PARTICIPANT HANDBOOK

Introduction to Agitation, Delirium, and Psychosis
Curriculum for Physicians

ENGLISH-HAITI
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.

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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 Agitation, Delirium, and Psychosis

**INTRODUCTION**

Psychotic disorders refer to a category of severe mental illnesses that produce a loss of contact with reality, including distortions of perception, delusions, and hallucinations. The most common psychotic disorders are schizophrenia and bipolar disorder, which together affect 81 million people. Despite the immense burden of illness from psychotic disorders, about 80% of people living with a mental disorder in low-income countries do not receive treatment.¹ The stigma and discrimination against people living with severe mental illnesses often result in a lack of access to health care and social support. Human rights violations such as being tied up, locked up, or left in inhumane facilities for years are all common.

Before a psychotic disorder can be diagnosed, however, patients require comprehensive medical evaluation to ensure that medical problems are not the root cause of the symptoms. The term ‘agitated’ is often misused to describe patients who appear to be psychotic and are, therefore, immediately referred to mental health facilities. However, often these patients are actually suffering from delirium, a state of mental confusion that can resemble a psychotic disorder but is actually caused by a potentially severe medical illness. Patients who are delirious are often injected with high doses of haloperidol to quell their ‘agitation’, and they frequently do not receive any medical evaluation or care. Unfortunately, this misdiagnosis and mismanagement can lead to death.

Fortunately, physicians can learn how to manage agitated patients safely and provide complete medical evaluation so they can properly treat delirium. Furthermore, within Zanmi Lasante, physicians have the opportunity to work with psychologists and social workers who assist them in making proper diagnoses and managing agitated, delirious, and psychotic patients. Community health workers and nurses also participate in this process. Psychotic disorders are treatable and for some, completely curable. With the right training and a system of coordinated care, people with psychosis can receive effective treatment and lead rich, productive lives.

In this training, you will learn how to manage agitated patients safely and effectively. You will also learn how to distinguish between delirium and a psychotic disorder caused by mental illness. Ultimately, you will learn how to provide high-quality humane medical and mental health care for agitated, delirious, and psychotic patients.
OBJECTIVES

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

a. Describe the epidemiology of psychotic disorders and the corresponding treatment gap.

b. Describe the various ways that psychosis may be viewed by the community and by health providers.

c. Describe the impact of stigma on patient care and outcomes.

d. Describe the Psychosis Care Pathway and its collaborative care approach.

e. Outline the main roles of physicians, psychologists, social workers, nurses and community health workers in the system of care related to the identification, treatment and management of agitation, delirium, and psychosis.

f. Explain the four pillars of emergency management of agitation, delirium, and psychosis.

g. Describe how a physician should use the biopsychosocial model when managing a patient with agitation, delirium or psychosis.

h. Describe the identification, triage, referral, and non-pharmacological management of an agitated patient through the use of the Agitated Patient Protocol and the Agitation, Delirium, and Psychosis Form.

i. Define medical delirium.

j. Describe the importance of proper medical evaluation for an agitated, delirious or psychotic patient.

k. Explain how to conduct a medical evaluation of an agitated, delirious or psychotic patient.

l. Determine the necessary pharmacological treatment of agitation, delirium, and psychosis using the Medication Card for Agitation, Delirium, and Psychosis.

m. Provide comprehensive psychoeducation messages to patients and their families around medication management.

n. Evaluate and document antipsychotic medication side-effects using the Abnormal Involuntary Movement Scale.

o. Explain how to provide follow-up for people living with psychotic disorders and severe mental illnesses.

p. Describe the importance of documentation during patient follow-up.

q. Describe how to use mhGAP for the management of Psychosis and Bipolar Disorder.

r. Describe how to use mhGAP for the management of self-harm/suicide.

s. Apply the use of mhGAP for self-harm/suicide to prior trainings delivered for depression, epilepsy, and psychosis.
Severe Mental Illness

Severe mental illnesses are mental illnesses of longer duration, longer treatment and have significant impact on the activities of daily living. Severe mental illness includes psychosis and mood disorders. The two most common severe mental illnesses are schizophrenia and bipolar disorder.

What is psychosis?

Psychosis is a syndrome. A syndrome is defined as the association of several clinically recognizable signs and symptoms which may have multiple causes.

Psychosis results in dysfunction in several domains:

- Cognition (disorganized thinking and speech, memory problems)
- Perception (hallucinations)
- Behavior (social withdrawal, catatonia)
- Emotion (decreased emotion)

There are some psychiatric disorders that mimic psychosis, which can include PTSD, acute stress, intellectual development disorder, and autism spectrum disorder.

Schizophrenia

Schizophrenia is characterized by profound disruptions in:

- thinking, affecting language
- perception
- the sense of self

It often includes psychotic experiences, such as hearing voices, visual hallucinations or delusions. Patients with schizophrenia often first begin to show symptoms of psychosis when they are teenagers. Prior to developing schizophrenia, patients may show subtle non-specific signs such as depression, social withdrawal, and irritability.

Schizophrenia affects more than 21 million people worldwide. The prevalence ranges from 1 – 7 per 1,000 people. People with schizophrenia have a 20% reduction in life expectancy.  

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Bipolar Disorder

Bipolar Disorder is a mood disorder that can include symptoms of depression, mania and/or psychosis. Manic episodes involve elevated or irritable mood swings, over-activity, pressure of speech, inflated self-esteem, and a decreased need for sleep. Some people with bipolar disorder experience mixed episodes that involve both symptoms of mania and depression at the same time or alternating frequently during the same day. Bipolar disorder usually starts during adolescence and early adulthood.

Bipolar disorder affects about 60 million people worldwide. It is the sixth leading cause of disability in the world. People with bipolar disorder have a reduced life expectancy of 9–20 years.³

Health systems have not yet adequately responded to the burden of mental disorders. As a consequence, there is a wide gap between the need for treatment and its provision all over the world. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder. In high-income countries, between 35% and 50% of people with mental disorders receive no treatment for their disorder.4

Stigma

Stigma refers to negative or prejudicial thoughts about someone based on a particular characteristic or condition, in this case someone with a severe mental illness.

As clinicians, it is not acceptable to have stigmatizing thoughts or behaviors toward people with severe mental illnesses. It the clinicians’ responsibility to overcome these feelings to be able to treat patients with dignity and respect.

The Zanmi Lasante psychosis system of care aims to diminish Haiti’s treatment gap by safely and effectively treating people living with severe mental illness in a community-based system of care. Physicians have the opportunity to close the treatment gap and reduce the stigma related to psychosis by building on the coherent system of care already developed for depression and epilepsy. Physicians have the opportunity to help some of the most vulnerable and marginalized people living in communities—those living with mental illness.

**STIGMA ROLE PLAY**

**STORY**
A patient is brought by his family to the emergency room. He is very talkative and focuses mainly on vodou and religion. The emergency nurse fears that he is violent and does not wish to touch him because he may be contagious. The nurse does not check vital signs or provide any medical care. Instead the nurse calls the psychologist and says “a mental health patient is here.” In the meantime, the patient is totally dehydrated, and has a high fever that goes undetected. His sister reports he has never behaved this way before and only became “a crazy person” after a dog bit him. For more than two hours, the patient and his sister wait and no one comes to them for help.

**SCRIPT**

**Family (Participant 2):** Brings in the sick patient to the emergency room. “Hello, please help us. My brother is sick.”

**Patient (Participant 1):** Arrives at the emergency room with his sister. Begins to talk a lot about vodou and religion.

**Nurse (Participant 3):** Acts scared because he might be violent and contagious. Calls the psychologist: “A mental health patient is here for you.”

**Patient (Participant 1):** Is sitting down now. Has a fever and is dehydrated. Does not look well. No longer very talkative.

**Family (Participant 2):** “Excuse me, nurse? I’m looking for help for my brother. He’s never been like this before. He only became like this after a dog bit him.” Looks frustrated that no one helps them. “Nurse, please help us.”

**Nurse (Participant 3):** “I have called the psychologist and I will let you know when he is available to see the patient.”
The Psychosis System of Care and the Four Pillars of Emergency Management of Agitation, Delirium, and Psychosis

The Psychosis System of Care

Physicians’ main roles in the Zanmi Lasante system of care are:

a. to ensure safety for the patient and others;
b. to rule out a treatable medical illness and to prevent further harm;
c. to provide treatment with appropriate medication;
d. to provide follow-up by educating the patient and families and coordinating care with the psychologist.

The physician’s responsibilities in the care pathway align with the four pillars of managing a patient with psychotic symptoms.

Four Pillars of the Emergency Management of Agitation, Delirium and Psychosis

Any decision around mental health or a treatment plan should include these four elements, in this order:

1. Safety
   a. Determine the risk of suicide
   b. Understand the exposure to violence
   c. Determine the risk of violence

2. Medical Health
   a. You cannot diagnose a mental illness without eliminating all medical causes
   b. Take vital signs, perform a physical and neurological exam, lab tests (RPR, HIV, hemogram), in some cases consider a scan

3. Mental Health
   a. Plan the assessment and ongoing treatment
   b. Psychotherapy, pharmacology
   c. Create a safety plan
4. Follow-up

a. Next appointment at the clinic

b. Which providers are involved in the patient’s care (CHW, psychologist/social worker, nurse, physician)?

Each pillar will be informed by the physician’s use of the biopsychosocial model.

Biopsychosocial Model

Medical providers need to approach the treatment and management of psychotic disorders and severe mental illness from a biopsychosocial approach, because there are biological, psychological and social factors involved in the development of mental disorders.

A biopsychosocial approach to mental health treatment will:

- Assist with understanding the condition
- Assist with structuring assessment and guiding intervention
- Inform multidisciplinary practices

Physicians are just one important element in the collaborative care approach; to provide the quality care they need to work closely with other team members that include psychologists, social workers, nurses, and community health workers.
## CASE STUDY

### CASE: Biopsychosocial Considerations

A 37-year-old man patient is brought by his family to the emergency room. He is very talkative and shouts about vodou and religion as he runs around the emergency room.

The emergency nurses fear that he is violent and do not wish to touch him because he may be contagious. They do not check his vital signs or provide any medical care. Instead they call the psychologist and say “a mental health patient is here.” In the meantime, the patient is totally dehydrated and has a high fever that goes undetected.

His family reports he has never behaved this way before and only became ‘a crazy person’ after a dog bit him two weeks ago. Since then he has been unable to work and care for his wife and two children. Other family members have to stay with him, thereby losing daily wages.

<table>
<thead>
<tr>
<th>BIO</th>
<th>PSYCHO</th>
<th>SOCIAL</th>
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</table>
# THE FOUR PILLARS OF EMERGENCY MANAGEMENT OF AGITATION, DELIRIUM, AND PSYCHOSIS

## 1. SAFETY

**Violence:**
- Is the patient agitated or violent currently? (Use the Agitated Patient Protocol)
- What is the history of violence? When did it happen, how severe was it?
- Is the patient being exposed to violence/abuse?

**Suicide:**
- Is the patient suicidal currently? Actively or passively?
- What is the history of suicide? Past attempts with medical severity, past suicidal ideation? When did it happen?

**Management:**
- How is safety being managed? Is 1:1 present?
- How is risk being decreased?

## 2. MEDICAL

**Medical Evaluation of Psychosis**
- Must do a physical and neurological exam, vital signs, weight, laboratory tests (hemogram, HIV and RPR for all patients; renal and hepatic panels if available; CD 4 count for all HIV patients).
- Consider a CT scan if the patient has a clear neurological deficit.

**Consider Delirium**
- Disturbance of consciousness with reduced ability to focus, sustain or shift attention; change in cognition/development of perceptual disturbance not due to dementia; disturbance develops over a short period of time (hours to days) and fluctuates during the day; evidence from the history, physical exam or lab tests that the disturbance is caused by a medical problem.
- Treatment is aimed at underlying medical problem and avoiding diazepam.

**Consider Epilepsy (Post-Ictal Psychosis)**
- The family reports the development of psychosis/agitation after seizures.
- Treatment is anti-epileptic.

**Medication Management**
- Use the medication card to dose and prescribe.
- Provide fluids and do an EKG for all hospitalized/emergency room patients receiving haloperidol.
- Check for medication side-effects; do AIMS.
- Check vital signs and weight for all patients.
### 3. MENTAL HEALTH

**Diagnosis:**
- Work with a psychologist/social worker, use the Differential Diagnosis Information Sheet.
- Reconsider the diagnosis at each visit.

**Psychoeducation and Support:**
- Provide education to patients and families regarding psychosis and medication.

**Medication Management:**
- Use Medication Card for Agitation, Delirium and Psychosis; consider diagnosis.

### 4. FOLLOW-UP

**Date of next appointment/visit:**
- Follow-up based on acuity; for hospitalized patients, daily or several times a day; for outpatients, can be every 1–2 days or weekly for more acute patients and every 2–4 weeks for stable patients.
- Involve community health workers in the care.
Safety and Management of Agitated Patients

Safety is the first pillar when dealing with an agitated, delirious or psychotic patient.

Agitation

Is agitation a disease? Agitation is not a disease, there are many causes:

- Delirium (medical): mental retardation, thyroid abnormalities, dementia, seizures, hypoglycemia, anti-cholinergic intoxication and urinary tract infection, HIV encephalopathy, various states of intoxication and withdrawal
- Psychiatric problems: psychosis, mania, trauma
- Emotional/psychological trauma

Agitation Spectrum

There is a spectrum of agitation and patients can fall anywhere on the spectrum.

<table>
<thead>
<tr>
<th>Agitation (Mild)</th>
<th>Aggression (Moderate)</th>
<th>Violence (Severe)</th>
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<tbody>
<tr>
<td>• wringing hands</td>
<td>• verbal threats</td>
<td>• destroying property</td>
</tr>
<tr>
<td>• pacing/moving restlessly</td>
<td>• yelling, cursing</td>
<td>• making a fist, physically threatening (e.g. hitting, kicking, biting)</td>
</tr>
<tr>
<td>• frequent demands</td>
<td>• does not respond to verbal redirection</td>
<td>• harming people</td>
</tr>
<tr>
<td>• loud, rapid speech</td>
<td>• does not respond to increased staff presence</td>
<td></td>
</tr>
<tr>
<td>• low frustration tolerance</td>
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Forms to Manage Agitated Patients

The Agitated Patient Protocol will assist clinicians in properly managing different levels of agitation, including reducing the use of physical restraints, and medication.

The Agitation, Delirium, and Psychosis Forms assist physicians in recording vital information related to determining if an agitated patient is delirious or psychotic.
Introduction to Agitation, Delirium, and Psychosis   
Curriculum for Physicians

**When Managing an Agitated Patient: Safety and Talking First!**

Often physicians and other health providers are unsure what to do when there is an agitated patient. By talking to the patient, the physician can evaluate the risk of violence, begin the medical evaluation and calm the patient.

How to ensure safety:

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

**Intramuscular Medication and Physical Restraint**

When should providers give medication intra-muscularly?

From a human rights perspective, you always want the **least restrictive approach** and should use the **fewest interventions** necessary. We only give medication intramuscularly to a severely agitated patient who is at risk of imminent self-harm or is harming those around him. We only administer medication intramuscularly when a severely agitated patient refuses oral medication or is unable to comprehend the request to take oral medication. We must remember that administering an intramuscular injection is invasive and can cause physical pain. It can also potentially lead to physical harm towards providers.

In what situations should clinicians use physical restraint?

The goal is to use the least restrictive means necessary. The rights of a person must take priority, in balance with the safety of those around them. Physical restraint can be considered if:

- If calming measures have been tried AND
- The patient has been offered an oral medication and refused AND
- The patient reaches a state of severe agitation where there is a significant worry about harm to self and others AND
- It is felt that all alternatives have been tried
Gathering Information and a Brief Assessment

Physicians should try to obtain as much history about the patient as possible to better inform the management of the patient's agitation. It is helpful to obtain this information from the patient, if possible, but also from family members or anyone who has accompanied the patient.

- What happened?
- How did this start?
- Has this happened before?
- Has the person suffered from a mental illness in the past?
- Does the person drink a lot of alcohol?
- Has the person been taking medication recently?
- Has the person had any recent physical illnesses?

Although it would be ideal to obtain information about the agitated patient (whether from the patient or someone else), it is not always possible, depending on the level of agitation.

<table>
<thead>
<tr>
<th>ROLE PLAY</th>
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<tbody>
<tr>
<td><strong>CASE: Agitated Patient</strong></td>
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<tr>
<td>A 55-year-old man is brought to the clinic by concerned neighbors. They report that he has been talking to himself, yelling at people for no reason and making threatening comments. They refer to him as 'crazy' and report that he has no friends or family. In the clinic he is disorganized and confused.</td>
</tr>
</tbody>
</table>
Medical Evaluation and the Management of Agitation, Delirium, and Psychosis

Once a clinician has calmed an agitated patient, the physician and psychologist/social worker need to determine if the patient is psychotic or has a medical delirium.

Definition of Agitation, Delirium and Psychosis

Agitation is a symptom to describe behavior. It is not a disease. It is not a mental illness. It can be a symptom of medical illness or mental illness.

Delirium is a medical emergency. It is not a mental illness. It occurs when medical illness results in mental confusion. Delirious patients are confused and off-center and have an increased chance of death. They also have an additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability or perception). The disturbance develops over a short period of time (usually hours to a few days) and tends to fluctuate in severity during the course of a day. Delirium is often misdiagnosed as psychosis or other psychiatric illnesses.

There are many causes for delirium including:

- Infections (HIV/AIDS, neurosyphilis, malaria)
- Metabolic disorders (electrolyte disorders, especially hypo/hyperglycemia related to diabetes)
- Drug intoxication/Alcohol withdrawal
- Medications (corticosteriods, cycloserine, phenobarbital, efavirenz, high doses of antihistamines, isoniazid)
- Malnutrition/Vitamin deficiencies
- Brain diseases (dementia, stroke, head injury with bleed)
- Malignancy
- Post-Ictal Psychosis
  - Takes place between seizures
  - Usually follows a ‘lucid’ interval that lasts from hours to days following a seizure
  - Characterized by delusions, hallucinations, and aggressive behavior
- Primary treatment is anti-epileptic medication
- Hypertension
Psychosis is a syndrome. A syndrome is defined as the association of several clinically recognizable signs and symptoms which may have multiple causes. It can be a sign of medical illness or mental illness. It is not always a mental illness! It results in dysfunction in thinking, perception (hallucinations) and behavior (decreased social and professional activity).

Treatment is aimed at a complete medical evaluation and treatment first, then a complete mental health evaluation and treatment, if necessary.

**Standard Medical Evaluation for Agitation/Delirium/Psychosis**

- History (epilepsy, delirium, substance abuse, medications)
- Vital Signs
- Physical Exam
- Neurological Exam
- Mental Status Exam
- Laboratory Tests (at least CBC, RPR, VIH, CD4 if VIH+)
- Additional Tests (CT Scan, EEG, lumbar puncture)

You should be using the Medical Evaluation Protocols and Agitated Patient Form when trying to decide if a patient has a medical illness or mental illness.
CASE STUDY 1

A 45-year-old woman is brought by her family to your health center. She is clearly psychotic, making nonsensical comments about God and other spirits and also yelling. You recognize her as she has been a patient seen in the HIV/AIDS program.

1. After managing her agitation, how would you evaluate her?

You performed a brief assessment and conducted a blood test. You discovered that the patient is HIV positive and the patient’s CD4 count has come back at less than 200.

2. What do you do next?

3. Is this person suffering from medical delirium or a psychotic disorder?
CASE STUDY 2

A middle-aged man arrives at the health center. His daughter brought him there. He is sweating, disoriented and is anxious. He is mildly agitated and wants to leave the health center. After performing an initial assessment, you find out from his daughter that he drinks alcohol every day (‘a lot’ she reports). The daughter took away all his alcohol and money yesterday because she wants him to stop. The nurse has taken his vital signs, and he has a pulse of 130.

1. What are the signs of alcohol withdrawal you would look for?

2. How would you treat the alcohol withdrawal?

3. Is this person suffering from medical delirium or a psychotic disorder?
Medication Management for Agitation, Delirium, and Psychosis

Once a medical evaluation has been performed, a physician must decide if pharmacological treatment is necessary. Physicians are responsible for prescribing antipsychotics but they must work with psychologists to determine the likely diagnosis. For physicians, identifying a delirium rather than a mental illness is the most important diagnosis that they can make. It can be life-saving.

Prescribing Principles for Agitation, Delirium and Psychosis

The primary tools that can be used to guide prescribing practices are:

- Zanmi Lasante Formulary
- Agitated Patient Protocol
- Medication Card for Agitation, Delirium, and Psychosis

Haloperidol and risperidone are the primary medications for the management of agitation, delirium, and psychosis. Risperidone has fewer side-effects and should be tried before haloperidol, unless the patient is violent or aggressive and could benefit from the sedation of haloperidol. Begin with a low dose and increase gradually.

Carbamazepine should typically be prescribed before valproate as a long-term mood stabilizer.

Valproate is particularly for patients with long-standing aggression or violence, and should never be prescribed to a pregnant woman (and avoided for women of child-bearing age).

Diazepam is only used in agitated patients and those going through alcohol withdrawal.

Children, the elderly, pregnant and breast-feeding patients are special populations. Please consult with the Mental Health team before prescribing for them. For suicidal patients, give a small supply of the medication to a family member to prevent possible overdose.
Psychoeducation about Medication

It is incredibly important to speak to patients and their family members in language that they understand, depending on their education level and knowledge. Do not speak to patients and family members in jargon or complex medical language.

Make sure to explain to the patient/family:

- What the medication is for
- How to take the medication properly
- Common side-effects
- Toxic side-effects and when to seek immediate medical care
- How long it takes for medication to work

**TIP:** To know if the patient/family actually understands the information you are providing about taking the medication, ask the patient/family member to repeat back to you how to take the medication.

Additional information about prescribing principles:

- It is important to take the medication regularly and not miss a dose.
- Do not double up on a dose if a dose is missed.
- It is important to continue to take medication even if symptoms improve.
- Symptoms may worsen if medication is discontinued.
- If any problems of concern develop, contact a member of the treatment team (community health worker, psychologist or physician) by phone, or return to the hospital for evaluation.

Antipsychotics: Side-Effects

Physicians will need to evaluate and manage antipsychotic medications’ side-effects.

Acute dystonia and neuroleptic malignant syndrome are two side-effects that constitute an emergency. Tardive dyskinesia is a possible side-effect of antipsychotic medications, particularly ‘typical’ antipsychotics such as haloperidol. Patients and their families need to know about these side-effects.
**Abnormal Involuntary Movement Scale: Examination and Scoring**

The Abnormal Involuntary Movement Scale is a 12-item scale that the clinician administers and scores. The clinician observes the patient and asks questions about involuntary movements due to tardive dyskinesia. If the physician can catch tardive dyskinesia early, they can intervene. Movements can include:

- Facial and oral
- Extremity
- Truncal
- Patient awareness of movements

The AIMS should be used at the beginning of treatment, and then every six months. It can be done in less than 10 minutes. The clinician tracks the numerical score over time.

Before performing the exam:

- Choose a quiet place. Distraction can cause anxiety, and anxiety can worsen movements.
- You will need two chairs side by side, one for you, in an area large enough for walking. The chair to be used in this examination should be a hard, firm and without arms.
- The AIMS exam begins before you actually begin talking to the patient.
- Look at the patient informally and unobtrusively, when the patient walks into the room.

A positive AIMS score does not mean that the person has tardive dyskinesia. Schizophrenia itself can be associated with dyskinetic movements and a positive AIMS score. This is why it is important to use the AIMS at the beginning of treatment, before initiating the medication. Other conditions that are associated with tardive dyskinesia include: Huntington's disease, Wilson's Disease, Lupus, Thyrotoxicosis, heavy metal exposure and dopaminergic medication. If there is an AIMS Score that indicates that abnormal movements are developing, it is important to have a conversation with the patient about what the AIMS indicates, and what the options are for the patient and the medication. With an AIMS score suggesting tardive dyskinesia, there are three choices for the clinician:

1. 50% of people improve if the medication is stopped. This is possible if the clinical condition allows it.
2. Another possibility is to lower the dose.
3. Another possibility is to change to another antipsychotic class (from haloperidol to risperidone, for example).
**Treatment Monitoring**

In addition to monitoring patients for tardive dyskinesia you need to monitor and measure the possible metabolic effects of antipsychotics.

<table>
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<tr>
<th><strong>RECOMMENDED SCHEDULE FOR MONITORING METABOLIC EFFECTS OF ANTIPSYCHOTICS</strong></th>
<th>Baseline</th>
<th>4 weeks</th>
<th>8 weeks</th>
<th>12 weeks</th>
<th>Quarterly</th>
<th>Annually</th>
<th>Every 5 years</th>
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<td>Personal/Family History</td>
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<td>Weight</td>
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<tr>
<td>Fasting Glucose</td>
<td>X</td>
<td></td>
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<td></td>
<td>X</td>
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</tr>
<tr>
<td>Fasting Lipid</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Risk greatest for aripiprazole, chlorpromazine, clozapine, paliperidone, quetiapine, resperidone, ziprasidone JClin Psychiatry 65:2, February 2004*
### MEDICATION REVIEW WORKSHEET

*Use the Medication Card for Agitation, Delirium, and Psychosis, and the Agitated Patient Protocol.*

1. Which three medications on the medication card can Zamni Lasante physicians prescribe without consulting the Mental Health team?

2. Which two medications on the medication card should NOT be routinely prescribed by Zamni Lasante physicians for bipolar disorder or other forms of mental illness?

3a. A 63-year-old man arrives in the emergency room. He is violent and out of control, pushing people and running around. He has been brought in by his wife and son, who report he has never behaved this way before. What level of agitation does he have (mild, moderate or severe)?
3b. According to the Agitated Patient Protocol Form, which medication should you give the patient? Give the medication name, dose, and form. Do you agree with this recommendation? Why or why not?

4. A 25-year-old woman who is six months pregnant is hospitalized for a clot in her leg. She has been psychotic for many years and is currently mildly agitated (she is irritable and does not cooperate with hospital staff, but is not threatening). She refuses to take the anti-coagulant because of her psychosis. Which antipsychotic would you prescribe for her?

5. A 50-year-old man comes to a local clinic and is clearly psychotic. He receives a comprehensive medical evaluation that showed no evidence of medical illness. He is thought to have a psychotic disorder due to mental illness. Due to his significant functional impairment, you decide to start medication for him. Which medication would you start (give a name, dose and form)?
### AIMS ROLE PLAY

**Clinician:** “Hello Samuel, it’s great to see you. Thank you for coming in for your follow-up appointment.”

**Patient:** Greets clinician.

**Clinician:** “Samuel, are you still taking the risperidone 2 mg at night?”

**Patient:** “Yes I am.”

**Clinician:** “Are you taking any other medication?”

**Patient:** “No.”

**Clinician:** “Good. I know that last time we did this exam it was about six months ago. So I’ll explain again: this brief exam is to look for abnormal physical movements. It is a routine diagnostic tool we use to ensure that the medication you are taking is not causing too much of a problem. If there is a problem we are able to measure it and think of ways to help with the problem. This will take less than ten minutes. Are you ready to begin?”

**Patient:** “Yes.”

**Clinician:** “Is there anything in your mouth, like gum or candy? If so, will you please remove it?”

**Patient:** “Ok.” Takes out gum.

**Clinician:** “How are you teeth feeling? Do you wear dentures?”

**Patient:** “My teeth are feeling OK, although one tooth hurts a little bit.”

**Clinician:** “Thanks for letting me know. Have you been noticing any movements in your mouth, face, hands or feet?”

**Patient:** “What do you mean?”

**Clinician:** “Any movements that were not there before. These movements usually are hard to control or might seem unusual.”

**Patient:** “No, I don’t think so.”

**Clinician:** “Great. Please sit in your chair with your hands on your knees, legs slightly apart and put your feet flat on the floor.” The clinician should model this pose to the patient.

**Patient:** Moves to sit in the chair with hands on knees, legs slightly apart and feet flat on the floor.

**Clinician:** “Please sit with your hands hanging unsupported between your legs.” The clinician should model this pose to the patient.

**Patient:** Sits with hands hanging unsupported, between his legs.
**AIMS ROLE PLAY**

Clinician: “Please open your mouth and relax your tongue.” (Observe the tongue at rest within mouth.)

Patient: Opens mouth.

Clinician: “I now want you to close your mouth, and then open it again, please.”

Patient: Closes and opens mouth.

Clinician: “Can you please stick your tongue out?”

Patient: Protrudes tongue.

Clinician: “I’m now going to ask you to tap your thumb with each finger as rapidly as possible for 10–15 seconds.” The clinician models the behavior.

Patient: “Is this right?” Taps thumb, with each finger, as rapidly as possible for 10–15 seconds with the right hand.

Clinician: “Yes, great job. Can you please do the same thing with the left hand now?” The clinician observes the facial and leg movements.

Clinician: “I’m now going to flex both your arms. Please relax your arms.” Flex and extend the patient’s left and right arms, one at a time.

Patient: Relaxes arms and allows them to be flexed.

Clinician: “Can you please stand up? I want to observe your entire body.”

Patient: Stands up.

Clinician: “While you are standing, can you please extend both arms with arms outstretched in front of you, with palms down?” The clinician models the behavior.

Patient: Extends both arms with palms down.

Clinician: “Great, thank you. Now, if you could please walk a few steps, turn and walk back to this chair. I’m going to observe how you walk.”

Patient: Walks a few paces, turns and walks back to the chair.

Clinician: “Can you do that again?”

Clinician: “Thank you Samuel. I’m just going to take a moment to record my observations.”
Follow-Up and Documentation

The Psychosis Care Pathway only works with functional follow-up and documentation.

Patients should be seen for follow-up appointments every one to two weeks if their symptoms are acute or if medications are being started, adjusted or stopped. Patients with psychosis whose symptoms are stable can be seen once a month or once every three months.

Monitoring Improvement through Coordination with Psychologists

Physicians will need to learn about patient improvement through conversation and interaction with psychologists.

The psychologists will be determining a patient’s improvement through using the Clinical Global Impressions (CGI) Scale and WHODAS 2. The CGI is a tool that psychologists will use to measure symptom severity, treatment response and the efficacy of treatments for a person with a mental disorder. The WHODAS will be used by psychologists to assess a patient’s abilities to perform activities of daily living over the previous 30 days. The WHODAS covers six domains of functioning:

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

Documentation

The documentation for psychosis, including the Zamni Lasante Follow-Up Form and the Agitation, Delirium, and Psychosis Form, will allow physicians to provide better care to patients. All the forms will be collected and managed by the psychologist and will ultimately go into the patient’s file.
Follow-Up Chart

<table>
<thead>
<tr>
<th>TESTS/ASSESSMENTS TO PERFORM</th>
<th>HOW TO DETERMINE A PATIENT’S IMPROVEMENT IN SYMPTOMS</th>
<th>FORMS TO COMPLETE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Advanced Practice – Using mhGAP for Psychosis and Bipolar Disorder

The mhGAP Intervention Guide is a document developed by the World Health Organization that outlines the diagnosis and management of various mental health disorders. It is designed to serve as a guide for clinicians around the world. It is an important resource to help guide decision-making for non-specialist providers such as physicians. The effective training of non-specialists is how the global treatment gap will be narrowed.

The mhGAP chapters on psychosis and bipolar disorder can be used to guide assessment and management of all these different disorders. mhGAP organizes psychotic disorders separately from bipolar disorder because bipolar disorder is considered a mood disorder. However, both bipolar disorder and depression can have psychotic features.

Signs and Symptoms of Psychosis

The various signs and symptoms associated with psychosis can be grouped into two major categories: positive and negative.

A ‘Positive’ symptom – something is present that shouldn’t be:
- Hallucinations
- Delusions
- Disorganized speech
- Disorganized or catatonic behavior

A ‘Negative’ symptom – disruption to normal emotions or behavior:
- Flattening of affect
- Social withdrawal
- Loss of motivation
- Cognitive impairments

Sometimes it is not obvious what symptoms a patient may have. By asking these questions, the physician may be able to better determine if a patient has psychotic features.

- “Have you ever heard voices, even when nobody is present? Do you currently hear voices? Are you bothered or harassed by these voices? What did the voices tell you? Can other people hear the voices too? Do you think that I can hear them?”
- “Have you ever seen things that may not actually be present?”
- “Have you ever felt that your mind or body was being secretly controlled or somehow controlled against your will?”
“Have you ever felt that others wanted to hurt you or really get you for some special reason, maybe because you had secret or special powers of some sort?”

**Determining Chronic vs. Acute Psychosis**

By asking the patient or caregiver about the onset of the psychotic episode and any prior episodes, you will be able to determine if the person has acute psychosis or chronic psychosis. This is important because it can have an impact on the duration of treatment with antipsychotic medication. For acute psychosis, the provider will want to stop the medication at some point to see if the patient can recover without the medication. Medication can have potentially significant side-effects, and we want to minimize the use of medication as much as possible.

**Self-Harm and Suicide**

During your work with depressed patients, epileptic patients and psychotic patients, you might come across a patient that has self-injurious behavior or suicidal ideation. It is critical to assess safety and risk of suicide for all patients for whom there is a mental health concern. By asking someone if they are thinking about hurting or killing themselves, physicians will not increase the risk of the patient doing so. Asking about thoughts of self-harm is an important responsibility of every provider: physician, nurse, community health worker, social worker and psychologist. For the physician assessing a patient for self-harm, mhGAP can assist the physician to take the appropriate next steps.

No matter the condition of the patient, it is important not to leave the patient alone. Self-harm and suicide can be attempted by anyone who might have mental health issues, including depression, epilepsy, psychosis and bipolar disorder.

**For Further Information**

mhGAP Intervention Guide
http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

<table>
<thead>
<tr>
<th>ROLE PLAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASE</strong></td>
</tr>
<tr>
<td>A mother has come to you with her 19-year-old son. He was just diagnosed with schizophrenia by the Zanmi Lasante psychologist. He has been referred to you for treatment. After careful consideration, you have decided to prescribe him a low dose of risperidone. You have already described to him how and when to take his medication, and the possible side-effects. What additional psychosis-specific psychoeducation messages would you give to the patient and his mother?</td>
</tr>
</tbody>
</table>
Review: Case Studies

CASE STUDY 1

A 65-year-old woman is brought into the health facility by her two sons. She is barely able to walk and is clearly confused. She is not able to speak easily and she cannot follow simple commands. Her sons said that she has been fatigued and feverish for the past few days. You are available to evaluate the patient. The patient does not seem agitated.

1. What would you do to determine if she has a psychotic disorder or a medical illness? What forms would you use to assist you?

You have concluded that the patient probably needs further neurologic testing to determine if the patient has a neurological problem. The patient also has a confirmed fever above 38°C. The two sons said that they are sad that she is now ‘crazy’ and want to know how you can cure her.

2. What would you say to the two sons?

3. What additional tests would you perform? What form would you use to assist you?
**CASE STUDY 1**

After performing various tests, you have determined that the patient has encephalitis.

4. What medication would you prescribe, and how would you ensure that the patient and her family are supported as she recovers?
CASE STUDY 2

A 27-year-old man is brought into the health center by two community health workers. He is yelling that the community health workers are trying to kill him. He lunges at anyone who tries to get close to him, screaming that he will kill everyone.

1. Is this patient agitated? If so, what do you do first? What forms would you use to assist you?

After a few minutes of speaking calmly with the patient you leave the room, and identify someone to keep an eye on the patient to ensure his safety and that of others (1:1). You have been able to calm the patient without giving any medication and have done an initial medical evaluation. He denies wanting to hurt himself or others. His lab tests have come back normal.

2. What would you do next? What forms would you be utilizing to guide your work?

After the patient has seen the psychologist, the psychologist diagnoses the patient with a chronic psychotic illness. The patient has been referred back to you for medication to manage the psychosis.

3. What medication would you prescribe for the patient and why? What are some important messages to give to the patient about this medication?
<table>
<thead>
<tr>
<th>CASE STUDY 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. When would you schedule to see the patient next? What other providers</td>
</tr>
<tr>
<td>would you include in the follow-up plan, and what would their role be?</td>
</tr>
</tbody>
</table>
CASE STUDY 3

During the past year you have been seeing a young, 18-year-old woman with a recent episode of psychosis. She was prescribed risperidone. Today during her monthly follow up visit, approximately eight months since the initiation of medication, you notice that she appears restless, frequently wringing her hands.

1. What do you do? How would you document this?

During her appointment, when you ask her how things are going, she begins to cry and tells you that things are not going well. She recently broke up with her boyfriend and cannot find a job to support herself.

2. What are some key messages you would give her during this time of stress related to medication and social support?
Annex
PSYCHOSIS CARE PATHWAY

CASE IDENTIFICATION AND REFERRAL

- Manage agitated patient
- Identify and refer
- Coordinate care
- Psychoeducation

EVALUATION, DIAGNOSIS AND TREATMENT

- Manage agitated patient
- Evaluation, diagnosis, and treatment
- Medication management
- Coordinated care with psychologist/SW
- Psychoeducation

Nurse

Physician

Psychologist or Social Worker

CHW

- Identify, triage, and refer
- Psychoeducation
- Follow-up
- Community activities

REFER

COLLABORATE

FOLLOW-UP

- Manage agitated patient
- Evaluation, diagnosis, and treatment
- Coordinate care with physician and CHW
- Psychoeducation
- MEQ/checklist
<table>
<thead>
<tr>
<th>CHW</th>
<th>PSYCHOLOGIST/SOCIAL WORKER</th>
<th>NURSES</th>
<th>PHYSICIAN</th>
</tr>
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<tbody>
<tr>
<td>AGITATED PATIENT</td>
<td>AGITATED PATIENT</td>
<td>AGITATED PATIENT</td>
<td>AGITATED PATIENT</td>
</tr>
<tr>
<td>- Accompany patient to emergency room immediately</td>
<td>- Accompany patient to emergency room</td>
<td>- Alert either psychologist/social worker</td>
<td>- Alert either psychologist/social worker</td>
</tr>
<tr>
<td>- Decrease risk and reinforce safety if risk for suicide or violence</td>
<td>- Refer to the Agitated Patient Protocol; support nurse and physician</td>
<td>- Follow Agitated Patient Protocol to determine level of agitation and to prescribe medication if necessary</td>
<td>- Follow Agitated Patient Protocol to determine level of agitation and to prescribe medication if necessary</td>
</tr>
<tr>
<td>- Complete the Initial Visit Form</td>
<td>- Collect information from patient and family</td>
<td>- Continue medical evaluation: physical/neuro exam, vital signs, lab tests</td>
<td>- Continue medical evaluation: physical/neuro exam, vital signs, lab tests</td>
</tr>
<tr>
<td>- Use the ZLDSI</td>
<td>- Arrange 1:1 if needed</td>
<td>- Use Medication Card to monitor antipsychotic side effects (consider EKG, fluids)</td>
<td>- Use Medication Card to monitor antipsychotic side effects (consider EKG, fluids)</td>
</tr>
<tr>
<td>- Do psychoeducation</td>
<td>- Remain at bedside until patient is stable</td>
<td>- Do vital signs ASAP</td>
<td>- Document in Agitated Patient Form</td>
</tr>
<tr>
<td>- Give the Referral Form and Initial Visit Form to psychologist/SW</td>
<td>- Follow patient 2x/day, give phone number to patient’s family &amp; nurse/physician</td>
<td>- Prepare oral and IM medications if needed</td>
<td>- Document in Agitated Patient Form</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>INITIAL EVALUATION (ONCE CALM)</td>
<td>INITIAL EVALUATION (ONCE CALM)</td>
<td>INITIAL EVALUATION (ONCE CALM)</td>
</tr>
<tr>
<td>- If suicidal/violent, accompany patient and family to the clinic immediately</td>
<td>- Complete Psychosis Checklist with CHW/nurse</td>
<td>- Review Initial Mental Health Evaluation Form with psychologist/SW to diagnose delirium/medical illness or mental disorder</td>
<td>- Review Initial Mental Health Evaluation Form with psychologist/SW to diagnose delirium/medical illness or mental disorder</td>
</tr>
<tr>
<td>- Decrease risk and reinforce safety if risk for suicide or violence</td>
<td>- Complete ZLDSI</td>
<td>- Do complete medical evaluation: vital signs, physical/neuro exam, lab tests. Use Medical Evaluation Protocol for Agitation, Delirium and Psychosis</td>
<td>- Do complete medical evaluation: vital signs, physical/neuro exam, lab tests. Use Medical Evaluation Protocol for Agitation, Delirium and Psychosis</td>
</tr>
<tr>
<td>- Document with the Mental Health Follow-Up Form</td>
<td>- Document in Initial Mental Health Evaluation Form</td>
<td>- If patient has a psychotic disorder or delirium, use Medication Card to dose</td>
<td>- If patient has a psychotic disorder or delirium, use Medication Card to dose</td>
</tr>
<tr>
<td>- Use the ZLDSI</td>
<td>- Speak with patient and TWW family members &amp; review physician’s Agitated Patient Form to complete initial mental health evaluation</td>
<td>- Do baseline AMS exam</td>
<td>- Do baseline AMS exam</td>
</tr>
<tr>
<td>- Do psychoeducation</td>
<td>- Ensure vitals, weight, and labs are checked</td>
<td>- Document everything in Initial Mental Health Evaluation Form</td>
<td>- Document everything in Initial Mental Health Evaluation Form</td>
</tr>
<tr>
<td>- Give the Referral Form and Initial Visit Form to psychologist/SW</td>
<td>- Accompany patient to see physician (sees all psychotic, suicidal, violent cases)</td>
<td>- Provide medication to last until next appt</td>
<td>- Provide medication to last until next appt</td>
</tr>
<tr>
<td>- Do follow-up of patient in the community (check patient adherence, side effects, encourage patients to do follow-ups)</td>
<td>- Help physician follow checklist</td>
<td>- Do follow-up of patient in the community (check patient adherence, side effects, encourage patients to do follow-ups)</td>
<td>- Do follow-up of patient in the community (check patient adherence, side effects, encourage patients to do follow-ups)</td>
</tr>
<tr>
<td>INITIAL EVALUATION (ONCE CALM)</td>
<td>INITIAL EVALUATION (ONCE CALM)</td>
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<td>INITIAL EVALUATION (ONCE CALM)</td>
</tr>
<tr>
<td>- Complete Psychosis Checklist with CHW/nurse</td>
<td>- Determine whether patient may be psychotic</td>
<td>- Review the Mental Health Follow-Up Form with psychologist/SW to see if patient is improving</td>
<td>- Review the Mental Health Follow-Up Form with psychologist/SW to see if patient is improving</td>
</tr>
<tr>
<td>- Complete ZLDSI</td>
<td>- Accompany patient to see psychologist/SW; support collaboration with physician</td>
<td>- Do physical/neuro exam</td>
<td>- Do physical/neuro exam</td>
</tr>
<tr>
<td>- Document in Initial Mental Health Evaluation Form</td>
<td>- If psychosis is diagnosed, provide psychoeducation and support</td>
<td>- Check weight/vitals each visit; lab tests and AMS every 6 months</td>
<td>- Check weight/vitals each visit; lab tests and AMS every 6 months</td>
</tr>
<tr>
<td>- Speak with patient and TWW family members &amp; review physician’s Agitated Patient Form to complete initial mental health evaluation</td>
<td>- Before discharge, ensure the patient has a follow-up appt with psychologist/SW</td>
<td>- Use Medication Card to check for side effects and to adjust dose as needed</td>
<td>- Use Medication Card to check for side effects and to adjust dose as needed</td>
</tr>
<tr>
<td>- Ensure vitals, weight, and labs are checked</td>
<td>- Provide psychoeducation and support related to medication and psychosis</td>
<td>- Provide medication to last until next appt</td>
<td>- Provide medication to last until next appt</td>
</tr>
<tr>
<td>- Accompany patient to see physician (sees all psychotic, suicidal, violent cases)</td>
<td>- Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
<td>- Do psychoeducation and support related to medication and psychosis</td>
<td>- Do psychoeducation and support related to medication and psychosis</td>
</tr>
<tr>
<td>- Help physician follow checklist</td>
<td>- Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
<td>- Plan follow-up for 1–2 weeks; coordinate with CHW</td>
<td>- Plan follow-up for 1–2 weeks; coordinate with CHW</td>
</tr>
<tr>
<td>- Make preliminary diagnosis of delirium/medical illness or mental illness with the physician</td>
<td>- Do psychoeducation and support related to medication and psychosis</td>
<td>- Do psychoeducation and support for medication and psychosis</td>
<td>- Do psychoeducation and support for medication and psychosis</td>
</tr>
<tr>
<td>- If patient needs medical care, coordinate with physicians, if patient has psychotic disorder, schedule follow-up within one week</td>
<td>- Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
<td>- Check labs when necessary</td>
<td>- Check labs when necessary</td>
</tr>
<tr>
<td>- Do psychoeducation and support related to medication and psychosis</td>
<td>FOLLOW-UP</td>
<td>FOLLOW-UP</td>
<td>FOLLOW-UP</td>
</tr>
<tr>
<td>- Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
<td>- Use Mental Health Follow-Up Form</td>
<td>- Do vital signs, weight at each visit</td>
<td>- Do vital signs, weight at each visit</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>- See whether patient is improving (check mental status exam, functioning, patient and family report)</td>
<td>- Check medication compliance, side effects</td>
<td>- Check medication compliance, side effects</td>
</tr>
<tr>
<td>- Check medication compliance, side effects</td>
<td>- Ensure vitals, weight, and labs are checked</td>
<td>- Accompany patient to see physician; help physician follow Agitation, Delirium and Psychosis Checklist</td>
<td>- Accompany patient to see physician; help physician follow Agitation, Delirium and Psychosis Checklist</td>
</tr>
<tr>
<td>- Accompany patient to see physician; help physician follow Agitation, Delirium and Psychosis Checklist</td>
<td>- Plan follow-up for 1–2 weeks; coordinate with CHW</td>
<td>- Plan follow-up for 1–2 weeks; coordinate with CHW</td>
<td>- Plan follow-up for 1–2 weeks; coordinate with CHW</td>
</tr>
<tr>
<td>- Do psychoeducation and support for medication and psychosis</td>
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<td>- Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
</tr>
</tbody>
</table>
MEDICAL EVALUATION PROTOCOLS FOR AGITATION, DELIRIUM AND PSYCHOSIS SUMMARY
PROTOCOL IN A CLINIC/HOSPITAL SETTING

STEP 1a: Is Person Agitated?
Patient is considered agitated if they are any of the following:
• Violent, aggressive
• Yelling, threatening
• Manic, delusional (has untrue, fixed beliefs)
• Hallucinating
• Acutely paranoid
• Wringing of hands, pacing, tapping hand
• Rapid speech, raising voice
• Frequent requests, low frustration tolerance

STEP 1b: Determine Level of Agitation and Manage
• Refer to Agitated Patient Protocol to guide agitation management depending on symptoms and severity
• Use calm voice
• Give verbal support
• Decrease stimuli
• Ask, “How can I help?”
• Alert staff
• Keep yourself safe
• Use WHO mhGAP (p.74) for Self-Harm/Suicide Assessment if necessary

NO

STEP 2: Perform Medical Assessment
(See Box 1, REFER to and RECORD information on Agitated Patient Form, including):
• Safety: talk first, do not medicate first
• Medical Health: take vital signs, physical exam, mental status exam to assess for delirium
• Mental Health: take history
• Follow-Up: contact psychologist

YES

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

YES

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

NO

See Page 2 for continuation of Medical Assessment

THEN

Box 1: Standard Medical Evaluation for Agitation/Delirium/Psychosis
• Brief History
  – Medical History
  – Alcohol/substance abuse
  – Current medications
  – History of mental illness
• Vital signs, physical exam
• Neurological Exam
• Mental Status Exam
  – Orientation
  – Alertness
  – Confusion

Box 2: Delirium
1. Disturbance of consciousness; reduced ability to focus, sustain or shift attention.
2. A change in cognition or the development of a perceptual disturbance (hallucinations) that is not due to a preexisting, established or evolving dementia.
3. The disturbance develops over a short period of time (usually hours to days) and fluctuates during the day.
4. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.
Medical Evaluation Protocols for Agitation, Delirium and Psychosis Summary (continued)

Continuation of Medical Assessment

Abnormal neurologic exam

NO

Recent onset and temperature > 38 C

YES

HIV+ with CD4 count < 200

NO

THEN

Positive RPR

YES

NO

Abnl glucose, electrolytes, or other evidence of medical illness (See Box 4)

YES

NO

Risk factors for drug or alcohol withdrawal or intoxication? (See Box 5)

YES

NO

YES

NO

Further neurological testing (See Box 3)
Consider CT, EEG, or LP
Consult with specialist

Malaria smear and consider empiric treatment for malaria
Lumbar puncture and consider empiric Rx with appropriate antibiotic medication
Consider CT before LP if asymmetric pupils or abnormal extra-ocular movement or gait.

LP, as above
Consider empiric Rx with appropriate antibiotic medication
Consider treatment for toxoplasmosis or cryptococcus.

Consider additional tests: renal panel, liver panel, chest x-ray
Treat accordingly

Treat alcohol withdrawal with 10 mg IV/IM diazepam, repeat after 15 mins as needed until response, then repeat in 6 hours.
Monitor respiratory rate to avoid overdose

Perform Mental Health Assessment and Consult Mental Health Team

Consider a primary psychotic disorder

Determine whether history of psychosis and medication use coincide.
Consider discontinuing medication.

On medication causing psychosis? (See Box 6)

YES

NO

Box 3: Neurological Conditions that Cause or Contribute to Psychosis
- Tertiary syphilis
- Encephalitis
- Dementia (HIV, Alzheimers)
- Parkinsons
- Brain tumors or other mass lesions (TB, lymphoma, toxoplasmosis)

Box 4: Common Systemic Conditions that can Cause/Contribute to Psychosis
- Malaria
- Electrolyte abnormalities (sodium, calcium)
- Malnutrition, thiamine deficiency
- Thyroid disease
- Alcohol withdrawal
- Hypoxia

Box 5: Alcohol Withdrawal
- History of heavy alcohol use (last drink 24–28 hours prior to symptoms)
- Severe alcohol withdrawal:
  - Within a few hours: withdrawal tremors, nausea, vomiting, sweating, anxiety
  - Within a few days: hallucinations, seizures, fever, disorientation, hypertension

Box 6: Medications that can Cause/Contribute to Psychosis
- Corticosteroids
- Cycloserine
- Isoniazid, Efavirenz
- Corticosteroids
- Phenobarbital
- High doses of anti-cholinergic medication
**AGITATED PATIENT PROTOCOL**

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

**STEP 1:**
Determine level of agitation by observing patient behavior

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

**Moderate Agitation**
- verbal threats
- yelling/cursing
- does not respond to verbal redirection
- does not respond to increased staff presence

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

**STEP 2:**
Manage agitation

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

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

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

1. SAFETY (USE AGITATED PATIENT PROTOCOL)

Patient is:  
- Not Agitated (But appears psychotic)  
- Agitated (Mild)  
- Aggressive (Moderate)  
- Violent (Severe)

History of Violence:  
- No  
- Yes: Describe violent behavior

When did it take place:

Does patient need a 1:1?  
- No  
- Yes:___________

2. MEDICAL HEALTH (USE MEDICAL EVALUATION PROTOCOL)

Vital Signs:  
- Temp:______ Pulse:______ BP:______ RR:______ O2:______ Weight:______

Physical Exam  
- HEENT:  
  - Normal  
  - Abnormal:___________

- Cardiac:  
  - Normal  
  - Abnormal:___________

- Pulmonary:  
  - Normal  
  - Abnormal:___________

- Abdominal:  
  - Normal  
  - Abnormal:___________

- Skin/Extremities:  
  - Normal  
  - Abnormal:___________

Mental Status Exam  
- Alert  
- Sleepy  
- Unable to Arouse  

- Thought Process:  
  - Normal  
  - Confused:___________

- Can Follow Simple Commands:  
  - No  
  - Yes:___________

- Hallucinations:  
  - No  
  - Yes:___________

- Orientation:  
  - Person  
  - No  
  - Yes:___________

  - Place  
  - No  
  - Yes:___________

  - Time/Date  
  - No  
  - Yes:___________

  - Friend/Family Member  
  - No  
  - Yes:___________

Current medications (names and doses):

Delirium  
- Disturbance of consciousness with reduced ability to focus, sustain or shift attention.
- A change in cognition or the development of a perceptual disturbance (hallucinations) that is not better accounted for by a preexisting, established or evolving dementia.
- The disturbance develops over a short period of time (usually hours to days) and fluctuates during the day
- There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.

- No  
- Yes  

(Patient must meet all four criteria above to make diagnosis)

3. MENTAL HEALTH

History of mental illness:  
- No  
- Yes:___________________________________________________________________________________

Has the patient gone to m&k/beudet/other psych facility?  
- No  
- Yes:_____________________________

Is this the first episode of agitation?  
- No  
- Yes:___________

History of suicide attempt:  
- No  
- Yes:___________

Post-Ictal Psychosis:  
- No  
- Yes (episodes of agitation/psychosis only take place after epileptic seizure)

Antipsychotic Medication (Use Agitated Patient Protocol; give dose and indicate whether PO/IM):
- Risperidone:_______________
- Haloperidol:_______________
- Other: Diphenhydramine:_______________

4. FOLLOWUP

- Psychologist contacted about patient

Presumed Etiology of Agitation/Psychosis:  
- Medical Problem/Delirium: _______________  
- Mental Health Problem:_____________________

Has Haloperidol been given?  
- No  
- Yes  
- Fluids ordered/given  
- EKG ordered/done

Notes: _________________________________________________________________________________________________________________
<table>
<thead>
<tr>
<th><strong>PARTNERS IN HEALTH</strong></th>
<th><strong>PARTICIPANT HANDBOOK</strong></th>
<th><strong>ANNEX</strong></th>
</tr>
</thead>
</table>

### Medication Card for Agitation, Delirium, and Psychosis

**Risperidone**
- **1st Choice:** "Atypical" Antipsychotic/Mood stabilizer
- **Use for:** Psychosis (with or without mania)

**Haloperidol**
- **2nd Choice:** "Typical" Antipsychotic/Mood stabilizer
- **Use for:** Aggressive or violent psychosis (with or without mania)

**Diazepam**
- **Benzodiazepine**
- **Use for:** Alcohol withdrawal, acute agitation with or without anti-psychotic

**Carbamazepine**
- **3rd Choice:** Mood stabilizer
- **Do not prescribe without consulting mental health team**
- **Use for:** Mania without psychosis

**Valproate**
- **4th choice:** Mood stabilizer
- **Do not prescribe without consulting mental health team**
- **Use for:** Mania without psychosis (longstanding aggression or violence in males)

**DO NOT USE IF**
- Caution if child/adolescent
- Prior history of dystonia on antipsychotic medication
- Children (18 or younger)
- Pregnant/breastfeeding women
- Children (18 or younger)
- Elderly (65 or older)
- Blood disorder
- Epilepsy: Absence seizures
- Caution if child
- Women of child-bearing age/pregnant women
- Liver disease
- Caution if child

**MUST CONSULT MENTAL HEALTH TEAM**
- For psychosis due to dementia (increased risk of death)
- Children 18 or younger
- Pregnant women
- For psychosis due to dementia (increased risk of death)
- Pregnant women
- For treatment of all mental illness (excluding epilepsy)
- Pregnant or breastfeeding women
- For treatment of all mental illness (excluding epilepsy)

**Starting Dose (Adult)**
- **Risperidone**
  - Take at night due to sedative effects
    - Bipolar/Psychosis – 0.5 – 1 mg
    - Delirium – 0.25 – 0.5 mg
- **Haloperidol**
  - Take at night due to sedative effects
    - Bipolar/Psychosis: 0.5 – 2.5 mg
    - Severe sx: 2.5 – 5 mg
    - Always prescribe diphenhydramine 25 – 50 mg daily with haloperidol
    - Delirium: 0.5 – 2.5 mg at night (Consider low-dose of risperidone first)
- **Diazepam**
  - Antipsychotics require 4 – 6 weeks to reach full effect. If there are safety concerns, physicians can increase doses more quickly (every 3 – 7 days) by 0.5 mg increments. Delirium: increase by 0.25 mg increments.
- **Carbamazepine**
  - Antipsychotics require 4 – 6 weeks to reach full effect. If there are safety concerns, physicians can increase doses more quickly (every 3 – 7 days) by 2.5 mg increments.
- **Valproate**
  - Antipsychotics require 4 – 6 weeks to reach full effect. If there are safety concerns, physicians can increase doses more quickly (every 3 – 7 days) by 2.5 mg increments.

**"Step" of uptitration**
- Risperidone: See Agitated Patient Protocol for guidelines regarding use.
- Diazepam: See Agitated Patient Protocol for guidelines regarding use.
- Carbmazepine: See Agitated Patient Protocol for guidelines regarding use.
- Valproate: See Agitated Patient Protocol for guidelines regarding use.

**Maximum Dose**
- **Risperidone**
  - 2 mg
  - Doses above 2 mg daily must be reviewed with the mental health team.
- **Haloperidol**
  - 10 mg
  - Doses above 10 mg daily must be reviewed with the mental health team.
- **Diazepam**
  - 10 mg
  - Doses above 10 mg daily must be reviewed with the mental health team.
- **Carbamazepine**
  - 800 mg (for mental illness)
  - Doses above 800 mg must be reviewed with the mental health team.
- **Valproate**
  - 1000 mg (for mental illness)
  - Doses above 1000 mg must be reviewed with the mental health team.

---

*Patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations.*
### Medication Card for Agitation, Delirium, and Psychosis (continued)

<table>
<thead>
<tr>
<th></th>
<th>Risperidone</th>
<th>Haloperidol</th>
<th>Diazepam</th>
<th>Carbamazepine</th>
<th>Valproate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toxicities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Serious</td>
<td>[Dystonia (especially of pharynx, eyes, neck—temporary but potentially fatal), Tardive Dyskinesia (permanent), Akathisia (restlessness), Diabetes, Cardiac arrhythmia leading to torsades des pointes]</td>
<td>[Risk of Seizure if diazepam withdrawn without taper after regular use at higher dose]</td>
<td></td>
<td>[Rash, liver failure, decreased white blood count (Carbamazepine can cause hyponatremia)]</td>
<td>[Fatigue, dizziness, nausea/vomiting, incoordination, double vision (Valproate can cause serious birth defects in pregnancy)]</td>
</tr>
<tr>
<td>Common</td>
<td>[Sedation]</td>
<td>[Sedation]</td>
<td>[Sedation]</td>
<td></td>
<td>[Fatigue, dizziness, nausea/vomiting, incoordination, double vision (Valproate can cause serious birth defects in pregnancy)]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Heavy tongue]</td>
<td>[Dependence (should not be given for long periods of time)]</td>
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<tr>
<td></td>
<td></td>
<td>[Stiffness]</td>
<td>[Sedation]</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>[Arrhythmia (for patients receiving more than 10 mg daily)]</td>
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<tr>
<td><strong>Monitoring</strong></td>
<td></td>
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<tr>
<td>Baseline</td>
<td>Aims, weight, fasting glucose, hemogram, hepatic panel (if available)</td>
<td>Aims, weight, fasting glucose, hemogram, hepatic panel (if available)</td>
<td>Aims, weight, fasting glucose, hemogram (if available)</td>
<td>LFTs, CBC, Sodium</td>
<td>Weight gain, LFTs, CBC</td>
</tr>
<tr>
<td>Every visit</td>
<td>weight, vital signs</td>
<td>weight, vital signs</td>
<td>weight, vital signs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every 6 months</td>
<td>Aims, fasting glucose, hepatic panel, hemogram</td>
<td>Aims, fasting glucose, hepatic panel, hemogram</td>
<td>Aims, fasting glucose, hepatic panel, hemogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tapering/Discontinuing</strong></td>
<td>Consult with the mental health team before tapering medication. Some patients may need to continue risperidone indefinitely.</td>
<td>Consult with the mental health team before tapering medication. Some patients may need to continue haloperidol indefinitely.</td>
<td>Consult with the mental health team before tapering medication. Some patients may need to continue haloperidol indefinitely.</td>
<td>Only used for the management of agitated/violent patients and alcohol withdrawal.</td>
<td>Reduce by steps above every 2–4 weeks.</td>
</tr>
<tr>
<td></td>
<td>If the patient has other significant side effects, consider decreasing the dose slowly (by 0.25–0.5 mg increments) and monitoring closely. Can also consider changing to haloperidol.</td>
<td>If the patient has other significant side effects, consider decreasing the dose slowly (by 2.5 mg increments) and monitoring closely. Can also consider changing to risperidone.</td>
<td></td>
<td>If the patient has other significant side effects, consider decreasing the dose slowly (by 2.5 mg increments) and monitoring closely. Can also consider changing to risperidone.</td>
<td>Reduce by steps above every 2–4 weeks.</td>
</tr>
<tr>
<td></td>
<td>For delirium, stop the medication after medical illness is treated.</td>
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<tr>
<td></td>
<td>For chronic psychosis due to mental illness: if the patient is showing improvement in symptoms and has no major side effects, do not stop the medication.</td>
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<tr>
<td></td>
<td>For acute psychosis due to mental illness: consider slowly tapering the medication after patient is symptom-free for 3–6 months.</td>
<td></td>
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</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>Do not prescribe to pregnant or breastfeeding patients without consulting with the mental health team; give folic acid 4 mg QD through pregnancy.</td>
<td>Do not prescribe to pregnant or breastfeeding patients without consulting with the mental health team; give folic acid 4 mg QD through pregnancy.</td>
<td>Do not prescribe (for mental illness) to pregnant or breastfeeding patients without consulting the mental health team; give folic acid 4 mg QD through pregnancy.</td>
<td>Do not prescribe. (for mental illness) to pregnant or breastfeeding patients without consulting the mental health team; give folic acid 4 mg QD through pregnancy.</td>
<td>Do not initiate. If already on, make sure taking 4 mg folic acid QD.</td>
</tr>
</tbody>
</table>

*Carbamazepine can cause hyponatremia.*

*Valproate can cause serious birth defects in pregnancy.*
## TREATMENT FOR ANTIPSYCHOTIC MEDICATION SIDE EFFECTS

<table>
<thead>
<tr>
<th></th>
<th>ESP (EXTRAPYRAMIDAL SYMPTOMS)</th>
<th>TARDIVE DYSKINESIA</th>
<th>NEUROLEPTIC MALIGNANT SYNDROME (NMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE DYSTONIA</strong></td>
<td>Muscle rigidity (potentially including: eye muscles, throat, neck, tongue, back)</td>
<td>Psychomotor restlessness</td>
<td>Confusion, delirium, stiffness (like a lead pipe), sweating, hyperpyrexia, autonomic instability, drooling, elevated WBC, elevated CPK, death</td>
</tr>
<tr>
<td><strong>AKATHISIA</strong></td>
<td><strong>EMERGENCY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Manifestation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Diphenhydramine 50 – 75 mg IM or PO daily</td>
<td>Propranolol 10 – 20 mg TID</td>
<td>Discontinue neuroleptic or lower dose</td>
</tr>
<tr>
<td></td>
<td>Several liters of IV or PO fluids daily</td>
<td>Can also decrease the dose of medication</td>
<td>Consider Vitamin C (500 – 1000 mg/d) + Vitamin E (1200 – 1600 IU/d)</td>
</tr>
<tr>
<td><strong>Toxicities</strong></td>
<td><strong>Serious</strong></td>
<td>Arrhythmia, anemia, arrhythmia</td>
<td>1. Discontinue offending medication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arrhythmia, bronchospasm, Stevens-Johnson syndrome</td>
<td>2. Medical evaluation and support (consider IV fluids)</td>
</tr>
<tr>
<td></td>
<td><strong>Common</strong></td>
<td>Drowsiness, dizziness, headache, dry mouth, tachycardia, constipation, blurred vision</td>
<td>3. Hospitalize</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatigue, dizziness, nausea, depression, insomnia</td>
<td>4. Consider dopamine agonists or dantrolene to improve outcome.</td>
</tr>
</tbody>
</table>
AIMS EXAMINATION PROCEDURE

SHOULD BE COMPLETED BEFORE ENTERING THE RATINGS ON THE AIMS FORM

Either before or after completing the Examination Procedure, observe the patient unobtrusively at rest (e.g. in waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask patient whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is, to remove it.

2. Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient now?

3. Ask patient whether he/she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.

4. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position).

5. Ask patient to sit with hands hanging unsupported. If male, between legs, if female, and wearing a dress, hanging over knees. (Observe hands and other body areas.)

6. Ask patient to open mouth. (Observe tongue at rest within mouth.) Do this twice.

7. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.)

8. *Ask patient to tap thumb, with each finger, as rapidly as possible for 10–15 seconds: separately with right hand, then with left hand. (Observe facial and leg movements.)

9. Flex and extend patient's left and right arms, one at a time. (Note any rigidity and rate it.)

10. Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)

11. *Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)

12. *Have patient walk a few paces, turn, and walk back to chair. (Observe hands and gait.) Do this twice.

*Activated movements.
ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

| Patient’s Name: | ____________________________ | Date: | dd/mm/yy |
| Provider’s Name: | ____________________________ | Phone Number: | ____________________________ |

CURRENT MEDICATIONS AND TOTAL MG/DAY

<table>
<thead>
<tr>
<th>Medication #1:</th>
<th>Total mg/Day:</th>
<th>Medication #2:</th>
<th>Total mg/Day:</th>
</tr>
</thead>
</table>

INSTRUCTIONS: COMPLETE THE EXAMINATION PROCEDURE BEFORE ENTERING THESE RATINGS.

Facial and Oral Movements

1. Muscles of Facial Expression
e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing

2. Lips and Perioral Area
e.g., puckering, pouting, smacking

3. Jaw
e.g., biting, clenching, chewing, mouth opening, lateral movement

4. Tongue
Rate only increases in movement both in and out of mouth, NOT inability to sustain movement

Extremity Movements

5. Upper (arms, wrists, hands, fingers)
Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous); athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT include tremor (i.e., repetitive, regular, rhythmic)

6. Lower (legs, knees, ankles, toes)
e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot

Trunk Movements

7. Neck, shoulders, hips
e.g., rocking, twisting, squirming, pelvic gyrations

SCORING:
• Score the highest amplitude or frequency in a movement on the 0–4 scale, not the average;
• A POSITIVE AIMS EXAMINATION IS A SCORE OF 2 IN TWO OR MORE MOVEMENTS or a SCORE OF 3 OR 4 IN A SINGLE MOVEMENT
• Do not sum the scores: e.g. a patient who has scores 1 in four movements DOES NOT have a positive AIMS score of 4.

Overall Severity

8. Severity of abnormal movements

9. Incapacitation due to abnormal movements

10. Patient’s awareness of abnormal movements (rate only patient’s report)

Dental Status

11. Current problems with teeth and/or dentures?

12. Does patient usually wear dentures?

Comments: ________________________________________________________________________________________________________

Examiner’s Signature ____________________________ | Next Exam Date ________________
