

Involving community group in depression care improves coping among low-income patients, study finds

June 25 2013

Improving care for depression in low-income communities—places where such help is frequently unavailable or hard to find—provides greater benefits to those in need when community groups such as churches and even barber shops help lead the planning process, according to a new study.

When compared to efforts that provided only technical support to improve depression care, a planning effort co-led by [community members](#) from diverse services programs further improved clients' mental health, increased [physical activity](#), lowered their risk of becoming homeless and decreased hospitalizations for behavioral problems.

The study was conducted in two large under-resourced areas of Los Angeles and the findings are reported in papers published online by the *Journal of General Internal Medicine*. The study team included researchers from the RAND Corporation and UCLA, and [community partners](#) from Healthy African American Families, QueensCare Health and Faith Partnership, and Behavioral Health Services.

"People who received help as a part of the community-led effort to improve depression care were able to do a better job navigating through the daily challenges of life," said [psychiatrist](#) Kenneth Wells, the project's lead RAND investigator. "People became more stable in their

lives and were at lower risk of facing a personal crisis, such as experiencing poor quality of life or becoming homeless."

Researchers say the findings demonstrate that incorporating an array of community groups in planning efforts to treat depression, and then providing trainings to address depression jointly across health care and community agencies, can provide a more-complete support system and help depressed people make broader improvements in health and social outcomes.

Depression is one of the world's leading causes of impairment and affects 15 percent to 20 percent of people from all cultural groups at some point in their lives. Wells said one participant in the study characterized depression as a "silent monster" in the low-income neighborhoods studied. Evidence-based treatments for depression, such as antidepressants or therapy, often are not available in these neighborhoods because of poor access to services and other obstacles such as stigma or cost.

The study team, including researchers and community leaders, worked together for a decade to determine how to address depression in communities with few resources. The latest project compared two models.

One approach involved providing technical support and culturally-sensitive outreach to individual programs, including health, mental health, substance abuse and an array of other community programs. The second was a community engagement approach. In this effort, programs across the same broad array of health, mental health, substance abuse and other community programs worked together with shared authority to make decisions and collaborate as a network in providing depression services.

The study took place in South Los Angeles and Hollywood-Metropolitan Los Angeles, and involved nearly 100 programs across the range of primary care, mental health, substance abuse and social services providers. Participating programs included those who provide homeless services, prisoner re-entry help, family preservation programs, and faith-based and other community-based programs like senior centers, barber shops and exercise clubs. All programs were randomly assigned to one of the two approaches (technical assistance or community engagement), but only in the community engagement approach did agencies work together to decide how best to provide training for providers and collaborate to deliver depression services.

"Community members helped us think about where in their neighborhoods people with depression go for help and to think about how support could be provided for depression in all those places," Wells said.

"We worked together as a community to create a system that would provide clear and consistent messages for anyone with depression, regardless of gender, ethnicity, medical conditions, age or income level," said Loretta Jones, one of the project's lead community investigators and CEO of Healthy African American Families.

Agencies in the community engagement approach created programs to aid depressed persons by combining the study resources with their own expertise. One substance abuse program operates a reading club based on the book, "Beating Depression: The Journey to Hope," which is based on a prior RAND study. A group of churches developed classes that teach people resiliency skills to better cope with life's challenges. And two park and senior centers linked outreach and social services to exercise classes to encourage depressed elderly people to increase their physical activity.

People enrolled in the study were primarily African American and Latino, most had earnings below the federal poverty level, and nearly half were both uninsured and at high risk for becoming homeless. The majority also had multiple chronic medical conditions, while many had multiple psychiatric conditions and substance abuse problems.

Once the two improvement efforts were in place, survey staff hired from the community screened about 4,400 clients from participating agencies, following about 1,200 who showed signs of depression. Symptoms and functioning were assessed at the beginning of the project and six months after the project began. The work was done during 2010 and 2011.

The study team found that the chance of having depression at six months was similar for the two groups, as well as the chance of having antidepressant medication or formal health care counseling for depression. But those participants involved in the community-partnered planning had better mental health-related quality of life and reported being more physically active.

In addition, clients from programs in the community-planning group had a lower risk of either being currently homeless or having multiple risk factors for future homelessness, including having prior homeless nights, food insecurity, eviction or a financial crisis. They also had a lower rate of hospitalization for behavioral problems and shifted their outpatient services from specialty medication visits toward primary care, faith-based and park-based depression services.

"The pattern of findings suggests that the community engagement approach increased support for depressed clients in nontraditional settings, with gains in quality of life and social outcomes like homelessness risk factors," Wells said. "This is in contrast to traditional depression improvement programs affecting use of [depression](#) treatments and symptoms."

Researchers also noted that there are few studies showing that community engagement and planning can improve health more than traditional training approaches. This is one of the largest and most rigorous studies of that issue in the field of mental health.

Provided by RAND Corporation

Citation: Involving community group in depression care improves coping among low-income patients, study finds (2013, June 25) retrieved 3 May 2024 from <https://medicalxpress.com/news/2013-06-involving-group-depression-coping-low-income.html>

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