MSW Initial Assessment

Study ID ________________ **Date** __________________ **MSW**__________________________________

Depressive Symptoms

English version

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

version de Español

¿Durante las **ultimas 2 semanas,** con que frecuencia le han molestado los siguientes problemas?	Nunca	Varios Días	Más de la mitad de los días	Casi cada todos los días
1. Tener poco interés o placer en hacer las cosas	0	1	2	3
2. Sentir desanimada, deprimida, o sin esperanza.	0	1	2	3
3. Con problemas en dormirse o en mantenerse dormida, o en dormir demasiada	0	1	2	3
4. Sentirse cansada o tener poca energía	0	1	2	3
5. Tener poco apetito o comer en exceso	0	1	2	3
6. Sentir falta de amor propio, o que usted a fracasado o decepcionado si misma o a su familia	0	1	2	3
7. Tener dificultada para concentrarse en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Se mueve o habla tan lentamente que otra gente se podra ar cuenta – o de lo contrario, está tan agitada o inquieta ue se mueve mucho más de lo acostrumbrado	0	1	2	3
9. Se le han ocurrido pensamientos de que sería mejor estar muerta o de que se haria daño de alguna manera	0	1	2	3

if suicidal ideation present, please document:

____

____

____

PHQ-9 Score: _________/27

(0-4 none; 5-9 mild; 10-14 moderate; 15-19 major; 20-27 severe)

Activities affected

☐ Social ☐ Personal ☐ Family ☐ Work

Does age limit your activity? ☐ Yes ☐ No

Dysthymia

1. Over the last 2 years, have you often felt down or depressed, or had little or no pleasure in doing things?
   [count as yes only if yes to]: Was that on more than half the days over the last 2 years?

   ☐ Yes ☐ No → ***skip to next page***

2. In the past 2 years, has that often made it hard for you to do your work, take care of things at home, or get along with other people? ☐ Yes ☐ No

Depression History

- ☐ History of prior depression episodes: number of episodes ______
- ☐ History of psychiatric hospitalization: number of admissions ______
- ☐ History of suicide attempts: number of attempts ______
- ☐ Family history of psychiatric disorder: specify – ____

Prior Depression Treatments

	☐ **Antidepressant(s)**	☐ **PST**
Was treatment helpful?	☐ Yes ☐ No	☐ Yes ☐ No
Notes:	(MEDS)____________	(PST)______________
	____________________	____________________
	____________________	____________________

On antidepressant when enrolled in the study? ☐ Yes – How long have you taken this med? ______________________
☐ No

Panic Disorder

In the last 4 weeks, have you had an anxiety attack-or suddenly feeling fear or panic? ☐ Yes ☐ No

PTSD

In the last 4 weeks, how much have you been bothered by thinking or dreaming about something terrible that happened to you in the past-like your house being destroyed, a severe accident, being hit or being assaulted, or being forced to commit a sexual act?

☐ Not bothered ☐ Bothered a little ☐ Bothered a lot

GAD

Over the last 4 weeks, how often have you been bothered by feeling nervous, anxious, on edge, or worrying a lot about different things?

☐ Not at all ☐ Several days ☐ More than half the days

Alcohol Use ☐ Yes - Frequency & Amount: ___________________________ (such as how many drinks per day/week/month)
☐ No

Drug use/abuse ☐ Yes - Agent: ________________________ Amount: ____________________________________
☐ No

Current Medical Problems

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Current Medications

List both prescription & non-prescription medications

1. ______________ 5. ______________
2. ______________ 6. ______________
3. ______________ 7. ______________
4. ______________ 8. ______________

Allergies/Adverse Reactions: ______________________________

____

Stressors

1. ______________________________
2. ______________________________
3. ______________________________

Diagnosis

☐ Major Depression (PHQ score 10-27) ☐ Dysthymia ☐ Other: ______________

Treatment Plan

☐ Education materials reviewed with patient
☐ Referred to CM

Patient prefers:

☐ Medication ☐ PST ☐ PST and Medication

Treatment Plan (fill out Tx. Plan): ______________________________

☐ Discussed with patient Next Appointment: ____________

Service Confounding Elements:

____

____

Notes:

____

____

____

New contact information (if any):

____

MSW Follow-Up Assessment

Study ID ________________ **Date** __________________ **DCS** __________________________________

Depressive Symptoms

English version

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3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

version de Español

¿Durante las **ultimas 2 semanas,** con que frecuencia le han molestado los siguientes problemas?	Nunca	Varios Días	Más de la mitad de los días	Casi cada todos los días
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5. Tener poco apetito o comer en exceso	0	1	2	3
6. Sentir falta de amor propio, o que usted a fracasado o decepcionado si misma o a su familia	0	1	2	3
7. Tener dificultada para concentrarse en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
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9. Se le han ocurrido pensamientos de que sería mejor estar muerta o de que se haria daño de alguna manera	0	1	2	3

if suicidal ideation present, please document:

____

____

____

PHQ-9 Score: _________/27

Other Symptomatic Conditions

☐ Panic disorder ☐ PTSD ☐ GAD ☐ Other____________________________

Alcohol Use Frequency and Amount: __________________________ (such as how many drinks per day/week/month)

Drug use/abuse Agent: __________________________ Amount: ______________________________

New Medical Problems

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

New Medications

List both prescription & non-prescription medications

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Stressors or other Psychosocial Problems

1. ____
2. ____
3. ____

Current Depression Treatment

a. Is the patient **on antidepressant medication**? ☐ Yes ☐ No

If yes:

List current antidepressant meds and daily dosing schedule.	Taking as prescribed?	Side effects/Concerns?
______________________________	☐ Yes ☐ No	________________
______________________________	☐ Yes ☐ No	________________
______________________________	☐ Yes ☐ No	________________
______________________________	☐ Yes ☐ No	________________

b. Is the patient **receiving PST**? ☐ Yes ☐ No

c. Is the patient receiving any other treatment? ☐ Yes ☐ No

If yes, specify: ____

Treatment-Related Adherence

a. ___ % of medication taken on schedule

b. Number of PST sessions to date (including this session) _________________________

c. PST Homework completed during the past month ___All ___Some ____None

Treatment-Related Expenses
Any expenses related to depression care? ☐ Yes ☐ No

If yes, how much since last visit? ______________________ What for? ____________________________________

Patient consultation with Study Psychiatrist ☐ Yes ☐ No

If yes: Study Psychiatrist change Treatment Plan? ☐ Yes ☐ No

Medication and dosages:
1. ____
2. ____
3. ____

PST: ____

Other: ____

MSW Interventions During this Month

a. Communication with PMD ☐ Yes ☐ No
Outcome ____
b. Communication with Clinic Staff ☐ Yes ☐ No
Outcome ____
c. Communication with Family Members ☐ Yes ☐ No
Outcome ____
d. Referral to CM ☐ Yes ☐ No
Outcome ____
e. Other ☐ Yes ☐ No
Outcome ____

Service Confounding Elements:____

____

Next MSW Appointment ______________________
Next PMD Appointment ______________________

Notes:

____
____
____

New contact information (if any): ____

Your Treatment Plan/Plan de Tratamiento

Patient/Nombre del Paciente: ID#: Date/Fecha:

Depression Clinical Specialist/Terapista: Tel. No:

Next appointment with ***Clinical Therapist***/Próxima cita con la Terapista: Date/Fecha: __________ Time/Hora: __________

Your medication ***schedule***/ Su medicamento y horario:

Name/Nombre		**Dose/Dosis**	**Morning/ Mañana**	**Noon/Día**	**Night/Noche**	**With meals? ¿Con comida?**
1.						
2.						
3.						

Possible side effects/Efectos secundarios posibles:

Remember: It may take a few weeks before you experience the medication's full effect, so don't get discouraged.
DON'T STOP THE MEDICATION BEFORE CALLING YOUR DOCTOR.
Recuerde: Puede pasar algunas semanas antes de que el medicamento le da efecto.
No se desanime, ni pare de tomarlo antes de hablar con la doctora.

Your Problem Solving Treatment schedule: Date/***Hour*** of next session: ____________________
Su siguente reunión para Tratamiento de Soluciónar Probelmas: Fecha/Hora de sesion ________________

Number of sessions agreed on/Numero de sesiones de acuerdo: _______

Weekly/Semanal_____Every other week/Cada otra semana

Remember: Practicing the exercises can help to alleviate symptoms.
Recuerde: Practicando los ejercicios le ayudara sentirse mejor mas pronto.

The above reflects a depression treatment plan that has been agreed upon by the patient, doctor and clinical therapist. This treatment plan is not permanent and can be changed if necessary. Any changes to this plan should be discussed first between the patient, doctor and therapist.
Lo mas arriba refleja un plan para el tratameinto de la depresión en la cual la paciente, el doctor y la terapista han quedado de acuerdo. Este plan de tratamiento no es permanente y se puede cambiar si es necesario. Cualquier cambio en este plan tendra que ser discutido con el paciente, el doctor y la terapista.

Patient's Signature/Firma del Paciente:

MSW Assessment of Treatment Barriers

Social Worker: ______________________________

Study ID #: |___|___|___|___|

PF # ___________________ **Date submitting form:** ____/____/____

Each time patient misses an appointment, please list the date and indicate the apparent reasons.

Barriers to Depression Treatment	Date	Date	Date	Date	Date	Date	Date	Date
Patient Psychosocial Problems								
Caregiving or other family responsibilities conflicted								
Family not supportive of treatment								
Health problems interfered								
Forgot appointment								
Afraid of losing job								
Couldn't take time off work / other work-related issues interfered								
Access to Care Problems								
Lacked adequate transportation								
Was concerned about the cost of treatment								
Patient Resistance to Diagnosis or Treatment								
Stigma-related issues interfered (denial of depression / worry about what others would think)								
Thought problem would go away on its own								
Thought social worker wouldn't really understand								
Didn't believe treatment would help								
Fears about treatment and what it would involve								
Any other reason ____________________________ ____								

Therapist: **Patient ID:** **Session:** **Score:**

PST – ADHERENCE AND COMPETENCY RATING SCALE

1. **Patient Symptoms:** Did therapist obtain a full account of the patient's symptoms and clarify that the patient understands that their symptoms have an emotional etiology?

1	2	3	4	5
No review		Some Review		Extensive and Appropriate Review

This item assesses the degree to which the therapist elicited a full description of the patient's symptoms. It also assesses the degree to which the therapist clarified that the patient is experiencing symptoms with an emotional basis versus a physical basis. A rating of 5 should only be given if both components were covered extensively without spending an excessive amount of time reviewing the symptoms.

2. **Patient Problems:** Did therapist elicit and compile a list of the patient's problems? Did therapist encourage patient to think about all relevant problems by asking about several key areas in the patient's life such as work, family, and finance

1	2	3	4	5
No review		Some Review		Extensive and Appropriate Review

This item assesses the degree to which the therapist elicited a comprehensive list of the relevant problems that are causing the patient distress. A high rating can be obtained by a therapist even if the patient is unable to identify problems if they clearly explore all possible areas where the patient could have problems. A rating of 5 should only be given if the therapist obtained a comprehensive list, clearly explored several areas not spontaneously raised by the patient, and did not spend an excessive amount of time listing the patients problems (e.g continued searching for problems even after a reasonable comprehensive list was generated).

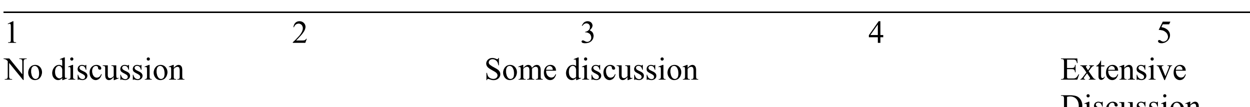
3. **Linking Problems and Symptoms:** Did therapist discuss the connection between problems and symptoms explaining that symptoms are an emotional reaction to problems, and that successful resolution of problems leads to resolution of symptoms?

1	2	3	4	5
No discussion		Some discussion		Extensive Discussion

This item assesses the degree to which the therapist provides a complete explanation for the rationale for problem solving therapy. Because the success of therapy depends in part on the

patient understanding and accepting the rationale for treatment, a rating of 5 should only be given if the therapist engages the patient in a discussion of the rationale to ensure that the patient understands and accepts the rationale.

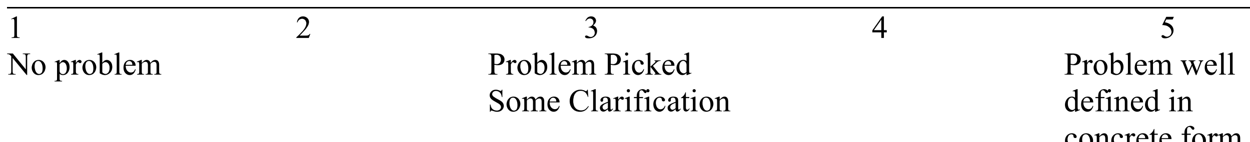
4. **Treatment Parameters:** Did therapist clearly discuss the time limited nature of treatment, the length of sessions and the collaborative nature of treatment?



1	2	3	4	5
No discussion		Some discussion		Extensive Discussion

This item assesses the degree to which the therapist discussed all relevant treatment parameters including: number of sessions, length of sessions, collaborative nature of treatment and the importance of homework (i.e. that the most important work often occurs outside of sessions). A rating of 5 should only be given if the therapist specifically discussed all of the above points and checked with the patient to ensure that the patient understood and agreed to these parameters. The therapist should also emphasize that problem solving is a skill to be learned and that the patient will take this skill with them when therapy is over.

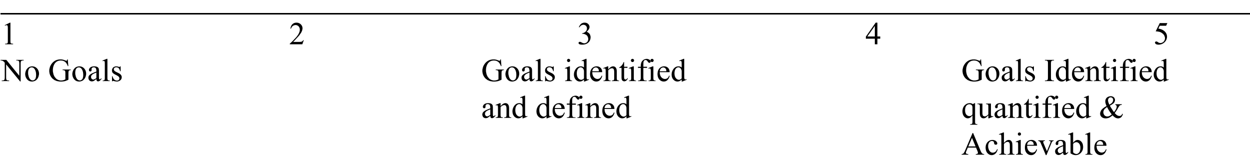
5. **Clearly Defining Problem:** Did the therapist assist patient in choosing a specific problem to work on, stating the problem in clear and concrete form, breaking down a complex problem into smaller more manageable parts?



1	2	3	4	5
No problem		Problem Picked Some Clarification		Problem well defined in concrete form

This item assesses the degree to which the therapist facilitates the selection of a specific problem by the patient, and assists the patient in defining the problem in clear concrete terms. Complex problems should be broken down and then the patient should select one of the smaller problems to initially tackle. A rating of 5 should only be given if the patient selected the problem (unless patient is unable/unwilling, in which case leading patient is acceptable), the problem is clearly defined in concrete terms, and the problem is small enough to be realistically tackled.

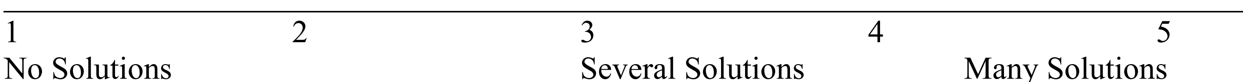
6. **Setting Achievable Goal:** Did the therapist assist the patient in identifying long, mid and short-term goals (as appropriate for chosen problem), stating the goal in clear and quantified language?



1	2	3	4	5
No Goals		Goals identified and defined		Goals Identified quantified & Achievable

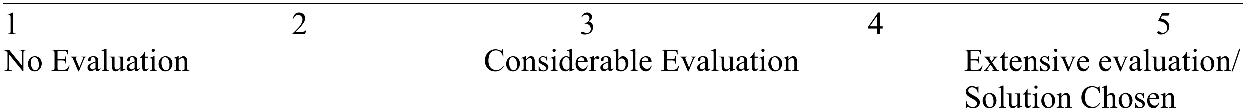
This item assesses the degree to which the therapist assists the patient in identifying achievable goals. In order to score a 5 goals must be: selected by the patient (unless patient is unable/unwilling, in which case leading the patient is acceptable), be clearly defined in quantifiable language, and be reasonable achievable so that the patient can experience success early on.

7. **Generating a Solution:** Did the therapist explain the rationale for brainstorming and assist the patient in generating as many solutions as possible while withholding judgment?



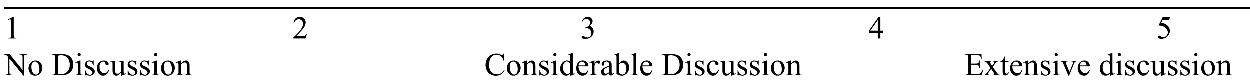
The goals in generating solutions is to generate as many solutions as possible. Solutions should not be discarded or prejudged just because they seem unworkable or silly. To score a 5 a therapist must: 1) encourage the patient to generate as many solutions as possible, even "impractical" solutions (this includes suggesting that the patient respond as other people might, if the patient is having difficulty generating solutions) 2) tell the patient that quantity of solutions is important 3) inform the patient that they can combine solutions 4) encourage patient not to judge solutions during the brainstorming process.

8. Evaluation/Choice of a Solution: Did the therapist teach the patient to strategically evaluate alternative solutions with the patient considering the consequences for each solutions and drawing up a list of pros and cons for each solution?



This item assesses the degree to which the therapist helps the patient evaluate solutions in a strategic manner. In order to receive a rating of 5 the therapist must: 1) help patient generate a list of pros and cons for each solution, 2) encourage the patient to consider whether the solution will have a significant impact on the problem, 3) encourage the patient to consider what the likelihood is that they can carry out the solution, 4) allow patient to choose solution, and 5) encourage patient to choose a solution based on the evaluation of solutions.

9. Homework: Did the therapist discuss the chosen solution with patient, helping to identify necessary steps required to implement the chosen solution, and clearly identify what tasks patient is expected to complete over the upcoming week?



This item assesses the degree to which the therapist discusses with the patient the steps required to implement the solution. In order to score a 5 the therapist must: 1)assess whether the patient feels confident about implementing solution, 2) discuss the specific steps required to implement the solution, break down specific steps into simpler sub-steps if initial steps are

too difficult, 3) clearly define what steps or sub-steps patient is expected to implement and discuss when the patient plans to implement these steps, 4) generate the specific homework assignments in collaboration with the patient and 5) list homework tasks on homework sheet.

10. **Use of Time:** Did therapist use time well, remaining within the 1 hour time frame and covering all applicable components of treatment for this session?

1	2	3	4	5
Covered none or few		Covered some		Covered all

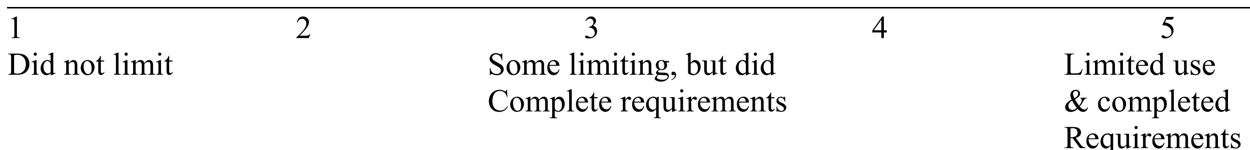
This item assesses the degree to which the therapist completed all components of the treatment during the session. In order to receive a rating of 5 the therapist must: have covered all applicable treatment components during the session, not have spent excessive amounts of time on any one component particularly early in the session, allocated longer periods of time as necessary, and tactfully limited peripheral and unproductive discussion.

11. **Alliance/Communication:** Did therapist use appropriate verbal and non-verbal communication skills to develop a working therapeutic alliance?

1	2	3	4	5
Limited Use of Communication Skills		Some use of Communication Skills		Extensive use of Communication Skills

This item assesses the degree to which the therapist utilized such communication skills as supportive vocalizations, head nodding, jargon free language, active listening, and utilizing patient's own language in order to build rapport and create a therapeutic alliance. In order to receive a rating of 5 the therapist should be warm, professional and confident in addition to communicating in a manner designed to build rapport.

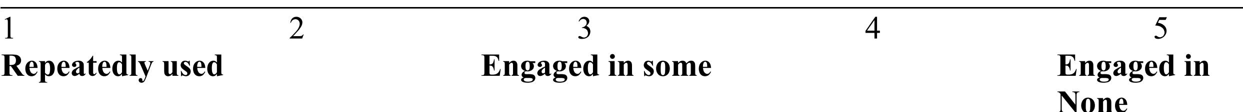
12. **Acceptable Interventions:** Did therapist limit use of acceptable but not required treatment interventions to appropriate situations and so that required treatment components could be completed?



1	2	3	4	5
Did not limit		Some limiting, but did Complete requirements		Limited use & completed Requirements

This item assesses the degree to which the therapist utilized "acceptable but not required" treatment interventions such as role-playing, activity scheduling and paraphrasing in an appropriate manner. A rating of 5 should only be given if the therapist utilized such acceptable interventions when appropriate and did not allow such use to interfere with completing the required components of treatment.

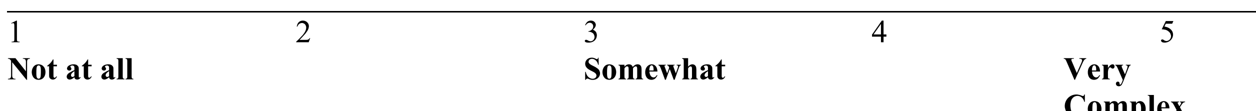
13. **Proscribed Interventions:** Did therapist exclude all proscribed behaviors/interventions during session?



1	2	3	4	5
Repeatedly used		**Engaged in some**		**Engaged in None**

This item assesses the degree to which the therapist resisted including any proscribe interventions during the session. These include cognitive restructuring, assertiveness training, relaxation training, exposure, anaylsis if unconscious material, exploration of childhood, modeling, direct advice giving.

14. **Case Complexity:** How complex/difficult is the case?



1	2	3	4	5
Not at all		**Somewhat**		**Very Complex**

This item assesses the degree to which the therapist is treating a complex or difficult case. Factors making a case difficult may include but are not limited to: many overwhelming or complicated problems to cope with, cognitive limitation in patient, or patient has great difficulty understaind treatment. Motivation for treatment should not be included in assessment of case difficulty or complexity.

Scoring: Score is based on the total of all items, divided by the number of items for which ratings were done. If an item is Not Applicable (N/A) for a given session, do not include it in the total. Thus, the total score will be an average of all rated items, and will range from 1 to 5.