Journal of Primary Care & Community Health
1–5

DOI: 10.1177/2150131916636630
jpc.sagepub.com
SAGE

Addressing the Need for Mental Health Screening of Newly Resettled Refugees: A Pilot Project

Kelly Polcher[1] and Susan Calloway[2]

Abstract

Background and Purpose: Refugees resettling to the United States are at increased risk for mental health disorders, which can lead to difficulty with adaptation and poor health outcomes. Standardized mental health screening of refugees is often neglected at primary care and community health clinics. A pilot project aimed to initiate early mental health screening for newly resettled adult refugees was implemented at a community health center in Fargo, North Dakota. **Methods:** Current refugee screening processes were evaluated to determine appropriate timing for refugee mental health screening. This took into consideration time, staffing, interpreter availability and the refugee "honeymoon" phase following resettlement. The Refugee Health Screener–15 (RHS-15) was identified as an efficient, valid, and reliable tool for assessing emotional distress in this population and was integrated into refugee health screening practices. **Results:** The RHS-15 was administered to 178 adult refugees with arrival dates between August 1, 2013 and July 31, 2014. Of those screened, 51 (28.6%) screened positive for risk of emotional distress. Follow-up with primary care provider was completed with 30 (59%) of those who screened positive. Half (15) requested mental health treatment. Although the largest group of refugees during this period of time were resettling from Bhutan, refugees from Iraq had greater incidence of positive screening compared with those from Bhutan. Refugees from Iraq were also found to have significantly higher scores on the RHS-15. **Conclusions:** Although there are some challenges to implementing a standardized mental health screening for refugees, this pilot reiterates the need for standardized mental health screening of refugees. Routine mental health screening should be a part of the overall comprehensive health assessment provided to refugees nationwide. Considerations should be taken in regards to how refugees from Iraq have even greater risk of mental health disorders compared to other refugee groups.

Keywords

mental health, screening, refugees, pilot, project

Introduction

Refugees are individuals who have fled their home countries due to natural disasters, war, and/or for fear of persecution for political, religious, or personal beliefs. As a result of experiences before, during, and after resettlement, refugees are at much higher risk for mental health disorders.[1,2] The prevalence rates for mental illness among refugees vary between studies and populations although rates for posttraumatic stress disorder (PTSD) and depression have been found to be as high as 30% for refugee populations.[2] This is significantly higher than the prevalence rates for the average US adult citizen, which are 6.9% for depression and 3.5% for PTSD.[3]

The United States is the top country globally providing resettlement opportunities to refugees.[4] On average, 50,000 refugees come to the United States annually.[5] Each resettlement country is responsible for providing health screening to refugees within the first few months after arrival. However, comprehensive health screenings often do not include screening for mental health issues.[6] Approximately half of community health centers in the United States are providing mental health screening to refugees, with only a third of those providing a standardized screening tool for mental health evaluation.[6]

The purpose of this pilot project was to develop and implement a standardized process for mental health screening of newly-resettled adult refugees in Fargo, North Dakota. North Dakota resettles an average of 500 refugees per year and the majority are resettled in Fargo.[7] Since

[1]Family Healthcare, Fargo, ND, USA
[2]Texas Tech University Health Science Center, Lubbock, TX, USA

Corresponding Author:
Kelly Polcher, Family Healthcare, 301 NP Avenue, Fargo, ND 58102, USA.
Email: kpolcher@famhealthcare.org

2008, the majority of refugees resettling in Fargo have come from Bhutan, Iraq, Somalia, Congo, Burundi, and Sudan.[6]

Methods

Setting

Family Healthcare is a community health clinic that provides primary care services to all populations within Fargo and the surrounding communities. Fargo's local refugee resettlement agency contracts with Family Healthcare to provide initial refugee health screening and treatment within the first few months after arrival. Since all newly resettled refugees in the Fargo area receive initial health evaluations at this clinic, it was an ideal place to implement a standardized mental health screening process.

Population

It was determined that initially only adult refugees, aged 18 years and older, would receive the mental health screening. The rationale for this decision was based on the lack of resources for treatment of mental health disorders in children and the risk of overwhelming current local agencies providing mental health services to these individuals. Ideally, screening should only occur when there are systems set in place to manage the mental health problem once it is identified.[8]

Screening Tool

The Refugee Health Screener–15 (RHS-15) was chosen as an appropriate mental health screening tool to implement at Family Healthcare. The RHS-15, currently available in 15 languages, screens refugees for risk of anxiety, depression, and/or PTSD[9] and demonstrates high levels of sensitivity (0.81-0.95) and specificity (0.86-0.89).[10] This tool is part of the Pathways to Wellness: Integrating Refugee Health and Well-Being packet and was developed with several iterations before finalizing the tool and was tested with 251 refugees from four ethnic groups including Iraqi, Nepali\ Bhutanese, Karen and Burmese.[9]

The RHS-15 has 14 questions that are scored on a Likert-type scale from 0 to 4. Total scores of 12 or greater on the first 14 questions are considered positive for risk of emotional distress related to anxiety, depression, and/or PTSD. The last item on the screening tool is a 0-10 distress thermometer with 0 being no distress and 10 being severe distress; a score of 5 or greater is considered positive.[9] This screening tool takes 10 to 15 minutes to complete. The RHS-15 is a predictive screening tool rather than a diagnostic tool so further evaluation is necessary in order to make a definitive diagnosis of mental health disorder.

Protocol

New refugees are seen at least 3 times at Family Healthcare in the first 3 to 6 months after resettlement. The initial visit is for screening laboratory tests, urgent medical needs, and general intake information. The second visit is for a general medical exam to evaluate overall health, infectious processes, and comorbid disorders. The third visit is typically to provide immunization updates. The first and third visits are conducted with groups or families.

Often refugees experience a "honeymoon" period, which is a phase of euphoria that often occurs initially following resettlement.[11] The staff at Family Healthcare have found this period to last from 1 to 3 months for the majority of the new refugees seen at the clinic. Therefore, it was determined that the third visit was the optimal time for mental health screening since most would no longer be in the "honeymoon" phase.

At their third visit to Family Healthcare, adult refugees were given the RHS-15. The screening tool was introduced as a tool to assess their emotional well-being and any struggles following resettlement. The screening was administered by interpreters and medical assistants who had been provided with training on the RHS-15 and screening protocol prior to implementation. The interpreters and medical assistants were provided with scripted information to present the RHS-15 to patients. Once completed, a medical assistance scored the results. RHS-15 scores of 12 or above for the questionnaire section and/or 5 or above for the distress thermometer were considered positive.

The refugee health nurse at Family Healthcare met with each refugee privately following screening to discuss results. The refugee health nurse presented the information in a culturally appropriate and sensitive manner that did not reflect judgment or bias. Since there is a significant stigma on mental illness for many cultures, this discussion focused on implications of not feeling well emotionally and its impact on successful resettlement. Staff avoided using terms such as "mental illness" or "psychiatric" disorder. The refugee health nurse recommended a follow up appointment for those who scored positive to discuss screening results further with the patient's primary care provider at Family Healthcare. For individuals who were severely distressed and/or expressed suicidal ideation, a primary care provider was available for immediate consultation.

Evaluation

Throughout the year-long pilot of integrating mental health screening of refugees into the current physical health screening protocol, results were recorded in a spreadsheet compiled by the clinic's refugee health coordinator. For refugees who screened positive, follow-up visit information, and treatment plans were reviewed in the electronic health record. Additionally, demographic characteristics of

those who screened positive were collected, including age, gender and country of origin. Additional data analysis was performed for comparison of screening scores due to observations that refugees from Iraq had significantly higher scores in comparison to other refugee groups.

Results

Initial data following implementation of the mental health screening was collected over a 12-month period on refugees who had arrived between August 1, 2013 and July 31, 2014. During this period, 178 refugees representing eight different countries were screened with the RHS-15. Although the initial plan was to screen all refugees, the rates for screening were lowest among Somalian and Congolese refugees and highest among Bhutanese and Iraqi refugees. This can be attributed to Iraqi and Bhutanese refugees being more likely to present to clinic in larger groups of family members therefore allowing for more individuals to be screened at one time. It was also found that the Somali group was more likely to relocate to another area within the U.S. in the first several months following resettlement.

Table 1 summarizes screening rates for resettlement groups. Table 2 summarizes the demographics of individuals who screened positive. Individuals who screened positive ranged in age from 18 to >51 years with the majority being female. The highest percentage of positive screens was from Iraq. Interestingly, overall RHS-15 scores for refugees from Iraq were significantly higher in comparison with the other groups. Mean scores for the questionnaire section was 31.04 points for refugees from Iraq (n = 25) compared with a mean score of 15 for all other refugees (n = 26). The mean distress thermometer rating was 5.24 points for Iraqi refugees compared with 2.85 points for all other groups.

Refugees who screened positive were offered follow-up with a primary care provider at Family Healthcare who was trained to provide further discussion and evaluation of their symptoms. Of those refugees who screened positive, 76.5% (39) agreed to follow up. A chart review was conducted to track follow-up data. This revealed that 23% (9/39) of patients did not attend the follow-up appointment although specific barriers to follow-up were not addressed at the time of review. Of the 30 who did keep their appointment, 50% agreed to treatment for their pscyhological distress. Treatments offered were based on the diagnosis, severity of symptoms, and each patient's perception of their illness. These treatment options included pharmacologic therapy, counseling services, and/or referral to a behavioral health specialist such as psychiatry or a psychiatric advanced practice nurse.

Table 1. Adult Resettlement Groups Screened in Fargo and Screening Rates, August 2013 to July 2014.

Country of Origin	Total resettled	Total screened	%
Bhutan	156	114	73
Iraq	87	46	52.8
Somalia	36	8	22.2
Congo	15	3	20
Sudan	4	2	50
Burma	3	3	100
Iran	3	1	33
Eritrea	2	1	50

Table 2. Demographic Characteristics of Individuals Screened Positive Using Refugee Health Screener–15, 2013-2014[a]

Characteristic	n	%
Age (years)		
18-30	12	24
31-40	14	27
41-50	9	18
≥51	16	31
Gender		
Male	21	41
Female	30	59
Country of origin		
Iraq	25	49
Bhutan	20	39
Somalia	2	4
Sudan	2	4
Congo	1	2
Eritrea	1	2

[a]Total number of refugees screened 179; 51 screened positive.

Discussion

There is a significant stigma toward mental illness among multiple refugee groups yet, taking into consideration the significant emotional distress caused by events leading to the need for resettlement and moving to a different country with different languages and customs, early mental health screening may lower emotional distress, improve adjustment and prevent crisis.[12,13] While individuals living in the United States have become more conscious of the prevalence of mental illness and the importance of treatment, other cultures may not acknowledge or recognize the impact that mental illness may have on overall health.

The findings in this pilot study that Iraqi refugees had the highest percentage of positive screens as compared to other ethnic groups screened was consistent with the findings from Johnson-Agbakwu, et al. in screening newly resettled refugees seeking routine obstetric and gynecologic care.[14] Of the women who screened positive on the RHS-15, 53.8% (n=14) were Iraqi, 3.8% (n=1) were Burmese, and 11.5% (n =3) were Somali. Additionally follow-through for positive screens in the Johsnon-Agbakwu study also mirrored the findings of this study with only 50% of those screening

positive actually following through with accessing mental health services. [14]

The implementation of this screening could be easily replicable by other community health and primary care centers. Consideration should be made in regards to resources available for individuals who screen positive. There may be challenges to inclusiveness of all refugees for larger communities who have multiple resettlement agencies, although this reinforces the importance of resettlement agencies having a standardized process for mental health screening of refugees.

The attitude and approach by resettlement agencies, case workers, and medical professionals can directly affect refugees' response to mental health screening when it is presented to them as a tool to assess for emotional distress following resettlement rather than screening for "mental illness". The manner in which the RHS-15 screening is presented to the refugee could directly impact willingness to seek further follow up. Additionally, screening should be conducted periodically, rather than only after initial resettlement as mental health is often not a static but a dynamic state of well-being. As with any therapeutic alliance, patient engagement is essential for positive outcomes, therefore follow up evaluations should focus on resources that the refugee feels would be helpful for their symptoms. Although refugees often decline any further treatment for their symptoms,[15] it is still equally important for healthcare professionals to communicate resources available if symptoms persist or become more bothersome.

Limitations

Further data needs to be collected on the reasons given for not wanting follow up after positive screen or the barriers to follow up after they had agreed to follow up. This data would enable the development of targeted interventions to improve help seeking. The limitation of the RHS-15 is that it does not include any questions on suicidal ideation and intent to harm self or others so these questions should be included with any assessment of pscyhological distress. The results of this pilot cannot be generalized to other populations.

Conclusion

Primary care and community health clinics play a critical role in mental health screening and treatment of refugees in the United States. This health assessment should include the integration of mental health screening in order to identify problems early so that primary and secondary prevention activities may be implemented. A deeper understanding of how emotional distress is exhibited in specific cultures and the major stressors they are encountering living in the United States is essential to facilitating a successful transition. Identifying barriers to help-seeking for psychological distress as reflected by lack of follow-up after referral and after the initial visit needs to be elucidated. Lastly, further research needs to be conducted regarding refugees resettling from Iraq in identifying factors that may contribute to higher emotional distress.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Savin D, Seymour D, Littleford L, Bettridge J, Giese A. Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Rep*. 2005;120:224-229.
2. Steel Z, Chey T, Silove D, Marnane C, Bryant R, VanOmmeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. *JAMA*. 2009;302:537-549.
3. National Institute of Mental Health. Statistics. 2012. http://www.nimh.nih.gov/health/statistics/index.shtml. Accessed February 10, 2016.
4. United Nations High Commissioner for Refugees. Resettlement. 2015. http://www.unhcr.org/pages/4a16b1676.html. Accessed February 10, 2016.
5. Centers for Disease Control and Prevention. Immigrant and refugee health. 2012. http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html. Accessed February 10, 2016.
6. Shannon P, Im J, Becher E, Simmelink J, Wieling E, O'Fallon A. Screening for war trauma, torture, and mental health symptoms among newly arrived refugees: a national survey of U.S. refugee health coordinators. *J Immigrant Refugee Stud*. 2012;10:380-394.
7. Lutheran Social Services. Refugee resettlement. 2015. http://www.lssnd.org/community-outreach/new-americans/mentors.html. Accessed February 10, 2016.
8. US Preventive Services Task Force. *The Guide to Clinical Preventive Services 2014: Recommendations of the U.S. Preventive Services Task Force*. Rockville, MD: Agency for Healthcare Research and Quality; 2015. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/foreword.html. Accessed February 10, 2016.
9. Pathways to Wellness. Refugee Health Screener–15. 2011. http://www.refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf. Accessed February 10, 2016.
10. Hollifeld M, Verbillis-Kolp S, Farmer B, et al. The Refugee Health Screener–15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *Gen Hosp Psychiatry*. 2013;35:202-209.
11. Miserez D. *Refugees: The Trauma of Exile* [Electronic version]. Norwell, MA: Kluwer Academic; 1987.

12. Bentley JA, Owens C. Somali refugee mental health cultural profile. 2008. https://ethnomed.org/clinical/mental-health/somali-refugee-mental-health-cultural-profile. Accessed February 10, 2016.
13. Center for Addiction and Mental Health. Best practice guidelines for mental health promotion programs: refugees. 2012. http://knowledgex.camh.net/policy_health/mhpromotion/Documents/BPGRefugees.pdf. Accessed February 10, 2016.
14. Johnson-Agbakwu C. Allen J., Nizigiyimana J.F., Ramirez G. Hollifield M. (2014). Mental health screening among newly arrived refugees seeking routine obstetric and gynecologic care. *Psychological Services, 11(4)*, 470-476. Retrieved from http://www.apa.org/pubs/journals/releases/ser-a0036400.pdf.
15. Annamalai A, ed. *Refugee Health Care: An Essential Medical Guide*. New York, NY: Springer; 2014.

Author Biographies

Kelly Polcher, DNP, APRN, FNP-C, is a primary care provider at Family Healthcare in Fargo, ND. She is a member of the New Americans Behavioral Health Network in Fargo.

Susan Calloway, PhD, FNP-BC, PMHNP-BC, FAANP, is an associate professor and PMHNP program director at Texas Tech University Health Science Center in Lubbock, TX. Her research focus is facilitating transitions among youth with mental health disorders and stigma reduction.