Training Agendas and Materials for Expert Leaders, Depression Nurse Specialists, and Psychotherapists

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RAND
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Training Materials

The training materials included in this volume are the ones we used to implement the *Partners in Care* quality improvement programs. These materials will help you plan education sessions for the broad group of clinicians in your practice, and training sessions for the individuals who will implement the quality improvement programs. Each component of the training materials is described briefly below:

1. **Agendas for the Expert Leader Training Sessions for the Psychotherapy and Medication Quality Improvement Programs**: Each of these training sessions included 21 expert leaders—one primary care expert leader, one psychiatry or psychology expert leader, and one nurse expert leader from each of the 7 managed care organizations in the study. Each of the 7 groups of expert leaders implemented the quality improvement programs with 5 to 30 primary care providers, depending on the size of the practice. Figure 1 provides the training agenda for the psychotherapy program; Figure 2 provides the agenda for the medication program.

The sessions began with a description of the study and quality improvement programs. We then reviewed the material in the *Clinician Guide*, which reflected the study’s clinical perspective based on Agency for Healthcare Research and Quality (formerly AHCPR) national guidelines for depression. This review of clinical material is part of the study’s collaborative care (i.e., across professional disciplines) model, designed to ensure that each type of expert leader understands, and can communicate, all key aspects of depression care.

Discussion and expert consultation periods were designed to promote discussion of the clinical points raised during lectures. It is empowering for expert leaders from each discipline to know that they speak from a base of shared clinical goals and information. As mental health specialists, primary care clinicians, and nurses ask and answer questions, they develop consensus. Without this sense of common expertise, it is likely that one or another of the group will back off from active participation once back home. Discussing the variety of issues that may come up, such as psychiatric co-morbidities and how they affect treatment, produces a deeper level of expertise than may be necessary for the average clinician in the practices. It will, however, enable the expert leaders to confidently give lectures, seminars, and one-on-one education back in their own clinical environments.

The next sessions shifted from clinical information to planning for implementation of the quality improvement programs. Meeting as a group, we reinforced and personalized general information on study roles and materials. Expert leaders from each site then broke into subgroups to plan how they would teach their colleagues at home—what seminars, one-to-one meetings, quality improvement meetings, etc. (see Figure 3, *Partners in Care Team Break-Out Sessions: Discussion Guide*). The full group then re-assembled, and during a one-hour practice session, someone from each expert leader subgroup practiced giving 10 minutes of a lecture on depression, using their choice of our slides.

We began the second day of training by reviewing the prior day’s questions. We then reviewed the *Guidelines and Resources for the Depression Nurse Specialist*, including materials, the study flow diagrams (see *Guidelines and Resources for the Depression Nurse Specialist*), and the study activities indicated in the flow diagrams. Activities included notifying the depression nurse specialist (DNS) of patients screening positive for depression, scheduling the nurse visit in
tandem with the visit to the primary care physician, transmitting the nurse’s patient assessment to the clinician, and transmitting the clinician’s care plan back to the nurse. For the medication arm of the study, these activities also included case management of patients for 6 to 12 months.

We then briefly reviewed the issues of staff supervision and quality monitoring. The most critical issue was supervision of the depression nurse specialist. In the medication arm, it was particularly important that a psychiatrist interact weekly with the nurse to review case progress for patients on medications.

The remainder of the second day focused on detailed planning by each site for implementation at their site (see Figure 3, Partners in Care Team Break-Out Sessions: Discussion Guide). Research team members rotated among groups, and the study PI and Co-PI sat in a central location so that questions could be routed to them. Groups presented key points from their plans to each other at the end of the day.

In addition to the materials described above, this unit includes the Clinician Pre-Training and Post-Training Questionnaires, (Figures 4 and 5) and the Expert Panel Feedback Form (Figure 6). We used the questionnaires and the form to assess providers’ knowledge before and after the training session, as well as their satisfaction with the training. This not only gave us useful information about how to improve what we did, but it served as the basis for providing CME credits to participants.

2. Partners in Care Intervention Nurse Training Agenda: This is the agenda for the one-day training session for the 14 Depression Nurse Specialists (Figure 7). These individuals were in most, but not all, cases the same individuals who came to the Expert Leader training. The majority of the participants were general RNs, though two had additional training (one in case management and one in mental health), one was an LVN, and one was a nursing assistant. Training focused on the nurse Guidelines and patient education materials. These materials were provided to the participants ahead of time, so that the session could begin with their questions.

The most important goal of the nurse training was to train nurses to simultaneously activate, educate, and assess a patient during an initial 45-minute visit. After a brief review of the study materials and the study flow-chart, nurses watched a videotape of a mock nurse/patient assessment to demonstrate our concept of how this would be accomplished. Other goals were to practice using all study materials, and, for the medication arm of the study, to practice case management.

To build these skills, most of the day was spent doing role-plays and reviewing problems that came up in the group as a whole. In pairs, nurses did role-plays structured around three case vignettes (see Figure 8), each of which involved an initial visit, and two follow-ups. Some of the follow-ups were telephone follow-ups, and some were actual visits with the nurse. Each stage, and the accompanying study materials, were role-played and reviewed in sequence. Each follow-up description was handed out sequentially, as soon as the preceding one was completed. Nurses assembled the relevant study materials from their packets and used them during each role-play.

3. Psychotherapist Training: Therapists who provided the mental health care for patients seen in the primary care clinics participating in PIC were trained in cognitive-behavioral therapy (CBT) methods during two-day training sessions. In addition, the training sessions emphasized the importance of working collaboratively with referring primary care clinicians, and of providing active follow-up to patients. For example, we expected them to call patients by
telephone when they did not show up for sessions, and to help patients overcome barriers to receiving care, such as obtaining time away from work, or childcare responsibilities. We also expected them to communicate with the primary care clinician, either in writing using a form we provided or by telephone, when a patient either completed or failed to complete CBT.

The first day of the training focused on teaching the principles of cognitive-behavioral therapy. This day’s sessions built upon a homework assignment completed by the therapists prior to the session that asked them to read two books describing the cognitive-behavioral therapy method (Beck, A.T., Rush, A.J., Shaw, B.F., and Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press. Persons, J.B. (1989). *Cognitive Therapy in Practice*. New York: W. W. Norton & Company) and one book for use with patients (Lewinsohn, P.M., Muñoz, R.F., Youngren, M.A., and Zeiss, A.M. (1986). *Control Your Depression*. New York: Prentice Hall Press). To supplement the didactic discussion, the therapists observed a cognitive-behavioral therapy session being carried out in the primary care clinic, either through a one-way mirror or as a videotaped presentation, and discussed the session with the training therapists.

In the second day of training, clinicians participated in practice exercises. First, the therapists in training role-played patients while the faculty role-played group therapists. During the role-play, trainees used the patient group therapy manuals provided in the PIC package (MR-1198/4-AHRQ and MR-1198/5-AHRQ) under the direction of the trainers, mimicking what would happen during an actual session. Following this exercise, pairs of therapists in training participated in another role-play in which one therapist played the patient and the other played the therapist. This second role-play focused on practicing techniques for modifying dysfunctional thinking.

Training continued for most participants after the initial two-day session. We encouraged each therapist to participate in supervision for a CBT case or group with the study faculty, and most therapists did. To participate in supervision, therapists forwarded weekly tapes of their sessions for review by the CBT faculty. Faculty reviewed each tape with the therapist during a half-hour telephone call prior to the therapist’s next appointment with the patient.

4. **Partners in Care Slides**: We have provided you with the slides we used and subsequently gave to the study expert leaders. There are six groups of slides:

- Overview of Clinician Guide to Depression Assessment and Management in Primary Care;
- Overview of Consultation;
- Understanding Medication Management for Depression;
- Partners in Care Approach Intervention Philosophy;
- The Partners In Care Team Approach: Enhanced Medication Management for Depression;
- The Partners In Care Team Approach: Enhanced Psychotherapy Management for Depression.

We have provided the full slides, in black and white, for the Overview of the Clinician Guide, which describes all of the steps for assessing and managing depression. We have also provided full slides on mental health specialty consultation.

For the other four groups of slides, we have provided reduced slides for each presentation, as well as full slides of any graphics.
## DAY 1

**THE INTERVENTION PLAN**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 - 8:00 AM</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>8:00 - 8:30 AM</td>
<td>Partners In Care Study Design</td>
</tr>
<tr>
<td>8:30 - 9:15 AM</td>
<td>Psychotherapy Intervention Philosophy And Goals</td>
</tr>
<tr>
<td>10:15 - 10:30 AM</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:30 - 11:30 AM</td>
<td>Review Of Part II Of Depression Manual; 7 Steps For Evaluation,</td>
</tr>
<tr>
<td></td>
<td>7 Steps For Management, Key Priorities For Improving Care For Depression</td>
</tr>
<tr>
<td>11:30 - 12:00 PM</td>
<td>Discussion, Expert Consultation</td>
</tr>
<tr>
<td>12:00 - 1:00 PM</td>
<td>LUNCH</td>
</tr>
<tr>
<td>1:00 - 2:00 PM</td>
<td>Understanding Medication Management</td>
</tr>
<tr>
<td>2:00 - 3:00 PM</td>
<td>Understanding Psychotherapy Management</td>
</tr>
<tr>
<td>3:00 - 3:15 PM</td>
<td>BREAK</td>
</tr>
<tr>
<td>3:15 - 4:00 PM</td>
<td>Discussion and Expert Consultation</td>
</tr>
<tr>
<td>4:00 - 4:15 PM</td>
<td>Brief Review Of Roles And Materials</td>
</tr>
<tr>
<td>4:15 - 5:00 PM</td>
<td>Break-Out Groups To Plan Teaching Activities</td>
</tr>
<tr>
<td>5:00 - 6:00 PM</td>
<td>Practice Teaching, Each Site Ten Minutes And Self-Critique</td>
</tr>
<tr>
<td>6:30 - 7:00 PM</td>
<td>Cocktails and Conversation</td>
</tr>
<tr>
<td>7:00 - 9:00 PM</td>
<td>Dinner and Conversation</td>
</tr>
</tbody>
</table>

## DAY 2

**IMPLEMENTATION PLAN**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 - 8:00 AM</td>
<td>BREAKFAST</td>
</tr>
<tr>
<td>8:00 - 8:15 AM</td>
<td>Questions and Priorities from Day 1</td>
</tr>
<tr>
<td>8:15 - 8:45 AM</td>
<td>Review Of Initial Nurse And Primary Care Provider Assessment</td>
</tr>
<tr>
<td>8:45 - 9:30 AM</td>
<td>Review Of Quality Monitoring And Staff Supervision</td>
</tr>
<tr>
<td>9:30 - 10:00 AM</td>
<td>Review Of Consultation</td>
</tr>
<tr>
<td>10:00 - 10:15 AM</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:15 - 12:00 PM</td>
<td>Break-Out Groups To Plan Intervention Implementation</td>
</tr>
<tr>
<td>12:00 - 1:00 PM</td>
<td>LUNCH</td>
</tr>
<tr>
<td>1:00 - 2:30 PM</td>
<td>Team Reports And Self-Critique Of Implementation Plans</td>
</tr>
<tr>
<td>2:30 - 4:00 PM</td>
<td>Develop Consensus On Materials Needed, Changes Necessary To Support Teams</td>
</tr>
<tr>
<td>4:00 - 5:00 PM</td>
<td>Discussion, Follow-Up Steps, Departures</td>
</tr>
</tbody>
</table>
PARTNERS IN CARE
MEDICATION INTERVENTION TRAINING AGENDA

DAY 1
THE INTERVENTION PLAN

7:30 - 8:00 AM  BREAKFAST
8:00 - 8:30 AM  Partners In Care Study Design
8:30 - 9:15 AM  Medication Intervention Philosophy And Goals
10:15 - 10:30 AM BREAK
10:30 - 11:30 AM Review Of Part II Of Depression Manual; 7 Steps For Evaluation, 7 Steps For Management, Key Priorities For Improving Care For Depression
11:30 - 12:00 PM Discussion, Expert Consultation
12:00 - 1:00 PM  LUNCH
1:00 - 2:00 PM  Understanding Psychotherapy Management
2:00 - 3:00 PM  Understanding Medication Management
3:00 - 3:15 PM  BREAK
3:15 - 4:00 PM  Discussion and Expert Consultation
4:00 - 4:15 PM  Brief Review Of Roles And Materials
4:15 - 5:00 PM  Break-Out Groups To Plan Teaching Activities
5:00 - 6:00 PM  Practice Teaching, Each Site Ten Minutes And Self-Critique
6:30 - 7:00 PM  Cocktails and Conversation
7:00 - 9:00 PM  Dinner and Conversation

DAY 2
IMPLEMENTATION PLAN

7:30 - 8:00 AM  BREAKFAST
8:00 - 8:15 AM  Questions and Priorities from Day 1
8:15 - 8:45 AM  Review Of Initial Nurse And Primary Care Provider Assessment
8:45 - 9:30 AM  Review Of Quality Monitoring And Staff Supervision
9:30 - 10:00 AM Review Of Consultation
10:00 - 10:15 AM BREAK
10:15 - 12:00 PM Break-Out Groups To Plan Intervention Implementation
12:00 - 1:00 PM  LUNCH
1:00 - 2:30 PM  Team Reports And Self-Critique Of Implementation Plans
2:30 - 4:00 PM  Develop Consensus On Materials Needed, Changes Necessary To Support Teams
4:00 - 5:00 PM  Discussion, Follow-Up Steps, Departures
Location
(Please submit one completed guide per site)

Partners in Care Team Break-Out Sessions: Discussion Guide

Day 1: Plan Teaching Activities

1. Partners in Care team education.

Who in your clinic needs to be educated about the Partners in Care study?

What kinds of educational sessions will you have?

What forums are available for providing the education sessions? Who will schedule them, notify participants, and maintain a log of sessions and attendees?

How long should each session be? How often should your sessions be? Are monthly sessions for six months feasible?
Which team members need which provider education materials? Where will the team members keep the materials so that they are available in clinic?

Who will provide the initial and follow-up presentations to primary care providers?

How much will you have to rely on one-on-one training, reminders, or feedback to individual members who do not attend sessions?

Will member physicians do the reading?
Day 2: Plan Intervention Implementation

2. Primary care clinic resources.

How will intervention resources be distributed to your clinics (e.g., therapist, nurse specialist days)?

What is needed to make the resources available to providers and study patients?

What problems do you foresee in utilizing the personnel resources in your sites?

3. Team member roles.

Who will keep a list of team members?

Who will the data collector call to schedule an appointment?

Who will supervise nurse specialists?

Who will supervise therapists?
4. Intervention Procedures.

How will necessary meetings between team members be arranged?

How will the nurse coordinate her care with the primary care clinician for individual patients (e.g., how will the nurse and physician communicate before and after the initial assessment)?

After the initial physician visit, how will the nurse accomplish the post-visit patient education?

Where will the nurse maintain study records and the study clinical contact record (in a confidential, secure place)? Where will copies of patient education materials be kept?

5. Consultation and specialty referral issues.

How should specialty referral issues for study patients be handled?

Should the PCP expert or mental health expert assist with decisions about specialty referrals or emergencies?
Which team experts will provide direct consultation to participating PCPs concerning care of study patients?

6. Access to therapists (counseling intervention clinics).

What specific activities would build a meaningful relationship between therapists and primary care clinician groups?

Can therapy be provided in some primary care clinic settings?

How frequently/should follow-up be provided from therapists to primary care providers?

7. Possible barriers to implementation.

Are the interventions feasible and realistic in your clinics?

Can the providers, clinics, and patients obtain access to the treatments and resources?
Will providers and patients participate and use the resources?

Will any of the member physicians in your intervention clinics be reluctant to use nurse specialists for initial assessments?

8. Quality assurance.

Where and when will you hold monthly meetings of the expert team?

Who chairs these meetings and sets the agenda?

How can the team follow-up on any particular problems (low referrals to therapy, low rates of initiating antidepressant medication)? Who will provide the feedback, and how will the feedback be delivered (to individuals, the group, in writing, informally, etc.)?
9. Minority or other historically underserved populations.

Minority populations seem to have lower levels of access to appropriate care for depression. How can your clinics and providers improve access to appropriate care for depressed minority general medical patients?

NOTE: Avoid potential contamination of study groups through use of expert leaders for clinical care of study patients from other study cells.

It is important to have alternative coverage other than intervention experts for one intervention for study patients from the other intervention. For example, if possible, the expert medication psychiatrist should not provide consultation on study patients from care as usual or psychotherapy; instead another psychiatrist (care as usual) should be available.

Review the particular clinics in your intervention (again) and consider whether contamination effects are a problem for your intervention, given the pool of expert leaders across interventions in your organization.
Partners in Care
CLINICIAN PRE-TRAINING QUESTIONNAIRE

Please complete this brief questionnaire and return it to a member of the Partners in Care research team before you leave.

1. What is your role for this training session?
   
   (Circle One)
   
   Expert Leader or "stand-in"................................. 1
   Other clinician site representative.......................... 2
   Other non-clinician site representative (skip to #10)..... 3

2. What type of clinician are you?
   
   (Circle One)
   
   Primary Care Physician..................................... 1
   Psychiatrist..................................................... 2
   Psychologist (Ph.D.)........................................... 3
   Physician Assistant.......................................... 4
   Nurse Practitioner............................................ 5
   Mental Health Nurse.......................................... 6
   Masters-level therapist...................................... 7
   Other (what?).................................................... 8

3. How many years have you been in your current practice?
   
   Write In # of Years

Thinking about a typical week in your main professional practice:

4. How many outpatient visits with adults 18 years or older per week do you have in your office, clinic, or other outpatient setting?
   
   WRITE IN NUMBER OF
   PATIENT VISITS PER WEEK:
   
5. Of these visits in #4, what percent involve patients who have major depression?
   
   WRITE IN PERCENT
   OF OUTPATIENT VISITS

6. About how much time during the past 3 years have you actively participated in continuing medical education (CME) specifically for the care of patients with depression?

   WRITE IN TOTAL # OF HOURS→
7. How prepared are you in managing the following aspects of depression in your current practice?

<table>
<thead>
<tr>
<th>(Circle One Number On Each Line)</th>
<th>Not At All Prepared</th>
<th>Slightly Prepared</th>
<th>Somewhat Prepared</th>
<th>Very Prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Counseling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Diagnosis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. Referral</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

8. How skilled do you think you are in providing the following services for depressed patients?

<table>
<thead>
<tr>
<th>(Circle One Number On Each Line)</th>
<th>Not At All Skilled</th>
<th>Slightly Skilled</th>
<th>Somewhat Skilled</th>
<th>Very Skilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Counseling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Diagnosis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. Referral</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

9. Of the moderate to severe depressed patients you see in your main practice, about what percentage in a typical month do you:

<table>
<thead>
<tr>
<th>(Circle One Number On Each Line)</th>
<th>None (0%)</th>
<th>25% or less</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prescribe tricyclic antidepressants...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Prescribe SSRIs.........................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Prescribe anxiolytics or sedatives (minor tranquilizers)......................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Personally counsel for depression...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Refer to mental health specialty......</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Schedule a follow-up visit without starting treatment............................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
10. To what extent do you believe each of the following statements is true or false?

On the line next to each statement, circle one number (from 1 to 5) for the answer that is closest to your own.

(Circle One Number On Each Line)

<table>
<thead>
<tr>
<th></th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don't Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The maintenance phase of treatment for major depression focuses on preventing recurrence...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. If psychotherapy for major depression has no effect within 6 weeks of regular sessions, medication is recommended...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. An appropriate trial of antidepressant medication for major depressive disorder requires use of therapeutic dosages daily for at least 4-6 weeks...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Psychotherapy for major depression should be fully effective within 4-6 weeks...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Side effects occur only in a small percentage of patients taking any antidepressant medication...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Medication and psychotherapy are efficacious for depression in elderly adults as well as for the non-elderly...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Evidence suggests that primary care clinicians prescribe appropriate dosages of antidepressants to fewer than a third of patients with a current major depressive disorder...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Most tricyclic antidepressants have equivalent efficacy as SSRIs for depressed patients...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. Dysthymic disorder is mild, brief depression...</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>j. The goal of cognitive therapy is to remove symptoms of depression by identifying and correcting patients' distorted, negatively biased thinking...</td>
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<td>l. The combination of antidepressant medication and short-term psychotherapy is more efficacious for major depression than either treatment alone...</td>
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Your Name (Optional):
Please complete this brief questionnaire and course evaluations. When you are finished, please return it to a member of the *Partners in Care* research team before you leave.

In this section, please rate the extent to which you believe each of the following statements is **true** or **false**?

On the line next to each statement, circle one number (from 1 to 5) for the answer that is closest to your own.

**Circle One Number On Each Line**

<table>
<thead>
<tr>
<th>(Circle One Number On Each Line)</th>
<th>Definitely True</th>
<th>Mostly True</th>
<th>Don't Know</th>
<th>Mostly False</th>
<th>Definitely False</th>
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<td>a. The maintenance phase of treatment for major depression focuses on preventing recurrence........</td>
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<td>b. If psychotherapy for major depression has no effect within 6 weeks of regular sessions, medication is recommended........................</td>
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<td>c. An appropriate trial of antidepressant medication for major depressive disorder requires use of therapeutic dosages daily for at least 4-6 weeks....</td>
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<td>d. Psychotherapy for major depression should be fully effective within 4-6 weeks........................</td>
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<td>e. Side effects occur only in a small percentage of patients taking any antidepressant medication.......</td>
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<td>f. Medication and psychotherapy are efficacious for depression in elderly adults as well as for the non-elderly........................</td>
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<td>g. Evidence suggests that primary care clinicians prescribe appropriate dosages of antidepressants to fewer than a third of patients with a current major depressive disorder........................</td>
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<td>h. Most tricyclic antidepressants have equivalent efficacy as SSRIs for depressed patients..............</td>
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<td>i. Dysthymic disorder is mild, brief depression........</td>
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In this section, please rate the overall quality of each aspect of the training.

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<th>Very Good</th>
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<td>a. Lectures</td>
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<td>b. Question/answer sessions</td>
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<td>c. Small group sessions</td>
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<td>d. Practice sessions</td>
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<td>e. Content/selection of topics</td>
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<td>f. Program format</td>
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<td>g. Written materials (manuals, charts)</td>
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<td>h. Length of training</td>
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Additional Comments:

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Your Name (Optional):__________________________________________________________
Partners in Care
Expert Panel Feedback Form

Please review and comment on the accompanying materials as outlined in the letter. Your feedback will enable us to improve the overall quality of the materials and increase their compatibility with your needs. Thank you for your comments. Please fax this form to Lisa Rubenstein at RAND, fax 310-451-6930; phone 310-393-0411 x6303.

Part I: Partners in Care Team Approach:

1. Interdisciplinary team role descriptions: Any questions? Anything unclear?

2. Educational Materials: Do you understand how these will be used?

3. Procedures for Patient Care: Questions or comments about these activities in your site?

4. Other comments about Part I:

Part II: Clinician Guide to Depression Assessment and Management in Primary Care Settings

1. Chapter 1: Brief Algorithm for Evaluation

Which parts of the algorithm do you feel are most difficult for you either in terms of patient care or in terms of your own language?

Which parts of the algorithm are most important to review?

2. Chapter 2: Brief Algorithm for Management

Which parts of the algorithm do you feel are most difficult for you?
Which parts of the algorithm are most important to review?

3. Chapter 1: Review of detailed algorithm and specific sections of the Chapter
   Which sections of the algorithm or chapter are unclear?

   Which sections of the algorithm or chapter do you disagree with?

   Which sections will you have most difficulty teaching to others?

4. Chapter 2: Review of detailed algorithm and specific sections of the Chapter
   Which sections of the algorithm or chapter are unclear?

   Which sections of the algorithm or chapter do you disagree with?

   Which sections will you have difficulty teaching to others?

5. Comments about Part II:

6. Comments on Part I and Part II combined:
   Is the overall organization of the materials clear to you?

   Are there areas missing that we have not covered adequately?

   General comments:
PARTNERS IN CARE
INTERVENTION NURSE TRAINING AGENDA

7:30 - 8:00 AM  CONTINENTAL BREAKFAST
8:00 - 8:15 AM  Study Overview
8:30 - 8:45 AM  Review Of Study Procedures
8:45 - 10:00 AM Review Of Depression Guidelines, Patient Brochure and Patient Videotape

10:00 - 10:10 AM  BREAK

10:10 - 11:10 AM  Role Play Initial Assessment (Groups of 4 to 6)

11:10 - 11:15 PM  BREAK (Transfer to Room 3730)

11:15 - 12:30 PM  Re-Cap and Review

12:30 - 1:30 PM  LUNCH

1:30 - 2:30 PM  Role Play Initial Assessment (Groups of 2)
2:30 - 3:15 PM  Review of Patient Flow, Post-Visit Education, And Follow-Up

3:15 - 3:30 PM  BREAK

3:30 - 4:30 PM  Role Play Of Post-Visit Education, Follow-Up, Charting, And Logging
4:30 - 5:15 PM  Review And Group Role Play Of What-Ifs
5:15 - 6:15 PM  Summary And Review Of Next Steps

6:30 - 7:00 PM  Cocktails And Conversation
7:00 - 9:00 PM  Dinner And Conversation
Vignettes for Nurse Training:
Role-Plays for Initial Assessment and Follow-up

Case 1

Initial visit
Mrs. D. is a 28-year-old married Caucasian mother of a seven-month-old baby boy. She did well immediately after the birth of the baby but now presents with five months of fatigue and poor energy. Even when the baby sleeps at night, she often wakes up around 3 am and has a difficult time going back to sleep. During the day, she can't concentrate and feels like she gets nothing accomplished.

She feels inadequate as a mother because she has a difficult time comforting the baby, who has had a lot of colic and crying spells.

She used to work in a marketing firm and had considered returning to work after 3 months, but now she feels that she cannot go back because she feels that nobody can adequately comfort the baby. She feels guilty about this because it will be very difficult for the couple to support their current lifestyle on her husband's income only.

She stays at home most of the day and has not seen many of her family and friends, who have offered to help with the baby.

Her husband has been trying to help as much as he can, but he has a significant amount of stress at work and the couple has been arguing more than they used to - usually over "little things."

She denies feeling depressed, but her husband says that she has been extremely emotionally labile, irritable, and crying multiple times a day.

1 week telephone follow-up
Mrs. D. has been taking sertraline 50 mg po qam for 1 week. She has not noticed much difference in her mood but has shared her diagnosis of depression with a friend of hers who had been successfully treated with an antidepressant in the past. She has managed to take the medication every morning but has had "upset stomach," mild nausea and diarrhea on four mornings. This reminds her of being morning sick with the baby, and she is somewhat discouraged by this. She has not been breastfeeding the baby, because of the antidepressant, and a number of people have warned her that this may cause the baby to have more colic or develop food allergies later on.

8 week follow-up
Mrs. D. is feeling significantly better. She is sleeping better, her mood is improved, and she doesn't cry as easily as she used to. She has started to go out and meet friends, and she has joined a play group with her son. She is still undecided if she should go back to work. She is still taking sertraline 50 mg and doesn't have any more side effects. She wonders if she should discontinue the medication at this time.
Case 2

Initial visit

Mr. B. is a 40-year-old African-American man who is the vice-president of a small software development company. Over the last year, he has developed symptoms of chest pain. His cardiac work-up including treadmill and angiogram have been normal, and he is frustrated about the fact that nobody has been able to find out what is wrong.

He states that he has been under a lot of stress at work because his company is going through a major financial restructuring. He works late hours, and his wife is resentful because he has not spent much time with his family. He has not seen any of his friends and has essentially stopped pursuing his hobbies such as playing golf.

Over the last year, he has had significant problems with his sleep. He often lies awake at night worrying about his business. During the day, he has low energy and cannot concentrate well. He is much more irritable than he used to be.

He denies feeling depressed and focuses on the fact that he experiences repeated episodes of rapid heart beat, sweating, dizziness, and shortness of breath - usually associated with his chest pain.

1 week telephone follow-up

Mr. B. has been taking imipramine - initially 50 mg po qhs and for the last 2 days 100 mg po qhs. He has slept better for the past three nights but feels even more tired during the day. He did take a short walk during his lunch hour two days ago and found that his chest pain actually decreased during the walk.

2 week clinic follow-up

Mr. B. has been taking imipramine 150 mg po qhs. His sleep at night is significantly improved, but he still complains of significant daytime sedation, dry mouth, and constipation. A few nights ago, on his way home from work, he had another episode of chest pain, this time associated with blurred vision, and he is quite concerned about this.
Case 3

Initial visit

Mrs. S. is a 74-year-old Hispanic mother of three grown children. She presents with complaints of extreme fatigue and constipation over the past year. Her children are concerned that she has cancer because she has lost 30 pounds in the past year, and her appetite is poor.

She has been sleeping poorly because she has been caring for her husband, who had a stroke two years ago and is bedridden. He is frequently incontinent and calls for her at night. She has considered placing him in a nursing home but just cannot bring herself to do this.

Mrs. S. herself has significant medical problems. She has a long history of hypothyroidism, for which she is on replacement hormones. She has hypertension and coronary artery disease, and she had a 3-vessel coronary bypass operation four years ago.

When asked about prior episodes of depression, her daughter states that she had a severe depression after the birth of her second daughter, which required an inpatient admission and treatment with electroconvulsive therapy. She has bad memories of this episode and does not wish to see a psychiatrist because of this.

She denies currently feeling depressed but says that she has been crying frequently, often “for no good reason.” She has stopped going out to see her friends because she feels she cannot leave her husband. Even when her children come over to help care for the husband, she does not feel like doing anything.

1 week follow-up

Mrs. S. was given a prescription of sertraline 25 mg po qhs but has not gone to fill the prescription. She cries on the telephone and states that she does not want to become dependent on a medication. She focuses on problems with her husband’s incontinence and calling at night.
Partners in Care
Slides
Overview of Clinician Guide to Depression Assessment and Management in Primary Care

Seven Steps of Assessment

Seven Steps of Management
Assessment Steps

Step 1: Detect Depression Symptoms

Step 2: Activate and Educate Patient as Partner in Care

Step 3: Identify Patients Needing Hospital Care or MH Specialist Now

Step 4: Review Current Treatments and Illnesses

Step 5: Diagnose Depression/Dysthymia

Step 6: Manage Patients NOT Meeting Criteria for Major Depression or Dysthymia

Step 7: Assess and Manage Psychiatric Comorbidity
Assessment Step 1: Detect Depression Symptoms

- Depressed mood
- Loss of interest or pleasure
- Significant change in weight or appetite
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Low self-esteem

- Feelings of worthlessness or guilt
- Impaired concentration or indecisiveness
- Thoughts of death or suicide
- Hopelessness
- Insomnia or hypersomnia
Assessment Step 1

- Depressive Symptoms, Current or Past Treatment for Depression?
  
  - NO, no past history or symptoms
    - THEN, no intervention
  
  - YES, symptoms of depression OR
  
  - YES, > 2 prior episodes of depression
    - THEN, educate, and continue assessment
Assessment Step 2: Activate and Educate Patient as Partner in Care

- UNDERSTAND the patient’s perspective
- EDUCATE the patients about the Cycle of Depression
- ENCOURAGE patients to ask questions and develop solutions
The Cycle of Depression

- **Stressors**
  - pain, medical illness
  - work/family problems

- **Thoughts and Feelings**
  - negative thoughts
  - low self-esteem, sadness
  - hopelessness, poor concentration

- **Depression**
  - depletion of brain chemicals

- **Physical Problems**
  - pain
  - low energy
  - decreased appetite
  - poor sleep

- **Behavior**
  - withdrawal
  - decreased activities
  - decreased productivity
Assessment Step 2

♦ Educate Patients

• Depression is common

• Depression causes changes in brain chemicals that cause many physical symptoms
  - e.g., headache, back pain, sleep disturbance, constipation, stomach symptoms, appetite changes

• Depression is a real medical illness, not a character defect or weakness

• Depression can almost always be treated

• Recovery is the rule, not the exception
Assessment Step 2

- Encourage Questions
  - Will I get better?
  - Do I have to take medications?
  - What if I become pregnant?
  - Will I become an addict?
Assessment Step 3: Identify Patients Needing Hospital Care or MH Specialist Now

- Inadequately nourished and elderly
- Suicidal
- Psychotic symptoms (delusions, hallucinations, disorganized thoughts)
Assessment Step 3

♦ Suicide Screening

ASK ALL DEPRESSED PATIENTS ABOUT

- Thoughts of death, hurting self
- Prior attempts
- Current plans
Assessment Step 3

♦ Suicide Risk

If suicidal thoughts or history, ASSESS RISK FACTORS

- PRIOR ATTEMPTS
- Family history of suicide, substance abuse
- Hopelessness
- Demographics: Caucasian, male, elderly, living alone
- Clinical: potentially terminal medical illness, psychosis, current substance abuse
Assessment Step 4: Review Current Treatments and Illnesses

♦ Review current medications
♦ Review current mental health treatments
♦ Review medical problems
♦ Manage medications and illnesses
♦ Manage mental health treatments
Assessment Step 4

- Review ALL Current Medications for Contributing to Depression
  *(See Clinician Guide Figs. 1.3, 1.4)*

  - Antihypertensive
  - Sedative-hypnotic
  - Anti-inflammatory and analgesic
  - Hormones, steroids
Assessment Step 4

⏯ Review Current Mental Health Treatments

- ASK patient about current psychotherapy
- REVIEW current psychotropic medications

- IF < 12 weeks of treatment and the patient is improving
  - Coordinate with other providers
Assessment Step 4

✦ Manage Mental Health Treatments

- Reassess ongoing MH treatment in four weeks
  - IF > 12 weeks of treatment and still depressed
  - OR
  - >6 weeks of treatment and not improving
    - THEN consider a change in treatment plan
Assessment Step 4

- Review Medical Problems
  - Review current medical problem list for diseases associated with depression
    - Thyroid
    - Hypercalcemia
    - Vitamin B-12 deficiency
    - Auto-immune
    - Debilitating infections
Assessment Step 4

- Manage Medications and Illnesses
  - Lower dosages or switch suspect medications AND
  - Treat suspect diseases
    - Wait 2-4 weeks and reevaluate
    - Treat if significant residual depression
Assessment Step 5: Diagnose Depression/Dysthymia

- Meets criteria for major depression?
- Meets criteria for dysthymia?
Assessment Step 5

- Meets criteria for major depression?
  - Has symptoms of depression
  - Has them nearly all day nearly every day for 2 weeks or more
  - Exclusions: Not first 2 months of bereavement, not mania
Assessment Step 5

- Has 5 or More of 9 Symptoms?
  - Depressed mood OR
  - Loss of interest or pleasure AND
    * Change in weight or appetite
    * Insomnia or hypersomnia
    * Psychomotor agitation or retardation
    * Fatigue or loss of energy
    * Worthlessness or guilt
    * Impaired concentration
    * Thoughts of death or suicide
Assessment Step 5

- Meets Criteria for Dysthymia?
  - More days than not, 2 years or more, not more than 2-month well period
  - Has dysthymia symptoms
    - Exclusions: Not mania, schizophrenia
Assessment Step 5

♦ Dysthymia Symptoms?

- 3 or more of seven symptoms present for 2 years or more
  - Depressed mood
  - Change in weight or appetite
  - Insomnia or hypersomnia
  - Fatigue or loss of energy
  - Impaired concentration
  - Hopelessness
  - Poor self-esteem
Assessment Step 6: Manage Patients NOT Meeting Criteria for Major Depression or Dysthymia

- Provide supportive counseling, education
- Refer to self-help groups
- Avoid minor tranquilizers
- Monitor bereavement (incl. health status)
- Refer to exercise programs
- Provide social work or supportive counseling referrals
- Reevaluate in 1-2 months
Assessment Step 7: Assess and Manage Psychiatric Comorbidity

- Current or past substance abuse
- Current or past mania
- History of major psychiatric complications
Assessment Step 7

- IF Current or Past Substance Abuse
  - Recommend self-help groups such as AA plus professional program
  - Achieve abstinence for at least 4 weeks before starting antidepressants
  - Reevaluate and treat if depression continues
Assessment Step 7

♦ IF Current or Past Mania (Bipolar Disorder)

  - THEN mood stabilizers, not antidepressants
  - Consider psychiatric referral
Assessment Step 7

♦ IF History of Major Psychiatric Complications

• OR suicide attempts
  – THEN consider mental health referral
  – Determine which treatments helped
Assessment Steps Completed....
Begin Management Steps
Begin Management Steps

- For patients already in treatment, identify treatment phase and start management steps accordingly

- Phases are:
  - Acute
  - Continuation
  - Maintenance
Acute Phase (Months 0-4)

- Management steps 1 - 4
  - Initiate treatment
  - Relieve depressive symptoms
  - Educate patient and family
Continuation Phase (Months 4-9)

- Management step 5
  - Monitor and maintain improvement
  - Prevent relapse
  - Continue antidepressant medication at full dose
Maintenance Phase (Months 9+)

- Management steps 6 - 7
  - Monitor for recurrence
  - Reinforce education
  - Continue antidepressant medication at full dose
  - Discuss early-warning signs of depression and make a "relapse prevention plan"
Management Step 1: Choose Initial Treatment

- Based on
  - Patient preferences
  - Indications for medications
  - Indications for psychotherapy
  - Choosing and starting psychotherapy
  - Choosing and starting antidepressants
  - Watchful waiting
Management Step 1

♦ Assess Patient Preferences

- Elicit their view of medications, psychotherapy
- Explain alternative treatments
  - Indications, contraindications
  - Side effects
  - Treatment charges, number of visits required
  - Insurance coverage
- Ask, “Would you prefer to take a pill, or talk with a therapist?”
Management Step 1

♦ Does the Patient Have Indications for Medications?

- Vegetative signs
  - Trouble with sleeping, concentrating, appetite, psychomotor changes, disheveled appearance
- Multiple prior episodes
- Need for rapid response
  - e.g., Suicidal, impending job loss
Management Step 1

Does the Patient Have Indications for Psychotherapy?

- Severe psychosocial stresses
- Contraindications for medication
  - e.g., pregnant or trying
- Poor coping or adherence
Management Step 1

♦ Summary

• IF patient prefers medication, has severe vegetative symptoms, incomplete response to psychotherapy alone, more than 2 prior episodes of major depression, or suicide attempts

• THEN choose medication
Management Step 1

♦ Summary (cont.)

- IF patient prefers therapy, has severe life stressors or contraindications to medication, or incomplete response to medication
  - THEN choose therapy

- IF patient has major indications for both
  - THEN consider therapy and medication
Management Step 1

♦ Summary (cont.)

- IF patient could have either and has no preference
  - THEN choose either treatment
Management Step 1

♦ Choosing and Starting a Psychotherapy Regimen

- Types of therapy that are equally effective as medications for most depressed patients:
  
  - Cognitive-Behavioral Therapy
  
  - Interpersonal Psychotherapy
  
  - Require 8 - 12 group or individual sessions
  
  - Manuals include patient education and homework
  
  - Give patient personal plan for psychotherapy (see Clinician Guide)
Management Step 1

Choosing and Starting Antidepressants

- 1st choice:
  - Secondary amine TCA or SSRI (equally effective)
  - SSRIs are often better tolerated
- See Tables 2.1 - 2.3 in Clinician Guide or Quick Reference Cards for approximate price, dose, side effects
- Discuss target symptoms and side effects with patient
- Give patient personal plan for medications (see Clinician Guide)
Watchful Waiting

- If the patient doesn’t want to start any treatment
  - Try to understand the patient’s concerns
  - Follow closely
    * Bring back in one month
  - Offer consultation
  - Give patient personal plan for watchful waiting
    (see Clinician Guide)
Management Step 2: Detect Comorbid Conditions and Barriers Affecting Treatment

- Panic disorder
- Somatization
- Substance abuse history
- Minor tranquilizers or pain medications
Management Step 2

- Panic Disorder

- Recurrent episodes of intense anxiety, often with multiple somatic symptoms as main complaint
- Often occurs together with depression
- Can be treated successfully with TCAs, SSRIs, and psychotherapy (CBT)
Management Step 2

♦ Panic Disorder (cont.)

- Begin with one-half of the usual antidepressant starting dose and advance slowly to full therapeutic dose

- Avoid long-term use of minor tranquilizers

- Consider other causes of anxiety: medical illness and substance abuse (including caffeine)
Management Step 3: Identify Treatment Barriers

- Practical barriers
  - Social support
  - Financial
  - Transportation
  - Work/family demands

- Ethnic/cultural barriers
  - See Clinician Guide
Management Step 4: Monitor Therapy Closely During Acute Phase

- Acute Phase: First 3 months
- Acute Phase: Transition to continuation phase
- What if patient doesn’t improve?
Management Step 4

♦ Acute Phase: First 3 Months

• Remember: 20-50% of patients stop their medications or psychotherapy in the first month. 30-50% on antidepressants don’t respond to the initial regimen.

• Patients on medications: Follow patients at 1 week (phone), 2 weeks, 4 weeks, and 6-8 weeks. Call if they don’t come to scheduled visits

• Patients in psychotherapy: Call patients who don’t come to sessions
Management Step 4

- **Acute Phase: Transition to Continuation Phase**
  - Once patient is fully recovered (usually at 8-12 weeks)
    - begin continuation phase therapy
    - follow every 3 months
Management Step 4

♦ If Patients Don’t Get Better

- Review the diagnosis

- Consider other complicating factors: psychological stressors, medical problems, substance abuse, personality disorders, adherence

- Consider adding or changing medication, adding psychotherapy, getting psychiatric consultation
Management Step 4

♦ If Patients Don’t Get Better (cont.)

- If not asymptomatic on meds by 8 - 12 weeks:
  - Be aggressive about changing meds
    * Switch to the other class (from SSRI to TCA or vice versa).
    * Consider tertiary amine tricyclic in young patients with insomnia
    * Consider other antidepressants or get consultation
Management Step 5: Monitor Treatment During Continuation Phase

- Continue the medication at full dose for 6-9 months after the patient is free of symptoms to prevent relapse; visits every three months
- Continue primary care-based monitoring of patients post-psychotherapy every three months
Management Step 6: Evaluate Need for Maintenance Therapy

♦ Risk factors for relapse
  - Greater than 2 prior episodes of depression
  - Concurrent dysthymia
  - Residual depressive symptoms

♦ Make a relapse prevention plan (consider involving a family member)
  - see Clinician Guide
Management Step 7: Maintenance Therapy

♦ If high relapse risk factors
  • Continue full-dose medication for at least 2 years
  • Discuss relapse prevention
    – Early-warning signs of depression
Reference Tables

Figures 2.4 - 2.10 and Appendices A - C in Clinician Guide provide the following information

- Overview/Comparison of medications
- Comparison of side effects
- Dosing guidelines
- Drug interactions
- Drug levels
- Other antidepressants
- Minor tranquilizers
Overview of Consultation
Overview of Consultation

- When to refer?
- Models for effective consultation
- The study psychiatrist
- Site-specific issues and challenges
Reasons for Referral

- Patient requests referral
- Suicidality
- Psychosis
- Mania
- Inability to eat
- Complicating factors: substance abuse, severe psychosocial stressors
- Patient is not improving at 8-12 weeks
- Prior hospitalization or suicide attempts
Preparing Patients for Consultation

- Address patient’s concerns and fears.
- Deal with stigma and other common concerns.
- You are looking for an expert opinion to help you treat the patient better - not to ‘dump’ the patient.
Effective Consultation

- One-time consultation vs. referral for ongoing specialty care
- Case conference, ‘curbside consults,’ telephone consults, in-person consults
- Ask specific questions
- Communicate directly (in person or by telephone)
- Give practical and concrete suggestions
The Study Psychiatrist

• Helps primary care providers to manage patients with depression

• Supervises depression nurse specialist’s caseload weekly

• Provides or facilitates consultation

• Provides education, training, and participates in continuous quality improvement activities
Site Specific Issues and Challenges

- Current consultation services - what works? what doesn’t?
- How can consultation be improved?
- How can consultation be used cost-effectively?
- What is the best role for the study psychiatrist?
Medication Management
Medication Management

Commonly Asked Questions About Antidepressants

- How does the medication work?
- How long will it take for the medication to work?
- Are there any dangerous side effects?
- How can the medication help with pain, stress, inability to sleep, or anxiety?

Commonly Asked Questions About Antidepressants (Cont.)

- Will I get addicted or dependent?
- How long do I have to take it?
- What if I miss a dose?
- Can I stop it once I am feeling better?
- Will I get better?

Medication Management of Depression

- Choose the right medication
- Educate patient about antidepressants
- Give an adequate trial of treatment (therapeutic dose for 6-8 weeks)
- Follow closely until patient responds
- Change treatment if patient doesn’t respond
- Continue medication for 6-9 months. If patient is at risk for relapse, continue for 2 years or more.

Choosing the Right Antidepressant

- Previous experience: patient, family, provider
- Side effects
- Contraindications
  - Absolute: heart block in tricyclics
  - Relative: pregnancy and breast-feeding
- Age
- Comorbid disorders: panic disorder
- Safety (in overdose)
- Cost

Overview of Antidepressants

- Tricyclic antidepressants (TCAs):
  - Secondary amines: nortriptyline, desipramine
  - Tertiary amines: imipramine, doxepin
- Selective Serotonin Reuptake Inhibitors (SSRIs): fluoxetine, sertraline, paroxetine
- Other antidepressants
- Minor Tranquilizers
Algorithm for Choosing Antidepressants

- **1st choice:** Secondary amine TCA or SSRI
- Both are equally effective. TCAs are cheaper. SSRIs are often better tolerated
- **2nd choice:** Switch to the other class (from SSRI to TCA). Consider tertiary amine tricyclic in young patients with insomnia or for whom cost is prohibitive.
- **3rd choice:** Consider other antidepressants or get consultation

Fluoxetine, Sertraline, Paroxetine

- Selective Serotonin Reuptake Inhibitors - SSRIs
  - Side effects: Insomnia, restlessness, agitation, sedation, fine tremor, GI distress (nausea, diarrhea), headache, sexual dysfunction
  - No absolute contraindications
  - Cost: expensive - about $2.00/day
  - Good first choice for elderly/medically ill patients or those who don't tolerate TCAs

Imipramine, Doxepin

- Side effects: Sedating, many anticholinergic side effects (constipation, blurred vision, urinary retention), orthostasis (dizziness), weight gain
- Avoid in patients with conduction defects, recent myocardial infarction, urinary retention, prostatic hypertrophy, constipation, or narrow-angle glaucoma
- Costs: the cheapest is $2.25/day
- Avoid in elderly/medically ill patients. May be reasonable in younger patients with insomnia or for whom higher cost is prohibitive

Nortriptyline, desipramine

- Secondary Amine Tricyclics - TCAs
  - Side effects: sedating, many anticholinergic side effects (constipation, blurred vision, urinary retention), orthostasis (dizziness), weight gain
  - Avoid in patients with conduction defects, recent myocardial infarction, urinary retention, prostatic hypertrophy, constipation, or narrow-angle glaucoma
  - Cost: the cheapest is about $2.25/day
  - Avoid in elderly/medically ill patients. May be reasonable in younger patients with insomnia or for whom higher cost is prohibitive.
  - Avoid in patients with high risk for suicide by overdose

Nortriptyline, desipramine

- Tertiary Amine Tricyclics - TCAs
  - Side effects: arrhythmias (tachycardia), dry mouth, constipation, fatigue or insomnia (desipramine), weight gain.
  - Avoid in patients with conduction defects, recent myocardial infarction, urinary retention, or narrow-angle glaucoma
  - Cost: about $1.00/day
  - A good first choice for young and relatively healthy patients who don't tolerate SSRIs
  - Avoid in patients at high risk for suicide by overdose

Minor Tranquilizers

- Benzodiazepines (Valium, Ativan, Xanax, and others)
- Barbiturates (Phenobarbital and others)
  - DO NOT USE IN THE LONG-TERM TREATMENT OF DEPRESSION!!!!!!
  - They don't treat depression; can cause dependence, cognitive impairment and accidents
  - Others (Chloral Hydrate, Benedryl, and others)
  - Consider tapering off patients who are on these medications either initially or as they respond to an antidepressant
Antidepressant Dosing

- Once a day dosing:
  - TCAs (sedating) at bedtime
  - SSRIs (activating) in the morning
- Starting dose is lower in older, medically ill, panic disorder.
- Titrate to therapeutic dose over 2-4 weeks as tolerated by side effects

Side Effects:
See Clinician Guide for details

- Are relatively common
- Are the number-one reason patients give for stopping medications
- Therefore:
  - Anticipate common side effects
  - Wait - many side effects resolve with time
  - Consider reducing the dose temporarily
  - Consider treating the side effects
  - Consider drug interactions and serum levels (TCAs)
  - Consider changing to another type of medication

Drug Interactions:
See Clinician Guide for details

- Antidepressants are metabolized by the P450 isoenzyme system in the liver and interact with a number of medications (see Figs. 2.1 – 2.3 in Clinician Guide)
- Dangerous:
  - SSRIs with MAOIs (tryptophan, meperidine)
  - TCAs with MAOIs
  - TCAs can potentiate quinidine-like antiarythmics, leading to complete heart block
- Relatively common problems
  - TCAs with antihypertensives - hypotension
  - SSRIs can increase levels of anticonvulsants (Dipotassium, Warfarin) and other drugs with narrow therapeutic margins

Therapeutic vs Side Effects

Special Populations

- Older adults
- Comorbid medical illness
- Pregnant or breast-feeding women
- Panic disorder
- Substance abuse

Special Populations:
Older Adults

- Often more sensitive to side effects
- Start lower and increase dose carefully
- Often on multiple medications - consider drug interactions
- Consider SSRIs or secondary amine TCAs
### Special Populations: Comorbid Medical Illness
- May be more sensitive to side effects
- Start lower and increase dose slowly
- May be using multiple medications - beware of drug interactions
- Cardiac conduction defects and narrow-angle glaucoma are absolute contraindications to TCAs
- Liver and kidney disease can reduce the metabolism of antidepressants

### Special Populations: Panic Disorder
- These patients often need closer follow-up initially
- Both SSRIs and TCAs are effective
- Start with lower doses (one-half usual starting dose). Antidepressants can initially worsen anxiety symptoms
- Avoid long-term use of minor tranquilizers
- Consider psychotherapy (cognitive-behavioral therapy)

### Special Populations: Comorbid Substance Abuse
- Depressive symptoms are often secondary to intoxication, withdrawal, or chronic abuse of substance
- Patient should be abstinent for at least 4 weeks before starting antidepressants
- In complex cases, consider referral for specialty evaluation/treatment

### Special Populations: Women Who Are Pregnant or Breast-Feeding or Who Plan to Get Pregnant
- Consider psychotherapy first
- Consider antidepressants in 2nd or 3rd trimester if mother or baby is at risk because depression is severe. In such complex cases, strongly consider psychiatric consultation.

### Follow Patients Closely Until They Get Better
- 20-50% of patients "drop out" in the first month of treatment
- 30-50% of patients don't have a complete response to the initial treatment
- Call patients after 1 week (nurse specialist)
- See patients after 2 weeks, 4 weeks, and 6-8 weeks
- Call (nurse specialist) if patients don't follow-up
- If patient is not better at 8 weeks, consider changing medication, adding psychotherapy, or getting a psychiatric consultation

### What to Do During Follow-Up Visits: The 'Your Personal Plan' can help
- For symptoms: DSM IV, review Beck score
- Check level of functioning
- Inquire about adherence to medication regimen ("do you ever forget to take it?") and barriers
- Ask about side effects
- Ask if there are other concerns/questions?
- Encourage continued treatment
- Make necessary changes: medication psychotherapy, consultation.
What to Do if Patients Don't Get Better

- Wrong diagnosis?
- Insufficient dose?
- Insufficient length of treatment?
- Problems with, barriers to adherence?
- Side effects?
- Other complicating factors?
- Treatment is not effective?

When to Get Serum Levels

- Not useful on a routine basis
- Not useful with SSRIs
- Useful with TCAs if there are no results at 4 weeks or if side effects are great at low doses
- Target ranges (in ng/ml)
  - Nortriptyline: 50-150
  - Desipramine and Imipramine: 150-330
  - Doxepin: 100-250

Common Barriers to Taking Medication

- Practical barriers
- Ethnic/Cultural barriers
- Patient doesn't agree with diagnosis or plan
- Patient doesn't understand treatment plan
- Patient is afraid of getting dependent or getting better

Common Barriers to Taking Medication (cont.)

- Side effects
- Patient forgets to take medications or runs out of pills early
- Cost is prohibitive
- Friends or family are not supportive
- Treatment is 'not working'; patient feels hopeless
- Treatment 'is working'; patient is better and wants off

Continue Medication for 6-9 Months or More

- Everyone should get medication for 6-9 months after they are better
- People at high risk for relapse (those with at least two prior episodes of major depression, dysthymia, or residual depressive symptoms) should get a full dose of medication for 2 years or more to prevent recurrences
- See patients at least every three months

What to Do if Patients Relapse

- Assess adherence to medication regimen
- Examine for new stressors
- Restart treatment at the last effective dose of antidepressants or consider an increase in dose if patient is still taking medication
- Consider adding psychotherapy
- Consider psychiatric consultation
Therapeutic vs Side Effects

Effects of antidepressant treatment

Therapeutic effects

Side effects

Time in weeks

0 1 2 3 4

Partners in Care Study: AHRQ
Partners in Care Philosophy
Partners in Care Philosophy

Partners in Care Goals
- Help primary care providers manage depression effectively
- Help patients become active participants in treatment
- Outreach to minorities and disadvantaged populations

Partners in Care Intervention Philosophy
- Integrated team approach
- Based on Agency for Healthcare Research and Quality (AHRQ; formerly AHCPR) guidelines for care for depression
- Educational materials and intervention plan developed by primary care, psychiatry, psychology and nursing collaboration

Intervention Priorities
- Recognize and diagnose depression
  - About 50% not diagnosed
- Start an effective treatment
  - About 50% of patients treated receive inadequate or subtherapeutic Rx
- Keep patients in treatment
  - 20% to 50% of patients started on treatment do not complete even 1 month

Intervention Priorities (cont.)
- Prevent relapse and recurrence
  - Risk of recurrence is 50% after one prior episode of depression and up to 90% with three or more prior episodes
- Follow functional status as well as symptom outcomes
  - With inadequate treatment, symptoms may improve but functioning remains impaired

Partners in Care Intervention Philosophy (cont.)
- Psychotherapy is as effective as medication in treating the usual types of depression seen in primary care
- To be effective for depression, psychotherapy must be active and directive
- Cognitive, behavioral, cognitive-behavioral and interpersonal therapies are effective
Enhanced Psychotherapy Management Philosophy

- Integrate psychotherapists into primary care
- Teach primary care MDs to make effective referrals
- Psychotherapists and primary care MDs work together to recruit and retain patients in treatment

Enhanced Psychotherapy Management Philosophy (cont.)

- Treatments and referrals must be culturally sensitive
- Treatments must be conducted well
- Psychotherapists must monitor patients and actively bring them into care

Cognitive-Behavioral Therapy (CBT)

- Supported by randomized trials
  - Effective for both mild and severe depression
  - May have more enduring effects than medication
- Teaches patients to actively monitor and alter depressive symptoms and behaviors

CBT Focus

- Active, direct treatment
- Alter depressogenic thinking
- Develop alternative thinking strategies
- Focus on activities
- Develop pleasant activities

CBT Focus (cont.)

- Develop/modify interpersonal skills
- Develop assertiveness
- Equip patients to monitor and intervene for depressive symptoms

Referring Patients for Psychotherapy

- Accept patient focus on external problems
- Argue that anyone with those problems may need help
- Reassure that they are not crazy
- Reassure that they should continue medical treatment with the primary care clinician
### Referring Patients for Psychotherapy (cont.)
- Encourage patients to consider "just trying" psychotherapy
- Assure patients that therapy is "here and now" focused
- Assure patients that many people with problems like theirs have been helped
- Somatizers may require time to agree to treatment

### Keeping Patients in Psychotherapy
- Depression makes adherence hard for patients
- Predict with the patient the desire to stop
  - Proactively develop plans to prevent dropout
- Call patients if they miss treatment
- Involve primary care clinician in supporting adherence

### Lack of Treatment Adherence
- Patient information should emphasize that:
- Depression is a medical illness, not a character defect
- Recovery is the rule, not the exception
- Treatment is effective for most patients
- The treatment goal is getting and staying well, not just getting better

Depression Guideline Panel, Depression in Primary Care, 1993 (Agency for Healthcare Research and Quality)

### Lack of Adequate Treatment
- Only 30-50% of patients accurately diagnosed receive AHRQ recommended duration and dosage of antidepressant medication
- Less than 10% receive AHRQ recommended psychotherapy

### Problems: Rx of Depression in Primary Care
- Lack of recognition
- Lack of adequate patient education
- Lack of adequate treatment
- Lack of treatment adherence
- Lack of close follow-up in first month
- Lack of close collaboration between psychiatrists, psychologists, and primary care physicians
- Lack of close outcomes monitoring
- Lack of maintenance treatment

### Lack of Adequate Patient Education
- Somatization
- Educational Messages
Lack of Maintenance Treatment

- High risk of recurrence (up to 90%) among patients with
  - 2 or more prior episodes of depression
  - Concurrent dysthymia
  - Residual depressive symptoms

Lack of Close Outcomes Monitoring

- Measuring Outcomes
- Patient-completed Beck or Zung
- Clinician-completed IDS, Hamilton
- Functional disability SF-36, GAF

Lack of Close Follow-Up in First Month

- Patients who are started on antidepressants in 'usual care' have on average only two visits in the first 8 weeks
- Patients in psychotherapy frequently drop out after 1-3 sessions
The *Partners in Care* Team Approach:

Enhanced Medication Management for Depression
### Challenges in Managing Depression in Primary Care

- Recognize and treat depression
- Educate the patient. Discuss diagnosis and treatment options
- Initiate effective treatment: antidepressants or psychotherapy. Avoid minor tranquilizers.

### Challenges in Managing Depression in Primary Care (cont.)

- Follow outcomes closely until patients are better and adjust treatment as needed
- Prevent relapse: continue medication for 6-9 months after patients are better
- People with ≥2 prior episodes of depression or dysthymia should stay on maintenance medications for 2 years or more

### Expert Leader Team

- Primary Care Physician, Mental Health Specialist, Nurse
- Provide monthly training for participating clinicians for six months
- Supervise intervention staff (nurses, therapists)
- Provide formal and informal consultation to participating patients and clinicians
- Perform quality assurance review based on achieving intervention goals

### Primary Care Clinicians Activities

- Confirm depression diagnosis with information from nurse specialist
- Initiate or continue treatment (medication or counseling)
- Monitor treatment outcomes with help from nurse specialist
- Use their own best judgment and have usual responsibility for clinical decisions
- Attempt to learn practice guidelines and use practice resources

### Depression Nurse Specialist

- Helps primary care providers in managing depression
- Provides initial patient assessment and education
- Provides feedback to primary care providers
- Coordinates follow-up
- Follows and keeps a record of patients' progress
- Reviews caseload with study psychiatrist weekly
- Participates in quality assurance activities
Mental Health Specialty Expert Leaders

- Psychiatrist
  - Team education with primary care leader
  - Formal and informal consultation to primary care team
  - Provide or facilitate referral
  - Supervise depression nurse specialist

Partners in Care Education Materials

- Patients (all materials English and Spanish)
  - Depression Symptoms Brochure
  - Depression Symptoms Videotape
  - Depression Therapy Manuals
  - Your Personal Plan: Relapse Prevention

Partners in Care Education Materials (cont.)

- Clinicians
  - Clinician Guide's antidepressant medication index (Tables 2.1-2.3 and Appendices A-C)
  - Quick Reference Cards

Medication Intervention Procedures

- Forms

  - Initial Nurse Assessment
  - Beck Depression Inventory
  - Depression Initial Assessment Feedback to Primary Care Provider
  - Your Personal Plans (for patients)

Nurse Specialist Assessment

- Symptoms (BDI)
- Functioning (SF-12)
- Life stress
- Prior psychiatric, family, and treatment history
- Sleep, agitation, pain, somatic complaints
- Other medications
- Coexisting disorders/substance abuse
- Patient preferences for treatment
- Social support/treatment barriers
Medication Intervention Procedures

For Patients with Major Depression or Dysthymia, Data Collector Schedules back-to-back Visits with:
- Nurse Specialist
- Primary Care MD

Data Collector Identifies Depressed Patients Using Validated Surveys:
- 5-Minute Depression Screen
- Diagnostic Assessment (CIDI) of those who screen positive

Initial Nurse Visit (45 Minutes)
- Assessment
- Education
- Activation

Initial MD Visit (15 Minutes)
- Diagnostic Evaluation
- Management Plan

Post Visit Education by Nurse-Specialist (10 Minutes - may be by telephone)

Psychiatric Consultation Indicated, e.g.:
- Requests Referral
- Suicidal
- Psychotic or Manic
- Diagnosis not clear

YES
- Refer to Psychiatrist

NO
- Started or continued on medication treatment

YES
- Follow-up Visits and Phone Calls by Nurse-Specialist and Primary Care MDs
  - 1 Week
  - 2 Weeks
  - 1 Month
  - 2 Months
  - 3 Months
  - Every 3 Months Thereafter
  - Compliance with Medication Plan
  - Barriers to Adherence
  - Depressive Symptoms
  - Level of Functioning
  - Side Effects
  - Questions/Concerns
  - Need for psychiatric referral
    (e.g., not improving after 8 weeks)

NO
- See Clinician Guide for Depression Management Suggestions
The *Partners in Care* Team Approach:

Enhanced Psychotherapy Management for Depression
The *Partners in Care* Team Approach:

**Enhanced Psychotherapy Management for Depression**

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**Expert Leader Team Activities**

- The Primary Care Physician, Mental Health Specialist, Nurse
- Provide monthly training for participating clinicians for six months
- Supervise intervention staff (nurses, therapists)
- Provide formal and informal consultation to participating patients and clinicians
- Perform quality assurance review based on achieving intervention goals

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**Primary Care Clinicians Activities**

- Confirm depression diagnosis with information from nurse specialist
- Initiate treatment (medication or counseling)
- Monitor treatment
- Use their own best judgment and have usual responsibility for clinical decisions
- Attempt to learn practice guidelines and use practice resources

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**Depression Nurse Specialist**

- Provides initial structured assessment
- Prepares patient for discussing depression
- Educates patients based on clinician's treatment plans
- Coordinates referral to CBT therapist
- Maintains a record of the treatment plan
- Participates in quality assurance meetings

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**Mental Health Specialty Expert Leaders**

- Psychotherapist (Psychotherapy)
  - Team education with primary care leader
  - Formal therapy provision
  - Provides feedback to primary care providers
  - Team member in primary care clinic
  - Facilitates psychiatric referral as needed
  - Supervises and does quality review for other therapists

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**Partners in Care Education Materials**

- Patients (all materials English and Spanish)
  - Depression Symptoms Brochure
  - Depression Symptoms Videotape
  - Depression Therapy Manuals

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*Partners in Care* Program Assessment Materials

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Partners in Care Education Materials (cont.)

- Clinicians
  - Clinician Guide's antidepressant medication index, Tables 2.1-2.3 and Appendices A-C
  - Quick Reference Cards

Forms

- Initial Nurse Assessment
- Beck Depression Inventory
- Depression Initial Assessment Feedback to Provider
- CBT Session Record
- Your Personal Plan (for patients)
- Psychiatric Consultation Form

Nurse Specialist Assessment

- Symptoms (BDI)
- Functioning (SF-12)
- Life Stress
- Prior psychiatric, family, and treatment history
- Patient preferences for treatment
- Sleep, agitation, pain, somatic complaints
- Treatment selection
- Other medications
- Coexisting disorders/substance abuse
- Social support/treatment barriers
Psychotherapy Intervention Procedures

For Patients with Major Depression or Dysthymia, Data Collector Schedules back-to-back Visits with:
- Nurse Specialist
- Primary Care MD

Initial Nurse Visit (45 Minutes)
- Assessment
- Education
- Actuation

Psychiatric Consultation Indicated, e.g.,
- Requests Referral
- Suicidal
- Psychotic or Manic
- Diagnosis not clear

YES

For Patients with Major Depression or Dysthymia, Data Collector Schedules back-to-back Visits with:
- Nurse Specialist
- Primary Care MD

Initial MD Visit (15 Minutes)
- Diagnostic Evaluation
- Management Plan

Post Visit Education by Nurse-Specialist (10 Minutes)

YES

Refer to Psychiatrist

NO

See Clinician Guide for Depression Management Suggestions

NO

Follow-up by Cognitive-Behavioral Therapist for 8-16 Weeks
- Adherence
- Depressive Symptoms
- Level of Functioning
- Side Effects
- Questions/Concerns
- Need for psychiatric referral (e.g., not improving after 8 weeks)

YES

Referred for Cognitive-Behavioral Therapy

NO