**Culturally Responsive Shared Decision Making for the Treatment of Depression**

**Specific Aims**

It is estimated that at least 25% of all adults 18 and older suffer from some kind of mental illness at any one time, the most common of which are depression and anxiety. Mental illness leads to more disability than the most prevalent physical chronic illnesses such as heart disease, diabetes, and cancer and may cost the US healthcare system as much as 300 billion dollars annually. We have demonstrated in our previous work that racial and ethnic minority patients are less likely to receive a diagnosis of depression and when diagnosed are significantly less likely to receive treatment of any kind. When they do receive treatment, they are less likely to adhere to this treatment, especially pharmacotherapy, than their non-Hispanic white counterparts. Non-adherence to treatment is one of the primary reasons that depression symptoms do not improve. Although racial and ethnic minorities are less likely to receive any treatment for their depression than non-Hispanic whites, there is a clear “preference” for psychotherapy when they do receive treatment and the disparities in adherence to psychotherapy among racial and ethnic groups are much less pronounced than those seen for pharmocotherapy. The reasons for these “preferences” are unknown. They may reflect a combination of healthsystem structural practices, and provider and patient attitudes towards depression treatment.

Shared decision making (SDM) offers a unique standardized process for addressing these disparities in treatment for depression. Unfortunately there have been very few systematic tests of SDM for depression treatment, those that have been done have not accounted for how SDM would be used in real-world healthcare settings, and none have been tested specifically with ethnically and linguistically diverse patient populations. It is possible that SDM in these patients would lead to better adherence to their depression treatment because they would have a role in choosing that treatment.

The proposed study will test the feasibility of adapting an existing SDM tool for the treatment of depression for different racial and ethnic groups of patients and then implementing this tool at the point of care when a patient newly diagnosed with depression must make decisions about treatment. Two sites will be chosen for the feasibility trial: a large integrated healthcare system that has over 400,000 patients diagnosed with depression and a large network of federally qualified health centers with 15,000 patients diagnosed with depression. Both healthcare systems serve very ethnically diverse patients and provide a unique opportunity to test the intervention in two very different models of care delivery.

The primary outcomes of this study will be: 1) treatment choice (including active surveillance) and 2) initial adherence to the treatment choice. Based upon our previous work, initial adherence to pharmacotherpy and psychotherapy will be measured as follows: any antidepressant prescription fill (either refill of the initial medication or new fill for an alternative antidepressant) within 180 days of the first prescription fill and 2) attendance at a second psychotherapy visit within 45 days of the index psychotherapy visit. We will also measure patient and provider satisfaction with the SDM process. In addition, we will test the application of Computational Ethnography, a multisensing video and audio recording system, in one healthcare site to provide detailed data about provider-patient communication during the SDM sessions. These will be used as descriptive variables to explain variation in the adherence and satisfaction outcomes. The following aims will be achieved in the proposed study:

1. To determine effective implementation strategies for a standardized SDM process in the treatment of depression at the point of care in large healthcare systems.
2. To understand the acceptability of, and satisfaction with, a standardized SDM intervention for ethnically and linguistically diverse patients and the providers who treat them.
3. To determine the resources needed to integrate the SDM process into a standard of care for patients making decisions about depression treatment.
4. To test the feasibility of audio and video recording SDM encounters and analyzing the recordings to examine the relationship between SDM behaviors and communication behaviors relate to initial treatment choice (psychotherapy versus psychotropic meds vs active surveillance) and initial adherence to the treatment choice.
5. To estimate adherence outcome effect sizes for a larger randomized trial.

**Budget Justification**

**KPSC**

Dr. Karen Coleman will serve as the PI for the proposed project and oversee the work done at Kaiser Permanente Southern California (KPSC). She will coordinate all aspects of the intervention at KPSC as well as oversee the work of the other two sites in the project.

**University of Colorado/Denver Health**

Dr. Jeanette Waxmonsky will serve as the site-PI at the University of Colorado as well as oversee the work done at Denver Health. She will coordinate all aspects of the intervention at Denver Health and participate actively in the adaptation of the chosen SDM tool for use with culturally diverse audiences. Dr. Robert Keely will serve as the liaison for the project to Denver Health and a research associate will recruit participants and collect data.

**University of California at San Diego**

Dr. Ming Tai-Seale will serve as a site-PI at the University of California at San Diego (UCSD), contributing to (1) the selection and implementation of the SDM tool, (2) the study design with respect to recording of clinical encounters, and (3) analyses of transcripts of the recordings using methods she had developed and applied in her previous NIMH-funded K01 and R01 research projects and current PCORI-funded research projects in this research area. The equipment used for the Computational Ethnography component of the proposed study will be donated without cost for use on this project.

**TIMELINE**

The timeline for this project is flexible and could start in year 2 or 3 of the parent award. The project period for the proposed pilot is two years.

**BUDGETS**

Please see attached