Cover Story

Culture Cure

Social work research improves depression care that's sensitive to racial and ethnic differences.

By William Vaughn
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Mary rested in her bed. She quietly looked around her home of the last two months—a basement ward for African-Americans at Barnes Hospital in St. Louis. The year was 1962.

She was dying from leukemia, a cancer of the blood. The doctors and nurses who took care of her tried to make her comfortable, but there wasn’t much they could do. Her bones hurt her a lot. It was a strange kind of pain, and it made Mary feel pretty low some days.

Her sister came to visit her when she could. Mary also had another regular visitor, a young white woman named Kathy Ell. Ell was a social worker and recent college graduate. Mary was her first client. They got to know each other well. Ell comforted Mary until she lost her battle with leukemia.

How to help a depressed person
Friends and family can be helpful partners during the process of getting better.

“Working in a ward like that,” recalls Ell, who now has a Doctor of Social Work degree. “I became so aware of the disparities in society.”

Today, Ell is a professor in the School of Social Work at the University of Southern California. She leads groundbreaking clinical studies on depression care for low-income racial and ethnic minorities.

The work examines how different cultural beliefs influence the way people deal with depression, and how and when they seek help. Researchers use these insights to make it easier for people of different races and ethnicities to get the care they need.

The studies also look at ways depression might affect other medical conditions such as cancer, diabetes and heart disease. Using social workers to deliver depression care is a cost-savings measure that relies on physician supervision and collaboration.
Ell’s research is at the forefront of addressing a massive gap in the delivery of mental health care to minorities. The goal is not only to improve patients’ health, but also to provide quality care with limited dollars.

**Focused attention**

Brought into focus by the first ever Surgeon General’s report on mental health in 1999, major depressive disorder, or depression, is a medical condition affecting approximately 14.8 million American adults every year, about 6.7 percent of the U.S. population. And for young to middle-aged adults, it’s the leading cause of disability. While the disorder has become better known to the public, it’s not what most people think of as “depression.”

“Everybody gets sad or down—that’s part of life,” explains Ell. “Major depression lasts longer and is much more debilitating. You’re so down that you stop talking to family and loved ones, you can’t get out of bed, you can’t go to work. And sometimes you stop taking care of other health problems. But it’s a medical disorder and we can treat it.”

According to recent studies, major depression is also a factor in rising health care costs.

“We know from epidemiologic data that patients who suffer from both chronic illness and major depression are heavier users of the health care system,” Ell says.

Racial and ethnic minorities are particularly vulnerable. Reports from the Surgeon General and other national health authorities reveal that while mental illness occurs at about the same level in all races, minorities suffer more because they have less access to care and the quality of the care they receive is not as good.

Cost remains the largest barrier to depression treatment for everyone, including those with health insurance. Racial and ethnic minorities face additional barriers such as discrimination and cultural stigma about the disease. Also, reluctance to obtain treatment (particularly antidepressant medications) and differences in language and communication styles create more problems.

**Social studies**

Bridging the gap in minority depression care starts with examining risk factors.

Ironically, the standard practice of defining racial and ethnic groups (African-American, Hispanic-American, etc.) in clinical studies can hide important information. Researchers at the USC School of Social Work are finding that differences within these groups often hold the key to designing depression care programs that work.

“When individuals within racial groups are viewed as being all the same, a lot of information is not being taken into account,” explains Karen Lincoln, Ph.D., M.S.W., assistant professor in the School of Social Work.

By analyzing different factors—ethnicity, gender, social habits, economic and immigration status—Lincoln works outside standard racial groups to create “risk profiles.” Her work is focused primarily on African-Americans.

The profiles Lincoln creates tell researchers what factors put a person at risk for depression. With this detailed information, health care planners can direct care to individuals and communities that need it the most.

“An African-American male who is highly educated and has a high income does not have the same risk for depression as an African-American woman who is poor and has a lower educational level,” says Lincoln.

Another step in delivering depression care to minorities requires researchers to explore cultural perceptions about the disorder and how individuals prefer to be treated.

“We need to understand how people express and identify the problem,” says Leopoldo J. Cabassa, Ph.D., M.S.W., assistant professor in the School of Social Work. “It helps us speak the same language when we’re trying to diagnose and treat them.”

Cabassa has studied low-income Hispanics, mostly of Mexican origin, who have both diabetes and depression. His work reveals a common patient misconception—they often believe depression is caused by stress and not related to a medical condition. Most prefer therapy as a first-line treatment because they fear medications are addictive and can harm their bodies. They also want their families to be involved in their care.

“A provider who reflects an understanding of these beliefs back to a patient can create a therapeutic relationship,” Cabassa explains. “And culturally informed patient education materials that use a familiar language and common expressions can help address many of the misconceptions people might have and help engage them in care.”
Randomized clinical trials are the gold standard in medical research—they provide the foundation for treatment guidelines. Ell now heads these types of trials at USC and is testing what she’s learned from more than 40 years of depression and health care behavior research.

Her current work is focused on treating depression in low-income patients with other serious medical conditions such as cancer, heart disease and diabetes.

One of her latest studies adapts a proven team approach for treating chronic diseases to depression care for low-income minority patients with cancer. It’s the first large-scale trial of its kind.

Conducted at the Los Angeles County + USC Medical Center, the trial used social workers as the primary providers of depression care. Working together with oncologists and psychiatrists, bilingual social workers provided the mostly female Hispanic patient population with one-on-one depression screening, treatment and long-term support. “I’m trying to establish that we can provide care even in the most under-resourced health systems and with the most underserved populations,” Ell says.

During the trial, culturally influenced treatment preferences, such as trying therapy before taking medications, were respected. Also, patients’ cancer treatments were integrated into their depression care. If a patient was in the hospital, social workers would come to them. If they were at home suffering from the effects of chemotherapy and radiation, social workers would provide therapy sessions by telephone.

Patients also had access to bilingual “patient navigators” who acted as their personal advocates. The navigators helped them set up appointments and manage problems in their lives related to family, work, transportation and child care. Culturally informed patient education materials were also used.

In the intervention group, researchers were able to detect depression better—approximately 62 percent more patients got the depression treatment they needed. Importantly, patients who entered treatment experienced a significant improvement.
in their depression symptoms and overall quality of life. At 12 months, patients who had received depression care were managing depressive symptoms much better than patients who were in the control group.

Over the next year, Ell and her fellow researchers will look at how the depression care patients received in the study is affecting their fight with cancer.

Although there’s debate, medical science is listening. The Institute of Medicine recently updated its recommendations, noting that all cancer patients should receive depression screening and care.

**Real world**

Translating clinical research into everyday practice can be more difficult than it seems. Even with depression treatment programs that seem to address access and quality of care issues, the task of adapting them to the real world is a big one.

Health administrators and providers are faced with a never-ending challenge: meet the growing needs of the patients with budgets that don’t change.

“The question from policymakers becomes, ‘Does this new program reduce costs so that we come out even, or is it an additional cost that we have to take into account?’” Ell explains.

It’s a question that’s not easily answered.

To facilitate the conversation, Ell is on a team of experts that leads the USC Clinical and Translational Science Institute. The organization was formed in response to an initiative by the National Institutes of Health that aims to get new research into practice sooner. The goal is to engage policymakers, clinicians and researchers in an ongoing discussion so the economics and infrastructure of change can be worked out.

**Doing more**

Ell is busy these days. She meets with health administrators and national policymakers to help them use what she’s learned about depression care. Her research at the School of Social Work continues, as does her work on a book about depression care management.

She’s collaborating with Cabassa and other colleagues in new clinical trials, one of which examines depression treatment in low-income Hispanics with diabetes. The trial’s team-based approach to depression care is similar to Ell’s study with cancer patients. It represents a process of adapting something that works to a new medical challenge.

Having bridged the fields of social work and medicine, Ell continues her work with psychiatrists, oncologists, endocrinologists and cardiologists. She encourages her younger colleagues to do the same.

With a smile, she says, “We’re all working in the same vineyard.”