

Community Engagement and Planning to Address Depression: An Approach to Health Equity

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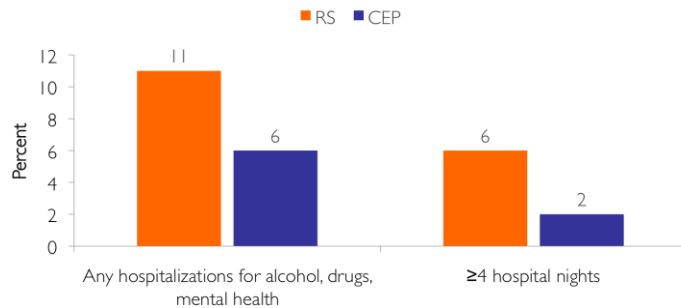
The World Health Organization identified depression as the leading cause of disability. Evidence-based treatments exist including medication and psychotherapy, but there are inequities in access, quality and outcomes of care for depression. Collaborative care for depression in primary care is effective in improving quality and outcomes including for ethnic/racial minority groups; but such programs are not available in under-resourced communities that may have distrust in health services and use alternative community-based programs for support. Health policies promote integration of healthcare and community services for health equity, but it has not been clear how to do so for behavioral health. Community Partners in Care was designed to address this issue in Los Angeles through a randomized demonstration of Community Engagement and Planning (CEP) for coalition support versus Resources for Services (RS) for technical assistance to implement collaborative care for depression in healthcare and community programs such as social services and faith-based settings.

Community Engagement and Planning is a model to bring together agency leaders and community members from diverse sectors into a collaborative—mental health, primary care, public health, substance abuse, homeless-serving, social services, and “trusted locations” like faith-based programs, community centers, hair salons and exercise clubs. Coalitions review goals, existing toolkits for collaborative care and plan trainings to fit the community. Resources for Services is a more traditional model of implementing collaborative care toolkits through a series of webinars by experts and site visits to primary care. In *Community Partners in Care (CPIC)*, 95 healthcare and community-based programs were randomized to CEP or RS for depression collaborative care, and over 1000 clients with depression were followed for 6, 12 and 36 months to compare outcomes. Clients were primarily African American or Latino, half uninsured, and most with chronic medical conditions.

Key Findings of CEP compared to RS:

- ◆ Improved mental health-related quality of life
- ◆ Increased physical activity and physical health-related quality of life
- ◆ Decreased risk of homelessness or having multiple risk factors for future homelessness (food insecurity, eviction or major financial crisis)
- ◆ Decreased rate of hospitalization for a behavioral health condition and reduced behavioral health hospitalization nights
- ◆ Shifted outpatient services from specialty medication visits toward primary care, faith-based, and park depression services

CEP vs. RS Reduced Behavioral Health Hospitalizations at 6 month follow-up (N=1,018)



Implications for Policy

Multi-sector coalitions supporting evidence-based collaborative care for depression offers a promising approach to enhance behavioral health equity. Relative to traditional program technical assistance, these collaborative care programs offer stronger short-term and long-term benefits. This coalition approach and underlying community engagement model have stimulated policy interest and dissemination requests in Los Angeles, Louisiana and New York. While further research is needed on improving and disseminating the model, CPIC offers an approach for inclusion in initiatives such as Accountable Communities and Whole Person Care.

1. Wells KB, et al. Community-Partnered Cluster- Randomized Comparative Effectiveness Trial of Community Engagement and Planning or Resources for Services to Address Depression Disparities. *J Gen Intern Med.* 2013; 28(10): 1268-1278.
2. Chung B, et al. 12-Month Outcomes of Community Engagement Versus Technical Assistance to Implement Depression Collaborative Care: A Partnered, Cluster, Randomized, Comparative-Effectiveness Trial. *Annals of Internal Medicine.* 2014; 161(10_Suppl) S23-S34.