

Participation in and Impact of a Depression Care Management Program Targeting Low-Income Minority Patients in an Urban Community-Based Clinic

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ABSTRACT

Background: African American people experience disproportionately higher rates of chronic depression, and among those affected, the condition is less likely to be detected and treated than in non-Hispanic white people.

Objective: To address this disparity in our primary care clinic, we introduced a validated framework for detecting and managing depression.

Methods: Over a 5-year period, there were 146 patients diagnosed as having depression and enrolled in a depression care management program. We evaluated the feasibility and effectiveness of that program using baseline and follow-up screening data from the Patient Health Questionnaire-9.

Results: The mean baseline severity score of 20.60 was reduced to 15.89 at 6 months ($P < 0.001$) and to 16.62 at 12 months. Patients achieved their best score, a mean of 12.93, 10.14 months after baseline ($P < 0.001$). The last mean severity score, after 15.47 months, was 14.60, a significant difference compared with baseline ($P < 0.001$). Although baseline severity scores for both groups were similar ($P = 0.534$), patients who remained engaged with the program demonstrated better scores and achieved greater severity score reductions from baseline to the last measure ($P < 0.001$). This study did not find any differences between the sexes when comparing PHQ-9 scores at baseline ($P = 0.074$), 6 months ($P = 0.303$), and 12 months ($P = 0.429$) and best ($P = 0.875$) and last ($P = 0.640$) scores.

Conclusions: Most of the improvement was witnessed in the first 10 months of treatment. Patients with more medical comorbidities participated longer in the study than patients with fewer comorbidities. Further research could elicit the relationship between

improvement in mental health and medical conditions. (*Clin Ther.* 2014;36:778–790) © 2014 Elsevier HS Journals, Inc. All rights reserved.

Key words: African American, care management, depression, minority, primary care, psychiatry.

BACKGROUND

Economic deprivation has been proposed to affect mental health, including depression. Thoits and Hannan,¹ Kaplan et al,² McLeod and Kessler,³ Ross and Mirowsky,⁴ and others outlined a cascade of events spawned by poverty, which constricts then erodes coping behaviors, contributing to a sense of powerlessness, which, in turn, weakens self-esteem and personal efficacy, which then militates against problem solving, a behavior suggested by Kaplan et al² to be important for preventing depression.⁵

More recent empirical evidence has been published to support the association between poverty and depression. For example, a cohort of 820 persons with no history of depression at baseline showed that the relative odds of incident depression after 18 months of follow-up, measured using a modified version of the Structured Clinical Interview for DSM-III-R major depressive disorder (MDD) subscale,⁶ was 2.19 (95% CI, 1.04–4.59) for participants living in neighborhoods with a low socioeconomic status (SES) compared with those in neighborhoods with a high SES.⁷ In a cross-sectional survey of 1355 residents of New York, New York, conducted to determine the incidence of

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depression during the recent 6-month period and the prevalence of lifetime depression, investigators found that respondents living in poorer neighborhoods were 29% to 58% more likely to report depression in the past 6 months and 36% to 64% more likely to report lifetime depression than those living in neighborhoods characterized by investigators as having better features of the built environment. In this study, depression was measured using the depression module from the National Women's Study, a validated measure that captures symptoms of major depression consistent with *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) criteria.^{8,9}

A review of 45 published observational studies¹⁰ found that 37 studies identified associations of ≥ 1 neighborhood characteristic with depression/depressive symptoms, and 7 of the 10 papers describing longitudinal studies reported associations with incident depression. The reviewer discerned that associations of depressive symptoms or depression were most consistent with neighborhoods characterized by their structural features, such as disorder, social cohesion and isolation, and level of violence, than with neighborhoods characterized by poverty, racial composition, or stability. Chronic stress that comes from being socially disadvantaged and experiencing sustained economic hardship has been suggested to be a mediator for depression in low-income populations,^{11–13} contributing to an increased number of depressive symptoms¹⁴ and reduced cognitive functioning.^{15,16}

Adults exposed to long-term poverty from childhood are affected by this experience throughout their lives.¹⁷ One aspect of this experience is an increased risk of depressive syndromes that may be more difficult to treat than those in less vulnerable populations. Childhood is a critical time for the development of conditions that are recognized as predisposing individuals to the development of mood disorders.¹⁸ However, the causal relationship between poverty and depression remains equivocal, with the 2 concepts of nature and nurture having different and potentially unique influences on adult functioning.¹⁹ For example, having a reduced SES has been found to be associated with an increased risk of childhood trauma; childhood trauma is, in turn, associated with an increased risk of mood symptoms in adulthood.²⁰ Medication response is also affected by SES. For example, Cohen et al²¹ reported that elderly patients had varying efficacy to antidepressant drug treatment:

individuals characterized as having a low SES were less likely to respond to antidepressant drug treatment than were participants characterized as having a higher SES (hazard ratio = 1.80; 95% CI, 1.18–2.75). Furthermore, depression in immigrant populations is well documented for its increased rate and increased severity of depressive symptoms, especially in those who immigrated at an earlier age.²²

Although depressed patients in primary care in general have a high risk of not having their condition identified by their treating physicians,^{23–25} only approximately 15% receive treatment.²⁴ Nevertheless, African American persons experience disproportionately higher rates of chronic depression, and among affected individuals, the condition is even less likely to be detected and treated than in non-Hispanic white persons. Data from the Third National Health and Nutrition Examination Survey suggest that although the prevalence of MDD was significantly higher in white persons than in African American and Mexican American persons, the opposite was discerned for a chronic type of depression, dysthymic disorder, which was more prevalent in African American and Mexican American individuals.²⁶ Lack of education remained a significant risk factor for dysthymic disorder in African American and Mexican American persons after controlling for income. Among patients presenting to UK primary care providers (PCPs), black African patients were less likely to be diagnosed as having psychological problems than black Caribbean and white English patients.²⁷ In a study of 3570 African American, 1621 black Caribbean, and 891 non-Hispanic white individuals, MDD affecting African American and black Caribbean persons was more likely to remain untreated and was more severe and more disabling than in non-Hispanic white persons.²⁸

Depression is not necessarily commonplace in primary care practices. A meta-analysis of 41 studies of primary care practices in 11 different countries (N = 50,371 patients) identified a 19.5% overall prevalence of depression.²⁹ In US primary care settings, the prevalence of MDD ranges from 5% to 13% of all patients,³⁰ and 1 of 3 primary care patients presents with clinical problems that may warrant a mental illness diagnosis.³¹ The incidence of any depressive symptom in New Zealand family practice patient populations was estimated to be 18.1%.³² The relatively high prevalence rates and the frequency with which depression accompanies more prominent

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