CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS

2017 Cultural Competence Summit XX: Supporting Community Defined Practices
March 15, 2017 – Santa Rosa, CA
TRANSLATION OF INSTRUMENT FOR DEPRESSION, ANXIETY, AND PTSD IN LAOTIAN, CAMBODIAN, AND VIETNAMESE: REPORT FROM THE FIELD
WORKSHOP SESSION

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LEARNING OBJECTIVES

LO1
• Participants will be able to apply methods to build collaborative relationships between mental health agencies and community service agencies.

LO2
• Participants will be able to integrate methods that enable agencies to work together to develop and evaluate services and interventions.

LO3
• Participants will be able to describe how we used translation-back translation methods to develop screening instruments in non-English languages.

LO4
• Participants will be able to discuss how to use formative evaluation in the training and administration of mental health services.
Vision
We envision **healthy** Asian & Pacific Islander Communities in San Francisco

Mission
To achieve **health parity** for San Francisco’s Asian and Pacific Islander communities by identifying and **addressing** health and healthcare **issues**
APIHPC

* Established in Spring 2006
* Mental Health Services Act (Prop 63)
* 20+ Coalition Members representing diverse API communities in San Francisco
* 2006 - Emerged from position paper to the Director of Health in San Francisco
* 2008 – Needs assessment of Samoans
* 2008 – Hepatitis B education among health and community providers who serve API
2011-12 – anti-stigma campaign on mental health among 6 API communities
2012 – needs assessment and conversations on mental health
2012-13 – workforce development, digital stories
**Assess Needs**  
(Jul '11-Jun '12)  
- Twelve **Focus Groups in 6 languages**

**Program Planning**  
(Jul ‘12-Dec '12)  
- 3 Workplans: Samoan, Filipino, Southeast Asian

**Implement Service Delivery Plan**  
(Aug '13 – Dec ‘13)  
- **Deliver:**  
  - Culturally-relevant health promotion activities  
  - Culturally-relevant clinical services

**Workforce and Capacity Development**  
(Jan ‘13-Jun ‘13)  
- Agency Capacity Building  
- Community Members  
- Service Providers
APIHPC MENTAL HEALTH PILOT PROJECT

Target Populations:
Cambodians, Filipinos, Laotians, Samoan, & Vietnamese

MHSA Funding:
Population-Focused, Prevention Early Intervention

Project Objectives:
1. Identify and address disparities in access to mental health care and outcomes
2. Increase cultural competency providers
3. Link providers and coordinate services
4. Increase bilingual/bicultural mental health promotion activities
5. Advance bilingual/bicultural workforce development
TRANSITION...

API Health Parity Coalition
2011 - 2013

API Mental Health Collaborative
2014 - Current
COMMUNITY COLLABORATORS

Filipino Mental Health Initiative

Samoan Wellness Initiative

SOUTH EAST ASIAN MENTAL HEALTH INITIATIVE

Mental Health and Wellness
Promote Mental Wellness
Increase Awareness of Mental Health
Reduce the Stigma of Mental Illness
APIMHC PLANNING
JAN – JUNE 2014

Outreach and Engagement
- Workgroup Meeting (monthly)
- Anti-Stigma Training and Community Presentations
- APIHPC Meeting (bi-monthly)

Wellness Promotion
- Culturally-Specific Mental Health Summit
- Culturally-Specific Community Gatherings/Celebrations/Festivals
- APIMHC Meeting

Culturally-Specific Program Tools & Resource Development
- Curriculum Development (Families, Youth/TAY, MHFA)
- MH Glossary of Terms Development
- Evaluation Development/Tailoring
APIMHC WORKPLAN

Outreach and Engagement
- Cultural Gatherings/Celebrations/Festivals
- Workgroup Convening
- Develop Resource List

Screening and Assessment
- Develop and Pilot S/A tool
- Screen and Identify Individuals
- Referrals (on-site or off-site)

Wellness Promotion
- Pilot Psychoeducation Curricula
- Anti-Stigma Presentations (DST)
- Culture/Topic-Specific Groups

Service Linkage
- Refer and Link Individuals to Services
- Provide Non-clinical/basic Case-Management to Individuals to Support Achieving a Goal!
WELLNESS PROMOTION
ACTIVITIES
STATISTICS and NEED
<table>
<thead>
<tr>
<th>Laotian Americans</th>
<th>Cambodian Americans</th>
<th>Vietnamese Americans</th>
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<tbody>
<tr>
<td>• 191,000 (232,000 in combination w/any other group)</td>
<td>• 232,000 (277,000). 8,600 in Bay Area.</td>
<td>• 1,548,000 (1,737,000). 37% live in CA.</td>
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<tr>
<td>• 10,000 in Bay Area.</td>
<td>• 5,900 in San Jose–Sunnyvale–Santa Clara.</td>
<td>• 66,000 in Bay Area.</td>
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<tr>
<td>• 12,800 in Sacramento Metro Area.</td>
<td></td>
<td>• 134,000 in San Jose–Sunnyvale–Santa Clara.</td>
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<td>• 4,300 in Stockton</td>
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Source: 2010 U.S. census (Hoeffel et al., 2012).
Lack of capacity in SF. Very few Lao or Khmer speaking therapists in SF.
Underuse of mainstream mental health services
High rates of PTSD and depression in older adults
Cultural conceptualizations of “mental illness” are holistic, spiritual, and screening needs to reflect this
Idioms of distress are somatic
Few assessment instruments in Lao, Khmer, and Vietnamese. No screening tools.
TOOLS AND RESOURCE DEVELOPMENT

Diagram:

- Yes
- ?
- maybe
- No
CONSULTATION WITH COMMUNITY PARTNERS

- Met with community services agencies
- Identified goals of screening
- Identified cultural idioms and terminology, e.g., “complicated heart” in Lao
- Considered various screening instruments for depression, anxiety, and PTSD
- Selected instruments (PHQ-2 for depression, GAD-2 for anxiety, PC-PTSD for PTSD)
- Developed appropriate cutoffs for screeners, based on research and community capacity
Assessed distress using cultural idioms of distress
Assessed distress using somatic symptoms
Assessed use of mainstream services and support
Assessed prior use of complementary and alternative medicine for problems.
Screeners for depression, anxiety, and PTSD were translated into Lao, Khmer, and Vietnamese using established translation-back translation methods
* Cultural idioms of distress: e.g., “complicated heart” means conflicted or confused, “lost soul” means spiritually incomplete or lost.

* Somatic symptoms: e.g., headaches/pain, backaches/pain, stomachaches/pain, discomfort, dizziness, fatigue, appetite, sleep

* Mainstream services and support: medical provider, psychologist/psychiatrist, therapist/counselor, family, friends

* Non-mainstream/complementary/alternative medicine use: e.g., spirituality/religion (prayer, blessing), healer, relaxation, meditation, shaman, make offering, putting up with it yourself/enduring it/using willpower, acupuncture, cupping, coining, healing massage, Tai Chi, etc.
**SCREENING INSTRUMENT: DEPRESSION, ANXIETY, & PTSD**

- **PHQ-2.** Assesses two core criteria of depressive disorders – “little interest or pleasure” and “feeling down, depressed or hopeless” - rated on a 4-point Likert type scale from 0 (not at all) to 3 (nearly every day). Cutoff for referral is 3.

- **GAD-2.** Assesses two core anxiety symptoms – “feeling nervous, anxious, or on edge” and “not being able to stop or control worrying” - rated on a 4-point Likert type scale from 0 (not at all) to 3 (nearly every day). Cutoff for referral is 3.

- **PC-PTSD.** Assesses four core symptoms of PTSD: re-experiencing, numbing, avoidance, and hyperarousal – using four yes-no items. Cutoff score for referral is 3.
The screening instrument was administered verbally in Laotian, Cambodian, and Vietnamese community agencies by agency staff. Agency staff scored the instruments as they were administered.

- Laotian community agency (N=11): 91% above cutoff for either depression, anxiety or PTSD. (82% for depression, 73% for anxiety, 36% for PTSD.

- Cambodian community agency (N=10): 100% above cutoff for either depression, anxiety or PTSD. (90% for depression, 60% for anxiety, 0% for PTSD.

- Vietnamese community agency (N=5): 40% above cutoff for either depression, anxiety or PTSD. (20% for depression, 20% for anxiety, 20% for PTSD.)
Agency staff reported that they preferred to administer the screening instrument verbally as part of an overall needs assessment interview.

Staff reported that verbal administration was necessary because, in some instances, community members were not literate in their native languages.

Staff also reported wanting to develop rapport with community members prior to screening, so screening sometimes took multiple meetings to complete.

Staff were able to administer and score the screening instruments with some modifications, i.e., verbal administration.

Problem-solving to reduce time to complete the screener.
Laotian community agency (N=31): 97% above cutoff for either depression, anxiety or PTSD. (100% for depression, 97% for anxiety, 52% for PTSD.

Cambodian community agency (N=26): 100% above cutoff for either depression, anxiety or PTSD. (100% for depression, 96% for anxiety, 65% for PTSD.

Vietnamese community agency (N=22): 50% above cutoff for either depression, anxiety or PTSD. (41% for depression, 50% for anxiety, 28% for PTSD.
**IMPLICATIONS**

* Very high rates of distress communities serviced by Laotian and Cambodian social service agencies. 97% needed to be referred at Laotian agency. 100% at Cambodian agency.

* High rates of distress at Vietnamese social service agency. 50% needed to be referred.

* These communities need culturally-responsive services.
WHAT WE LEARNED

- Lao and Cambodian Community: English version of the S/A was administered with clients. Most can speak but cannot read their own language.
- Clinical/technical mental health terms difficult for Lao, Cambodian, & Vietnamese clients to fully grasp and understand.
- Using the English would in any case be necessary for those from other ethnic groups in Laos such as the Mien.
**CONCLUSIONS**

- Collaborative partnership resulted in screening process that agencies could implement.
- While this was an effective way to screen community members, there were few mental health services that offered therapy in Lao and Khmer.
- Staff often referred community members to non-traditional forms of help, including visiting temples and peer support.
- Staff believed that an on-site therapist would be beneficial. This is something we implemented.
Lack of workforce to implement program
Lack of culturally competent/relevant clinicians/therapists
Lack of tools and resources
Lack of language capacity to advocate
Lack of cultural familiarity to navigate
Partner organization capacity
Infrastructure capacity
Skills capacity gap
Lack of data to reflect challenges of small communities
Q & A