Best Practices in Depression: Closing the Gaps in Diagnosis and Treatment

Content based in part on a satellite symposium presented Wednesday, August 9, 2006, at the National Medical Association 2006 Annual Convention and Scientific Assembly.

NMA FAX BLAST NEWSLETTER #3

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Program Overview

People of color experience disparities in the diagnosis and treatment of depression compared with other Americans. Depression is frequently concomitant with and complicates the course of many chronic diseases that are highly prevalent in people of African, Asian, Hispanic, and Native American descent. Even when members of these ethnic groups receive care for depression, it is often of poor quality. Issues related to cultural beliefs and limited access to care, as well as bias, lack of cultural competence, and poor communication skills among clinicians are some of the issues that contribute to disparities in depression care. Interventions and techniques that enhance cultural competency among primary care physicians will enhance quality of depression care and decrease disparities in its diagnosis and treatment.

Target Audience

This activity has been designed to meet the educational needs of primary care physicians who treat adults with depression.

Estimated Time to Completion

This activity should take approximately one-half hour to complete.

Educational Objective

Upon completion of this activity, participants should be better able to apply strategies for closing the gaps in the treatment of depression in minority patients.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the

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Decreasing Disparities in the Treatment of Depression is a series of 3 newsletters, based on a symposium at the National Medical Association 2006 Annual Convention and Scientific Assembly, that seeks to educate physicians about disparities in the diagnosis and treatment of depression in ethnic and minority populations. Major depression is prominent in racial and ethnic minorities and is frequently misdiagnosed or untreated in these populations. Moreover, the significant morbidity and mortality associated with depression exacerbate comorbid illnesses that commonly occur in minority patients. Compounding this issue are the multiple factors experienced by racial and ethnic minorities—socioeconomic factors, cultural issues, poor access to care, and biases among patients and health care providers—that contribute to disparities in care for these patients. The primary care setting is often the initial point of contact for many patients who suffer from depression. Primary care physicians thus require an awareness of screening tools as reliable markers for detecting depression, an understanding of the emerging and accepted best practice standards for treating depression, and the acumen for cultural competence and how depression may manifest within a specific racial or cultural context.

Each of the 3 newsletters contains a short learning module followed by a post-test. The first issue in this series discussed best practices in diagnosing and treating depression. The second issue focused on enhancing cultural competence skills, and this one will discuss closing the gaps in the diagnosis and treatment of depression in minorities.

Introduction

Although depression affects all populations, striking disparities exist in mental health care for African Americans, Asian Americans and Pacific Islanders, Hispanics, and Native Americans, compared with other Americans. These disparities impose a tremendous disability burden on affected population groups, which together constitute an emerging majority. Unfortunately, more is known about the existence of disparities in mental health services for minorities than the reasons behind those disparities. According to a 2001 Report of the Surgeon General, which addressed issues of culture, race, and ethnicity in mental health, people of color in the US are much less likely than whites to receive mental health services.1 When minority groups do receive mental health care, it is often of poorer quality, and minorities are generally underrepresented in mental health research. Overcoming ethnic and racial disparities in depression diagnosis and treatment requires heightened awareness of the barriers to care, utilization patterns, and mediators that include clinical cultural proficiency and effective communication.

The Extent of Racial and Ethnic Disparities in Health Care

In an effort to assess the extent of racial and ethnic disparities in health care, the Institute of Medicine (IOM) reviewed more than 100 studies that evaluated the quality of health care for various racial and ethnic minority groups.[2] The IOM report revealed that:

- Minorities are less likely than whites to receive the same quality of health care, even when they have similar insurance or ability to pay for care
- Disparities in care exist in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness

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co-sponsorship of Vanderbilt University School of Medicine and the University of Alabama School of Medicine and the joint sponsorship of Vanderbilt School of Medicine and Indicia Medical Education, LLC. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation

Vanderbilt School of Medicine designates this educational activity for a maximum of 0.5 *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclosures

As an accredited provider of CME, Vanderbilt University School of Medicine follows ACCME requirements regarding industry support of CME and provides the following information:

Commercial Support

Vanderbilt University School of Medicine, the University of Alabama School of Medicine, and Indicia Medical Education, LLC, express appreciation to Wyeth Pharmaceuticals for generous support of this activity through an unrestricted educational grant.

Conflicts of Interest—Speaker

Annelle B. Primm, MD, MPH, disclosed that she has consultant relationships with Eli Lilly, Pfizer, and AstraZeneca. Vanderbilt CME has determined that there are no conflicts of interest between these financial relationships and the content of Dr. Primm's presentation.

Conflicts of Interest—Planning Committee

Donald E. Moore, Jr., PhD, Vanderbilt University, disclosed that he serves on the External Education Advisory Board for Wyeth Pharmaceuticals and has received a grant from Wyeth Pharmaceuticals. Vanderbilt CME has determined that there are no conflicts of interest between this financial relationship and the content of this symposium.

Robert E. Kristofco, MSW, University of Alabama School of Medicine, disclosed that he has no financial relationships related to the content of this symposium.

Karen M. Overstreet, EdD, RPh, Indicia Medical Education, LLC, disclosed that she has no financial relationships related to the content of this symposium.

Disclosure of Unlabeled Use

Dr. Primm does not reference an unapproved, unlabeled, or investigational use of a therapeutic agent or biomedical device in this presentation.

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The IOM report[2] also revealed that disparities in the delivery of health care have multiple causes and sources, including:

- The way health care systems are organized and how they function—Practices and policies adopted by health care systems, hospitals, or clinics to reduce health care costs may be well-intentioned but may impede minority patients' ability to access care.
- Patients' attitudes and behaviors—Some minority patients do not trust health care professionals and may postpone seeking professional help until their illness is very advanced, and others may not accept their physician's recommendations.
- Health care providers' biases, prejudices, and uncertainty when treating minorities—providers' attitudes and beliefs, even those they are not consciously aware of—may influence the quality of patient care.

People of Color and the Impact of Health and Mental Health Disparities

The social stigma and shame experienced by individuals who suffer from mental illness significantly affect whether they even seek treatment. This is particularly true among racial and ethnic populations, who often rely on alternative sources of help, such as their faith, family, and folk remedies. Limited mental health services in the native languages of ethnic minorities are another deterrent for persons seeking help for their depression. Many people of color do not have access to a physician for regular care, and consequently, they seek out mental health services only in times of crisis, which often portends a poorer prognosis.

People of color experience disproportionately high rates of chronic diseases, such as heart disease and stroke, diabetes, arthritis, HIV/AIDS, and cancer, all of which commonly co-occur with depression. Depression that is undiagnosed, untreated, or poorly treated can compromise medical outcomes. These factors, combined with the common socioeconomic contextual factors people of color experience, may result in poor health outcomes and possibly premature death.[1]

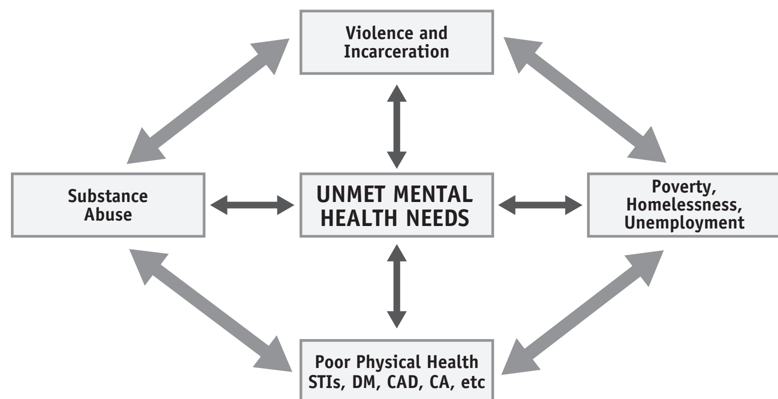
The Cultural Divide

The high likelihood of ethnic and cultural differences between health care providers and their patients presumably contributes to disparities prevalent in depression care. Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care. The disproportionately low number of health and mental health professionals of color may also exacerbate this cultural divide. Factors that contribute to the vicious circle of unmet health care needs of racial and ethnic minorities are shown in **Figure 1.**

Variations in Depression-related Complaints

Depression-related complaints vary according to ethnic or minority segment. People of color are less likely to voice symptoms of depression that clinicians recognize, such as low energy level, inability to sleep, appetite disturbance, and

Figure 1. Unmet Health Needs and the Vicious Circle Fueled by Racism.



DM=diabetes mellitus; CA=cancer; CAD=coronary artery disease; STIs=sexually transmitted infections

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Method of Participation

This is a CME Enduring Material. It consists of a newsletter and a CME post-test. There are no fees for participating and receiving credit for this activity. To receive your CME credit in the period from December, 2006 through December 15, 2007, you must 1) read the newsletter, including the learning objectives and disclosure information, 2) go to https://www.cme.vanderbilt.edu/online/onlinequiz/user/user_exam_view.php?COURSE_EX=PS2006A3601, 3) follow the instructions to log in, and 4) complete the CME post-test. If you answer 80% of the questions correctly, you will be prompted to print your certificate.

Release date: December 2006
Expiration date: December 15, 2007

lack of interest in daily activities. Examples of culture-specific complaints of depression are noted in **Table 1.** Clinicians who treat ethnic and minority patients should be alert to such variations in depression-related complaints.

Table 1. Depression-related Complaints Specific to Culture

Culture	Complaints
Latino	"Nerves" and headaches
Asian	Weakness, tiredness, "imbalance"
Native American	"Heartbroken"
African American	Bad nerves, "evil"

Cultural Competency Techniques

Although the need for cultural competency is often presented on the level of patient-provider interaction, most health care is delivered by clinicians who are part of groups or systems. Hence, these clinicians will become culturally competent only with the support and encouragement of the health systems they practice in.[3] Cultural competency techniques include:

- Interpreter services
- Education and training
- Community health workers
- Health promotion
- Organizational supports

The reader is referred to the second newsletter in this series, *Decreasing Disparities in the Treatment of Depression: Enhancing Cultural Competency*, for a detailed discussion of cultural competency.

What Can You Do to Eliminate Disparities?

There are a number of things that the individual clinician can do to diminish and eliminate disparities in mental health care for ethnic and minority patients **(Table 2)**. Above all, trust is key in establishing an effective patient—health professional relationship.

Table 2. Clinician Interventions to Eliminate Disparities in Mental Health Care

- Know your community
  - — Demographics
  - — Socio-environmental conditions
  - — Epidemiologic vulnerabilities
- Know yourself (challenge your biases)
- Listen to your patients and make a concerted effort to understand cultural context and belief system
- Be observant and question differences in health care quality by race and ethnicity
- Collect data by race and ethnicity
- Educate your patients about what their illness is, what to do to manage it, and why it is important (health literacy)
- Practice the "platinum rule"—treat patients the way they want to be treated
- Show your patients that you care
- Encourage patients to ask questions, bring an advocate, and be an active participant

Culturally and Linguistically Appropriate Services Standards

The need for health care providers and organizations to understand and respond effectively to the cultural and linguistic needs of their patients has resulted in the development of national standards for culturally and linguistically appropriate services (CLAS) in health care.[4] The CLAS standards, developed by the Department of Health and Human Services' Office of Minority Health, are a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the needs of all patients/consumers. There are 14 CLAS standards, which are categorized as mandates, guidelines, and recommendations. CLAS mandates are required for recipients of all federal funds; guidelines are recommended by OMH for adoption by federal, state, and national accrediting agencies; and recommendations are suggested for voluntary adoption by health care organizations. A more detailed description of the CLAS standards may be found on the following website: http://www.omhrc.gov/assets/pdf/checked/executive.pdf.

Conclusions

Vast disparities exist in mental health care for ethnic and minority populations compared with other Americans. These disparities are evidenced by differences in overall quality of care and underrepresentation of minorities in mental health research. Multiple causes are thought to underlie disparities in the delivery of care, among them organizational function of health care systems, patients' attitudes and beliefs, and providers' attitudes and beliefs. The ethnic and cultural differences that exist between physicians and their patients further contribute to treatment disparities. Strategies that enhance cultural competency among physicians who treat depression are key elements in closing the gaps in depression care. For individual physicians, acquiring knowledge about the culture and beliefs of the populations they serve and obtaining skills for working with diverse populations are fundamental to the process of developing cultural competence. Achieving and maintaining cultural competence must begin on an individual level and extend more broadly throughout health care organizations.

References

1. US Dept of Health and Human Services. Mental Health: Culture, Race and Ethnicity—A supplement to Mental Health: A Report of the Surgeon General. 2001. Available at: http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-36313.pdf. Accessed September 27, 2006.
2. Unequal treatment: what healthcare providers need to know about racial and ethnic disparities in healthcare. Institute of Medicine, 2002. Available at: http://www.iom.edu/CMS/3740/4475/4175.aspx. Accessed September 29, 2006.
3. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Res Rev.* 2000;57(Suppl 1):181-217.
4. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Executive Summary. U.S. Department of Health and Human Services. Office of Minority Health. March, 2001. Available at: http://www.omhrc.gov/assets/pdf/checked/executive.pdf. Accessed September 29, 2006.

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Additional Recommended Resources

1. Kirmayer LJ, Dao THT, Smith A. Somatization and psychologization: Understanding cultural idioms of distress. In: Okpaku SO (ed). *Clinical Methods in Transcultural Psychiatry*. Washington, DC: American Psychiatric Press; 1998:233-265.
2. Levy R, Hawks J. *Cultural Diversity and Pharmaceutical Care*. Reston, VA: National Pharmaceutical Council.
3. Ton H, Lim RF. The Assessment of Culturally Diverse Individuals. In: Lim RF (ed). *Clinical Manual of Cultural Psychiatry*. Arlington, VA: American Psychiatric Publishing. 2006:3-31.

Erratum

The correct URL to access the posttest and receive credit for completing the second educational activity in this series, "Decreasing Disparities in the Treatment of Depression: Enhancing Cultural Competency," is:

https://www.cme.vanderbilt.edu/online/onlinequiz/user/user_exam_view.php?COURSE_EX=PS2006A3521

We apologize for this error and any inconvenience it may have caused.

New Resource on *Disparities in Depression*

We are pleased to announce the release of *Insights on Decreasing Disparities in Depression,* an electronic compendium of information and resources on depression detection and treatment in ethnic and racial minority populations.

An extension of the mission of Initiative for Decreasing Disparities in Depression (I3D), this Webzine was developed to assist physicians with adopting professional practices that could reduce and eventually eliminate disparities in the diagnosis and provision of care for patients with depression. Each edition of *Insights* will include a series of educational cases that physicians can complete for CME credit, as well as links to key references, educational resources, assessment tools, and news related to depression and issues that impact minority populations.

To access this CME activity or to learn more about I3D, please visit **www.i-3d.org**.

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