
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 is 13. What is your course of action?

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?
Managing the Suicidal Patient

Suicide is the act of deliberately killing oneself.

Self-harm is a broader term referring to intentional self-inflicted injury, which may or may not have a fatal intent or outcome.

Psychologists/social workers have the responsibility within the system of care to evaluate and properly screen patients for suicidality. If the patient does have a history of suicide attempts, as determined during the Initial Mental Health Evaluation, the psychologist/social worker will immediately use the Suicidality Screening Instrument to determine the patient’s level of risk.

If it is not immediately apparent if the patient has a history of suicide attempts, but there is a concern about the possibility of self-harm (either because of a history of self-harm, or because the patient didn’t preclude the possibility during the Initial Mental Health Evaluation, or for any other reason), the psychologist/social worker should also administer the Suicidality Screening Instrument.

Any person over 10 years of age experiencing any of the following conditions should be asked about thoughts or plans of self-harm in the last month and about acts of self-harm in the last year:

- Mental illness, including depression, but also psychosis, bipolar, adolescent behavioral disorders, alcohol/drug use
- Chronic pain
- Acute emotional distress

Evaluate thoughts, plans and acts of self-harm during the initial evaluation and periodically thereafter as required. Attend to the person’s mental state and emotional distress.
|
|---|
|**ROLE PLAY**|

**Psychologist/Social Worker:** Hello Emmanuel.

**Patient:** Hello.

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

**Patient:** OK.

**Psychologist/Social Worker:** Sometimes, when things are particularly difficult, some people have thoughts of not wanting to live. Over the last two weeks, have you wished you were dead?

**Patient:** No.

**Psychologist/Social Worker:** Over the last year, have you wished you were dead in the past year?

**Patient:** Yes.

*Interview continues because patient said yes.*

**Psychologist/Social Worker:** Over the last two weeks, have you had thoughts of killing yourself?

**Patient:** No.

**Psychologist/Social Worker:** Over the past year, have you had thoughts of killing yourself?

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

*Interview continues because patient said yes.*

**Psychologist/Social Worker:** Over the last two weeks, have you been thinking of ways to do this?

**Patient:** No.

**Psychologist/Social Worker:** Over the past year, have you been thinking of ways to do this?

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

*Interview ends because patient said no to each column of a question.*
Safety Plan

All patients who are screened for suicidality, whether low risk or high risk, need a safety plan. A safety plan is a plan, collaboratively developed by the patient and psychologist/social worker that supports patients to decrease their risk of suicide.

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

Plan’s six essential components:
Recognize warning signs of a suicidal crisis about to happen.

1. Identify & employ internal coping strategies without needing to contact another person
2. Utilize contacts with people as a means of distraction from suicidal thoughts & urges
3. Contact friends or family members who can help resolve a crisis & with whom suicidality can be discussed
4. Contact mental health professionals or agencies
5. Reduce potential use of lethal means

The most important aspect of the safety plan is its accessibility and ease of use. A safety plan will not be helpful if there are obstacles in the plan that the patient cannot overcome. The psychologist’s/social worker’s role is to discuss with the patient the feasibility of each step in the plan so the patient is prepared.
Basics of Interpersonal Psychotherapy (IPT)

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

Background information on common techniques:

- Interpersonal therapy:
  a. Effective for depression.
  b. Addresses relationships in the “here and now,” with a focus on four areas: grief; role transitions; role disputes; and interpersonal deficits.

- Supportive psychotherapy:
  a. Aims to minimize levels of emotional distress.
  b. 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.

- Cognitive-behavioral therapy:
  a. First-line treatment for anxiety and mild depression.
  b. Based on the theory that antecedent events stimulate thoughts and beliefs that cause emotional consequences. Problem-oriented.

- Family Therapy:
  a. Problems exist in family interactions and not just in individuals.
  b. Solutions involve improving communication, reframing of behaviors and giving directives to disrupt dysfunctional patterns.
IPT: General Principles

• A time limited treatment for depression

• Makes explicit the diagnosis of depression and the treatment plan

• Stresses to the patient that he/she is not to blame for having depression

• Therapy goes back to point in time in patient’s life when current depression began

• IPT helps persons express both positive and negative feelings about their problems.

• It focuses on:
  – “Here and Now”
  – People who are important in a person’s life
  – The link between the person’s depression and current problems
  – Finding new ways to deal with these problems

Problems Associated with Depression

• One or more of four problems are associated with the onset of depression

  – Grief - death of a loved one
  – Disputes – unsolvable disagreement with someone important
  – Transitions – any life change, bad or good
  – Loneliness and Social Isolation – feeling lonely, bored and/or cut off from others

Grief

• Symptoms start around time of the death or in the following months

• Person cannot stop thinking about the dead person

• Normal grief: depressive symptoms go away in a few months

  – The person does not feel guilty or suicidal

• Unresolved grief: symptoms are prolonged, associated with impairment

• Goals of therapy:

  – Help person mourn their loss
  – Help him/her find other activities/people to make life better
Disputes

• Depression symptoms are connected to an ongoing disagreement with someone important

• Stages of disagreement:
  – Renegotiation
  – Impasse
  – Dissolution

• Goals of therapy:
  – Help person decide what he wants in the relationship
  – Figure out the stage of the disagreement
  – Develop new skills for negotiation

Life Changes

• Depression connected to difficulty managing new situation

• Not all life changes are negative
  – Even positive life changes (ex., marriage or birth of child) can lead to depression

• Adjusting to life changes means understanding the losses and gains that the new situation presents.

• Goals of therapy:
  – Help person recognize her feelings (sadness and anger, confusion, powerlessness about the change)
  – Learn the skills necessary for the change, including finding advocates/supporters who can help
  – See what is positive about the change

Social Isolation

• Person has a history of problems making friends and/or keeping them

• Person talks about feeling lonely and feeling separate from others

• The feelings are not connected to anything that has happened recently but have been felt for a long time
• Goals of therapy:
  – Help the person make friends by learning how to start and keep friendships and identify obstacles to forming friendships

**IPT: Three Phases**

• Initial phase (2 sessions), therapist:
  – Gets to know depressive symptoms
  – Explains what depression is
  – Begins to learn the problems associated with the onset of the symptoms

• Middle phase (6-12 sessions), therapist and patient:
  – Discuss the problems that triggered the depressive episode
  – Discuss strategies to improve symptoms and functioning

• Termination (2 sessions)
  – A summary of changes in symptoms and problems
  – Discussion about possible new problems that might bring about depression
  – Patients express feelings about finishing treatment.

**Tips For The Psychologist/Social Worker**

1. The therapist is not a friend.

2. Encourage clients to express their feelings about problems, even when those feelings are painful.

3. Gently bring the focus back to clients’ mood and interpersonal problem area(s) when they talk about something unconnected.

4. Get information by asking direct or open-ended questions.

5. Encourage clients to express feelings, including anger, sadness, guilt.

6. Make links between clients’ thoughts and feelings as well as between symptoms and what is going on in their lives.

7. Encourage clients to practice the new interpersonal skills they are developing between sessions.
**Interpersonal Psychotherapy (IPT): Practice**

**DEATH OF A LOVED ONE—GRIEF, CASE 1**

Paula is a 20 year old woman who has had two recent deaths in her family. Nine months ago her husband died of an unknown illness and four months ago her infant daughter also died. Paula just can’t get over their deaths. She cries every day, has trouble taking care of her two remaining children, she isn’t eating, can’t take care of her home, and feels that the future holds no happiness. She says that she never cried after her husband died because she didn’t have time. She was numb after her infant died. Her husband’s family took all of her possessions. When friends come to visit, Paula doesn’t want to talk and quickly finds reasons to have the friend leave. She stays at home whenever she can. Paula is fearful that she might die and leave her other children without any parent.

**DISAGREEMENTS—DISPUTES, CASE 2**

A 32 year old woman, Carol, is married with four children. Since she became sick with a medical illness nine months ago, she was unable to care for her children, husband, and home as she had in the past. She tires easily and frequently felt so sick that she could not get out of bed. Carol says that she and her husband have been arguing more over the past few months. Her husband criticized her because the house was dirty, the dinner was not cooked, and she was not herself. He did not seem to understand, she says, that she doesn’t feel well anymore. He wants to take another wife so that he will be happy. Carol says that their home just isn’t happy anymore. She feels like giving up. Carol cries every day, she’s not eating or sleeping, she’s angry all the time, and she feels that she’s letting her husband and children down.

**LIFE CHANGES—TRANSITIONS, CASE 3**

Susan is a 40 year old woman and mother of three children. Last year she and her family moved to another village. At first she was happy about the move because her husband had found a better paying job. For the past two months, Susan hasn’t felt as happy as she did when she first moved. She missed her old friends and did not feel close to her new friends. In her former town, Susan saw her two sisters and mother every day. Since the move she’s seen them only once. Her husband isn’t home as much as he was in his former job as he must work harder and longer hours. Susan finds that she’s angrier than ever before, she feels sad all the time, she doesn’t have any energy, and she can’t sleep at night. She wants to move back to her old home.
### DEATH OF A LOVED ONE—GRIEF, CASE 4

A married woman in her early 60s lives with her husband and was diagnosed to be depressed. The woman was initially resistant to the process of IPT, but finally agreed to begin treatment. The first HIV related death struck her home in 1990 and by 2002 she had lost six of her eight children. One year after the deaths of the children, her married son disappeared and after a while she received information that her daughter had also died. She did not know exactly what happened and never saw the body nor buried her son. Together with her husband they had educated their children up to university level and most of the dead were the wage earners for their families. During the initial phase of IPT, she spent most of the time crying, and very little time talking about her problems. She spoke slowly and reported having difficulties sleeping, loss of memory, walking, eating, was emotionally exhausted, fearful, sad and very angry. She mentioned that she was sick but did not know what she was suffering from.

### LIFE CHANGES—TRANSITIONS, CASE 5

A middle-aged man in a small village had his own business, which went bankrupt in 1992. He tried again but failed. At this point he felt useless and a failure as a man and became depressed. He began IPT treatment with the hope of dealing with his depression and finding something to do. During the initial phase, he was quiet and depressed. He saw his depression as clearly related to the difficulties associated with the failure in his business, which disrupted his life and left him with no role in the village.

### DEATH OF A LOVED ONE —GRIEF, CASE 6

The son of an old man died in the earthquake in Port-au-Prince. This son was his father’s sole helper. The old man began treatment in the hope of getting material help. According to him, the trigger for depression was grief plus the loss of assistance from his son. The belongings of the boy were still in Port-au-Prince, but the father didn’t have the money to collect them. This made him feel even worse.

### DISAGREEMENTS—DISPUTES, CASE 7

Maria lives a quiet life in Port-au-Prince with her husband of six years and three children. Her husband has been a good father to their children and a good wife to Maria. Two months ago, a new woman moved into the neighborhood and the husband confessed he is attracted to this new woman. Months later, Maria found out that her husband has been having an affair with this woman and he stopped providing money, food, and psychological support to their family.
LIFE CHANGES—TRANSITIONS, CASE 8

A depressed man in his late 50’s began IPT treatment to see whether it might help him feel better. In the initial phase, he told the therapist that his real problem was that he had been impotent for nine years since developing prostate cancer. His illness and impotence brought about his divorce. He told his story of how he learned about his prostate cancer and when his sexual problem began.


**Medication Management and Other Treatments for Depression**

**Treatment: General Principles**

- Both psychosocial and psychopharmacologic treatments of depression are effective

- Mild depressive symptoms can often be treated with psychotherapy and psychosocial interventions alone.

- Moderate and severe depression are best treated with a combination of medication, psychotherapy and social support.

As per the depression care pathway, the physicians should only consider prescribing antidepressants in cases of severe depression, as per ZLDSI score (> 18), suicidal ideation.

**Medications for Depression**

**Amitriptyline**

- Effective but side effects often limit their use as primary antidepressants
- Fatal in overdose
- Depression; anxiety disorders including PTSD; migraine; neuropathic pain

**Fluoxetine**

- Fewer side effects than amitriptyline
- Not fatal in overdose
- Depression; anxiety disorders including PTSD

Other than fluoxetine and amitriptyline, medications that are commonly prescribed for mental illnesses other than depression include:

- **Diazepam**, which is indicated for anxiety disorders, catatonia (characterized by muscular rigidity and mental stupor, sometimes alternating with great excitement and confusion), insomnia, seizures (status epilepticus), alcohol withdrawal.

- **Lorazepam**, which is indicated for anxiety disorders, catatonia, insomnia, seizures (status epilepticus), alcohol withdrawal.

- **Haloperidol**, which is indicated for schizophrenia, schizoaffective disorder, bipolar disorder in pregnant women, agitation in delirium.
• **Risperidone**, which is indicated for treatment of schizophrenia schizoaffective disorder, bipolar disorder, irritability in autism.

• **Valproic Acid**, which is indicated in the treatment of seizures and bipolar disorder. It is considered the most teratogenic of all antiepileptics, use carbamazepine for women who are pregnant.

**Depression in Pregnancy**

• 20% of women suffer from depression or anxiety during pregnancy

• Treatment with medication must balance risks of medication with the risks of psychiatric disease to mother and child

**Geriatric Depression**

• Elderly are at increased risk for depression because of isolation, losses and medical illness

• Additional symptom: “pseudodementia” which may include confusion, forgetfulness and cognitive/motor slowing but improves with treatment

• Careful physical exam and lab studies are important to rule out medical illness

• Antidepressants should be used with caution, initiated at 50% usual starting dose

**Pediatric Depression**

• Occurs in 2% of children and 4–8% in adolescents in US.
  
  – More prevalent as a co-occurring disorder.
  
  – Most common co-occurring disorders include anxiety, disruptive behavior, ADHD and substance use disorder.

• Median duration of episode 8 months for clinical referred youth.

• 60% of youth with depression think about suicide, 30% attempt.

• Antidepressants should be used with caution, initiated at 50% usual starting dose

**Psychoeducation**

Psychoeducation is an essential component of depression care. Psychoeducation involves letting the patient 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.
Psychoeducation Key Messages

• Depression is a very common problem

• Treatment is available and effective

• Adherence to prescribed treatment is important

• It is important for you to continue activities that used to be interesting or give pleasure, regardless of whether these currently seem interesting or give pleasure

• Maintain a regular sleep schedule

• Minimize alcohol use

• It is important to recognize thoughts of self-harm or suicide and seek help if those occur
**MEDICATION PSYCHOEDUCATION CASE STUDY**

Your patient is a 68 year old male who is agitated and complains of appetite loss and low mood over the previous two months. During the consultation he was 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. The physician’s physical examination and other investigations are normal, and the diagnosis of major depression is made by you [the psychologist/social worker]. This man was put on fluoxetine.

a. What psychoeducation messages will you discuss with him on the day he is first provided with his medications?

b. Assuming he is not experiencing any major side effects, what psychoeducation messages will you discuss with him during his first follow-up visit?

b. How about during his second follow-up visit, assuming no major side effects?

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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
Follow Up and Documentation

Psychologist/Social Worker Responsibilities: Follow up Evaluation

• Review depression checklist with CHW/nurse to track care

• Document with Mental Health Follow Up Form

• Check if depression is improving based on patient report, ZLDSI, mental status exam, CHW/family input; check medication compliance, side effects

• Consult physician for suicidal ideation, epilepsy/other medical problems, psychosis, or severe depression
  – Accompany patient and present information to physician in person.

• Track physician care with depression checklist

• Do psychoeducation, include medication side effects
  – Check supply of medication.

• Determine CHW role:
  – Severe depression: follow up, support/education
  – Mild depression: transfer to CHW

• Schedule proper follow-up
  – With psychologist, CHW, physician

• Enter patient into registry. File ZLDSI, complete checklist/patient encounter form.

Frequency of Follow Up

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.
Determine if Patient is Improving

Physician and psychologist/social worker will work together to decide if patient is improving. Determined by a combination of:

- Improvement in ABCDs (affect, behavior, cognition, development)
- ZLDSI scores

Document Evaluation and Plan

- Document in Mental Health Follow-Up Form
- In the Mental Health Follow-Up Form the physician documents in four sections:
  - Mental Status Examination (p. 1, bottom)
  - Positive Findings on physical examination/lab (p. 2)
  - Response to recent interventions (p. 2), with support from psy/sw
  - Plan (P. 2), with support from psy/sw
- The psychologist/social worker is responsible for the rest of the form and ensuring that the physician completes the sections for which he/she is responsible.

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.
### FOLLOW UP CASE STUDY

**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**

a. Discuss what you suspect might be the differential diagnosis for this case.

b. What treatment do you think the physician might recommend?

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Depression and mhGAP

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

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).

It is common that patients may be suffering from multiple mental or physical health conditions at once. Conditions should be treated as necessary.

<table>
<thead>
<tr>
<th>MHGAP CASE STUDY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>This man does not have any episodes of manic symptoms nor does he exhibit any psychotic features or other concurrent conditions. The psychologist/social worker should go through the screening questions on pages 10 and 11 of the mhGAP guide.</td>
</tr>
<tr>
<td>The psychologist/social worker should turn to page 10 of the depression mhGAP guide and initiate the interview as if this man were a new patient.</td>
</tr>
</tbody>
</table>
MHGAP CASE STUDY

Script

The psychologist/social worker: 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 psychologist/social worker:
  • 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 psychologist/social worker: Screens for bipolar depression, psychotic features and concurrent conditions as per page 11 of the mhGAP Guide.
Review

CASE STUDY 1

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

The physician 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

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

2. Which forms will you use?

3. You diagnose Marie-Flor with severe depression because her functioning is impaired (she is not sleeping or eating), and her ZLDSI score is high and she sometimes thinks about dying. The physician prescribes amitriptyline. What messages would you give to Marie-Flor about her medication?
CASE STUDY 1

4. Look at the Depression Checklist. Which tasks did you complete? Which ones do you still need to do?

5. Look at the diagram on the other side. Which boxes would you check off for this patient care encounter?

CASE STUDY 2

Chief Complaint:
You are asked to see a 72 year old woman, named 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.
**CASE STUDY 2**

(continued)

**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**
1. What ABCD’s of major depressive order are present in this case?

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

3. If you suspect depression, what should your next steps be?
CASE STUDY 2

4. What should you communicate to Yveline?


CASE STUDY 3

A 30 year old male patient that you initially saw 6 weeks ago has returned for a follow-up visit. When you ask him how he’s been doing, he states that the medicine has made him feel restless. He has difficulty concentrating, his mind is always racing. And now his wife is threatening to leave him because he’s started gambling again. When you question him further, it’s obvious that he’s not only spending money on betting, but he’s also staying out late and spending his money on “ladies”.

Case Question

1. How would you manage this case?

Case 3 is adapted from: Davis, JL. WebMD Misdiagnosis: Depression, When Sadness Masks the Read Problem. Available at: http://www.webmd.com/depression/misdiagnosed-depression-6/depression?page=1
Annex
### DEPRESSION CHECKLIST

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

<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>□ Provide psychoeducation about medication.</td>
<td>□ Identify patients at risk for depression and check for depression symptoms in nursing protocol.</td>
</tr>
<tr>
<td>□ Ask patient/family to give psychologist Referral Form.</td>
<td>□ Do psychoeducation. Check medication supply.</td>
<td>□ Based on referral process, provide psychoeducation and support to patient and family.</td>
<td>□ Provide psychoeducation and support to patient and family.</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>□ Ensure follow-up with psychologist/SW.</td>
</tr>
<tr>
<td>□ Give ZLDSI and Initial Visit Form to psychologist.</td>
<td>□ Enter patient into registry. File ZLDSI, complete checklist/Patient Encounter Form.</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>Follow-Up Evaluation</td>
<td>Follow-Up Evaluation</td>
<td>Ongoing Care</td>
<td>Follow-Up Evaluation</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>If patient has been suicidal during hospitalization, check for suicidal ideation before discharge. If patient is suicidal, contact psychologist immediately.</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>Determine whether patient is improving.</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>Document evaluation and plan in Mental Health Follow-Up Form.</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></td>
<td></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>
<td></td>
</tr>
</tbody>
</table>
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 his/her work and when collaborating with CHWs and physicians. The checklist ensures complete, quality care.

THANK YOU
PARTNERS IN HEALTH MENTAL HEALTH & PSYCHOSOCIAL SERVICES
ADULT MENTAL HEALTH EVALUATION

Record Number: ____________________  EMR Number: ____________________  Date: ___ / ___ / ___

Site: ______________________________

Surname: ____________________  Given Name: ____________________  Nickname: ____________________

Sex: ☐ M  ☐ F  Date of Birth (Day/Month/Year): ___ / ___ / ___  Age: ____________________

Referred by: ____________________

Address: ______________________________

Commune: ____________________  Profession: ____________________  Telephone: ____________________

Religion: ____________________  Marital Status: ____________________

Name of Emergency Contact: ____________________  Relation: ____________________

Address: ______________________________  Telephone: ____________________

Name of Provider: ______________________________

Name of Community Health Worker/Telephone: ______________________________

Chief Complaint (in the patient’s own words):

History of Present Illness (Date of symptom onset, precipitants, course, any prior treatment):
### PSYCHIATRIC REVIEW OF SYSTEMS

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

---

*Partners In Health | PARTICIPANT HANDBOOK | ANNEX 51*
### Introduction to Mental Health and Depression

#### Curriculum for Psychologists and Social Workers

<table>
<thead>
<tr>
<th>SUICIDE</th>
<th>VIOLENCE/HOMICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever thought of causing harm to yourself or committing suicide in the past?</td>
<td>Do you now or have you ever thought about harming others? Have you ever gotten into fights, quarrels or harmed someone else?</td>
</tr>
<tr>
<td>What about now?</td>
<td></td>
</tr>
<tr>
<td><strong>Past</strong></td>
<td><strong>Present</strong></td>
</tr>
<tr>
<td>Ideation</td>
<td>Attempts</td>
</tr>
</tbody>
</table>

- [ ] Yes  [ ] No

If yes, explain __________________________________________________________________________________________

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

---

### SUBSTANCE ABUSE

Do you use any of the following?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Beer</th>
<th>Home Brew</th>
<th>Liquor</th>
<th>Tobacco</th>
<th>Marijuana</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Present</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

If yes, explain quantity, first use, last use: __________________________________________________________________________________________

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

---

### TRAUMA

Did you ever experience a trauma, such as physical, sexual, or emotional abuse, that is impacting your current functioning?

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

If yes, explain: __________________________________________________________________________________________

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

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

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

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

<table>
<thead>
<tr>
<th>Head/Ears/Eyes/Nose/Throat</th>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Sight problems?</td>
<td>☐ Stiffness of the neck?</td>
</tr>
<tr>
<td>☐ Hearing problems?</td>
<td></td>
</tr>
<tr>
<td>☐ Voice change?</td>
<td></td>
</tr>
<tr>
<td>☐ Dizziness?</td>
<td></td>
</tr>
<tr>
<td>☐ Gum and teeth status?</td>
<td></td>
</tr>
<tr>
<td>☐ Difficulty swallowing?</td>
<td></td>
</tr>
</tbody>
</table>
PAST PSYCHIATRIC HISTORY

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

Psychiatric Family History:

Past Medical History and Active Medical Problems

☐ Head Injury: Last Date Of Menstruation: ___ / ___ / ___

☐ Loss Of Consciousness: Other Things:

Medication/Allergies/Side Effects:

Medical Family History:

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

Legal Problems:
PHYSICAL EXAM (PHYSICIAN)

Vital Signs: ________________________________

HEENT: _____________________________________________________________________________

Chest/Lungs: _______________________________________________________________________

Cardio-vascular: ____________________________________________________________________

Abdomen: __________________________________________________________________________

Genitals: __________________________________________________________________________

Extremities: _________________________________________________________________________

Skin: ______________________________________________________________________________

Lymph nodes: _______________________________________________________________________

NEUROLOGIC EXAM (PHYSICIAN)

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

Motor: _____________________________________________________________________________

Pronator drift: ______________________________________________________________________

Sensory: ___________________________________________________________________________

Vibration: _________________________________ Position: _________________________________

Reflexes: DTR __________________________ Clonus __________________________ Babinsky __________

Coordination and Gait: Rapid alternating movements ______________________ Nose finger test _______

Romberg ______________________ Gait ______________________ Heel toe walk test __________
### MENTAL STATUS EXAM

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

**General Impressions:**

________________________________________________________________________________

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

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
Introduction to Mental Health and Depression  Curriculum for Psychologists and Social Workers

DIAGNOSIS:

Axis I: ____________________________________________________________

Axis II: __________________________________________________________

Axis III: _________________________________________________________

Axis IV: _________________________________________________________

PLAN/AVAILABILITY:

Next Visit: _________________________________________________________

Follow Up:

☐ Reevaluation using the ZLDSI: When? ________________

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

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

☐ Hospitalization: When? ________________

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

Necessary Intervention:

Safety: _______________________________________________________________________

Psychoeducation: _______________________________________________________________________

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

_________________________________________________________________________________

Other: _____________________________________________________________________________

_________________________________________________________________________________

___________________________________________  ____________________________
Signature of Evaluating Clinician                        Date

_________________________________________
Print Name of Evaluating Clinician

Discipline (Psychiatry, Psychology, Social Work, Primary Care)
### ZANMI LASANTE — MENTAL HEALTH

#### SUICIDALITY SCREENING INSTRUMENT

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

**Low:** Current = 0  Past = 0

**Medium:** Current = 1–2 yes  OR  Past = 1 or more yes

**High:** Current = 3 or more yes  OR  Past = 3 or more yes

<table>
<thead>
<tr>
<th><strong>Total “yes” in past two weeks</strong></th>
<th><strong>Total “yes” in past year</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Introduction to Mental Health and Depression

**Curriculum for Psychologists and Social Workers**

**ZANMI LASANTE — MENTAL HEALTH**

**SUICIDALITY TREATMENT GUIDELINES**

<table>
<thead>
<tr>
<th>Provider: ___________________________</th>
<th>Location: ___________________________</th>
<th>Date: ___ / ___ / ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name: __________________________</td>
<td>First Name: _________________________</td>
<td>Nickname: ______________</td>
</tr>
</tbody>
</table>

**For ALL Patients**

<table>
<thead>
<tr>
<th>Act</th>
<th>1. Ensure that the environment will be private, safe and non-threatening.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Begin the process of ensuring that the patient will be able to access necessary medication.</td>
</tr>
<tr>
<td></td>
<td>3. Always work with the patient to develop a Safety Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Say</th>
<th>4. Use the patient’s name often, give hope, insist that there are other options, and declare your intent to help.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5. Start IPT and collect IP inventory.</td>
</tr>
<tr>
<td></td>
<td>6. Provide psychoeducation about depression, suicidality, psychopharmacology, therapy and ZL resources.</td>
</tr>
<tr>
<td></td>
<td>7. Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact</th>
<th>8. Always contact at least one person close to the patient to support and monitor them.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9. Contact as many of the current and potential supports as a patient will permit</td>
</tr>
<tr>
<td></td>
<td>• Ensure that the environment will be private, safe and non-threatening.</td>
</tr>
<tr>
<td></td>
<td>• Always work with the patient to develop a Safety Plan.</td>
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<td></td>
<td>• Use the patient’s name often, give hope, insist that there are other options, and declare your intent to help.</td>
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<tr>
<td></td>
<td>• Identify specific current supports and potentially welcome supports (e.g. neighbors, clergy).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team</th>
<th>10. Consult and involve colleagues to help.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Social Worker  ■ Psychologist  ■ Community Health Worker  ■ Doctor  ■ ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow Up</th>
<th>11. If the patient has a higher risk level, continue to the guidelines below.</th>
</tr>
</thead>
</table>

**Provider:** ___________________________  **Location:** ___________________________  **Date:** ___ / ___ / ___
### ZANMI LASANTE — MENTAL HEALTH

#### SUICIDALITY TREATMENT GUIDELINES

**For patients with MEDIUM risk, include these additional aspects in your care.**

<table>
<thead>
<tr>
<th>Act</th>
<th>1.</th>
<th>☐ Maintain a high index of suspicion for understatement and concealed ideation. Be sure of your assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Say</td>
<td>2. ☐ Ascertain what caused the ideation to increase in seriousness and specificity and/or what caused it to occur.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. ☐ Seek agreement or at least acceptance that individuals in that patient’s milieu may need to be notified explicitly.</td>
</tr>
<tr>
<td></td>
<td>Contact</td>
<td>4. ☐ Close family should be informed quickly and explicitly of the patient’s suicidality.</td>
</tr>
<tr>
<td></td>
<td>Team</td>
<td>5. ☐ At least one social worker and psychologist should cooperate closely on all cases with greater than low risk.</td>
</tr>
</tbody>
</table>
|     | Follow-Up | 6. If the patient is medium risk, schedule follow-up within 7 days. **Date** __________ **Time** __________  
**If the patient is high risk, continue to the guidelines below.** |

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

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

STEP 1  Warning signs that a crisis is developing (such as thoughts, images, moods, situations, behavior):
1. ____________________________  2. ____________________________
3. ____________________________  4. ____________________________
5. ____________________________  6. ____________________________

STEP 2  Internal coping strategies – activities that I can do without others to distract myself from my problems, such as relaxation techniques:
1. ____________________________  2. ____________________________
3. ____________________________  4. ____________________________
5. ____________________________  6. ____________________________

STEP 3  People and social environments that offer distractions and support:
Name ____________________________ Telephone ____________________________
Name ____________________________ Telephone ____________________________
Name ____________________________ Telephone ____________________________
Where ____________________________ Where ____________________________

Step 4  People and social environments that offer distractions and support:
Name ____________________________ Telephone ____________________________
Name ____________________________ Telephone ____________________________
Name ____________________________ Telephone ____________________________

STEP 5  Professionals and agencies I can contact during a crisis:
Community Health Worker ____________________________________ Telephone ____________________________
Ajan Sante ________________________________________________ Telephone ____________________________
Social Worker ______________________________________________ Telephone ____________________________
Psychologist ______________________________________________ Telephone ____________________________
Doctor ____________________________________________________ Telephone ____________________________
Spiritual Healer ______________________________________________ Telephone ____________________________
Emergency Room/Hospital ____________________________________ Telephone ____________________________

STEP 6  Making the environment safe:
___________________________________________________________
___________________________________________________________

I, ________________________________________________________, will follow the steps when I’m in a crisis, and one thing more important to me than anything else that will help me live is__________________________
___________________________________________________________
# Medication Card for Depression

## FLUOXETINE

<table>
<thead>
<tr>
<th>Use:</th>
<th>Antidepressant, SSRI: depression, anxiety Use for: depression, anxiety, post-traumatic stress disorder</th>
</tr>
</thead>
</table>

## AMITRIPTYLINE

<table>
<thead>
<tr>
<th>Use:</th>
<th>Tricyclic antidepressant: depression, anxiety, migraine, neuropathic pain Use for: depression, anxiety, post-traumatic stress disorder, migraines, neuropathic pain</th>
</tr>
</thead>
</table>

### 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
- **Dosing Forms:** 25 mg tablets
- **Dosage:** Start with 25 mg at bedtime
- **Typical maintenance dosage:** 50-75 mg daily

### “Step” of Uptitration

- If necessary, increase by 20 mg increments each month until a maximum of 80 mg daily.
- If necessary, increase by 25 mg increments every two weeks until a maximum of 200 mg daily.

### Maximum Dose

- **FLUOXETINE:** 80 mg
- **AMITRIPTYLINE:** 300 mg

### Toxicities

**Serious**

- Special warning: serotonin syndrome may occur for 4-6 weeks
- Special warnings: less well tolerated than Fluoxetine. Risk of death in overdose. High risk of arrhythmias and sudden death due to prolonged QT interval and also high risk of myocardial infarction. For patients over 40 years, we must obtain the history of symptoms of arrhythmia, disorders of the cardiac conduction system, diseases of the coronary arteries and make an electrocardiac examination before starting treatment.

### Serotonin Syndrome

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

### Common

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

### Tapering/Discontinuing

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

### Breastfeeding

- Safety unknown; caution advised.
- Probably safe; caution advised.
**Mental Health Follow-Up Form**

<table>
<thead>
<tr>
<th>File Number:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMR Number:</th>
<th>Date: DD/MM/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Name of CHW: ____________________ Number of visits: __________ Date of last visit: ___ / ___ / ___

### Patients' Demographic Data

<table>
<thead>
<tr>
<th>Name:</th>
<th>Nickname:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Sex: | | |
| M | F |

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change in phone number: Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth: DD/MM/YYYY</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</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

<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>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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**Partners In Health**

*Department of Mental Health & Psychosocial Services*

*Curriculum for Psychologists and Social Workers*
### 4. Mental Status Examination

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

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

### 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: ___________________________