Multicultural Mental Health Australia & Victorian Transcultural Psychiatry Unit

Issues in Outcome Measurement with CALD consumers

AMHOCN 2010 Forum presentation

Issues in Outcome Measurement with CaLD Consumers

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Acknowledgement: Queensland Transcultural Mental Health Centre

Queensland Government

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Victorian Transcultural Psychiatry Unit

- A state-wide service that works with mental health services to increase their responsiveness to Victoria's culturally & linguistically diverse (CaLD) population
- Provides:
  - Education & professional development
  - Service development
  - Website with multiple resources
  - Telephone support service
  - Collaborative research projects

Outline

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- Background
- Cultural relevance of items
- Formal translation of a measure
- Translation with an interpreter
- Cultural guidelines
- Outcomes for CaLD consumers?

Background

- In 2006 more than half a million people in Australia spoke English with low proficiency
  - *N*=561,416, 2.3% (ABS, 2006)
- In Victoria, clients who preferred to speak a language other than English comprised:
  - 5% (*N*=1,057) of adult mental health clients, and
  - 16% (*N*=1,021) of aged mental health clients
- Mental health legislation, human rights, & duty of care provisions require that people with limited English proficiency must not be disadvantaged in service provision

Issue for outcome measures

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- *Not all the world speaks a direct translation of English* (Wierzbicka, 1992)
- *People who speak different languages live in different worlds; not in the same world with different labels attached* (Sapir, 1930)

Cultural issues for consumer-rated measures: BASIS-32

- Norms regarding *household responsibilities* vary across cultures; may be gender-based
- *Independence* and *autonomy* are not valued in collectivist cultures: interdependence and group harmony are emphasised
- *Physical symptoms* may represent a cultural "idiom of distress"
- There is no word for *depression* in Somali, Shona, Vietnamese, Chinese…
  - If there is no word for it, what is the interpreter saying?
- 5-point rating scale may not be understood.

Translations: consumer-rated

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- BASIS-32 Translations - Vic
  - Arabic
  - Cambodian
  - Chinese
  - Filipino
  - Finnish
  - French
  - Greek
  - Italian
  - Japanese
  - Korean
  - Portuguese
  - Spanish
  - Thai
  - Vietnamese
- Mental Health Inventory – Qld
  - Arabic
  - Chinese
  - Croatian
  - Farsi
  - Filipino
  - Greek
  - Indonesian
  - Italian
  - Khmer
  - Samoan
  - Serbian
  - Spanish
  - Vietnamese

Translation of the Mental Health Inventory: QTMHC

- QTMHC 6-month project to formally translate the MHI into 13 languages
- Bilingual facilitators with MH background conducted 2+ focus groups per language
  - 185 participants
- Facilitators helped accredited translators to understand MH terminology: ensured language was appropriate at all community levels
  - No slang or idioms
- First translation drafts sent back to facilitators for comment
- Independently back-translated into English:
  - reconciliation of differences

Translation with an interpreter

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- But 200+ *more* languages are spoken in Australia
- If no formal translation is available, book a NAATI Level 3/Professional interpreter
- Allow the interpreter time to become familiar with the measure, and discuss possible translation difficulties before administering
- The role of the interpreter is to convey equivalence in meaning, not a word-for-word translation

Parent-rated measure

- The SDQ is publicly available in multiple languages, but "translations follow the UK English version, which has some variation in wording and there is only one parent version for 4-16 year old, not 4-10 and 11-17"
- "It is unclear how appropriate the translated versions are and should be used with caution" (DHS, Vic., 2008, DoH, Vic., 2009)
- Parents' ratings may be made according to different cultural norms; expectations of children may differ
- May not understand items such as "*easily distracted, concentration wanders*", "*good attention span*"

Cultural issues for clinician-rated measures: HoNOS (QTMHC)

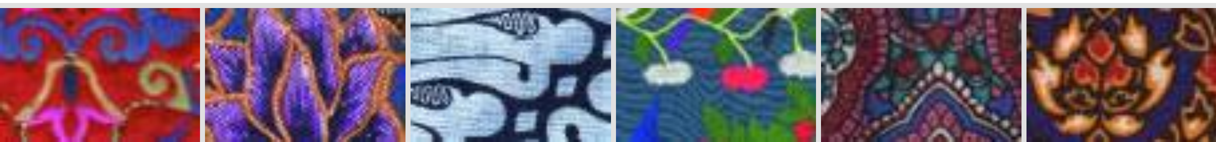
- Scales most difficult to complete with CaLD clients:

  4. Cognitive problems
     - Language barrier: cognitive problems are often most obvious through language
  6. Hallucinations
     - Differentiating perceptual disturbance vs spiritual belief; consumer could not understand questions
  8. Other mental or behavioural problems
     - Eliciting symptoms requires understanding of language use and other nuances
  9. Relationship problems
     - Difficult to assess what is normal in consumer's culture. Reluctant to discuss relationships (QTMHC, 2005)

QTMHC have published

- Culturally sensitive guidelines for the application of the HoNOS/HoNOS 65+
  - Consult a bicultural mental health consultant about behaviour
  - Some drinking/drug-taking may be culturally sanctioned, e.g., chewing Qat
  - Physical symptoms may be a cultural expression of emotional distress
  - Living conditions: consumers may be satisfied living in crowded conditions with large extended families

This project and material was developed by the Queensland Transcultural Mental Health Centre on behalf of Queensland Health". For further information contact Rita Prasad-Ildes, QTMHC Manager, ph 07 3167 8333, email Rita_Prasad-Ildes@health.qld.gov.au. Reports can be downloaded from: www.health.qld.gov.au/pahospital/qtmhc/



What are the outcomes for CaLD consumers?

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- Data are needed to evaluate whether CaLD consumers show differences on outcome measures
- If there are differences, is this because:
  - there are differences in mental health/outcomes for CaLD consumers…
  - or are scores invalid due to inappropriate application of measures?
- To answer these questions data are needed on birthplace, and preferred language, and for this information to be linked to outcome data
- Are translated measures being used by clinicians?

Victorian OM brochure

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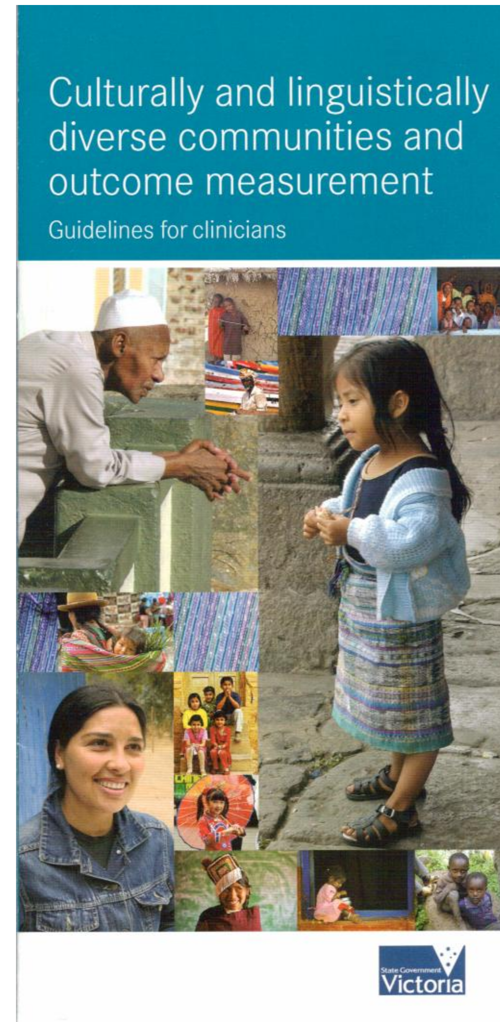
- **Brochure**:
  Culturally and linguistically diverse communities and outcome measures: guidelines for clinicians
- Order from Victorian Dept of Health

http://www.health.vic.gov.au/mentalhealth/outcomes/index.htm



Multicultural Mental Health Australia

Purpose: National program to promote mental health and well being and improve access, responsiveness & quality of mental health services for CALD communities.	
Priority Area 1	**Policy advice, development and implementation**
Priority Area 2	**Community capacity building and development**
Priority Area 3	**Communication, education & information dissemination**
Priority Area 4	**Carer & consumer support & representation**
Priority Area 5	**Workforce development**

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Agenda

Mental health data and CALD populations - MMHA

- What's the problem?
- CALD MH research priorities
- What do we know?
- Data and planning
- Data needed
- Summary

CALD consumers & outcome measurement - VTPU

- Cultural relevance of items
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What's the problem?

Results from the 2007 Survey of Mental Health and Well Being show that…

The prevalence of 12-month mental disorders was similar for those born in Australia and mainly English-speaking countries (21.8 and 21.0 per 100,000 population respectively) and ***much lower*** (12.3) for those born in other countries. (AIHW, 2010)

Can we therefore assume that mental health problems are not as big an issue for CALD communities as they are for the general population?

Key issues with 2007 SMHWB:

- Did not use interpreters
- And excluded people with low English proficiency

Without adequate data it can therefore be erroneous to generalise findings to all people from CALD backgrounds.

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CALD MH research priorities

Review of MH research priorities revealed:

- CALD MH issues were identified in only 2.2% of published articles and attracted only 1.5% of competitive research grant funding
- Transcultural comparisons accounted for only 0.6% of articles and 0.04% of funding.

(Griffiths et al, 2002)

What do we know?

Consumers from CALD backgrounds tend to*:

- Have lower rates of access to community and inpatient mental health services compared with Australian-born people
- Those who do reach services are more likely to be admitted involuntarily and tend to be hospitalised for longer
- Therefore it appears that it is more likely that presentation is at the acute, crisis end of an episode

However, findings are based on assumptions of similar prevalence rates and limited data. It is also difficult to make conclusive statements due to the lack of consistent CALD mental health data collection across the nation.

*(Minas, Lambert, Kostov, & Boranga, 1996; Klimidis et al, 1999; Stolk, Minas, & Klimidis, 2008; Minas, Silove, Kunst, 1993; Sozomenou, Mitchell, Fitzgerald, Malak & Silove, 2000; DOHA, 2004)

Data and planning

The accurate measurement of the mental health status of CALD communities is fundamental to the provision of quality mental health services. (Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia).

Unfortunately, there are limited data collections systems available to observe and measure:

- The demographics of CALD mental health service users
- The prevalence rates of mental health problems in CALD populations
- The utilisation rates of mental health services by CALD populations.

Data needed

MMHA recommends the ABS Minimum Core Set of CALD data variables:

1. Country of Birth of Person
2. Main language Other than English Spoken at Home
3. Proficiency in Spoken English and
4. Indigenous status
5. In addition, MMHA recommends “interpreter use”.

Why is additional data needed?

Additional data to COB is needed because:

"For those born overseas, their year of arrival in Australia… and their country of birth provides a useful indication of a person's likely ethnic or cultural background.

However, for some overseas-born people their country of birth may be different from their ethnicity, such as people of Chinese ethnicity born in Malaysia, or people of Indian ethnicity born in England." *(ABS, 2006)*

Summary

1. There is a lack of research into prevalence and incidence of mental health problems in CALD communities
2. Existing research shows inequity of access for CALD consumers to MHSs
3. There is a lack of prioritising of consistent CALD data collection across service systems and jurisdictions that enables meaningful analysis
4. Availability of reliable and valid CALD data is essential for monitoring and delivering quality outcomes for all.

For those that do get to the front door, what do we know about their outcomes?

And what could this tell us about their mental state on arrival?

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