A pilot study of a telephone-supported self-care intervention for depression among older adults with a chronic physical illness in primary care

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Funded by the FRQ-S

Outline

- Background
  - Self-management interventions in chronic disease management
  - Depression self-management interventions
- Our research program
  - Results of a feasibility study
  - Implications for design of an RCT

Self-management / self-care

- "..the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, role management, and emotional management."

Johnston 2011

Self-management support

- "the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support."

Johnston 2011

Self-management support interventions for people with chronic diseases

- Advocated as component of chronic disease management guidelines, and patient-centered care
- Types:
  - Group vs individual, professional vs lay-led
  - Education vs skills-building
- Effectiveness:
  - Limited; best evidence for group interventions for diabetes and hypertension
  - Economic effects unclear

Depression and chronic disease self-management

- Depression: a chronic illness with major impact on morbidity and mortality
- Reciprocal relationship between chronic physical illnesses and depression
- Depression reduces adherence to self-management interventions
  - E.g., post-MI, diabetes
- Chronic disease self-management interventions may have beneficial effects on depression outcomes:
  - E.g., diabetes, CHF, arthritis.

Depression self-management interventions

- Types:
  - A “low-intensity” intervention (< 3 hours professional support)
  - Media: bibliotherapy, internet-based, AV materials,
- Policies:
  - Stepped-care programs (e.g., NICE)
  - UK - low-intensity alternative to psychotherapy
  - Canada: group and/or individual programs offered to selected populations (BC, Ontario, Manitoba, QC)

Depression self-management interventions

- Effectiveness:
  - Meta-analyses indicate that these interventions can be effective
  - Supported interventions are more effective (vs unsupported)
  - Interventions in clinical populations may be less effective than in non-clinical populations
  - Lack of research on chronic physical illness with comorbid depression

Our research program

- Target population: adults aged 40 and over in primary care settings
  - One or more chronic physical illnesses
  - At least mild symptoms of depression.
  - Capable of participation in intervention
- Feasibility:
  - 3 perspectives: doctors, patients, family
- Intervention (for feasibility):
  - Toolkit of 8 tools: informational and cognitive - behavioral
  - Patient choice
  - Telephone-supported, up to 6 months, by non-clinical coach
- RCT (in progress)

Feasibility: 1) Family doctor perspective

- Random sample of 375 FPs
  - Invited to participate, distribute short screening forms
- Results:
  - Participation among 24.6 -57.3%, of those eligible
- Questionnaires/focus groups
- Barriers:
  - Lack of interest in mental health, self-care, or research
  - Practice organization – screening difficult to implement
- Intervention mostly conducted independent of doctors
  - 28% of patients reported discussing intervention with doctor.

Feasibility: 2) Patient perspective

- Participation:
  - 254 completed screening forms returned
  - 98 (39%) interviewed and met all eligibility criteria
  - 63 (64%) of those eligible provided written consent
  - 55 (87%) of participants completed follow-up at 6 months

Patient sample (n=63)

- Median age: 61; 75% female
- 33% with 2+ chronic diseases, mean 5.5 medications /day
- Health services:
  - 21% ED visit past 3 months
  - 21% hospitalized past year
- Average depression score: mild-moderate symptoms
- Depression treatment:
  - 66% antidepressants (prior or current)
  - 58% counseling or therapy (prior only)

Feasibility: 2) Patient perspective

- Choice of tools and adherence (2 months):
  - Completion (at least half) of individual tools:
    - DVD: >60%
    - cognitive-behavioral tools, information brochure: 26-40%
    - Internet tool: 7%
- Coach telephone calls:
  - Mean 10.5 calls, 10.6 mins/call

Feasibility: 2) Patient perspective

- Depression outcomes (months):
  - PHQ-9, SF-12 MCS, antidepressant medications significantly reduced
  - Moderate (or better) adherence to cognitive-behavioral tools at 2 months predicted greater improvement (PHQ-9)
  - No effect of informational tools, # contacts

Feasibility: (3) family member perspective

- Patient-reported discussions of tools with family/friends:
  - 46% with family member(s)
  - 38% with friend(s)
- Analysis in progress of quantitative & qualitative data from family members

What did we learn?

- Intervention was feasible and acceptable among those recruited
  - BUT Physician and patient barriers to recruitment
- Similar adherence and outcomes in age 60+ and those with more severe depression
- Intervention largely independent of physicians

Current RCT

- RCT to compare a supported vs unsupported toolkit
- Intervention:
  - Structured around CBT-based workbook
  - Individualized to address patient problems/priorities
- Expanded eligibility criteria: any chronic physical illness or chronic pain
- Recruitment procedures:
  - MD participation not required
  - MDs may refer patients

Future directions

- Integration of interventions for depression and chronic physical illness
- Enhancing role of:
  - Primary care providers
  - Family members
  - Community agencies involved in chronic disease management