RAND CORPORATION
OBJECTIVE ANALYSIS.
EFFECTIVE SOLUTIONS.

Incorporating Community Groups Into Depression Care Can Improve Coping Among Low-Income Patients

FOR RELEASE
Tuesday
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.

Media Resources

RAND Office of Media Relations

(703) 414-4795
(310) 451-6913
media@rand.org

Researcher Spotlight

Kenneth B. Wells
Senior Scientist

Kenneth B. Wells, MD, MPH is Professor-in-Residence of Psychiatry and Biobehavioral Sciences at UCLA Neuropsychiatric Institute & Hospital and Senior Scientist at RAND. He is a psychiatrist and health services researcher. Dr. Wells is the

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.

Principal Investigator of the NIMH-funded UCLA/RAND...

Explore Our People »

Featured Reports

Community-partnered Cluster-Randomized Comparative Effectiveness Trial of Community Engagement and Planning or Resources for Services to Address Depression Disparities — 2013

Community-partnered Evaluation of Depression Services for Clients of Community-Based Agencies in Under-Resourced Communities in Los Angeles — 2013

Explore

All News Releases

By Date

Related Topics

Community Health

Community-based Health Care

Depression

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.

Health Care Quality
Health Disparities
Los Angeles

Research Conducted By
RAND Health

Explore All Topics »

"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 homelessness 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.

Support for the study was provided by the National Institute of Mental Health, the Robert Wood Johnson Foundation and the California Community Foundation. The project was led by Wells at RAND with UCLA psychologist Jeanne Miranda, and three lead community

investigators, including Jones for South Los Angeles, Elizabeth Dixon for Hollywood-Metropolitan Los Angeles, and James Gilmore across areas.

The study team included researchers from RAND, the Semel Institute for Neuroscience and Human Behavior at UCLA, the Geffen School of Medicine at UCLA, the Fielding School of Public Health at UCLA, the Greater Los Angeles Veterans Affairs Health System, Healthy African American Families, QueensCare Health and Faith Partnership, Behavioral Health Services, and more than two dozen community-based agencies on the project's steering council.

RAND Health is the nation's largest independent health policy research program, with a broad research portfolio that focuses on health care costs, quality and public health preparedness, among other topics.

About the RAND Corporation

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous.

RELATED RESOURCES

JOURNAL ARTICLE

Community-partnered Cluster-Randomized Comparative Effectiveness Trial of Community Engagement and Planning or Resources for Services to Address Depression Disparities

Jan 1, 2013 | Kenneth B. Wells, Loretta Jones, et al.

Journal Article

JOURNAL ARTICLE

Community-partnered Evaluation of Depression Services for Clients of Community-Based Agencies in Under-Resourced Communities in Los Angeles

Jan 1, 2013

ABOUT

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

1776 Main Street
Santa Monica, California 90401-3208