7

Collaborative Models of Mental Health Care for Older Iowans

Clinical Resources
CLINICAL MATERIALS

Basic Model

The Mental Health Screen for Older Iowans

Mental Status Examination

Five Key Counseling Points

Diagnostic Testing
  Patient Health Questionnaire – 9
  Zung Anxiety Scale
  Modified Short Michigan Alcohol Screening Test
  Mini-Mental Status Examination
  Short Form 12 Health Survey

Diagnostic Interviewing

Treatment Plan

Evaluation Form
Basic Clinical Model - Four Procedural Steps

1. Screening
   *If patient screens positive for mental health problem, then proceed*

2. Counseling & Referral
   *Counsel patient about benefits of mental health care and schedule diagnostic assessment*

3. Diagnostic Assessment
   *Conduct formal assessment and start treatment within two weeks*

4. Treatment
   *Initiate 24 week treatment plan*
### Basic Clinical Model - with Clinical Procedures

#### 1. Screening

The Mental Health Screen for Older Iowans

*If patient screens positive for mental health problem, then proceed*

#### 2. Counseling & Referral

Discuss the importance of mental health care

Schedule Diagnostic Assessment

#### 3. Diagnostic Assessment

- Testing
- Interview
- Begin Patient & Family Education

#### 4. Treatment

- Treatment Plan Agreement
- Pharmacotherapy
- Problem Solving Therapy
- Supportive Services
- Evaluation
THE MENTAL HEALTH SCREEN FOR OLDER IOWANS

Provider Statement:
I am going to ask you some questions. Even if you are not sure, please just go ahead and provide your best answer.

I want to start by asking you to repeat and remember three words. Please wait until I say all three words, repeat them, and then try to remember what they are because I am going to ask you to name them again in a few minutes. OK?

Repeat these words after me:
- APPLE
- TABLE
- PENNY

Now I want to ask you some other questions:

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What year is this?</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>2</td>
<td>Have you ever had trouble remembering what you did or said after drinking or taking any of your prescription medication?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>3</td>
<td>Who is the current President of the United States?</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>4</td>
<td>What day of the week is this?</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>5</td>
<td>In the past month, have you lost interest or found it difficult to enjoy activities?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>6</td>
<td>Have you ever thought about cutting down on your drinking or prescription drug use?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>7</td>
<td>In the past month, have you feared the worst happening?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>8</td>
<td>Do you ever feel guilty about your drinking or prescription drug use?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>9</td>
<td>In the past month, have you felt down or depressed?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>10</td>
<td>Do you get annoyed when someone asks about your drinking or prescription drug use?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>11</td>
<td>In the past month, have you been bothered by feelings of nervousness?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>12</td>
<td>Do you ever drink as soon after you wake up?</td>
<td>Yes (1) No (0)</td>
</tr>
<tr>
<td>13</td>
<td>What were the three objects I asked you to remember?</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>14</td>
<td>Apple</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>15</td>
<td>Table</td>
<td>Wrong (1) Right (0)</td>
</tr>
<tr>
<td>16</td>
<td>Penny</td>
<td>Wrong (1) Right (0)</td>
</tr>
</tbody>
</table>

TOTAL SCORE __________
A total score of 2 or more indicates a need for formal diagnostic assessment.

Source: University of Iowa, Center on Aging (2007)
MENTAL STATUS EXAMINATION

1. Speech
   a. rate - volume
   b. coherence

2. Thought process
   a. content – logic
   b. computation

3. Thought Association
   a. loose-tangential
   b. circumstantial

4. Abnormal, psychotic thoughts
   a. hallucinations-delusion
   b. obsessive thinking

5. Judgment
   a. concerning social situations
   b. insight into own condition

6. Orientation

7. Recent and remote memory

8. Attention span and concentration

9. Language
   a. name objects
   b. repeat list of words

10. Fund of knowledge
    a. current events

11. Mood and affect
2. Counseling & Referral

A. Convey that mental illness among older adults is not so uncommon, and many types of mental illness do not appear until later in life.

B. Discuss how many mental illnesses among older adults can co-occur with other health problems.

C. Underscore the notion that mental illnesses are not normal aspects of getting older.

D. Highlight the fact that treatment works.

E. Tell them about the collaborative model.
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Score ____ = ____ + ____ + ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Source: Developed the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ) by Drs. Robert L. Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues. PRIME-MD PHQ is a trademark of Pfizer Inc. Copyright 1999
## ZUNG ANXIETY SCALE

**PROVIDER:** “Over the last two weeks, how often have you been bothered by the following...”

“Please indicate if not at all, some days, more than half, or nearly every day.”

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feel more nervous and anxious than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Bothered by dizzy spells</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Feel afraid for no reason at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Have fainted or feel like fainting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Get upset easily or feel panicky</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Have trouble breathing in and out</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feel like falling apart or going to pieces</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Feel numbness or tingling in fingers or toes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Feeling that everything is wrong and nothing good will happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Bothered by stomach aches and indigestion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Arms and legs shake and tremble</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Have to empty bladder often</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Bothered by headaches, neck and backaches</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Hands are usually warm and dry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Feel weak and tired</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Face gets hot and blushes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Feel restless and cannot sit easily</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Have trouble falling asleep and feeling rested</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Feel heart beating fast</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Have nightmares</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Score _____ = _____ + _____ + _____**

If score is 40 points or higher, then further interviewing should be conducted.

### SHORT MICHIGAN ALCOHOL SCREENING TEST - GERIATRIC VERSION (MODIFIED)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When talking with others do you ever underestimate how much you drink or how much medication you take?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>After a few drinks or pills, have you sometimes not eaten or been able to skip a meal because you didn’t feel hungry?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Does having a few drinks or pills help decrease your shakiness or tremors?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Does alcohol or prescription drugs sometimes make it hard for you to remember parts of the day or night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Do you usually take a drink or a pill to relax or calm your nerves?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Do you drink or take a pill to take your mind off your problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Have you ever increased your drinking after experiencing a loss in your life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Has a doctor or nurse ever said they were worried or concerned about your drinking or prescription drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Have you ever made rules to manage your drinking or use of your prescriptions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>When you feel lonely does having a drink or taking a pill help?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL YES = ________**

A total of 2 or more “YES” responses indicates a need for further assessment.

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Copyright: The Regents of the University of Michigan  
Ann Arbor, MI: University of Michigan Alcohol Research Center.
MINI MENTAL STATUS EXAMINATION (MMSE)

PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST AS YOU CAN

1. What is today’s date?
2. What is the year?
3. What is the month?
4. What day is today?
5. What season is it?
6. What building are we in?
7. What floor are we on?
8. What town are we in?
9. What state are we in?
10. What country are we in?

PLEASE REPEAT THE FOLLOWING WORDS AFTER ME “ball”, “flag”, “tree”
11. BALL
12. FLAG
13. TREE

STARTING AT 100, COUNT BACKWARDS BY 7 UNTIL I ASK YOU TO STOP
14. 93
15. 86
16. 79
17. 72
18. 65

POINT TO THE FOLLOWING TWO OBJECTS AND ASK THE PATIENT TO NAME EACH “WHAT’S THIS?”
19. Point to a watch or clock
20. Point to a pen or pencil

ASK PATIENT TO REPEAT THE FOLLOWING “NO IFS, ANDS, OR BUTS”
21. No ifs, ands, or buts

ASK THE PATIENT TO “take a piece of paper, fold it in half, and put it on the floor”
22. take paper
23. fold in half
24. place on floor
ON A PIECE OF PAPER, WRITE ‘CLOSE YOUR EYES’ AND ASK THE PATIENT TO READ THE SIGN AND DO WHAT IT SAYS

______________ 25. “CLOSE YOUR EYES” (1 point)

______________ 26. ASK THE PATIENT TO WRITE A SENTENCE WITH A NOUN AND VERB

______________ 27. ASK THE PATIENT TO DRAW 2 INTERSECTING PENTAGONS (1 POINT)

PLEASE RECALL THE THREE WORDS I ASKED YOU TO REPEAT EARLIER

______________ 28. BALL
______________ 29. FLAG
______________ 30. TREE

TOTAL SCORE

Scoring

Because the MMSE is sensitive to age and education level, the following scoring system should be used to establish whether or not the patient may have a cognitive problem. A score that falls below these numbers indicates a need for more focused clinical examination.

<table>
<thead>
<tr>
<th>Age/Education Level</th>
<th>4th Grade</th>
<th>8th Grade</th>
<th>High School</th>
<th>College</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-64</td>
<td>23</td>
<td>26</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>65-69</td>
<td>22</td>
<td>26</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>70-74</td>
<td>22</td>
<td>25</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>75-79</td>
<td>21</td>
<td>25</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>80-84</td>
<td>20</td>
<td>25</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>85+</td>
<td>19</td>
<td>23</td>
<td>25</td>
<td>27</td>
</tr>
</tbody>
</table>

1. In general, would you say your health is excellent, very good, good, fair, or poor?

2. Does your health limit you a lot, a little, or not at all when doing moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

3. Does your health limit you a lot, a little, or not at all when climbing several flights of stairs?

4. During the past four weeks, have you accomplished less than you would like as a result of your physical health?

5. During the past four weeks, were you limited in the kind of work or other regular activities you do as a result of your physical health?

6. During the past four weeks, have you accomplished less than you would like to as a result of any emotional problems, such as feeling depressed or anxious?

7. During the past four weeks, did you not do work or other regular activities as carefully as a result of any emotional problems such as feeling depressed?

8. During the past four weeks, how much did pain interfere with your normal work, including both work outside the home and housework?

9. How much time during the past month have you felt calm and peaceful?
   - All of the time
   - Most of the time
   - Some of the time
   - None of the time

10. How much of the time during the past month did you have a lot of energy?
    - All of the time
    - Most of the time
    - Some of the time
    - None of the time

11. How much time during the past month have you felt down?
    - All of the time
    - Most of the time
    - Some of the time
    - None of the time

12. During the past month, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends, relatives, etc?
    - All of the time
    - Most of the time
    - Some of the time
    - None of the time

Source: (SF-36.org, 2007)
# MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

## BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>___________________________</th>
<th>DOB</th>
<th>__________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>___________________________</td>
<td>SOC SEC</td>
<td>___________________</td>
</tr>
</tbody>
</table>

## CONTACT INFORMATION

- St: ___________________________
- City: ________________________
- Phone: ________________________

## COUNTY OF RESIDENCE

<table>
<thead>
<tr>
<th>COUNTY OF RESIDENCE</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## PRIMARY INSURANCE

<table>
<thead>
<tr>
<th>PRIMARY INSURANCE</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## SECONDARY INSURANCE

<table>
<thead>
<tr>
<th>SECONDARY INSURANCE</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## NAME OF ASSESSOR

<table>
<thead>
<tr>
<th>NAME OF ASSESSOR</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## PLACE OF ASSESSMENT

<table>
<thead>
<tr>
<th>PLACE OF ASSESSMENT</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## REFERRAL SOURCE

<table>
<thead>
<tr>
<th>REFERRAL SOURCE</th>
<th>___________________________</th>
</tr>
</thead>
</table>

## REASON FOR REFERRAL

- ____________________________________________
- ____________________________________________
- ____________________________________________

## PRIMARY CARE SCREEN INDICATIONS

- ____________________________________________
- ____________________________________________
- ____________________________________________

---

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### MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

**HISTORY**

**DEVELOPMENTAL**  
**Ethnic-Culture**  
__________________________________________

**Education**  
__________________________________________

**Significant Relationships**  
__________________________________________

**MEDICAL - PHYSICAL**  
**Disease**  
__________________________________________

**Other Diagnoses**  
__________________________________________

**Hospitalizations**  
__________________________________________

**Other Service Use**  
__________________________________________

**Relevant Family Hx**  
__________________________________________

**PSYCHIATRIC**  
**Disease**  
__________________________________________

**Other Diagnoses**  
__________________________________________

**Hospitalizations**  
__________________________________________

**Other Service Use**  
__________________________________________

**Family History**  
__________________________________________

**FUNCTIONING**  
**Chronic Disability**  
__________________________________________

**Periods of Difficulty**  
__________________________________________

**OCCUPATIONAL**  
__________________________________________
## MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

### CURRENT STATUS

**SIGNIFICANT OTHER**

**HOUSING SITUATION**

### MEDICAL - PHYSICAL STATUS

<table>
<thead>
<tr>
<th>Disease</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Diagnoses</td>
<td></td>
</tr>
<tr>
<td>Service Use</td>
<td></td>
</tr>
<tr>
<td>Pain - Headaches</td>
<td></td>
</tr>
<tr>
<td>Appetite</td>
<td></td>
</tr>
<tr>
<td>Sexual Relations</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
</tr>
</tbody>
</table>

### FUNCTIONING

<table>
<thead>
<tr>
<th>Activities of Daily Living</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise - Leisure Activities</td>
<td></td>
</tr>
<tr>
<td>Social Activities</td>
<td></td>
</tr>
<tr>
<td>Independent Activities of Daily Living</td>
<td></td>
</tr>
<tr>
<td>Recent Losses</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

PRESCRIPTION DRUG USE
Go through brown bag and fill out the chart and determine if any drugs are potentially high risk.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic-Class</th>
<th>Prescribing Physician</th>
<th>Reason for Rx</th>
<th>Dose</th>
<th>Daily Freq</th>
<th>How long</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
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</table>

The following are considered to be potentially high risk drugs for older adults (generic name (brand name)):

amiodarone (Cordarone),
amitriptyline (Elavil, Limbitrol, Triavil),
amphetamines and anorexic agents,
barbiturates (except phenobarbital for seizures),
long-acting benzodiazepines (Dalmane, Librium, Limbitrol, Librax, Praxipam, Tranxene, Valium),
chlorpropamide (Diabinese),
disopyramide (Norpace),
doxepin (Sinequan),
gastrointestinal antispasmodics (Bentyl, Donnatal, Levsin, ProBanthine),
guanethidine (Ismelin),
guanadrel (Hylorel),
indomethacin (Indocin),
ketorolac (Toradol),
meperidine (Demerol),
meprobamate (Equanil, Miltown),
mesoridazine (Serentil),
methylbromide (Aldomet, Aldoril),
methyltestosterone (Android, Testred, Virilon),
muscle relaxants (Flexeril, Norflex, Robaxin, Soma, Skelaxin),
NSAIDS (Daypro, Feldene, Naprosyn),
pentazocine (Talwin),
thioridazine (Mellaril),
ticlopidine (Ticlid),
trimethobenzamide (Tigan).

Consult with primary physician regarding current prescription use and treatment plan for mental health problem.

Source: http://www.fda.gov/cder/drug/drugreactions
MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

MOTIVATION FOR TREATMENT

WHAT DO YOU WANT TO GET OUT OF YOUR TREATMENT?

___________________________________________________________________
___________________________________________________________________

WHAT DOES YOUR SIGNIFICANT OTHER WANT TO GET OUT OF YOUR TX?

___________________________________________________________________
___________________________________________________________________

ON A SCALE FROM 1-10, HOW SERIOUS ARE YOUR PROBLEMS?  __________

HOW WOULD YOU LIKE TO DESCRIBE YOURSELF ONE YEAR FROM NOW?

___________________________________________________________________
___________________________________________________________________

HOW OFTEN WOULD YOU BE WILLING TO PARTICIPATE IN TREATMENT?

___________________________________________________________________
___________________________________________________________________

HOW LONG DO YOU THINK THE TREATMENT SHOULD LAST?

___________________________________________________________________
___________________________________________________________________

DO YOU THINK YOU MIGHT HAVE TROUBLE PAYING FOR TREATMENT?

___________________________________________________________________
___________________________________________________________________

DO YOU HAVE ANY CAREGIVING RESPONSIBILITIES?

___________________________________________________________________
___________________________________________________________________

WOULD YOU HAVE TROUBLE GOING TO THE OFFICE FOR TREATMENT?

___________________________________________________________________
___________________________________________________________________

OTHER FACTORS THAT MIGHT AFFECT YOUR PARTICIPATION IN TX?

___________________________________________________________________
### MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

**DIAGNOSTIC IMPRESSION**

**AXIS I: Clinical disorders; other conditions that may be focus of attention**

_____________________________________________________________________
_____________________________________________________________________

**AXIS II: Personality disorders**

_____________________________________________________________________

**AXIS III: Medical conditions**

_____________________________________________________________________

**AXIS IV: Psychosocial and environmental problems**

_____________________________________________________________________

**AXIS V: Global assessment of functioning**

_____________________________________________________________________
_____________________________________________________________________
TREATMENT PLAN

SITE: ________________________________________________________________

PATIENT INITIALS: ______________________________

PARTICIPATING STAFF:

Mental Health Specialist _____________________________  p: ___________________

Primary Care Staff _____________________________  p: ___________________

Consulting Psychiatrist _____________________________  p: ___________________

Client Emergency Contact _____________________________  p: ___________________

TREATMENT OVERVIEW:

Presenting Problem: __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Diagnosis: __________________________________________________________________

Other Diagnosis: _____________________________________________________________

Goal of Treatment: __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Date of Treatment Initiation:   __________________________________________________

Expected Date of Treatment Completion: ________________________________________
# TREATMENT METHODS:

**PRESCRIPTION MEDICATION:**
- Treatment target: _______________________________________________
- Type/Brand Name: _______________________________________________
- Dosage/Frequency: _______________________________________________
- Adjustment Dates: _______________________________________________

**PROBLEM SOLVING THERAPY:**
- Treatment Target(s): _______________________________________________
- _______________________________________________
- _______________________________________________
- _______________________________________________

- Method of Focused Intervention:
  - Homework _______________________________________________
  - Activity _______________________________________________
  - _______________________________________________
  - _______________________________________________

**SUPPORTIVE SERVICES**
- Treatment Target: _______________________________________________
- _______________________________________________
- Recommended Services:
  - _______________________________________________
  - _______________________________________________
  - _______________________________________________

Contacts:
- _______________________________________________
<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Dates</th>
<th>Place</th>
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<tbody>
<tr>
<td>Agree to Treatment Plan</td>
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<tr>
<td>Prescribe medications</td>
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<tr>
<td>Review PST - Supportive Services</td>
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<tr>
<td>Educational Materials</td>
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<tr>
<td>Week 2-3:</td>
<td>Dates</td>
<td>Place</td>
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<tr>
<td>Problem Solving Therapy</td>
<td></td>
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<tr>
<td>Supportive Services</td>
<td></td>
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<tr>
<td>Week 4:</td>
<td>Dates</td>
<td>Place</td>
</tr>
<tr>
<td>Medication Management</td>
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<tr>
<td>Problem Solving Therapy</td>
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<tr>
<td>Evaluation I</td>
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<tr>
<td>Treatment Adjustments</td>
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<td>Week 5-7:</td>
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<td>Week 8:</td>
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<tr>
<td>Problem Solving Therapy</td>
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<tr>
<td>Evaluation II</td>
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<tr>
<td>Treatment Adjustments</td>
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<tr>
<td>Week 9-15:</td>
<td>Dates</td>
<td>Place</td>
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<tr>
<td>Problem Solving Therapy</td>
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<tr>
<td>Supportive Services</td>
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<tr>
<td>Week 16:</td>
<td>Dates</td>
<td>Place</td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
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<tr>
<td>Problem Solving Therapy</td>
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<tr>
<td>Evaluation III</td>
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<tr>
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<tr>
<td>Week 17-23:</td>
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<td>Week 24:</td>
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<td>Treatment Plan Continuation</td>
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</table>
CLIENT EVALUATION

SITE: __________________________________________________________________________

PATIENT INITIALS: ____________________

PARTICIPATING STAFF:

Mental Health Specialist ___________________________  p: _______________________
Primary Care Staff _____________________________  p: _______________________

Initial Screening Date: _______________________________________________________
Initial Screening Score: ______________________________________________________
Initial Screening Impression: __________________________________________________

Diagnostic Assessment Date: ________________________________________________

Assessment Test Scores:

PHQ9  _____________
ZUNG  _____________
SMAST-G  _____________
MMSE  _____________
SF-12  _____________

Other: ________________________________________________________________________

Diagnosis: ____________________________________________________________________

Treatment Initiation date: ______________________________________________________

Treatment Plan Goals: ____________________________________________________________________
### CLIENT EVALUATION

**EVALUATION 1 (4 weeks)**

<table>
<thead>
<tr>
<th>PHQ9</th>
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**Other:**

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**EVALUATION II (8 weeks)**

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**Other:**

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**EVALUATION III (16 weeks)**

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**Other:**

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**EVALUATION IV (24 weeks)**

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</table>

**Other:**

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*Collaborative Models of Mental Health Care for Older Iowans*