GUIDELINE FOR INITIAL TREATMENT VISIT

In the initial treatment visit, the patient and the depression care manager discuss preferences for treatment and the treatment options available. The depression care manager also conducts a patient assessment, which is documented on the *Initial Assessment Form* as the session proceeds.

Goals for the Initial Visit:

1) Review any questions from the Pre-Treatment Engagement Session. If necessary, provide additional education and/or learn more about the patient's views regarding depression.
2) Assess whether the patient has the following:
   a) Current symptoms of depression or dysthymia (DSM-V criteria, assess suicidality, etc.)
   b) A history of depression or treatment for depression
   c) A family history of depression
   d) Coexisting psychiatric, medical, or psychosocial problems that may cause depressive symptoms
   e) Impaired social, personal, family, or work functioning
   f) Low social support or involved family/friends who should to be taken into account
   g) Strong pre-existing treatment preferences
3) Ask the patient for at least two questions that she would like to ask her OB-GYN.
4) Document the findings on the *Initial Assessment Form* and summarize the relevant parts of the assessment on the *Patient Tracking Form*.
5) Record the initial visit on the electronic *Caseload Supervision Form*.
6) Write a brief clinical SOAP-type note in the patient's medical record, according to the clinic standards, copying the patient's OB-GYN.

Guidelines for Conducting the Initial Visit:

1) During the initial visit:
   a. Depression care manager should try **not** to advocate excessively for the patient; get the patient to become an advocate for herself.
   b. Depression care manager should try **not** to provide information that is outside the domain of depression and its symptoms.
2) For any but the most basic questions, refer the patient to other sources of information. For example, say to the patient:
   - *"That's an excellent question, and it's something your OB-GYN will want to know that you are concerned about. Let's note it here."* **OR**
   - *"That's something we deal with in our educational materials. Let's look at this together…"*

Continued

© 2014 University of Washington - Users may print, distribute, and post the DAWN Study Resources on internal websites. Commercial or sublicensing of Study Resources require written permission from the University of Washington. Users assume the entire risk as to the use of the DAWN Study Resources.

Queries Helpful in Completing the Initial Assessment Form:

The initial assessment by the depression care manager is guided by an understanding of the key features of depression, but follows the depression care manager's judgment about which areas to explore in detail during the limited time available. The following probes may be useful in framing questions to gather information required by the *Initial Assessment Form*.

1) Health Concerns / Questions for the OB-GYN:
   Pick up important questions as the interview progresses. Ask the patient what she most wants to ask the doctor at the end of the interview, and be prepared to feed back earlier questions to the patient as possible targets if the patient cannot tell you in answer to your direct request. These may be the same or different health concerns/questions than those the patient expressed on the *Health Concerns Symptom Questionnaire* at the pre-treatment engagement session. You should list at least two questions.

2) Symptoms of Depression and Other Psychiatric Disorders:
   a) **To assess for sadness:** *"How much time in the past month have you been feeling down or depressed?" "Did you feel so down in the dumps that nothing could cheer you up?"*

   b) **To assess for mania:** *"Have you ever had a period of four or more days when you were so happy or excited that you got into trouble, or your family or friends worried about you, or a doctor said you were manic?" "Have you ever had a period when you were much more active than usual, or felt that you hardly needed to sleep at all but did not feel tired or sleepy?" "Did a doctor ever prescribe Lithium for you?"*

   c) **To assess for suicidality:** *"Do you ever have thoughts of wishing you were dead?" "Have you actively thought of killing or hurting yourself?" "What have you thought of doing?" "Are you having such thoughts now?"* **Refer to the clinic's protocol for handling psychiatric emergencies if a patient endorses active thoughts or plans of suicide.**

   d) **To assess for somatic symptoms:** Look especially for stomach or intestinal complaints (abdominal pain, constipation), musculoskeletal complaints (back pain, shoulder/neck pain), palpitations, dizziness or lightheadedness, and weakness.

   e) **To assess for alcohol or drug use:** *"Do you currently drink alcohol?" "How many alcoholic drinks do you have on a typical day?" "What is the most that you ever drink at one time?" "Do you use drugs?" "If so, which ones and how often?" "Do you ever feel the need to cut down your use of alcohol or drugs?" "Have you been annoyed by others' criticism of your drinking or drug use?" "Have you ever had a blackout?" "Does your use impact your ability to function and meet your responsibilities?"*

3) Activities Affected:
   To assess social, personal, family, and work activities, and bed days or restricted activity days: *"Do you participate in social and community activities (religious, family, and friends)?" "Has your social activity decreased from the past?" "Do you have difficulty performing family responsibilities?" "Do you have trouble fulfilling job responsibilities?" "Do you have days when you don't get out of bed (bed days)?" "Do you have days when you cut down on the things you usually do for half a day or more (restricted days)?"*

4) Social Stressors:
   To assess for stress: Consider losses (deaths, separation or divorce, recent surgery, new health problems in self or significant others, children leaving home), job loss or change, moving, past history of physical or sexual abuse.

Continued

© 2014 University of Washington - Users may print, distribute, and post the Dawn Study Resources on internal websites. Commercial or sublicensing of Study Resources require written permission from the University of Washington. Users assume the entire risk as to the use of the DAWN Study Resources.

5) Social Support:
To assess for social support: *"How many friends or relatives do you see or hear from at least once a month?" "Which friends or relatives do you have the most contact with?" "Do you talk to any of these people about private matters?" "Do you ask any of them for advice on private matters?*

6) Treatment Preferences:
Explore with the patient whether she would prefer initial treatment with a brief therapy (PST-PC) or antidepressant medication. For pregnant or breastfeeding patients without a prior history of treatment, encourage PST-PC as initial treatment. For pregnant or breastfeeding patients desiring to start antidepressant medication instead of PST-PC, perform a risk-benefit analysis for the patient with her OB-GYN and the study team.

> *"For most patients, the initial choice of treatment is either a course of counseling (psychotherapy) or an antidepressant medication. How would you feel if your physician would recommend a trial of an antidepressant medication at this time? Would you be more comfortable starting a course of counseling or psychotherapy with me here in the clinic? This means that we would meet for about 8 counseling sessions over the next three months?"*

If the patient is not ready to start an antidepressant medication or PST-PC, discuss this with the OB-GYN and tell the patient that you would like to follow up with her to make sure the symptoms of depression improve or at least don't get worse. **Follow-up with a phone or in-person contact every two weeks**. If significant depressive symptoms persist, work with the patient's OB-GYN to convince the patient to try either an antidepressant or psychotherapy.

7) Choosing an Antidepressant:
All approved antidepressants currently on the market are roughly equally efficacious in the treatment of major depression. However, some medications are much easier to use than others. Unless there are compelling reasons to start with other medications, most participants should be recommended to start with a selective serotonin reuptake inhibitor (SSRI) as a first choice. However, there are a number of reasons to consider starting with a medication other than an SSRI:
a) A patient specifically requests a medication from another class
b) A patient has responded well to a medication from another class in the past
c) A patient has responded poorly to an adequate trial of an SSRI in the past
d) A patient has had intolerable side effects with an SSRI in the past

One way to talk about initial drug choice would be to say something like, *"We generally recommend an SSRI because medications of this class work well and have fewer side effects than older medications."*

8) Coordination of Prescriptions for Patient:
After consulting with the program psychiatrist, the depression care manager works with the patient's OB-GYN to provide the appropriate medication to the patient. The process needs to be consistent with clinic protocols and procedures, but could include some of the following elements.
a) The depression care manager does not call in the prescription to a pharmacy on behalf of the provider.
b) The depression care manager emails the OB-GYN, asking that s/he do one of the following:
   - Call in a prescription to the pharmacy
   - Drop off a written prescription at the clinic pharmacy
   - Mail the prescription to the patient
c) The coordination role for the depression care manager is with the OB-GYN provider, not with the pharmacy.

© 2014 University of Washington - Users may print, distribute, and post the Dawn Study Resources on internal websites. Commercial or sublicensing of Study Resources require written permission from the University of Washington. Users assume the entire risk as to the use of the DAWN Study Resources.