

Partnering to Combat Depression

March 26, 2014

We strongly encourage you join the call by receiving a call-back.

If you choose to dial-in, please be sure to use your **attendee #** found under the “Event Info” tab.



CALIFORNIA
HEALTHCARE
FOUNDATION

California
Improvement
Network Better Ideas
for Care Delivery

Today's Speakers



Loretta Jones, MA

Founder and CEO
Healthy African American Families



Kenneth Wells, MD, MPH

David Weil Endowed-Chair and professor-in-residence in the department of psychiatry and biobehavioral sciences

UCLA David Geffen School of Medicine



Community Engagement and Planning To Address Mental Health Disparities

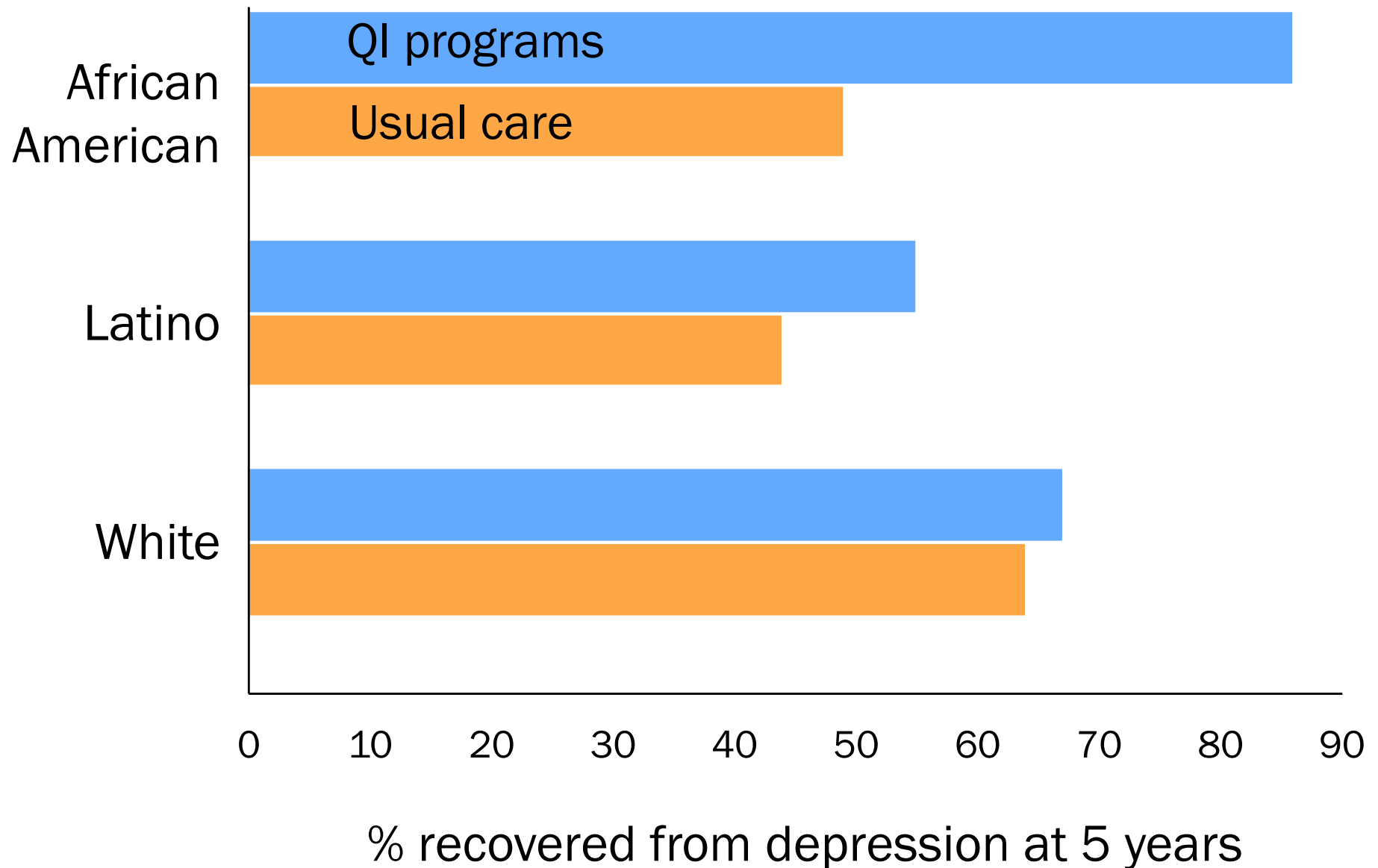
Loretta Jones & Kenneth Wells



Mental health is not just the absence of mental disorder, but a **state of well-being** in which every individual **realizes his or her own potential**, can **cope with the normal stresses of life**, can **work productively and fruitfully**, and is able to **make a contribution** to her or his community.

World Health Organization

Quality Improvement Can Address Depression Disparities (PIC)



Yet Disparities in Care Persist

- Minorities are less likely to get any or appropriate mental health care when needed
- Disparities in care remain or are worsening over time
- Barriers to implementation of collaborative care for depression in primary care exist, especially for under-resourced communities and public sector clinics

Disparities in the Clinical Workforce Exist (2006)

- **White Americans:** 65% of the population but 79% of psychiatrists and 92% of clinical psychologists
- **Latinos:** 15% of the population and 5% of psychiatrists and 3% of clinical psychologists
- **African Americans:** 13% of the population and 3% of psychiatrists and 3% of clinical psychologists
- **Asians:** 5% of the population and 10% of psychiatrists and 2% of clinical psychologists
- **American Indians/Alaskan Natives:** 1.5% of the population and .4% of psychiatrists and .4% of clinical psychologists
- **Many other services sectors** support under-resourced communities and communities of color, but are seldom included in clinical goals and improvement efforts

The Promise of Community Engagement to Address Disparities

- Trains a broader network of providers that are ethnically diverse and trusted in the community—*addressing manpower issues*
- Exposure diverse populations to key components of collaborative care in familiar settings—*addressing access*
- Improves client quality of life and social determinants of mental health—*addressing multiple sources of disparities*

How can we translate the benefits of
high-quality depression care
into **better lives**
for under-resourced,
communities of color today?

“Little is known about the independent contribution
of community linkages to improving health and
behavioral health outcomes.”—SAMSHA 2012

H.R. 3590: The Patient Protection and Affordable Care Act





SKID ROW
HOUSING
TRUST
HOMES
SUPPORT
SUCCESS



New Vision Church of
Jesus Christ



DEPARTMENT
OF
MENTAL
HEALTH



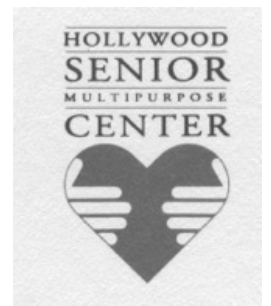
Working together in an *equal* partnership
to learn how to improve depression care
and build community strength



Watts Counseling and
Learning Center



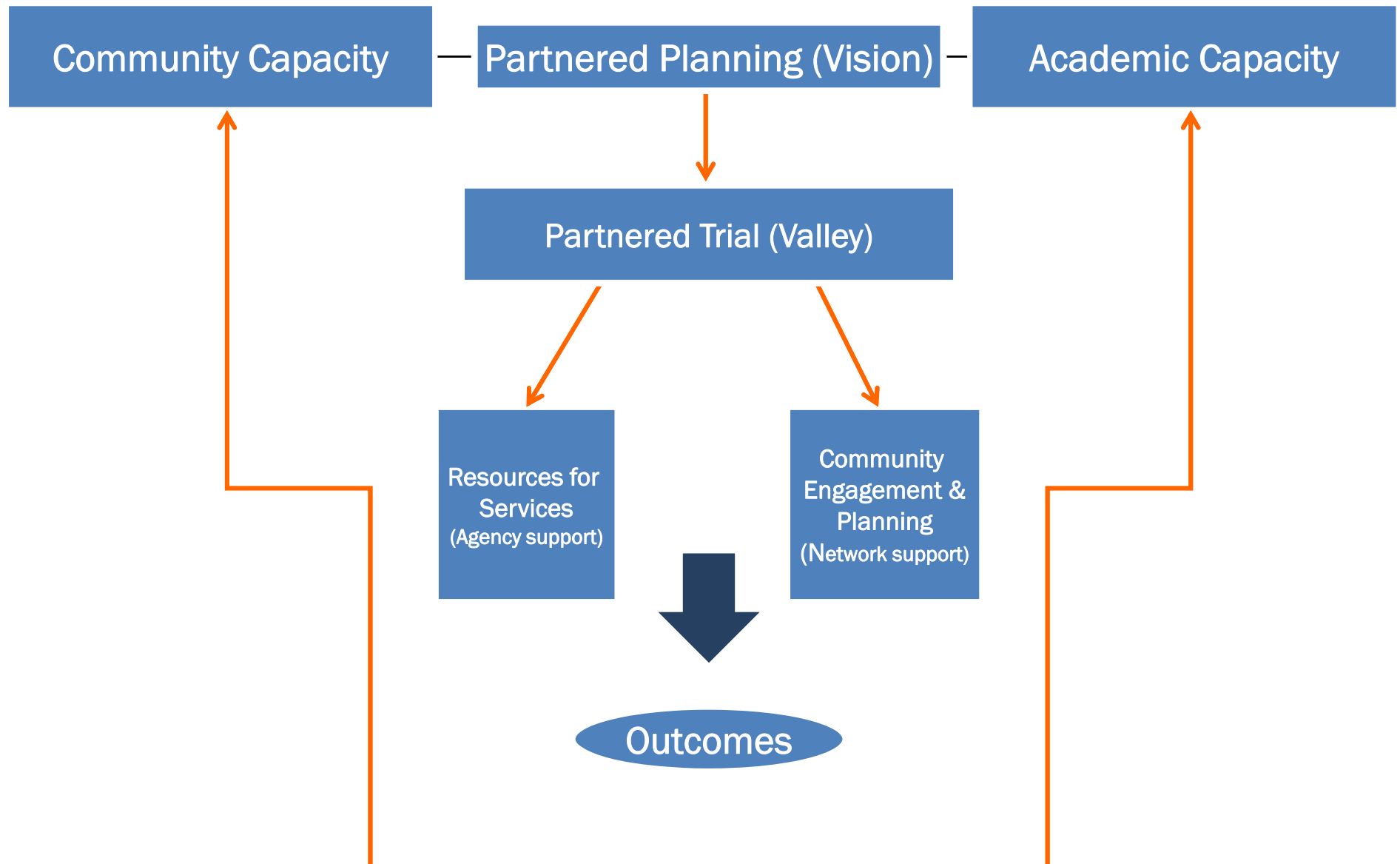
A family
of services.
A family
that serves.



CPIC Research Questions

- **How can we best build community capacity to address depression?**
 - By training individual programs in best practices?
 - By bringing programs together to plan how to implement best practices as a community?
- Are both models feasible?
- Which builds provider capacity the most?
- Which improves client outcomes the most?

CPIC's CPPR Design Framework



Partnered Dissemination (Victory)

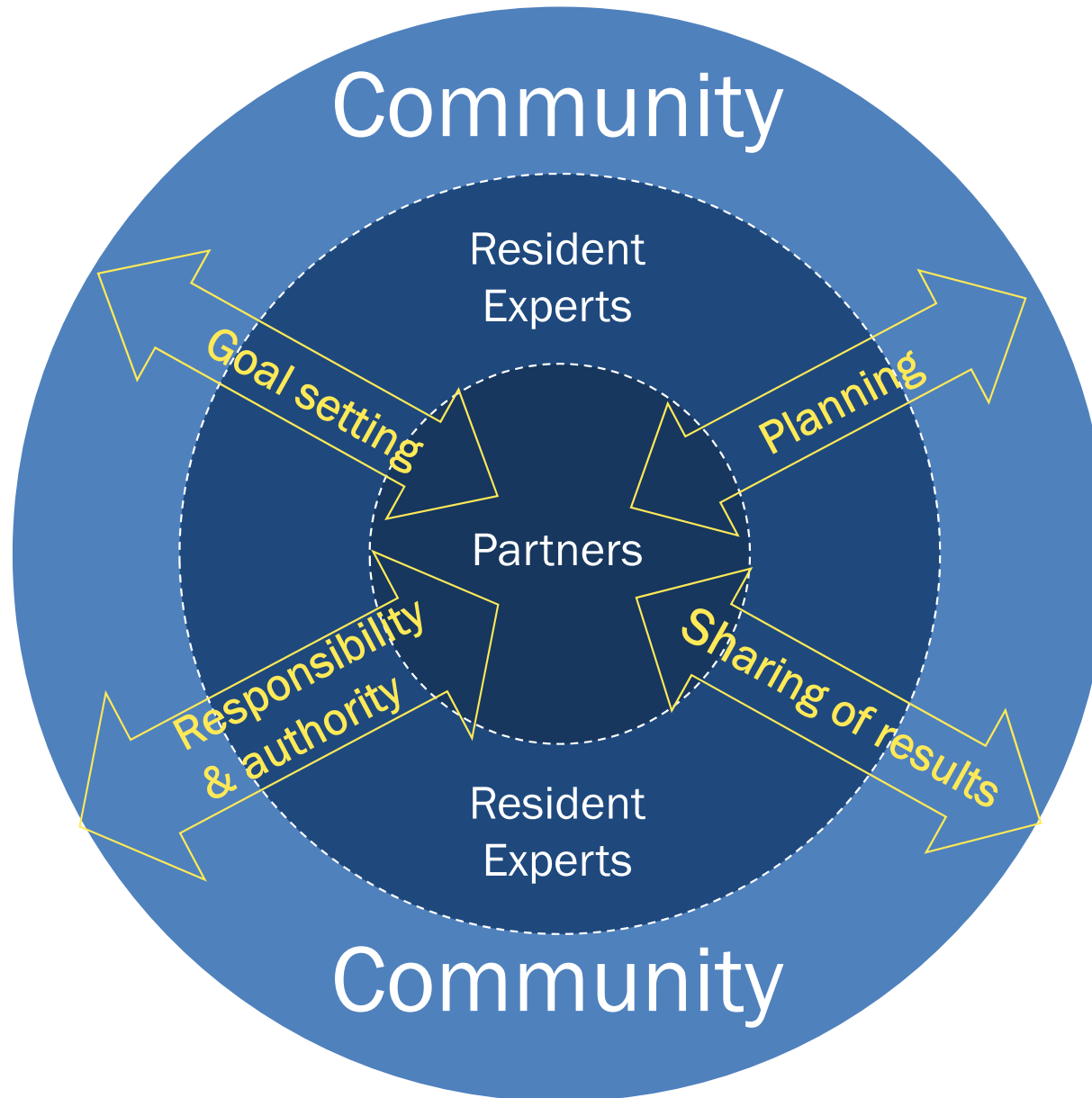
Model of Community Engagement: Community Partnered Participatory Research (CPPR)

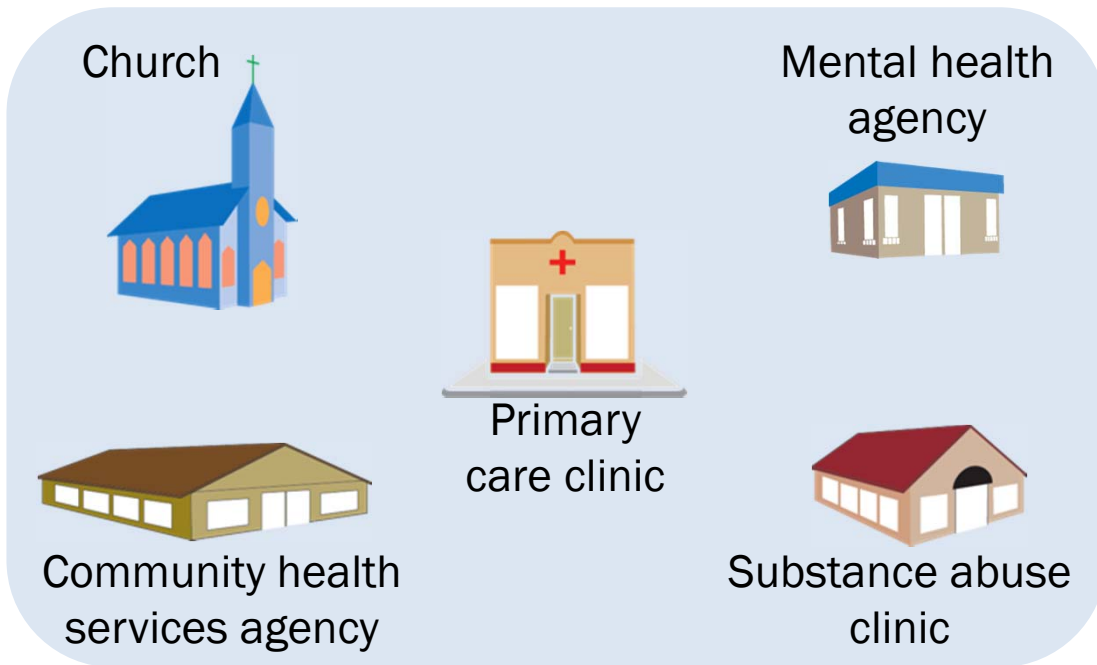
CPPR Principles:

- Transparency
- Respect
- Power sharing
- Co-leadership
- Two-way knowledge exchange



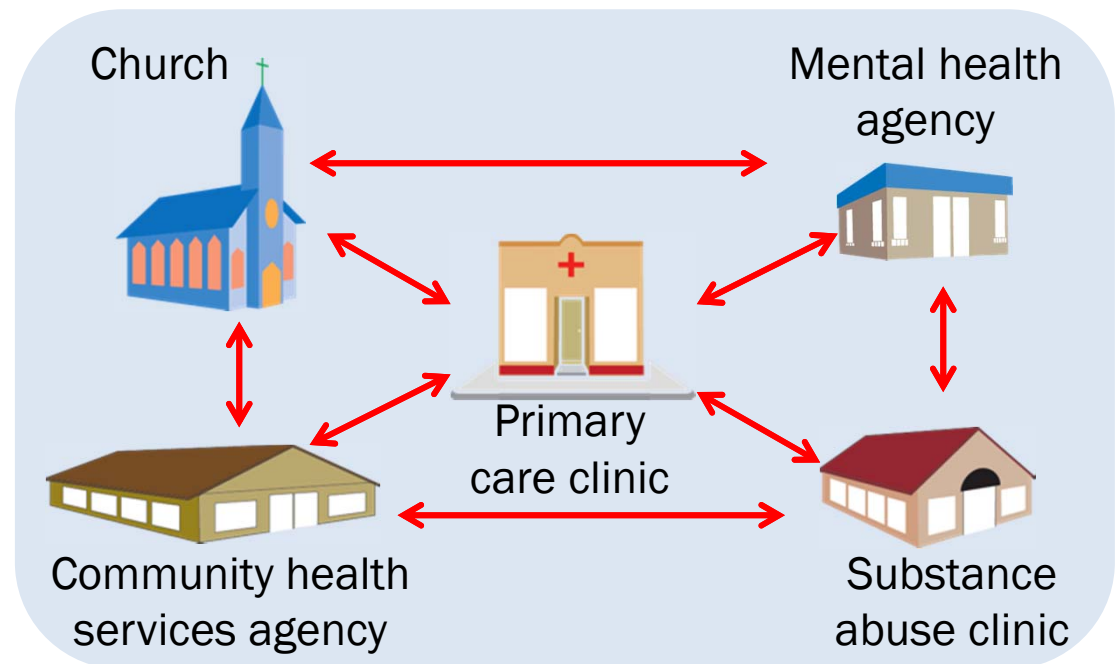
Circle of Influence Model for Collaborative Research © 2002





95 Programs in Los Angeles

Community engagement and planning

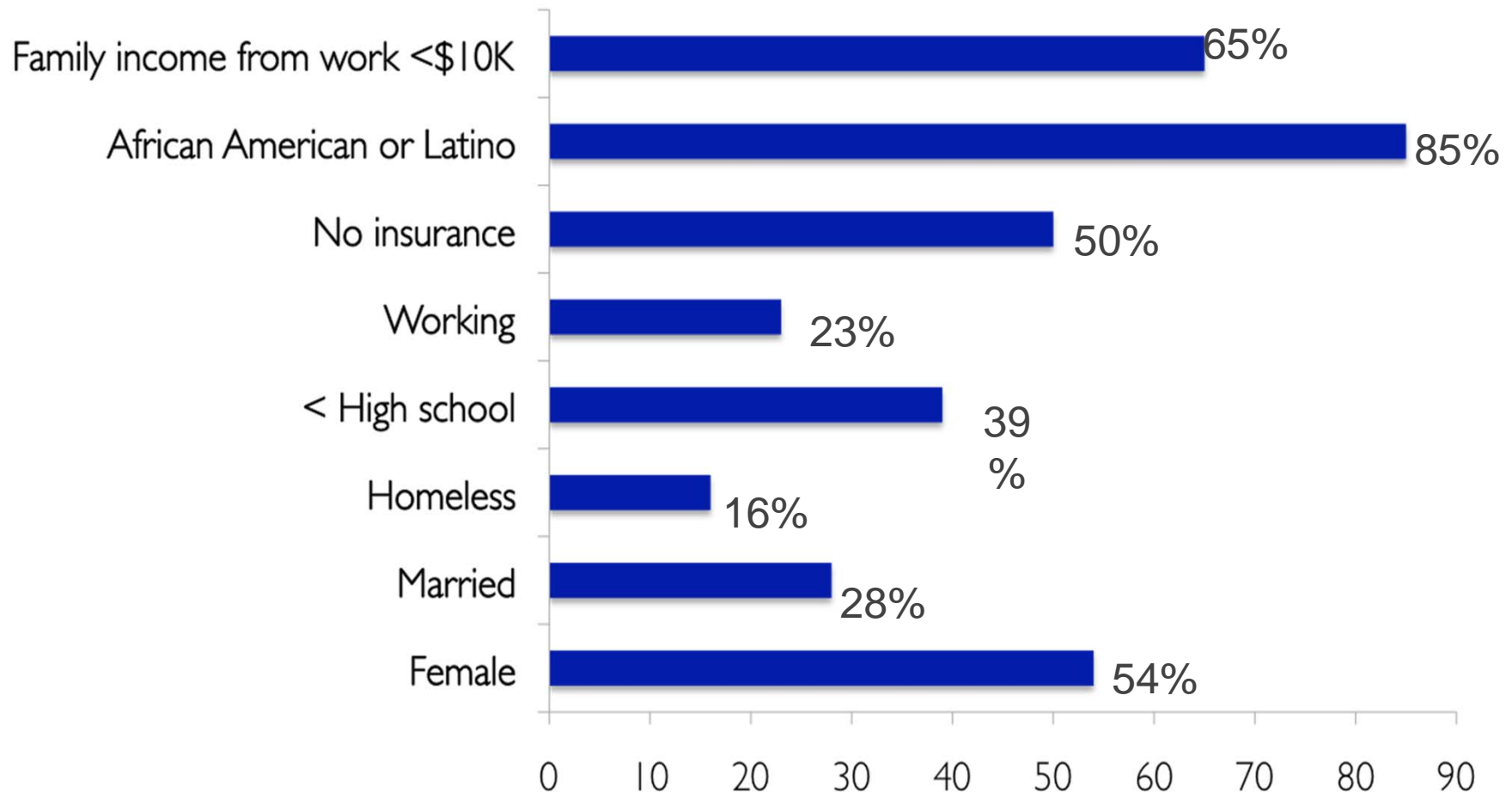


Collaborative Care Tools, CEP and RS

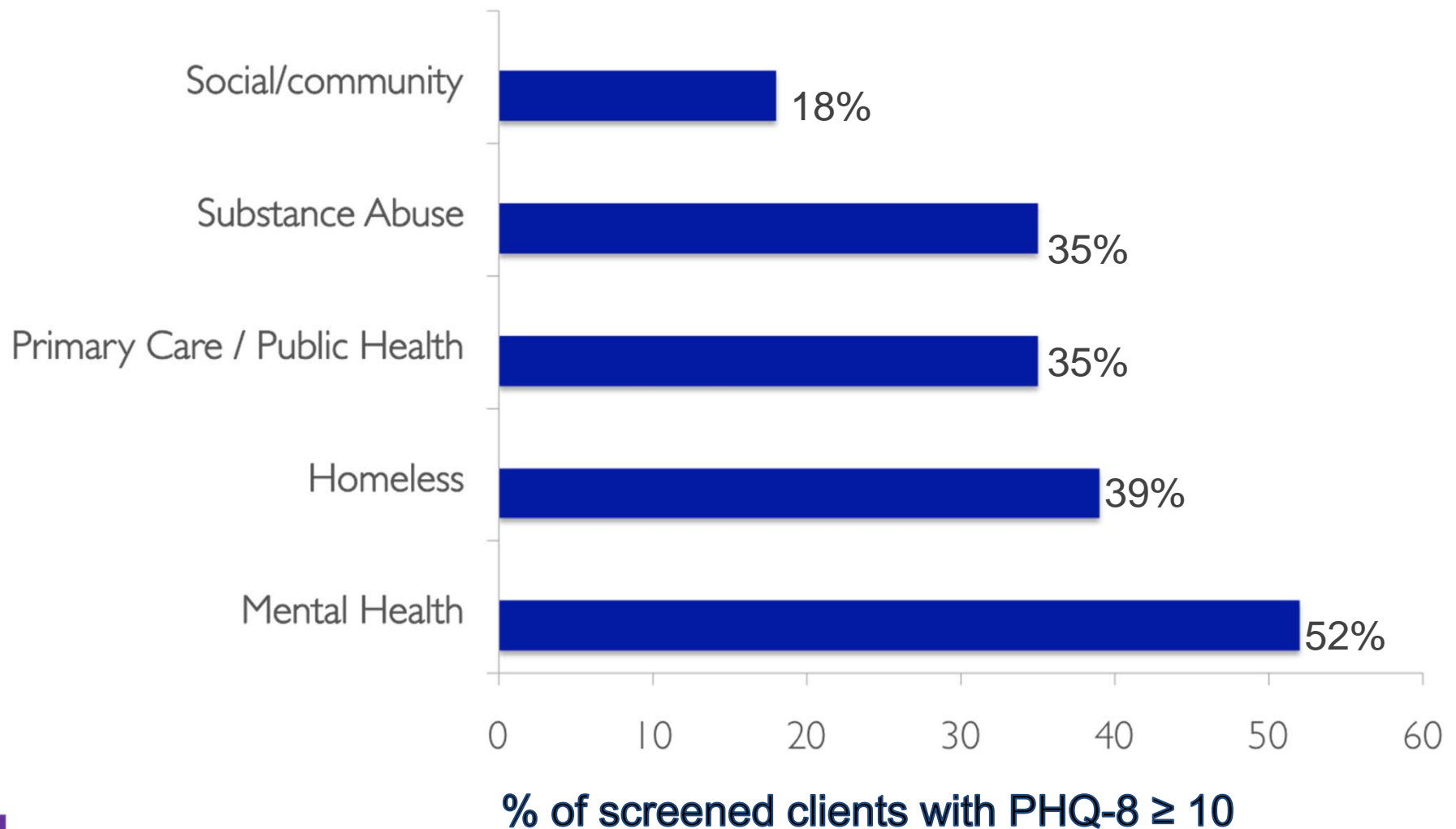
- Team management (IMPACT)
- Clinical assessment and medication management and alternative health practices (PIC)
- Cognitive behavioral therapy for depression (We Care)
- Care management/case management/health workers (MHIT/New Orleans, PIC)
- Patient education resources (PIC)

CPIC's Diverse Clients

(N = 4,440, mean age 47 years)



Client Depression Common Across Program Types (N=4,440)

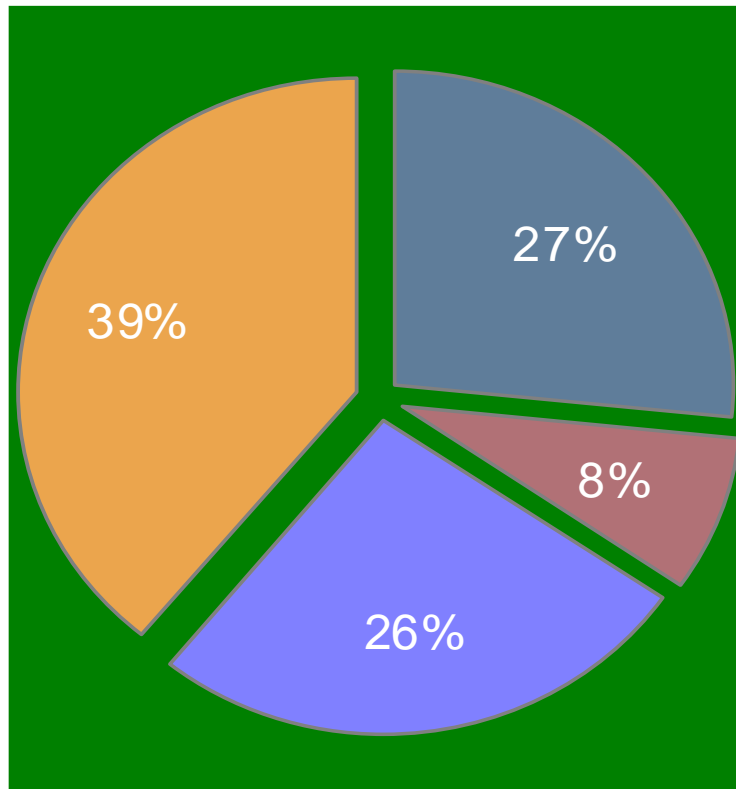


Most Services for Depression in Community-based Agencies

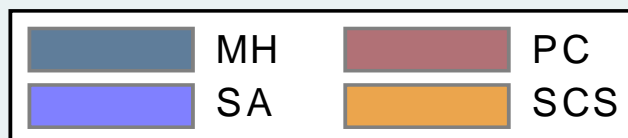
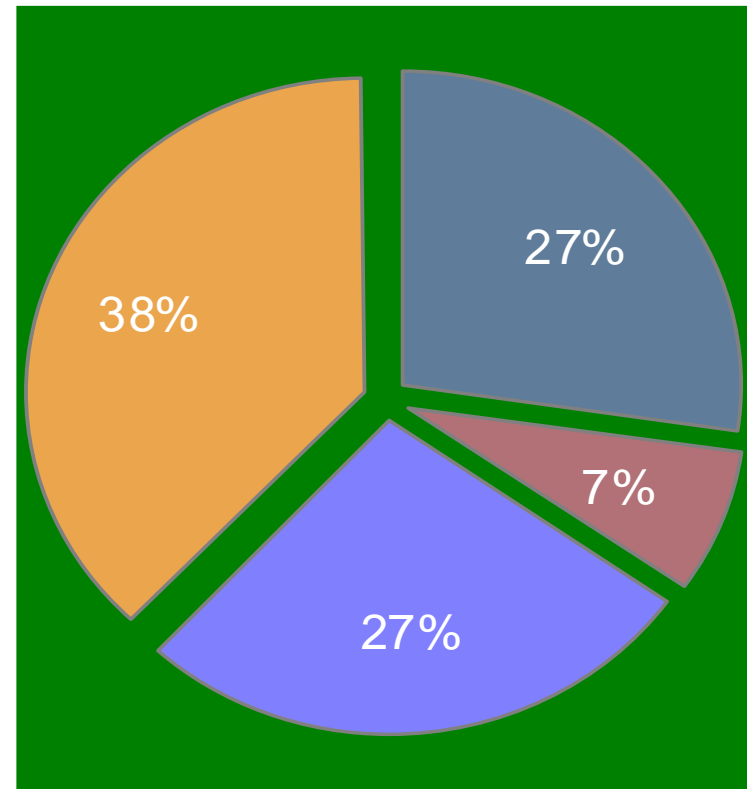
SPA 4, Metro

SPA 6, South

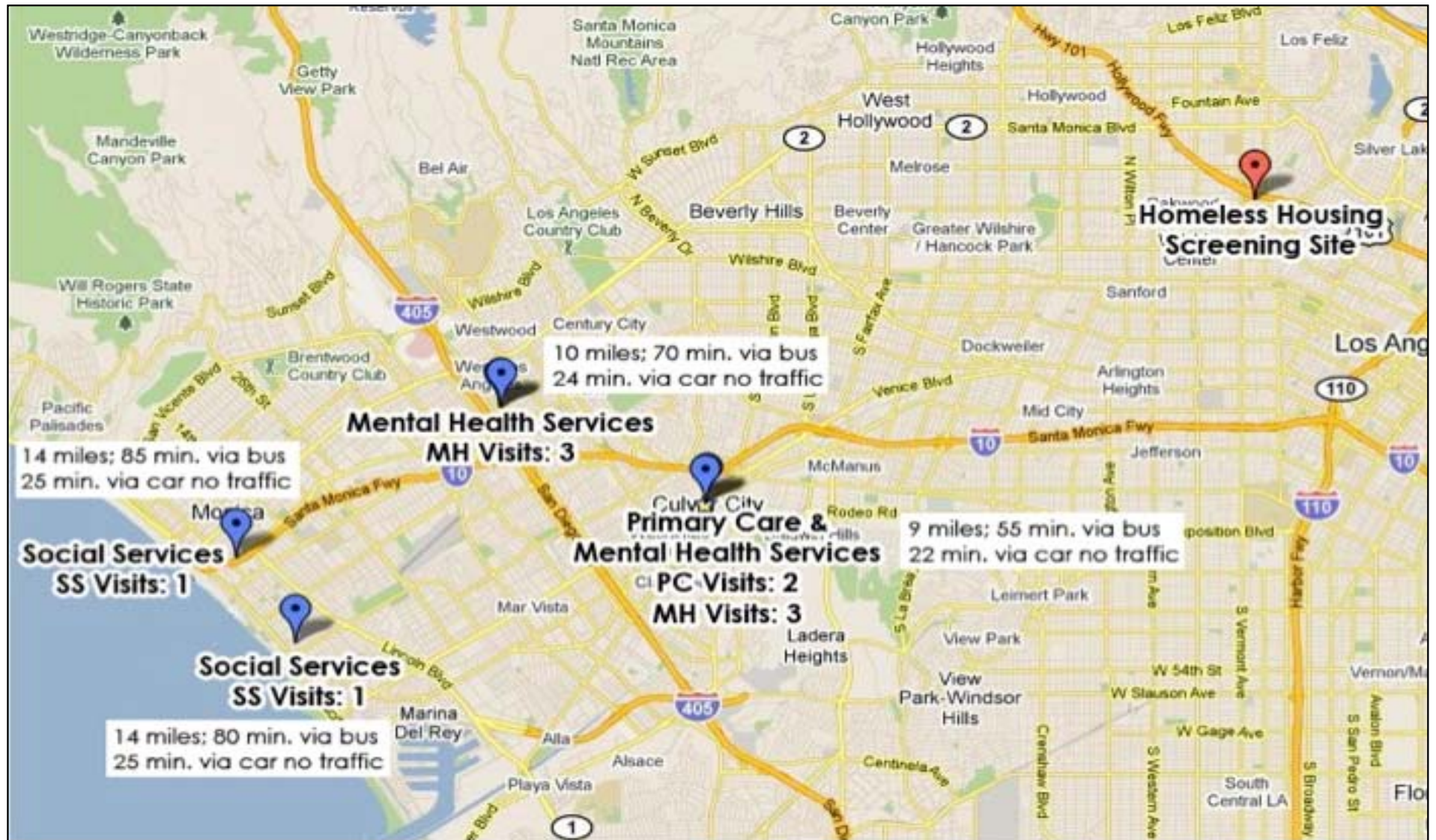
Total contacts= 13,062, n=374



Total contacts=15,390, n=425



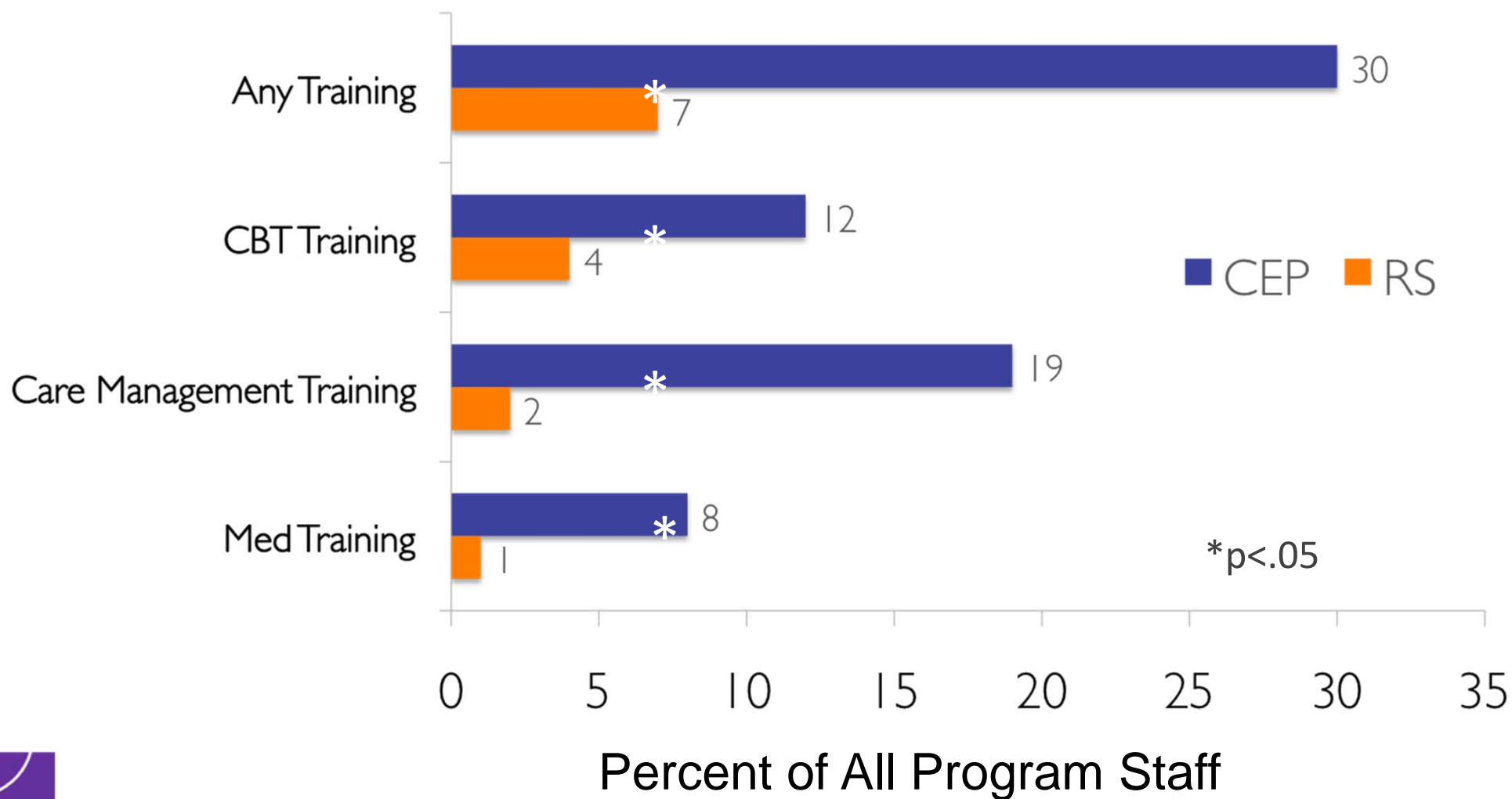
One Homeless Participant's Quest for Services



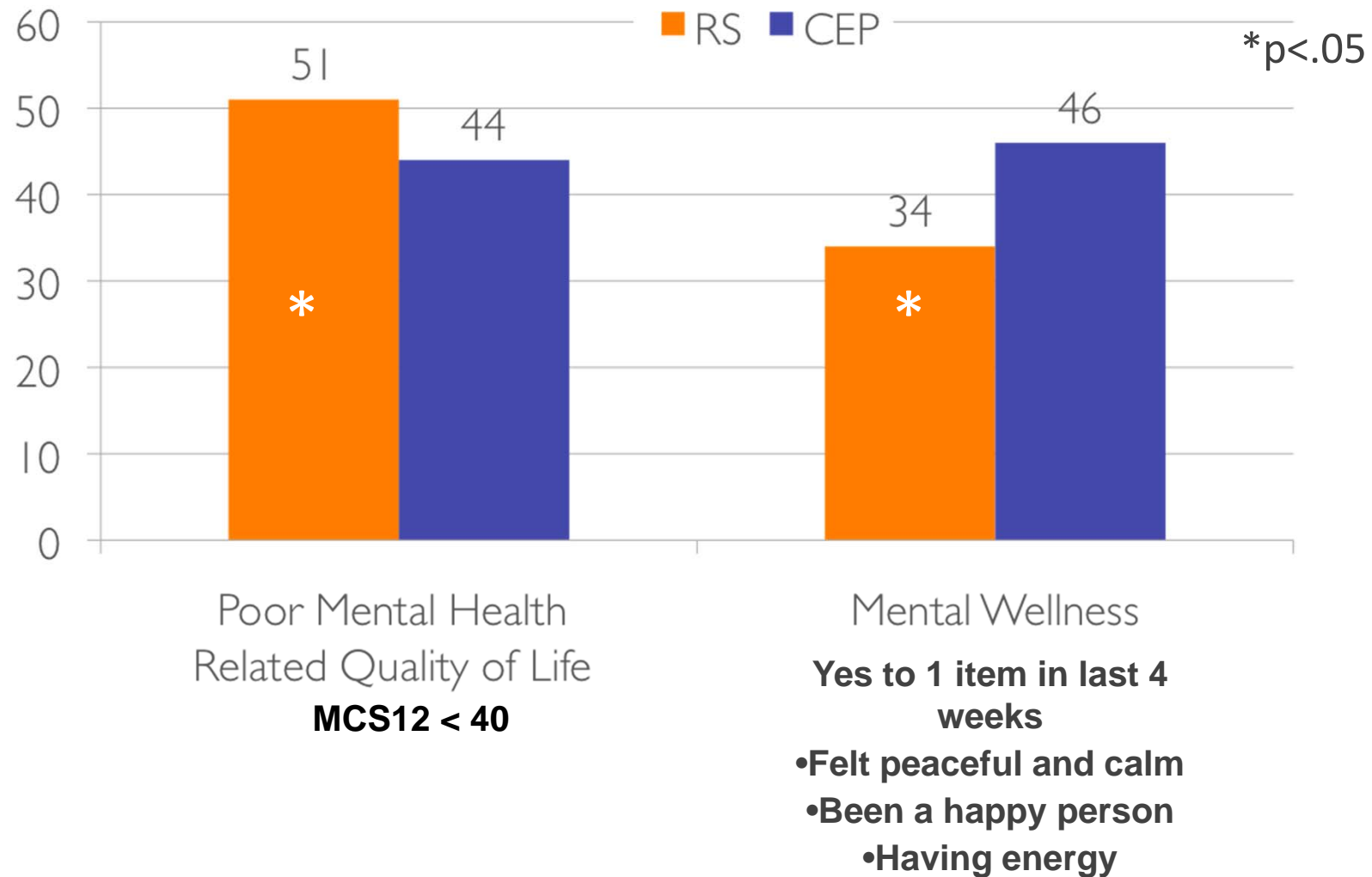
Summary of 6-Month Outcomes

- **CEP relative to RS**
 - **increased** staff participation in trainings
 - **improved** mental health quality of life and physical activity
 - **reduced** homelessness risk factors
 - **reduced** behavioral health hospitalizations
 - **shifted** outpatient depression services
 - away from specialty medication visits
 - toward primary care, faith-based and park services for depression
- **BUT: No significant difference in depressive symptoms, use of antidepressants or healthcare counseling for depression**
 - *So mechanism is not more “formal” treatment*

CEP Increased Staff Participation in Evidence-based Trainings (N=1,622)

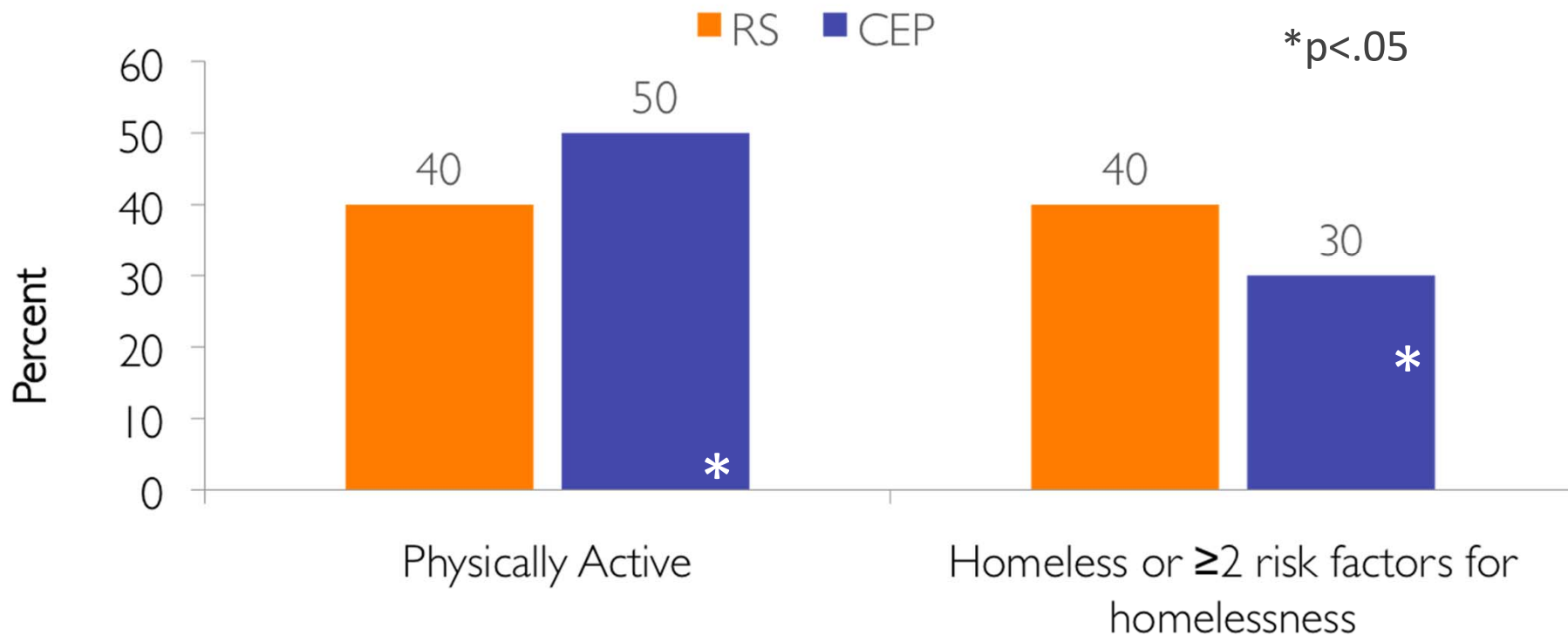


CEP Improved Client Mental Health Quality of Life (N=1,018)



CEP Improved Physical Health and Reduced Homelessness Risk Factors

(N=1,018)



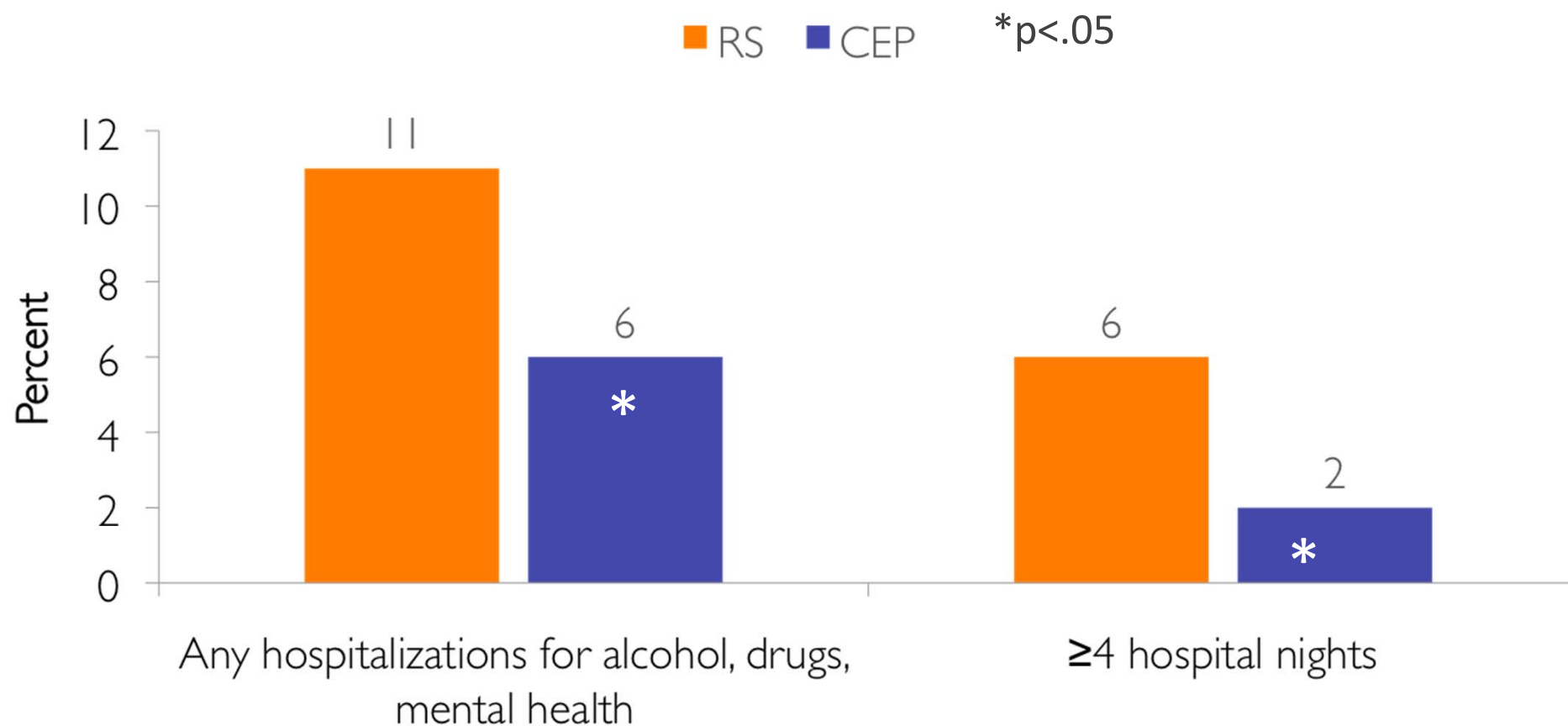
Yes to all health limits

- Moderate activity
- Stairs
- Physical activity

Risk Factors:

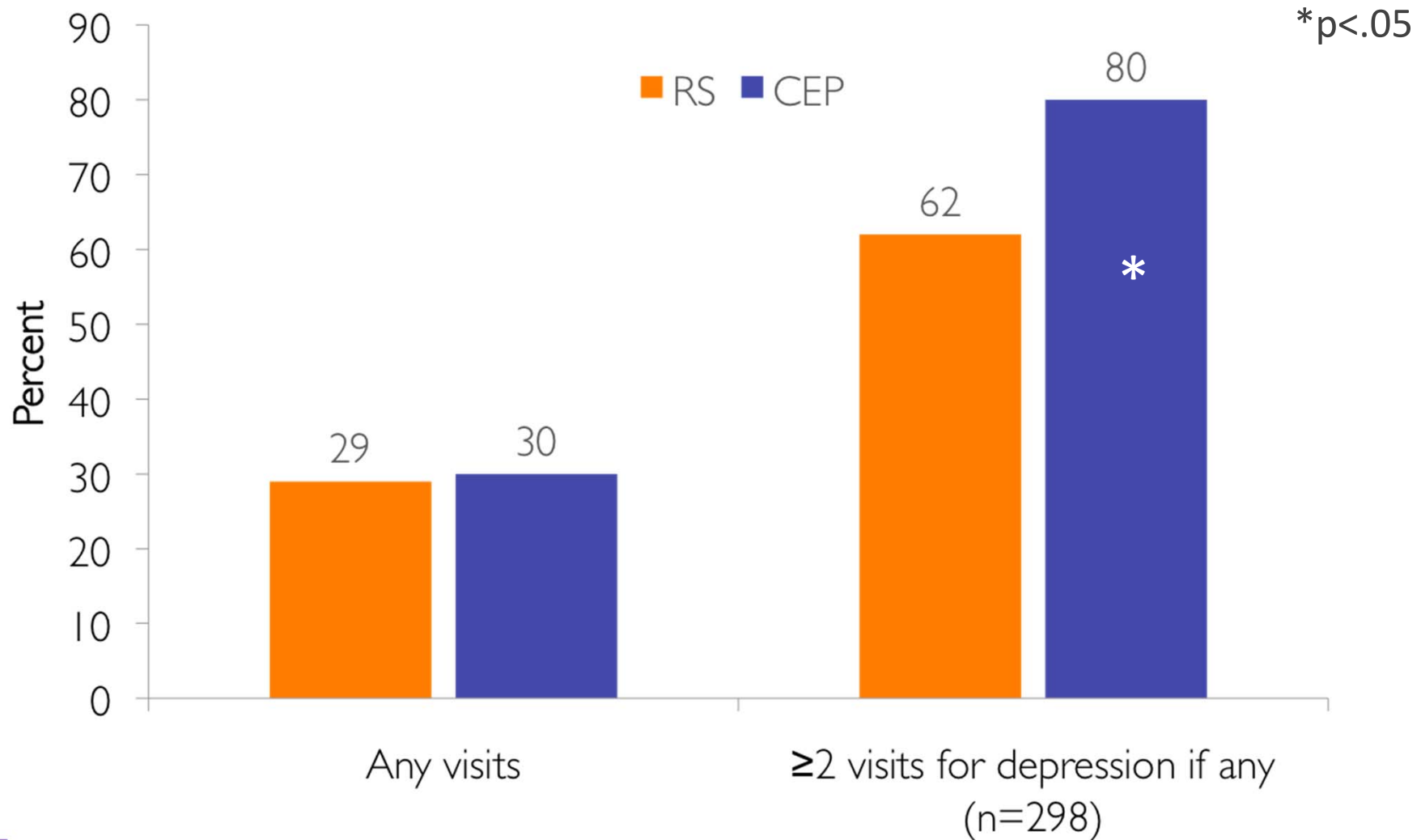
- food insecurity
- eviction
- severe financial crisis

CEP Reduced ADM Hospitalizations (N=1,018)



CEP Increased Primary Care and Public Health Visits for Depression

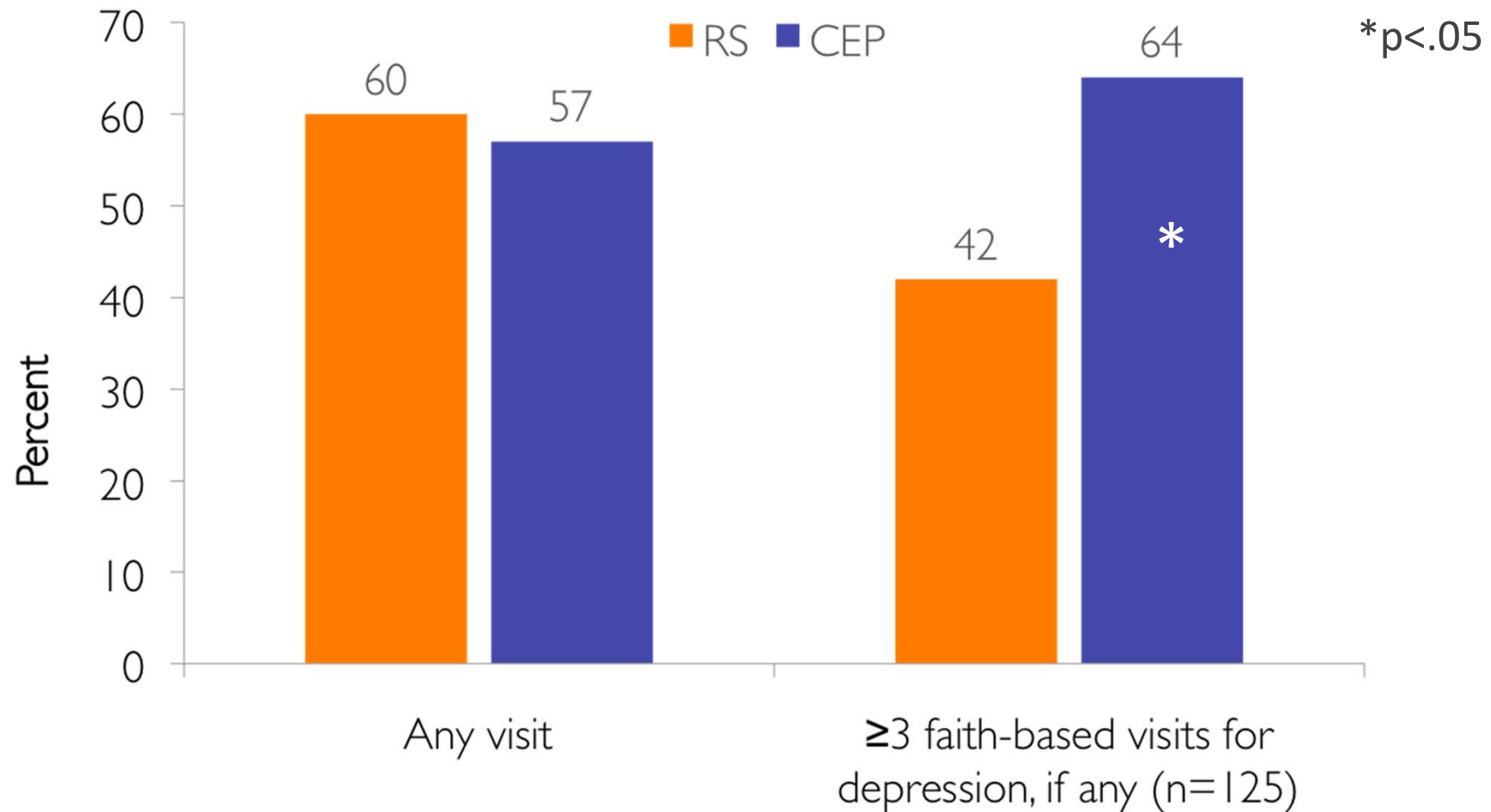
(N=1,018)



CEP Increased

Faith-Based Visits for Depression

(N=1,018)



How? Some Ideas



- Case management/counseling delivered in community-trusted locations
- Social service programs learned to engage depressed clients in usual social services (addressing social determinants)
- Networks bridged gaps in services
 - *Potential model for neighborhood behavioral health homes in under-resourced communities*

Using Community Engagement to Address Disparities

- Train a broader network of providers that are ethnically diverse and trusted in the community
- Exposure diverse populations to key components of collaborative care in familiar settings
- Improve client quality of life and social determinants of mental health

Implications for Affordable Care Act Implementation

- Collaborative care programs for behavioral disorders improve quality and outcomes of care for diverse populations
- Many services for depressed people are outside of healthcare settings already
- By partnering around a common model, health and social disparities may be jointly addressed
- Co-leadership by healthcare and community providers to deliver evidence-based care is key
- Requires a model of community engagement to engender trust while expanding capacity for services

Thank you to Partners & Funders!



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Robert Wood Johnson Foundation; California Community Foundation;
UCLA Clinical and Translational Science Institute

Thank you for joining our call today!

For more information about the California Improvement Network, go to
www.chcf.org/cin

Today's webinar slides and recording will be available at that site within a week.