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

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

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

Many PIH and Zanmi Lasante staff members and external partners contributed to the development of this training. We would like to thank Giuseppe Raviola, MD, MPH; Rupinder Legha, MD; Père Eddy Eustache, MA; Tatiana Therosme; Wilder Dubuisson; Shin Daimyo, MPH; Noor Beckwith; Lena Verdeli, PhD; Ketnie Aristide; Leigh Forbush, MPH; and Jenny Lee Utech.


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

© Text: Partners In Health, 2015
Photographs: Partners In Health
Design: Katrina Noble and Partners In Health
This manual is dedicated to the thousands of health workers whose tireless efforts make our mission a reality and who are the backbone of our programs to save lives and improve livelihoods in poor communities. Every day, they work in health centers, hospitals and visit community members to offer services, education, and support, and they teach all of us that pragmatic solidarity is the most potent remedy for pandemic disease, poverty, and despair.
Table of Contents

Introduction to Agitation, Delirium, and Psychosis

Introduction ........................................................................... 1
Objectives ............................................................................. 2
Time Required ....................................................................... 4
Materials ............................................................................... 5

Session 1: Introductions, Pre-test and Confidentiality .......... 6
Session 2: Epidemiology, the Treatment Gap and Stigma.....10
Session 3: Diagnosis of Severe Mental Disorders .......... 18
Session 4: The Psychosis System of Care and the
Four Pillars of Emergency Management of Agitation,
Delirium and Psychosis ....................................................... 26
Day 1 Review: Group Presentations ................................. 33
Session 5: Safety and Management of Agitated Patients ..34
Session 6: Medical Evaluation and Management of
Agitation, Delirium, and Psychosis ........................................ 45
Session 7: Biopsychosocial Clinical Formulation ............ 48
Session 8: Medication Management for Agitation,
Delirium, and Psychosis ....................................................... 55
Day 2 Review: Jeopardy .................................................. 61
Session 9: Psychotherapy and Family & Patient Education...63
Session 10: Clinical Outcome Measures –
CGI and WHODAS............................................................ 70
Session 11: Follow-Up and Documentation ......................... 81

Session 12: Using mhGAP for Psychosis and Bipolar Disorder ......................................................... 83

Session 13: Review Session, Post-Test and Training Evaluation .............................................................. 87

Annex

Pre-Test and Post-Test ........................................................ 96

Pre-Test and Post-Test Answer Key .................................... 101

Psychosis Care Pathway ................................................... 106

Differential Diagnosis Information Sheet for Severe Mental Disorders ...................................................... 107

Agitation, Delirium and Psychosis Checklist ........................ 110

Agitated Patient Protocol .................................................. 111

Agitation, Delirium and Psychosis Form ............................. 112

Medication Card for Agitation, Delirium, and Psychosis ..... 113

Medical Evaluation Protocol for Agitation, Delirium, and Psychosis ............................................................ 116

Suicidality Screening Instrument ........................................ 118

Suicidality Treatment Guidelines ........................................ 119

Safety Plan ........................................................................ 121

Jeopardy Review Questions and Answer Key ..................... 122

Clinical Global Impressions Scale (CGI) ............................ 125

WHODAS 2.0 12 Item Version .......................................... 127

Training Evaluation Form ................................................... 131

Additional Resources:

mhGAP Intervention Guide English:
http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf

Diagnostic and Statistical Manual of Mental Disorders (DSM) IV
Introduction to Agitation, Delirium, and Psychosis

INTRODUCTION

Psychotic disorders refer to a category of severe mental illness that produces a loss of contact with reality, including distortions of perception, delusions, and hallucinations. The most common psychotic disorders are schizophrenia and bipolar disorder, which affect a combined 81 million people. However, these two conditions do not account for all psychotic disorders. 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 Stigma and discrimination against people living with severe mental illness often result in a lack of access to health care and social support. Human rights violations including 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 psychotic and are, therefore, immediately referred to mental health. However, oftentimes 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, psychotic disorders are treatable and for some, completely curable. With the right training and system of coordinated care, people with psychosis can receive effective treatment and lead rich, productive lives. In this training, psychologists and social workers will learn how to manage agitated patients safely and effectively and will also learn how to properly diagnosis psychotic disorders caused by 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 agitated, delirious, and psychotic patients.

OBJECTIVES

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

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

Session 2:
  d. Identify participants’ current and past attitudes surrounding severe mental illness.
  e. Describe the epidemiology of psychotic disorders and the corresponding treatment gap.
  f. Describe the various ways that psychosis may be viewed by the community and by health providers.
  g. Describe the impact of stigma on patient care and outcomes.

Session 3:
  h. Identify key clinical information related to the diagnosis of various psychotic disorders.
  i. Develop a basic mental health differential diagnosis using the Differential Diagnosis Information Sheet.

Session 4:
  j. Describe the psychosis care pathway and its collaborative care approach.
  k. Outline the main roles of physicians, psychologists, social workers, nurses and community health workers in the system of care.
  l. Explain the four pillars of emergency management of agitation, delirium and psychosis.
  m. Describe how a psychologist/social worker should use the biopsychosocial model when managing a patient with agitation, delirium or psychosis.

Session 5:
  n. Describe the identification, triage, referral, and non-pharmacological management of an agitated patient through the use of the Agitated Patient Protocol and Agitation, Delirium and Psychosis Form.
  o. Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.

Session 6:
  p. Define medical delirium.
  q. Describe the importance of proper medical evaluation for an agitated, delirious or psychotic patient.
r. Explain the process of carrying out a medical evaluation for an agitated, delirious or psychotic patient.

Session 7:
s. Explain how to gather information for a complete mental health history.
t. Describe how to create a biopsychosocial clinical formulation to guide a patient’s treatment.

Session 8:
u. Explain the collaboration between the physician and the psychologist/social worker in managing medication for agitation, delirium and psychosis.
v. Describe the physician’s use of the Medication Card for Agitation, Delirium and Psychosis.

Session 9:
w. Explain the core psychotherapy approaches for patients with severe mental illness.
x. Describe how to educate patients and family members about the effects and management of psychosis and bipolar disorders.

Session 10:
y. Describe how to use the CGI and WHODAS to assess clinical improvement.
z. Explain the importance of outcome measures to assess care quality and systems improvement.

Session 11:
aa. Explain the process of follow-up for people living with psychotic disorders and severe mental illness.
ab. Describe the importance of documentation during patient follow-up.

Session 12:
ac. Describe how to use mhGAP for the management of psychosis and bipolar disorder.
ad. Describe how to use mhGAP for the management of self-harm/suicide.

Session 13:
ae. Review all unit objectives.
af. Demonstrate learning through a post-test.
ag. Give feedback on the training.
**TIME REQUIRED**

3½ days (19 hours and 10 minutes of training sessions)

**DAY 1: 5 hours and 15 minutes of training sessions**

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions, Pre-Test and Confidentiality</td>
<td>• Facilitator presentation</td>
<td>1 hour 45 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Icebreaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assessment</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Epidemiology, the Treatment Gap, and Stigma</td>
<td>• Reflection journey</td>
<td>1 hour 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facilitator presentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Role play</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Diagnosis of Severe Mental Disorders</td>
<td>• Facilitator presentation</td>
<td>1 hour 15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case studies</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The System of Care and the Four Pillars of Emergency Management of Agitation, Delirium, and Psychosis</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Large group discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case studies</td>
<td></td>
</tr>
</tbody>
</table>

**DAY 2: 5 hours 40 minutes of training sessions**

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Day 1 Review</td>
<td>• Group presentations</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5</td>
<td>Safety and Management of Agitated Patients</td>
<td>• Facilitator presentation</td>
<td>2 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Role play</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Medical Evaluation and Management of Agitation, Delirium and Psychosis</td>
<td>• Facilitator presentation</td>
<td>30 minutes</td>
</tr>
<tr>
<td>7</td>
<td>Biopsychosocial Clinical Formulation</td>
<td>• Facilitator presentation</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Small group work</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Medication Management of Agitation, Delirium and Psychosis</td>
<td>• Facilitator presentation</td>
<td>1 hour 10 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Worksheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Role play</td>
<td></td>
</tr>
</tbody>
</table>
DAY 3: 5 hours and 45 minutes of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Day 2 Review</td>
<td>• Jeopardy</td>
<td>1 hour</td>
</tr>
<tr>
<td>9</td>
<td>Psychotherapy and Family &amp; Patient Education</td>
<td>• Facilitator presentation&lt;br&gt;• Case Study</td>
<td>1 hour 15 minutes</td>
</tr>
<tr>
<td>10</td>
<td>Clinical Outcome Measures: CGI and WHODAS</td>
<td>• Facilitator presentation&lt;br&gt;• Role Play</td>
<td>2 hours</td>
</tr>
<tr>
<td>11</td>
<td>Follow-Up and Documentation</td>
<td>• Facilitator presentation&lt;br&gt;• Small group work</td>
<td>45 minutes</td>
</tr>
<tr>
<td>12</td>
<td>Using mhGAP for Psychosis and Bipolar Disorders</td>
<td>• Facilitator presentation&lt;br&gt;• Role Plays</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

DAY 4: 2 hours 30 minutes of training sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Methods</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Review, Post-Test and Training Evaluation</td>
<td>• Case studies&lt;br&gt;• Assessment&lt;br&gt;• Reflection</td>
<td>2 hours 30 minutes</td>
</tr>
</tbody>
</table>

**MATERIALS NEEDED**

<table>
<thead>
<tr>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator Manuals—1 copy/facilitator</td>
</tr>
<tr>
<td>Participant Handbooks—1 copy/participant</td>
</tr>
<tr>
<td>Agitation, Delirium, and Psychosis PowerPoint presentation</td>
</tr>
<tr>
<td>Jeopardy PowerPoint</td>
</tr>
<tr>
<td>DSM IV (participants should bring their own copies)</td>
</tr>
<tr>
<td>mhGAP—1 copy/participant (for optional Session 12)</td>
</tr>
<tr>
<td>Computer and Projector</td>
</tr>
<tr>
<td>Flip chart</td>
</tr>
<tr>
<td>Markers</td>
</tr>
<tr>
<td>Post-it Notes (estimate 7/participant)</td>
</tr>
<tr>
<td>Tape</td>
</tr>
</tbody>
</table>
SESSION 1: Introduction, Pre-Test and Confidentiality

Methods: Facilitator presentation, ice breaker and assessment

Time: 1 hour 45 minutes

Materials:
- PowerPoint presentation (Agitation, Delirium, and Psychosis slides 1–9)
- Pre-Test (1 copy/participant)
- Flip chart or chart paper
- Markers, pens
- Tape
- Post-it notes

Preparation:
- Review PowerPoint (Agitation, Delirium and Psychosis), slides 1–9.
- Post a blank sheet of paper on the flip chart and title it "Goals & Expectations."
- Post a blank sheet of paper on the flip chart and title it "Training Rules."
- Photocopy the pre-test (see appendix).

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

NOTE FOR FACILITATOR PREPARATION

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

Encourage participant feedback during PowerPoint presentations. Some slides have a clinician depicted with a conversation bubble that is intended to look like she is asking a question. Use her conversation prompts to ask the audience questions and hear their feedback before clicking forward to reveal the answers.
**STEPS**

20 minutes

1. Turn on projector and begin the PowerPoint at Slide 1: Agitation, Delirium and Psychosis. Welcome participants, introduce yourself and this training. Tell the participants that this training is about management of agitation, delirium and psychosis.

2. Show Slide 2: Session 1: Welcome and Learning Objectives.
   Read the objectives on the slide.

   Explain how this training ties into past trainings on depression and epilepsy. Tell the participants that taken together, these three trainings articulate the beginnings of a coherent community-based system of mental health care. Tell the participants that a community-based system of care facilitates:
   - High-quality care (safe, effective, evidence-based and culturally attuned) that keeps patients in their local communities, resulting in less socioeconomic burden on families.
   - Comprehensive medical evaluation.
   - Multi-disciplinary and biopsychosocial approach to care involving physicians, nurses, community health workers, psychologists/social workers.
   - Humane care that does not involve institutionalizing patients for years or traumatizing them by tying them up, beating them, or injecting them with high doses of medication.

4. Show Slide 4: Psychosis Care Pathway.
   Tell the participants that they may remember seeing similar care pathways for both depression and epilepsy. These pathways guide how these mental health issues are handled in Zanmi Lasante’s community-based mental health system of physicians, psychologists, social workers, nurses and community health workers. Tell the participants that today we will be introducing a similar care pathway for psychosis. Allow the participants to look at the various responsibilities of the health providers in the psychosis system of care. Explain that the participants will be seeing this model throughout the training.

5. Show Slide 5: Zanmi Lasante Mental Health.
   Explain that since the development of the community-based system of mental health care, Zanmi Lasante has been able to identify and treat many patients with various mental health issues.

6. Turn off the projector (or cover the lens).
40 minutes

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

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

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

CONFIDENTIALITY

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

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

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

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

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

13. Collect the completed pre-tests.

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

15 minutes

15. Explain to the participants that they have materials and resources that will be referred to throughout the training. The materials and resources will also be a resource to them once the training is over. Tell them that they can refer to the training materials when they are seeing patients or need clarification on the topics covered in the training.

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

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

18. Tell the participants that the additional materials will be distributed and explained as the training progresses.

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

20. Turn on the projector (or uncover its lens).

   Animate and read each objective (ask a participant to read the objectives aloud or do so yourself). Tell the participants that these objectives will be covered by the training in the next three and a half days.
SESSION 2: Epidemiology, the Treatment Gap, and Stigma

Methods: Reflection journey, facilitator presentation, role play

Time: 1 hour 15 minutes

Participant Handbook page: 4

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 10–18
- Flip chart
- Markers

Preparation:
- Practice implementing the Reflection Journey.
- Review the PowerPoint (Agitation, Delirium, and Psychosis), slides 10–18.

Objectives:
- Identify the participants’ current and past attitudes surrounding severe mental illness.
- Describe the epidemiology of psychotic disorders and the corresponding treatment gap.
- Describe the various ways that psychosis may be viewed by the community and by health providers.
- Describe the impact of stigma on patient care and outcomes.

STEPS

20 minutes

1. Show Slide 10: Session 2: Epidemiology, Treatment Gap and Stigma.
   Read the objectives and explain to participants that the group will begin to discuss psychotic disorders.

2. Ask the participants to begin by closing their eyes or putting their heads down. Explain that you will take them through a ‘Reflection Journey’—some quiet thinking before a large group discussion.
3. Once the participants are ready, lead them through the following ‘Reflection Journey’. Be sure to pause for 5–10 seconds after each question to allow the participants to reflect. Keep in mind that you do not need to ask every question (and you may add any questions that might be more relevant).

When you hear the word “psychosis”:
- What words come to mind?
- What images come to mind?

Think back to a time when you were very young:
- How did you learn about psychosis? What were your thoughts or feelings about it?
- What words did you hear and use related to psychosis?
- What did you think or feel about people with psychosis?

Think about your life since then:
- How have your thoughts about psychosis changed?
- What events or experiences changed the way you think or feel about psychosis?
- In what ways have your ideas about psychosis remained the same?

4. Ask participants to open their eyes. Invite a few volunteers to share their thoughts (maintaining patient and family confidentiality), and lead a brief discussion during which you discuss participants’ past and current experiences with psychosis.

5. Ask the participants if they think their understanding and views around psychosis and severe mental illness are different than their patients’. If so, ask the participants to elaborate on how patients and families might interpret psychosis. Write the participants’ ideas on a flip chart as they share their ideas.

6. Emphasize the importance of understanding that patients and families might have different understandings than psychologists/social workers as to why someone has psychosis. Explain that each person and family, depending on their personal and cultural background, has an “explanatory model of illness”, which helps them to understand and make sense of their experience. Explain that participants are going to be introduced to some biomedical terms in this training, but it is important to note that using these terms with patients is less important than understanding patients’ and families’ experiences. It is important to help families feel heard and understood, and psychologists/social workers can do this by avoiding medical jargon and instead engaging with patients on their level.
40 minutes

7. Show Slide 11: Psychosis.
   Animate the speech bubble. Ask the participants the following question:
   • What is psychosis?

   Wait for a few responses, and then respond by animating the answer. Tell the participants that there are some psychiatric disorders that mimic psychosis, which can include PTSD, acute stress, intellectual development disorder and autism spectrum disorder.

   Animate the speech bubble. Ask participants the following question:
   • How would you define schizophrenia?

   Wait for a few responses, and then respond by animating the answer.

   Animate the speech bubble. Ask participants the following question:
   • What is bipolar disorder?

   Wait for a few responses, and then respond by animating the answer. Tell the participants that many symptoms of anxiety tend to be confounded with mania. Psychologists/social workers should pay close attend to the signs and symptoms of bipolar disorder.

   Animate the speech bubble. Ask participants the following question:
   • How many millions of people are affected by schizophrenia and bipolar disorder?

   Wait for a few responses, and then respond by animating the answer. Tell the participants that approximately 1 in 100 people globally lives with a psychotic illness.

11. Ask the participants to reflect upon the following question:
   • As we just learned, people with schizophrenia/bipolar disorder have a reduced life expectancy. Why do you think this is?

   Have the participants share their answer with the person sitting next to them, and then have the pairs share their ideas with the group.

12. Explain that there are many reasons for reduced life expectancy, some of which are consequences of what we call the “treatment gap.”
   Animate the speech bubble. Ask the participants the following question:
   
   • What does “treatment gap” mean?

   Wait for a few responses, and then respond by animating the answer. Tell the participants that the two most common severe mental illnesses are schizophrenia and bipolar disorder.

14. Explain that 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.²

15. Show Slide 16: Reasons for the Treatment Gap.
   Animate the title. Ask participants to specifically share why they think there is a treatment gap. After all ideas have been given, respond by animating the text on the slide.

16. Show Slide 17: Consequences of the Treatment Gap.
   Animate the title. Ask participants the following question:
   
   • What are the consequences of this treatment gap in Haiti?

   Allow participants to respond. Animate the picture and text. Explain to the participants that lack of awareness around mental health treatment often leads to abuse and mistreatment of those living with severe mental illness.

17. Show Slide 18: Consequences of the Treatment Gap.
   Explain that lack of treatment can have direct effects on the physical health of those living with severe mental illness. This photo is of a girl with epilepsy who fell into a fire when she had a seizure.

18. Explain that the treatment gap directly affects society’s concepts of severe mental illness and leads to stigma and discrimination of those with severe mental illness. Use the exercise below to demonstrate this concept further.

Ask the following questions sequentially to the participants:

Raise your hand if:
1. You have been to a doctor’s appointment during the last year.
   – Wait for the participants to raise their hands.
2. You were admitted to a hospital for any reason during the past year.
   – Wait for the participants to raise their hands.
3. You have taken any medication during the last year.
   – Wait for the participants to raise their hands.

Ask participants how it felt to answer these questions in this group setting. Allow participants to respond.

Now say:
If we were to ask you to raise your hand (BUT no need to raise your hand) if...

1. You saw a mental health professional during the past year.
2. You were admitted to a psychiatric hospital, such as Mars and Kline, for any reason during the past year.
3. You have taken any psychiatric medication during the last year.

….how would you feel? Why?

Have the participants share how they felt during this exercise.

19. Tell the participants:

   Even though we are providers of mental health care, and understand the epidemiology behind severe mental illness, we can still feel stigma towards severe mental illness. This can lead to discrimination and unfair or low-quality treatment of patients.

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.

20. Highlight the fact that, 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.

21. Tell the participants that they are now going to role play how providers can perpetuate stigma in their work with people with severe mental disorders—sometimes without even realizing it.

22. Ask for three volunteers to participate in the role play. Assign one volunteer to be the patient, one volunteer to be the nurse, and one volunteer to be the family member. Give the three volunteers two to three minutes to read over the role play found in their participant handbook (refer to Facilitator Notes). Tell the volunteers that the ‘story’ section of the role play is intended to give the role play participants key background information, however, the participants should just use the script when performing.

23. Invite the role play volunteers to the front of the room to complete the role play about stigma.
**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 she thinks he may hit her. The nurse does not check vital signs or provide any medical care. Instead the nurse calls the psychologist/social worker on the phone and says “a mental health patient is here.” In the meantime, the patient is totally dehydrated, and has both a high fever and pulse that go undetected. His family 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 mother wait and no one comes to them for help.

**SCRIPT**

Family Member (Participant 2): Brings in sick patient to the emergency room.

Patient (Participant 1): Arrives to emergency room in the arms of a family member. Begins to talk a lot about vodou and religion in the emergency room.

Nurse (Participant 3): Acts scared because he might be violent. Calls psychologist/social worker to say a mental health patient is here.

Patient (Participant 1): Has a fever and becomes dehydrated. Does not look well.

Family Member (Participant 2): Reports to nurse that patient has never behaved this way before and only became “a crazy person” after a dog bit him. Becomes frustrated that a lot of time has passed and no one has helped them.
24. After the role play, ask the following question:
   - Which of the nurses’ actions might have perpetuated the stigma around people with severe mental disorders?
   - What should have been done?
   - Has anyone ever encountered a similar situation in their work? What was done well or done poorly by the clinician in those situations?

25. Tell the participants:
   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. Psychologists/social workers 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. Psychologists/social workers have the opportunity to help some of the most vulnerable and marginalized people living in communities—those living with mental illness.
SESSION 3: Diagnosis of Severe Mental Disorders

Methods: Facilitator presentation, large group discussion, case studies

Time: 1 hour 15 minutes

Participant Handbook page: 8

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 19–33
- DSM IV (participants should bring their own copies)

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 19–33.
- Identify pages in DSM IV that have diagnostic criteria for illnesses outlined in steps 11–18.

Objectives:
- Identify key clinical information related to the diagnosis of various psychotic disorders.
- Develop a basic mental health differential diagnosis using the Differential Diagnosis Information Sheet.

STEPS

40 minutes

1. Show Slide 19: Session 3: Diagnosis of Severe Mental Disorders.

   Tell the participants that they will review the basics of diagnosing mental health problems that fall under the umbrella of “severe mental illness.” Explain that the participants will use the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), as a guide to frame the discussion. The DSM IV is used in the United States and is similar to The International Classification of Diseases, Tenth Revision (ICD-10) that is used in other parts of the world.

2. Show Slide 20: Defining Severe Mental Disorders.

   Ask the participants.
   - What is a severe mental disorder and how is this different than a common mental disorder?

   Wait for a few responses, and then respond by animating the answer.
   Read the points on the slide, emphasizing that each patient could have a combination of symptoms—they do not need to have them all to be psychotic. Explain that negative symptoms are the opposite of what is expected in a normally behaving person.

   Explain that there are three distinct phases of psychosis that psychologists/social workers will see throughout their work with psychotic patients: the prodromal phase, the acute phase and the stable phase.

5. Show Slide 23: Range of Psychotic Disorders.
   Animate speech bubble. Ask the participants the following question:
   • Who can name a psychotic disorder?
   Wait for a few responses, and then respond by animating the answer.

6. Ask the participants if they understand what the text on the bottom of the slide means: “A medical delirium, which looks like a psychosis, is not a psychotic disorder. It is a medical emergency!” Take answers.
   Tell the participants that delirium is a medical condition that produces a disturbance in attention and awareness. A delirious person might have psychotic symptoms, however they do not have a mental illness, they have a medical illness. Once the medical illness is treated, the psychotic symptoms disappear.

**DELIRIUM**

<table>
<thead>
<tr>
<th><strong>Delirium</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium is a disturbance in attention and awareness due to a medical illness. A medical delirium can appear like psychosis; however it is not a psychotic disorder!</td>
</tr>
</tbody>
</table>

7. Explain to the participants that there is a Differential Diagnosis Information Sheet in their participant handbook that outlines various severe mental illness diagnoses. Have the participants open their participant handbooks to the Differential Diagnosis Information Sheet located in the annex. Give the participants a few minutes to review the document.
8. After a few minutes, ask the participants to describe the way in which the Differential Diagnosis Information Sheet is organized. Take a few answers. Explain that:

- The Differential Diagnosis Information Sheet begins with the category of psychosis-appearing symptoms due to medical conditions. Later in the training psychologists/social workers will learn about physicians' roles in determining if a patient has a medical illness or mental illness.
- The second category on the Differential Diagnosis Information Sheet describes mental health issues that are NOT psychosis.
- The third and fourth categories describe psychotic or manic disorders, and these categories are divided up by “episodic” illnesses and “continuous” illnesses.

Ask if there are any questions on how the Differential Diagnosis table is organized.


Tell the participants that there are some medical conditions and mental health conditions that may look like psychosis, but are not. These include all the conditions in the first two categories on the first page of the Differential Diagnosis Information Sheet. These conditions should still be treated by a psychologist/social worker and physician, but today's training will not focus on these conditions. Ask if there are any questions about psychosis mimics on page one of the Differential Diagnosis Information Sheet.

10. Have the participants go to the next page to the “Episodic Psychosis or Mania” section. Explain that symptoms that are present for less than six months are considered episodic. Tell them that this category includes both mood disorders (depression with psychotic features and bipolar disorder) and psychosis.


Ask for participants to open their DSM IV. Have them find this diagnosis in the DSM and follow along. Read the slide aloud.


Have the participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud. Tell them that bipolar disorder is diagnosed when a patient has at least one manic episode. Explain that:

- Bipolar disorder usually starts during adolescence and early adulthood. It is not common that bipolar disorder develops in children who have no family risk factors and it is rare that it develops in people over 60 years (except when associated with another disease).
- 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. Some people may have as many manic and depressive episodes, while others may experience one type of episode (usually depression). If you are not sure which episodes the patient has had, document it as bipolar unipolar.
• **Hypomania** is a less severe form of mania, with similar symptoms, but less severe. Hypomania has a less of a negative impact on the daily activities of the person.

• Around half of people initially diagnosed with bipolar disorder achieve syndromal recovery within six weeks, and nearly all achieve it within two years, with nearly half regaining their prior occupational and residential status in that period. However, nearly half of people go on to experience a new episode of mania or major depression within the next two years.

13. **Show Slide 29: Brief Psychotic Disorder.**

Have the participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud. Tell participants that in the DSM a brief psychotic disorder can only be diagnosed if the episode lasts less than 1 month.

14. **Show Slide 30: Schizophreniform Disorder.**

Have participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud. Tell participants that the main difference between brief psychotic disorder, schizophreniform disorder and schizophrenia is the duration of the symptoms/episode. Schizophreniform can be diagnosed if symptoms are present for 1–6 months only.

15. **Show Slide 31: Psychosis NOS.**

Have the participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud. Ask if anyone has ever encountered a patient that they thought should be diagnosed with Psychosis NOS, and if so, ask for that participant to share their experience with the symptoms and diagnosis of the patient.

16. **Explain to the participants that symptoms that are present for more than six months are considered continuous, which includes the illnesses of schizophrenia and delusional disorder.**

17. **Show Slide 32: Schizophrenia.**

Have the participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud. Explain that:

• Schizophrenia is thought to be caused by physical changes in the brain, however it may begin after a stressful event.

• Schizophrenia may begin at any time but most commonly it begins in the mid- to late teens or early 20s.

• Prior to developing schizophrenia, patients may show subtle nonspecific signs such as depression, social withdrawal, and irritability.

• Patients can have periods of stability with or without treatment during which their symptoms are absent or minimal.
Emphasize that among adults, hallucinations are viewed as synonymous with psychosis and as harbingers of serious psychopathology. In children, however, hallucinations can be part of normal development or can be associated with non-psychotic psychopathology, psychosocial stressors, drug intoxication, or physical illness. The first clinical task in evaluating children and adolescents who report hallucinations is to sort out those that are associated with severe mental illness from those that derive from other causes.

18. Show Slide 33: Delusional Disorder.
   Have the participants find this diagnosis in the DSM and follow along. Ask for a participant to read the slide aloud.

35 minutes

19. Tell the participants that they will now practice using the Differential Diagnosis Information Sheet for four different cases. Tell the participants they will be divided into four groups. Each group will be assigned a case and will have 10 minutes to complete the questions related to their case. The participants will use their Differential Diagnosis Information Sheet to help determine a diagnosis.

20. After 10 minutes has elapsed, bring the class back together. Invite each group to read their case studies aloud and give their answers.

21. Conclude by telling the participants that proper diagnosis of severe mental illness is one of the key responsibilities of the psychologist/social worker in the system of care. This includes making an accurate diagnosis and not overdiagnosing severe mental disorders such as schizophrenia and bipolar disorder. Misdiagnosis leads to poor treatment and overmedication.
FACILITATOR NOTES

DIFFERENTIAL DIAGNOSIS CASE STUDIES

*For all cases assume that a medical illness has already been ruled out by the physician. All the patients referred to you have been determined to have a mental illness.

CASE STUDY 1

A mother has brought her 12-year-old girl to the health facility. She says that her daughter is often unfocused, seemingly “far away.” The daughter sometimes wakes up in the middle of the night screaming. The girl refuses to enter any cars. Through questioning the mother, you find out that this has been happening for 7 weeks. The girl has had difficulty falling asleep, has been sleeping poorly, and reports that sometimes she sees “shadows of people” at night who are not there. The mother reveals that their son died in a car accident about two months ago, and that the daughter was in the car when it happened. After performing a mental status exam, taking a history and asking the patient a few questions about her friends and school, you see she has no evident problems with cognition or emotion. There is no history of mental illness in the family.

1. Is the girl, in your opinion, psychotic? Why or why not?
   - No. She does not seem to have dysfunction in cognition, behavior or emotion. There are no positive and negative symptoms present. Although she may see “shadows” at night, this does not mean that she has psychosis. Often when people, particularly children and young people, have stress they can both hear and see things that may not be present. This is usually not psychosis. It is important to remember that while true psychosis develops in the late teen and early adult years, it is extremely uncommon in children younger than 12. In this case, to diagnose psychosis and to prescribe an antipsychotic medication would do more harm to the girl than good. Antipsychotic medication could cause unwanted medication side-effects, such as diabetes or permanent abnormal muscle movements.

2. What diagnosis might you present to the girl? Why?
   - Acute stress, anxiety or trauma related problem.
   - She has been in a traumatic event and is experiencing transient sensory experiences, like nightmares and flashbacks. She is anxious to enter cars. Helping her to cope with the loss of her brother, and the terrible experience of being in the car when the accident happened, should be the focus of treatment. This should be done in close collaboration with a supervising psychologist who can advise on the most effective and safest approach to treatment.
CASE STUDY 2

A 22-year-old woman is brought in by her husband. He says that his wife has been acting strangely recently. He reports that she has refused to get out of bed for the past week and has been crying frequently. He was worried she was depressed. However, yesterday she got out of bed extremely happy and was so energized cleaning the house she didn’t sleep at night. You observe the wife chatting excitedly with other people in the waiting room. She says she feels wonderful and doesn’t know why her husband brought her here. The husband reports that over the past few days she has been spending the family’s money on nonessential items and that he is worried that this is putting the family at risk.

1. Is the woman, in your opinion, psychotic? Why or why not?
   - The behavior of the woman is concerning. The history provides evidence of real depression, followed by mania. Being in a good mood is a good thing, but if the mood is so elevated that it seems abnormal, and if the associated behavior puts the person or others around the person at risk, this is concerning for mania. However, the woman does not hear voices and does not have symptoms that are clearly indicative of psychosis.

2. What diagnosis might you present to the woman? Why?
   - Bipolar disorder with mania and depression. She has periods of elation and depression. She has had a manic episode characterized by a decreased need for sleep, is more talkative than usual and is involved in pleasurable activities that have a high potential for consequences. She also has periods of depression where she stays in bed and cries.

CASE STUDY 3

A 20-year-old man is brought in by his friend. The friend says that recently, the patient started saying that his neighbor is watching him all the time. The patient cannot stop talking about the neighbor’s spying. The patient describes that he even hears what the neighbor is saying about him in his mind. When you ask how long this has been happening for, the friend says almost three months.

1. Is the man, in your opinion, psychotic? Why or why not?
   - Yes. He has dysfunction in cognition and behavior. He is experiencing delusions and hallucinations.

2. What diagnosis might you present to the man? Why?
   - Possibly schizophrenia, but it has not been long enough to be diagnosed. At this time schizophreniform disorder would be diagnosed because the issue has been occurring for more than three months. The clinician should be cautious about making a diagnosis of schizophrenia because six months have not yet passed.
CASE STUDY 4

A 25 year-old man is brought in by a neighbor. This patient has disorganized behavior and has not bathed recently. He is mumbling words under his breath and is not able to speak in complete sentences. You try to have a conversation with the patient, but cannot easily communicate. You ask the neighbor how long he has been like this. The neighbor responds that he has been like this for a few years already, but this is the first time that he is seeing a psychologist/social worker. The neighbor says that the man cannot work because of his mental state and sometimes the man is aggressive and yells threats to no one in particular. What diagnosis might you present to the man?

1. Is the man, in your opinion, psychotic? Why or why not?
   Yes. He has dysfunction in cognition and behavior. It is reported that he is experiencing hallucinations.

2. What diagnosis might you present to the man? Why?
   Schizophrenia. He has hallucinations, disorganized speech and disorganized behavior for more than six months. Since the onset of the disturbance his ability to work and self-care has been affected.
SESSION 4: The Psychosis System of Care and the Four Pillars of Emergency Management of Agitation, Delirium, and Psychosis

Methods: Facilitator presentation, large group discussion, case studies

Time: 1 hour

Participant Handbook page: 17

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 34–52
- Markers
- Tape
- Flip chart

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 34–52

Objectives:
- Describe the Psychosis Care Pathway and its collaborative care approach.
- Outline the main roles of physicians, psychologists, social workers, nurses, and community health workers in the system of care.
- Explain the four pillars of emergency management of agitation, delirium, and psychosis.
- Describe how a psychologist/social worker should use the biopsychosocial model when managing a patient with agitation, delirium or psychosis.

STEPS

20 minutes


   Explain to the participants that you will discuss how Zanmi Lasante clinicians will facilitate care for complex patients, including psychotic patients.
2. Show Slide 35: Discussion About Psychosis Care Pathway.

Tell the participants that psychologists and social workers main roles in the Zanmi Lasante system of care are:

a. to ensure safety for the patient and others through correct agitation management;
b. to make a preliminary diagnosis of delirium/medical illness or mental illness in coordination with the physician;
c. to provide psychotherapy and psychoeducation to patient and families;
d. to coordinate care with the physician and CHW.

Explain that psychologists/social workers 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 physicians, nurses and community health workers.

3. Have the participants turn to the Agitation, Delirium and Psychosis Checklist in their participant handbooks. Explain that all cadres will be receiving this checklist, which is an outline of key responsibilities. Give participants several minutes to read the checklist. Once the participants have finished reading it over, read the “Psychologist/Social Worker” column aloud, going through each responsibility. Ask if there are any questions.


Explain this is a summary of the checklist responsibilities for each cadre.

5. Assess the participants’ understanding of the checklist by asking the questions below. Call randomly on participants. If a participant is unable to answer correctly, ask if another participant might be able to assist with the correct answer. Give participants at least 1–2 minutes to look for an answer before calling on someone else.

1. According to the psychosis care pathway, which providers are responsible for deciding if a patient has a medical problem or psychological disorder?
   – Psychologists and physicians work together to determine whether patients have a medical problem or a psychotic disorder (a mental health problem).

   Animate slide 37: Question 1: Psychologists & Physicians

2. According to the psychosis care pathway, which providers are responsible for managing an agitated patient?
   – Physicians, psychologists/social workers, and nurses work together to manage agitated patients. However, physicians are expected to take the lead, due to the need for prompt medical evaluation to rule out a treatable medical condition, and to possibly prescribe an initial medication for either a medical or mental health problem.

   Animate slide 38: Question 2: Physicians, Psychologists & Nurses
3. According to the psychosis care pathway, which providers are responsible for giving psychoeducation?
   - All providers.

Animate slide 39: Question 3: All Providers

4. According to the psychosis care pathway, how should physicians collaborate with psychologists/social workers during the initial evaluation of a calm patient and the follow-up visit for a calm patient?
   - During an initial visit: to diagnose delirium/medical illness or mental disorder and to plan follow-up visits.
   - During a follow-up visit: to determine whether a patient is improving and to plan follow-up visits.

Animate slide 40: Question 4: Diagnose Delirium/Medical Illness, Plan Follow-Up visits, Patient Improvement.

6. Show Slide 41: Psychosis Care Pathway.
   Animate the slide. Tell the participants to turn to their neighbor and discuss for five minutes the questions on the slides. After five minutes, bring the participants together and ask for the participants to share some of their ideas.

7. Show Slide 42: Tools Used by Physicians with Which Psychologists/Social Workers Should be Familiar.
   Explain that psychologists/social workers and physicians each have their responsibilities in the system of care that require tools. There are some diagnostic tools that are only used by physicians, however, psychologists/social workers should be familiar with these tools.

   Explain that there are other tools only used by psychologists/social workers.

   Emphasize that these tools will be used by both psychologists/social workers and physicians.
40 minutes

    Explain that psychologist’s responsibilities in the care pathway align with the four pillars of managing a patient with psychotic symptoms. Emphasize that these pillars lay the framework for how clinicians manage patients with psychotic symptoms. Tell the participants that they will be coming back to these pillars throughout the training.

11. Show Slides 46: How do These Pillars Direct our Thinking and Action with Psychotic Patients?
    Explain that there are several steps and processes within each pillar that the participants will learn to address when confronted with a psychotic patient. Read the slide and explain that these are some of the main steps that will guide all cadres of health workers to provide appropriate care for a patient with psychotic symptoms.

12. Show Slide 47: Biopsychosocial Model.
    Explain that clinicians 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.

    Explain to participants that a biopsychosocial approach to mental health treatment, will:
    • Assist with understanding the condition
    • Assist with structuring assessment and guiding intervention
    • Inform multidisciplinary practice

    Animate the title. Ask the participants what biological considerations psychologists and social workers should have when working with patients with psychotic symptoms. Once they have responded, animate the “bio” column.

    Ask the participants what psychological considerations psychologists and social workers should have when working with patients with psychotic symptoms. Once they have responded, animate the “psycho” column.

    Ask the participants what social considerations psychologists and social workers should have when working with patients with psychotic symptoms. Once they have responded, animate the “social” column.

    Emphasize that the biopsychosocial approach to evaluation will lead to better identification of problems, communication between providers, and care for patients.

Animate the slide. Ask for a volunteer to read the case aloud. Remind the participants they did a role play earlier today based on this case. Ask the participants to think about the four pillars of emergency management and how they can apply the pillars to this case.

15. Show Slide 50: Case 1: How Should We Think About Mental Health?"

Animate the title. Before animating the text for the “safety” pillar, ask the participants what questions they would ask the patient and his family about patient’s safety. Then, animate the text. Repeat this process for each of the following pillars: medical health, mental health and follow-up.

16. Show Slide 51: Case 1: Biopsychosocial Considerations.

Animate the title. Ask participants to take five minutes to fill out the biopsychosocial considerations table in their participant handbook for Case 1. Specifically have the participants write what information they know, and what further considerations or information they would want to find out. Then, ask the participants to share their answers for the “bio” column, animating the column after all responses have been given. Ask the participants to share their answers for the “psycho” column, animating the column after all responses have been given. Repeat the same process for the “social” column.

17. Show Slide 52: Case 1: Resolution.

Ask a participant to read the slide. Ask the participants if they can appreciate how the four pillars of emergency management and the biopsychosocial approach were used to manage this case. Ask if there are any questions.

18. Ask the participants to take a moment to review the checklist again. Emphasize how the checklist draws upon these two approaches (four pillars of emergency management and biopsychosocial approach). Note how psychologists and social workers are responsible for completing the mental health evaluation while physicians are responsible for the medical management of patients.

19. Before finishing this session, show the participants the table in their participant handbook entitled “Four Pillars of Emergency Management of Agitation, Delirium and Psychosis.” Inform them that they can use this table as a reference tool.
## 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.
DAY 1 REVIEW: Group Presentations

Methods: Group presentations
Time: 30 minutes
Materials:
- Flip chart
- Markers

Steps

30 minutes

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

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

3. Divide the participants into three groups. Distribute the flip chart paper and markers. Assign one of the following sessions to each group (if there are more than five participants in each group, participants should be divided into further groups. You can assign the same session to more than one group):
   - Session 2: Epidemiology, Stigma and the Treatment Gap
   - Session 3: Diagnosis of Severe Mental Disorders
   - Session 4: The Psychosis System of Care and the Four Pillars of Emergency Management of Agitation, Delirium and Psychosis

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

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

Methods: Facilitator presentation, role plays

Time: 2 hours

Participant Handbook page: 22

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 53–67
- Flip chart
- Markers

Preparation:
- Review the PowerPoint (Agitation, Delirium, and Psychosis), slides 53–67.
- Make copies of Suicidality Screening Instrument (1 copy/participant).
- Facilitators should review and practice the role play.

Objectives:
- Describe the identification, triage, and non-pharmacological management of an agitated patient through the use of the Agitated Patient Protocol, and Agitation, Delirium and Psychosis Form.
- Explain how to screen for suicidal ideation and manage suicidal patients consistent with their severity and risk level.

STEPS

45 minutes

   Remind the participants that they learned about the four pillars of emergency management yesterday. Ask the participants what the first pillar is: safety! Explain that participants will spend this session learning about safety and management of agitated patients.

2. Ask the participants:
   - Why it is important to be able to manage an agitated patient?
   - What experiences do you have managing agitated patients?

   Allow for a few participants to respond.
3. Have the participants turn to the Medical Evaluation Protocols for Agitation, Delirium and Psychosis in their participant handbook. Explain that this protocol guides physicians from managing an agitated patient (Step 1a) to performing a medical assessment to rule out delirium (Step 2). Give the participants a minute to read over the protocol.

4. Show Slide 54: What is the first step in managing an agitated patient?

Animate the slide. Tell the participants that often physicians and other health providers are unsure what to do when there is an agitated patient. Ask the participants to show how they would answer the question by raising their hands:

- Who thinks the first step is A?

Pause for the participants to raise their hands. Continue by asking who would do B, C, and D as a first step.

Explain that the answer is D, and animate the slide. Tell the participants that talking to the patient allows you to evaluate the risk of violence, begin the medical evaluation, and calm the patient. The physician and psychologist/social worker should always attempt to talk to the patient before prescribing medication.

5. Show Slide 55. Managing Agitated Patients Following the Psychosis Care Pathway.

Emphasize to the participants that physicians manage agitated patients as a team with psychologists/social workers and nurses. Clarify that these roles listed on the PowerPoint slide are found on the Agitation, Delirium and Psychosis Checklist under “Agitated Patient” for each cadre.

6. Have the participants turn to the Agitated Patient Protocol, and Agitation, Delirium and Psychosis Form in their participant handbooks. Explain that these forms are the main tools that participants will use to evaluate and manage agitated patients. Specify that the Agitated Patient Protocol will assist participants in properly managing different levels of agitation. The Agitation, Delirium and Psychosis Form assists physicians in recording vital information related to determining if an agitated patient is delirious or psychotic. Give the participants several minutes to review the forms independently.

7. Show Slide 56: Agitation Etiology.

Animate the speech bubble. Ask participants the following question:

- By a show of hands, who thinks agitation is a disease?

Wait for participants to raise their hands.

- Who thinks agitation is not a disease?

Wait for participants to raise their hands. Respond by animating the text on the slide.

Explain that there is a spectrum of agitation and patients can fall anywhere on the spectrum. Choose participants to read aloud the various behaviors of those with mild, moderate and severe agitation. Ask the participants to take a moment to look at the Agitated Patient Protocol. Ask participants if they see the different degrees of agitation/aggression/violence and that this level determines the management of the patient. Explain that the purpose of the Agitated Patient Protocol is to guide safe and effective care of patients, including reducing the use of physical restraint and medication.

9. Explain to the participants that there are some key differences in agitation management, especially in the treatment between moderate and severe agitation. Ask the following questions to provoke critical thinking and discussion. Pause between questions to allow participants to respond. Give additional information as needed.

- When should we give medication intramuscularly?
  - From a human rights perspective, we always want the least restrictive approach and use the fewest interventions necessary. Physicians only give medication intramuscularly to a severely agitated patient who is at risk of imminent self-harm or is harming those around him. Physicians 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.

- Why is it important that we monitor the vital signs of the patients to whom we give medication?
  - The process of taking medication or having medication administered against one’s will can be stressful. Stress, in combination with medical and psychiatric conditions, can lead to physiological instability. The medications themselves can affect the heart, for example potentially causing heart arrhythmia. Vital signs are key measures to physiologic status and are therefore essential.

- In what situations should clinicians use physical restraint?
  - From a human rights perspective, 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.
• It is important for providers to learn from their experiences, and from each other. A “debrief” can be an important measure to take in the context of managing agitation. Physicians can take the lead in organizing a team debrief. When you organize the team and debrief with staff, what should you talk about?
   – A brief summary of the event; what worked well; what didn’t work well; what should be done differently in the future; who is responsible for follow-up.

    Read the slide. Tell the participants that this safety information is on the Agitated Patient Protocol. Explain to the participants how to ensure safety and remind them it is the first of the four pillars of emergency management for a reason. Emphasize that a physician or nurse should never inject a patient with haloperidol without speaking to the patient first, even if the patient is agitated.

11. Have the participants turn to the Agitation, Delirium and Psychosis Form. Point out that the first box on the form is about safety. Explain the steps in completing the safety section of the form. Remind the participants that while physicians will be responsible for filling out this form psychologists/social workers should know what is on the form to help if needed.

< 30 minutes

    Have a participant read the case study aloud.

13. Tell the participants that the facilitators will now put on a three minute role play acting out this case.

INSTRUCTIONS FOR THE FACILITATOR

During this role play, one facilitator will play the part of a physician and the other will play the part of the patient. The facilitator playing the physician will demonstrate inappropriate, commonly-used tactics for managing agitated patients. In particular, the facilitator playing the role of the physician should raise his/her voice at the patient, threaten to inject the patient with medication and tie the patient up, demonstrate anger and frustration, and not provide any medical care (such as doing vital signs or a physical exam).
14. After the role play concludes, ask the participants: What went wrong? Allow them to respond and add any of the following points they may have missed.

- Raising one's voice at the patient
- Threatening to tie up the patient/give an injection
- Showing anger and frustration
- Not providing care to the patient

15. Ask the participants to use the Agitated Patient Protocol to discuss how they would approach the patient instead. Allow them one minute to read over the Agitated Patient Protocol and then have the participants share their answers with the person sitting next to them. Ask for a few pairs to share their answers. Responses should include emphasizing safety first, talking before injecting, and managing the behavior and the environment.


Animate the slide’s title. Explain to the participants that psychologists/social workers should try to obtain as much history about the patient as possible to better inform the management of the patient’s agitation. Show the patients the top box of the Agitated Patient Protocol that says “Throughout Visit: Assessment.”

Then, ask the participants what questions they might ask the neighbors who brought the man to the health center in the case study. Ask for the participants to share their answers. Once all answers have been shared, animate the text on the slide. Mention that while 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.

17. Show Slide 61: Performing a Brief Assessment.

Remind the participants that throughout the process of interacting with the agitated patient, physicians and psychologists/social workers will be working together to perform assessments to understand if there is a medical illness or mental illness. Physicians will be doing the medical portion of assessments, while psychologists/social workers will be helping to obtain information about mental health history and suicide and violence risk.


Tell the participants they will continue to practice their use of the Agitated Patient Protocol and the Agitation, Delirium and Psychosis Form through another three to five minute role play. Ask for five volunteers and assign each of them to one of the following roles: a patient, two family members, a physician, and a psychologist/social worker. The physician will be responsible for using Agitation, Delirium and Psychosis Form to properly manage and medically evaluate the patient. Both the psychologist/social worker and physician should use the Agitated Patient Protocol.
After the role play has concluded, debrief with the audience. Ask the audience the following questions:

• What level of agitation did this patient have?
• What did the psychologist/social worker and physician do well?
• What could have been improved?

45 minutes

19. Tell the participants that another key part of safety includes the identification and triage of patients who may have suicidal ideation. It is important that each agitated or psychotic-appearing patient with a concern of self-harm is screened for suicidality.

20. Explain to the participants that psychologists/social workers have the responsibility within the system of care to evaluate and properly screen patients for suicidality. The physician, when managing an agitated patient will ask and then record on the Agitated Patient Form if that patient has a history of suicide attempts. If the patient does have a history of suicide attempts, 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 patient’s self-harm (whether past or present), the psychologist/social worker should also administer the Suicidality Screening Instrument.

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

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

23. Explain when the psychologist/social worker has finished asking the questions (or has received a no for both columns, ending the interview), the psychologist/social worker will add up the number of “yes” in each column and write the total number of “yes” for each column on the scoring line. Then, the participants will look at the scoring criteria below and determine the risk depending on the scores for the current column and the past column.
24. Tell the participants they will now have the opportunity to practice screening for suicidality through two guided role plays (refer to Facilitator Notes). Ask the participants to turn to the role plays in their participant handbook. Explain that the participants will be split into pairs, and one person will play the psychologist/social worker, while the other will play the patient. The participants will have three minutes to complete Role Play #1, following the script in the participant handbook. Once the role play is complete, the psychologist/social worker role will have the responsibility of scoring the interview.

25. Divide the participants up into pairs, have each pair choose who will play each role, and have all pairs begin Role Play #1. After the participants have finished the role play (it should take no more than three minutes), remind the psychologist/social worker role to record his score on the sample screening instrument in his participant handbook.

26. Tell the participants that now, staying in their pairs, they will switch roles and conduct Role Play #2.

27. After the participants have finished the role play (it should take no more than three minutes), remind the psychologist/social worker role to record his score on the sample screening instrument in his participant handbook. Bring all the participants back together.


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

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

Go over any questions if participants determined a different score.

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

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

Go over any questions if participants determined a different score.

29. Tell the participants that once they have a score from the Suicidality Screening Instrument, they will determine a category of risk. As the participants see, there are different categories of risk that span from low risk to high risk. Tell the participants it is important to determine the category of risk so the psychologists/social workers can properly use the Suicidality Treatment Guidelines. The level of risk takes into account both the scoring from the questions “now or in the past two weeks” and “in the past year.”
30. Ask the participants to use the scores for the past two role plays to determine the level of risk of each of those patients.
   - Ask: What would the participants label “Emmanuel” (Role Play #1 patient)?
     Wait for participants to give answers. Confirm that he would be “medium risk.”
   - Ask: What would the participants label “Katrina” (Role Play #2 patient)?
     Wait for participants to give answers. Confirm that she would be probably “high risk” because she has a current score of three, a past score of three, and indicated she might act on her suicidal thoughts.

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

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

   Explain that 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).

   Have a participant read through the steps on the slide that outline the components of a safety plan. Remind the participants that their role as psychologist/social worker is to support patients in creating this plan (the psychologists/social worker is not creating this plan for the patients!).
35. Show Slide 67: Considerations When Creating a Safety Plan.

Read the points on the slide and emphasize that the most important aspect of the safety plan is its accessibility and ease of use. A safety plan will not be helpful if there are obstacles in the plan that the patient cannot overcome. The psychologist’s/social worker’s role is to discuss feasibility of the plan’s steps with the patient so the patient is prepared. Ask if there are any questions about the Safety Plan.

36. Conclude the session by reminding the participants that safety is the first pillar of emergency management. Talking to a patient effectively and helping the patient to feel safe and respected—not simply medicating a patient—is a key part of safety and evaluation.
ROLE PLAY 1

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

Patient: No.

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

Patient: Yes.

*Interview continues because patient said yes.*

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

Patient: No.

Psychologist/Social Worker: Have you had any thoughts of killing yourself in the past year?

Patient: Yes. Things were just so hard!

*Interview continues because patient said yes.*

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

Patient: No.

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

Patient: No. I never decided to do anything.

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

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

**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 hospital/clinic is to help people feel safe, and to help all of the physicians and nurses to ensure the safety of people we see here. Please know that you can trust me, and that I would like to be helpful to you.

**Patient**: OK.

**Psychologist/Social Worker**: Have you ever wished you were dead in the past two weeks?

**Patient**: Yes.

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

**Patient**: Yes.

*Interview continues because patient said yes.*

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

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

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

**Patient**: (Nods).

*Interview continues because patient said yes.*

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

**Patient**: Yes, I think a lot about it.

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

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

*Interview continues because patient said yes.*

**Psychologist/Social Worker**: Do you have any intention to act on these thoughts?

**Patient**: I’m not sure…

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

*Interview ends as clinician develops a plan to support the patient based on the rest of the history obtained.*
SESSION 6: Medical Evaluation and the Management of Agitation, Delirium, and Psychosis

Methods: Facilitator presentation

Time: 30 minutes

Participant Handbook page: 28

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 68–78
- Markers
- Tape
- Flip chart

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 68–78.

Objectives:
- Define medical delirium.
- Describe the importance of proper medical evaluation for an agitated, delirious or psychotic patient.
- Explain the process of carrying out a medical evaluation for an agitated, delirious or psychotic patient.

STEPS

45 minutes

   Tell the participants that once they have calmed an agitated patient, the team of clinicians will need to determine if the patient is psychotic or has a medical delirium.

   Review the case by having a participant read the case aloud. Allow the participants to indicate whether they agree or disagree with the management of the case and why.
   Ask the participants what went wrong. Give them time to respond. Highlight the points below:
   • The patient did not receive a comprehensive medical evaluation.
   • Haloperidol was used inappropriately and dangerously to sedate the patient (using haloperidol to sedate patients can kill them!).
   • The patient was not properly diagnosed with delirium (psychosis and agitation are medical problems until proven otherwise).

4. Show Slide 72: Consequences of Mismanagement of Agitation, Psychosis and Delirium.
   Walk the participants through the case timeline on the PowerPoint slide, highlighting the consequences of sedating a patient rather than doing a medical evaluation that would have uncovered a medical delirium (not psychosis).

5. Show Slide 73: Definition of Agitation, Delirium and Psychosis.
   Read through the definitions. Emphasize how all of these phenomena are considered medical problems unless proven otherwise; these patients are not automatically “mental health patients,” rather they are medical patients who need care from physicians.

   Tell the participants that delirium is not well understood biologically, but that it can be understood as a physiological imbalance in the body and brain that can be potentially fatal. Delirium is often misdiagnosed as psychosis or other psychiatric illnesses. Remind the participants of the case of the 28-year-old woman who was seven months pregnant and died.

7. Show Slide 75: Physical Illness Causes Delirium.
   Ask the participants:
   • Which physical illnesses cause delirium?
   Read the list of medical problems and indicate which ones are common in Haiti.

8. Show Slide 76: Other Medical Causes of Psychosis/Agitation.
   Read the slide.
   Ask the participants:
   - How would you medically evaluate patients to determine whether a medical problem is
     the cause of their agitated or psychotic behavior?

   Once the participants have responded, animate the answers on the slide. Remind the par-
   ticipants that the physician will be performing the medical evaluation, but it is important
   for psychologists/social workers to understand what physicians will be doing.

10. Have the participants turn to the Medical Evaluation Protocols for Agitation, Delirium
    and Psychosis in their participant handbooks. Remind the participants that they saw
    this protocol last session, and were focused on the managing agitation portion (Steps 1a
    and 1b). Now, they can use this protocol (Step 2) to assist the physician in managing
    the medical assessment portion. Read aloud the steps of the medical assessment as described
    by the protocol. Emphasize that a mental health problem cannot be considered until the
    physician has completed this entire medical protocol and has established whether the
    patient does or does not have a medical delirium.

11. Show Slide 78: How do you distinguish between mental illness and medical illness?
    Animate the title. Allow the participants to look at the Medical Evaluation Protocols for
    Agitation, Delirium and Psychosis and then respond with their ideas. Then, animate the text.
SESSION 7: Biopsychosocial Clinical Formulation

Methods: Facilitator presentation, case studies

Time: 1 hour 30 minutes

Participant Handbook page: 30

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 79–93
- Markers
- Tape
- Flip chart

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 79–93.

Objectives:
- Explain how to gather information for a complete mental health history.
- Describe how to create a biopsychosocial clinical formulation to guide a patient's treatment.

STEPS

1 hour


Tell the participants that, if after a medical evaluation, it has been concluded that a patient has a mental illness, the psychologist/social worker will complete the Initial Mental Health Evaluation Form. This includes recording a complete mental health history and creating a biopsychosocial clinical formulation for a patient.

2. Show Slide 80: Information to Obtain from Patient/Family.

Explain to the participants that during the management of an agitated patient, there may have been some mental health history taken and recorded on the Agitated Patient Form. However, once a medical illness has been ruled out and the patient is no longer agitated, it is very important for the psychologist/social worker to obtain a complete mental health history to inform diagnosis and clinical formulation.

3. Show Slide 81: General Principles for Evaluating Patients with Mental Disorders.

Tell the participants that these are basic principles that they already have learned, but should review.
4. Show Slide 82: Conducting a Complete Mental Health History.
   Animate the three questions on the slide. Tell the participants that they will take the next three minutes to brainstorm the answers to the questions on the slide with the person sitting next to them. Once three minutes has elapsed, ask the participants to share their responses.

5. Show Slides 83–84: Questions to Ask to Obtain History.
   After the participants have shared their answers, animate the text. Explain that it is crucial to obtain details regarding illness progression, impact on overall functioning and family history. Clarify what questions psychologists/social workers should ask to obtain mental health history. Ask the participants if they notice that these different pieces of history comprise a biopsychosocial history.

6. Emphasize that the Initial Mental Health Evaluation Form has specific sections to record each of type of history, which includes “History of Present Illness,” “Past Psychiatric History,” “Past Medical History,” “Psychiatric Family History.”

7. Show Slide 85: Start General Then Be Specific.
   Explain that psychologists/social workers should always start their conversations with open-ended questions and then probe with specific questions when they hear about a certain illness or symptoms. Psychologists/social workers should always try and speak to the family or someone who knows what has been occurring. Ask the patient’s permission before you do this. While it is very important to hear what is going on from family members, it is also important that the patient has the chance to speak. Remember it is up to the psychologist/social worker to decide if a person has a mental illness, not the person's family. If the person is not allowed to speak or not given enough time to answer questions by their family, you may miss important symptoms. You may also wrongly diagnose a mental illness when a person is in fact healthy!

   Do not correct the patient if the patient says things that are strange or unbelievable. Do not agree with them either. Make sure they have understood the question you have asked and let them know that you have listened to their response. An example would be to say: “Thank you for telling me that. I am grateful you could be so honest. I guess there are a lot of different ways of looking at the world.”

8. Show Slide 86: Utilize the Systematic Interview Technique.
   Tell the participants that once they receive information about a patient’s symptoms, they should use the systematic interview technique to help identify what mental disorder a patient may or may not have. The psychologists/social workers should use the Differential Diagnosis Information Sheet to guide their questions about symptoms for specific disorders.
   Read the questions aloud to the participants.

10. Show Slide 88: After Trust has Developed, Further Assess Safety and Stressors.
    Tell the participants that they should assess the safety of the patient through asking the questions listed on the slide.

    Animate the title and speech bubble. Ask the participants who has made a clinical formulation before and what a clinical formulation is. Wait for a few responses and then animate the text.

    Tell the participants that a clinical formulation is not a summary of the clinical data. A formulation must contain a theory about the etiology of the patient’s problems, related developmental status and strengths.

    Animate the title and speech bubble and ask why a clinical formulation is important. Wait for a few responses and then animate the text.

    Read the points on the slide. This clinical formulation will be recorded on the Initial Mental Health Evaluation Form on page 4.

14. Instruct the participants to look at the example of the biopsychosocial clinical formulation in their participant handbook. Have all participants take two minutes to silently read the example in their participant handbook. Ask if there are any questions.

### BIOPSYCHOSOCIAL CLINICAL FORMULATION EXAMPLE

Peterson is a 21-year-old male living in Mirebalais who lives with his parents and presented to the hospital with a chief complaint of “hearing voices.” From a biological perspective there is a family history of a similar problem (his father), and he also experienced head trauma in a motorcycle accident several years ago. From a psychological perspective, Peterson has experienced significant shame about his illness, which has significantly affected his self-esteem. He and his family believe that these symptoms are related to a curse that was cast on the family. From a social perspective, they also are poor, Peterson’s father drinks alcohol excessively, and at times there is domestic violence. Peterson has strengths in that he has been a good student at school, he goes to church, and he participates in a musical group.
15. Have the participants look at the table in their participant handbook that outlines how to document a clinical formulation from a biopsychosocial perspective (refer to Facilitator Notes). Tell the participants they can use this table’s wording to help them create a clinical formulation. Read through the table with the participants.

30 minutes

16. Tell the participants they will practice formulating a biopsychosocial clinical formulation using case studies (refer to Facilitator Notes).

17. Ask the participants to turn to the biopsychosocial formulation cases in their participant handbooks. Tell the participants that they will spend 15 minutes individually creating biopsychosocial formulations for two cases.

18. After 15 minutes, choose a few participants to present their answers for Case #1.
   • Show Slide 92: Case #1.

   Explain to the participants that the clinical formulation on the slide is a sample formulation. Emphasize that biological, psychological, social and strengths perspectives should always be present in a biopsychosocial formulation.

19. Choose 1–2 participants to present their answers for Case #2.
   • Show Slide 93: Case #2.

   Explain to the participants that the clinical formulation on the slide is a sample formulation. Emphasize that biological, psychological, social and strengths perspectives should always be present in a biopsychosocial formulation.
## Biopsychosocial Clinical Formulation Table

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>There appear to be no significant biologic factors in the patient’s current presentation.</td>
<td>From a general psychological perspective, XYZ describes his/her closest relationships to be __. He/she lives with __ and the nature of these relationships is __.</td>
<td>From a social perspective, areas of concern include __. There are several social considerations in assessing the patient’s current presentation. These include:</td>
<td>Areas of significant strength, competency and mastery</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are several biologic considerations in assessing the patient’s current presentation. These include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a developmental history notable for __.</td>
<td>• a history of personal and family losses notable for __.</td>
<td>• family/living situation, specifically __.</td>
<td></td>
</tr>
<tr>
<td>• a history of substance abuse</td>
<td>• a history of interpersonal conflicts notable for __.</td>
<td>• work, specifically __.</td>
<td></td>
</tr>
<tr>
<td>• a family history of __ and a potential predisposition to illness</td>
<td>• a history of internal conflict about __.</td>
<td>• financial/economic, specifically __.</td>
<td></td>
</tr>
<tr>
<td>• a history of head trauma, seizures, or infection</td>
<td>• a history of challenges regarding __.</td>
<td>• recent changes and transitions of note such as __.</td>
<td></td>
</tr>
<tr>
<td>• stereotypies notable on exam that might indicate potential psychiatric co-morbidities</td>
<td>• belief system with regards to mental health and illness</td>
<td>• high risk behaviors such as sexual or behavioral</td>
<td></td>
</tr>
<tr>
<td>• developmental disabilities or serious developmental findings</td>
<td>These have affected the person in the following ways: __.</td>
<td>• high environmental risk such as domestic violence or being harmed or threatened at home, school, work or in the community</td>
<td></td>
</tr>
<tr>
<td>• a history of medication side-effects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• co-morbid medical illness, and difficulty coping with that illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CASE 1
A 22-year-old woman, Darline, is brought in by her husband to the health facility in Cange. He says that his wife has been acting strangely. He reports that she has refused to get out of bed for the past week and has been crying frequently. Darline is usually very active in church but hasn’t gone the past two weeks. He was worried she was depressed. However, yesterday she got out of bed extremely happy and was so energized cleaning the house she didn’t sleep at night. You observe Darline chatting excitedly with other people in the waiting room. She says she feels wonderful and doesn’t know why her husband brought her here. When you ask Darline if there is any family history of mental illness she declines to reply. She asks angrily what you are trying to suggest. She says that nothing is wrong with her, although she does admit she was feeling sad last week. The husband mentions that he is worried and frustrated because she hasn’t been able to work as much the past two weeks because of her condition, and that it’s straining the family finances. When asked about her physical health, Darline states she has no health problems. Her husband reports that this is the first time that Darline has acted this way.

Biopsychosocial formulation:  
(To be filled in by participant)

Darline is a 22-year-old female living in Cange with her husband. Her husband brought her to the hospital with a chief complaint of depression and “acting strangely.” The patient did not answer when asked if there is a family history of mental illness, but from a biological perspective it is possible that the current situation represents a manic episode. It does not appear that there was a recent stressor that may have made things worse, but it does appear that her condition is causing significant stress to the family and there is risk of lost productivity and greater financial stress from her inability to work effectively. From a general psychological perspective, Darline does not seem to have insight into her mood swings. She describes everything is fine, although she admits she was depressed last week. From a social perspective, areas of concern include her relationship with her husband, who is worried and frustrated about Darline’s behavior, and is unable to work because of it. Darline has strengths in her connection to the church and the support of her husband. Of primary concern currently is the possibility that this episode is a manic episode consistent with bipolar disorder, which places both Darline and her family at risk on multiple levels. Further history and observation will help in clarifying the diagnosis. In the meantime the treatment team will focus on treating this as a manic episode and will work to stabilize the situation in collaboration with her and her family.
CASE 2
A 20-year-old man, James, is brought in by his friend, Simon. Simon says that recently James started saying that his neighbor is watching him; James cannot stop talking about it. James thinks that the neighbor is a spy. James lives with his aunt and used to go to school. James was a good student, but he stopped going to school because he couldn’t concentrate. James reports that he hears what the neighbor is saying about him in his mind. The neighbor says “I’m watching you. I’m going to get you.” When you ask how long this has been happening for, James says almost three months. James is so scared that he can’t sleep at night. When you ask about his family history, James says he has never met his father, and he hasn’t seen his mother since she was hospitalized at Mars and Kline in 2011. Simon reports that James’ girlfriend broke up with James because she was scared of how James was acting. James has begun to use alcohol to relax because he is nervous all the time about his neighbor.

Biopsychosocial formulation:
(To be filled in by participant)

James is a 20-year-old male who was brought to the health facility by a friend. James lives with his aunt (his parents are not around) and reports that his neighbor is spying on him. James can hear the neighbor’s voice in his head. From a biological perspective, there is a family history of mental illness (his mother), who has been hospitalized. From a psychological perspective, James is feeling very worried and scared about his neighbor. It would be helpful to know more about the relationship he has with his neighbor and if there were previous problems. He is unable to sleep at night and cannot focus on other things. There are several social considerations in assessing the patient’s current presentation, which include: James recently losing his girlfriend and missing school. He is using alcohol to cope with these losses. James’ strengths are his intelligence and social supports including his friend Simon. Given the biological vulnerability and the family history, the current situation is concerning for a first psychotic episode. Further history and observation will help in clarifying the diagnosis. In the meantime the treatment team will focus on treating this as a first episode and will work to stabilize the situation in collaboration with James and his family.
SESSION 8: Medication Management for Agitation, Delirium, and Psychosis

Methods: Facilitator presentation, worksheet, role play

Time: 2 hours

Participant Handbook page: 36

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 94–109
- Medication Card for Agitation, Delirium and Psychosis
- Flip chart
- Markers
- Flip chart
- Markers

Preparation:

Objectives:
- u. Explain the collaboration between the physician and the psychologist/social worker in managing medication for agitation, delirium and psychosis.
- v. Describe the physician’s use of the Medication Card for Agitation, Delirium and Psychosis.

STEPS

30 minutes

1. Show Slide 94: Session 8: Medication Management for Agitation, Delirium and Psychosis.
   Tell the participants that once a medical and mental health evaluation has been performed, a physician must decide if pharmacological treatment is necessary.

   Briefly review the primary tools that can be used to guide physicians’ prescribing practices. After you illuminate the bullet point “Medication Card for Agitation, Delirium, and Psychosis” on the PowerPoint, give the participants five minutes to review the medication card independently.
   Animate the title and speech bubble. Ask the participants what medication for mental disorders they can name. Animate the table.

4. Show Slide 97: Risperidone.
   Read the important points outlined on the slide. Mention to the participants that this medication should be the first-choice drug for any patient that needs an antipsychotic or mood stabilizer.

   Read the important points outlined on the slide. Emphasize that 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.

   Read the important points outlined on the slide. Emphasize that carbamazepine should typically be prescribed before valproate as a long-term mood stabilizer.

7. Show Slide 100: Valproate.
   Read the important points outlined on the slide. Emphasize that valproate is particularly for patients with longstanding aggression or violence, and should never be prescribed to a pregnant woman (and avoided for women of child-bearing age).

8. Show Slide 101: Diazepam.
   Read the important points outlined on the slide. Emphasize that diazepam is only used in agitated patients and those going through alcohol withdrawal.

   Explain to the participants that while physicians will need to evaluate and manage antipsychotic medication side-effects, it is important that psychologists/social workers know about side-effects.

   Read the text on the slide, emphasizing that acute dystonia and neuroleptic malignant syndrome are two side-effects that constitute an emergency. Tell the participants that 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. Explain to the participants that lactation and missed periods for women are a side-effect from risperidone commonly encountered in Haiti.
10. Show Slide 103: Prescribing Principles for Agitation, Delirium, and Psychosis.

Note that physicians should only prescribe risperidone and haloperidol. Mood stabilizers should not be routinely prescribed for bipolar disorder. Explain that if physicians prescribe more than the maximum dose of a medication to a client, the Zanmi Lasante Mental Health team must be notified.


Explain that physicians are responsible for prescribing antipsychotics but they must work with psychologists/social workers to determine the likely diagnosis. For physicians, identifying a medical delirium rather than a mental illness is the most important diagnosis that they can make. It can be life-saving. It is also important to note that physicians should not make diagnoses of specific psychiatric illnesses such as schizophrenia or bipolar disorder without the collaboration of a psychologist/social worker and the Zanmi Lasante Mental Health Team. This is because once a wrong diagnosis is made, a person may not only be labeled with the diagnosis, but also the stigma that can accompany a diagnosis. Wrong diagnosis can also lead to poor care for the patient, including prescription of the wrong medication. All patients who receive antipsychotics (for agitation, delirium, or psychosis) must be evaluated by Zanmi Lasante psychologists/social workers.


Ask the participants to take out their Agitation, Delirium and Psychosis Checklist and to review the physician sections (specifically the Initial Evaluation and Follow-Up sections). Ask them to focus on identifying their roles related to medication management. After a few minutes, have the participants share their answers with the person sitting next to them. After two minutes, animate the slide to show the Agitation, Delirium and Psychosis Checklist with physicians’ roles related to medication management in red.

20 minutes

13. Tell the participants that they will now take time to review information about medication for agitation, delirium and psychosis. They will have 10 minutes to complete the medication review questions in their participant handbook. Explain that they may use the Medication Card and Agitated Patient Protocol (refer to Facilitator Notes).

14. After 10 minutes, bring the participants together and go over the answers on the medication review sheet, asking for the participants to share their answers (refer to Facilitator Notes).

Animate the title. Ask the participants:

- If you or a family member were being prescribed an antipsychotic, what information would you like to know about the medication?

Once some participants have responded, animate the text. Explain that it is important to speak to patients and their family members in language that they understand, depending on their education level and knowledge.

Mention 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.


Ask a participant to read the case on the slide aloud. Give the participants one minute to consult the Medication Card for Agitation, Delirium and Psychosis, and ask for responses.

- **What the medication is for:** used for psychosis.
- **How to take the medication properly:** take it at night before bed because it can make you sleepy.
- **Common side effects:** sedation, weight gain.
- **Toxic side-effects and when to seek immediate medical care:** difficulty breathing, muscle tightness in body, difficulty seeing or controlling eyes (dystonia, tardive dyskinesia, akathisia), rash, hot feeling or fever, abnormal blood sugars (diabetes).
- **How long it takes for the medication to work:** It can work within one day. But for the full effect it takes 4–6 weeks.

- **What the medication is for:** used for psychosis, especially in violent patients.
- **Common side-effects:** sedation, stiffness, a heavy tongue.
- **Toxic side-effects and when to seek immediate medical care:** difficulty breathing, muscle tightness in body, difficulty seeing or controlling eyes (dystonia, tardive dyskinesia, akathisia), rash, hot feeling or fever, abnormal blood sugars (diabetes).
- **How long it takes for medication to work:** Immediately. Once it has been given, the physician will wait 30 minutes and if patient remains agitated we can give haloperidol again (but only half the original dose).


Read the slide and tell the participants that physicians will be utilizing the AIMS (Abnormal Involuntary Movement Scale) every six months with patients that are on an anti-psychotic medication. Explain to the participants:

- Tardive dyskinesia can develop over the course of months and years, and should be monitored using AIMS. AIMS is useful for detection and follow-up of tardive dyskinesia. If one can catch tardive dyskinesia early, one can intervene.
- The AIMS should be used 1) at the beginning of treatment, and then 2) every six months. It can be done in less than 10 minutes.
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 Zanmi Lasante physicians prescribe without consulting the mental health team?
   - Haloperidol
   - Risperidone
   - Diazepam

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

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)?
   - Severe (violent)

3b. According to the Agitated Patient Protocol, which medication should the physician give the patient? Give the medication name, dose, and form.
   - Haldol 5–10 mg IM + diphenhydramine 25 mg IM or diazepam 10 mg IM

4. You are working in the emergency room of a local clinic when a father brings his 19-year-old daughter in. She is totally rigid, unable to walk, unable to turn her head, and unable to open her mouth. Her father has to carry her. He reports that she was taken to a psychiatric facility after becoming violent following a break-up with her boyfriend. At the facility, she was given multiple injections. How would you work with the physician to treat this case?
   - The patient has severe dystonia, and, therefore, should be given diphenhydramine 50–75 mg IM daily. The patient should receive liters of fluids to flush out the haloperidol and because she is receiving a strong dose of an anti-cholinergic medication. She should also be monitored closely for signs of neuroleptic malignant syndrome.
DAY 2 REVIEW: Jeopardy

Methods: Game

Time: 1 hour

Materials:
- PowerPoint (Jeopardy)
- PowerPoint (Agitation, Delirium, and Psychosis), slides 110–111
- Flip chart
- Markers
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Jeopardy)
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 110–111.
- Delegate the various game roles to the co-facilitators

Steps

1 hour

1. Explain that the participants will now review the content that was just presented using a game called Jeopardy. Jeopardy is a question-and-answer type of game where participants can earn points by answering questions correctly.

2. Show Slide 110: Jeopardy Rules.

   Explain that the first row on the slide shows the categories. Each question under that category column is related to that category.

3. Explain that each category will have a series of values listed under the category title. Each value corresponds to a different question. The questions with a greater value are more difficult questions. For example, a question with a value of 100 is easier than a question with 300 points. The value also corresponds to the points that are awarded for a correct answer.

4. Divide the participants into two or three groups according to the total number of participants (ideally, about five to seven participants per group). Tell the teams that they should decide on a team name and a team leader. The team leader will speak for the team.
5. To begin the game, the facilitator will ask the first team to choose a category and a value. The facilitator will read the question that corresponds to the category and value aloud. For this activity, one of the facilitators will keep score on a flip chart. Another facilitator should lead the game. A third presenter can be the “time-keeper” to monitor the elapsed time.


   Explain that the team leaders are responsible for raising their hand once their team thinks that they know the correct answer. The facilitator will watch carefully and will decide which team leader raised his or her hand first. The team whose team leader raised his or her hand first is given the first opportunity to try to respond to the question.

7. Each team has 30 seconds in which to answer the question that they are asked. If they answer incorrectly, the next team has an opportunity to answer correctly and so on. The team that answers correctly is awarded the points AND has the opportunity to choose the next category and value.

8. As play continues, questions about the training content often arise. Use the game to clarify information and answer questions that the participants may have.

9. Start the game, have fun, alter the rules as necessary, and reward the team who wins in the end!
SESSION 9: Psychotherapy and Family and Patient Education

Methods: Large group discussion, case study

Time: 1 hour 15 minutes

Participant Handbook page: 40

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 112–119
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 112–119.

Objectives:
- Explain the core psychotherapy approaches for patients with severe mental illness.
- Describe how to educate patients and family members about the effects and management of psychosis and bipolar disorders.

STEPS

20 minutes

   Read the objectives and introduce the session.

2. Show Slide 113: Vulnerability/Stress Model – Severe Mental Illness.
   - Animate the title and speech bubble.
   Ask the participants:
   - What makes a patient with a severe mental illness more symptomatic?
   Take a few responses from the participants, and animate the text on the slide.
   • Animate the title and speech bubble.

   Ask the participants:
   • What type of psychotherapy have you used in the past with patients who were psychotic or had severe mental illness?

   Take a few responses from the participants, and animate the text on the slide.

   Remind the participants that there are a variety of approaches for treating mental illnesses, many of which can be useful for treating patients with severe mental illness, like psychosis or bipolar disorder.

4. Show Slide 115: Considerations in Choosing a Therapy.
   • Animate the title and speech bubble.

   Ask the participants:
   • For those of you who have used therapy with severe mentally ill patients, how did you decide what type of therapy to use?

   Take responses from the participants, and animate the text on the slide.

5. Mention that a patient’s barriers are a large consideration in deciding what approach may work best. Ask participants what some patient barriers to receiving psychotherapy treatment may be, and mention the following barriers if not mentioned by participants:
   • Caretaking responsibilities
   • Financial limitations of patient and family
   • Travel to clinic
   • Family/peers are against treatment
   • Cognitive limitations
   • Immaturity
   • Personality or psychopathological factors

   Tell the participants this is a type of therapy that works well for those suffering from severe mental illness. Read the main points on the slide aloud.
7. Show Slide 117: Interpersonal Therapy.
Remind the patients that they have already been doing interpersonal therapy with patients with depression. Explain that interpersonal therapy can be helpful for some patients with severe mental illness because their illnesses often cause problems in their social relationships.

Tell participants that family-focused therapy can be one of the most helpful types of therapy for patients with severe mental illness. Explain that family dynamics are often stressed when a member of the family has a severe mental illness. Families may blame the patient for their symptoms, or be hostile towards the patient. Often, families feel helpless and hopeless to control the illness. Unfortunately, this stressful home environment can lead to the worsening of the patient’s symptoms, creating a cycle of stress in the home. Family-focused therapy emphasizes the importance of building family support through education, problem solving techniques and communication skills.

15 minutes

9. Explain to participants that all of the therapy approaches previously mentioned include educating the patient and their family. Because of the importance of psychoeducation, all Zamni Lasante health providers have a role in delivering psychoeducation. Psychologists and social workers will practice psychotherapy that includes psychoeducation components, while the other cadres of health workers will provide basic education around severe mental illness.

10. Tell the participants they are now going to brainstorm important psychoeducation messages to share with patients and their families. Draw three columns on a piece of flip chart paper. On top of column one write “general messages,” on top of column two write “psychosis-specific messages,” and on top of column three write “bipolar-specific messages.”

Ask participants:
• What are key messages to share with patients and families when counseling them?

Have the participants respond while you write the answers on the flip chart. All answers in column one should be exhausted before continuing to column two, and then column three. Add any ideas from below that are not mentioned by the group.
### GENERAL MESSAGES TO SHARE WITH PATIENTS AND FAMILIES

- A patient’s symptoms can improve with treatment and they can even recover.
- It is important to continue with work, social, and school activities as much as possible.
- The patient has a right to be involved in making decisions about their treatment.
- It is important to exercise, eat healthy, and maintain good personal hygiene.
- Families should not tie up or lock up patients. Instead, bring them to the clinic/hospital or ask the CHW for help/support.
- Information about medication:
  - 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.

### PSYCHOSIS-SPECIFIC MESSAGES

- Psychosis is a medical condition that is treatable.
- Psychosis is not contagious.
- Patients with psychosis are often stigmatized and mistreated.
- Many patients recover from psychosis with medication and therapy and return to their normal functioning.
- The patient may hear voices or may firmly believe things that are untrue.
- The patient often does not agree that he or she is ill and may sometimes be hostile.
- If there is a return/worsening of symptoms the patient should come back for re-assessment.
- The patient should be included in family and social activities.
- Family members should avoid expressing criticism or hostility towards the patient.
- The patient may have difficulties recovering or functioning in high-stress working or living environments.
### BIPOLAR-SPECIFIC MESSAGES

- It is important for the patient to maintain a regular sleep cycle (e.g., going to bed at the same time every night, trying to sleep the same amount as before illness, avoiding sleeping much less than usual). Difficulty sleeping, if it is persistent, can be helped with medication.

- Relapses can be prevented, by recognizing when a patient’s symptoms return, such as sleeping less, spending more money or feeling much more energetic than usual. The patient should come back for treatment when this occurs.

- A patient in a manic state can lack insight into the illness and may even enjoy the euphoria and improved energy, so carers must be part of relapse prevention.

- Alcohol and other psychoactive substances should be avoided.

---

40 minutes

11. Show Slide 119: Case Study: Family and Patient Education.

Tell the participants they will practice counseling patients and families about severe mental illness.

12. Divide the participants into four groups. Assign each group of participants one case study (refer to Facilitator Notes). Give the participants 10 minutes to brainstorm psychoeducation messages related to their case study.

Participants should consider:
- What questions to ask the patient and family.
- How and when to share key messages.
- How to involve other health providers in this case to continue supporting the patient and family.

13. At the end of the 10 minutes, invite each group to the front of the room to present their cases and related psychoeducation messaging.

14. After thanking the groups for presenting, summarize key learning points and ask the participants what questions still remain.
**FACILITATOR NOTES**

**CASE STUDY 1**

- Gerard is a 25-year-old man with bipolar disorder. He is a patient of yours that you have seen for the past year and the physician has prescribed him carbamazepine.
- His mother, Amelie, has accompanied Gerard to the health center.
- Amelie says that Gerard stopped taking his medication a week ago. She says he has been acting “crazy.” Gerard confirms that he stopped taking his medication, but says he did so to see if he was cured.
- The psychologist/social worker counsels Gerard and his mother.

**CASE STUDY 2**

- Rose is a 21-year-old who has been accompanied to the health center by her older sister and a community health worker. Rose is clearly agitated, having visual hallucinations and speaking to someone who is not there.
- The older sister tells the psychologist/social worker that for the past three days she has been like this. The older sister says that someone has put a spell on her.
- The community health worker says that Rose has a fever and that Rose’s mother is also sick with a fever.
- The psychologist/social worker counsels Rose’s sister and community health worker about Rose’s condition and the process of determining if this is a medical illness or psychiatric illness.

**CASE STUDY 3**

- Jean is a 19-year-old man who is disheveled and was brought to the clinic by his brother.
- Jean’s brother explains that Jean has stopped going out with friends and refuses to leave his house. Jean hasn’t attended his university classes in a month. Jean’s brother sometimes sees Jean talking to himself.
- Jean refuses to speak to the psychologist/social worker. The psychologist/social worker shares general mental health messages with Jean and his brother.
CASE STUDY 4

- Ronald is a 55-year-old man who is brought to the clinic by his wife and son.
- Ronald’s wife, Esther, explains that Ronald went out last night and spent all their money. He was up all night, repeating that he was the King of Haiti. She said he has had many of these types of days since they first met 25 years ago. Ronald’s son is very angry that Ronald has spent all their money and demands that the psychologist fixes Ronald’s disturbed mind.
- The psychologist/social worker counsels Esther and her son.
SESSION 10: Clinical Outcome Measures — CGI and WHODAS

Methods: Facilitator presentation

Time: 2 hours

Participant Handbook page: 44

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 120–136
- Flip chart

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 120–136.
- Photocopy the CGI (1 copy/participant).

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

STEPS

20 minutes

1. Show Slide 120: Session 10: Clinical Outcome Measures – CGI and WHODAS.
   Tell the participants that effective care is that which has been shown to improve functioning and quality of life. Effective care may be based on several different types and levels of evidence, and it reflects the best care a system can offer at any given point. To measure effective care, the Zamni Lasante system of care will use the Clinical Global Impressions Scale (known as “CGI”) and the World Health Organization Disability Assessment Schedule (known as “WHODAS”).

2. Show Slide 121: Clinical Global Impressions Scale (CGI).
   Explain that the Clinical Global Impressions Scale (CGI) is an easily adopted tool that measures the effect of treatment over time. It is a global assessment of current symptoms, behavior, and the impact of illness on functioning. Its goal is to allow the clinician to rate the severity of illness (CGI-S), change over time (CGI-I), and efficacy of medication.
3. Tell the participants that they will complete the CGI when they first meet with a patient, then every time they meet with a patient (but not more frequently than once per week). Have the participants open their participant handbook to the annex where they can find the CGI Scale. Explain that there are three different measures on the CGI:

- **Severity scale** – which assesses a patient’s symptom severity over the past 7 days.

- **Improvement scale** – which measures the overall clinical change of the patient using the baseline assessment as the reference point.

- **Side-effects scale** – which analyzes the side-effects of the medication.

Allow the participants to read over the CGI scale.


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

<table>
<thead>
<tr>
<th>CGI SEVERITY TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Err on the side of a more severe rating if in doubt between two values</td>
</tr>
<tr>
<td>• Always use the same time period (past seven days)</td>
</tr>
<tr>
<td>• Do not compare the patient to a superior functioning person: compare “relative to your past experience with patients who have the same diagnosis...considering your total clinical experience with this population.”</td>
</tr>
</tbody>
</table>

5. Show Slide 123: CGI Severity.

Tell the participants they will now have an opportunity to practice scoring the CGI-S through two case studies. Read aloud Case 1 and begin a discussion about the patient’s level of severity.
CASE 1

A 38-year-old, well-groomed, female patient, who is a successful professional, reports a one-month unprecipitated depressive episode that seems to be worsening. She is currently experiencing early morning awakening, loss of pleasure in her usual activities, feelings of guilt, reduced appetite, tearfulness, and depressed mood. She has found herself weeping several times over the past week, but cannot identify a reason. She is continuing to work, but found herself fighting back tears at an important meeting and believes her work may be less sharp than it had been in the past. No one has noticed, but she is concerned that the depression is worsening and may result in a significant impact on work. She is worried that she may lose her “edge.” She denies suicidal ideation. She has no previous psychiatric history.

6. Ask participants what rating they might give the patient in the case, and why. Once you have taken several ideas from the participants, explain that a suggested CGI-S score for this case is a 4 (moderately ill). Explain the following rationale to the participants. Answer questions as they arise.

RATIONALE

This patient has symptoms that are consistent with major depressive disorder and are beginning to affect her functioning. She might benefit from medication. These elements both suggest a score no less than a 4 (moderate). The patient’s functioning at a very demanding job is only affected to a limited degree at this point; no one has noticed and her lessened performance does not seem extreme. She continues to work her normal schedule. Although distressed, her illness has not caused a distinct impairment of occupational function that would raise the score to a 5 (markedly ill).

7. Show Slide 124: CGI Severity.

Tell the participants they will now have the opportunity to practice scoring a case individually. Ask the participants to take three minutes to read Case 2.
CASE 2

A 34-year-old, male patient with a diagnosis of paranoid schizophrenia has been in treatment at Zanmi Lasante for the past several years, having started medication treatment more than ten years ago after a hospitalization at Mars and Kline. According to his community health worker and physician, he had been stable on his medication regimen for the past year, but recently stopped taking his medication and would not cite a reason. He attended his church twice this past week, but missed four other days which he usually would have attended. After receiving a call from a family member, the community health worker went to his home and drove him to the hospital for evaluation and possible hospitalization. The community health worker reports he has become increasingly threatening and difficult to manage at home, and has been seen responding to auditory hallucinations, including taking cover in attempts to hide from “enemies.” In the past week, he obeyed a command hallucination to “go after” a neighbor, but was physically circumvented from harming the neighbor by three community health workers, who physically restrained him. The community health worker reported that although the patient was passively cooperative about coming to the clinic, he did not speak with her at all during the trip. In the clinic office, he is guarded and suspicious. He mumbles under his breath, but refuses to elaborate as to what he has said or to whom it was directed. Twice he makes a fist and raises his arm threateningly in the direction of the physician, but then puts his hand back in his lap. He appears disheveled and is not groomed; he has not changed his clothing over the past week, which his community health worker reports is a new behavior for him.

8. Ask the participants: by a show of hands, who gave the patient a score of one? Two? Continue asking until you reach seven. Ask if any participants would like share their answers and the reasoning behind their answers.

9. Tell the participants that a suggested CGI-S Score for this case is a 6 (severely ill). Explain the following rationale to the participants. Answer questions as they arise.

RATIONALE

The patient’s functioning is clearly affected by his symptoms to the extent that he is not attending church or taking his medication. Previously well groomed, he has now stopped even basic elements of self-care and hygiene. His behavior required restraint and may have posed a physical risk to others. This is a patient one might actively consider hospitalizing. Based upon his disruptive pathology and behavior influenced by symptoms (hallucinations), a CGI-S score of 6 (severely ill) is warranted. This patient did attend his church one day and did willingly accompany the community health worker to his visit with the psychologist, suggesting a somewhat lessened level of severity than a 7 would imply.
10. **Show Slide 125: CGI – Improvement.**

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

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

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

11. **Show slide 126: CGI Improvement.**

Tell the participants they will now have an opportunity to practice scoring the CGI-I through two case studies. Read aloud Case 1 and begin a discussion about the patient’s level of severity.

**CASE 1**

A patient who has been in treatment and receiving an SSRI for an anxiety disorder for four months comes in for a medication check. The patient’s CGI-S at the visit at which SSRI medication was initiated (“baseline” visit) was 4 (moderate). At today’s visit, the patient reports that the anxiety symptoms have decreased considerably. The patient is now able to sleep 7 to 8 hours each night, with no initial insomnia. This represents a significant change from baseline, at which time the patient spent 2 to 3 hours each night trying to fall asleep, with a nightly total of 4 to 5 hours of fitful sleep. The patient reports having felt excessively anxious this week about running out of gas and about a burglar entering the house. The estimated time spent engaged in these anxious thoughts was less than one hour per day, compared to an estimated 3 to 4 hours per day at baseline. The patient drove over a bridge this week, which was described as somewhat difficult and fear-provoking, but manageable. At baseline, the subject was wholly avoidant of bridges, which caused him to drive 30 minutes out of his way each day to get to work.

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

The patient’s clinical status has clearly changed in the direction of improvement. For a CGI-I score of 3 (minimally improved), the level of change would not be sufficient to make an appreciable difference to the patient’s clinical status, level of distress, or functioning. This patient is now experiencing a significant nightly improvement in sleep, a reduction in time spent engaged in worry, and is driving over bridges allowing him to cut 60 minutes off his daily commute. These improvements in distress level, symptom severity, and functional ability suggest an improvement score better than 3 because of his noticeable clinical improvement and better functioning. Nonetheless, the patient is still symptomatic; he endures the drive over the bridge with distress and still experiences anxious ruminations each day. Consequently, a rating of 2, much improved, rather than 1, very much improved, best captures this patient’s improvement relative to his baseline state.


Tell the participants they will now have the opportunity to practice scoring a case individually. Ask a participant to read aloud Case 2 and then give participants three minutes to fill in the CGI – Improvement practice document in their participant handbook.

CASE 2

The anxious patient in the previous example (CGI-I Case 1) returns one month later. He reports that he is now afraid of leaving his house without accompaniment. This is a new development for him. He is anxious and worried all day long. He called work and told them he had the flu. In reality, he was afraid to leave his house. He has only left the house three times this week, including his visit to the clinic today, all accompanied by his wife. He felt panicky on all three occasions. Although he denies any lightheadedness or other symptoms suggesting impending syncope, he reports worrying constantly about “passing out” in front of a moving car or bus. He is fearful that he will forget the name of a well-known friend or relative should they call him on the phone. He is sleeping only 1 to 2 hours a night. His wife reports that she has “never seen him so bad.” He cries in the interview and admits he has considered “ending it all” to make the pain go away.

14. Ask the participants: by a show of hands, who gave the patient a score of one? Two? Continue asking until you reach seven.

15. Ask if any participants would like to share their answers and their reasoning behind their answers. Tell the participants that a suggested CGI-I Score for this case is a 7 (very much worse). Explain the following rationale to the participants. Answer questions as they arise.
**RATIONALE**

The patient has clearly worsened relative to his baseline condition. The patient has stopped going to work and is barely leaving his home. His worries are almost constant, clearly excessive, and are virtually all-consuming. The worries have become less reality-based and are a source of almost unendurable mental distress. He is barely sleeping. The patient finds his situation painful to the point of entertaining suicidal thoughts. Overall, the patient’s level of symptoms, frequency of symptoms, and its effect on his functioning are far above a CGI-I of 5, (minimally worse), or even 6, much worse. His clinical status, relative to baseline, reflects a severe exacerbation of symptoms with a loss of functioning suggesting a CGI-I score of 7 (very much worse). As the ultimate decision-maker, the clinician rater decides if the patient rates a 6 or a 7. What is most important is that ratings are consistent across time and across patients.


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

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

30 minutes


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

19. Have the participants turn to the WHODAS 12-Item Version in their participant handbook annex. Tell the participants that there are several sections of the WHODAS, but the main sections that psychologists/social workers will be training on today is Section 3–4.
20. Ask the participants to read over Section 3 silently. Tell the participants that this section tells the psychologist/social worker how to introduce the WHODAS interview to the patient. The words in blue are what the psychologist/social worker should say to the patient.

21. Show Slide 130: WHODAS Flash Cards.

Tell the participants that there are two flashcards that the psychologist/social worker can use to help the patient communicate their answers. The purpose of the flashcards is to provide a visual cue or reminder to the patient about important pieces of information while answering questions. Show the participants the laminated flashcards they have been provided. Flashcard 1 provides information about how “health conditions” and “having difficulty” are defined, and reminds the respondent that the timeframe for evaluation is the past 30 days. The information on this card provides the respondent with useful reminders throughout the interview. Flashcard 2 is the second card to be used in the interview. It provides the response scale to be used for most questions. When introducing this scale to a patient, the psychologist/social worker should read aloud the number and the corresponding word. Explain these cards may or may not be useful depending on the literacy level of the patient.


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


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

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

25. Show Slide 136: Tips for Using the WHODAS

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

26. Tell the participants that a participant and facilitator will role play a dialogue related to a WHODAS interview. Choose a participant to fill the psychologist/social worker role. Have both the participant and the facilitator (who will play the role of the patient) move to the front of the room to act out the dialogue found in the Participant Handbook.

27. Have the participants open their handbook to the WHODAS interview dialogue to follow along.

28. Begin the role play, following the script provided in the Participant Handbook. At some point the participant will need to make up some of the dialogue and answer questions as part of the learning experience (there are six questions/fill-in-the-blanks). At these points the facilitator can “freeze” the scene to go over the new dialogue/questions and ask if other participants agree with the answer the participant gave.

29. Conclude by emphasizing that often, patients will not give you the exact answer to the question. It is important to repeat the questions, clarify if necessary and probe with additional questions.
**WHODAS ROLE PLAY**

**Psychologist/Social Worker:** “I now want to ask you a few questions. The interview is about difficulties people have because of health conditions. By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs. Do you understand what I mean by health condition?”

**Patient:** “Yes.”

**Psychologist/Social Worker:** “Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about: increased effort, discomfort or pain, slowness, changes in the way you do the activity. When answering, I’d like you to think back over the past 30 days.”

**Patient:** “OK.”

**Psychologist/Social Worker:** “I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it. Use this scale when responding: none, mild, moderate, severe, extreme or cannot do.”

**Patient:** “OK.”

**Psychologist/Social Worker:** “In the past 30 days, how much difficulty did you have in: standing for long periods such as 30 minutes?”

**Patient:** “I am always standing.”

**Psychologist/Social Worker:** 1. “That’s good to hear you are always standing. Did you have any difficulty and can you tell me using the scale: none, mild, moderate, severe, extreme or cannot do?”

(What should you say to the patient to obtain an answer of none, mild, moderate, severe, extreme or cannot do?)

**Patient:** “I did not have any difficulty.”

2. How would you record this answer on the WHODAS scale? Which category would you circle?

   a. None
   b. Mild
   c. Moderate
   d. Severe
   e. Extreme or cannot do
<table>
<thead>
<tr>
<th>WHODAS ROLE PLAY (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychologist/Social Worker:</strong> “In the past 30 days, how much difficulty did you have in: taking care of your household responsibilities?”</td>
</tr>
<tr>
<td><strong>Patient:</strong> “What type of household responsibilities?”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> 3. “Things that you normally do around the house to keep the household functioning. An example of this might be…”</td>
</tr>
<tr>
<td><em>(What should you say to the patient to clarify what you mean?)</em></td>
</tr>
<tr>
<td><strong>Patient:</strong> “I had no difficulty.”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> “In the past 30 days, how much difficulty did you have in: learning a new task, for example learning how to get to a new place?”</td>
</tr>
<tr>
<td><strong>Patient:</strong> “I haven’t learned any new tasks.”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> 4. “Ok. If you had to learn a new task, such as learning how to get to a new place, how difficult do you think it would be for you?”</td>
</tr>
<tr>
<td><em>(What should you say to the patient to probe about whether this question is not applicable?)</em></td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> “In the past 30 days, how much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?”</td>
</tr>
<tr>
<td><strong>Patient:</strong> “I always go to church but I don’t like going to other community activities.”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> 5. “OK. But if you were interested in going to other community activities, how difficult would it be for you to join that activity, on a scale of none, mild, moderate, severe, extreme or cannot do? Remember, we are thinking about health status when we answer these questions.”</td>
</tr>
<tr>
<td><em>(What should you say to the patient to obtain an answer of none, mild, moderate, severe, extreme or cannot do? Remind the patient these questions are based on his health status.)</em></td>
</tr>
<tr>
<td><strong>Patient:</strong> “I can go to everything—it’s just that I don’t want to. I suppose my answer is none.”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> “In the past 30 days, how many days were these difficulties present?”</td>
</tr>
<tr>
<td><strong>Patient:</strong> “Oh, I don’t know. I can’t say.”</td>
</tr>
<tr>
<td><strong>Psychologist/Social Worker:</strong> 6. “Can you give me your best guess on the number of days these difficulties were present in the past 30 days?”</td>
</tr>
<tr>
<td><em>(What should you say to the patient to obtain the number of days?)</em></td>
</tr>
<tr>
<td><strong>Patient:</strong> “I guess I could estimate that four days a month these difficulties were present.”</td>
</tr>
</tbody>
</table>
SESSION 11: Follow-Up and Documentation

Methods: Facilitator presentation, small group work

Time: 45 minutes

Participant Handbook page: 51

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 137–148
- Flip chart
- Markers

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 137–148.

Objectives:
- aa. Explain the process of follow-up for people living with psychotic disorders and severe mental illnesses.
- ab. Describe the importance of documentation during patient follow-up.

STEPS

45 minutes

   Read the objectives of the session.

2. Show Slide 138: Psychosis Care Pathway.
   Remind the participants that this pathway only works with functional follow-up and documentation. Emphasize the importance of using consistent protocols and procedures in continued evaluation and treatment.

   Tell the participants that there are certain follow-up activities that need to be accomplished each follow-up visit. 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.

4. Tell the participants they will now be doing an individual activity where they will think about the important elements of patient improvement and documentation. Ask participants to turn to the “Follow-Up Chart” in their participant handbook (refer to Facilitator Notes).
5. Tell the participants they will spend the next five minutes filling in the two blank columns of the chart individually. Explain that they should reflect on the different column titles and write their corresponding ideas in the chart.

   
   Animate the title. Ask the participants to share their responses from column two: “How to Determine a Patient’s Improvement in Symptoms”. Tell the participants that they will be determining a patient’s improvement through using the Clinical Global Impressions Scale and WHODAS. A patient’s improvement is also based on the patient and family report, along with a mental status exam.

   
   Animate the title. Ask the participants to share their responses from column three: “Why is documentation important?”. Emphasize that the documentation for psychosis, including the Mental Health Follow-Up Form will allow psychologists/social workers to provide better care to patients. Explain that all the forms will be collected and managed by the psychologist/social worker and will ultimately go into the patient’s file.

   
   Ask a participant to read the case over the next four slides. Once the four slides have been read, ask for participants’ reactions. Reinforce that documentation:
   
   - Ensures comprehensive evaluation
   - Tracks patient evolution
   - Improves communication with other providers
   - Encourages accountability to patients
   - Is a legal document

9. On a piece of flip chart paper, draw two columns. Label the left column “challenges documenting information” and the right column “strategies to ensure documentation.” Ask participants what challenges they face in properly documenting information. Take a few responses. Then, divide up the participants into groups of two to three and tell them they have five minutes to brainstorm strategies to overcome the barriers listed on the flip chart.

10. After five minutes, have a representative from each small group share their strategies with the entire group. Record participants’ strategies in the right column on the flip chart.

   
   Read the question presented on the slide. After asking the question, give the participants time to look at the documents and determine where to document. Allow several participants to give responses before animating the answer.
SESSION 12: Using mhGAP for Psychosis and Bipolar Disorder

Methods: Large group discussion and role play

Time: 45 minutes

Participant Handbook page: 52

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 149–163
- Markers
- Flip chart
- mhGAP (1 copy/participant)

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 149–163.

Objectives:
- ac. Describe how to use mhGAP for the management of Psychosis and Bipolar Disorder.
- ad. Describe how to use mhGAP for the management of self-harm/suicide.

STEPS

30 minutes

1. Show Slide 149: Session 12: Using mhGAP for Psychosis and Bipolar Disorder.
   Tell the participants that in this next session they will learn about mhGAP and how it connects to their work with agitation, delirium and psychosis. Read the objectives on the slide.

2. Show Slide 150: mhGAP.
   Remind the participants that they have been introduced to mhGAP in previous trainings. 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.

3. Ask the participants:
   - Has anyone referenced mhGAP in their work?

   If so, ask for the participant(s) to describe the experience of using mhGAP.

5. Show Slide 152: Psychosis.
   Have the participants open their mhGAP to page 18 and choose a participant to read Step 1 in the psychosis assessment section aloud. Mention that the participants have already learned about these acute symptoms of psychosis.

   Tell participants that in some cases it is not clear which symptoms a patient has. By asking questions listed on the slide, the psychologist/social worker can better determine if the patient has psychotic features.

7. Show Slide 154: Determining Chronic vs. Acute.
   Explain that by asking the patient or carer about the onset of the psychotic episode and any prior episodes, psychologists/social workers will be able to determine if the person has acute psychosis or chronic psychosis. For acute psychosis, the physician will want to stop the medication at some point to see if the patient can recover without the medication. Medications have potentially significant side-effects, and clinicians should minimize the use of medication as much as possible. Call on a participant to read Box 2 about chronic psychosis.

   Tell participants: The red box in the middle of page 18 in mhGAP emphasizes the importance of ruling out medical delirium before prescribing any medication to someone with acute psychosis—just as you learned about earlier during this training.

8. Ask the participants to take a minute and read silently the two end boxes on page 18 that describe the actions for a patient with acute and chronic psychosis. Ask the participants what similar actions are mentioned by these boxes for patients with psychosis. Answers should include:
   • Provide education to patient and carers
   • Begin medication
   • Provide psychological interventions
   • Provide follow-up
   • Maintain hope

9. Highlight that the actions mentioned in the mhGAP mirror the actions taken collectively by physicians, psychologists/social workers, nurses and CHWs in the Zanmi Lasante system of care.
10. **Show Slide 155: Mania and Concurrent Conditions.**

Have the participants turn to the next page in mhGAP (page 19), which guides the reader through the diagnosis of mania and concurrent conditions. Allow the participants to read this page silently. Mention the fact that it is common that patients may be suffering from multiple mental or physical health conditions at once. Conditions should be treated as necessary. Those who are pregnant or of child-bearing age should be prescribed medication with caution.

11. **Show Slide 156: Psychoeducation.**

Have the participants continue to the next page in mhGAP (page 20). Mention that one of the most useful tools that mhGAP provides to clinicians is psychoeducation messages. The messages on this page are psychosis-specific. Allow participants to read over the psychoeducation materials in their mhGAP.

12. **Show Slide 157: Bipolar Disorder.**

Tell the participants to turn to page 24 in mhGAP. Call on a participant to read the bipolar assessment and management section on page 24 aloud. Tell participants that this first page of mhGAP for bipolar disorder assists clinicians to decide if a patient has bipolar disorder with just manic symptoms, or if the patient has bipolar depression.

13. **Ask the participants to take a minute and review the two end boxes on page 24.** Ask the participants to think about the differences between treatment for a patient who is has bipolar disorder with mania and a patient with bipolar depression. Once you have given the participants a minute, ask the participants to turn to their neighbor to take one minute to discuss the differences they observe. Ask for a few participants to share their ideas with the group.

14. **Show Slide 158: Concurrent Conditions or History of Mania.**

Tell the participants to turn to the next page in mhGAP (page 25) which covers screening for the presence of other conditions or a past history of mania. Note that if a patient is not currently experiencing mania, but has a history of mania, the physician should start that patient on a mood stabilizer.

15. **Tell the participants to turn to page 26 which describes special populations.** Pregnant women, the elderly and adolescents should be prescribed medication with caution.

16. **Show Slide 159: Psychoeducation.**

Explain that like psychosis, mhGAP provides clinicians with bipolar disorder-specific messages. Allow the participants to read over the bipolar disorder-specific messages. Ask if there are any questions.

Explain that mhGAP can help psychologists/social workers assess a patient for self-harm and can guide the psychologist/social worker to take the appropriate next steps. Instruct the participants to turn to page 74 in mhGAP and take a few minutes to look through the first step of the Self-Harm/Suicide protocol.

18. Emphasize that no matter the condition of the patient, it is important not to leave the patient alone. Ask the participants: what does “offer and activate psychosocial support” mean?

19. Ask the participants to turn to the next page in mhGAP (page 75). Have a participant read the page aloud to the group.

20. Tell the participants that they will now practice making decisions around self-harm and suicide. Explain that you will facilitate a quick quiz that asks participants to judge if there is an imminent risk of self-harm/suicide.

21. Show Slides 161–162: Is There an Imminent Risk?

Read the case on the slide aloud. Tell the participants that this case is also in their participant handbook.

Ask the participants, by a show of hands, who thinks that “yes, there is an imminent risk”? Wait for participants to raise their hands. Then ask them to raise a hand if they do not think that “there is an imminent risk.” Animate the answer.

22. Instruct the participants to turn to the next page in mhGAP (page 76) and read over the flow diagram. Tell the participants that just like psychosis and bipolar disorder, the self-harm/suicide chapter recognizes that there can be concurrent conditions, including complex emotional or pain symptoms. Instruct the participants to take time to also read the following page (77) which details how to facilitate a supportive environment for someone who is at risk of self-harm/suicide.

23. Show Slide 163: mhGAP Guides All Work.

Conclude by reminding the participants that mhGAP is a guide not only for psychosis and bipolar disorder, but also for depression, epilepsy and other conditions. Encourage the participants to use mhGAP along with the DSM IV to help inform their methods of working with patients living with mental disorders. Ask the participants if there are any remaining questions.
SESSION 13: Review, Post-Test and Training Evaluation

Methods: Case studies, assessment, evaluation

Time: 2 hours 30 minutes

Participant Handbook page: 54

Materials:
- PowerPoint (Agitation, Delirium, and Psychosis), slides 164–165
- Flip chart
- Markers
- Post-it notes
- Post-Test Answer Key (downloaded on a computer to be projected)
- Training Evaluation Forms (1 copy/participant)
- Post-Test (1 copy/participant)

Preparation:
- Review PowerPoint (Agitation, Delirium, and Psychosis), slides 164–165.
- Review the case studies ahead of time.
- Photocopy the post-tests and training evaluation forms.
- Create three flip chart pages, each individually titled:
  1. How will you share what you’ve learned?
  2. What strategies will you use to ensure collaboration with other team members?
  3. When I’m unsure or struggling I will...

Objectives:
- ae. Review all unit objectives.
- af. Demonstrate learning through a post-test.
- ag. Give feedback on the training.

STEPS

1 hour

   Explain to the participants that they will discuss case studies as a way to review both the management of patients with severe mental illness and to become familiar with the forms and tools that are available to help with patient management.

2. Divide the participants into small groups of three or four people.
3. Have them turn to the case studies in their participant handbook. Tell the participants that the case studies are formatted like stories. They should read the first part of the case, respond accordingly, and then continue on to the next part of the case.

4. Tell the participants they will have 40 minutes to complete the case study questions.

5. Remind the participants to reference the tools and forms with which they have been provided. Encourage them to think about the system of care more broadly and their roles within the system. Ask the participants to consider how they should best work with community health workers, nurses, and physicians.

6. After 40 minutes, ask everyone to join the larger group again. Review the case studies by asking a different group to present each case and their answers. Use the questions included in the case studies to guide the discussion.

7. Answer any questions that arise.

Post-Test:

8. After the case study discussions have finished, administer the post-test to the participants. Allow them 30 minutes to complete the post-test.

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

Reflection:

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


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

12. Once they have finished writing their three Post-it notes, they should go and post their Post-it notes on the corresponding flip chart page. Once the participants have posted their Post-it notes, all the participants should circulate between the three flip chart pages to view what others have written.
13. After all the participants have had a few minutes to circulate and read others’ reflections, ask them to sit down.

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

**Evaluation:**

30 minutes

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

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

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

18. Congratulate the participants on having completed this training. Thank them for their participation. Distribute certificates as appropriate.
CASE STUDY 1

A 40-year-old woman is brought into the health facility by her two sons. She is barely able to walk and is clearly confused. She cannot follow simple commands. Her sons said she has been fatigued and feverish for the past few days. The patient is mildly agitated, clearly frustrated with her sons. You, the nurse and the physician are available to evaluate and manage the patient.

1. How would you support the physician in evaluating the agitated patient? What forms would you help the physician manage during the medical evaluation?

Support the physician:
- Ensure the physician uses the Medical Evaluation Protocols
- Ensure the physician completes the Agitated Patient Form
- Ensure medication is given if necessary

Forms to help manage:
- Use Agitation, Delirium and Psychosis Checklist
- Agitated Patient Protocol
- Medical Evaluation Protocols for Agitation, Delirium and Psychosis

The physician has concluded that the patient likely needs further neurological 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?

- Emphasize that most likely, their mother does not have a mental disorder and should not be considered “crazy.”
- Explain that through further testing, the physician might be able to identify the medical issue and then identify possible solutions.
CASE STUDY 2

A 27-year-old man, Pierre, 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. What level of agitation does the patient have?
   • The patient is severely agitated

2. What do you do to manage the behavior and environment? Who do you collaborate with?
   What you do:
   • Manage behavior and environment
     – Use calming interventions, such as talking with the patient or arranging a 1:1
     – Show sympathy and empathy, make eye contact
     – Allow the patient to show anger
     – Decrease stimulation
     – Keep yourself and the staff safe by using safety considerations including removing objects that can be used to harm
   Collaborate with:
   • The nurse
   • The physician

3. What forms would you use to assist you to manage this agitated patient?
   • Agitation, Delirium and Psychosis Checklist
   • Agitated Patient Protocol
   • Agitation, Delirium and Psychosis Form (assist the physician with this document)

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 medications and the physician has done an initial medical evaluation. The patient denies wanting to hurt himself or others. His lab tests have come back normal and the physician says he is not suffering from medical delirium.

4. What would you do next? What forms would you be utilizing to guide your work?
   Next steps:
   • Complete ZLDSI
   • Use Suicidality Screening Instrument (if needed)
   • Speak with patient and family and begin to complete Initial Mental Health Evaluation Form
## CASE STUDY 2

**Forms to utilize:**
- Agitation, Delirium and Psychosis Form
- Agitation, Delirium and Psychosis Checklist
- Initial Mental Health Evaluation Form
- ZLDSI
- Suicidality Screening Instrument (if needed)

You see the patient for an initial mental health evaluation and the patient reports that he has been hearing voices that tell him that everyone wants to kill him. He is disheveled and it is apparent he has not bathed in many days. You ask the community health workers about the patient, and they say that he is typically locked in the house by his family. However, the community health workers were able to convince the family to let him come to the health facility. The community health workers say the patient has been this way for a few years. You are unable to get further information from the patient as his speech is disorganized and tangential.

5. **What diagnosis would you give the patient? Why? Where would you record the diagnosis?**
   - **Schizophrenia.** The patient has delusions and hallucinations. The patient has disorganized speech and is disconnected from reality. This psychotic behavior has been happening for more than six months and seems to be continuous.
   - The diagnosis would be recorded in the Initial Mental Health Evaluation Form.

6. **What clinical formulation would you record on the Initial Mental Health Evaluation Form?**
   - **Pierre is a 27-year-old male who was brought to the health facility by two community health workers. Pierre is reportedly locked inside the house by his family and left isolated much of the day. Pierre can hear threatening voices in his head. From a biological perspective, it is unclear if any family members suffer from mental illness. From a psychological perspective, Pierre is clearly affected by his illness, as he is unable to carry on a conversation and appears out of touch with reality. Pierre is socially isolated and has poor hygiene. It is unknown what Pierre’s strengths are presently. It appears that Pierre has had this illness for the past few years, but has never received treatment. It appears that Pierre is suffering from psychosis, and specifically, schizophrenia. Further history and observation will help in clarifying the diagnosis. In the meantime the treatment team will focus on treating his acute psychosis and agitation and will work to stabilize the situation in collaboration with him and his family.**
### CASE STUDY 2 (continued)

7. What type of psychotherapy would you consider beginning with the patient during the next visit? Why?
   - Supportive Therapy – specifically for low-functioning adults with schizophrenia
   - Family-Focused Therapy – involve family in therapy to help rehabilitate patient and improve living situation

8. After diagnosis, how would you collaborate with the physician that day?
   - Accompany the patient to get medication from the physician
   - Support the physician in giving psychoeducation about medication
   - Plan follow-up

9. What would be the follow-up plan for this patient? What other providers would you include, and what would their role be?
   - The patient should return within one week because they just began treatment.
   - The patient should return to see both the psychologist/social worker and physician. The psychologist/social worker should ensure that the CHW is providing support in the community to the patient and his family.
   - The patient would begin psychotherapy during a follow-up appointment.
CASE STUDY 3

This past year you began 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 8 months since the initiation of medication, you notice that she appears restless, frequently wringing her hands and looking upset.

1. What forms will you use or complete during your follow-up visit?
   
   Use:
   - Agitation, Delirium and Psychosis Checklist

   Complete:
   - CGI
   - Mental Health Follow-Up Form
   - Registry

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. How would you counsel her? What are some key messages you would give her during this time of stress?

   - It is important to continue taking her medication.
   - She should visit you (the psychologist/social worker) with more frequency, if needed.
   - She should look to her social supports for assistance during this time.

You are worried that this stress could trigger a relapse.

3. How would you collaborate with other providers to ensure she is adherent to her medication and has social support during this time of stress?

   - Speak with the physician and CHW about medication adherence and support.
   - Offer to see the patient more frequently for support.
Annex
![PRE-TEST  POST-TEST (check one)](image)

Name: ________________  Date: ________________

Site: ________________  Supervisor: ________________

---

1. Combined, psychotic and mood disorders such as schizophrenia and bipolar disorder affect how many people worldwide? (Choose one)  
   - a. 5 million people  
   - b. 81 million people  
   - c. 500 million people  
   - d. 25 million people

2. What are the responsibilities of the psychologist/social worker in the psychosis care pathway? (Choose one)  
   - a. Ensure safety for the patient and others through correct agitation management  
   - b. Prescribe anti-psychotic medication  
   - c. Diagnose psychotic patients with mental illness  
   - d. Provide psychotherapy and psychoeducation to patient and families  
   - e. A, C and D  
   - f. All of the above

3. What are the four pillars of emergency management of agitation, delirium, and psychosis? (Choose one)  
   - a. Vital signs, history of illness, mental health evaluation, treatment  
   - b. Agitation reduction, physician visit, psychologist visit, CHW visit  
   - c. Physicians, psychologists, social workers, and nurses  
   - d. Safety, medical health, mental health, follow-up

4. Which of the following are biopsychosocial considerations that psychologists/social workers should have when approaching the treatment and management of psychotic disorders? (Choose one)  
   - a. Religious and spiritual beliefs  
   - b. Personality  
   - c. Medications  
   - d. Exposure to stigmatization  
   - e. Socioeconomic stressors  
   - f. All of the above
5. You observe a patient in the waiting room who is punching the wall and threatening staff. What level of agitation does this patient have?
(Choose one)
   a. No agitation
   b. Mild agitation
   c. Moderate agitation
   d. Severe agitation

6. When you encounter an agitated patient, what is the first step to managing their agitation? (Choose one)
   a. Give the patient medication to sedate him
   b. Ask the patient to leave the health facility
   c. Use calming interventions and talk to try to get as much information from the patient as possible
   d. Refer the patient to Mars and Klein

7. Intramuscular medication of an antipsychotic, such as haloperidol, should only be used when… (Choose one)
   a. A patient is physically aggressive and has refused oral medication
   b. A patient is verbally threatening and cursing at staff
   c. A patient is running around the emergency room and nurses are scared
   d. Intramuscular medication should be used on all agitated patients

8. True or false: Delirium is a psychiatric illness. (Choose one)
   a. True
   b. False

9. What psychotherapy approaches are recommended for psychotic/manic patients? (Choose one)
   a. Interpersonal Therapy
   b. Supportive Therapy
   c. Family-Focused Therapy
   d. Behavioral Activation
   e. A, B and C
   f. All of the above
10. Which of the following could cause a medical delirium? (Choose one)  
   a. Dementia  
   b. HIV encephalopathy  
   c. Emotional trauma  
   d. Alcohol withdrawal  
   e. A, B, and D  
   f. None of the above  

11. True or False: Agitation is a disease. (Choose one)  
   a. True  
   b. False  

12. Psychologists are in charge of completing which of the following documents for their patients? (Choose one)  
   a. Initial Mental Health Evaluation Form  
   b. ZLDSI  
   c. WHODAS  
   d. Clinical Global Impressions Scale (CGI)  
   e. All of the above  

13. Which medications below are antipsychotic medications? (Choose one)  
   a. Carbamazepine and haloperidol  
   b. Haloperidol and diazepam  
   c. Risperidone and diphenhydramine  
   d. Haloperidol and risperidone  
   e. Valproate and carbamazepine  

14. What is a safety plan? (Choose one)  
   a. An already-created form that a psychologist/social worker will give to the patient to tell them what to do in case of a suicidal crisis.  
   b. A plan that the community health worker uses to identify suicidal patients in the community.  
   c. A two-step plan that tells the patient who to contact and where to go in case of crisis.  
   d. A six-step plan developed by the psychologist/social worker and patient that guides the patient about what to do if in a suicidal crisis.
15. Clinical formulations recorded on the Initial Mental Health Evaluation Form should be composed of which of the following? (Choose one) (____ / 1 point)
   a. Biological, psychological, social factors of a patient’s situation
   b. Past psychiatric history and active medical problems of a patient
   c. Biological, psychological, social factors and strengths of a patient’s situation
   d. Chief complaint and diagnosis

16. The Abnormal Involuntary Movement Scale (AIMS) helps physicians to… (____ / 1 point)
   (Choose one)
   a. Recognize when a patient has psychotic symptoms
   b. Determine how quickly a patient metabolizes medication
   c. Identify if a patient is experiencing involuntary movements as part of antipsychotic medication side-effects
   d. Monitor an agitated patient’s movement after sedation

17. Brief psychotic disorder is defined as… (Choose one) (____ / 1 point)
   a. A disorder marked by alternating periods of elation and depression
   b. A disorder with symptoms of schizophrenia that are present for 1–6 months
   c. A disorder with psychotic symptoms in which there is inadequate information to make a diagnosis
   d. A disorder with a short-term episode of psychotic thinking that lasts less than a month

18. The World Health Organization Disability Assessment Schedule (WHODAS) measures… (Choose one) (____ / 1 point)
   a. Six domains of functioning and is an assessment instrument for health and disability
   b. Abnormal involuntary movements due to medication side-effects
   c. Severity of illness and improvement after beginning treatment
   d. None of the above

19. With what frequency should physicians see patients for follow-up appointments if their symptoms are acute, or if medications are being started or adjusted? (Choose one) (____ / 1 point)
   a. Once a month
   b. Once every three months
   c. Once every 1–2 weeks
   d. Every 5 days
20. How often should the Clinical Global Impressions Scale (CGI) be administered to a patient? (Choose one)
   a. Every visit
   b. Every six months
   c. Once a year
   d. Just when the patient is starting a new type of treatment
PRE-TEST AND POST-TEST ANSWER KEY

Name: ___________________________ Date: ___________________________

Site: ___________________________ Supervisor: _________________________

1. Combined, psychotic and mood disorders such as schizophrenia and bipolar disorder affect how many people worldwide? *(Choose one)*
   a. 5 million people
   b. **81 million people**
   c. 500 million people
   d. 25 million people

2. What are the responsibilities of the psychologist/social worker in the psychosis care pathway? *(Choose one)*
   a. Ensure safety for the patient and others through correct agitation management
   b. Prescribe anti-psychotic medication
   c. Diagnose psychotic patients with mental illness
   d. Provide psychotherapy and psychoeducation to patient and families
   e. **A, C and D**
   f. All of the above

3. What are the four pillars of emergency management of agitation, delirium, and psychosis? *(Choose one)*
   a. Vital signs, history of illness, mental health evaluation, treatment
   b. Agitation reduction, physician visit, psychologist visit, CHW visit
   c. Physicians, psychologists, social workers, and nurses
   d. **Safety, medical health, mental health, follow-up**

4. Which of the following are biopsychosocial considerations that psychologists/social workers should have when approaching the treatment and management of psychotic disorders? *(Choose one)*
   a. Religious and spiritual beliefs
   b. Personality
   c. Medications
   d. Exposure to stigmatization
   e. Socioeconomic stressors
   f. **All of the above**
5. You observe a patient in the waiting room who is punching the wall and threatening staff. What level of agitation does this patient have? (Choose one)
   a. No agitation
   b. Mild agitation
   c. Moderate agitation
   d. Severe agitation

6. When you encounter an agitated patient, what is the first step to managing their agitation? (Choose one)
   a. Give the patient medication to sedate him
   b. Ask the patient to leave the health facility
   c. Use calming interventions and talk to try to get as much information from the patient as possible
   d. Refer the patient to Mars and Klein

7. Intramuscular medication of an antipsychotic, such as haloperidol, should only be used when… (Choose one)
   a. A patient is physically aggressive and has refused oral medication
   b. A patient is verbally threatening and cursing at staff
   c. A patient is running around the emergency room and nurses are scared
   d. Intramuscular medication should be used on all agitated patients

8. True or false: Delirium is a psychiatric illness. (Choose one)
   a. True
   b. False

9. What psychotherapy approaches are recommended for psychotic/manic patients? (Choose one)
   a. Interpersonal Therapy
   b. Supportive Therapy
   c. Family-Focused Therapy
   d. Behavioral Activation
   e. A, B and C
   f. All of the above
10. Which of the following could cause a medical delirium? (Choose one) (___ / 1 point)
   a. Dementia
   b. HIV encephalopathy
   c. Emotional trauma
   d. Alcohol withdrawal
   e. A, B, and D
   f. None of the above

11. True or False: Agitation is a disease. (Choose one)
   a. True
   b. False

12. Psychologists are in charge of completing which of the following documents for their patients? (Choose one) (___ / 1 point)
   a. Initial Mental Health Evaluation Form
   b. ZLDSI
   c. WHODAS
   d. Clinical Global Impressions Scale (CGI)
   e. All of the above

13. Which medications below are antipsychotic medications? (Choose one) (___ / 1 point)
   a. Carbamazepine and haloperidol
   b. Haloperidol and diazepam
   c. Risperidone and diphenhydramine
   d. Haloperidol and risperidone
   e. Valproate and carbamazepine

14. What is a safety plan? (Choose one) (___ / 1 point)
   a. An already-created form that a psychologist/social worker will give to the patient to tell them what to do in case of a suicidal crisis.
   b. A plan that the community health worker uses to identify suicidal patients in the community.
   c. A two-step plan that tells the patient who to contact and where to go in case of crisis.
   d. A six-step plan developed by the psychologist/social worker and patient that guides the patient about what to do if in a suicidal crisis.
15. Clinical formulations recorded on the Initial Mental Health Evaluation Form should be composed of which of the following? (Choose one) ( ___ / 1 point)
   a. Biological, psychological, social factors of a patient’s situation
   b. Past psychiatric history and active medical problems of a patient
   c. Biological, psychological, social factors and strengths of a patient’s situation
   d. Chief complaint and diagnosis

16. The Abnormal Involuntary Movement Scale (AIMS) helps physicians to… (Choose one) ( ___ / 1 point)
   a. Recognize when a patient has psychotic symptoms
   b. Determine how quickly a patient metabolizes medication
   c. Identify if a patient is experiencing involuntary movements as part of antipsychotic medication side-effects
   d. Monitor an agitated patient’s movement after sedation

17. Brief psychotic disorder is defined as… (Choose one) ( ___ / 1 point)
   a. A disorder marked by alternating periods of elation and depression
   b. A disorder with symptoms of schizophrenia that are present for 1–6 months
   c. A disorder with psychotic symptoms in which there is inadequate information to make a diagnosis
   d. A disorder with a short-term episode of psychotic thinking that lasts less than a month

18. The World Health Organization Disability Assessment Schedule (WHODAS) measures… (Choose one) ( ___ / 1 point)
   a. Six domains of functioning and is an assessment instrument for health and disability
   b. Abnormal involuntary movements due to medication side-effects
   c. Severity of illness and improvement after beginning treatment
   d. None of the above

19. With what frequency should physicians see patients for follow-up appointments if their symptoms are acute, or if medications are being started or adjusted? (Choose one) ( ___ / 1 point)
   a. Once a month
   b. Once every three months
   c. Once every 1–2 weeks
   d. Every 5 days
20. How often should the Clinical Global Impressions Scale (CGI) be administered to a patient? (Choose one)

   a. Every visit
   b. Every six months
   c. Once a year
   d. Just when the patient is starting a new type of treatment
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

Refer

Collaborate

Follow-up

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

- Manage agitated patient
- Follow-up
## Differential Diagnosis Information Sheet for Severe Mental Disorders

### Medical Symptoms or Psychosis Caused by Medical Conditions

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SYMPTOMS</th>
<th>DIAGNOSTIC HINTS</th>
<th>GENERAL MANAGEMENT</th>
</tr>
</thead>
</table>
| Delirium | New onset abnormal mental status | • Abnormal physical exam, vital signs or laboratory studies  
• Abnormal mental status examination | • Seek medical source of illness  
• Follow Medical Evaluation Protocol for Agitation, Delirium and Psychosis |
| Psychotic Disorder Due to a General Medical Condition | Psychosis is the direct physiological consequence of a medical condition | • Psychotic symptoms  
• Evidence of a contributing medical illness | |
| Substance-Induced Psychotic Disorder | Prominent hallucinations or delusions | • Evidence of recent substance intoxication or withdrawal | |
| Post-Partum Psychosis | New onset psychosis in a female following childbirth | • Recent childbirth | |

### Mental Health Related Symptoms that are not Psychosis

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SYMPTOMS</th>
<th>DIAGNOSTIC HINTS</th>
<th>GENERAL MANAGEMENT</th>
</tr>
</thead>
</table>
| Transient hallucinations | Anomalous experiences, may occur in a person in a state of good mental and physical health, even in the apparent absence of a trigger (stress, fatigue, intoxication, etc.) | • Common in children and youth | • Ensure safety of patient: assess for self-harm  
• Seek to understand patient’s explanatory model, and to assess internal level of distress |
| Acute stress, anxiety, and trauma-related problems | Stress and traumatic experiences can result in unusual sensory and perceptual experiences that can mimic psychosis | • Significant trauma history | • Obtain Biopsychosocial history  
• Identify potential stressors  
• Consult traditional healer if currently involved in management |
| Conversion Disorder | Usually in response to stress, a person can develop blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation | • Identification of stressor  
• Poor insight into emotional stressors | |
| Obsessive-compulsive disorder | Excessive thoughts (obsessions) that can lead to repetitive behaviors (compulsions), with a potential component of disordered thinking | • Specific area of focus | |
| Autism spectrum disorders | A serious developmental disorder that impairs the ability to communicate and interact | • Longstanding history of unstable interpersonal relationships | |
| Personality Disorder | A deeply ingrained and maladaptive pattern of behavior of a specified kind, typically manifest by the time one reaches adolescence and causing long-term difficulties in personal relationships or in functioning in society | • Longstanding history of unstable interpersonal relationships  
• Poor insight | |
<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SYMPTOMS</th>
<th>DIAGNOSTIC HINTS</th>
<th>GENERAL MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episodic Psychosis or Mania</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression with psychotic features (Mood Disorder, depressed)</td>
<td>A primary depression with psychotic symptoms.</td>
<td>• Depressive symptoms before psychotic symptoms</td>
<td>• Ensure safety of patient: assess for self-harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Seek to understand patient’s explanatory model, and to assess internal level of distress</td>
</tr>
<tr>
<td>Bipolar Disorder (Mood Disorder, manic or depressed)</td>
<td>Marked by alternating periods of elation and depression; some develop mania without depression, others can develop hypomania with depression</td>
<td>• Period of mania, or hypomania with depression</td>
<td></td>
</tr>
<tr>
<td>Brief psychotic disorder (less than one month)</td>
<td>A sudden, short-term episode of psychotic thinking and behavior which occurs with a stressful event; can be informed by social and cultural factors</td>
<td>• Person returns to functioning</td>
<td></td>
</tr>
<tr>
<td>Schizophreniform Disorder (Schizophrenia symptoms 1-6 months)</td>
<td>Symptoms of schizophrenia are present for a significant portion of the time within a 1-month period, but signs of disruption are not present for the full six months required for the diagnosis of schizophrenia</td>
<td>• Do not make diagnosis of Schizophrenia if symptoms are less than 6 months</td>
<td>• Obtain Biopsychosocial history</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Identify potential stressors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Consult traditional healer if currently involved in management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Consider co-morbid mental health diagnoses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Both depression and psychosis are treated with distinct medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Antidepressant medications (fluoxetine, amitryptiline) can cause mania in a person with Bipolar Disorder</td>
</tr>
<tr>
<td>Psychosis Not Otherwise Specified (NOS)</td>
<td>Psychotic symptoms about which there is inadequate information to make a diagnosis</td>
<td>• Examples include: psychosis of a few days or weeks duration, post-partum psychosis, and situations in which diagnosis is unclear</td>
<td></td>
</tr>
</tbody>
</table>
### Continuous Psychosis

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SYMPTOMS</th>
<th>DIAGNOSTIC HINTS</th>
<th>GENERAL MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia (greater than 6 months)</td>
<td>DSM 5 criteria&lt;sup&gt;1&lt;/sup&gt; Two (or more) of the following, each present for a significant portion of time during a 1-month period. At least one of these must be (1), (2), or (3): 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly disorganized or catatonic behavior 5. Negative symptoms, i.e., affective flattening, alogia, or avolition</td>
<td>- Consider age at onset  - Consider prodromal period before onset of initial symptoms</td>
<td>- Ensure safety of patient: assess for self-harm  - Seek to understand patient’s explanatory model, and to assess internal level of distress  - Obtain biopsychosocial history  - Identify potential stressors  - Take conservative approach to medication  - Consult traditional healer if currently involved in management  - Consider co-morbid mental health diagnoses</td>
</tr>
<tr>
<td>Delusional disorder (plausible, circumscribed delusions)</td>
<td>Associated with one or more nonbizarre delusions of thinking such as expressing beliefs that can occur in real life, provided no other symptoms of schizophrenia are present</td>
<td>- Delusion is usually realistic</td>
<td></td>
</tr>
</tbody>
</table>
## Agitation, Delirium and Psychosis Checklist

<table>
<thead>
<tr>
<th>Role</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW</td>
<td>Accompany patient to emergency room (if suicidal, accompany patient immediately)</td>
</tr>
<tr>
<td></td>
<td>Document with the Mental Health Follow-Up Form</td>
</tr>
<tr>
<td></td>
<td>Do Psychoeducation for medication and psychosis</td>
</tr>
<tr>
<td></td>
<td>Ensure visit, weight, and labs are checked</td>
</tr>
<tr>
<td></td>
<td>Ensure medication compliance, side effects</td>
</tr>
<tr>
<td></td>
<td>Plan follow-up with psychologist/SW</td>
</tr>
<tr>
<td></td>
<td>Use CG/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
</tr>
</tbody>
</table>

### INITIAL EVALUATION (ONCE CALM)

<table>
<thead>
<tr>
<th>Role</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Referral to Agitated Patient Protocol; support nurse and physician</td>
</tr>
<tr>
<td></td>
<td>Make preliminary diagnosis of delirium/medically ill or illness with</td>
</tr>
<tr>
<td></td>
<td>Physician; follow-up of patient in the community; coordinate side effects</td>
</tr>
<tr>
<td></td>
<td>Use the ZLSI</td>
</tr>
<tr>
<td></td>
<td>Document with the Mental Health Follow-Up Form</td>
</tr>
<tr>
<td></td>
<td>Do the Referral Form and Initial Visit Form to the psychologist/SW</td>
</tr>
<tr>
<td></td>
<td>Complete CGI/WHODAS, Registry, Checklist</td>
</tr>
</tbody>
</table>

### FOLLOW-UP

<table>
<thead>
<tr>
<th>Role</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Do psychoeducation about medication</td>
</tr>
<tr>
<td></td>
<td>Document everything in Initial Mental Health Evaluation Form</td>
</tr>
<tr>
<td></td>
<td>Do follow-up of patient in the community (check patient adherence side effects)</td>
</tr>
<tr>
<td></td>
<td>Use the ZLSI</td>
</tr>
<tr>
<td></td>
<td>Evaluate patient, coordinate with physician, prescribe medication</td>
</tr>
<tr>
<td></td>
<td>Plan follow-up with psychologist/SW</td>
</tr>
<tr>
<td></td>
<td>Do psychoeducation about medication</td>
</tr>
<tr>
<td></td>
<td>Do the ZLSI</td>
</tr>
<tr>
<td></td>
<td>Complete CGI/WHODAS, Registry, Agitation, Delirium and Psychosis Checklist</td>
</tr>
</tbody>
</table>

### AGITATED PATIENT

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>Alert either psychologist/social worker or nurse to determine level of agitation and to prescribe medication if necessary</td>
</tr>
<tr>
<td>Follow</td>
<td>Follow Agitated Patient Protocol; support nurse and physician</td>
</tr>
<tr>
<td>Patient</td>
<td>Patient is agitated and needs to be addressed, either by Alert or Follow</td>
</tr>
<tr>
<td>Room</td>
<td>Room is agitated and needs to be addressed, either by Alert or Follow</td>
</tr>
<tr>
<td>Phone</td>
<td>Phone is agitated and needs to be addressed, either by Alert or Follow</td>
</tr>
<tr>
<td>Attire</td>
<td>Attire is agitated and needs to be addressed, either by Alert or Follow</td>
</tr>
<tr>
<td>Behavior</td>
<td>Behavior is agitated and needs to be addressed, either by Alert or Follow</td>
</tr>
</tbody>
</table>

### AGITATION, DELIRIUM AND PSYCHOSIS CHECKLIST

1. **AGITATED PATIENT**
   - Alert either psychologist/social worker or nurse to determine level of agitation and to prescribe medication if necessary.
   - Follow Agitated Patient Protocol; support nurse and physician.
2. **INITIAL EVALUATION (ONCE CALM)**
   - Review: Initial Mental Health Evaluation Form with Agitated Patient Protocol; determine delirium/medical illness or mental illness.
   - If patient has a psychiatric disorder or delirium, use Medication Card to dose.
   - Do complete medical evaluation: vitals, signs, physical/med/neuro exam, lab tests, use Medica lEvaluation Protocol for Agitation, Delirium, Psychosis.
3. **INITIAL EVALUATION (ONCE CALM)**
   - Collect information from patient and family.
   - Ensure vitals, weight, and labs are checked.
   - Do baseline AM/PM exam.
4. **INITIAL EVALUATION (ONCE CALM)**
   - Provide psychoeducation and support to patient and family.
   - Make preliminary diagnosis of delirium/medical illness or illness with physician.
5. **INITIAL EVALUATION (ONCE CALM)**
   - Do psychiatric evaluation and support related to medication and psychosis.
   - Do the ZLSI.
   - Document everything in Initial Mental Health Evaluation Form.
6. **INITIAL EVALUATION (ONCE CALM)**
   - Do follow-up of patient in the community; coordinate side effects.
   - Use the ZLSI.
   - Complete the Initial Visit Form.
7. **INITIAL EVALUATION (ONCE CALM)**
   - Do vital signs ASAP.
   - Document in Agitated Patient Form.
   - Do complete medical evaluation: physical/neuro exam, lab tests.
   - Continue to follow patient closely (at least every 15 min check).
8. **INITIAL EVALUATION (ONCE CALM)**
   - Do baseline AM/PM exam.
   - Document in Agitated Patient Form.
   - Do follow-up of patient in the community; coordinate side effects.
   - Use the ZLSI.
   - Complete the Initial Visit Form.
9. **INITIAL EVALUATION (ONCE CALM)**
   - Do complete medical evaluation: vitals, signs, physical/med/neuro exam, lab tests, use Medical Evaluation Protocol for Agitation, Delirium, Psychosis.
   - Document everything in Initial Mental Health Evaluation Form.
   - Do psychoeducation about medication.
   - Do follow-up with psychologist/SW.
10. **INITIAL EVALUATION (ONCE CALM)**
    - Do vital signs, weight, at each visit.
    - Do Psychosis Checklist with CHW/nurse.
    - Give patient/family psychoeducation and support.
11. **INITIAL EVALUATION (ONCE CALM)**
    - Give the Referral Form and Initial Visit Form to psychologist/SW.
    - Do complete medical evaluation: physical/neuro exam, lab tests, use Medical Evaluation Protocol for Agitation, Delirium, Psychosis.
    - Document everything in Initial Mental Health Evaluation Form.
12. **INITIAL EVALUATION (ONCE CALM)**
    - Do the ZLSI.
    - Document in Agitated Patient Form.
    - Do F6 or more.
    - Document in Agitated Patient Form.
13. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
14. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
15. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
16. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
17. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
18. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
19. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
20. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
21. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
22. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
23. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
24. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
25. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
26. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
27. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
28. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
29. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
30. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
31. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
32. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
33. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
34. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
35. **INITIAL EVALUATION (ONCE CALM)**
    - Do psychiatric evaluation and support related to medication and psychosis.
    - Document in Agitated Patient Form.
    - Do follow-up of patient in the community; coordinate side effects.
    - Use the ZLSI.
AGITATED PATIENT PROTOCOL

THROUGHOUT VISIT: Assessment

- REFER to Medical Evaluation Protocols for Agitation, Delirium and Psychosis
- RECORD on Agitation, Delirium and Psychosis Form

Remember:
- Safety: talk first, do not medicate first
- Medical Health: vital signs, physical exam, mental status, exam to assess for delirium, labs and studies
- Mental Health: take history
- Follow-Up: contact psychologist/social worker

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.”)

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

STEP 2: Manage 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

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

1. Manage Behavior/Environment
2. Consider ORAL Medications
3. Consider INTRAMUSCULAR Medications
   - Haldol 5–10 mg IM + diphenhydramine 25 mg IM OR Diazepam 10 mg IM
   - Wait 30 minutes; if patient remains agitated, can re-dose with ½ the original dose
   - Use Medication Card to monitor side effects
   - Debrief with staff
   - Consult mental health team if etiology is psychiatric

1. Manage Behavior/Environment
2. Consider ORAL Medications
3. Consider INTRAMUSCULAR Medications
   - Haldol 5–10 mg IM + diphenhydramine 25 mg IM OR Diazepam 10 mg IM
   - Wait 30 minutes; if patient remains agitated, can re-dose with ½ the original dose
   - Use Medication Card to monitor side effects
   - Debrief with staff
   - Consult mental health team if etiology is psychiatric
### AGITATION, DELIRIUM AND PSYCHOSIS FORM

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Sex:</th>
<th>Phone:</th>
<th>Provider:</th>
<th>Date: dd/mm/yy</th>
</tr>
</thead>
</table>

#### 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: ______________________________________________________________________

- **Manage Behavior/Environment Completed**
  - ☐ 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:_________

**Neurological Exam**
- Cranial Nerves: ☐ Normal ☐ Abnormal:_________
- Motor Strength: ☐ Normal ☐ Abnormal:_________
- Sensory: ☐ Normal ☐ Abnormal:_________
- Reflexes: ☐ Normal ☐ Abnormal:_________

**Gait/Coordination:**
- ☐ 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:** __________________________________________________________________________________________
# Medication Card for Agitation, Delirium, and Psychosis

<table>
<thead>
<tr>
<th>Risperidone</th>
<th>Haloperidol</th>
<th>Diazepam</th>
<th>Carbamazepine</th>
<th>Valproate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Choice:</strong> “Atypical” Antipsychotic/Mood stabilizer</td>
<td><strong>2nd Choice:</strong> “Typical” Antipsychotic/Mood stabilizer</td>
<td>Benzodiazepine for: Alcohol withdrawal, acute agitation with or without anti-psychotic</td>
<td><strong>3rd Choice:</strong> Mood stabilizer Do not prescribe without consulting mental health team</td>
<td><strong>4th Choice:</strong> Mood stabilizer Do not prescribe without consulting mental health team</td>
</tr>
<tr>
<td>Use for: Psychosis (with or without mania)</td>
<td>Use for: Aggressive or violent psychosis (with or without mania)</td>
<td><strong>Use for:</strong> Mania without psychosis</td>
<td><strong>Use for:</strong> Mania without psychosis</td>
<td><strong>Use for:</strong> Mania without psychosis (longstanding aggression or violence in males)</td>
</tr>
</tbody>
</table>

**DO NOT USE IF**

- Caution if child/adolescent
- Prior history of dystonia on antipsychotic medication
- Children (18 or younger)
- Patient is delirious
- Pregnant/breastfeeding women
- Children (18 or younger)
- Elderly (65 or older)
- Blood disorder
- Epilepsy: Absence seizures
- 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)

- **Take at night due to sedative effects**
  - Bipolar/Psychosis – 0.5 – 1 mg
  - Delirium – 0.25 – 0.5 mg
- **Take at night due to sedative effects**
  - Bipolar/Psychosis Moderate sx: 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)
  - Aggressive/Violent Patients: See Agitated Patient Protocol

<table>
<thead>
<tr>
<th><strong>See Agitated Patient Protocol for guidelines regarding use.</strong></th>
<th><strong>200 mg twice daily</strong></th>
<th><strong>200 – 250 mg twice daily</strong></th>
<th><strong>Patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations</strong></th>
</tr>
</thead>
</table>

**“Step” of uptitration**

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.

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.

See Agitated Patient Protocol for guidelines regarding use.

<table>
<thead>
<tr>
<th><strong>200 mg total daily</strong></th>
<th><strong>250 – 500 mg total daily</strong></th>
</tr>
</thead>
</table>

**Maximum Dose**

- 2 mg
  - Doses above 2 mg daily must be reviewed with the mental health team.
- 10 mg
  - Doses above 10 mg daily must be reviewed with the mental health team.
- 10 mg
  - Doses above 10 mg daily must be reviewed with the mental health team.
- 800 mg (for mental illness)
  - Doses above 800 mg must be reviewed with the mental health team.
- 1000 mg (for mental illness)
  - Doses above 1000 mg must be reviewed with the mental health team.
Medication Card for Agitation, Delirium, and Psychosis (continued)

<table>
<thead>
<tr>
<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><strong>Serious</strong></td>
<td><strong>Dystonia</strong> (especially of pharynx, eyes, neck—temporary but potentially fatal), <strong>Tardive Dyskinesia</strong> (permanent), <strong>Akathisia</strong> (restlessness), <strong>Diabetes</strong>, <strong>Cardiac arrhythmia</strong> leading to torsades des pointes</td>
<td><strong>Risk of Seizure</strong> if diazepam withdrawn without taper after regular use at higher dose</td>
<td>Rash, liver failure, decreased white blood count (Carbamazepine can cause hypotension)</td>
</tr>
<tr>
<td><strong>Common</strong></td>
<td>• Sedation</td>
<td>• Sedation</td>
<td>• Sedation</td>
<td>Fatigue, dizziness, nausea/vomiting, incoordination, double vision (Carbamazepine decreases efficacy of oral contraceptives; Valproate causes tremor)</td>
</tr>
<tr>
<td>Monitoring</td>
<td>• Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available)</td>
<td>• Baseline: AIMS, weight, fasting glucose, hemogram, hepatic panel (if available)</td>
<td>• Monitor for signs of sedation</td>
<td>LFTs, CBC, Sodium</td>
</tr>
<tr>
<td></td>
<td>• Every visit: weight, vital signs</td>
<td>• Every visit: weight, vital signs</td>
<td>• Monitor for dependence (need for increased dose to achieve same effect)</td>
<td>Weight gain, LFTs, CBC</td>
</tr>
<tr>
<td></td>
<td>• Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram</td>
<td>• Every 6 months: AIMS, fasting glucose, hepatic panel, hemogram</td>
<td></td>
<td>HIV patients receiving valproic acid may require a zidovudine dosage reduction to maintain unchanged serum zidovudine concentrations.</td>
</tr>
<tr>
<td>Tapering/Discontinuing</td>
<td>If there is a life-threatening/toxic side effect, stop immediately.</td>
<td></td>
<td>• Only used for the management of agitated/violent patients and alcohol withdrawal.</td>
<td></td>
</tr>
<tr>
<td></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></td>
<td>It should not be continued for more than several days.</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>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>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</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>Contraindicated</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>
</tr>
</tbody>
</table>
## 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>Manifestation</strong></td>
<td>Muscle rigidity (potentially including: eye muscles, throat, neck, tongue, back)</td>
<td>Psychomotor restlessness</td>
<td>Involuntary orofacial movements (may be permanent)</td>
</tr>
<tr>
<td></td>
<td>EMERGENCY</td>
<td></td>
<td>Confusion, delirium, stiffness (like a lead pipe), sweating, hyperpyrexia, autonomic instability, drooling, elevated WBC, elevated CPK, death</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></td>
<td></td>
<td></td>
<td>1. Discontinue offending medication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Medical evaluation and support (consider IV fluids)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Hospitalize</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Consider dopamine agonists or dantrolene to improve outcome.</td>
</tr>
<tr>
<td><strong>Toxicities</strong></td>
<td>Serious</td>
<td>Arrhythmia, bronchospasm, Stevens-Johnson syndrome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Common</td>
<td>Fatigue, dizziness, nausea, depression, insomnia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drowsiness, dizziness, headache, dry mouth, tachycardia, constipation, blurred vision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMERGENCY**
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

**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

**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.

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

- Continue evaluation and treatment of underlying medical condition.
- Consider low-dose antipsychotic for delirium (see medication card)
- Consult mental health team/psychologist
Medical Evaluation Protocols for Agitation, Delirium and Psychosis Summary (continued)

**Box 3: Neurological Conditions that Cause or Contribute to Psychosis**
- Tertiary syphilis
- Encephalitis
- Dementia (HV, 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

---

**Continuation of Medical Assessment**

- **Abnormal neurologic exam**
  - **YES**
    - Further neurological testing (See Box 3)
    - Consider CT, EEG, or LP
    - Consult with specialist
  - **NO**

- **Recent onset and temperature > 38 C**
  - **YES**
    - 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.
  - **NO**

- **HIV+ with CD4 count < 200**
  - **YES**
    - LP, as above
    - Consider empiric Rx with appropriate antibiotic medication
    - Consider treatment for toxoplamosis or cryptococcus.
  - **NO**

- **Positive RPR**
  - **YES**
    - Treat for neurosyphilis with penicillin
  - **NO**

- **Abnl glucose, electrolytes, or other evidence of medical illness (See Box 4)**
  - **YES**
    - Consider additional tests: renal panel, liver panel, chest x-ray
    - Treat accordingly
  - **NO**

- **Risk factors for drug or alcohol withdrawal or intoxication? (See Box 5)**
  - **YES**
    - 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
  - **NO**

---

**Perform Mental Health Assessment and Consult Mental Health Team**

- **YES**
  - 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**
    - Consider a primary psychotic disorder
    - Determine whether history of psychosis and medication use coincide.
    - Consider discontinuing medication.
  - **NO**
    - Continue medical assessment
  - **NO**
### ZANMI LASANTE — MENTAL HEALTH SUICIDALITY SCREENING INSTRUMENT

<table>
<thead>
<tr>
<th>LEVEL REACHED</th>
<th>IN THE PAST TWO WEEKS?</th>
<th>IN THE PAST YEAR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Passive</td>
<td>No Yes</td>
<td>No Yes</td>
</tr>
</tbody>
</table>

**Ask:** Do you have any thoughts of ending your life, even if they are not clear in your mind?

**Possible Response:** 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

**Description:**

| 2. Non-Specific Active                          | No Yes                  | No Yes            |

**Ask:** Do you want to die? Do you often think or talk about death?

**Possible Response:** desire/wish to be dead...prefer to be dead...think frequently/talk about death...God would rather have me

**Description:**

| 3. Methods but no Intent to Act                | No Yes                  | No Yes            |

**Ask:** If you would do it, how would you do it?

**Possible Response:** bleach, pesticide, herbicide, battery acid, hang themselves, medication overdose, stop taking medication, a knife, a gun

**Description:**

| 4. Intent to Act                                | No Yes                  | No Yes            |

**Ask:** Do you intend to act on these thoughts?

**Possible Response:** 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

**Description:**

| 5. Planification                                | No Yes                  | No Yes            |

**Ask:** Have you started planning the details about how you will kill yourself?

**Danger Signs:** 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).

**Description:**

| 6. Attempted                                    | No Yes                  | No Yes            |

**Ask:** 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?

**Danger Signs:** 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.

**Low:** Current = 0  Past = 0  
**Medium:** Current = 1–2 yes  OR  Past = 1 or more yes  
**High:** Current = 3 or more yes  OR  Past = 3 or more yes

Total “yes” in past two weeks:  
Total “yes” in past year:  

---

118  Partners In Health | FACILITATOR MANUAL | ANNEX
### For ALL Patients

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

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

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

<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>
<tr>
<td></td>
<td>3.</td>
<td>☐ Determine who will be available to watch the patient and when so that they are not left unattended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name ___________________ Time ___________________ Name ___________________ Time ___________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name ___________________ Time ___________________ Name ___________________ Time ___________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name ___________________ Time ___________________ Name ___________________ Time ___________________</td>
</tr>
<tr>
<td>Say</td>
<td>4.</td>
<td>☐ Despite the potential necessity of negating the patient’s autonomy, do as much as possible to preserve dignity.</td>
</tr>
<tr>
<td>Contact</td>
<td>5.</td>
<td>☐ Any and all accessible individuals from the patient's milieu (you are justified in breaching confidentiality here).</td>
</tr>
<tr>
<td></td>
<td>6.</td>
<td>☐ Any and all potentially influential individuals (neighborhood elder, clergy, Freemason).</td>
</tr>
<tr>
<td>Team</td>
<td>7.</td>
<td>☐ MD: Make sure no attempt has been made occultly, and rule out remediable organic processes (especially pain).</td>
</tr>
<tr>
<td></td>
<td>8.</td>
<td>☐ Any available clinical staff can be called upon to help in monitoring - if necessary, other patients can be as well.</td>
</tr>
<tr>
<td>Follow Up</td>
<td>9.</td>
<td>☐ Keep the patient admitted and under continuous monitoring (e.g. 4x/hr).</td>
</tr>
<tr>
<td></td>
<td>10.</td>
<td>☐ Frequently re-assess risk level.</td>
</tr>
<tr>
<td></td>
<td>11.</td>
<td>☐ If the patient leaves or can’t be kept, follow through with continued intensive psychosocial activation.</td>
</tr>
</tbody>
</table>
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
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... ____________________________
PSYCHOSIS JEOPARDY QUESTIONS ANSWER KEY

SAFETY
1. When do you use the Suicidality Screening instrument? (100 points)
   • If the patient does have a history of suicide attempts or if there is a concern about the patient’s self-harm (whether past or present).

2. Name the two people that work together to create a suicidality safety plan. (200 points)
   • The psychologist/social worker and the patient

3. Name the three levels of agitation. (300 points)
   • Mild, moderate, severe.

4. When should a patient be physically restrained? (400 points)
   • Only if they are violent and have refused oral medication and pose a threat to themselves or others.

5. How many family members should a psychologist/social worker speak to, to complete the initial mental health evaluation form? (500 points)
   • If possible, two!

AGITATION
1. Name three possible causes for medical delirium. (100 points)
   • Brain diseases (dementia, stroke)
   • Metabolic disorders (electrolyte disorders)
   • Infections
   • Drugs
   • Pain
   • Immobility
   • Malignancy

2. True or False: Someone who is physically violent and refuses medication would be considered a moderately agitated patient. (200 points)
   • False, they would be a severely agitated patient

3. Once an agitated patient is given medication, what does the nurse or physician need to monitor? (300 points)
   • Vital signs or side-effects
4. Name three calming interventions for agitated patients. (400 points)
   • Ask: “How can I help?”
   • Reassure the patient that you are there to keep the patient safe
   • Use a soft voice and slow movements
   • Decrease stimuli
   • Allow venting

5. Which clinicians should use the Agitated Patient Protocol? (500 points)
   • Physician
   • Nurses
   • Psychologists/social workers

MEDICAL EVALUATION AND MEDICATIONS
1. Who prescribes medication for medical illness and mental illness? (100 points)
   • The physician

2. Why do we suggest that risperidone be prescribed first over haloperidol? (200 points)
   • Because risperidone has fewer long-term side-effects than haloperidol.

3. When do physicians administer the Abnormal Involuntary Movement Scale (AIMS)? (300 points)
   • When they first prescribe medication, then every six months after.

4. What are possible serious side effects of antipsychotic medications, aside from death? (Name two possible side effects.) (400 points)
   • Weight gain leading to heart disease
   • Diabetes
   • Tardive dyskinesia/permanent abnormal muscle movements
   • Cardiac arrhythmia

5. Which form should you assist physicians with for documenting a medical evaluation of an agitated patient? (500 points)
   • The Agitation, Delirium and Psychosis Form
CLINICAL FORMULATION

1. What are the four factors that should always be included in a case formulation? (100 points)
   - Biological factors, psychological factors, social factors and strengths of the patient

2. Give two examples of types of history that should be asked about by a psychologist/social worker when recording a patient's history in the Initial Mental Health Evaluation Form. (200 points)
   - Family History
   - Medical history
   - Psychiatric history
   - History of present illness

3. Why is a clinical formulation important? (300 points)
   - It is a guide to treatment planning and helps communicate providers’ impressions to other providers, and to a patient and their family.

4. True or false: A clinical formulation is the summary of the clinical data. (400 points)
   - False

5. For an agitated patient, what form can you refer to get the patients' basic medical and psychological history to inform your Initial Mental Health Evaluation? (500 points)
   - The Agitation, Delirium and Psychosis Form
**Clinical Global Impressions Scale**

Date: ________________________________

Name: ________________________________  Psychologist / SW: ________________________________

Patient ID: ________________________________  Age: ________________________________

Male/ Female (circle one)  Phone #1: ________________________________

Town: ________________________________  Phone #2: ________________________________

District: ________________________________  Session#: ________________________________

Date received patient info: ________________________________

I. Severity of Illness

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

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

0 = Not assessed

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

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

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

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

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

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

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

Rating  
(Number 0–7)  

---

Partners In Health | FACILITATOR MANUAL | ANNEX 

125
### II. Improvement

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

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

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

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

**Rating**
(Number 0–7)

### III. Side Effects

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

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

**Rating**
(Number 0–3)
Section 3  Preamble

Say to respondent:
The interview is about difficulties people have because of health conditions.

Hand flashcard #1 to respondent
By health condition I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

Point to flashcard #1
• Increased effort
• Discomfort or pain
• Slowness
• Changes in the way you do the activity.

When answering, I’d like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

Hand flashcard #2 to respondent
Use this scale when responding.

Read scale aloud:
None, mild, moderate, severe, extreme or cannot do.

Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview

Please continue to next page...
**Section 4  Core questions**

*Show flashcard #2*

<table>
<thead>
<tr>
<th>In the past 30 days, how much difficulty did you have in:</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme or cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1</strong> Standing for long periods such as 30 minutes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S2</strong> Taking care of your household responsibilities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S3</strong> Learning a new task, for example, learning how to get to a new place?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S4</strong> How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S5</strong> How much have you been emotionally affected by your health problems?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

**H1** Overall, in the past 30 days, how many days were these difficulties present?  
**Record number of days ____**

**H2** In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?  
**Record number of days ____**

**H3** In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?  
**Record number of days ____**

This concludes our interview. Thank you for participating.
Health conditions:
• Diseases, illnesses or other health problems
• Injuries
• Mental or emotional problems
• Problems with alcohol
• Problems with drugs

Having difficulty with an activity means:
• Increased effort
• Discomfort or pain
• Slowness
• Changes in the way you do the activity

Think about the past 30 days only.
WHODAS 2.0

Flashcard 2

1. None

2. Mild

3. Moderate

4. Severe

5. Extreme or cannot do
EVALUATION FORM

What training activity did you like the most? Why?

__________________________________________________________________________

__________________________________________________________________________

What training activity did you like the least? Why?

__________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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

__________________________________________________________________________

__________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What additional comments do you have?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for completing this evaluation.