Outreach supported antidepressant treatment and cognitive behavioural therapy are effective for depression in low income minority women

Miranda J, Chung JY, Green BL, *et al*. Treating depression in predominantly low-income young minority women: a randomized controlled trial. *JAMA* 2003;**290**:57–65.

Q What is the effect of guideline concordant care (ie antidepressant medication or cognitive behavioural therapy) compared with community care for depression in low income minority women?

METHODS

Design: Randomised controlled trial.

Allocation: Concealed.

Blinding: Single blind (outcome assessors blinded).

Follow up period: Six months.

Setting: Four suburban county health and welfare services, Washington, DC, USA; March 1997 to May 2002.

Patients: 267 low income women (117 black and 16 white women born in the USA, 134 Latina women born in Latin America) diagnosed with major depressive disorder using the Composite International Diagnostic Interview. Exclusions: bereavement, substance abuse, pregnancy or planning pregnancy in next 6 months, breast feeding, and current mental health care.

Intervention: Antidepressant medication for 6 months (paroxetine 10–50 mg per day, or buproprion for participants not tolerating paroxetine or not improving after 9 weeks of paroxetine); cognitive behavioural therapy (CBT) for 8 weeks (weekly group or individual sessions; followed by 8 further sessions for non-improvers; participant and therapist manuals adapted from a programme specifically for low income English and Spanish speakers), or referral to community care (information about depression and mental health treatments available in the community, offer of referral to mental health care physician). Participants were assessed at baseline and monthly follow up by telephone interview.

Outcomes: Improvement in depressive symptoms (Hamilton Depression Rating Scale (HDRS) score); improved instrumental role functioning (Social Adjustment Scale (SAS) interview); and improvement in social functioning (Short Form 36-Item Health Survey (SF-36)).

Patient follow up: Community care: 9% attended ⩾4 sessions; antidepressants: 75% received antidepressants for ⩾9 weeks and 40% received antidepressants for ⩾24 weeks; cognitive behaviour therapy: 53% received ⩾4 sessions and 36% received ⩾6 sessions.

MAIN RESULTS

About 75% of women offered community care referral accepted; only 17% received any mental health treatment. Antidepressants and CBT significantly improved depressive symptoms at 6 months compared with community care (adjusted mean HDRS score: 5.2 with antidepressant *v* 7.2 with CBT *v* 10.1 with community referral; antidepressant *v* community referral $p<0.001$; CBT *v* community referral $p=0.006$). Only antidepressant treatment significantly increased instrumental role functioning at 6 months compared with community care (adjusted mean SAS score: 1.7 with antidepressant *v* 2.2 with CBT *v* 2.3 with community referral; antidepressant *v* community referral $p=0.006$; CBT *v* community referral $p=0.58$). Both antidepressant and CBT significantly increased social functioning compared with community referral (adjusted mean SF-36 score: 88.0 with antidepressant *v* 83.7 with CBT *v* 74.5 with community referral; antidepressant *v* community referral $p=0.001$; CBT *v* community referral $p=0.02$).

CONCLUSIONS

Guideline based antidepressant treatment or CBT are more effective than community care in treating depression in low income minority women.

NOTES

Authors note that both antidepressant and CBT interventions involved considerable additional support that was not provided to community care referred women. This support included outreach, childcare, transportation to care, and encouragement to comply with treatment. Therefore, the effect of guideline based care alone cannot be gauged by this study.

Commentary

This study reports promising results for a population at great risk: that is, depressed, low income, young minority women. Using an enhanced care management strategy and randomising participants to either cognitive behavioural therapy, antidepressant medication (paroxetine switched to buproprion if no response), and usual care, the authors demonstrated that both the medication intervention and the psychotherapy intervention reduced depressive symptomatology. Both conditions improved social functioning and, in addition, the medication intervention resulted in improvements in the instrumental role.

Low income minority women have historically been underserved and this study provides important information for both policy makers and clinicians. Depression can be effectively treated when educational meetings are held and therapy delivered in a carefully monitored way accompanied by outreach but such interventions require considerable effort. For example, a nurse practitioner spoke with a client a mean of 8.8 times to enable a first medication visit. Most attended several education visits as well as having transportation and childcare provided. 83% of the women offered community referral failed to attend even a single session. Given how difficult it is to engage these clients, the results of the study are encouraging but must be tempered by the fact that it takes a large amount of effort and support to effectively treat depression in this population. This is similar to the large amount of additional effort required to transpose manual based prevention strategies.

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1 Beardslee WR, Gladstone TRG, Wright EJ, *et al*. A family-based approach to the prevention of depressive symptoms in children at risk: evidence of parental and child change. *Pediatrics* 2003;**112**:e119–e131.
2 Podorefsky DL, McDonald-Dowdell M, Beardslee WR. Adaptation of preventive interventions for a low-income, culturally diverse community. *J Am Acad Child Adolesc Psychiatry* 2001;**40**:879–86.

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