Guidelines for the Study Therapist

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Guidelines for the Study Therapist

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Preface

*Partners in Care* is a Patient Outcomes Research Team (PORT) II study, funded by the Agency for Healthcare Research and Quality, formerly the Agency for Health Care Policy and Research (AHCPR). It is a randomized trial to evaluate whether externally designed, evidence-based interventions for improving care for depression can be locally implemented in managed care organizations. The study took place in 46 primary care clinics within six diverse, nonacademic managed care plans in various locations across the United States. It involves 181 primary care providers and 1,356 patients with current depressive symptoms and either 12-month, lifetime, or no depressive disorder.

The materials designed for clinicians, nurse specialists, and psychotherapists to use for the interventions were developed at RAND in collaboration with researchers and clinicians at many institutions, including the VA Greater Los Angeles Healthcare System, Los Angeles, California; the University of California, Los Angeles; Georgetown University; and the University of California, San Francisco. They are published in 7 volumes, along with the patient-education videotape and brochure developed for the *Partners in Care* study.

The interventions for which these materials were developed took place in 1995-2000. The authors recognize that clinics implementing the interventions today would want to update some of the manuals to take into account subsequent advances—for example, in psychotropic medications and in informatics support for documenting case management. However, the approach remains current, and is the basis for a variety of ongoing interventions for depression for adults, adolescents, and older adults.

This document, *Guidelines for the Study Therapist*, contains all the information required for the therapist to assess patients’ needs for Cognitive-Behavioral Therapy, decide whether group or individual treatment is most appropriate, conduct therapy sessions, and maintain records for each client.

The other *Partners in Care* documents are as follows:


Research findings from the Partners in Care study will be of interest to providers, patients, and managed care plans. More information about the study can be found on its web site at http://www.rand.org/organization/health/partners.care/portweb.
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Introduction

The team responsible for the quality improvement program focused on psychotherapy includes the primary care physician, the depression nurse specialist, and the therapist. The therapist assesses patients' needs for Cognitive-Behavioral Therapy, decides whether group or individual treatment is most appropriate, conducts therapy sessions, and maintains records for each client. In the Partners in Care quality improvement program, the study therapist was trained and supervised by the clinic's expert psychotherapy leader.

This manual contains all the information required for the therapist to perform these functions. It provides a step-by-step guide for the therapist's interaction with the patient, including initial contact, tracking and recordkeeping, and concluding therapy. The manual also contains forms for documenting symptoms, treatments, and medications, and for recording the results of evaluations, as well as templates for recording a patient's individual treatment plan. To provide context, the manual duplicates some of the forms used by the depression nurse specialist (Figures1a-c).
Overview of the Clinical Care Team

The *Partners in Care* clinical care team for the psychotherapy intervention comprises the primary care clinician, the depression nurse specialist, and the study therapist. Each has received training in the assessment and management of depression under the supervision of the site's expert psychotherapy intervention leaders. All study therapists have been trained in Cognitive-Behavioral Therapy (CBT). CBT supervision for the study therapists is provided by the expert psychotherapy leader. The primary care clinicians have also received education about the efficacy of Cognitive-Behavioral Therapy. The Depression Nurse Specialist (DNS) facilitates a thorough initial assessment and assists with patient education. All members of the team will work together to provide the best possible treatment for the patient under the coordination of the primary care clinician.

The role of the study therapist is to assess each study patient's need for CBT, deciding whether individual or group, full or abbreviated CBT, and English or Spanish sessions are most appropriate. The therapist organizes CBT groups and conducts CBT sessions according to the study's standardized protocol manual. The study therapist maintains individual client records using forms provided by the study (*Figures 2a-d*) and also maintains a comprehensive patient register and session record (*Figures 3a and b*), to be used in supervision sessions. The study therapist attends regular supervision sessions with his/her organization's expert psychotherapy leader.
Step-by-Step Guide for *Partners in Care* Psychotherapy Intervention

1. **Identification of Depressed Patients**

Patients identified by the study as having depressive symptoms are assessed by the primary care clinician, who is assisted by the DNS. Based on this assessment, the primary care clinician and the patient develop an appropriate treatment plan. Nurse specialists may provide additional education to patients regarding the treatment of depression. The treatment plan may include no treatment (monitoring only), anti-depressant medication, full (12-16 session) CBT, abbreviated (2 session) CBT, or a combination of CBT and medication.
2. Referral to Psychotherapy

Patients who already have an established relationship with a non-study therapist may choose to stay with that therapist. In that case, the patient will receive therapy under care-as-usual conditions. If full or abbreviated (brief) CBT is selected, the DNS will forward the patient's study record to a study therapist and either s/he or the study therapist will schedule an appointment.

• The Study Record

The study record will include several forms already completed by the DNS prior to the patient's referral to the study therapist. These are: the Initial Telephone Call Notes (Figure 1a*), the Initial Visit Worksheet (Figure 1b*), and the Post-Initial Visit Evaluation (Figure 1c*). The information on these forms provides baseline data for therapists. The study record also includes the following blank forms to be completed by the study therapist before, during, and after treatment, as outlined in sections 3-9:

◇ CBT Session Record (Figure 2a)
◇ Individual Patient BDI® Progress Graph (Figure 2b)
◇ Communication Form (Figure 2c)
◇ Your Personal Plan: Relapse Prevention (Figure 2d)

• Comprehensive Patient Records

The study therapist will receive a Client Register and Initial Contact Summary (Figure 3a) and a Therapy Session Record and BDI Score Sheet (Figure 3b), onto which the study psychotherapist will record information for all clients. Each new patient referred to the study therapist will be immediately recorded onto the register. The therapist should update the session record before each supervision session (at least monthly), transferring the information from each CBT Session Record.

* These figures are also included in the Guidelines and Resources for the Depression Nurse Specialist as follows:
   
   Figure 1a = Figure 3a
   Figure 1b = Figure 3b
   Figure 1c = Figure 3c

* Beck Depression Inventory (see the Appendix)
3. Initial Therapist-Patient Contact

- Telephone/Visit Assessment
  When the patient is referred to a study therapist, the study therapist will call the patient for an initial assessment and/or schedule an initial visit. The date and type (telephone or in-person) of the initial contact will be recorded in Column F of the Client Register and Initial Contact Summary (Figure 3a). It is important that the study therapist call the patient within a day or two of receiving the referral.

During the initial contact with the patient, the study therapist discusses treatment options and assesses the patient’s readiness to begin treatment. If a treatment start date is decided, the study therapist records the information in Column G of Client Register and Initial Contact Summary. Patients who appear ready for group therapy will be scheduled for the first available opening (see Section 4). They will need to arrive 1-1/2 hours prior to the scheduled session to attend an orientation for new patients. A patient who is unwilling to attend a group, is unable to attend a group because of time constraints, or who is a poor candidate for group therapy (e.g., probability of not being liked or supported by the group, or not being able to take part in a group) will be scheduled for individual CBT sessions. A CBT Session Record (Figure 2a) should be completed for each patient for each session.

- Consultation with CBT Therapist
  A patient who is not ready to begin treatment may be scheduled for a motivational session with a therapist. During this session, the therapist encourages the patient to begin treatment and helps the patient overcome barriers to treatment. The outcomes of this session should be recorded on a CBT Session Record (mark “motivational” session under “Module/Session Information”).
4. Initiating Cognitive-Behavioral Therapy

If psychotherapy is selected as the treatment option, the study therapist will schedule the patient to begin group or individual Cognitive-Behavioral Therapy sessions. The study therapist will maintain both open and closed* CBT groups. If an open group is available, patients selected for group CBT will be scheduled immediately. If not, these patients will be scheduled as soon as a new group is started. The type of therapy (group or individual, full or brief, English or Spanish) is recorded in Columns H, I, and J, respectively, on the Client Register and Initial Contact Summary. The primary care clinician and/or the study therapist may select a brief (2-session) form of CBT for patients with minor depression. Full-session CBT for patients with depression or dysthymia lasts from 8 to 16 weeks, depending on the patient’s needs and willingness to engage in therapy. Optimal treatment duration is approximately 12 weeks. However, for patients who recover quickly and are reluctant to attend further sessions, 8 weeks is acceptable. Therapy will follow the standardized CBT manual.

* An open CBT group is one where patients can enter at any time during the course of the treatment. A closed CBT group is one where patients must enter the group at the first session.
5. Tracking Patients' Progress

The study therapist charts the patient's progress in three ways. First, the study therapist completes a CBT Session Record for each patient for each session, indicating which CBT session the patient has just attended (e.g., the 2nd activities session), the patient's level of participation, and his/her treatment plan, BDI score, and any additional comments.

Second, at least once a month the study therapist transfers information from the CBT Session Records to the Therapist Session Record and BDI Score Sheet (Figure 3b). For sessions 1-16, or until the patient completes the therapy, the study therapist enters the date of the session, circles the type of session, and indicates the patient's BDI score for that session.*

Third, after each session the study therapist records the patient's BDI score on the Individual Patient BDI Progress Graph (Figure 2b) and draws a continuous line connecting one score to the next. After sessions 4, 8, and 12, the study therapist sends an NCR copy of the progress graph to the patient's primary care clinician.

---

* Each patient will need to complete a Beck Depression Inventory after each session.
6. Supervision and Consultation

- **Patient Progress Review with the Expert Psychotherapist**

  The *Partners in Care* expert psychotherapist reviews patient progress and adherence to therapy for all study cases by reviewing the *Client Register* and the *Therapy Session Record* with each therapist every two weeks. If the patient is not progressing well, the expert psychotherapist will discuss alternative therapy strategies with the study therapist and the primary care clinician. Therapists may also bring individual patient records for discussion to this supervision session.

- **Patient Progress Review with Primary Care Clinician**

  Throughout the patient’s treatment, the study therapist will inform the primary care clinician of the patient’s progress via the *Communication Form* (Figure 2c). This form will be used to inform the primary care clinician about the patient’s symptoms, treatment plan and general progress. The study therapist will also use this form to solicit comments and request consultation from the primary care clinician. The first *Communication Form* will be completed after the patient’s initial visit with the study therapist and marked “Initial Report.” For the duration of the patient’s treatment, *Communication Forms* will be marked as “Progress Reports” and sent to the primary care clinician every 4 weeks. At the completion of treatment, the study therapist will send a “Final Report” and, if the patient has recovered, a *Your Personal Plan: Relapse Prevention* (Figure 2d) to the primary care clinician (see Section 7).
7. Completion of Cognitive-Behavioral Therapy

- **Patient Fully Recovered**
  
  If, at the completion of the 8-16 week CBT course, the patient has fully recovered from depression, the therapist completes a *Your Personal Plan: Relapse Prevention* (Figure 2d) with the patient. The therapist will also send a *Communication Form* (marked "Final Report") back to the primary care clinician, informing him or her of the outcome of the treatment and providing management advice for the clinician should the patient become symptomatic in the future.

- **Patient Not Recovered**
  
  If a patient does not respond at least partially to treatment within 6 to 8 weeks (4-6 weeks if sessions are more frequent), the therapist and his/her expert psychotherapist may refer the patient to a psychiatrist or to the primary care clinician for the possible addition of antidepressant medication or a change in therapy strategies. The primary care clinician will be informed about this discussion via a *Communication Form*. If the patient is referred to a psychiatrist, usual clinic referral methods should be used. For medication intervention, patients will be seen by psychiatrists other than the expert psychiatrist leader, in most cases.
Partners in Care

INITIAL TELEPHONE CALL NOTES

(See suggested script in Guidelines and Resources for the Depression Nurse Specialist, Section 2)

Patient Name: ___________________________ Study ID: ______________
Primary Care Clinician: ________________________ Tel. No: (___) _________
Depression Nurse Specialist: ____________________ Tel. No: (___) _________

Patient Questions
1. _______________________________________
2. _______________________________________
3. _______________________________________

Scheduled Patient Visits

Initial Depression Nurse Specialist visit
Date of visit: __/__/___ Time of visit: ___:___ am / pm

Initial MD visit
Date of visit: __/__/___ Time of visit: ___:___ am / pm

Was patient given depression nurse specialist's telephone number?

Record of Calls ☑

__/__/___ (date) Notes: ____________________________________________

__/__/___ (date) Notes: ____________________________________________

__/__/___ (date) Notes: ____________________________________________

Notes
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Recorded by: __________________________________________ Phone number: (___) __________
Reviewed by: ____________________________________________________________________ (Signature of MD/Primary Care Clinician)
Partners in Care

INITIAL VISIT WORKSHEET

Refer to Appendices A and B in Guidelines and Resources for the Depression Nurse Specialist.

To: (Primary care clinician) ________________________________

Today's date: __/__/___

Mr./Ms. ___________________ (Study ID ______ MR# ____________) has been identified by the Partners in Care study team to have symptoms of depression. She attended an initial educational session on ___/___/___ and (has / has not) received the video tape and educational brochure in (English / Spanish). Refer to step-by-step guide for Depression Nurse Specialist's initial visit assessment (Appendix A) and Depression Nurse Specialist's initial assessment queries (Appendix B) in Guidelines and Resources for the Depression Nurse Specialist.

List 2 questions for the doctor or primary care clinician:

1. __________________________________________________________

2. __________________________________________________________

Symptoms (Check all that apply, then circle the symptom that bothers the patient the most)

- Sad or empty
- Thoughts of suicide or self-harm
- Loss of interest
- Sleep disturbance (sleeps ___ hrs/night)
- Poor concentration
- Appetite/weight change (+/- ___ lbs.)
- Poor energy
- Physical agitation or slowness
- Worthless/guilty
- Periods of over-excitement
- Anxiety
- Sees/hears things not apparent to others
- Hopelessness/poor future
- Drug misuse/abuse
- Drinks alcohol (type(s)) ___________________________ drinks/day ___

NOTE: The patient meets DSM-IV major depression criteria IF at least 5 of the 9 symptoms shown in the outlined box are present nearly every day for 2 weeks or more, and one of these symptoms is marked by a ◊ ◊. (Dysthymia has fewer/milder symptoms and lasts for 2 years or more.)

Other Indicators for Depression:

- (check all that apply)
- Beck score: ______
- Activities affected: □ social □ personal □ family □ work/school
- Patient last felt good ___ (who / moa) ago
- # bod days last month ___
- # restricted days last month ___

Treatment:

- Patient treated for depression in the past? □ Yes □ No
- Treated currently? □ Yes □ No

  a. Any of these treatments? (✓ if yes)

     □ Psychotherapy
     □ Yes □ No
     □ Medication
     □ Yes □ No
     □ Electro-Convulsive Therapy
     □ Yes □ No

  b. Was/is treatment helpful?

     □ Yes □ No

  c. Patient wants:

     □ medication □ psychotherapy □ no strong preference

  c. Patient is opposed to:

     □ medication □ psychotherapy □ no strong opposition

Current Medications

List both prescription & non-prescription medications

(Circle medications which may interact significantly with antidepressants)

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

Social Situation

Stressors: ____________________________________________________

Social support: ________________________________________________

Assessed by: _________________________________________________

Reviewed by: ________________________________________________

Phone number: (___) _______________________

(Signature of MD/Primary Care Clinician;)

Healthform.2-02/00
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POST-INITIAL VISIT EVALUATION

Patient Name: ____________________________  Study ID: ____________
Primary Care Clinician: ____________________  Tel. No: (____) _________
Depression Nurse Specialist: ________________  Tel. No: (____) _________

This post-initial telephone call was with__________________________ on __/__/____
(date)

Patient Questions

1. _______________________________________
2. _______________________________________
3. _______________________________________

Patient Handouts

Patient received:

☐ Your Personal Plan: Medications
☐ Your Personal Plan: Psychotherapy
☐ Your Personal Plan: Watchful Waiting
☐ Your Personal Plan: Relapse Prevention

Depression Phase of Patient (at time of post-initial visit evaluation)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Follow-up</th>
<th>Next Visit</th>
<th>Handouts/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Acute</td>
<td>Call next week</td>
<td>2 weeks</td>
<td>• Your Personal Plan: Medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Your Personal Plan: Psychotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Other Your Personal Plans as appropriate</td>
</tr>
<tr>
<td>☐ Continuation</td>
<td>Call next week</td>
<td>3 months</td>
<td>• Your Personal Plan: Relapse Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Other Your Personal Plans as appropriate</td>
</tr>
<tr>
<td>☐ Maintenance</td>
<td>Call in 1 month</td>
<td>3 months</td>
<td>• Your Personal Plan: Relapse Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Other Your Personal Plans as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Consider continuing/starting antidepressants</td>
</tr>
</tbody>
</table>

➢ Next Primary Care Follow-up Appointment: __/__/____  With: ________________________

Assessed by: ____________________________________________  Phone number: (____) _________
Reviewed by: ____________________________________________  (Signature of MD/Primary Care Clinician)

ORIGINAL – STUDY RECORD  YELLOW – MD/PRIMARY CARE CLINICIAN  PINK – PATIENT  GOLDENROD – OTHER

Healthform.3 -02/00

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Figure 2a

CBT SESSION RECORD
(Fill out one for each patient for each session)

Patient Name: ___________________________ Study ID: ________________
Therapist Name: ___________________________ Study ID: ________________

Patient Participation

Patient attended? □ Yes □ No
If NO, was patient contacted? □ Yes □ No
Reason for absence: ____________________________________________
Patient participated: □ Fully □ Partially □ Not at all
Completed homework? □ Yes □ No

Module/Session Information

Type of therapy: □ Individual □ Group No of patients attending this session _____

This session was: (check one)

<table>
<thead>
<tr>
<th>Full CBT</th>
<th>Brief CBT</th>
<th>Motivational</th>
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<tbody>
<tr>
<td>Thoughts</td>
<td>Activities</td>
<td>People</td>
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<td>1st □</td>
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</tbody>
</table>

Treatment Progress

BDI score: _______

Treatment plan: ____________________________________________

Comments: ________________________________________________

________________________________________ Date: ____/____/____

Signature of Therapist
Partners in Care
Individual Patient BDI Progress Graph

Therapist: ________________________________
Patient: ________________________________ Primary Care Clinician: ________________________________

30-63 = Severe
20-29 = Moderate
10-19 = Mild
0-9 = None/minimal

Date:
Year:

Session 1
Session 2
Session 3
Session 4
Session 5
Session 6
Session 7
Session 8
Session 9
Session 10
Session 11
Session 12

Give an NCR copy of this Progress Graph to the Primary Care Clinician after recording sessions 4, 8, and 12.
Partners in Care
COMMUNICATION FORM

Patient Name: __________________________ Study ID: ________________

Therapist: ______________________________ Date of Session: ___/___/___

Primary Care Clinician: ___________________ Tel. No: (___) _________

This is a(n):  □ Initial Report  □ Progress Report  □ Final Report

The patient is now having the following symptoms:

- □ Sad or empty
- □ Loss of interest
- □ Poor concentration
- □ Poor energy
- □ Worthless/guilty
- □ Anxiety
- □ Hopelessness/poor future
- □ Drinks alcohol (type(s) __________________ drinks/day ____)
- □ Thoughts of suicide or self-harm
- □ Sleep disturbance (sleeps ____ hrs/night)
- □ Appetite/weight change (+ / - ___ lbs.)
- □ Physical agitation or slowness
- □ Periods of over-excitement
- □ Sees/hears things not apparent to others
- □ Other symptoms: (list)
- □ Somatic symptoms: (list)

Progress of patient: ________________________________________________
_________________________________________________________________
_________________________________________________________________

Recommended treatment plan: ________________________________________
_________________________________________________________________
_________________________________________________________________

Comments/consultation requested: ____________________________________
_________________________________________________________________
_________________________________________________________________

Please contact me  □ Yes  □ No

at:  (___) _____________ (___) _____________ e-mail____________
     phone               beeper

Signature of Therapist: ____________________________ Date __/___/___
YOUR PERSONAL PLAN: Relapse Prevention

Patient Name: ____________________________  Study ID: ____________

CONTACT INFORMATION
Primary Care Physician: ____________________________  Tel. N2: (____) ____________
Depression Nurse Specialist: ____________________________  Tel. N2: (____) ____________
Psychotherapist: ____________________________  Tel. N2: (____) ____________

PERSONAL WARNING SIGNS
1. ____________________________________________
2. ____________________________________________
3. ____________________________________________

STRESSFUL LIFE EVENTS AND HOW TO MINIMIZE THEM
Event: ____________________________________________  How to minimize: ______________
______________________________________________
Event: ____________________________________________  How to minimize: ______________
______________________________________________
Event: ____________________________________________  How to minimize: ______________
______________________________________________

MEDICATIONS
Name of antidepressant: ____________________________  Dose: ____________________________
Take medication until: __/__/__
Questions: Call your primary care clinician or your depression nurse specialist.
   (See Contact Information, above)

WHAT YOU SHOULD DO IF SYMPTOMS OF DEPRESSION RECUR
1. ____________________________________________
2. ____________________________________________
3. ____________________________________________

Reviewed by: ____________________________  (Signature of MD/Primary Care Clinician)
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<td><strong>Study ID</strong></td>
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<td><strong>Medical Record No.</strong></td>
<td><strong>Clinic Where Patient Enrolled</strong></td>
<td><strong>Patient's Primary Care Clinician</strong></td>
<td><strong>Initial Contact</strong> <em>(date &amp; type)</em></td>
<td>*<em>Start Date of Treatment (scheduled)</em></td>
<td><strong>Group or Individual</strong> <em>(✓ one)</em></td>
<td><strong>Brief or Full</strong> <em>(✓ one)</em></td>
<td><strong>English or Spanish</strong> <em>(✓ one)</em></td>
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* Allocate a sequential Line Number for each patient as he/she is registered on this form. Continue sequential numbering for each subsequent page.
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* I = Individual Therapy Session; G = Group Therapy Session; N = 'No Show'

* Remember: For each patient, transfer the corresponding Line Number from the Client Register and Initial Contact Summary (Healthform.33 -02/00).
Appendix

Beck Depression Inventory (BDI)

© 1978 by Aaron T. Beck. Qualified individuals may obtain this instrument by contacting The Psychological Corporation, Order Service Center, P.O. Box 839954, San Antonio, Texas 78283-3954, 800 228 0752 (phone), 512 270 0327 (fax).