

*Training Bilingual, Bicultural
Social Workers in Culturally Competent
Evidence Based Psychotherapy:
Lessons Learned from a Randomized Based
Cognitive Behavioral Therapy*

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Background—What we know

- Depression is common among low-income Latinos in primary care.
- Latinos benefit from primary care depression interventions.
- Many barriers to psychotherapy for rural Latinos including: geographic isolation, lack of transportation, lack of bilingual and bicultural mental health providers and lack of specialty mental health.

System of Care



THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING
MENTAL HEALTH CARE
IN AMERICA

FINAL REPORT
July 2003

“Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often undeserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups.” (p. 49)

Rates of Depression

- While four studies found higher rates among US-born Mexican Americans vs. Mexican immigrants (Alegria et al., 2007, Burnam et al., 1987, Grant et al., 2004, Vega et al., 1998) another found rates of depression in immigrant Mexican American women are likely to be underestimated (Fox et al., 2001).
- Higher rates of depression are associated with older age, low social support, high stress, and higher degrees of acculturation among Latinos (Black et al., 1999; Golding et al., 2001; Harmon et al., 1996)

Care for Latinos

- Rates of major depressive disorder are also significantly higher among low-income people (Kessler, 1994; Miranda et al., 1998).
- In terms of depression, Latinos remain underserved (DHHS, 2001).
 - Latinos are less than half as likely as whites to receive a depression diagnosis or anti-depressants when visiting a medial provider (Sclar et al., 1999).

Disparities

- Among Latinos, men (Young et al., 2001), recent immigrants (Vega et al., 1999), and those with limited English proficiency (Sentell et al., 2007, Brach et al., 2005) are particularly unlikely to receive appropriate care for depressive or anxiety.
- For rural Latinos, the lack of mental health providers, language/cultural barriers, and geographic isolation are serious barriers.
- While healthcare access and quality is improving for many groups, disparities in care for Latinos are actually increasing (Quality AfHRa, 2005).

More Barriers

- Lack of a regular source of care, inflexible work schedules, lack of transportation (especially in geographically isolated rural areas), and childcare can also present significant barriers.
- Family, work, acculturative, economic, and migration-related stress, poor housing conditions, and competing life priorities may deter Latinos from seeking and remaining in care (Magana et al., 2003; Ell et al., 1998; Hovey et al., 2000; Miranda et al., 1996; Bernal et al., 1995)

Latino Care in Washington State

- In Washington State's public mental health system, Latinos are not only underrepresented (after controlling for Medicaid status) but also receive fewer service hours than other ethnic groups.
(WA State DSHS, 2005)

Provider level Barriers

- Competing demands
- Knowledge
- Lack of Spanish-speaking and culturally competent providers
- Clinician cultural beliefs and bias may also contribute to poor quality of care (Schraufnagel et al., 2006)
- Lack of time

System level Barriers

- Competing priorities
- Limited resources
- No systematic outcome monitoring or proactive follow-up
- Lack of integration between primary and mental health care
- Lack of financial incentives

Primary Care and Depression

- Up to 30% primary care patients have significant depressive symptoms
- 5-20% meet criteria for major depression
- Rates are higher in primary care settings serving low income patients
- Due to the dearth of rural mental health professionals, primary care is the preferred setting for depression interventions in rural areas (Lambert et al., 1999; Geller, 1997) and for Latino agricultural workers (Vega et al., 1985; Acierno et al., 1999).

Seeking Mental Health Care

- Among Latinos with diagnosable mental health condition:
 - Fewer than 1 in 5 contact a general health provider (<1 in 10 among recent immigrants)
 - Fewer than 1 in 11 contact a mental health specialist (<1 in 20 among recent immigrants)

Poorer quality of depression care for ethnic minority patients

- Even when primary care providers diagnose depression and recommend treatment:
 - African Americans (OR=0.30) and Latinos (OR=0.42) are less likely than whites to report taking an antidepressant
 - Latinos are less likely than whites to obtain specialty mental health services (OR=0.50) (Miranda & Cooper, 2004)
- In one primary care study, 12.8% of Latinos received appropriate depression care compared to 35.3% of whites (Miranda et al., 2003)

Preferences for Depression Care

- African Americans and Latinos particularly likely to prefer psychotherapy over medication (Dwight-Johnson et al., 2000)
- Compared to whites, African Americans and Latinos:
 - Less likely to find antidepressants acceptable
 - Less likely to believe antidepressants are effective
 - More likely to believe antidepressants are addictive (Cooper et al., 2003)

Partnership with Yakima Valley Farm Workers Clinic

- Historical barriers
- Identification of depression by YVFWC as a prominent unaddressed area within its network of 17 clinical sites
- Collaborative efforts

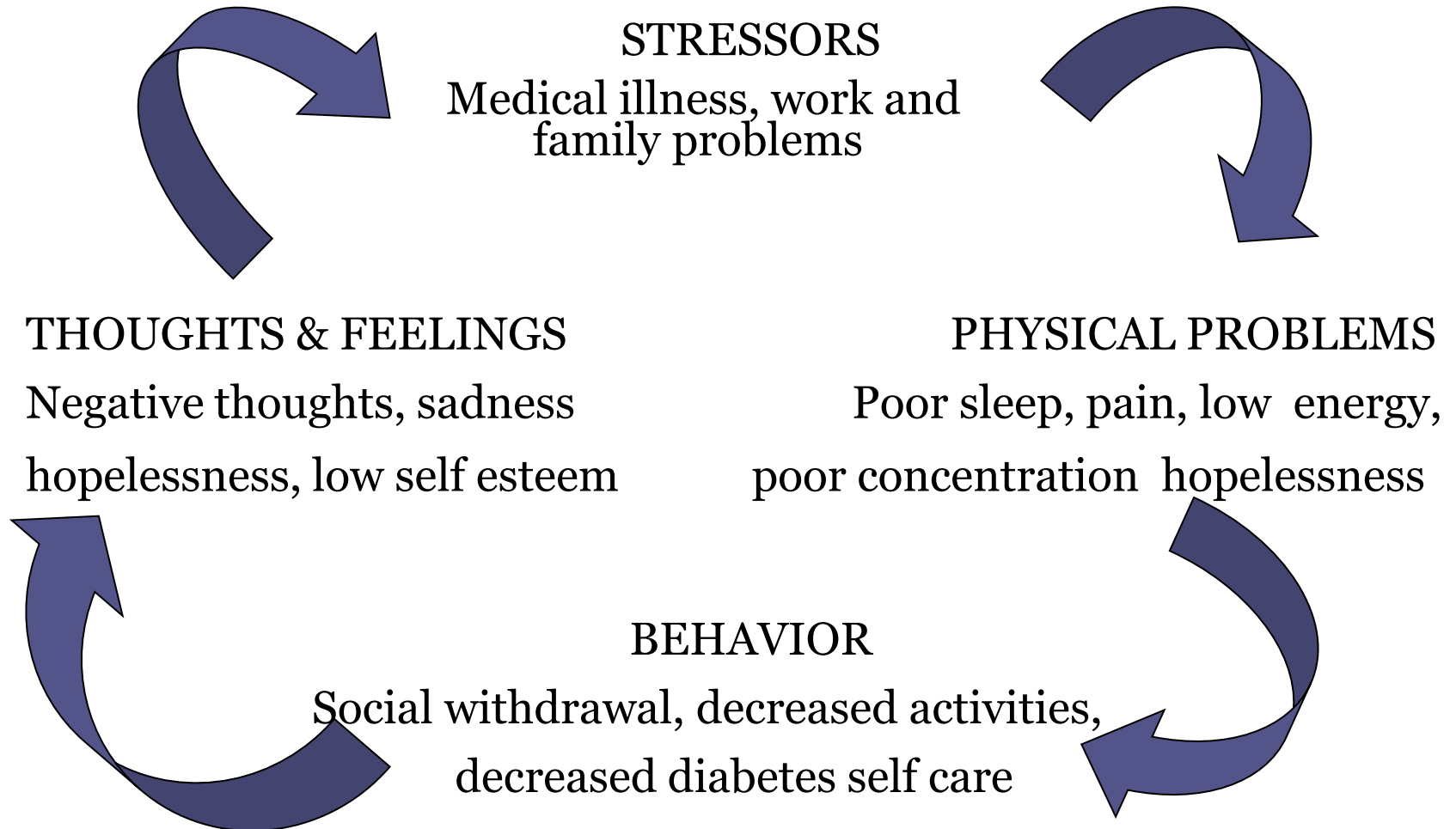
Aims of Telephone based Manualized Depression Care Study

1. To determine whether a telephone-based depression care intervention known to be effective in managed primary care can be effectively implemented with minimal adaptation in a clinic serving low-income, rural Latino patients.
2. To examine the effect of the minimally adapted intervention compared to usual care on depressive symptoms & functional status.

AIMS of Intervention II

3. To determine the patient, provider, and health system barriers encountered in implementing the intervention using qualitative and quantitative assessments.
4. To determine what modifications and sociocultural adaptations in the intervention model are acceptable, feasible, and appropriate for the clinic and patients using qualitative and quantitative assessments.

The Cycle of Depression



Cognitive Behavioral Therapy

- Focuses on understanding the nature and development of an individual's behavioral repertoire and the accompanying cognitive processes.
- Affirms the key role of an individual's appraisal of perceived and actual threat
- Emphasizes the learning process and empowers clients to monitor their thought processes, especially negative thought patterns
- Emphasizes the effects of maladaptive or dysfunctional beliefs and attitudes on current behavior
- Fundamental assumption:
cognitions influence emotions and behavior

Study site

- Yakima Valley Farm Workers' Clinic (YVFWC), Walla Walla Family Medical Center site
 - Private, not for profit
 - Serves low-income predominantly Latino patients, including patients from Oregon
 - Wide range of integrated primary care services
 - No on-site psychotherapeutic intervention available
 - No licensed, bilingual practitioner available in region to provide psychotherapy

Intervention Components

- **Care management**
 - Assistance with making appt w/ PCP for medication if desired
 - Active follow-up and intervention with community resources
 - Provided by trained BSW level person
- **Structured 8-session CBT**
 - Provided by trained MSWs
 - In Spanish or English
 - On-going supervision by Dr. Evette Ludman in CBT model and by Mary O'Brien, MSW LMHC- YVFW Clinical Services Manager for Behavioral Health Program's
- Feedback to PCPs
- Registry to track patient progress

Manual

- Developed by:

Greg Simon, PhD, & Evette Ludman, PhD,
from
Group Health Cooperative in Seattle

Our Philosophy

- In order to be effectively disseminated and sustained, EBPs must be adapted to the cultural characteristics and context of the patient population and the resources and context of the organization that will deliver it.
- Extensive outreach—do all you can

Sociocultural Adaptations

- Translation of manual into *Spanish—Nueva Vista*
- Revision of manual to include vignettes reflective of local rural experiences
- Use of trained bilingual, bicultural personnel
- First session in person if pt. preferred

Study Sequence

- Wait-room Screening for depression by trained recruiters (provider referrals were accepted as well)
- Criteria for exclusion---schizophrenic or bipolar pts, patients abusing substances, & pts. manifesting suicidal ideation
- Baseline interview by telephone
- Randomization to intervention (50) vs. usual care (51)
- Study manual given to patient
- Initial contact made by study therapist

Intervention

- 50 Patients received CBT intervention:
 - Initial session with DCS (clinical assessment, education)
 - Review treatment plan with PCP
 - Weekly supervision by study psychiatrist and study investigators to review DCS case load
 - 8-session CBT by phone (8-12 weeks in duration)
 - Care management as warranted

Usual Care

- 51 Patients received Usual Care:
 - Educational pamphlet
 - Referral to PCP
 - Medication management if provided by PCP

Assessments

- Standardized Measures
 - Symptom Checklist (SCL) depression scale
 - Patient Health Questionnaire (PHQ-9)
- Blinded telephone assessments at 6 weeks, 3 months, 6 months post screening
- Qualitative exit interviews with all patients and providers at 6 months

Demographics

	<u>Intervention</u>	<u>Usual Care</u>
Female	39 (78.0%)	40 (78.4%)
Male	11 (22.0%)	11 (21.6%)
Latino	45 (90.0%)	47 (92.2%)
Nativity		
--US born	0 (0%)	4 (7.8%)
--Mexico	47 (94.0%)	45 (88.2%)
--Other	3 (6.0%)	2 (3.9%)

- 91.1% of all patients enrolled were from Mexico

More Demographics

	<u>Intervention</u>	<u>Usual Care</u>
Education		
<6 yrs,	15 (30.0%)	15 (29.4%)
>6 and <11 yrs	24 (48.0%)	26 (51.0%)
HS graduate	7 (14.0%)	7 (13.7%)
Some college	4 (8.0%)	5 (9.8%)
79.2% of total sample had < 11 years of formal ed.		
Married	32 (64.0%)	32 (62.7%)

Work Status and Income

	<u>Intervention</u>	<u>Usual Care</u>
Employed	26 (52.0%)	24 (47.1%)
Migrant worker	7 (14.0%)	3 (5.9%)
Seasonal worker	15 (30.0%)	17 (33.3%)
Income		
<=\$5000	2 (4.2%)	6 (11.8%)
\$5001-\$15,000	23 (47.9%)	13 (25.5%)
\$15,001-\$25,000	16 (33.3%)	15 (29.4%)
>=\$25,000	7 (14.6%)	10 (19.6%)

Comorbidity

	<u>Intervention</u>	<u>Usual Care</u>
Anxiety Disorders	23 (46.0%)	35 (68.6%)*

comorbid medical problems

0	11 (22.0%)	12 (23.5%)
1	11 (22.0%)	13 (25.5%)
2	11 (22.0%)	13 (25.5%)
>=3	17 (34.0%)	13 (25.5%)

29.7 % of total sample had 3 or more comorbid mp

*p<0.05

Previous Treatment

Intervention

Usual Care

**Lifetime medication
for emotional problems**

28 (55%)

22 (42%)

Lifetime counseling

9 (18%)

18 (35%)*

* $p < 0.05$

Baseline Depression Scores

	<u>Intervention</u>	<u>Usual Care</u>
• SCL	1.8 (0.8)	1.8 (0.8)
• PHQ 9	16.5 (3.5)	17.7 (3.4)

Outcomes

	<u>Intervention</u>	<u>Usual Care</u>
PHQ 9—6 week	10.4 (6.5)	12.8 (7.1)
--3 mo.	7.3 (5.4)	10.4 (7.0)*
--6 mo.	5.6 (6.5)	10.1 (8.1)*
SCL—6 week	1.3 (0.8)	1.6 (0.9)
--3 mo.	0.9 (0.7)	1.3 (0.8)*
--6 mo.	0.8 (0.9)	1.2 (1.1)

*p<0.05 Intervention vs. Usual Care

Study Therapists

- Varied in terms of experience, nativity, and gender
- Later, 2 p/t MSW students were trained as therapists

Lessons Learned

In hiring it is important to:

- assess a candidate's comfort level with the need for manual adherence
- assess candidates' comfort with the concept of tracking of outcomes and their skills and comfort regarding computer technology
- address cultural factors and not presume cultural competency even if Latino

More Lessons

- Role playing each session by phone in pairs was particularly helpful in training
 - provided a deepened learning experience
 - encouraged mutual support

Still More Lessons

- Sustained communication with PCPs is desired and beneficial
- Case Management Services are valuable to patients, PCPs, and study team
- Pts experience multiple stressors—be patient, extensive outreach and follow-up is crucial
- Be responsive to gender matching concerns or issues

Other Important Lessons

- Small rural communities can be challenging places to practice psychotherapy due to familiarity.
 - Prior to their first therapy session, several patients expressed concerns about confidentiality when patients recognized therapists from church or other social settings or when patient's relatives were also under the care of the same therapist.
 - We addressed these concerns and often transferred the patient to a different therapist, an advantage of employing multiple part-time providers.

Future Work

- Publication and presentation of findings
- Submission of RO1 for full scale randomized study with YVFWC (February 2010)
 - decision needed re: clinic sites to implement comprehensive model of depression care intervention
 - work force development component--training of BASW students in partnership with Heritage University & Walla Walla University

GOAL: The provision of improved, sustainable depression care for rural Latinos