Executive summary of completed research

Depression intervention via referral, education, and collaborative treatment (Project DIRECT): a pilot study

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DEPRESSION INTERVENTION VIA REFERRAL, EDUCATION, AND COLLABORATIVE TREATMENT (PROJECT DIRECT): A PILOT STUDY

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INTRODUCTION

Major depression occurs in at least 1 to 3% of the general elderly population\(^1\), the prognosis of which is poor. Studies of depressed adults report that those with depressive symptoms, with or without depressive disorder, have poorer functioning\(^2,3\) comparable to or worse than those with chronic medical conditions.\(^4\) Moreover, depression increases the perception of poor health,\(^4\) the utilization of medical services,\(^5\) and health care costs.\(^6\) Despite these worrisome findings, probably less than 25% of these depressed seniors are detected in primary care settings\(^7,8\) and among those that are detected few receive appropriate treatment for a sufficient period of time.\(^5,9\)

Two recently published multi-center clinical trials may offer a solution. The two interventions, IMPACT (Improving Mood-Promoting Access to Collaborative Treatment)\(^9\) and PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial),\(^10\) include elements of education of family physicians about depression, use simple instruments to screen for clinically significant depressive symptoms and diagnoses, and employ a depression care manager, i.e. a specially trained nurse, psychologist, or social worker. This combination approach has proven successful for both interventions and suggests that the treatment and outcomes of depression in this population can be improved substantially.

Success notwithstanding, the above interventions were implemented in the United States in the context of several health maintenance organizations. Whether such interventions are feasible and effective in a Canadian setting is unknown. This feasibility study aimed to collect data necessary to plan and justify a multi-site randomized controlled trial in Canada.

OBJECTIVES

The objectives were to determine the feasibility and acceptability of the following:

1) Recruitment of family physicians and practices;
2) Identification and recruitment of subjects;
3) Training of depression care practitioners and delivery of the intervention by the depression care practitioner;
4) Delivery of the intervention by the family physicians;
5) Communication and collaboration between family physicians and the depression care practitioner in delivering the intervention;
6) Cluster vs individual randomization;
7) Depression care practitioner intervention delivered primarily face-to-face vs primarily by telephone;
8) Proposed study measures for family physicians and patients;
9) Follow-up procedures (family physicians family physicians and patients).
METHODS

This pilot study used a randomized trial design to test the feasibility of randomizing patients to the intervention vs usual care. Two methods of randomization were compared: individual randomization and cluster randomization. Data were collected from participating family physicians and patients. Data sources included: family physician questionnaires, patient questionnaires, and patient charts.

The study protocol was approved by the research ethics review boards of St. Mary’s Hospital, the Montreal General Hospital, and the Centre local de services communautaires Côte-des-Neiges.

Family physicians were recruited by the study coordinator from a list of community family physicians. Patient recruitment took place in the offices of family physicians and included determination of eligibility, screening for possible depression, screening for major depression, and informed consent.

The experimental intervention was delivered to the patients by a Depression Care Practitioner. The intervention was limited to 2 months follow-up by the depression care practitioner and a maximum of 4 Problem Solving Therapy sessions. The initial assessment consisted of the following: current symptoms of depression; a history of depression or depression treatment; a family history of depression; coexisting psychiatric, medical or psychosocial problems; social, personal, family or work functioning; social supports; treatment preferences. This initial assessment form was then faxed to the family physician.

The depression care practitioners worked with the patients and the family physician for up to 8 weeks to establish a treatment plan that included a medication algorithm. Patients were also offered short Problem Solving Therapy at weekly visits. During subsequent follow-up visits and telephone contacts, the depression care practitioner monitored the patient’s progress using a 9-item measure of symptoms of depression. The follow-up forms were faxed to the family physician.

In the control intervention, the family physician was informed that the patient had major depression and was allocated to care as usual. The Depression Care Practitioner did not contact patient or family physicians in the usual care group. Data were collected in the form of patient interviews, family physician questionnaires, depression care practitioner forms, and patient chart reviews. Information abstracted from both groups included reason for visit, treatment for depression, and depression prognosis.

RESULTS

Objective 1: The recruitment of family physicians and practices. From the initial list of 108 family physicians, 21 signed the consent forms and participated in the study. Another 10 family physicians referred from the members of the initial group signed the consent forms later during the study. The most frequent reason for non-participation appeared to be a patient profile hat did not match our inclusion criteria.

Objective 2: The identification and recruitment of patients. Among the 29 family physicians that screened their patients, 14 screened the patients themselves (family physician screening), 2 had patients self-screen in the waiting room, 11 had the patients screened by the research assistants in the waiting room, one family physician had the patients screening themselves in the waiting room.
and 2 family physicians provided a list of eligible patients to be screened by the research assistants. We estimate that, among those family physicians that chose to screen themselves, the proportions of eligible patients screened varied from 0 – 27%. The proportion that screened positive varied between 11% and 39%. Among the 203 patients who screened positive, 21 (10.3%) were not interested in study participation. Among 172 patients who completed the step 2 screen, 77 patients had major depression, and 68 were enrolled in the study.

Objective 3: Training of Depression Care Practitioners and delivery of the intervention. Both Depression Care Practitioners were trained and certified as superior by the psychologist responsible for this training in the IMPACT study. A total of 36 patients were referred to the Depression Care Practitioners for intervention, of these 7 (19.4%) refused the intervention (2 for health reasons, 2 did not want any treatment, 1 already saw a social worker weekly, and in 2 the reason was unknown). Among the 29 patients that accepted the intervention, 4 chose not to receive Problem Solving Therapy.

Objective 4: Delivery of the intervention by the family physicians. Among patients whose progress reports were received from the family physician, changes in management were made in 78.5% of in the usual care group and in 90.3% in the intervention group.

Objective 5: Communication and collaboration between family physicians and the depression care practitioner. Sixteen family physicians (16/29, 51.6%) returned the End of Study Questionnaire. Among the 10 family physicians who reported that they worked with a depression care practitioner, all were satisfied with the professional qualities/skills, communication/interaction, frequency of contact and timeliness of the information.

Objective 6: Cluster vs individual randomization. Most of the family physicians who returned the End of Study Questionnaire were not aware of which study arm they were in. There were no clinically important differences in patient satisfaction between patients in the 2 study arms, either in the intervention or control group.

Objective 7: Intervention delivered primarily face-to-face vs primarily by telephone. Among the 29 patients that accepted the intervention, 17 were assigned to receive the intervention primarily face-to-face, and 12 primarily by telephone. The actual proportion of the contacts that were face-to-face in the 2 groups were 29% in the face-to-face group and 23% in the telephone groups. In general, patients were satisfied with the treatment they received, with higher levels of satisfaction in the intervention group. A statistically significant difference was noted in the satisfaction with the amount of help received (50% satisfied in usual care patients versus 88.5% satisfied in intervention group patients, p=0.04) and with the treatment received (35% satisfied in usual care patients versus 80.8% satisfied in intervention group patients, p=0.01). Patients who were assigned to receive the intervention primarily by telephone tended to be more satisfied than those assigned to receive it face-to-face.

Objective 8: Proposed study measures (family physicians and patients). The research assistants rated the interviews with the patients (Step 2 screening, baseline and follow-up) as easy or very easy in 95.8% cases at Step 2, 95.5% cases at baseline and 95.1% cases at follow-up. The large majority of the interviews took place with no interruptions, the patients had no language or cognition problems and RAs perceived the patients as co-operative during the interviews.
Objective 9: Follow-up procedures (family physicians and patients). Patient follow-up interviews were completed for 97.0% (66/68) of enrolled patients. Notably, 2 refusals were in the control group of arm 1; the reason for refusal was disappointment in not receiving any treatment.

CONCLUSIONS

The intervention and the trial methodology are feasible. A telephone-based intervention may be a cost-effective intervention for depression in Canadian seniors with major depression who live either in rural or urban areas. A full-scale randomized trial should be conducted.

REFERENCE LIST


