Author's response to reviews

Title: More age-care staff report helping care recipients following a brief depression awareness raising intervention

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Author's response to reviews: see over
Changes made as requested:

Page 2 Change to Abstract to add: Staff then participated in a two hour depression awareness raising intervention.

Bottom of Page 3 paragraph added: Recognition rates of depression in older persons have typically been reported to be low [13] although more recent research indicates that the situation may be improving [14]. Recognition in this age group is particularly difficult because of the overlap of symptoms between depression and physical health problems [15, 16] and between depression and dementia [17, 18]).

Last paragraph Page 4 added: For example, a meta-analysis [24] found little or no impact of depression screening questionnaires on either the detection or management of depression by clinicians.

Bottom of Page 4 and top of Page 5 paragraph changed: A recent study [25] investigated staff knowledge and self-efficacy related to recognizing and responding to depression and whether training improved numbers of referrals for depression. While the authors did find significant improvements in knowledge and self-efficacy there were no significant increases in referrals for depression at follow up.

Last paragraph Page 5 changed: While a number of studies have looked at staff training in depression recognition [26-28]; staff knowledge of depression [23, 29] and confidence in managing depression [22, 25]; to our knowledge, no other studies have explored unprompted knowledge of appropriate help giving behaviours or examined staff confidence in knowing how to respond to depression in high care environments.

Page 6 paragraph added to describe high and low care populations: In Australia, care recipients are assigned to high or low care status in accordance with the Aged Care Funding Instrument (ACFI) and assignment is based on the severity of scores on three domains: activities of daily living, behaviour, and complex health care (see http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-
Nursing home accommodation is provided for care recipients with high care needs and hostel accommodation is provided for care participants with low care support needs who require some assistance with the demands of daily living, but who do not have complex ongoing care needs.

Top of Page 7, paragraph added to justify use of general staff and managers: General staff and managers were included for both comparison purposes and because there may be occasions when they, particularly facility managers, are required to assist potentially depressed care recipients.

Page 7 changes made to clarify coding of responses for Knowledge of appropriate helping responses: Helping responses were coded according to whether they were considered appropriate, that is ‘evidence based’/procedural (e.g. counselling/therapy/CBT; discuss with GP/family/social worker; make appointment with health care professional;) or ‘non-specific’ (e.g. be positive/cheerful, praise them, encourage pride in appearance). Each appropriate response was given a score of ‘one’ and these scores were totalled to give an overall knowledge of appropriate help.

Page 10 Statistical analysis information added to include completers versus non-completers responses to outcome variables at baseline: Chi square analyses were also used to assess differences at baseline between completers and non-completers on the categorical outcome variable helped/didn’t help for each of the six helping behaviours and the Mann Whitney U test was used to assess differences at baseline on the two continuous outcome variables (Confidence in knowing how to assist depressed care recipients and Knowledge of appropriate helping responses).

Page 12 wording changed as requested: At BT, nurses did not name significantly more appropriate help giving responses than any of the other staff categories.
Page 13 information added on completers and non-completers as requested: There were no other demographic differences or differences at baseline on the three outcome variables between completers and non-completers.

Page 13 changes made to first paragraph of Discussion: The results of this study suggest that a brief depression awareness training program for age-care facility staff is associated with increased confidence in knowing how to help age-care recipients who may be depressed and this change was sustained at the six month follow up.

Page 13 additional information added to end of first paragraph in Discussion, as requested: It appears that increasing confidence levels leads to an increase in helping behaviours possibly by making it more likely that staff will act on the knowledge that they have when they were not confident to do so beforehand. It is therefore important that aged care facilities explore ways to increase staff confidence such as by using the training program outlined in this study.

Top of Page 14, wording changed as requested: In the present study, prior to training, the nursing staff reported that they were not significantly better at identifying appropriate responses to care recipients with depression than other staff and neither were they more confident in knowing how to respond. This is similar to Bagley et al., 2000 (op cit). In addition, nurses were no more likely than other staff members to help care recipients who were potentially depressed. If this is an accurate indication of their actual clinical responses this would be of concern as it is likely to be the nurses’ role to liaise with GPs and ensure that care recipients receive help. In the current study all of the nurses surveyed worked in high care where they would have a high level of exposure to care recipients with depression so it is of considerable concern that they did not have either greater knowledge of appropriate responses to depression or were more likely to help than other groups of staff.

Last paragraph page 14 and top of page 15, wording changed as requested and information added: Those with previous training in the health field showed significantly higher confidence in knowing how to respond to depression than those without such training but they did not have greater levels of
knowledge of appropriate ways of assisting care recipients with depressive symptoms and were no more likely to provide assistance. In contrast, while those with previous training in the mental health field could name significantly more appropriate ways of providing assistance to depressed care recipients and were also significantly more likely to provide help, they were no more confident than those without. This may be a reflection of the type of training they had received, which somehow failed to improve confidence. In contrast, the Davison et al. study (op cit) found that those with prior training in mental health had greater confidence but not greater knowledge to those without prior training. More research into the relationship between confidence and knowledge is warranted and into how each affect the other.

Page 16, a number of changes and additions made to limitations section as requested: There are a number of limitations in the present study. For example, this was not a randomized controlled trial but a single group pre-test post-test design and therefore because there was no comparison group any changes identified in outcome measures may be due to historical, maturation and testing effects. The study needs to be repeated with a control group for an accurate assessment of the benefits of the intervention. The measures used for help giving behaviors were based on staff self-report and recall rather than on objective, prospectively collected measures. It is possible that staff may have exaggerated their helping behaviours to appear depression-aware. However, the proportion of staff who said they provided assistance for each of the helping behaviours was extremely low, so it seems unlikely that numbers were inflated. Although staff in the current study may not have endorsed the six help giving behaviours included in the survey that does not mean that they did not provide some other kind of help for care recipients such as listening to them or recording their concerns in the care recipients’ notes. However, as the facilities used in the current study did not have formalized procedures for responding to depression some measures were needed for assessing helping behaviours. It is also not necessarily the case that the helping behaviour measures used in the current research would be available options for all the staff in all of the aged care facilities investigated which further highlights the need for formalized procedures to assist care recipients who may be depressed and for staff to be aware of and act upon these procedures. More appropriate measures may be
determined in future research. In addition, only slightly more than half of staff returned surveys at baseline; a high percentage of staff were lost from the sample at FU, mainly due to high turnover of staff at the participating facilities; and missing demographic data (particularly for carers) at baseline means that results must be interpreted with caution. Those with a higher education status were less likely to have follow up data. These factors and the sampling of staff from only one geographic location limit the external validity of the results.

Additional information added to last paragraph of Discussion Page 17: More research is needed to identify barriers to providing care to age-care recipients with depression, to find the best methods for providing training for staff to assist information retention; to understand the relationship between confidence and knowledge; to increase staff confidence; and to facilitate moving from a theoretical understanding to a practical application of knowledge by staff in their day to day work.

Changes made to Table 1, page 23 to clarify stats and missing data:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nurse</th>
<th>Carer</th>
<th>Manager</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 19</td>
<td>n = 55</td>
<td>n = 5</td>
<td>n = 21</td>
</tr>
<tr>
<td><strong>Female % (n/N)</strong></td>
<td>94.1 (16/17)</td>
<td>92.6 (50/54)</td>
<td>100.0 (5/5)</td>
<td>75.0 (15/20)</td>
</tr>
<tr>
<td><strong>Age (years) Mean (SD)</strong></td>
<td>47.3 (12.7)</td>
<td>46.7 (10.7)</td>
<td>51.2 (6.0)</td>
<td>46.5 (12.2)</td>
</tr>
<tr>
<td><strong>Education: certificate or diploma and above % (n/N)</strong></td>
<td>75.0 (12/16)</td>
<td>46.2 (12/26)</td>
<td>25.0 (1/4)</td>
<td>50.0 (10/20)</td>
</tr>
<tr>
<td><strong>Length of service (years) Mean (SD)</strong></td>
<td>3.6 (6.0)</td>
<td>4.3 (4.3)</td>
<td>5.6 (7.3)</td>
<td>5.8 (6.2)</td>
</tr>
<tr>
<td><strong>Professional training in the health field % (n/N)</strong></td>
<td>87.5 (14/16)</td>
<td>30.8 (8/26)</td>
<td>0/4</td>
<td>16.7 (3/18)</td>
</tr>
<tr>
<td><strong>Professional training in the mental health field % (n/N)</strong></td>
<td>25.0 (4/16)</td>
<td>11.5 (3/26)</td>
<td>0/4</td>
<td>5.3 (1/19)</td>
</tr>
</tbody>
</table>
Changes made to title of Table 3, page 25 as requested: **Table 3: Proportion of staff who reported providing assistance before training (BT) and at six month follow up (FU).**

Please note stats in Table 3 are correct.