

Refugee Mental Health Screening

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Edward M. Kennedy Community Health Center (formerly Great Brook Valley Health Center)

- Founded in 1972 by 7 mothers from Great Brook Valley (subsidized housing project)
- First located in an apartment in the GBV housing project
- Currently offers primary and specialty medical, dental, mental health, optometry, and pharmacy services to about 24,000 patients annually at 140,000 visits.

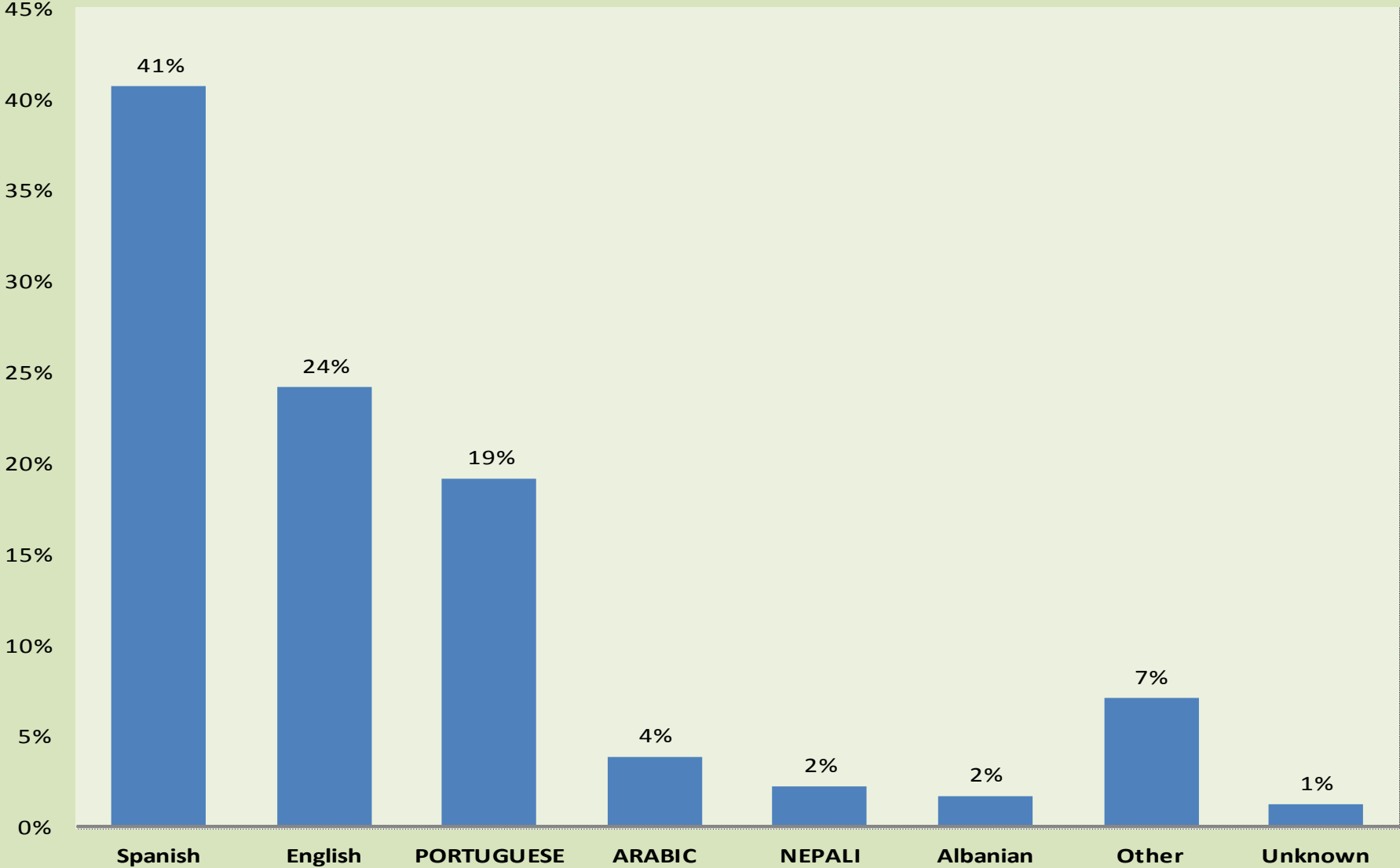
Language/ethnicity as of May 2012

- Our staff speak 30 languages, come from 39 countries, represent 40 ethnic groups.
- 73% are bilingual, and 23% of those are trilingual
- Overall, 93 languages are represented among patients and staff (2013 statistic)

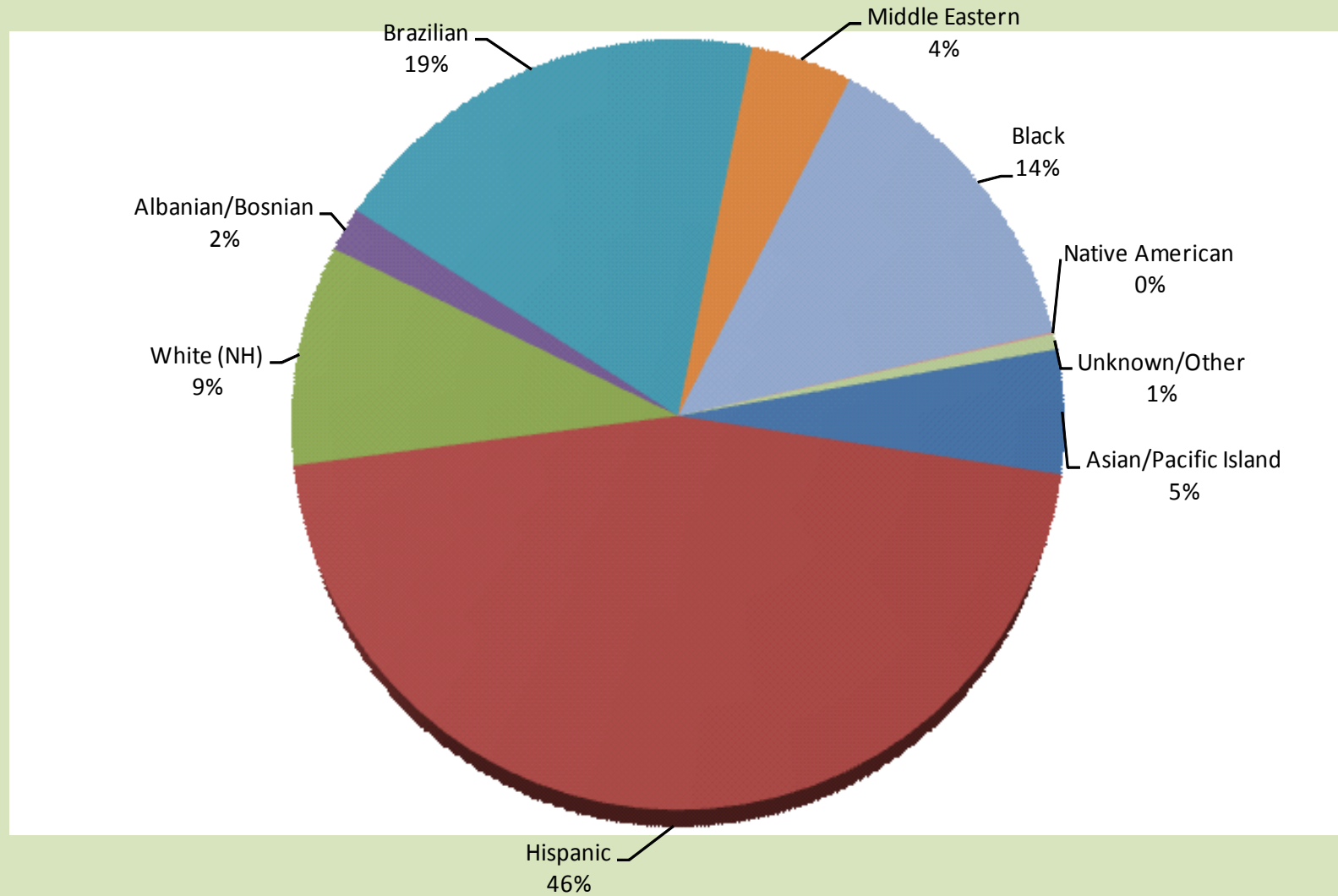
EMKCHC, cont

- Refugee Health Assessment site since 1995
- MA Refugee Preventive Health Provider (ORI) since 2006
- ORR grantee (2009-2010) - refugee health groups, community learning sessions on new refugee populations, literacy volunteer program, and expansion of primary care access for refugees.

EMKCHC 19 Tacoma Users by Languages FY 2011



EMKCHC 19 Tacoma Users by Race/Ethnicity FY 2011



Worcester Sites:

19 Tacoma Street (Medical, Dental, Social Services, Mental Health...)

2000 Century Drive (Administrative Offices)

11 Norwich Street (Norwich Dental Care)

633 Lincoln Street (Community Programs)

Framingham Sites

354 Waverly Street (Medical)

32 Concord Street (Dental Only)

Clinton Site

200 High Street (Dental Only)

School Based Health Centers

Burncoat School Health Center (Medical only)

Roosevelt School Health Center (Dental and Medical)

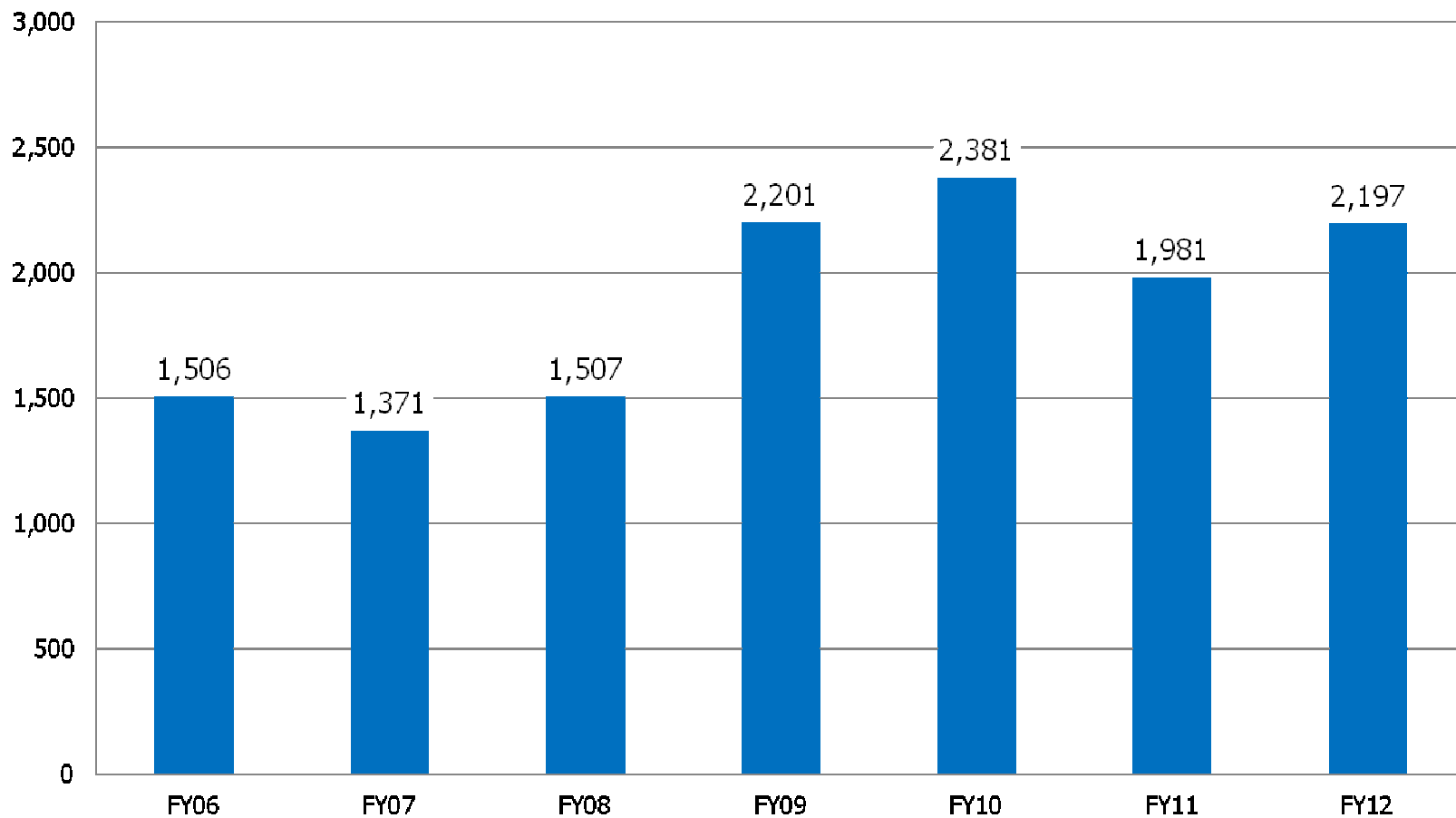
Worcester Tech High School Health Center (Medical only)

North High School Health Center (Medical only)

Norrback (Dental only)

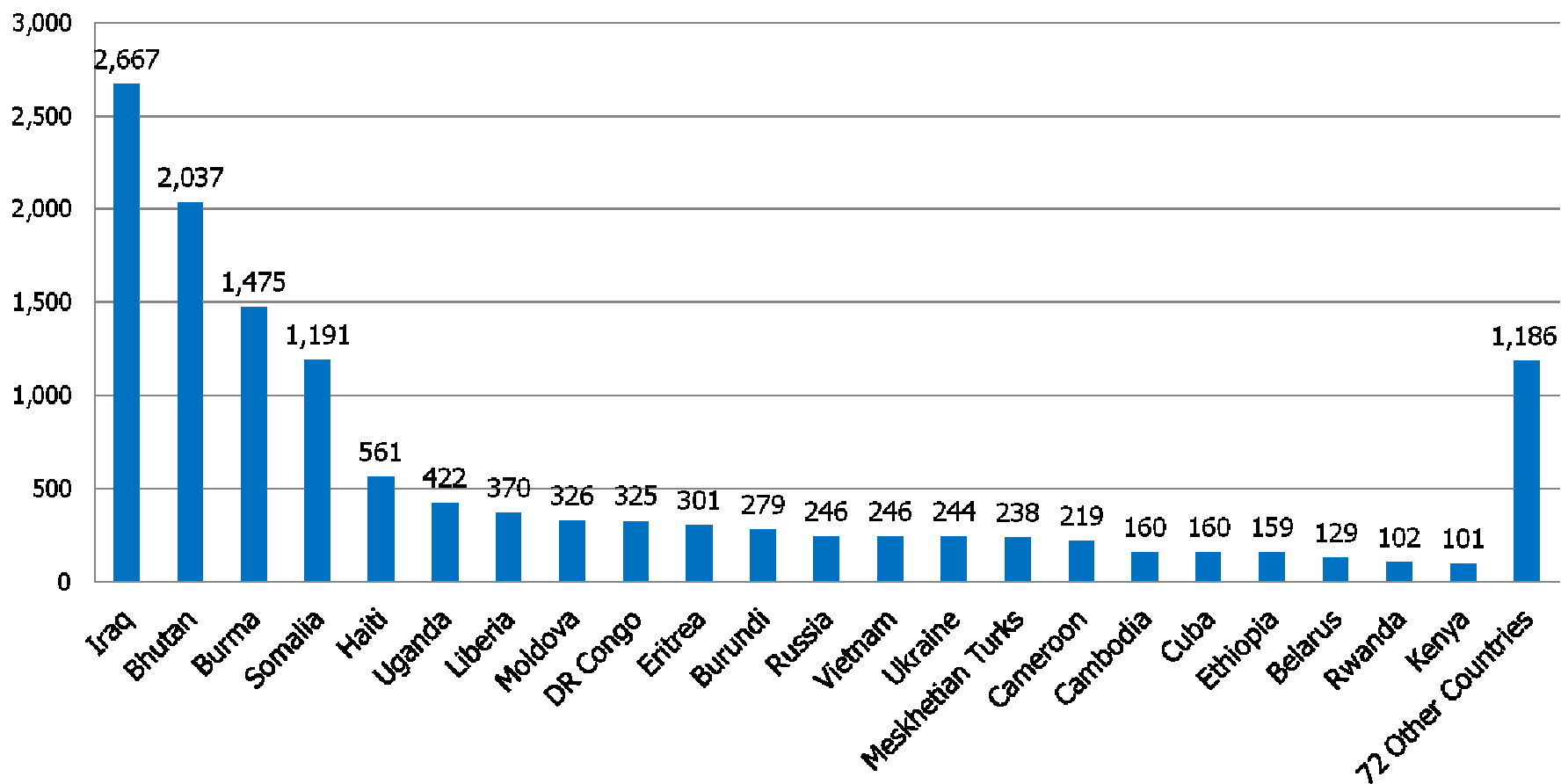
Framingham High School (Medical only)

New Refugee/Asylee Arrivals in All MA FY06-FY12
Total=13,144 (not including all secondary migration)
Data from MA Office for Refugees and Immigrants (ORI)*



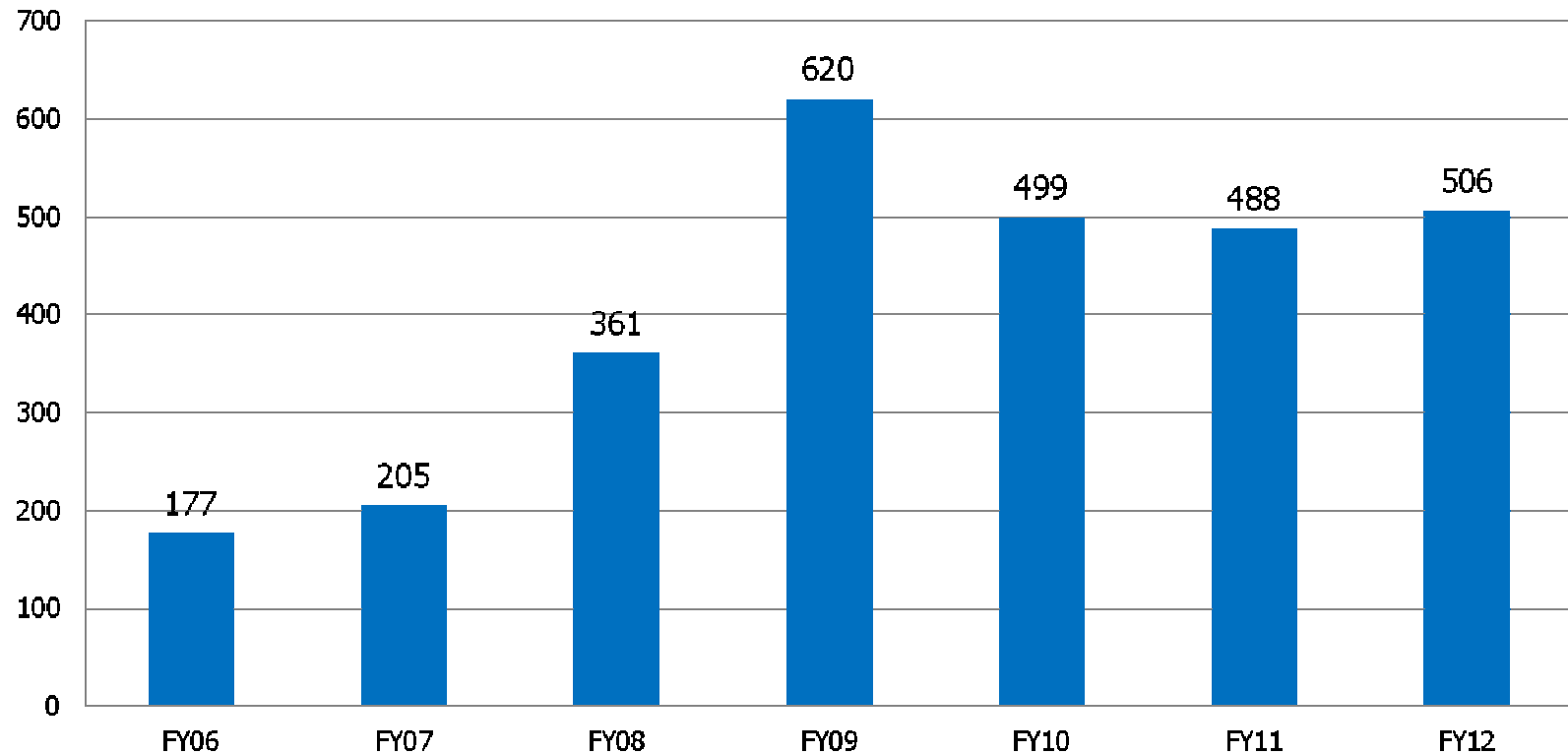
*Data provided by ORI from MA refugee case management provider reports

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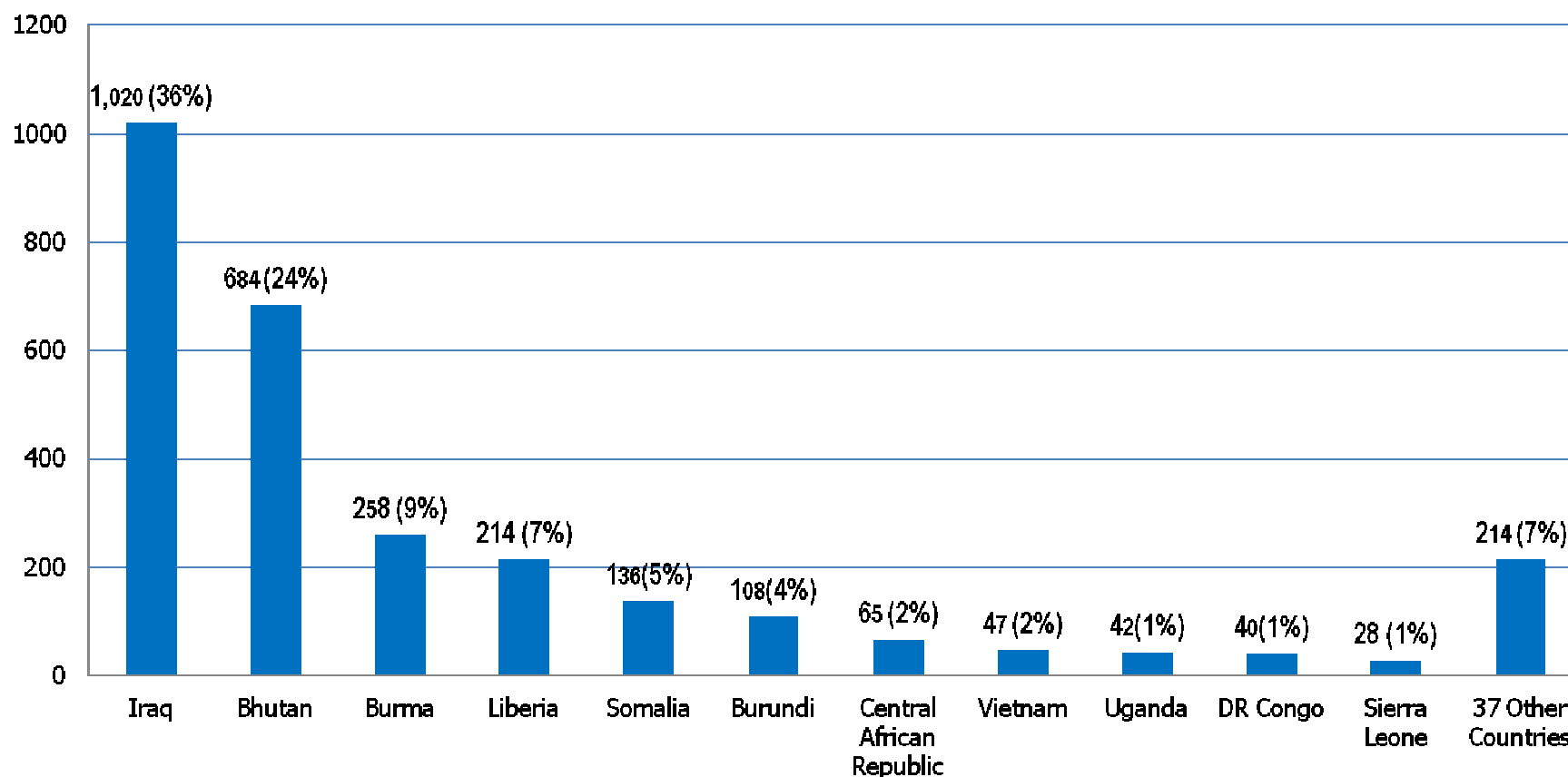
*Data provided by ORI from MA refugee case management provider reports

New Refugee/Asylee Arrivals in Central MA FY06-FY12
Total=2,856 (not including all secondary migration)
Data from MA Office for Refugees and Immigrants (ORI)*



*Data provided by ORI from MA refugee case management provider reports

New Refugee/Asylee Arrivals in Central MA FY06-FY12
Total=2,856 (not including all secondary migration)
Data from MA Office for Refugees and Immigrants (ORI)*



*Data provided by ORI from MA refugee case management provider reports

- The United Nations High Commissioner for Refugees lists 16 million refugees and asylum seekers and 26 million internally displaced persons in the world as of mid-2009.
- Over 1.8 million reside in the United States.
- All refugees have experienced extremely stressful events related to war, oppression, migration, and resettlement.
- The best evidence shows that a large minority of refugees experience multiple, distressing somatic and psychological symptoms and poor mental health that are associated with stressful events in a dose-dependent manner.

- Because this high burden of combined emotional and physical distress is often symptomatic of preexisting or developing mental disorders, screening upon arrival in the host country is important.
- Screening for mental disorders is not currently a standard practice in the majority of refugee resettlement programs in the U.S.
- Barriers to screening include time, cost, follow-up, refugees' health seeking behaviors, accessibility and availability of services, language, and cultural or conceptual differences in perceptions of health.
- Another challenge to screening is that symptoms in refugees are most often not characteristic of single, western-defined psychiatric disorders.

- A screening instrument for refugees needs to be efficient and sensitive to a range of common psychiatric diagnoses.
- A standard instrument that is effective and efficient in screening for emotional distress that is a common marker across psychiatric diagnoses in many ethnic groups would be helpful for resettled refugees.
- PTSD, anxiety, and depression symptoms are the most common mental symptoms in refugees.
- Psychotic illnesses are relatively easy to detect by non-psychiatric providers.

???

When in the course of resettlement is the best time to screen for mental health conditions?

- Early in the resettlement process?
- Later, to catch delayed onset of symptoms?

Our Decision Process

- We realized the homeland conditions refugees experienced prior to resettlement might result in the development of depression, anxiety, and PTSD.
- We realized these conditions would not disappear once resettled refugees were in the USA.
- We realized these conditions might interfere with a successful resettlement experience.

SO, IT MAKES SENSE TO CONDUCT MH SCREENINGS EARLY
IN THE RESETTLEMENT PROCESS – i.e., DURING THE RHA.

BUT

- Screening with no or minimal access to MH resources will not work out well for patients who need MH service, or for staff conducting the screenings.
- Everyone will be distressed.
- So we decided it might be better to screen after a refugee became our patient, not at the time of the RHA.

quick reminder

- All resettled refugees must have a two-visit RHA – Refugee Health Assessment – a physical exam that assesses a number of specific physical health points.
- Our health center's mental/behavioral health services are available only to our patients.
- Refugees attending RHA's are not patients yet.

BUT

- By the time a refugee became our patient, saw their PCP (a few times, since complaints were frequently presented as physical problems/pain), was referred to the BH Dept after no positive medical resolution to the initial complaint, was scheduled for and kept an initial BH visit, a LONG TIME had passed.

(just look how long it took me to explain all that!)

BY THAT TIME

- It was quite difficult to convey the idea to the refugee patient that perhaps how they were feeling was the result of psychological/emotional reactions to some of their life experiences – not a physical condition.
- Mostly they didn't believe us, and thought, rather, their PCP wasn't being thorough enough, and maybe they needed a different doctor.

SO

- We decided it might be worthwhile to provide some patient education around the phenomenon of somatization (without using jargon!) early in the resettlement process.
- As long as we were going to talk about somatization, we might as well do MH screening.
- We could “fast-track” refugee patients for a BH visit, as soon as they signed up to be our patient.

Our Implementation Process

- We wanted a screening tool that asked about depression, anxiety, and PTSD
- We wanted a tool that wasn't going to take an hour or more to administer
- We wanted to ask the screening questions in a way that would link mental health conditions to physical symptoms.

This is what we put together

The 4 question Primary Care PTSD screen

Some PHQ9 depression questions

Some anxiety questions

One question about physical symptoms:

YOU ARE HAVING PHYSICAL SYMPTOMS (heart pounding, trouble breathing, sweating, pain) especially when something reminds you of the bad experience you have had

We wrote a script for staff

- To explain to the refugee why we were asking these questions:
- Intro – why we are meeting
- obtaining medical and symptom history – this helps your provider understand the problem you are having, and what treatment options are available
- Giving some information about stress/reactions and about pain
- incl some to take home and read

Script, cont

- Confidentiality and Consent
 - We'll be asking you some questions about how you've been feeling and what symptoms you've been having, is that okay?
 - If you are not sure of the answer to a question, that's okay, you can tell us you don't know or are not sure.
 - We will only be sharing the information you give us with your doctors.

Script, cont

Trauma Info: we know that -

- Bad things happen to people, and leave a lasting impact that doesn't always go away by itself
- We know that many refugees have experienced very bad events before they were resettled to America.
- Bad events change the way we think, change our feelings, and even cause physical pain
- When our patients are in pain or distress, we first have to figure out what is causing this.
- Then we can do something to help patients begin to recover.

Script, cont.

- To help your providers figure out what is causing your distress, we'd like to ask you some questions about how you've been feeling. We are going to write down what you say, and give this information to your doctor.

Then we administered the screening tool

How we started

- A BH clinician conducted the combination screening/psycho-ed visit, through an interpreter
- The visit was billed as a 45-50 minute individual session
- Based on the screening results (+/-), treatment options might be offered

What were the results?

- About half the time the screening results were positive, and refugees were offered further BH intervention (individual tx, psychiatric appt)
- Screening results became part of the patient's medical record, and available to the PCP
- Some ethnic groups tended to prefer the psychiatric visit option, rather than individual psychotherapy
- The visit contained minimal psycho-ed because it was conducted by a BH clinician who was focused on screening, not educating.

Then we discovered the RHS-15

- We liked the RHS-15 question formulation better than the tool we put together
- We loved the thermometer!
- A 5 point Likert scale yields a more refined answer than our “yes/no” answer set
- It was being used in other places, and someone was studying those results.

RHS-15

http://refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf

BACK TO THE DRAWING BOARD

- We scrapped our tool in favor of the RHS-15
- We decided to train Community Health Workers (CHW's) to conduct the intervention
- We re-looked at the possibility of screening and educating refugees during or between the 1st and 2nd RHA visit

Benefits of this approach

- CHW's are already focused on providing health education to patients
- We had the luxury of matching (sometimes) the ethnicity/language of the CHW to that of the refugee patient (so no interpreter)
- We could schedule the CHW to meet with the refugee patient at the time of the PPD reading, so as to not interfere with all the medical things that needed to happen during both RHA visits.

More Benefits

- CHW's already were providing quite a lot of health education during RHA visits – so including education about somatization helped to normalize this concept
- The RHS-15 questions ask about symptoms many of the medical providers had already touched on to some degree, so screening was more integrated into the entire process.

A Final Benefit

- A CHW is able to be more flexible about their schedule than is a BH clinician, thus can be more available for providing screening and education for refugees returning to the health center for a PPD reading.

Next Steps

- Development of a “deeper bench” of staff who can conduct screening/education visits with refugee patients. This will involve getting buy-in from medical staff (RN’s and/or MA’s) who then can be trained to conduct these visits.
- Infrastructure that supports medical staff as well as CHW’s, to conduct these visits.