



Maternal Depression Low-income Minorities

Where should we provide care?
How does care effect children?

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Minorities in the U. S. 2006

- 14.80% Hispanic American
- 12.25% African American
- 4.3% Asian American
- .75% American Indian/Alaskan Native
- 1.37% Other

Minorities in the U.S.

POVERTY

- 8.7% of White Americans
- 9.8% of Asian/Pacific Islanders
- 21.9% of Hispanic Americans
- 24.5% of Am Indians/Alaskans
- 24.7% of African Americans

Rates of Mental Disorders

	Lifetime	Past Year
Latino American	%	%
Puerto Rican	38.98	22.88
Cuban	28.38	15.91
Mexican	28.42	14.48
Other Latino	27.29	14.42
Asian American	%	%
Chinese	18.00	10.00
Filipino	16.74	10.00
Vietnamese	13.95	6.69
Other Asian	18.29	9.55
Black American	%	%
African American	30.54	14.79
Caribbean Black	27.87	16.38
White American	37.37	19.00

Disparities in Mental Health Care

- Minorities are less likely to get mental health care when needed.
- Minorities are less likely to get appropriate mental health care when they do seek care.

Disparities in Mental Health Care

Health Insurance Coverage
(3-yr Average: 2003 to 2005)

White	11.2%
Asian	17.7%
Black	19.5%
American Indian	29.9%
Hispanic	32.6%

Disparities in Mental Health Care

Providers

Race	U.S. 2005	Physicians 2005	Psychiatrists 2002	Psychologists 2004	Social Work 2004
White	67%	77%	81%	93%	92%
Hispanic	14%	4%	5%	3%	3%
Black	13%	5%	3%	2%	4%
Asian	5%	14%	11%	2%	1%
Amer. Indian	1.5%	0.1%	0.1%	0.3%	0.2%

Screening in County Entitlement Clinics

- **16,286 women screened**
 - 2,311 excluded study related
 - 13,975 eligible
- **1,583 (11%) screen depressed**
 - 566 excluded (pregnant/breast feeding)
 - 590 excluded no interview (345)/not depressed (177)/(68) rule out diagnosis
- **427 (2.6%) depressed and eligible**
 - 149 no interview/ 11 refused clinical assignment
- **267 (1.6%) randomized**

County Entitlement Clinics-WIC and Family Planning

- One of the few settings young women enter, except OB-GYN (may not be good timing for care)
- No providers exist in these settings
- Women are guarded in settings and not bonded to providers
- Follow-up is difficult

Where should we treat poor and minority women?

- Settings they frequent
 - Head Start Programs
 - Extend childcare
 - Provide dinner
 - Churches?
 - Low-income housing centers
 - Schools

Response to Evidence-based Care

WE Care for Impoverished Women

- Randomized trial of 267 women screened in county entitlement clinics
 - CBT
 - Guideline concordant medication (Paroxetine)
 - Referral to community care
- 9-11 telephone outreach calls necessary to engage women in care
- Flexibility of care
- Babysitting and transportation provided

Response to Evidence-based Care

Treatment Received

- 88 medication
 - 67 (76%) received appropriate care
- 90 CBT
 - 32 (35.5%) received appropriate care
- 89 referred
 - 15 (16.9%) received at least one session
 - 74 (83.1) did not attend care

Response to Evidence-based Care

Response to Care

- 6-month outcomes – asymptomatic
 - 44.4% medication
 - 32.2% CBT
 - 28.1% referred

Response to Evidence-based Care

Response to Care

- 12-month outcomes – asymptomatic
 - 41.6% medication
 - 48.9% CBT
 - 30.3% referred
- Cost-effectiveness ratios similar to those in advantaged populations

Response of Children

- Examined children of depressed moms (n=84) and never depressed moms (n=49)
- Outcome: Behavioral Symptoms Index (BSI) of the Behavioral Assessment System for Children (BASC)

Child BIS by Mother's Depression

