

Mental Health Screening Among Newly Arrived Refugees Seeking Routine Obstetric and Gynecologic Care

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Posttraumatic stress disorder (PTSD), anxiety, and depression are common mental health disorders in the refugee population. High rates of violence, trauma, and PTSD among refugee women remain unaddressed. The process of implementing a mental health screening tool among multiethnic, newly arrived refugee women receiving routine obstetric and gynecologic care in a dedicated refugee women's health clinic is described. The Refugee Health Screener-15 (RHS-15) is a culturally responsive, efficient, validated screening instrument that detects symptoms of emotional distress across diverse refugee populations and languages. An interdisciplinary community partnership was established with a local behavioral health services agency to facilitate the referral of women scoring positive on the RHS-15. Staff and provider training sessions, as well as the incorporation of bicultural, multilingual cultural health navigators, greatly facilitated linguistically appropriate care coordination for refugee women in a culturally sensitive manner. Twenty-six (23.2%) of the 112 women who completed the RHS-15 scored positive, of which 14 (53.8%) were Iraqi, 1 (3.8%) was Burmese, and 3 (11.5%) were Somali. Among these 26 women, 8 (30.8%) are actively receiving mental health services and 5 (19.2%) have appointments scheduled. However, 13 (50%) are not enrolled in mental health care because of either declining services (46.2%) or a lack of insurance (53.8%). Screening for mental disorders among refugee women will promote greater awareness and identify those individuals who would benefit from further mental health evaluation and treatment. Sustainable interdisciplinary models of care are necessary to promote health education, dispel myths, and reduce the stigma of mental health.

Keywords: Refugee Health Screener (RHS-15), refugee women, women's health, community-based participatory research

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Refugee women and girls constitute 49% of persons of concern to the United Nations High Commissioner for Refugees (UNHCR), and account for 48% of all refugees, as well as half of all internally displaced persons and returnees (former refugees) worldwide (UNHCR, 2011a). "Women at risk," as defined by the *UNHCR Resettlement Handbook* (UNHCR, 2011b), encompasses situations in which women's safety or well-being remains threatened on the basis of gender, ethnicity, religion, culture, and power structure (UNHCR, 2011b, 2013). The percentage of UNHCR resettlement referrals as women-at-risk has risen from 6.8% in 2007 to 11.1% in 2011 (UNHCR, 2013). In 2011, the United States resettled almost half of the UNHCR women-at-risk referrals worldwide, comprising approximately 4% of total U.S. refugee admissions (UNHCR, 2013). Refugee women are often stigmatized or victimized as survivors of rape, abuse, and a wide range of traumatic war-related violence (Hollifield et al., 2006). Evidence suggests that refugee women resettled in Western countries possess a tenfold risk of developing posttraumatic stress disorder (PTSD) symptoms than women of the same age in the general population (Kirmayer et al., 2011).

There are numerous pre- and postmigratory stressors that may impact a refugee woman's health throughout her process of resettlement (Gagnon, Tuck, & Barkun, 2004), and are associated with increased risk for depression, anxiety, and PTSD. The experience of past trauma is only one of many issues facing refugees (Davidson, Murray, & Schweitzer, 2008), as past trauma may also persist in the form of acculturative stress related to loss of family and social networks, family and friends remaining in refugee camps and combat zones, social isolation, social stigma, shifting gender roles, racism, language barriers, loss of employment and socioeconomic status, and intergenerational conflicts (Essén, Hanson, Ostergren, Lindquist, & Gudmundsson, 2000; Fung, & Wong, 2007; Redwood-Campbell et al., 2008; Siegel, Horan, & Teferra, 2001).

Furthermore, refugees must learn to navigate an entirely new community, language, and cultural system, while simultaneously coping with the loss of homeland, family, and way of life (Murray, Davidson, & Schweitzer, 2010). Evidence suggests that refugee women's personal experience with biomedicine, fear, and lack of awareness about mental health influences how they seek help to manage mental distress (Donnelly et al., 2011). Inadequate local services or support networks to respond to this vulnerable population may increase their risk of retraumatization in their country of first asylum (UNHCR, 2013). An examination of the mental health status of newly arrived Burmese refugees in Brisbane, Australia, found that although premigration exposure to traumatic events impacted Burmese refugees' mental well-being, it was their postmigration living difficulties (i.e., communication barriers, worry about family not in Australia, difficulties with employment, and difficulty accessing health and social services) that had greater relevance in predicting mental health outcomes (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). In addition, an examination of the mental health status of Iraqi refugees resettled in the United States found that longer duration in the United States, rating one's health as fair or poor, and having a self-reported chronic health condition were associated with an increased likelihood of reported depression (Taylor et al., 2013). Consequently, it is important to increase the awareness of potential mental disorders in the refugee community and connect identified individuals with available resources. Screening for mental disorders among refugee

women will promote greater awareness and identify those individuals who would benefit from further mental health evaluation and treatment.

As of January 2011, approximately 264,574 refugees resided in the United States (UNHCR, 2011a). In 2012, Arizona ranked eighth nationally in resettling new refugee arrivals to the United States (Office of Refugee Resettlement, 2012). The detection of mental disorders remains challenging. There is limited availability of valid and reliable tools for assessing mental health in the refugee population (Gagnon et al., 2004; Hollifield et al., 2002). As many refugees are not literate in English, valid, reliable, linguistically and culturally appropriate screening instruments for the most common mental disorders (anxiety, depression, and PTSD), are critical to accurately assess refugees' mental health needs and to refer them to appropriate services. The Centers for Disease Control and Prevention (2011) has established guidelines for mental health screening of newly arrived refugees during the domestic medical examination. However, each state differs in assistance given, and mental health screening is only offered sporadically (Barnes, 2001).

The Refugee Health Screener-15 (RHS-15) was developed by the Pathways to Wellness: Integrating Community Health and Well-Being project as a culturally responsive, efficient, validated screening instrument that detects symptoms of anxiety, depression, and PTSD across multiple refugee populations. It has been validated in the following languages: Arabic, Burmese, and Nepali; translations are available in Farsi, Karen, Russian, and Somali; and the process of translation is currently underway for French, Amharic, Tigrinya, and Swahili (Hollifield et al., 2013; Pathways to Wellness, 2011). The RHS-15 has been field tested for use in public health and community settings, and requires limited training for staff, and adds approximately 5 to 10 min to a patient's visit. Health care providers who are in close contact with refugee patients have a role in identifying women with potential mental health concerns. Use of the RHS-15 as a behavioral health screen for refugee women will enhance our understanding of their mental health service needs and facilitate referrals for targeted mental health services and interventions. This article presents preliminary findings of the process of implementation of the RHS-15 and rates of probable mental disorders among newly arrived refugee women receiving routine obstetric and gynecologic care.

Method

The Refugee Women's Health Clinic (RWHC) is a dedicated clinic that cares for newly arrived refugee women from over 35 countries across Sub-Saharan Africa, Southeast Asia, and the Middle East, providing comprehensive women's health services across the reproductive life span with a team of bicultural, multilingual cultural health navigators (CHNs), a program manager skilled in social work and case management, and medical assistants, all of whom reflect the ethnic and cultural diversity of the patient population served. Female obstetricians and gynecologists, and certified nurse midwives, provide clinical services. The RWHC has an established infrastructure of community partnership, engagement, and shared community leadership through its Refugee Women's Health Community Advisory Coalition (RWHCAC), which represents an interdisciplinary team of more than 60 individuals from community organizations, including local

ethnic organizations, refugee resettlement and voluntary agencies, mental health and social services agencies, as well as academic partners who serve as coequal partners in the community outreach and engagement activities of the RWHC, informing the RWHC's initiatives, as well as facilitating the coordination of culturally competent care, services, and support.

Community-Partnered Approach and Engagement

Community engagement was an essential step in creating a “safe space” for dialogue on mental health. It was important to glean from the community their perceived need for care and receptivity to accessing mental health services. Hence, community outreach and mental health education became a critical component of the implementation of this initiative, which enabled the team to understand cultural and logistical challenges in reaching the refugee community. The CHNs were an integral part of this process, wherein educational seminars were held with key community members, refugee resettlement agencies, providers, and refugee women to discuss issues of distrust of the health care system, and to provide orientation to the historical background and culture of the various refugee communities served.

Behavioral Health Partnership

An interdisciplinary partnership was established with Jewish Family and Children Services (JFCS), a local behavioral health services agency sensitive to the needs of refugee populations. A joint work plan was created to maximize the seamless integration of culturally appropriate evaluation and treatment modalities. Cross-cultural training sessions were held with staff, CHNs, therapists, and clinicians from the RWHC and JFCS, as well as the senior author, representing Pathways to Wellness, to provide orientation on the RHS-15 and to discuss the logistical process of screening, patient eligibility requirements, and referral processes. In addition, for patients referred for services, mechanisms were in place to ensure that their linguistic and transportation needs were met. This also provided an opportunity for the team to understand the processes that were in place by JFCS to provide mental health evaluation and treatment.

As a result of these sessions, a bicultural, multilingual peer navigator from the refugee community was hired by JFCS to facilitate the linguistic and care coordination needs of the refugee community in a culturally sensitive manner. Our collaboration was further strengthened by the RWHCAC, which provided a community-wide forum to discuss the newly formed partnership, dispel myths and stigma concerning mental health, as well as gain critical input and support from the refugee community on how best to ensure a seamless referral and integration process for women who scored positive on the RHS-15. In this setting, as implementation of the RHS-15 was evaluative, a review by the hospital's institutional review board was obtained.

Implementation of the RHS-15

The RWHC partnered with Pathways to Wellness to implement the RHS-15 across its multiethnic refugee population. Details of the process of development and validation of the RHS-15 have been published (Hollifield et al., 2013). The

15-question screener consists of two sections. The first 14 questions are rated on a scale from zero (*not at all*) to 4 (*extremely*), with variably full jars of sand representing these numbers. A total score ≥ 12 on the first 14 questions is a positive screen. Question 15 comprises the second section, which is a distress thermometer, in which individuals can mark their distress from 0 (*no distress*) to 10 (*extreme distress*). A distress thermometer score ≥ 5 is a positive screen. An individual only has to score positive on one of these two sections to warrant a positive screen (Pathways to Wellness, 2011).

Between April and October of 2012, women over the age of 18 receiving routine women's health care in the RWHC were screened in the preferred language of their choice—Arabic, Burmese, English, Karen, Nepali or Somali—with the assistance of a CHN. If a patient scored positive on the RHS-15, her health care provider would then discuss the screening results with the patient and assess whether she would be amenable to be referred for a formal mental health evaluation. If the patient agreed to be referred, care coordination would then ensue between the RWHC and the behavioral health service partner agency, wherein follow-up appointments were scheduled within 1 week of screening and included arrangements for appropriate language interpretation services and transportation, if necessary, to ensure seamless continuity of care and the seamless integration of health care services.

Results

RHS-15

As displayed in Table 1, 221 women were eligible for screening. Over the course of 7 months, trained CHNs verbally administered the RHS-15 in English, Somali, Burmese, or Arabic based on patient language preference and the availability of a CHN. The RHS-15 was completed for 112 (50.7%) individuals from the eligible sample; 62 (28.1%) were awaiting the availability of an interpreter, and for 47 (21.3%), the RHS-15 was not available in their language. Twenty-six (23.2%) scored positive on the RHS-15, of which 14 (53.8%) were Iraqi, one (3.8%) was Burmese, and three (11.5%) were Somali. Among these 26 women, eight (30.8%) were actively receiving mental health services, and five (19.2%) had appointments scheduled. However, 13 (50%) were not enrolled in any mental health care because of either declining services (46.2%) or a lack of insurance (53.8%).

Sustainability

As a result of the first 7 months of this initiative, educational seminars and trainings remain ongoing. Efforts are also being made to close gaps in services for the uninsured by partnering with local behavioral health resources to provide psychological counseling and therapy for newly arrived refugees. The refugee community, health care providers, and social service agencies acknowledge the need for distinct and culturally responsive mental health services tailored to the refugee population, particularly refugee women. Furthermore, efforts to promote community capacity building, mutual bidirectional learning, community empowerment, and coequal partnership are understood to be critical for

Table 1
Administration of the RHS-15

Patients eligible for RHS-15 screening (N = 221) n (%)							
RHS-15 screen completed		Awaiting screening with interpreter			Language unavailable in RHS-15		
112 (50.7)		62 (28.1)			47 (21.3)		
<i>Note.</i> Screening verbally administered in English, Somali, Arabic, or Burmese, based on patient preference.							
Patients screened (N = 112) n (%)							
RHS-15 screen negative						RHS-15 screen positive	
86 (76.8)						26 (23.2)	
Country of origin	Iraq	Burma	Somalia	Sudan	Other Africa	Other Middle East/Asia	Total
<i>n (%)</i>							
Total completed	30 (26.8)	33 (29.5)	22 (19.6)	6 (5.4)	15 (13.4)	6 (5.4)	112
Screen positive	14 (53.8)	1 (3.8)	3 (11.5)	0 (0)	5 (19.2)	3 (11.5)	26
<i>Note.</i> Other Africa denotes Burundi, Congo, Egypt, Ethiopia, Kenya, Liberia, Morocco, Namibia, Togo, or Not Specified. Other Middle East/Asia denotes Jordan, N. Korea, Thailand, Turkey, or Not Specified. Screen positive denotes a score on items 1–14 ≥ 12 or Distress Thermometer ≥ 5.							
Status of mental health services provision among those who screened positive (n = 26) n (%)							
Actively receiving mental health services			Appointment scheduled		Not enrolled in mental health services		
8 (30.8)			5 (19.2)		13 (50)		
Status of those who screened positive who are not enrolled in mental health services (n = 13) n (%)							
Ineligible for services due to lack of insurance						Declined services	
7 (53.8)						6 (46.2)	

sustained success in the reduction of mental health disparities in this population.

Discussion

To the authors’ knowledge, this is the first reported and targeted program in the United States utilizing the RHS-15 among a multiethnic sample of newly arrived refugee women seeking routine obstetric and gynecologic care. This innovative initiative identified women with emotional distress who would otherwise not have been referred for a mental health assessment. Furthermore, a unique and robust interdisciplinary partnership was built between an obstetrics and gynecology practice specifically dedicated to caring for newly arrived refugee women and a behavioral health services agency. A community-partnered approach engendered trust and promoted mutual bidirectional learning and refugee empowerment toward greater receptivity to mental health services. In addition, refugee community capacity building in mental health was promoted through the RWHC’s CHNs, as well as the hiring of a patient navigator from the refugee community by JFCS. This initiative was also an opportunity for providers to better comprehend mental health disparities and health equity across a vulnerable medically complex population.

Providers caring for refugees should be cognizant of the cultural idioms by which suffering is expressed, and the social stigma associated with traumatic experiences and mental illness (Boynton, Bentley, Jackson, & Gibbs, 2010; Craig, Jajua, & Warfa, 2009).

This partnership has been sustained by offering ongoing provider and staff trainings across both institutions on the unique needs of refugee populations, and capacity has been built within the local refugee community through the use of CHNs. The CHNs are bicultural, multilingual paraprofessionals who are medically trained interpreters able to provide face-to-face interactions with patients in facilitating care coordination, arranging transportation to and from appointments, educating the patient and her family on medications and treatment plans, and conducting home visits when necessary, without the reliance on telephonic interpretation. Furthermore, the providers and CHNs are all female, which engenders trusting relationships, dialogue, and rapport, wherein women were less encumbered in discussing sensitive concerns in their native language.

The literature is replete with evidence on the utility of bicultural, multilingual paraprofessionals in mental health services in building trust, respect, and mutual understanding in working with refugee populations to mitigate the challenges of this medically

complex and vulnerable population (Musser-Granski & Carrillo, 1997). Bicultural interpreters enhance patient-provider communication, in that, although based in the host society, they share not only a language but also a common set of cultural beliefs with the patient. This enables them to be more reflective, thus enhancing their work as patients feel freer to talk about their cultural and religious beliefs (Tribe, 1999). Moreover, among nonhomogenous East and Southeast Asian immigrant and refugee groups possessing differing health beliefs, it has been shown that perceived access to culturally, linguistically, and gender-appropriate health care were among the main factors influencing attitudes toward seeking professional help (Fung, & Wong, 2007).

There are a few limitations of this initiative, namely, the socio-cultural influences on refugee women's receptivity to mental health care. Among the 13 women who screened positive but were not enrolled in mental health services, six (46.2%) declined care. Some of the factors that may have influenced women's ability to be screened effectively and/or referred for care included the following: not perceiving a need for mental health care; indicating that symptoms had resolved by the time of mental health services appointment; responding negatively on the RHS-15 despite an overt display of symptomatology as perceived by the provider; declining mental health evaluation because of sociocultural stigma; perception that seeking mental health care would result in children being removed from the home and/or precipitate marital strain; and reluctance to seek care outside of familiar health care surroundings and staff, where trust had already been established. It has been shown that refugees may avoid health care because of the uncertainty associated with interacting with the health care system, and the unclear role they perceive government agencies playing in health care that could compromise their freedom or immigration status (Hollifield, 2004). Moreover, concerns over social stigma may have introduced social desirability bias among participants who may have screened negative despite the overt display of symptoms. This may have been further heightened by the fact that, because of the presence of extremely low literacy among our patient population, the RHS-15 was verbally administered with the assistance of a CHN. The notion of introducing social desirability bias, because of mental health being highly stigmatized, has also been reported in the literature among Somali refugees (Henning-Smith, Shippee, McAlpine, Hardeman, & Farah, 2013).

Although every effort was made to verbally administer the RHS-15 individually and confidentially to patients without the presence of family members or friends, it was not always possible. At times, patients' spouses either influenced the patients' responses or responded on behalf of the patient, even with the CHN present providing appropriate interpretation. A qualitative study of Asian immigrant communities in Australia identified factors influencing access to mental health care, which revealed an unwillingness to access help from mainstream services, with stigma and shame being key factors influencing their reluctance (Wynaden et al., 2005). In addition, studies have identified the underutilization of mental health services as also influenced by the perception of mental health disorders as somatic illness, and related to family discord, social pressure, poor physical health, and adverse life events (Hollifield, 2004).

There were also language barriers, wherein the extent of English proficiency was not assessed among those patients for whom English was a second language but who chose to com-

plete the RHS-15 orally in English. Moreover because of the nature of an extremely busy obstetrics and gynecology practice, and the need to verbally administer the RHS-15 in the preferred language of the patient, the CHNs were not always available to facilitate the administration of the RHS-15. Because of the extremely low literacy (in English as well as the native languages), self-administration of the RHS-15 in this patient population was not feasible. Moreover, there was a limitation in the number of available languages of the RHS-15, as 47 (21.3%) women eligible for screening were unable to complete the screening because of its unavailability in such languages as Amharic, Farsi, French, Swahili, Kirundi, and Oromo at the time of program implementation.

Lastly, among the seven women who screened positive on the RHS-15 but lacked health insurance, and were thereby unable to be referred for further mental health evaluation, efforts were made to secure alternative behavioral health resources.

Preliminary findings on the first 7 months of the implementation of the RHS-15 in a refugee-focused obstetric and gynecologic clinic in partnership with a behavioral health agency have been described. The next steps in the continuation of this initiative are to track longitudinal outcomes in mental health diagnoses and continuity of care among women who screen positive on the RHS-15. Research has shown that mental health services may not provide appropriate support to women with postpartum depression (O'Mahony & Donnelly, 2010). Hence, the association of the RHS-15 with adequacy of prenatal care utilization, obstetric and neonatal outcomes, and postpartum depression, and whether changes in the RHS-15 occur over time and with subsequent pregnancies, will be assessed. Furthermore, future studies will explore whether correlations exist with RHS-15 scores and ethnicity, age, length of time in the United States, health status, and social support. Of note, an incidental finding observed with this initiative was the comparison between the 30 Iraqi and 33 Burmese women who completed the RHS-15 (26.8% and 29.5% of the total sample, respectively). Among the Iraqi women, 46.7% scored positive, whereas only 3% scored positive among the Burmese. This is consistent with ethnic variability in the initial RHS-15 validation study (Hollifield et al., 2013). The extent to which unique cultural attributes and/or refugee experiences may influence RHS-15 scores, as well as receptivity to seek mental health services, requires future exploration with qualitative studies.

There is a need for community-partnered, culturally tailored interventions to provide health promotion education, dispel myths, and reduce the stigma of mental health, while accentuating asset-based, strength models of resiliency and community social support. Positive attributes such as strong family relations, community-centered values, sharing within the cultural unit, and resiliency have been shown to contribute toward coping and problem solving during very difficult circumstances (O'Mahony & Donnelly, 2010). There is a dearth of empirical evidence of refugee-specific interventions that have garnered consistently strong effects because of varying factors including the design of the intervention, its social and cultural suitability, appropriateness for patients at a particular stage of resettlement, the cultural competence of service providers, the measurability of anticipated outcomes, and the reliability and validity of instruments across different cultural and ethnic groups (Murray

et al., 2010). Moreover, there has been limited research, to date, on refugee women's social support needs, the barriers they experience, and their preferred support interventions (O'Mahony & Donnelly, 2010). Qualitative research methods would help elucidate the sociocultural context and complexities of refugee women's pre- and postmigratory experiences as it impacts not only women's reproductive health but also receptivity to accessing mental health services. There is growing interest in the integration or colocation of primary care with behavioral health services to enhance mental health services as a best-practice model for improving the recognition of and quality of care for mental illness (Feldman, & Feldman, 2013). However, longitudinal interventional trials are needed, targeting newly arrived refugee populations. In addition, this study may also have implications for screening refugees for mental health concerns who are seeking other types of medical care or other types of services. Moreover, also necessary are sustainable interdisciplinary models of care that support an integrated approach, incorporating not only multidisciplinary health care providers but also intensive care coordination and case management; trusted, gender-matched patient health navigators and interpreters; as well as community capacity building and empowerment.

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Call for Nominations

The Publications and Communications (P&C) Board of the American Psychological Association has opened nominations for the editorships of **Developmental Psychology** and the **Journal of Consulting and Clinical Psychology** for the years 2017–2022. Jacquelynn S. Eccles, PhD, and Arthur M. Nezu, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2016 to prepare for issues published in 2017. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

Search chairs have been appointed as follows:

- **Developmental Psychology**, Suzanne Corkin, PhD, and Mark Sobell, PhD
- **Journal of Consulting and Clinical Psychology**, Neal Schmitt, PhD, and Annette LaGreca, PhD

Candidates should be nominated by accessing APA's EditorQuest site on the Web. Using your Web browser, go to <http://editorquest.apa.org>. On the Home menu on the left, find "Guests." Next, click on the link "Submit a Nomination," enter your nominee's information, and click "Submit."

Prepared statements of one page or less in support of a nominee can also be submitted by e-mail to Sarah Wiederkehr, P&C Board Search Liaison, at swiederkehr@apa.org.

Deadline for accepting nominations is January 7, 2015, when reviews will begin.