Association of Refugee Health Coordinators (ARHC)
Refugee Mental Health Screening Survey

August 2015

Prepared by: ARHC Refugee Mental Wellness Committee

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ARHC Refugee Mental Wellness Committee Co-Chairs:

Amy Greensfelder, Maryland Department of Health and Mental Hygiene

Amber Gray, Center for Victims of Torture

Committee Members:

Jane Evans

Ellen Frerich

Alicia Helion

Carrie Gould Kabler

Susan Stiker

Amira Suton

Monica Vargas

Acknowledgments:

Many thanks to the Association of Refugee Health Coordinators Executive Board for their guidance and support in development and implementation of this survey and report. Thanks are also due to Tim Kelly, Program Specialist with the Division of Refugee Health at the Office of Refugee Resettlement and Sasha Verbillis-Kolp, Program Coordinator at Lutheran Community Services of the Northwest for their assistance in development of the survey.

Association of Refugee Health Coordinators: The Association of Refugee Health Coordinators (ARHC) is comprised of Refugee Health Coordinators (RHCs) and associates, representing U.S. jurisdictions that have a Refugee Health Program. The mission of ARHC is to strengthen state and local refugee health leadership, expertise, and advocacy in order to achieve wellness in domestic refugee populations. For more information please visit the ARHC website: http://www.refugeehealthcoordinators.org/

ARHC Refugee Mental Wellness Committee (RMWC): The RMWC is charged with: 1) increasing dialogue on refugee mental health between ARHC members and the refugee resettlement community; 2) sharing best practices in the field of refugee mental health with the ARHC membership; 3) providing support and encouragement about mental health care to states with limited resources; 4) sharing culturally and linguistically appropriate mental health educational resources and materials with the refugee resettlement community; and 5) encouraging the delivery of culturally and linguistically appropriate mental health care to refugees throughout the United States.

INTRODUCTION AND PURPOSE OF STUDY

State refugee health programs use a variety of tools to conduct mental health screening for arriving refugees. Mental health screenings may occur within state refugee health programs as well as in other venues; and, individuals from a variety of professions may conduct the screenings. Over the past three years, many Association of Refugee Health Coordinators (ARHC) members had noticed that mental health screenings of refugees seemed to be inconsistently conducted from jurisdiction to jurisdiction. The ARHC Refugee Mental Wellness Committee (RMWC) had frequently received requests from members asking how different states conducted mental health screening, how many states were doing mental health screening, and what screening models were available. The RMWC values the importance of sharing accurate, and up-to-date information on mental health screening management in different states. This would allow interested state Refugee Health programs to learn from and adopt the available models.

To respond to these inquiries, the RMWC conducted the ARHC Refugee Mental Health Screening survey of the association's membership in November 2014. The purposes of this survey were: 1) to gather updated information on the current refugee mental health screening practices in various state refugee health programs, 2) to identify the tools that state refugee health programs use in refugee mental health screening, and 3) to identify challenges and barriers in refugee mental health screening.

This report, generated by the committee, includes a summary of findings and recommendations.

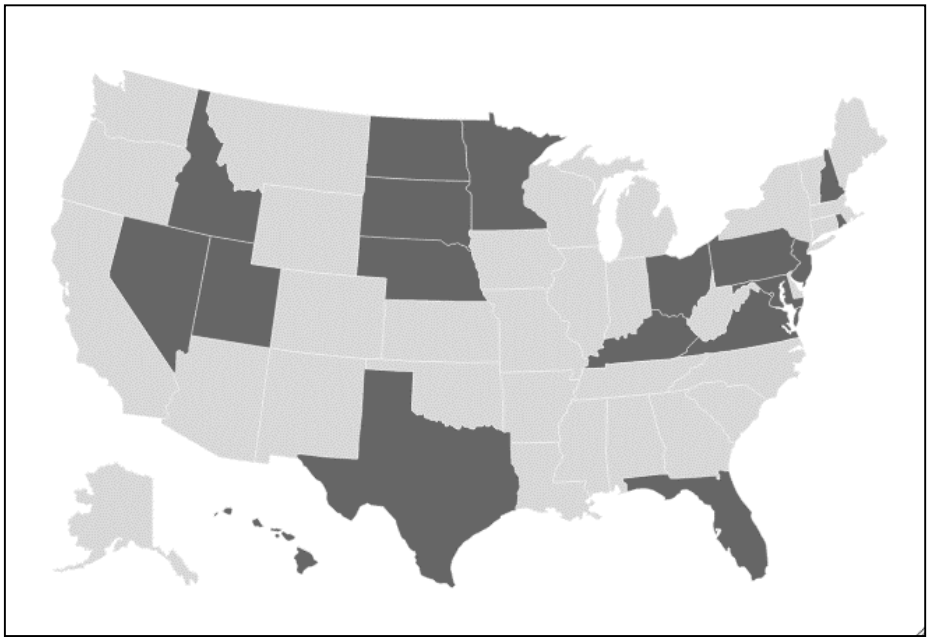
METHODS

The Refugee Mental Health Screening Survey asked respondents whether their state had a Refugee Mental Health Program Coordinator, and whether their state engaged in refugee mental health screening. States which ***did*** engage in refugee mental health screening were asked to further identify: 1) where the screening takes place; 2) who administers it; 3) which screening tool(s) is/are used; and 4) any gaps and challenges in carrying out mental health

screening. States which *did not* engage in refugee mental health screening were asked about their future plans to implement mental health screening, and to identify gaps and challenges that might prevent them from implementing mental health screening.

The survey was sent to 48 ARHC primary members across the United States in November 2014. There were 18 total respondents to the Refugee Mental Health Screening Survey. Respondents included 15 State Refugee Health Coordinators (SRHC), one individual acting as a Refugee Health Coordinator, one Affirmative Action Officer, and one Registered Nurse Consultant. The following states participated: Florida, Hawaii, Idaho, Kentucky, Maryland, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, and Virginia (Fig. 1). While a small sample size, these states represent a variety of refugee health programs, from states with large arrival numbers (Texas, Florida, Pennsylvania) to one of the smallest (Hawaii), Wilson-Fish programs (Idaho, Kentucky, Nevada, North Dakota, South Dakota), public-private partnership states (Maryland, Minnesota, Texas), and state administered programs (Florida, Hawaii, Nebraska, New Hampshire, New Jersey, Ohio, Pennsylvania, Rhode Island, Utah, Virginia). Additionally, they represent a good geographical distribution of refugee health programs.

Figure 1. Map of survey respondents.



LIMITATIONS

The survey asked participants to respond within five days of receipt. It is possible that the short turnaround time impacted the survey response rate. Further, the survey was administered using "Google Forms" software. Many Refugee Health Coordinators work within state government systems, and some state IT departments block access to the "Google Forms" program. Individuals who noted difficulty accessing the form were provided with a copy of the survey in a Microsoft Word Document to complete the survey. It is possible that others experienced difficulty accessing the survey but did not convey their difficulty to ARHC.

It is also important to note that not all refugee mental health screening in all states is being done under the auspices of the State Refugee Health Coordinator. In some states, refugee resettlement agencies conduct the refugee mental health screening. The survey asked the SRHC to share information about mental health screening that might take place outside of the State Refugee Health Program; however, in some states the State Refugee Health Coordinator may not have been knowledgeable of the mental health activities of all organizations serving refugees.

RESULTS

Respondents were asked about the presence of a Refugee Mental Health Coordinator, the distribution of mental health screening activities, the mental health screening tools used, the locations where mental health screening occurs, the profession of the individuals responsible for screening, and any referral and follow-up protocols. States were also asked to identify any gaps and challenges regarding the implementation of refugee mental health screenings.

Presence of Refugee Mental Health Program Coordinator

Four states (22.22%) indicated that there is an individual who coordinates refugee mental health programs. Those states are Kentucky, Maryland, Pennsylvania, and Virginia.

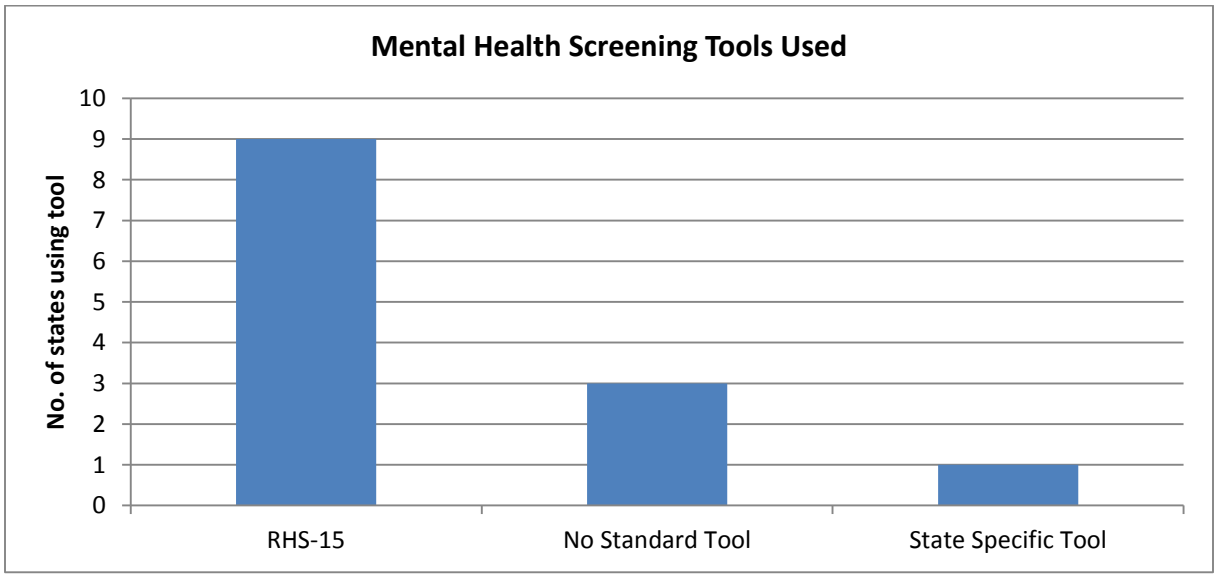
Distribution of Mental Health Screening Activities

States were asked whether the state refugee health program is engaging in mental health screening. In five states (Idaho, Florida, Ohio, Utah, and Pennsylvania), all adult refugees receive a mental health screening through the state refugee health program. Three states, (Maryland, North Dakota, and Virginia), have implemented mental health screening through the state refugee health program, but not every adult is screened. In five states, (Kentucky, Nebraska, New Hampshire, Nevada, and Rhode Island), mental health screening is done at partner sites. Five states, (Hawaii, Minnesota, New Jersey, South Dakota, and Texas), are not currently engaged in refugee mental health screening.

Mental Health Screening Tools

States that have refugee mental health screening were asked which tools they used. Of the 13 states that indicated that they are engaged in screening, nine are using the RHS-15, three are not using a standard tool, and one state is using a state-specific tool (Fig. 2). States indicating that they are engaged in mental health screening include: Florida, Idaho, Kentucky, Maryland, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Pennsylvania, Rhode Island, Utah, Virginia.

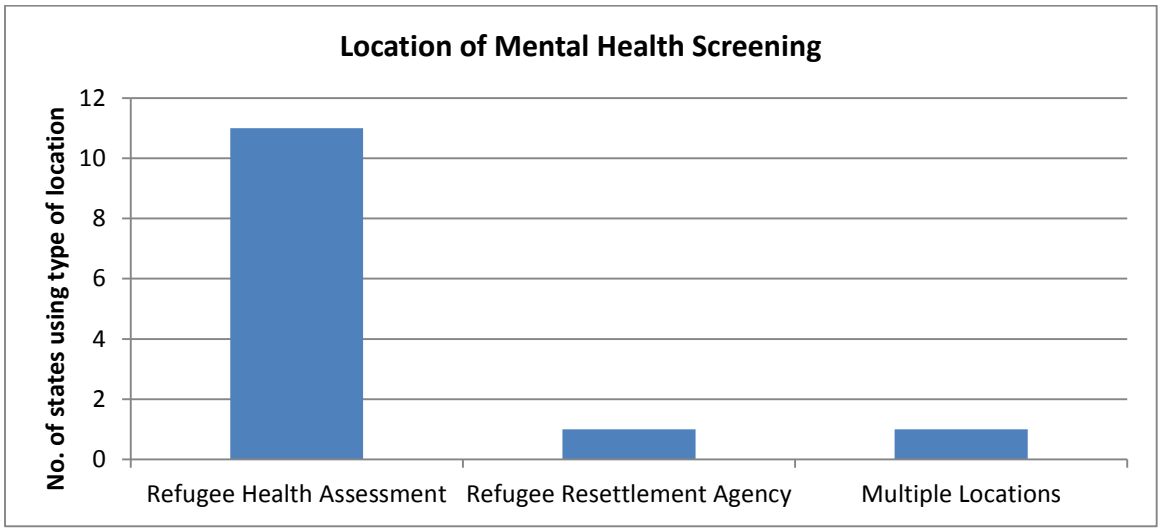
Figure 2. Mental health screening tools used by states with mental health screenings.



Location of Screening

Each state was asked to indicate whether mental health screening took place during the Refugee Health Assessment, at a Refugee Resettlement Agency, or at some other location. The chart below shows that the majority of states (84.6%, 11/13) perform refugee mental health screenings during the refugee health assessment (Fig. 3). Those states are Florida, Idaho, Kentucky, Maryland, Nevada, New Hampshire, North Dakota, Ohio, Pennsylvania, Utah, Virginia. One state (Nebraska) performs mental health screening at refugee resettlement agencies, and one state (Rhode Island) performs mental health screens in multiple settings, including at refugee health assessments and at resettlement agencies.

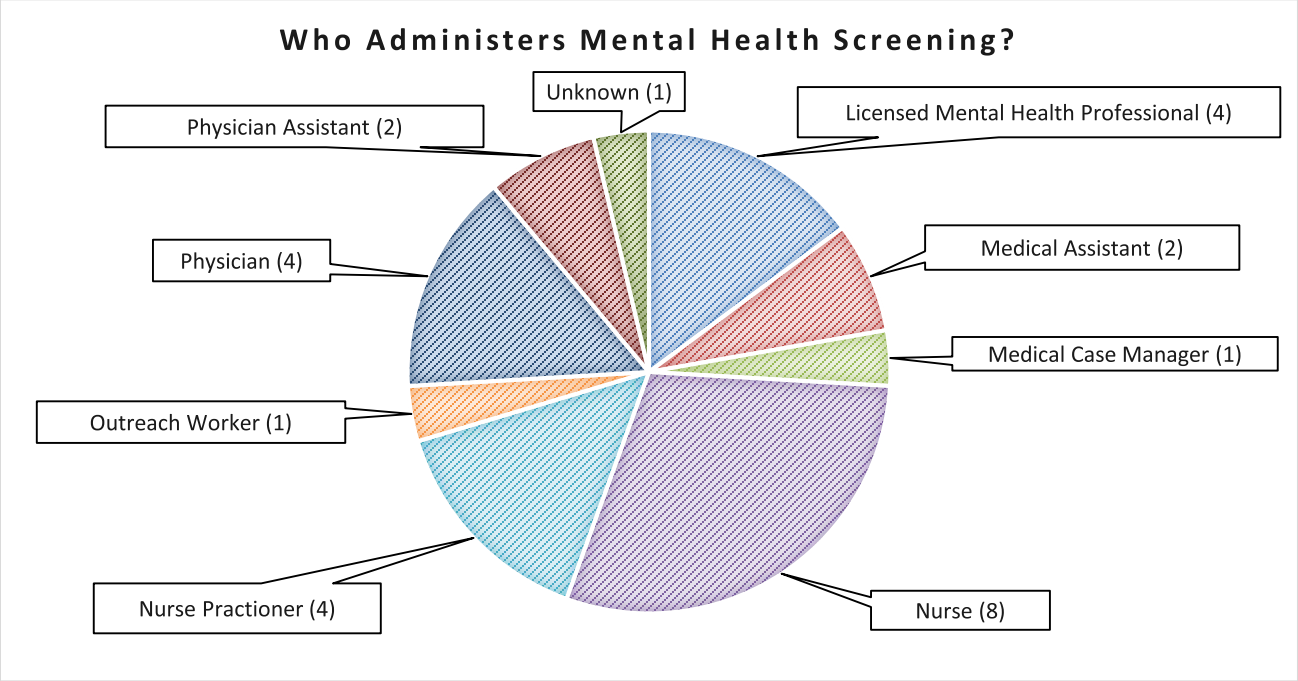
Figure 3. Location of mental health screening.



Profession of Individual Responsible for Screening

States engaged in refugee mental health screening were asked to identify the profession of the individual administering the screen. Survey participants were allowed to mark more than one response. A variety of professions were identified, with nine states indicating that mental health screening is performed by individuals from more than one profession. Figure 4 below illustrates the frequency with which each health profession was identified as participating in screening. One state, where screening takes place at partner sites, was uncertain of the professional background of individuals responsible for screening.

Figure 4. Profession of individuals performing mental health screenings.



Referral and Follow-Up Protocols

States engaged in refugee mental health screening were asked to indicate whether they had a referral protocol in place to ensure referrals for any refugees who screened positive on the mental health screening tool. Twelve states indicated they had a referral protocol, and one state indicated it did not have a referral protocol.

States engaged in refugee mental health screening were asked to indicate if they have a follow-up protocol to ensure continued care after the initial mental health screening. Eight states indicated they had a follow-up protocol, while five states did not have a follow-up protocol.

Gaps and Challenges

States were asked about any gaps and challenges with regard to mental health screening. In examining the identified gaps and challenges certain themes emerge. The most commonly identified issues reflect concerns with implementation, screening processes, referrals, and systems.

In addition, these concerns varied, depending on a state's capacity for, or involvement in, conducting mental health screenings. Figure 5 below presents survey responses about the types of gaps and challenges states experience in implementing refugee mental health screening by type of gap/challenge, and by state model of screening.

Figure 5. Gaps and challenges by type, and by state model of refugee mental health screenings

Type of Concern/ Challenge	States without refugee mental health program coordinator/ Not engaged in refugee mental health screening	States with refugee mental health program coordinator and engaging in mental health screening	States without refugee mental health program coordinator, but which are engaging in mental health screening
Implementation	Need to identify a standardized, validated, short screening instrument	Effectiveness of screener for refugee populations	Not all clinics use the same instrument
Screening	Provider concerned about ability to screen and make successful referrals	Staff at clinic level not accepting mental health screening as part of basic refugee health screening	Lack of standardized tool for children under the age of 14
	Screening sites use their own mental health screening tool		Not all health clinics have the time capacity to implement the RHS-15
	Screening quality oversight		Not every health department uses the RHS-15. Some use abbreviated questions per state guidelines.
	Lack of uniformity across screening sites		Lack of provider knowledge on mental health needs
			Lack of time during screening
			Mental health issues are typically not present when refugees arrive to the U.S.

			Mental health screening results will not be accurate when refugees arrive to the U.S.
Referrals	Limitations/difficulties navigating the mental health referral system	Local Mental Health providers' capacity to accept referrals	Lack of providers that accept Medicaid clients
	Difficulty finding providers who can assist refugees in culturally sensitive manner	Lack of medically trained interpreters at referral sites	Lack of trained mental health professionals
	Long wait times for referrals	Cost of interpretation services	Lack of follow up resources
	Inadequate workforce/capacity to complete successful referrals	Lack of mental health services for follow-up	Need for formal protocol to ensure initial intake and continued care are continued after initial referral
			Need for ensuring resettlement agency follows-up with providers and clients to ensure the client is accessing available mental health services
			Language capacity
Systems	State hiring restrictions restricting hiring of a State Refugee Mental Health Coordinator, despite available funding.	Ensuring that the State is looped in on status of referral acceptance	Refugee clinics that are not run by the Department of Health seeking to work with partners to provide universal screening and mental health services for refugees.
		Cases with chronic mental health conditions that need long term follow-up and treatment that the program cannot afford to support	
Miscellaneous			Screening started [only] month prior to ARHC survey

DISCUSSION

This survey sought to identify which states were engaged in refugee mental health screening, to understand the gaps in, and challenges for, mental health screening, and to determine the methods used in states that are currently engaged in refugee mental health screening. Seventy-two percent of respondent states (13/18) indicated there is some form of mental health screening for refugees in their states. The most common screening tool used is the RHS-15. Screening most commonly occurs at the refugee health assessment, and in many states it is performed by a nurse. The great majority of states (92.3%, 12/13) with refugee mental health screening have a referral protocol, while only 38.5% (5/13) have a protocol to ensure continuity of care after the initial referral.

Common themes emerged when states were asked to identify the gaps and challenges in implementing refugee mental health screening. The most commonly cited challenges reflect concerns with implementation, screening processes, referrals, and systems:

- **Implementation** concerns included provider ability and capacity to engage in screening, (including resistance to mental health screening from staff), lack of uniformity across screening sites, sites using different tools, concerns about length and validity of tools, and language and interpretation.
- **Screening process** concerns included implementation challenges and not having enough time to administer the mental health screening.
- **Referral concerns** included limited options for timely, culturally competent referral sources for those who screen positive and challenges in ensuring clients access care once initially referred.
- **Systems concerns** included state hiring restrictions (including budget issues), inability to support long-term follow-up and treatment for some chronic cases, and the necessity of working with outside partners to provide screening and services.

RECOMMENDATIONS FROM THE ARHC REFUGEE MENTAL WELLNESS COMMITTEE

The Refugee Mental Wellness Committee and ARHC leadership have had ongoing formal and informal discussions to address the inconsistencies of refugee mental health screening processes across the nation. Thinking creatively, and consulting with other states, may alleviate some gaps or challenges that programs may feel about implementing a refugee mental health screening program. For example, next steps to address lack of uniformity across screening sites, states might: 1) work with the State Refugee Health Coordinator to ensure consistency of the Refugee Health Assessment at each screening site; or 2) monitor clinic sites and tie funding to the completion of all elements of the Refugee Health Assessment in a standard manner. In order to address concerns about the validity of screening tools, states might discuss specific questions of validity with the screening tool developers.

To address screening processes, adequate training of staff prior to implementation of the mental health screening, and provision of frequent follow-up in the form of observation and feedback may be necessary. High levels of staff turnover may require more frequent training cycles. To manage perceived time constraints, thorough training and interstate data sharing about length of time for mental health screening may allay fears of providers.

Referral and follow-up capacity pose real problems for refugees with mental health issues, and for state refugee health programs. To address limited availability of competent referral and follow-up resources, interstate technical assistance from more experienced states, and working with academic institutions, torture survivor programs, and local non-profits may be helpful. To ensure that clients are able to access care after being referred, strategies such as: sharing curricula (e.g., mental health orientations) that seek to reduce stigma; connecting with mental health caseworkers or interns at refugee resettlement agencies; or coordinating mental health referrals/diagnoses in conjunction with the refugee health assessments (including having appropriate behavioral health staff on hand) may help.

Systems change is often difficult at the state level. Providing education about refugee resettlement, health and mental health needs may be required. Sharing reports such as this and drawing on experiences of other state refugee health programs may help initiate and sustain the dialogue.

CONCLUSION

The CDC Guidelines for domestic Refugee Health Assessments recommend that all refugees over the age of 16 be screened for depression and Post Traumatic Stress Disorder. State Refugee Health Programs should be working toward meeting this standard. The information gathered from this survey can help states achieve this goal. There is a large body of knowledge in the states that have already begun to implement screening which can be shared with those states that are seeking to start refugee mental health screening. The Refugee Mental Wellness Committee looks forward to building on this initial snapshot of refugee mental health screening and sharing best and emerging practices with the ARHC general body.