Chapter 12
Mental Health Screening

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Introduction

There has been a long-standing discussion amongst scholars about the role and use of early mental health screening to detect common mental disorders in refugees. In the development of a health screening protocol for refugees arriving to the US, models were deemed inadequate, in part at least, due to the lack of mental health screening [1]. The wide variance in reported prevalence of symptoms among refugees may be in part due to the lack of empirically developed instruments for use [2]. In encouraging the practice of mental health screening with refugees, authors have discussed both the value of self-report questionnaires to help normalize symptoms in refugees [3] and the use of structured interviews to enable the collection of

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important details relevant to mental health [4]. While this debate continues, some suggest that early detection of mental health symptoms in refugees is believed to improve long-term functioning [4, 5].

The Office of Refugee Resettlement guidelines require a health screening in the first 90 days; however, there has been a lack of procedural or financial support for mental health screening for refugees [6]. Technical instructions provided to resettlement agencies by the Centers for Disease Control dated 2012 stated that a mental health screen "may be performed according to resources available for intervention for conditions identified" [7].

State refugee health coordinators surveyed in 2010 reported that only 4 of the 44 states surveyed used a formal screening instrument and 68 % used informal conversation [8]. Refugees endure a high burden of distress and illness with its concomitant impairment; best estimates are that up to 10 % of refugees suffer diagnostic levels of PTSD and depression [9] and approximately 30 % have high levels of distress that might require treatment [10]. This may suggest that routine screening for mental health during resettlement be conducted, as is done for infectious diseases.

The Need for Specialized Instruments

Understanding a refugee's expression of distress requires careful consideration of a variety of factors including language, culture, the individual traumatic history, and the client's medical worldview [11, 12]. Outlined below is research conducted over a period of years leading to the development of screening instruments by a number of authors considering these complex issues. The human biological system response to stress includes a series of common physiological changes [13] which might predict core symptoms, yet the language used to express these varies based on social and cultural factors. For the purpose of screening, identifying the central symptoms that arise from the neurological process and less on the complex communication of them avoids being distracted by cultural and medical frameworks. Assessment after screening contributes to understanding the complex symptoms, comorbidities, and explanatory models that help define treatment needs.

While most refugees anticipate an end to the long-term suffering and uncertainty when they arrive to the city of resettlement, the initial weeks and months is a period of emotional adjustment that can fluctuate between relief and distress, even, in some cases reactivating symptoms of trauma. For others, emotional distress can appear years after arrival. Therefore, mental health screening, at any time, can play a vital role in identifying refugee mental health needs.

The role of a screener requires understanding of the unique challenges related to refugee mental health and refugee trauma [1]. This chapter begins by presenting several issues to be considered when screening refugee clients and continues with an overview of research related to screening instruments. Screening is best thought of as a distinct process from diagnosis or assessment with the intent to efficiently

detect common mental disorders and distress with reasonably high sensitivity and specificity.

It is important to note that refugees are a diverse group and represent a broad variety of ethnic, language, and people groups, and this chapter can only present generalizations of the issues affecting them.

Considerations for the Screening Process

Refugees, by definition, have endured experiences of harm, persecution, and loss of security, all of which can reduce an individual's level of trust. Therefore, careful engagement of a refugee and consideration of their need for safety are important. Based on past experience, many refugees hesitate to speak openly or disclose too much information for fear of retaliation, persecution or that the information will be used against them. Establishing a feeling of security is necessary for an accurate measure of health symptoms of any kind [14].

The period of adaptation in the preliminary months of resettlement adds another layer of physical, social and psychological stress, and some refugees may find the process of adjustment to be overwhelming. Emotional responses during this period vary widely, and while some individuals experience an initial "honeymoon" period that masks symptoms, others may find that specific events trigger symptoms even years after arrival. Ongoing challenges of adjustment referred as acculturation can induce significant stress. Language and cultural adjustments, changes in family roles, and social expectations can manifest in a variety of medical or psychological complaints for many years after arrival to the country of resettlement.

Refugee descriptions of symptoms and emotional distress are communicated using language that reflects their medical worldview. Many refugees come from naturalistic or personalistic medical models both of which understand the nature of illness and the body differently than Western medicine [10, 14–16]. A significant number of refugees come from worldviews that do not differentiate between mind and body symptoms [17]. Research has demonstrated that experiences of extreme stress effect a variety of changes in the body [18] and refugees will often report physical symptoms of distress.

Another issue affecting communication is the respect awarded to people in authority. In many cases, refugees will not initiate communication but will only respond to specific questions, and in some cases will avoid any appearance of disagreement even when a provider's advice goes counter to the refugee's belief or understanding.

Language and cultural barriers make using trained interpreters and translated instruments a requirement. Providers working with refugees must have knowledge of and follow proper interpreter protocol. It is important that providers do not ask interpreters to answer questions or "fill in the blanks." Providers should have sufficient knowledge of the cultural context to ensure that an interpreter being used is not representative of a tribe, clan, or ethnic group that had previously persecuted the

patient's refugee group. It is important to watch for signs of discomfort, to ask clarifying questions, and to ask the interpreter to follow protocol.

Even with the best tools at hand, understanding what the refugee intends to communicate can, at times, be a challenge. Screening that includes both standardized instruments and an interview is best, as refugee literacy (in their primary language) and comprehension of scale formats may interfere with accurate conclusions [4].

Providers can help overcome some of the challenges of communication by using concrete simple language, and focusing on symptoms, rather than diagnosis. Also, a provider can never assume that a refugee understands the context of the medical encounter and should take time to provide clarity about their role and intention [11]. Careful explanation of the use of any paperwork or documentation the refugee has to sign is warranted, as many may have signed stacks of papers they did not understand either in the context of traumatic experience or in the resettlement process.

Most of all, the refugee experience is one of disempowerment. Refugees are best served when provided with education about procedures and services that include opportunities for choice. Refugees who are protective of information or reluctant to participate in activities that might improve their health are often mislabeled as noncompliant or suffering from a stigma. Explanations and instructions that allow refugees to have control over choices are more effective. When referring refugees for follow up assessment or mental health services, rather than using diagnostic or psychological language, it is useful to describe the services as an opportunity to meet with another provider who can help them to manage the symptoms and increase their comfort.

Besides PTSD and depression, mental health issues that should be considered in a mental health screening include traumatic or acquired brain injuries, forms of psychosis, and conditions previously undiagnosed in adults, including developmental delays, autism spectrum disorders, and similar diagnoses [5]. According to screening guidelines from the CDC, physicians should screen for undiagnosed psychosis and traumatic or acquired brain injury. These conditions are often more complex and may require additional visits or evaluations after primary mental health screening.

Primary care physicians are an important source to identify survivors of torture, and to help them obtain necessary medical and psychiatric care. Statistics for survivors of torture vary widely but according to the International Rehabilitation Council for Torture Victims, up to 35 % of the refugee population is survivors. The best approach to establish whether a refugee is a survivor of torture is to ask several direct questions such as: What led you to become a refugee? or Were you ever held against your will? For more information on evaluating torture survivors see Chap. 14.

Some instruments for screening are discussed below. Providers are also encouraged to familiarize themselves with diagnostic criteria as set forth by the Diagnostic and Statistical Manual—fifth edition (DSM-V) [19].

Instruments for Screening

In a recent survey, respondents composed of refugee health coordinators identified the need for short, culturally appropriate mental health screening tools to identify refugees who need assessment and treatment services [7]. Depending on the clinic environment, and for a busy practitioner, only a primary screening and referral process may be feasible. However, in clinics with additional resources, a second tier clinical assessment that allows for a more comprehensive narrative by the refugee(s), an in-depth history, and diagnostic formulation may be possible.

The primary challenge to developing a screening instrument is that refugees are heterogeneous groups who collectively experience many psychological and somatic symptoms of distress. Theoretically, a screening instrument should include symptoms that optimally predict common disorders in multiple refugee groups with high efficiency. A few instruments have been developed in refugees for specific diagnostic identification.

The Vietnamese Depression Scale (VDS) consists of 15-items that effectively identify depression in Vietnamese refugees [20]. The Harvard Trauma Questionnaire (HTQ) has a 30-item section assessing symptoms that have been used as a proxy for PTSD [21]. Both instruments were developed by expert consensus methods for use in the clinical setting.

The 15-item Health Leaflet (HL) developed to screen for PTSD in two Iraqi language groups reported that the HL was 0.70 sensitive and specific to diagnosis, with two items (difficulty concentrating and exposure to torture), accounting for the discriminatory performance [4]. A Diagnostic and Statistical Methods (DSM-IV) based symptom checklist developed by an expert consensus process identified a psychiatric disorder in nearly 14 % of the 1,058 adult refugees in the Colorado Refugee Program [5].

More recent work on developing a screening instrument has been done by the *Pathways to Wellness* project. The Refugee Health Screener-15 (RHS-15) was designed to be short (15 questions) with neutral language that does not directly address violence, torture, or trauma. The RHS-15 was empirically developed to be a valid, efficient and effective screener for common mental disorders in refugees. The RHS-15 has been integrated into standard physical health screenings for newly arrived refugees at Public Health Seattle & King County and in a number of other places across the country.

Symptoms that form the validated RHS-15 were derived from twenty-seven New Mexico Refugee Symptom Checklist-121 items (NMRSCL-121), the Hopkins Symptom Checklist-25, and the Posttraumatic Stress Symptom Scale Self-Report that were found to be most predictive of anxiety, depression, and PTSD across the target sample of Iraqi, Nepali, Bhutanese, and Burmese refugees. Multiple exploratory methods were used during analysis, including correlations and general linear models using t-tests and analysis of variance to establish the most useful and efficient set of symptom items. The RHS-15 is composed of fourteen symptom items

and a distress thermometer that predict each of three diagnostic proxies with sensitivity ranging between 0.81 and 0.95 and specificity ranging from 0.86 to 0.89.

Strengths of the RHS-15 are its metric properties, the efficiency of administration, and its demonstrated preliminary effectiveness and desirability in meeting a clear need. The RHS-15 grew from initial work utilizing empirical multi-method participatory research. Initial items came from qualitative work respecting the voice of Vietnamese and Kurdish refugees used in the development of the NMRSCL-121 which assesses the broad range of persistently distressing symptoms and is a reliable and valid predictor of traumatic experiences, PTSD, anxiety, and depression in Kurdish and Vietnamese refugees [22]. Because developers of the RHS-15 were sensitive to the cultural beliefs and expressions regarding symptoms of mental health, participatory community translation helped ensure cultural equivalence for important words and phrases of distress. The RHS-15 is available in Amharic, Arabic, Burmese, Farsi, French, Karen, Nepali, Russian, Somali, Spanish, Swahili, and Tigrinya. Limitations of the RHS-15 are that prospective efficacy and effectiveness testing is yet to be reported, and generalizability to other refugee groups is still pending.

The RHS-15 has open access and may be obtained through Lutheran Community Services Northwest (LCSNW) at *http://www.lcsnw.org/pathways/index.html*

There are a few instruments developed for refugees that assess symptoms as diagnostic proxies (DPs). None are definitive diagnostic equivalents. The Hopkins Symptom Checklist-25 (HSCL-25) is a valid indicator of anxiety and depression for the general US population and for Indochinese refugees and demonstrates transcultural validity. Item-average scores $\geq$1.75 predict clinically significant anxiety and depression on the scale in general US and refugee samples and are considered valid DPs [23].

The Posttraumatic Symptom Scale Self-Report (PSS-SR) predicts PTSD diagnosis in US populations. Cronbach alpha is 0.91, and 1-month test–retest reliability is 0.74. The 17 items on the scale, each scored from 0 to 3 for symptom frequency, are DSM-IV PTSD diagnostic items. The PSS-SR that may be scored as continuous or a dichotomous DP was found to be highly correlated with war-related trauma, symptoms, and impairment in Kurdish and Vietnamese refugees [24].

Finally, it should be noted that for some refugees post-migration living difficulties may be an equal or stronger predictor of emotional distress than war and migration stress. These factors, such as poverty and unemployment, may be a source of distress either immediately or months after arrival in the new country. The authors recommend that providers remain aware of this issue when screening for mental disorders.

Conclusion

One concern expressed by primary care physicians about mental health screening with a refugee is that it may cause a strong emotional reaction. There is no evidence to suggest that physicians need to be concerned with this and following the guidelines above will increase refugee comfort. Screening for symptoms using an instrument such as the VDS for depression or the RHS-15 for PTSD, anxiety or depression and not initially discussing trauma, torture, or other emotionally laden issues, will mitigate immediate distress. Effective screening of refugees in the primary care setting may increase visit time and does require a focused effort. However, the need for services is great and outcomes have shown that there is value for refugees in receiving services [25]. Ultimately, providers can support the healing process by creating a safe and engaged connection that allows refugees to improve their understanding of the medical system and have power over their own medical care.

Appendix 1

Mental Health SCREENING of Refugees

Sample Screening Questions

Diagnostic criteria	Suggested questions
Hypervigilance	Do you feel you are waiting for something bad to happen?
Intense fear	Do you feel that your body is out of your control?
General anxiety	What do you worry about? Or are you always thinking?
Heart palpitations	Does your heart ever suddenly beat quickly?
Distressing recollections flashbacks	Do you sometimes remember bad things that happened in the past?
Isolation/detachment	Who do you spend time with? How do you spend your time?
Nightmares/sleep disturbance	When do you fall asleep and when do you wake? What keeps you awake or wakes you?
Dissociative periods	Does your mind sometimes go far away?
Startle	Do you jump at loud noises?
Avoidance	Do you visit friends or neighbors? What do you do when you are not at work or school?
Lack of concentration	Do you have trouble learning new things?
Poor memory	Do you forget things?
Anger	Do you get angry?
Lack of affect	Do you feel you do not care about anything?
Depression	Do you get sad? How often do you cry?
Poor future imagining	Can you imagine a happy future in America?
Loss of appetite	How many times in a day do you eat?

Tips for Effective Screening

Reminders	
To Dos	Cautions
Establish connection/safety	Do not assume that you understand
Check understanding with directed questions	Avoid medical jargon and acronyms
Learn something of the social/political context of events faced by the refugee groups in your area	Be aware of ethnic rivals and relationships in your area
Normalize the trauma response and educate in simple terms	Talk in symptoms, not diagnosis
Know and follow interpreter use protocol!!	DO NOT use interpreters to diagnose
Use trained interpreters	Use simple non-colloquial language. Avoid technical medical language
Ask the refugee what is their first language and what is their level of literacy in that language	Clarify understanding by asking specific questions that cannot be answered with yes/no
Ask the refugee what they think is the problem	Do not assume that the refugee understands the purpose of the appointment

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