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The Abell Report

What we think about, and what we'd like you to think about

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High incidence of clinical depression among the City's poor is closely linked to their high rate of poverty.

"What if you could help end poverty by treating depression?"[1]

ABELL SALUTES:

Teach For America: For enriching the talent pool of new teachers in the Baltimore City Public Schools

There are easier ways to make a living.

Teaching in Baltimore's inner city schools is, by all accounts, stressful and low paying, and, in comparison to law, medicine and business careers, offers limited no promise of financial success. But the bright young college graduates who take teaching positions in the Teach For America Corps know all that, and they take the jobs anyway, and willingly. Their rewards lie in helping Teach for America make a difference in the education of the poor and disadvantaged. In pursuing this mission, these new teachers strive to help their students progress at a level that is beyond the traditional growth for students in urban schools. By all reports, they are succeeding.

Teach For America Baltimore (TFA) is the local corps of recent college graduates from varied academic majors and backgrounds who commit to teach in urban and rural public schools for two years. During that period, TFA Corps members attain their teacher certification and have the option to earn a master's degree in Education. TFA recruits high-

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This report makes the case that clinical depression and poverty are closely linked, and together have created a public health crisis. With a grant from The Abell Foundation, the Mental Health Policy Institute for Leadership and Training[2] surveyed the current literature on depression and poverty and documented the effects of these intertwined problems: a life of poverty, an inability to work productively, and high rates of HIV, substance abuse, and other illnesses. Yet, the report also reveals, very few of the poor who suffer from depression are in treatment. The reasons for this failure include apathy among those afflicted that is attributable to the disease itself; stigma associated with mental health treatment; and failure to recognize and understand the disease -- all exacerbated by a lack of access to mental health services. The challenge to the community is to identify those who suffer from depression and link them to easily accessible services.

Background: Depression and Poverty

"Poverty was termed many years ago the mother of all diseases."[3]

Depression is a common and severe mental health disorder. More than just "feeling bad," clinical depression is a serious and debilitating illness that can undermine one's ability to perform routine daily activities. It is one of the most disabling disorders facing the nation and is one of the highest causes of death and disease in the world.[4] It is estimated that anywhere from 4 percent to 10 percent of the United States population suffers from depression at any given time.[5]

As common as depression is in our nation as a whole, it is even more common among Americans who live in poverty. Poor people suffer significantly higher rates of depression than any other social group in the United States. They are four times as likely as affluent people to suffer from depression and are among the most severely disabled populations in this country.[6] "Looking for the depressed among the poor," says one expert, "is like checking for emphysema among coal miners."[7]

Although depression rates are clearly high among the poor, it is difficult to say exactly how many poor people in America are suffering from depression. Nonetheless, a number of studies have shown that there is a "greater prevalence [of depression] among minorities and individuals who are vulnerable, [and] high-need subgroups such as persons who are homeless, incarcerated or institutionalized."[8] The ramifications of this epidemic are staggering. People who are depressed perceive themselves as helpless. Often, they try to self-medicate with alcohol or drugs and are then caught up in the world of substance abuse and addiction.[9] They can't work; therefore, the poverty and trauma accumulate. An unending cycle of pover-

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ty, depression, and despair can result.

Moreover, depression harms not only the individuals afflicted with the disease, but often their loved ones as well, and its effects can extend from generation to generation. Single women with children on welfare are at particularly high risk for developing depression.[10] Single parents suffering from depression may be unable to care for their children. Their depression may prevent them from finding jobs within the time limits set by welfare reform, undermining their ability to earn a living and threatening their welfare benefits, which are often their sole source of financial support. Their children may end up under the jurisdiction of child welfare or juvenile justice agencies, setting the stage for an intergenerational cycle of poverty, depression, substance abuse, and violence: "Sons of mothers with untreated depression are eight times more likely to become juvenile delinquents as other children. Daughters of these mothers have earlier puberty linked to promiscuity, early pregnancy and mood disorders."[11] One doctor has noted, "Depression among mothers has been linked to poor nutritional, educational and health outcomes for their children."[12]

Studies have also shown a link between maternal depression and the cognitive development of young children. Maternal depression and poverty can lead to cognitive delays and behavioral problems in young children. "Studies have found that babies of depressed mothers have cognitive difficulties and that depressed mothers provide less care for their babies. Data also suggests mental growth of such babies is retarded when compared to their peers."[13]

Single men are also devastated by depression. They cycle from despair to substance abuse to jail and back again. Often, they engage in life-threatening behavior, bringing long-lasting harm to themselves and to society. According to the lead researcher for a study at Johns Hopkins University examining and treating depression among indigent people with HIV and AIDS, "many people get HIV when they can't muster the energy to care any more. These are people who are utterly demoralized by life and don't see any point in it."[14] He predicted that the rate of HIV could be cut in half if treatment for depression were more widely available.

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Some people who serve or interact with people living in poverty in Baltimore City believe that depression is a significant problem among this population and a barrier to success in life. Clayton Guyton, director of the Rose Street Community Center in East Baltimore, says that it is imperative that mental health care be available to identify people in need and link them to treatment. Sherry Adeyami, program director for the Baltimore City Health Department's Men's Health Center, reports that "as men in substance abuse groups begin to cope with their addiction, the underlying disease of depression is unmasked. If there is no treatment for the depression, the addiction will return as the only way to 'treat' their problem."

Barriers to Treatment

Many depressed adults suffer in silence and do not receive the treatment they need. African-Americans and other minorities are significantly underserved; services they do receive are often ineffective. Likewise, treatment for poor people suffering from depression is extremely limited and inadequate. According to one recent national survey, only 29.7 percent of low-income respondents with serious mood disorders (including major depression) had received any treatment in the past 12 months, and only 12.3 percent had received minimally adequate treatment.[15] Barriers to diagnosis and treatment of depression in poor communities have multiple causes, including systemic and structural problems with the delivery of services, as well as individuals' lack of understanding or knowledge of depression and reluctance to seek care.[16] Even though Baltimore's public mental health system delivers a broad range of effective services to many individuals with serious and persistent mental illness, there remain many others who are not reached. Among the reasons for this shortcoming are:

- Medicaid pays for inpatient hospital days and visits to psychiatric emergency rooms but not for community services that could prevent crises or inpatient stays. Poor people often remain untreated until their depression

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deteriorates to the point that they are dangerous to themselves or others.[17]

- Poor single men have an especially difficult time qualifying for and using mental health services covered by Medicaid. Without Medicaid to pay for treatment, it is extremely difficult for these men to obtain ongoing, integrated community services.

- There is little outreach to identify people who are suffering from depression but who do not seek treatment in a traditional mental health program. For reasons described below, some people need to be identified and offered services in their communities, but the current mental health care delivery system is not set up to provide services in this way.[18]

- There is a dearth of mobile services that integrate mental health and substance abuse treatment, even though the rate of dual diagnosis in low-income communities is extremely high.

- Social services, services to people in extreme poverty, mental health services, and substance abuse treatment are delivered by different agencies. Many poor people have needs that cross these boundaries, but they do not have access to integrated services.[19]

- Social and health services for ex-offenders re-entering the community, many of whom suffer from mental health disorders, are limited.

- For medications to be effective in treating and relieving depression, both patient and provider must make a long-term commitment to treatment, and the medications must be administered under a physician's care, preferably a psychiatrist. Recent studies demonstrate that medication and therapy combined are highly successful in treating depression.[20] However, it is extremely difficult to offer this treatment when so few clinics serve the low-income population and the medications are very expensive.

- Studies demonstrate that people in poverty who suffer from depression are more likely to walk into a primary care clinic than a mental health center, yet they are unlikely to receive appropriate mental health care in a primary care clinic, because primary care and mental health care are delivered in separate systems.[21]

These systemic and structural barriers are compounded by the effects of poverty and depression on individuals, making it difficult for them to recognize that they have depression and to seek treatment for it. The disease is so prevalent in the culture that it seems to be just a part of normal life. If life has always been lousy, expectations remain low, and it may be difficult to recognize, for example, insomnia and persistent feelings of hopelessness as signs of a serious but treatable illness. Depressed poor people perceive themselves as helpless, and this perception itself contributes to their inability to find help or seek care.[22] For the people who decide to find help to overcome their depression, the daunting barriers to treatment described above may cause them to give up their search for care. Finally, the poor suffer from the stigma not only of their disease but of their poverty. People in poverty, especially single men, are often deemed to be lazy or beyond help. Understandably, many of them are unwilling to ask for help, even if they recognize they need it.

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Effectiveness of Treatment

Depression is a complex disease that cannot be cured, but it is a highly treatable illness.[23] Studies show that aggressive treatment of depression can improve patients' mental health and functioning. Most people who receive treatment experience significant improvement, and almost all of those treated derive some benefit. With treatment, people can take control of their lives and make changes. A recent study of young, predominantly minority women demonstrated that treating depression in this population can significantly improve the ability of these women to function. "Some pilot studies are under way on the treatment of depression among the poor and the results appear surprisingly consistent. People in these studies report that they feel their lives improved during treatment. Even when faced with insurmountable obstacles, they progressed."[24]

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Therapy, support groups, and medication, used together, decrease the symptoms of depression, enabling people to regain control of their lives and begin to lift themselves out of poverty.[25]

To overcome both the systemic and the individual barriers of poverty, stigma, and hopelessness, it is imperative to provide treatment for depression in innovative settings and to provide services that are individualized and flexible.

Recent efforts to provide mental health treatment to previously underserved and treatment-resistant populations, including those who are homeless, jailed, or frequent users of emergency rooms, have shown the need to use teams of mental health professionals who provide treatment in the communities where people live.[26] It may be possible to link some people to traditional clinics after their initial screenings and treatment, but it is important to provide services where the people are -- in community centers and primary care clinics, for example -- and to build trust and relationships.[27] Outreach is necessary for identification, screening and, for many people, for continuing treatment. People with depression will rarely venture out to locate a doctor or a clinic and ask for treatment. It is necessary to go into the neighborhoods or to other places that they frequent and begin serving them there.[28]

The efficacy of mobile treatment teams is well documented. On the national level, several mobile approaches have achieved recognition as "evidence-based treatment:" that is, their success has been documented in the research.[29] These include the Assertive Community Treatment (ACT) approach and Multi-Systemic Therapy as well as specialized teams for homeless and homebound elderly.[30] The Surgeon General's 1999 Report on Mental Health recommended the use of ACT and other mobile approaches as integral to

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building an effective mental health system, and the National Alliance for Mentally Ill (NAMI) has mounted a national campaign to disseminate information on the ACT approach because of its effectiveness. Citing various national studies, NAMI reports that "research indicates that this intervention reduces hospitalization, improves housing stability, improves symptoms and improves quality of life for persons with severe and persistent mental illness."[31]

In Baltimore, there are several examples of ACT teams as well as a variation of ACT that integrates innovative funding with the innovative services and is currently available only for the highest end users of mental health services, (i.e., those who have either been in a psychiatric inpatient unit for a long period or have been in psychiatric emergency rooms for frequent visits). Additionally, there is a specialized mobile team to serve the homeless, and the PATCH program, operated by Johns Hopkins, that provides mobile outreach and services to elderly persons living in low-income housing. Each of these programs demonstrates the value of providing mobile outreach and treatment services that are specially designed and targeted to meet the needs of a specific population but are provided as part of a comprehensive community mental health system.

For all of the reasons described above, the key to success in finding and treating depression in poor people is to reach out to people "where they are" both physically and mentally.[32] Therefore, the plan for services described below focuses primarily on treatment that is provided in the streets, neighborhood centers and communities where people live and includes plans to educate staff on the special cultures and needs of the people they serve.

Recommendations

1. **Identify people at risk for depression in their neighborhoods.** Visitation teams working out of neighborhood health clinics need to be in the homes and on the streets where people at risk for depression live and work to help them understand what depression is, identify whether they suffer from it, and understand what relief can be provided.

2. **Treat clients where they are.** Treatment teams must be located in community settings such as community centers, primary health clinics serving the uninsured, and welfare offices.

3. **Teach the teachers to teach.** To be effective, mental health professionals who work with people in low-income communities must be familiar with the culture of the neighborhoods where they work. These professionals must have training in cultural norms and beliefs about mental health disorders, particularly the stigma associated with mental health care that is prevalent among the poor.

4. **Provide continuing education** on depression, mental health, parenting and living skills in community-based settings, as well as in traditional treatment centers. Because the problems of

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depression and its consequences are ongoing, education must also be ongoing.

5. **Put treatment of depression among the poor, and the strong relationship between clinical depression and poverty, high on the community agenda.** Government, educational institutions, and private foundations at city, state, and national levels must recognize that treating clinical depression is one means to reduce poverty in communities, and they should appropriate the funds necessary to establish and deliver effective mental health interventions that will ease both depression and poverty.

In an effort to address some of the barriers to identification and treatment of depression among Baltimore City's poor population, The Abell Foundation recently funded a pilot project to provide mental health screening and treatment to clients at two agencies serving low-income adults, the Rose Street Community Center, in East Baltimore, and the Baltimore City Health Department's Men's Health Center, in West Baltimore. The pilot project will send mental health treatment teams to both sites to identify those suffering from depression and provide them with appropriate treatment on site at the two agencies. While limited in scope, this pilot project has the potential to produce significant results: addressing the disabling symptoms of depression, and thereby enabling people to regain control of their lives, function effectively, and ultimately, it is hoped, maintain stable employment.

Footnotes:

[1] Solomon, Andrew, "A Cure For Poverty," New York Times Sunday Magazine, May 6, 2001.

[2] The Mental Health Policy Institute for Leadership and Training, a non-profit corporation affiliated with Baltimore Mental Health Systems, Inc. was recently created to bridge the gaps between research, practice, policy, education and training to provide comprehensive and innovative programs for vulnerable populations suffering from mental illness. The Board of the Institute is comprised of academics from a variety of related disciplines and policy-makers.

[3] Patel, Vikran, "Is depression a disease of poverty?" Regional Health Forum 5(1):15 (2001).

[4] Rosack, Jim, "JAMA depression issue highlights reasons for concern." Psychiatr News 38(14), July 2003; World Health Organization, "Mental Health: New Understanding, New Hope" (2001).

[5] World Health Organization Report, n. 4; Rosack, n. 4; American Psychiatric Association Public Information "Let's Talk Facts About . . . Depression" (1999), available 6/26/04 on the Web at http://www.psych.org/public_info/depression.cfm.

[6] "Let's Talk Facts," n. 5 supra; Solomon, n. 1 supra.

[7] "Making 'Welfare to Work' Really Work," American Psychological Assn. (Aug. 2003), available 6/26/04 on the Web at http://www.apa.org/pi/wpo/welftowork.html.

[8] Ibid., citing Breakey et. al., "Health and mental health problems of homeless men and women in Baltimore. Journal of the American Medical Association, 262:1352-57 (1989); Teplin, L.A., "The prevalence of severe mental disorder among male urban jail detainees: Comparison with the Epidemiologic Catchment Area Program," Am J Public Health, 80:663-669 (1990).

[9] "Making 'Welfare to Work' Really Work," n. 7 supra.

[10] Ibid.

[11] Ibid.

[12] Patel, Vikram, M.D. "Depression, Disability, Dollars, Development," B-SPAN World Bank Webcast (World Bank Group, May 13, 2003), available 6/26/04 on the Web at http://www.worldbank.org/wbi/B-SPAN/sub_depression_disability.htm.

[13] Patel, Vikram MD, "Depression, Disability, Dollars, Development" www.Worldbank.org/wbi/B-Span/sub_depression_disability.htm (May 13, 2003). Patel, supra, Note 3.

[14] Dr. Glen Treisman, quoted in Solomon, n. 1 supra.

[15] Wang, Philip S., Demler, Olga, Kessler, Ronald. "Adequacy of Treatment for Serious Mental Illness in the United States," Am J Public Health 92:92-98 (2002).

[16] Wang, n. 15 supra.; "Mental Health: Culture, Race & Ethnicity. A Supplement to Mental Health: Report of the Surgeon General." Office of the Surgeon General, 2001.

[17] Supplemental Report of the Surgeon General, n. 16 supra.

[18] Henning, Cathleen, "Poverty Increases Risk for Mental Illness," Psychiatric News, July 18, 2003, Vol.39, No. 14; Solomon, n. 1 supra.

[19] Supplemental Report of the Surgeon General, n. 16 supra.

[20] Badamgarav, E., et al., "Effectiveness of Disease Management Programs in Depressions: A Systematic Review," Am J Psychiatry 160:2080-2090 (Dec. 2003).

[21] Henning, supra, Note 18. Patel, supra. Note 3.

[22] Salver, Mark, et al., "Adult Mental Health Services in the 21st Century," National Mental Health Information Center, U.S. Department of Health and Human Services, available 6/26/04 on the Web at http://www.mentalhealth.org/publications/allpubs/SMA01-3537/chapter11.asp; Solomon, n. 1 supra.

[23] Sheerer, Richard. "Surgeon General's Report Highlights Mental Health Problems Among Minorities" Psych. Times March 2002; "Depression," American Psychiatric Association Public Information, n. 5 supra.

[24] National Institutes of Health, "Medication and Psychotherapy Treat Depression in Low-Income Minority Women"(news release, July 1, 2003), available 6/26/04 on the Web at http://www.nih.gov/news/pr/jul2003/nimh01a.htm.

[25] Badamgarav, E., et al., n. 22 supra.

[26] Dixon, Lisa, "Assertive Community Treatment: Twenty-Five Years of Gold," Psychiatric Services 51:759-65 (June 2000).

[27] Supplemental Report of the Surgeon General, n. 16 supra.

[28] Dixon, n. 27 supra.; National Council on Disability, "The Well Being of our Nation: An Inter-Generational Vision of Effective Mental Health," (Sept. 16, 2002), executive summary available 6/26/04 on the Web at http://www.openminds.com/indres/wellbeingnation.htm.

[29] Supplemental Report of the Surgeon General, n. 16 supra.

[30] Dixon, n. 27 supra.

[31] See www.mentalhealthpractices.org/pdf_files/act_pmha.pdf.

[32] Letter from Sherry Adeyami, Director Health Program Planning and Evaluation, Municipal Health Services Program, Baltimore City Health Department (March 30, 2004).

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achieving graduates from competitive colleges who had not originally planned or trained to become teachers. The Grade Point Average of students admitted into the program is 3.5 on a 4.0 scale, and 70 percent earned a bachelor's degree from one of America's most prestigious and competitive colleges. Beyond these statistics, the TFA corps is a diverse group – socio-economically, racially and ethnically.

TFA has been highly successful in attracting applicants that meet its high standards, and the number of core members has expanded rapidly in recent years. Between 2000 and 2003 the national TFA applicant pool grew almost fourfold, from 4,086 to 17,706; and the number of new TFA Corps members nearly doubled from 868 to 1, 656. In 2004, TFA plans to place new teachers in 22 urban and rural regions, an increase from 15 regions served in 2000, casting a wider net to bring more teachers into those school districts where they are most needed.

TFA has been working with the Baltimore City Public School System since 1992, and was one of the first organizations to make use of Maryland's Alternative Teacher Certification route. In the last decade, TFA/Baltimore has placed over 500 members into teaching positions in City public schools. Currently, in Baltimore City, TFA teachers reach 14,000 students a day in 54 elementary, middle and high schools; in 2003-04 there were approximately 160 first and second year TFA teachers in the Baltimore City Public School System (BCPSS). Another 180 regional alumni are working from all sectors to open opportunities for disadvantaged children.

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TFA teachers are making a difference: According to Danielle Peterson, Executive Director of TFA/Baltimore, "Every year we have first and second year teachers achieving multiple grade-level advances with their students, in reading and mathematics, as well as measurable strides in social studies, the sciences, foreign languages. TFA corps members have started chess and debate clubs, sports and outdoor programs, and college prep activities for the students in the BCPSS who would probably not get to enjoy these educational opportunities were it not for the TFA teachers."

An independent study just released by Mathematica Policy Research, Inc. (June 2004) demonstrates that TFA teachers are highly effective in the classroom. According to the study, students of these teachers make 10% more progress in a year in math than is typically anticipated; reading scores slightly exceed the expected. TFA teachers also attain greater student gains in math and similar gains in reading as compared to other new teachers and to veteran teachers. It should be noted that TFA teachers are working in some of the highest-need classrooms in the nation.

Finally, since TFA teachers are paid the same salaries as other teachers, the school system pays little additional costs for the achievement increase; school districts typically contribute funding to offset recruiting and training costs of each Corps member. This contrasts with other interventions that have been shown to increase achievement, such as class size reduction, which can entail substantial direct costs.

TFA's survey of Baltimore City principals who have hired and worked with TFA teachers shows:

- 100 percent say that having a TFA corps member is advantageous to the students and their schools; that 95 per cent of the teachers had a positive impact on student academic achievement; and that 85 percent of TFA members' second graders read at or above grade level by the end of the first year, with some scoring as high as fourth grade level.

Furthermore, Baltimore's TFA alumni remain in the forefront of educational reform in the city.

- Felicity Messner Ross, '94 corps, received the Presidential Award For Excellence in Mathematics and Science teaching in 2000
- Jason Botel, '97 corps, was named a Fisher Fellow for school leadership, and has started a nationally acclaimed KIPP Academy middle school in Baltimore City
- Laura Wheeldryer, '91 corps, became the Director of New Schools Initiatives, a program designed to establish innovative schools in Baltimore City.
- In 2002 a TFA alumnae was named Baltimore City Teacher of the Year and four other teachers were recognized as Model Teachers in the CEO District.

The Abell Foundation salutes Teach For America/Baltimore and its Executive Director Danielle Peterson for "widening the net" to allow highly-successful college graduates to teach and become certified in Baltimore City classrooms. These teachers, in turn, have brought their successful academic records, numerous talents, and high expectations to our children. They have earned the recognition they are receiving in such generous measure — from the community, from the city's leadership, and from the students.