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Evaluation of the AC-OK mental health and substance abuse screening measure in an international sample of Latino immigrants



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ABSTRACT

Background: Early detection and intervention in primary care is integral to behavioral health. Valid, practical screening assessments are scarce, particularly for non-English speaking populations. We address this need by evaluating the psychometric properties of the Spanish version of the AC-OK Screen for Co-occurring Disorders for first and second generation immigrant Latinos in Massachusetts, USA, and Madrid and Barcelona, Spain.

Methods: 567 Latino participants were recruited in waiting areas of clinics or by referral from Primary Care, Mental Health, Substance Use, and HIV Treatment Clinics, as well as Community Agencies. We use confirmatory factor analyses to evaluate the factor structure, correlation analysis to examine concurrent and discriminant validity, and receiver operating curves (ROC) to determine the ability of the AC-OK to approximate a composite of established instruments designed to measure depression, generalized anxiety, post-traumatic stress disorder symptoms, alcohol, and drugs (including benzodiazepines) as external criteria.

Results: The original two factor structure was replicated in samples of Latino respondents in the US and Spain. Correlations with other measures followed the expected pattern. In both the US and Spain, ROC analyses suggested that the AC-OK scale was an adequate approximation to other specific measures of mental health (ROC = 0.90) and substance abuse problems (ROC = 0.83).

Conclusions: The Spanish version of the AC-OK Screen has good to excellent psychometric properties in both its subscales. These findings are robust across sites, gender, and type of clinic. We recommend its use for clinical research and for routine screening at treatment centers.

1. Introduction

Co-occurring disorders of addiction and mental health, referred to as dual diagnosis, are common among healthcare service users (Sacks et al., 2013). Approximately 8.9 million U.S. adults have co-occurring addiction and mental health disorders (Cherry and Dillon, 2012). Yet only 7.4% of them receive treatment for both conditions (Sacks et al., 2013). The prevalence of co-occurring substance use and mental health problems (sub-diagnostic, defined as drug or alcohol use and elevated mental health symptoms which interfere with functioning and/or result in social, work and/or legal difficulty) is substantially higher (Fein et al., 2007; Grant et al., 2004; Rohde et al., 2001; Saitz et al., 2010). If

unrecognized, the individual and societal cost of these co-occurring conditions can be physically and economically damaging (Burns and Teesson, 2002; Kushner et al., 2000; Lasser et al., 2000). In the United States, 7.9 million adults have co-occurring mental health and substance use disorders (Hedden, 2014). We also know that nearly one third of people with any mental illness and approximately one-half of people with severe mental illness additionally experience substance abuse (National Alliance on Mental Illness, 2013). At a rate of 5.8%, Latinos have the second highest rate of lifetime co-occurring psychiatric illness and substance abuse disorders after Whites (Mericle et al., 2012). For Spain, to our knowledge, no specific prevalence rates of co-occurring disorders among Latinos have been published, but a recent report

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by the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) lists prevalence rates of co-occurring disorders found across several studies. The prevalence of co-occurring disorders was found to be 21% in a general population study, and ranged from 13 to 59% among drug users in treatment and 18–67% among drug users not in treatment (Torrens et al., 2015).

People who have a dual diagnosis tend to enter treatment struggling with suicidal ideation, and are more likely to attempt suicide and to die from their suicide attempts (National Alliance on Mental Illness, 2013). They are also at increased risk of impulsive and violent behaviors and are therefore slightly more likely to be involved in the criminal justice system, and have more problems with substance abuse than others entering treatment solely for addiction (Cherry et al., 2008; National Alliance on Mental Illness, 2013).

Although Latino adults have one-fourth the risk of dual diagnoses compared to the general U.S. population (Vega et al., 2009), Latino immigrants show an increased risk of developing mental illness, substance use, and co-morbid psychiatric illness and substance use after immigration to the U.S. (Borges et al., 2011; Breslau et al., 2011; Jiménez-Castro et al., 2010). Furthermore, U.S. nativity seems to increase the likelihood of reporting a dual diagnosis among Latinos (Vega et al., 2009). There are also significant racial/ethnic disparities in accessing behavioral health treatment among people with co-occurring disorders, with Whites more likely to receive and be referred to treatment than other racial/ethnic groups, including Latinos (Priester et al., 2016). Latino immigrants in both the United States and Spain also cite significant barriers to accessing behavioral health care including being unfamiliar with available services and wanting to resolve the problem by themselves and location-specific issues of cost and linguistic barriers (Falgas et al., 2017).

While both Spain and the United States offer competitive employment and better wages, there is variation in the composition of Latino immigrants that are more likely to immigrate to the U.S. versus Spain (Connor and Massey, 2011). Because of its geographic proximity and thus lower costs of immigration, it is more common for Latino immigrants from Mexico, Central America, and the Caribbean to move to the U.S. (Connor and Massey, 2011). In fact, 53% of all U.S. migrants are Latino (Acosta and De la Cruz, 2011). Data from the 2011 U.S. Census indicates that Mexicans account for more than half (55%) of the foreign born Latinos, followed by El Salvador and Cuba in the Caribbean (Acosta and De la Cruz, 2011). The nature of migration and immigration to the U.S. may also vary by country of origin (Torres and Wallace, 2013). For Mexican immigrants or Puerto Rican migrants, involuntary or unplanned migration may be more likely to result from economic circumstances or family obligation (Ellis et al., 1996), while for Cubans and other Central and South Americans, involuntary immigration may be more likely to result from political conflict or a combination of political and economic reasons (Cislo et al., 2010). In contrast, Latino immigrants from South America—more distant from the U.S.—may be more likely to move to Spain because of a comparatively easier process of social integration (Connor and Massey, 2011). Out of all the countries in the European Union (Padilla and Peixoto, 2007), Spain has the largest number of Latino migrants, with Latinos from the South, Central America and the Caribbean representing 28% of all migrants (Padilla and Peixoto, 2007). Demographic data from 2014 shows that in Spain, the largest numbers of Latin American immigrants are from Ecuador, followed by Colombia and Bolivia (Arroyo-Perez et al., 2014). Altogether, both countries have different composition of Latinos, but the shared magnitude of the migratory populations suggests there is a need to address certain challenges, in our case in terms of screening for dual disorders. Having available a Spanish language instrument with good psychometric properties will assuredly prove beneficial for all Spanish speaking populations.

The principal barriers to universal screening for dual disorders are the lack of availability of trained staff and of reliable and valid

screening instruments (Cherry et al., 2008). These barriers are exacerbated when aiming to screen non-English speaking populations (Martinez, 2010). The requirement to allocate trained staff to screening can be facilitated if the screening measure is simple and easy to understand and complete. However, there are few such screening measures for dual diagnosis with demonstrated adequate psychometric properties.

Our search for available screening instruments identified that instruments designed for a comprehensive dual diagnosis assessment are extensive and therefore time consuming, and most entail specialized clinical skills and extensive training to administer such as the Composite International Diagnostic Interview (CIDI) (World Health Organization, 1993) or the Comprehensive Addictions and Psychological Evaluation (CAAPE) (Hoffmann, 2000). Other instruments focus only on one disorder (mental health or substance abuse) such as the Fagerström Test for Nicotine Dependence (FTND) (Heatherton et al., 1991) or the Patient Health Questionnaire 9 (PHQ-9) (Kroenke et al., 2001) for depression. And still others such as the CAGE-AID (Brown and Rounds, 1994), designed to identify people with a mental health disorder that have a substance use problem, only collect information on lifetime and not current use. As a result, we chose the AC-OK Screen (AC– Andrew Cherry and OK – Oklahoma) (Cherry et al., 2008) for the evaluation of co-occurring disorders because it was easy to interpret, did not require much training to administer and had good psychometric properties in English-speaking populations (Cherry and Dillon, 2012). It was designed to cast a wide net to be a useful screener in mental health and substance abuse treatment agencies. It seeks to identify people that may have co-occurring problems (to have high sensitivity), and to identify people who do not need a comprehensive co-occurring disorder assessment because they lack a dual disorder (specificity).

This paper evaluates the Spanish translation and adaptation of the AC-OK for use with Latino migrants in Spain and the United States. Psychometric properties are compared to the original English version. Further, it analyses receiver operating curves for predicting mental disorder and substance abuse using various cut-off points on the AC-OK, with a range of concurrent screener measures as the validity criterion.

2. Methods

2.1. Setting and study sample- screener

We recruited participants through direct contact in mental health, substance use, primary care, and HIV clinic waiting rooms, as well as community agencies in Boston, Massachusetts (MA), and Madrid and Barcelona, Spain. We also expanded our efforts to include community-based organizations (i.e., organizations providing social or cultural services for immigrants) serving a diverse population of Latinos. Recruitment activities were conducted between July 2013 and August 2014. Approval was obtained from the institutional review boards of participating institutions.

2.2. Research procedures

We trained research staff to conduct the research protocol using standardized interviewing techniques and conducted mock interviews before entering the field. To ensure consistency across sites quality control procedures were implemented and included a quality check of the first 3 cases of all new interviewers and a continued randomized 15% of additional cases was implemented. Once certified, interviewers recruited patients in waiting areas of clinics, by referral in community groups, or by telephone screening of people in clinics who had consented to learn about the study. Participants were usually screened in the clinic, in a private setting. In cases where some interviews or portions of interviews were unable to be completed in person, they were later completed over the phone. Participation in this study did not interfere with the treatment received.

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