

**Tools and Strategies for Refugee Mental Health Screening: Introducing the RHS-15
Wednesday, January 25, 2012
Webinar Questions and Answers**

During the Tools and Strategies for Refugee Mental Health Screening: Introducing the RHS-15 webinar, participants had the opportunity to submit questions to Michael Hollifield, MD the presenter. Due to time constraints, Dr Hollifield was not able to answer all the questions. Here are his responses to questions that were not covered during the webinar. In addition, one of his colleagues, Annette Holland from the Seattle King County Public Health provided additional information for some of the questions.

The webinar can be viewed on the RHTAC website <http://www.refugeehealthta.org/>. For further questions, please contact RHTAC by email at refugeehealthTA@jsi.com.

What languages is the RHS-15 available in?

It is available in Karen, Burmese, Arabic, Nepali, Russian, Somali and Tigriyna. Other languages are planned for release later in 2012.

When administering the RHS-15, what do you recommend for refugees who are not literate in their native language, or any other languages?

We recommend that it be administered with the assistance of bi-cultural workers and an interpreter who can read aloud each item and any other visual aids as needed. The scale on the top of the RHS-15 shows jars with beans in it- one could replicate this and have real jars with beans or rice- to help describe the variance in the scale. Regardless, it should be clear that the instructions are understood by the refugee.

How do we make sure that language and culture don't handicap the administration of the instrument?

The RHS was developed with back, forward, and consensus translation and community participatory methods to ensure appropriate translation as part of the validity of the instrument. This ensures appropriate idioms of distress for each language group. We feel confident that because of the back and forth and consensus methodology and in engaging refugees in the process that we achieved an efficient instrument representative of each cultural semantic expression on a given item.

When conducting screening in a language you don't have the RHS-15 translated, what are some logistical recommendations you have to ensure that there is a high validity?

We would recommend working with an onsite interpreter if possible, providing a conceptual and contextual orientation prior to administration, and through a feedback loop that offers suggestions to yield a consistent approach when delivering among these populations. The health provider could take additional time to learn some of the cultural terms expressed in such language, so as to incorporate this into their approach.

We have adopted RHS-15 to optimize this needed service to refugees resettling in our county. We do not have dedicated interpreters and often use different interpreters based on their availability. How detrimental is this to the screening process and do you have any suggestions to overcome this?

That is not clear. It is best to have a modicum of training for all interpreters in medical translation, meaning they understand the intent and know how to follow the intent of the instrument. This is true for the RHS or any other medical questions. It would be very helpful if there is time to have a 5 minute pre-meeting with the interpreter to explain the use of the instrument, and for them to have a translated copy to read from while interpreting.

If the re-screening is administered after the initial period of refugee assistance has stopped (i.e., during the civil surgeon visit at 12 months post-arrival) doesn't this impact a refugee's ability to seek care and address their symptomology? It seems that a re-screen at 4-6 months would pick up on acculturation distress, but also allow for time to access services.

We totally agree with this comment. We did this at the civil surgeon exam for evaluation purposes (i.e. to look at the issue of delayed distress and chronic distress), and believe that our data will support your comment.

It may be ideal to offer the RHS-15 at multiple times during the first year of resettlement for this reason. While the majority of patients will have the 8 months of limited medical and other social provisions, others may continue on with TANF or have obtained insurance. In some states there are dollars allocated for Community Mental Health agencies to offer mental health services for those that have expired their medical coupons- as an advocacy approach this is highly recommended.

Some locales as well – like in King County – have other funding sources that may allow refugees to go into treatment. Each locale will need to look at what the available resources are in their community and make decisions based on that landscape.

Should this screening be incorporated along with the initial health screening? It would make a difference in the length of time allowed for the appointments.

Yes and yes, by 5 to 15 minutes, though those literate can do it while waiting for other things to happen in public health or primary care. This should be approached like any other component of health care screening and in fact be integrated to diminish stigma, and could be done by a primary care clinic.

How did you decide on the specific visual analogue scale on the first page, and why didn't you use a VAS for #14?

Good question. This was based on the conceptualization and layout of the pilot RSQ. There are many options for formatting and these issues are ALWAYS a challenge, and sometimes better seen in retrospection. We appreciate the comment.

We have seen a number of teens who have not experienced a discreet traumatic event (e.g. born in a camp and major life event is moving to the US). For these teens, what is the best way to handle questions 10 & 11?

Great question. This is often true of people with chronic abuse/trauma or even with some combat veterans who were immersed in risky and fear producing situations for a long period of time. This is where it is incumbent on the person giving the RHS to the refugee to say that “trauma” may mean a series of events, such as.... It is a good question to consider whether re-phrasing the instruction here may be useful. Thank you.

Why does the screener contain no questions about coping or strengths, such as: "When you feel (tense, sad) what helps, even just a little? Singing? Sitting near your mother? Drinking your special tea? Playing music from home? etc."

This is a very important clinical issue. Item #14 is about one’s capacity to cope as a “constitutional” symptom. We think this is a screening of potential emotional distress and diagnostic problems that need attention. When people are then referred would be the time to ask follow-up diagnostic, cultural, contextual and other questions about mitigating variables.

Is the score of 5 or above alone predictive of positive PTSD diagnosis?

If I understand this question, the reference is to the Distress Thermometer, item #15. A score of 5 or greater was .87 sensitive and .85 specific to classify someone as a PTSD case by the PSS-SR which has been shown to be highly sensitive and specific for clinical diagnosis.

How can you determine the urgency for a referral?

That is very individualized. In King County we are required to have an intake within 10 days, so most referrals are treated in an expedited manner. We also attempt to call everyone referred within 24-48. If they circle high on the distress thermometer, we try to call them the same or next day that we got the referral and assess over the phone for urgency. This is generally an acceptable time frame. I would say an “urgent” request would be those that presented as extremely distressed, so much so, that the person administering the tool felt worried about the person’s well-being. This only happened on one occasion with the RHS-15 (out of 251 cases) and we did a same-day intake.

This may also be based on other clinical observation or in some cases notification that a patient needed medication and so warranted an emergency intake. Counties and states will differ in their requirements for when to establish an intake after completing a referral.

Do you forward the test to the mental health providers once a referral is made?

Great question. It was an issue for us because we were not doing so and providers were screening again with less culturally competent questions, and this was causing clients not to accept services. We got a universal consent form implemented at Public Health Seattle and King County and now the instrument is faxed too. The place of referral uses

this instead of a phone screen. Pathways devised a central referral source and with the permission of the agency the RHS-15 can be forwarded on. This is extremely helpful for intake staff who can reference the symptoms a patient endorsed.

Are there follow up diagnostic measures you recommend if a person is referred on following a high score on the screener?

Yes. The RHS is just a screener such as a TB test or an EKG. As such, each clinical site should utilize a diagnostic procedure as part of the assessment toward a treatment plan.

Another answer is that it may be useful to have a “second level” screen, using the diagnostic proxies such as the PSS-SR and the HSCL-25 both of which have been utilized with refugees. We cannot comment from a strict scientific perspective the value of such an approach.

Is there an accompanying script or guide for those administering the RHS-15 with refugees which would guide them in how to present the RHS-15 to clients and then what information is shared after the score is obtained? Is a referral automatic or is a high score then discussed with the patient?

This is a great question. First, the score is briefly discussed and that a referral will be made. Of course, the refugee person may refuse this. In all cases an approach should include referencing the symptoms one is having, normalizing their experience (lots of refugees experience...) and describing concretely how one can get help for these symptoms. Then asking if they'd like more support is always good. We have a script that we use during trainings and technical assistance.

Annette Holland from Seattle King County Public Health writes:

At the beginning of each screening visit, the nurse explains how the visit will flow, what will happen in terms of medical history review, heights and weights, blood draws, immunizations, etc. The interpreter is introduced as part of the care team. It is explained that the last part of the visit will involve some questions that will ask how the refugee person is feeling/doing and the questions can be answered by each individual solo or with the help of the interpreter. The purpose of the questions is to identify if anyone needs any extra help.

After immunizations have been administered for the whole family, the nurse hands out the RHS-15, and reminds the family that this is the last part of the visit and tells them that he would like each person (over 14 years of age) to answer a few questions to tell us how they are doing, how they are feeling. The nurse will remind everyone that each person will answer the questions by themselves unless they need an interpreter to help them (if client is illiterate or finds the questions confusing). The nurse explains how to answer the questions (only pick one number for example) and encourages everyone to ask the nurse or interpreter if they need assistance.

It is hoped that this approach puts the family at ease and normalizes the screening tool.

The RHS-15 is typically the last piece of the screening visit after immunizations have been administered and before the exit interview and review of the “what to do next” form.

What is your opinion on whether or not screening should include risk for SI and substance abuse?

We discussed this issue at length. We believe that this screener for emotional distress should not, but that these should be addressed at the clinical site. This reasoning is for good clinical practice AND logistics of use in the public health setting, where one huge concern is time spent and risk

Is the RHS-15 being used in refugee camps, and if so, how? The problem is, of course, whether there is capacity to follow-up with clinically significant scores on the screener.

Right, that would be the problem. To my knowledge, I don't think it is in use in any refugee camps. It could be used, but the DATE of when it was administered and if the receiving country of resettlement could be notified of their health condition in the IOM report.

Has the RHS-15 been used with individuals coming from East Africa, such as the Congo, Burundi, Rwanda, etc?

Not yet. We are expanding translation into some East African languages and based on arrival trends will consider others representing the Central African region.

Is the Traumatic Event Questionnaire (TEQ) a good screening tool for developmental trauma/chronic abuse?

The TEQ, developed by Cunningham and adapted in our other refugee work was primarily to screen for UN defined torture, non-torture war-related trauma, and immigration (non-trauma) status. So, I think not.

Is there a screening tool for refugees for substance abuse especially cultural items for abuse?

Great question, and, I think the answer is no. I would like to hear of one if anyone knows of one! We think that programs in Colorado and Minnesota may be developing such an approach.

If you found the HSCL-25 to be a good tool, why not continue testing it and utilizing it, as it is available/tested with multiple populations? They also have a simple depression tool from it, also w/15 questions, that they say is effective in predicting symptoms of anxiety/PTSD (those symptomatic on the 15 question scale may also be on the others). Do you disagree with that?

I do not totally disagree with that. However, the claims of its utility broadly to PTSD in addition to depression and anxiety remains an empirical question. The RHS-15 was

developed specifically to be an efficient screener for broad emotional distress categories across refugee populations, to be used in the public health context.

Which states are using the RHS-15? Can RHTAC post the list of state collaborators?

Utah, New Mexico, and Washington states are using it in the Public Health setting. Arizona officials and University sites are planning on using it. Other city and county agencies (e.g., San Diego, Omaha, Boise, Nashville, and Denver) are in discussion about using it. We would like to hear if there are others who plan/wish to utilize it, and would like to track with the Utilization Form that is now posted on the RHTAC website.

How do you get permission to use RHS-15? Also, how would a state go about participating in the study or be a test site?

You may fill out the Utilization Form that indicates who you are and your level of interest in participating in research or qualitative feedback, and the Pathways team will contact you.

Is there a national policy for public health to use the RHS-15, so that states can leverage that when working locally?

The answer is no although CDC guidelines do recommend screening and attending to mental health.

Can the RHS-15 be used by federally funded primary care providers through the Affordable Care Act?

Yes- primary care is another venue that could offer this screening and across many groups. Both the method for screening and referral would need to be developed.

How is reimbursement obtained?

We are not sure yet, though Seattle King County Public Health is developing a pay line for the administration.

Annette Holland from Seattle King County Public Health writes:

We now have a pay point of \$20 per referral to Pathways. The cost of interpreters is covered as part of the visit.

How can we approach refugee clinics in our respective cities with suggestions to utilize the screening methods? We have many refugees that complain of these symptoms, but often they need a referral from a family physician to see a specialist before they can receive any help. Do you have any advice?

This is a great comment and question about a very practical conundrum across our country. This is a different standard than many other medical conditions. For example, even though TB is not common anymore, it is considered important, and is screened for, and an automatic referral is made if positive. We think that it perhaps should be that way for emotional health. The capacity to screen in public health or primary care with a referral system in place probably has to be worked out in each locale. Another

suggestion might be to have the primary care clinic screen if they are the referral source needed.

This proxy system that is in place, how does it play out for the refugees with medical challenges in the area of the anxiety, depression or PTSD it might pose?

Please comment on using a proxy diagnosis instead of a clinician diagnosis.

This is an honest debate scientifically in terms of what is best/most accurate. However, even if using proxy diagnoses turn out to be a best practice, the clinician must interpret them in the context of the refugees' experience and current social situation.

Is this research peer reviewed and published? If yes, what is the reference?

Not yet, but this is in process.

I work with the HIP project at The Center for Victims in Torture in the Twin Cities. We have been working to develop a MH screening tool and also trying to then connect people to needed resources. My question is: how has your project addressed the question of the mental health community's capacity to treat refugees? How do you find and increase places in the community for referrals? One of the barriers I have seen is the reluctance of clinicians who are not experienced with refugees to working with interpreters. How have you addressed this barrier?

We have seen the same thing here. That is why we offered community trainings that included how to work with interpreters. We had dozens of meetings with community mental health agencies to recruit them for the trainings and specifically asked them to commit to taking 'x' number of referrals. It's a difficult issue and has worked, but with difficulty, in King County.

We noticed that any type of intervention with refugees is dependent on not only their family but the influence of their community. Do you have any suggestion to assist with community education or even educating primary care physicians and the refugee PTSD or depression?

We had community trainings for refugee communities. We found them surprisingly open to the idea of mental health when explained from symptoms as opposed to a diagnostic perspective.