

**Eliminating Disparities in
Depression Care for
Racial/Ethnic
Communities:
An APA-NAMI
Collaborative**

CME Curriculum Goals

- Equip primary care physicians with the appropriate knowledge and tools to identify and provide appropriate treatment of depression in minority populations.
- Create awareness of cultural influences and how depression manifests within a cultural context.
- Model successful communication and partnership between providers and consumers of different cultures.
- Promote desire for continued education in this area.

Depression

- Highly common condition
- Leading cause of disability
- Underrecognition and undertreatment
- Racial and ethnic disparities in diagnosis

Depression in Communities of Color

- Racial and ethnic disparities in diagnosis and treatment
- Stigma
- Poor quality care common
- Multiple reasons for disparities
 - Cultural differences
 - Lack of access
 - Bias
 - Lack of knowledge
 - Poor communication skills among clinicians

Depression Treatment in Primary Care

- 2nd most common illness in primary care.
- Depression often missed or misdiagnosed
- Routine screening important especially for minority consumers
- Use emerging and accepted best practice standards in a culturally appropriate way.

Characteristics of the Curriculum

- 4 hours long
- Topics:
 - Depression diagnosis and treatment
 - Disparities
 - Physician-consumer communication
- Presented by a team of 3 trained facilitators (1 doctor and 2 consumers/family members).
- Innovative collaborative format models effective provider-consumer interaction

Doctors and Consumers as Co-facilitators

- Treatment must be consumer centered. In the words of the New Freedom Commission:

“In the ideal mental health system, consumers, along with service providers, will actively participate in designing and developing the systems of care in which they are involved. An individualized plan of care will give consumers, families of children with serious emotional disturbances, clinicians, and other providers a valid opportunity to construct and maintain meaningful, productive, and healing relationships.”

Doctors and Consumers as Co-facilitators

- Medical and scientific evidence
- Lived-experience of people with depression and their families
- Innovative model: providers interact with other providers and appreciate the consumer/family perspective.
- Power of consumers' stories of with depression motivates changed behavior

Highlights from Consumers' Focus Group

- Important that the doctor listens and shows interest in them as a person.
- Make the consumer feel comfortable in treatment.
- Comfortable environment and a relaxed setting.
- Showing respect is not talking down to them, not taking phone calls, and not going in and out of the room, the M.D. should focus on them.
- Barriers: stigma and fear, lack of insurance, lack of information, not knowing where to go for help, language, difficulty discussing personal issues such as depression is sometimes embarrassing, bad communication.

Highlights from Doctors' Focus Group

- Disconnect between a clinician and a patient, 20 minute visit with 60% of the time spent documenting so you literally have 8 minutes with the patient.
- Address doctors' stigma and his entire team. This will help with comfort level and trust.
- Patients spend about 90 minutes in a room waiting and talking to different members of the team, so the whole team has to embrace the issue of depression.
- Lack of tools for diagnosis (diabetes has simple tools) MH tools are longer - not OK according to culture?
- Training issues: are we as qualified as psychiatrists?
- We are not giving patients the message that we are interested in treating them. Could it make a difference if a doctor's office had pamphlets about depression?

Joint Focus Group:

Issues to consider during treatment

- Different beliefs, values, and terms for depression in consumers of different culture, race or ethnicity.
- Immigration stressors: language, family, new system, etc.
- M.D.s need to explain the medication (because of fear) and why it is important prior to treatment.
- Family and friends are important to depression knowledge before diagnosis and for encouragement to seek help.
- Successful M.D. communication: take time, show interest, professionalism, honesty, and respect.

Highlights from Draft Curriculum

Stigma

- Self-stigma may cause additional feelings of isolation, hopelessness, rejection, and shame.
 - “I’m not crazy”
 - Fear that seeking help connotes weakness
 - Prevents seeking help and staying in treatment
- Family stigma damages the consumer’s self-esteem and family relationships (Wahl & Harman, 1989)
 - May negatively affect treatment
- Lack of understanding and support from others.
 - “I tried to talk to my friends. They discouraged me from seeking treatment, dismissed my illness, ‘what do you have to be depressed about?’”

Stigma among Providers

- “I think a lot of primary care physicians are not that comfortable themselves saying to patients why are you taking Zoloft because they don’t want to embarrass the patient and bring up a situation that might lengthen the visit in which they are already behind. So we don’t ask patients and I think we’ve just got to get over that, if you see the person is on insulin will you ask him about diabetes...well a lot of times we skip over the psychiatric medicines and then we’re giving a strong message that we just don’t want to know about it.”

Quote from APA-NAMI Focus Group with Providers, 2007.

Communication Barriers

- Minorities seek/advocate for health information differently than whites and have different expectations of their physicians
- Physicians were less consumer-centered with African American than with non-Hispanic whites
 - Less consumer input is associated with less information recall, treatment adherence, satisfaction with care, return visits, and suboptimal health outcomes

Person-Centered Care

- Holistic, culturally competent, collaborative
- Congruent with the person's values, needs and preferences
- Physician skills must include:
 - Data gathering
 - Relationship building
 - Partnering skills
 - Counseling
 - Communication skills

Treatment Preferences

- If diagnosis confirmed, educate the person with depression about:
 - Depression
 - Treatment process
 - Peer supports
- During collaboration about treatment options consider
 - Cultural and Social context - Language
 - Spirituality
 - Inquire about the depressed person's view of illness
 - Determine preference for treatment options
 - Tailor information to person's level of understanding

*Samples, Appendix II: Patient Education Tools

Successful Communication

- Be sure consumers are aware that antidepressants don't work like antibiotics and that it might take time to get beneficial effects
- Explain the probability of relapse
- Explain depression carefully to minimize stigma
- Physician openness – comfort with broaching the issue with the consumer

Major Project Phases

- Convene focus groups
- Write the curriculum
- Train “trainers” to present the curriculum
- Pilot test the curriculum
- Evaluate project methods, outcomes, results

Lessons Learned Thus Far

1. Focus groups are vulnerable to random events like bad weather.
2. Would we have gotten a broader perspective if we had held more focus groups with differentiated groups of patients?

Lessons Learned cont'd.

3. What could we have done to make focus group members feel comfortable enough to intermingle with people who are different from them? Is group cohesion necessary in this situation?

Lessons *to be* Learned ???

- What if there is dissension among the scientific advisors about program content?
- Did we select the best trainers?
- What challenges await us with regard to piloting the curriculum?
- Your insights welcome!