Mental Health Screening Tools and Referral Networks

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Meet NPCT’s Ahmed family
What we know

• ORR guidelines recommend health screening within first 30 days
  – Most often this occurs at the DME (Domestic Medical Exam)

• CDC recommends screening for mental health among refugees
  – Screening should occur with available resources for conditions identified

• Health Settings
  – Tiered screening processes

• Screening within resettlement
Different Approaches to Screening

Spectrum of detection

• Detection of common mental disorders and distress should be done as sensitively and accurately as possible

Methodology varies

• Informal conversation
• Site-specific questionnaires
• Condition specific
• Standardized measures, linguistically and culturally relevant
• Based on availability of community and treatment resources
Different Approaches to Screening

Choosing a Screening tool
• Non-stigmatizing, non-invasive and relevant to population
• Efficient and easy to administer
• Reimbursable within health systems
• Scientific rigor - sensitive and specific

Context
• Ability to train and re-train as needed
• HIPAA compliant
• Staff willing to perform the services
• Processes in place for crisis
• Place to refer
Screening for Mental Health Issues among Refugees

Universal vs. Site Specific
Universal: Screening Considerations

1. **What conditions** do we assess for?

2. **Who should screen** refugees for mental health conditions?

3. **When** should we screen refugees for mental health conditions?

4. **What type of setting** should screening occur?

5. **How is information** shared with clients providers?

6. **What type** of treatment is available?

7. **How** referral outcomes will be tracked?
Site Specific: Screening Considerations

- Health Screening Site
- Community Referral Capacity
- Health System Structures
- State Health Reform Efforts
Screening Considerations

1) What **conditions** do we identify through screening?

2) Who **completes** a mental health screening?

3) When **to administer** a screening tool (if available)?

4) In what **type of setting** should screening occur?
Screening Considerations

5) How is information shared with clients providers?

6) What type of treatment is available?

7) How will referrals be followed up with?
Referral Pathways

1) What type of treatment is available?

2) When should we refer refugees?

3) Who will support identified refugees for mental health?

4) In what type of setting will emotional support be provided?
Referral Pathways

5) How is information shared with treatment providers?

6) What systems need to be in place to support the client in getting care?

7) How will referral outcomes be tracked?
Pathways to Wellness
Program Model
Pathways Program Model

- Screening & Referral
  - Community Outreach
  - Treatment & support
  - Provider Outreach
Mid-County Clinic Refugee Screening

**Intake Appointment**
1) Scheduling procedures before intake
2) Intake: consent for care, overview of process, blood draws, introduce RHS-15 as part of the overall visit.

**Health Screening at Public Health**
Family starts health screen
- Reviews result of any lab work
- FU, completes, X-ray if warranted, etc.
- Checks insurance and offers information on PCP/clinic

**REFERRAL**
Nurse:
- Scores RHS-15
- Completes referral
- Share screen and referral for treatment*

**Pathways Central Referral Process**
Sasha receives referral info and works with Intake Coordinator, and LCS interpreters to secure first appointment

**Client continues further treatment at LCS or IPP**

**Interpreter debrief at end of each session**

**Results of RHS-15 screening recorded in EPIC**

**LOOP Back to Mid County**
Work Flow – MCC: Future State

Intake

Screening Visit #1
Physical & RHS-15
Referral for +RHS-15 triage

Follow up Visit BHC+RHS-15
-Further assessment
-Out refer
Screen Introduction
- Literacy level of refugees
- BH integration & healthcare processes
- Use of provider script
- Patient trust/understanding

BH Resources
- In-house versus ancillary providers
- Availability of culturally sensitive BH resources
- Collaboration between organizations

Time Pressures
- Average time to administer RHS-15
- Who should administer the screener

Interpreters
- Trained interpreters and use of intro script needed
- Effect of case administration
- Lack of comprehension of certain items on screener

Patients accepting care
- False negatives?
- Timing of screening
- Perception of BH care available in community

Goal: Early Identification of BH needs via an effective screening process
## Challenges

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ARHC, Refugee Mental Health Screening Survey, 2015
Where Can You Start?

Different Analysis to get started

1. **Landscape** Analysis – *What is already out there?*

2. **Resource** Analysis – *Do we have any money to do this?*

3. **Partner** Analysis – *Can anyone help us do this?*

4. **Capacity** Analysis – *Do we have any staff to do this?*

Refer to Landscape Analysis
Where Can You Start?

Different types of buy-in approaches

1. From internal staff- *Does the direct service staff understand and support this effort?*

2. From community stakeholders- *Does the community understand and support this effort?*

3. From funders- *Do they want to invest in this issue?*

Refer to Landscape Analysis
New Mexico Refugee Program Model & Colorado example
Screening for ?

- Screening vs. assessment
- Types and range of screenings
- Context: Centralized programs vs. decentralized programs
Centralized vs. Decentralized

- Treatment planning: Clinical and MDT
- Clinical screen and/or assessment
- Screening for services
- Screening for program eligibility

- Referrals to treatment
- DOH screen and assess
- Input into provider training, systems, provider community
New Mexico

• Based on needs and resource assessment, mental health screening occurred at DOH health screen

• 4 domains embedded in health screen:
  – Pain
  – Energy
  – Appetite
  – Sleep
  – Probes for flight, refugee camps, torture etc.

• Conversational meeting with RMHC
New Mexico

• Due to changes in client demographics, added RHS-15 as secondary screening
• Increased specificity of referrals
• Trained all DOH colleagues
• Second screen appointment
• Referrals informed by cut off scores and/or requests
• Assessments done by RMHC to ensure proper referrals and to streamline process
• Assessments adjusted based on individual need
• Referral community met regularly, networked, shared and staffed cases which improved success of referrals
New Mexico

• **Strengths:**
  – Multi-tiered process; i.e. similar to IASC guidelines
  – Utilized best available resources
  – Developed and maintained a RMH expert referral network
  – Consistent local capacity building & training
  – Orientation and ongoing psycho-education for refugees
  – Strong multi-agency teamwork, case management & consultation, staffing
  – Receptive and participatory refugee community

• **Challenges:**
  – Variable (in size) referral group
    • Interpretation
  – Susceptibility to political and budget changes
  – Multiple organizations, partners, providers
New Mexico

• With switch to Centennial (Affordable Care) and other political changes, access to treatment and interpreter funding changed
  • Strengths:
    – Increased provider base with referrals to Molina/Medicaid providers
    – More directly connected to case management and care coordination
    – Psychoeducation occurs throughout resettlement process, may reduce stigmatization
    – Partner collaboration for case management to increase access and bridging to services
    – New providers are learning to use interpretation and transportation services

• Challenges
  – Finding other sources of funding for MH services, as Medicaid billing is not feasible for all willing providers.
  – Need for training for expanded referral network
  – High no-show rates for health services (including MH)
  – Communication and collaboration between partners can always be improved
  – Access to diverse sources of trainings and expertise is also needed to support providers in developing their ability to serve refugees
The Art of Referral

Referral is an art, a process, and a science.
It is more than a step in a process or a box to check.
Referrals: Needs & Resources

Define the Communities

Refugees ( Clients )
Providers

Needs & Resource Assessments

Refugee arrivals, demographics, contextual layers, exposures, etc.

Provider trainings, skills, years experience, cross cultural and TIC expertise, refugee and SOT experience, willingness, openness to supervision & consultation
Creating Referral Systems & Networks

Referral Community

- Centralized or decentralized treatment?
- Client needs and therapist skills/modalities/theoretical orientation
- Sharing information/HIPAA
- Tracking referrals & follow up
Creating Referral Systems & Networks

- Centralized or decentralized treatment?
- Sharing information/HIPAA
- Tracking referrals & follow up
- Client needs
- Therapist skills/modalities/theoretical orientation
- Funding/Donor needs and limitations
IRC US Programs
Mental Health Program Model
GREATER IMPACT

in the lives of the people we serve, improving their

SAFETY  POWER  EDUCATION

HEALTH  ECONOMIC WELLBEING
HEALTH

Physical

Emotional

Mental
The goal of IRC’s mental health programming is to help clients normalize their experience and reactions to stress as well as provide a connection to other individuals, promoting healing and reconnection.
IRC Approaches to Mental Health

- Seeking out **partnerships** in communities and at a national level
- **Explore Integrated models** of support in existing programs
- Foster **community based models**
- **Screening** Considerations and **Referral** Pathways
Where we work in the United States
“Case management towards true self-sufficiency cannot occur while a person is in crisis. Mental Health should always be a part of our care for our clients.”

Quote from IRC Dallas staff member
• “More than ¼ of the total refugee population (27%) in Utah had symptoms of mental health conditions.”

• “Of the RHS-15 scores reported, 39% had a high enough score to be referred for follow-up mental health services.”

• “The Iraqi and Sudanese populations had the highest collective burden of the three risk factors: torture and violence, anxiety, and depression. Past experience with torture and violence was the most common risk factor, even after stratifying by age and nativity/culture.”
Screening

Community Resources

Staff response

Successes and Challenges
Screening considerations

- Who screens?
- When?
- How is information shared?
- Referrals?
Key Learning Points for IRC

- Observe trends in office.
- Conduct asset mapping or landscape analysis of office and community.
- Ongoing psycho-education is crucial.
- Screening provides an opportunity to prevent/respond rather than react.
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Questions for Participants

1) Do all refugee clients (adults, adolescents, children) consistently receive a mental health screening during the initial refugee health exam conducted by your county or local health clinic in the first 30 days?

2) Are clients assessed and/or screened in your office, or agency for mental health concerns?

3) Are treatment options available in your community?