**Refugee Mental Health Screening: Operationalizing the RHS-15**
**RHTAC webinar**
**May 23, 2012**
**1:00-2:30pm EDT**

Operator: Ladies and gentlemen thank you for standing by and welcome to the Operationalizing the RHS 15 webinar. During the presentation all participants will be in a listen only mode.

If you would like to ask a question during the presentation please use the chat feature located in the lower left corner of your screen.

If you need to reach an operator at any time please press star 0. As a reminder this conference is being recorded Wednesday May 23 2012.

It is now my pleasure to turn the conference over to Jennifer Cochran, please go ahead.

Jennifer Cochran: Great, thank you and hello, welcome everyone to our presentation today on refugee mental health screening, operationalizing the RHS 15. My name is Jennifer Cochran and I'm project director for RHTAC, the refugee health technical assistance center, a project that's administered by the refugee and immigrant health program at the Massachusetts Department of Public Health.

I really want to acknowledge and thank the Office of Refugee Resettlement of the US Department of Health and Human Services for their funding of the TA center and their support makes today's webinar and our work possible.

We are web broadcasting today so please listen to the webinar over your computer speakers. If you need a call in number then please chat to the chairperson.

We're offering today's webinar as a follow up to the tools and strategies for mental health screening, introducing the RHS 15 presentation that was delivered by Dr. Michael Hollifield of the Pathway to Wellness project on January 25 earlier this year.

The RHS 15 is being presented only as a model that's been successfully field tested and used in King County. Its presentation through RHTAC doesn't necessarily correspond to its endorsement as a mandated model by either RHTAC or ORR.

Also note that the presentation may contain references to insurance coverage or other issues which are specific to the geographic areas where the RHS 15 has been implemented.

Now as you may know ORR is currently engaged in a process of reviewing its existing 1995 medical screening protocol for newly arriving refugees.

And they're doing this through the network of refugee health coordinators and state coordinators. ORR will make its updated version of the protocol available in the near future through its own networks and affiliates including RHTAC.

So our structure for today's webinar is summarized on this slide. Our presenters today are Beth Farmer and Sasha Verbillis-Kolp whom I'll introduce in a minute.

They'll speak for about 50 minutes. We'll pause during the presentation for a few questions and then we'll have a full Q&A session at the - after the main talks.

As the operator said you can type your questions via the chat function, really at any time we'll be reviewing those and we'll try to get to them all on today's webinar.

If we don't we'll post a Q&A document online after the webinar. I want to encourage you to visit our website, refugeehealthta.org where we'll post the recording, the transcript and the slides from today's presentation.

And we'll have that together with the Q&A document and additional resources related to the presentation. Please keep in mind that the recording transcript and slides will be posted within the week while the other documents may take a little bit longer to get up.

So we encourage you to check back regularly and check out earlier webinars as well. Our email address is here, refugeehealthta@jsi.com

And feel free to email after the webinar if you have questions. and a reminder that there will be an evolution form that appears as you leave the webinar, please do take the time to fill it out because it's very helpful to us as we're doing the webinars.

So before introducing our speakers, it's - we like to check and see who's in our virtual hall here today, if you could quickly pick as close as you can identify the type of organization that you're with and as the responses come I'm going to give you five seconds so do it quickly.

We'll count down, I'm going to wait another couple seconds, so five, four, three, two, and okay. So this gives - it's very helpful for the speaker also to know who's here today so we're mostly - about half from public health agencies, very - not surprising since many of us doing this work are interested in mental health screening.

Eleven percent from healthcare providers, 16% from resettlement and 5% from community based organizations and then another large other category. Great, so we have one more question for you and that is what's your role within this organization where you're working?

And we also know people have multiple roles, this is only a pick one so pick the role that feels the best to you either in terms of being on today's webinar, the work that you are identifying most closely with.

Again if you can quickly select that, medical clinical care, administration management, case management, social work, community education community engagement and planning, patient education so more individually focused, program support, education, academics.

Looks like it's slowing down so we'll see. So the largest group in administration and management but followed closely by medical, clinical and case management social work. Very good.

So our objectives for today are up here, so really what we're going to try to do today is describe the process and approach taken in integrating the RHS 15 in King County Washington.

To analyze various issues to consider before adopting the RHS 15 in your community and third to discuss the challenges and successes with integrating mental health into resettlement.

So now I want to introduce our presenters, Beth Farmer and Sasha Verbillis-Kolp. Beth is project director for the Pathways to Wellness project, a project designed to offer early intervention and support to refugees with depression, anxiety and traumatic stress disorders.

She's also director of the international counseling and community services, a licensed mental health program of Lutheran Community Services Northwest that primarily serves refugees.

Beth received her bachelor's of Science degree from Texas Christian University and her Master's in social work from University of Washington. She spent over two decades as a social worker primarily in the fields of women's health and multi-cultural issues.

Her co-presenter is Sasha Verbillis-Kolp who is trained as a social worker with secondary course work in international development and management and forced migration studies.

Sasha has experience in the refugee field including direct service and refugee resettlement, curriculum development, policy and program development, training and group facilitation.

International development and human rights advocacy so she has done really quite a lot. Internationally she researched the needs of women, migrant workers in Thailand and has conducted field work on Buddhism and cultural healing in Cambodia.

She coordinated the evaluation activities for the Pathway to Wellness project and is currently supporting expansion of the project to Portland Oregon.

She provides technical assistance to sites interested in replicating the model. Again we're very pleased to have Beth and Sasha join us today and with that I'm going to turn the floor over to Beth.

Thank you, and Beth I'm going to advance your first slide.

Beth Farmer: Thank you very much for having me. I wanted to say before we get started that we certainly could not have gotten here on our own. This is a partnership project between Lutheran Community Services Northwest, Asian Counseling and Referral Service, public health Seattle and King County and Dr. Michael Hollifield, all of those different organizations were essential to making this work.

And we'd also like to thank our funders Robert Wood Johnson Foundation, the Bill and Melinda Gates Foundation, the Murdock Charitable Trust, United Way, Seattle Foundation Medina and the Boeing Employee's Community Fund.

The project, the Pathways to Wellness project was really designed to find incidences of extreme emotional distress primarily depression and anxiety in newly arrived refugees.

And it grew out of long discussions, probably about seven years of discussions within our community in King County.

We were seeing that there were refugee clients with severe emotional distress, we weren't sure where and how to refer them. We knew that there wasn't any systematic screening of new arrivals.

And we also were concerned that even if we did find a way to refer them that because of the different meaning around mental health we wouldn't be successful in that, and we wouldn't have agencies that would be able to successfully work with them.

So we knew there were a lot of barriers. We spent a lot of time engaging people in discussions and out of that grew this coalition project the Pathways to Wellness.

And the three visions we had were that we would do mental health screening very early on in the process primarily because there was central catchment, there was one place that they were going, the refugee health screening.

And people still had resources at that time, they still had a medical coupon, they still had a resettlement agency that could assist in this.

As well we figured that if we were to aide people in kind of that path to healing, that would improve their adjustment to the United States.

We knew that we also really needed to build the capacity both within the refugee community and with mental health providers to be able to accept referral and to serve people.

In other words we had to find people, we had to get them to accept referral and then they had to go to a place that they would get better. All of those three things really had to work together.

We wanted to make sure the project was evidence based because that way the investment and the time, the energy, the financial investment in this could then be given for free to other sites so that they could then have a nice foundation to be able to implement this project into their location.

And we'd really have some good scientific data that this actually worked. So our model was that screening and referral, community outreach and provider outreach would all work together to funnel people in to treatment and support.

Sasha Verbillis-Kolp: This is Sasha Verbillis-Kolp and I wanted to start off by giving more of a background on this RHS 15, the screening tool that's been developed with the pathways project. We partnered as Beth had mentioned before with Dr. Michael Hollifield in developing a short screening tool that is culturally competent in addressing those in need.

It is a predictive tool that is it's not a diagnostic screener, it's predictive of anxiety and depression which are common diagnoses for refugees.

After a year long evaluation we did find of all of those coming through the King County public health refugee screening clinic that about 30% of those were showing significant distress of anxiety or depression related symptoms.

Of those 30% by incorporating a robust referral process into the screening and referral of our work we found about 70% of individuals willing to go for treatment, to go for care.

Currently the RHS 15 has been translated into the languages identified here, Arabic, Nepali, Korean, Burmese, Russian we're just about to wrap up our Somali translation.

We're targeting some other refugee communities with our participatory translation and that will be in (Tagurnia), Key Swahili and Farsi. Importantly the RHS 15 was designed for people age 14 and older.

In developing the RHS 15 we engaged in the robust participatory and iterative translation process. Here you can see a model for how we went about this. Importantly we wanted to make sure that what we were saying was the right thing in each language.

And to do that we engaged both in a blind and back and forth translation process. Importantly we took to the community the tools that we were utilizing as we validated the RHS 15 and engaged them in back and forth sort of consensus and committee process at arriving at both the magic and symbiotic meaning, significant in each language.

By validating a mental health screening tool in this way we really wanted to show that cultural and contextual factors are so key to our work whether as researchers, practitioners, or ultimately within the health systems we're working in.

Here we see the RHS 15 as the new validated tool. This is the first page of the RHS 15, it's a demographic cover sheet which we find that different health sites may be able to incorporate into their record systems and/or their electronic data systems.

It has a couple of features that can look at demographic information, their name, their gender, the date of their screening, their birthday etcetera.

We then move to the second page of the RHS 15 which again these arose out of an extensive evaluative process in which I had the pleasure of working with Dr. Michael Hollifield and validating our tool.

We have a series of items that are most co-related to anxiety and/or depression symptoms and that of PTSD, post traumatic stress disorder. So first it's nine items on the first page of the RHS 15 are looking at symptoms that have been bothersome to the individual during the last one month including today.

They range from thematic expressions from depression related symptoms and that of anxiety. The next three questions on this first

page of the RHS 15 are looking at how one has coped with traumatic experiences related to war and migration.

And those are really refugee centric and came out strongly in our validation process. As we move to the third page of the RHS 15 you'll see there are two items here and then a scoring box. Item 14 is a constitutional item that's asking about how one has handled or coped with stressful life events that have come across their life or have happened throughout their lifetime.

Item 15 is a distress thermometer which is asking how much distress has one had during the last week including today. You can see here it's a pictorial image which we felt would be most applicable with some of the new arrival populations or with refugees that may have less literacy as a way to measure how much distress they may be experiencing.

In terms of how we go about scoring the RHS 15 again that has gone through an extensive evaluative process for we've identified on items 1 through 14 as one scores 12 or higher they are considered significant for emotional distress, be it depression or anxiety related symptoms.

Or if they score five or higher on the distress thermometer they are equally screened significant and can be routed for a referral.

I wanted to say that anecdotally we're seeing that those that may be at this cut off value of 12 on items 1 through 14 or five on the distress thermometer that they may be less likely to accept referral and you know more work is being done in that but the point that I want to make with this is that those that are having a cumulative score on items 1 through 14 on much higher than 12 tend to be those that are very willing to go for more support.

I think we have a polling question.

Jennifer Cochran: Yes, we have a polling question. So the question here is from your perspective are there appropriate and accessible mental health resources in your communities for refugees? So it's a yes, no, don't know.

So if you can quickly weigh in in terms of the availability of mental health resources for refugees, watch the numbers come up.

Three, two, one, and take a - so it's a - I see they keep moving up but it's about 60% are saying no and a third are saying yes and about 10% don't know.

Turn it back to you.

Sasha Verbillis-Kolp: Well that's a critical piece to how we look at how mental health screening for refugees utilizing a tool like ours, our RHS 15 can be utilized in your community.

We really get at the heart of this in terms of how can different communities work towards incorporating this based on a series of different factors. First while we've seen that the RHS 15 has been effective in our setting in King County, we really wanted to design tools that could be useful for other sites.

And the goal of this would be that this tool could be easily used in your community. So how can different communities go about adopting or integrating this as another health component or health screening intervention in your community.

To answer that question we want to look at a series of different universal questions as well as site specific. So of the universal overarching considerations that we have with this is really the who, the how, the why or sorry, the when of integrating mental health screening for newly arrived refugees.

How much of this will depend so much on your site specific factors, such as your community funding structures, whether it be locally based or federally, the type of screening site where refugees are coming for their initial health visits, the capacity to then treat them for appropriate mental health services and then there are options for ongoing or long term healthcare.

Of the universal implementation questions, the first one I wanted to look at here is who can administer the RHS 15?

Health workers, interpreters, any other individuals that are involved in ongoing patient care that are part of that health screening visit, whether you're in a clinic, a public health clinic or potentially in a primary care clinic.

We do recommend that there is at least an hour of training for whoever is administering the tool so that we can really assist the practitioner or clinician in understanding the reasoning behind it, how to set it into your specific context and then how to go about scoring it and where to refer and how.

Pathways as a team we also recommend if possible that there is a way to train interpreters because we know that many interpreters come from refugee communities that may hold the same stigma or beliefs around mental health that could hinder or potentially be a barrier for others accessing care.

And when you know this continues to be an ongoing question, when should we intervene? When should we screen refugees for this distressing symptom of anxiety or depression.

Well in our work we thought it was very critical to do this early on, building from a public health model with that if we can intervene early while refugees still have their resources and coverage by Medicaid then we can plug them into the right care so that they can heal.

And it's ideal we strongly believe that this is done in healthcare settings where there is likely to be less stigma. How does one go about administering and scoring the RHS 15?

I spoke to that a little bit earlier but importantly I wanted to mention here that because of the different target languages that the tool has been translated into that it can be self administered, that is an individual or in a family setting can go about administering these questions themselves.

Even if one is literate they will often utilize the support of a bilingual or bicultural worker as it is available to them.

If one is not literate and they have the resource of an interpreter on site then that interpreter can assist them in the process. Importantly we're asking these questions on the RHS 15 retrigger someone making it difficult for them to get to the next step of their health clinic visit.

And our experience, patients really did not be compensate to the point where this was an issue. There may be someone that experiences some emotive relief, they may cry, they may have a sense of relief

really at knowing that there are additional resource that are available to them.

That said it is important for health sites in your community to consider having a crisis protocol in place should there be a situation where there's a need to have an emergent interaction with another provider and accelerated intake or something of that nature.

And in Seattle and King County we had a lot of well standing multidisciplinary relationships were established and we do encourage other communities to go about having these relationships if they're not already in place.

I want to emphasize here that the RHS 15 is again a predictive tool, it is just showing that one is likely having the symptoms of anxiety and depression. It is the mechanism that can route one to care so they can have a further diagnostic assessment.

Another question that's asked with this in our universal implementation question, go back one, is that they score high on items 1 through 14 or high on their distress thermometer, does that mean that they have post traumatic stress disorder or major depression?

Again it's not necessarily so but we do want to emphasize that it is a predictive tool and that their diagnostic process can happen once they're referred for care.

And will refugees accept referrals? Well we think that they will especially in terms of how we go about offering support in a non-stigmatizing way.

So with that I want to shift gears a little bit, I think there's a polling question and then we'll get to some more content.

Jennifer Cochran: Yes, thanks. The question that we have is kind of thinking about screening again and to ask you what behavioral health issues are you interested in screening for?

Depression, PTSD, psychotic illness, suicide, substance abuse, domestic violence and in this case you may pick more than one. So most of our polls it's a select one, this is a multi-select is fine. Again we'll - okay.

The responses are still coming in so I'm going to give you another couple seconds to think about it. Again what issues are you interested in screening for?

All right, we'll move from there to the results, a lot. I'm going to give these to our presenters to mull over in terms of what they mean.

Sasha Verbillis-Kolp: I think that's great to see, all of these are important issues that different communities are considering as important and looking out for newly arrived refugees.

And to speak to a couple of these I want to mention that with our project we specifically hone in on the depression anxiety related symptoms because that is the most common diagnoses that refugees experience.

We did not include with this work anything on substance abuse or domestic violence because we felt strongly and quite intentionally that that would be something that would occur during their diagnostic assessment with the treating clinician.

Move on to how we look at how mental health is conceptualized in the United States. As many of us know mental health has a much broader meaning than mental illness. Symptoms range from non-severe to mild to moderate to more severe.

They range along the spectrum of feeling sad, having trouble sleeping, problems with too much worry, racing thoughts and whatnot.

And the United States we conceptualize mental health within this realm or range of experiences and it is really along the spectrum of symptoms that a given diagnosis can be used simply as a way to have a common language and working with refugees and developing the right treatment plans.

And while mental health may have a distinct meaning in the United States for many in many different communities and countries, mental health carries a high degree of stigma and is most often related to that of the - I guess it would be the lower right hand arc of that symptom, arc from the last slide.

It holds the equivalent to that of being crazy and this is a result of the explanatory or cultural lens that we are all uniquely embedded with and for many this sense of mental health is really not about mental health, it's really at that more extreme point of being mental illness.

And many communities that we're working with there are traditional beliefs and perceptions and for example many refugees may be - that would be having these conditions could be identified as having bad blood, they could indicate having a problem in the spirit world, that their distress that they're experiencing is a result of some karmic activities or problems with their ancestors and/or with their social relationships.

Having mental health could be a sign of weakness or immaturity and it's important to remember that the (unintelligible) plays a large part in how one will go about seeking help and we took that to heart in the work in terms of how we went about creating a bridge for refugees.

And similar to US history and understanding the full range of experiences related to our emotional well being in many countries where refugees come from mental health issues may have instilled that people have been locked away or experimented on.

Importantly the way that we talk about these symptoms in our context and describe the type of services that are available to them can either hinder or motivate someone to enter services.

So when we talk about creating a bridge we want to really recognize that there is different meanings, that there is stigma and shame among the communities that we're working with and that we need to create a bridge so that these issues are normalized.

We can then think of the clinic visits as that first opportunity or gateway at psycho education. Going to move into how we look at introducing the RHS 15 in the clinic settings.

Whether you are a clinic that has one health screening visit for refugee new arrivals or you're a clinic that has multiple, one two or three visits in which you can identify and treat refugees for the various health conditions that you're screening for, we do recommend that as you incorporate the RHS 15 or any other mental health screening into your work that you introduce this as the next component of their health screening visit.

So we could use an example of someone, let's say it's (Kadra), (Kadra) has come to the clinic, a Somali woman and is about ready to proceed with her medical screening visit.

You would as the health worker identify as part of her overall screening that in addition to the blood draws, the medical review, etcetera that your visit will include some questions about how you're doing today both in your body and in your mind.

Then she would proceed in her health visit going through the various screenings and at that time when it was the appropriate time to hand out the RHS 15 we would remind her or a family if it's a family that this is that last part of the visit where we are talking about questions related to sadness, worries, body aches and pains and other symptoms that may be bothersome to you.

Importantly it's the point we want to make here is that you're incorporating it into your overall health screening process and later on you'll have a chance to hear from Annette Holland who was instrumental really in helping us set the context in the clinic setting.

It's key that we want people to understand what they can anticipate and then what the type of questions will look like. Then we move in to another script and both of these scripts will be available to listeners on the RHS - or sorry on the RHTAC website.

As the health worker is going in to introducing the RHS 15 they can normalize the experience that they are having as refugee patients and state some refugees have these symptoms because of a difficult and it's difficult really to be a refugee having lived through the things that you've lived through and because it's stressful to move to a new country.

These questions help us find people who are having a hard time who may need extra support. Importantly I think it's key to emphasize that their answers will not be shared with anyone without their prior permission, that the concept of confidentiality as its already detailed I'm sure in your clinic settings is emphasized.

But importantly that it's not something that would be shared with immigration, with teachers or with their employers without their former permission.

Now that we've looked at how we can incorporate language for introducing the RHS 15 into the clinic setting and that one has gone about completing the screener, we now need to address how offering support can occur.

Again when somebody has been identified with significant symptoms of anxiety or depression the goal would be that you as a health worker can quickly score the right RHS 15 and then proceed into offering referral directly thereafter.

When possible we recommend that this happens on site and that there isn't a fragmented experience for the refugee patient where they are later called or they are seen a couple days later.

We recommend offering support by referring back to the symptoms that they had endorsed previously on RHS 15, for example lots of refugees experience too many worries, bad memories, or too much stress because of everything they have been through and because it is difficult to adjust to a new country.

It appears you have been bothered by crying easily and having too many thoughts during the last one month. Moving into how to normalize their experience, sometimes people need extra support to help them through a difficult time.

That's what can occur here now that you're in the United States. And then again looking at this as an opportunity for ongoing psycho education, in the United States people who are having these symptoms find it helpful to get extra support.

Well who do they go to in the United States, there are counselors, there are therapists, either a certain type of healer that can support you during this time.

It's important to really give a name to the type of person that would then be providing any treatment for a refugee. And then lastly after you've spent some time reeducating and emphasizing what mental health treatment person will look like in the United States you can really ultimately give them the choice.

Is this the type of service or resource they would like at this time? Are you interested in being connected to these services?

Beth Farmer: This is Beth again, so Sasha's talked a little bit about in general who can administer the RHS 15, how to score it, some best practices and how to refer people.

So you're talking about symptoms instead of diagnoses so you're normalizing the issues. Now what we're going to be really doing is talking about what happens at your individual site.

Because this is not a one size fits all model. Every community has different resources, this may be right for some communities, it may be right but not right now for some communities. It may have to be modified or tweaked for other communities.

So a lot of this is really looking at what does your community have and can you use this and if so how do you use it? Some of the things to consider are who are the health providers in your community and what's their capacity to serve refugees?

And more than that, are they interested in serving them? People can get the capacity to serve this community if they're interested. Who is doing the health screening in your community? Who can act as that central referral point so people don't fall through the cracks and also on a much more macro scale how does this fit in to your state's health reform efforts?

Because there's a big move to integrate primary and physical and mental health and could this fit in to that?

So some questions that each site, each community may be asking themselves that are important in deciding whether this is right for them, is how many refugees are resettling annually?

Are there patterns, concentrated or dispersed? If they're concentrated it's often much easier to arrange transportation and referral than if they're dispersed.

Who conducts the health screening and how many agencies conduct it? If it's one site like it is in King County and they screen 100% of the people who are primarily resettled in the county, then it's fairly easy.

If it's ten sites, it may be more difficult, you have to get a lot more buy in. and then what kind of community mental health resources do you have in your community as well as private resources.

And I didn't put that on this slide but some communities have found a very welcoming and willing partnership with pro bono workers.

But since newly arrived refugees do have Medicaid it's likely to be federally qualified community mental health clinics.

You also need to think about the funding piece. Most of the refugees will have Medicaid, most states cover mental health for Medicaid, but the states may decide what the medical criteria is that they cover.

They do cover post traumatic stress disorder and depression in Washington State but your state may be different. They may only cover persistent severe mental illness.

And so that's going to be a pretty big barrier since that's not the primary thing that refugees end up needing help with. Do they cover interpreter services? What kind of interpreter services are available?

Do the mental health agencies view case management as part of moving people on the spectrum to wellness. Many refugees have an overwhelming sense of need, not even sense of need, they have overwhelming needs when they come in to the country.

They also don't often really understand counseling so many times the therapeutic relationship starts on a very functional basis with what can you help the refugee with in the here and now, what can you help the client with in the here and now?

And it may be DSHS, it may be explaining a letter and through that the therapist or counselor builds trust and credibility that allows you to move into a therapeutic relationship.

But if the mental health agency is very clear that they are focused on insight oriented therapy the 50 minute session, a very traditional therapy there's going to be a mismatch there.

And also are there other sources of funding or pro bono resources in your community? When we started this process in King County these were some of the challenges that were expressed here that we really had to look at.

There was concerns about cost and time, Sasha spoke before about not looking at suicide or not looking at domestic violence or substance abuse.

Part of that was because we felt firmly that people would be able to get that when they had a thorough assessment but also it was the time. Most nurses or the people who administer the refugee health screening are incredibly busy like many of us in the non-profit or public health field.

We are over deployed and under resourced and so we really wanted to create something that was short, that would catch people that could be easily integrated.

The other thing that people have talked about as a concern is that they may not have available interpreters. Or they only have interpreters over the phone. I think that is a legitimate concern and people have to look at what is the possibility of being able to then start with an effort to recruit more interpreters from newly arrived communities?

That was something that we had to do here in King County with refugees coming from Burma, we just didn't have enough interpreters in that area and so one of our first steps was to get more people trained and certified.

Another that we've encountered is the belief that physical and mental health should be separated. We found this sometimes at medical facilities where they're very worried that they won't be able to do mental health.

What happens in the person starts bringing up all of these things that they don't know what to do with? And that's why this is really a surface look just to triage people, this isn't an in depth look at mental health.

There's other screening tools that some sights have already mandated that people use and so that can be a barrier to implementation as well.

And then you know our regular barriers in working in the refugee field or mental health field or public health field or federally qualified health clinic field which is lack of coordination, limited funding and an absence of community will to tackle this.

So really the first step for any community is to do a landscape analysis of your community's needs and resources. I would consider inviting community mental health agencies, whoever's doing the refugee health screening, primary care providers, the mutual assistance associations, public health.

Who plays a role in touching refugee's lives, especially during that first year? Get them in a room, assess the will for people. Do they consider it a problem? Do they want to tackle it?

What are the barriers to them doing it So first I wanted to talk a little bit about King County and how we did it here and then we'll go into some other communities. King County Washington accepts about 3000 newly arrived refugees each year.

And most of those - or Washington state I should say and King County gets about two-thirds of those folks. We are a really large urban area with about two million people in the entire county.

And even though our refugees are screened at one location, after they're screened they are dispersed throughout a very wide geographic region.

So that's important because we're looking at they are going to geographically be located in different, close to different community mental health agencies and different primary care agencies.

So there's a lot of coordination that's going to take place on that referral piece. So one of the first questions that we had to ask ourselves here in King County were are mental health services covered for newly arrived refugees?

And I spoke about that briefly before and Washington state the answer is yes, Medicaid does cover mental health treatment.

If the client meets diagnostic criteria and both post traumatic stress disorder and major depression are covered. In King County we also have some additional funding for newly arrived refugees through the state of Washington who need mental health treatment.

So for those folks who are on refugee cash assistance and only have eight months of coverage, we actually had a little bit of padding that we could see that afterwards through another source of funding.

Therefore we found that we really had a good funding stream for direct service delivery after they were screened, including the refugees who might lose coverage at eight months.

And again going back to these questions may be different for every community. The next thing that we really had to look at was who does the initial screening?
Here it was public health, they screened everybody, so our central and universal point of entry would be there. So after a refugee screens significant, for distress we had to think well how do we get them to the agency for support?

And this is really critical because for anybody who's worked with refugees for a long time, you know that handing somebody a referral is pretty close to not handing them a referral at all.

The chance that they just handing somebody referral when they don't speak the language, they don't understand the system, they may have to arrange transportation, they're not entirely sure what they're asking, what they're being referred to.

It's often the same as just kind of throwing it into the wind. So we really had to manage that referral process. And there was no central entry point to mental health agencies here.

Every single community mental health agency did their own telephone screening. So one of the things that we had to do was develop a central referral line so everybody who screens significant from public

health, their referral went to one agency which was Lutheran Community Services.

And we took on the responsibility for helping get those refugees connected. The other thing we really had to figure out was did we actually have the physical capacity within the different community mental health agencies to be able to handle the number of people being referred.

So we had to look at how many people did we anticipate being referred and did we think we could absorb that? So for us during the pilot phase of this project which was seven months, we had estimated about 675 refugees arriving, we were only screening 14 and over, that was about 73% of the population.

So that was 493, here we were only able to screen 251, we anticipated that about 30% would screen significant so that's 77 refugees. Here 70% accepted referral so it was 54 refugees who we had to manage to get into a community mental health agency.

We went into this with many sites only having about a 30 to 35% referral rate and so we did anticipate that the numbers initially would be lower.

But we had a higher referral rate here so I would go with somewhere between 30 and 70% accepting referral.

So we had to look at also if we were going to refer, where were we going to refer? And luckily in King County both Asian Counseling Referral Services, refugee women's alliance and Lutheran community services had mental health agencies who served linguistically and culturally diverse clients.

However with that number, the 54 number that I talked about we weren't sure because at least Lutheran community services and RWA had smaller mental health departments.

We weren't sure that we would be able to handle that number of referrals in that short of period of time. So we met with other community mental health agencies and did a lot of outreach with them to see gosh, were they interested in seeing these clients?

And some were and some won't and for those that were we had to ask them what are your barriers to service? And many of them were afraid they wouldn't know how to work with refugees.

So then we talked to them about well what can we do to train you so you can build additional capacity?

So this is how it currently works right now in King County. A refugee family is - an interpreter is scheduled for their health screening. They go to public health, they sign a universal consent form which is something that we developed here in public health was able to get passed which allowed the information on whether they screened significant as well as any other next steps to go to their case workers.

So everybody's in a big loop and everybody's informed of what needs to happen next. The site visit there is explained, they get the blood draws, their medical reviews, then the RHS 15 is administered.

It's filed in their records and if they screen significant they go through that script, the referral script that Sasha talked about before. The nurse will also mark it on the what to do next form.

Which is given to both the refugee and the resettlement worker so they know that there are certain steps that need to be taken after their visit.

The - if the client accept referral then they go ahead and fax the referral form and a copy of the RHS 15 to the central referral source which they're allowed to do because the universal consent form was signed.

Then we make sure here at Lutheran that we get them placed in an agency and an intake is established. And Annette, I'm going to pull Annette Holland on the line because she is the person here at Public Health that really was critical to making sure that it was implemented as well as she knows about all of the barriers that were expressed initially before we started this process.

Annette are you on the line?

Annette Holland: Yes I am. Can you hear me?

Beth Farmer: I can.

Annette Holland: Oh good. Hi everyone. So thanks for going through the flow chart, that is our process here at King County and initially when we started this process and it was a long process, we had to do a lot of work getting everybody on board including the refugee screening health team.

So all that screening is conducted solely by a nurse, not by a physician and so initially the nurse had some reservations about their capacity to be able to handle this piece of the screening.

And as Sasha pointed out early on, what the nurse found, and this is really through working with Sasha was that most of the refugees that

were participating in the study found that they were more relieved than anything to be asked questions about how they were doing.

We didn't see any cases of serious decomposition, and so that was - going through that pilot enabled the nurse to see that this was an important part of the screening and should be integrated into our screening and was not as risky as they had initially thought.

We do have a backup system in case there is any decompensation but that hasn't happened, it hasn't been necessary and although we had some reluctance in terms of taking on this part and there was some concern about how long it might take, particularly if the refugees were not literate.

We haven't found that - the administration of this tool takes more than about 10 minutes honestly. The - most of the refugees are either able to administer the tools by themselves or with the help of the interpreter.

And what has been very important for us is to make sure that the interpreters understand this project, understand why we are administering the RHS 15 and to get their buy in from the beginning.

So we did provide training for the interpreters that are involved in interpreting for refugee health screening. They're all former refugees themselves and they represent the communities, the new arrivals, the Burmese, the Bhutanese and the Iraqis.

So having them on board so that they fully understood the history and the process was very important for us. And they do play an integral part in ensuring that the tool is completed properly and successfully.

So I would say that the RHS 15 is now an integral part of our screening, there is no question about it being integrated. At the beginning when we do the review of what's going to happen during the screening visit, it's explained that this will be the last piece of the puzzle and that this is a self administered tool.

And we don't separate it from the physical screening, so it's a natural part of the flow now in our health screening. So that has been - that took a little while for us to get there, as people fine tune their scripts.

The nurse fine tunes the way they explain the process but I think we're there now. The universal consent form has been very helpful in terms of being able to loop the case worker into the information that is shared during the visit.

And any referrals that are made, so by having the case worker looped in they are then part of the referral process and that increases the chance that the refugee client will actually get where they need to get.

So they will get into the Pathways project and will be linked into the care they need because the case worker is on board also. So I think that is a really important tool or forum to build into this process.

Beth Farmer: So this is Beth again and I'm going to turn it over to Sasha in a minute to profile Kentucky but I wanted to say when we first started this there was a lot of hesitation.

And I think normally so, I mean people are busy and they have a lot to do in a short amount of time but when we pause the project to do the evaluation, I was really thrilled that the nurses were really concerned that we were going to stop screening for two months and they said what are we going to do?

How are we going to know that people are upset? How are we going to get them to care? So that was really heartening. Somebody else asked where does the resettlement agency fit into this picture? And so I quickly wanted to say with the universal consent form and the next steps, typically they have been able to help us arrange the transportation for the first visit, not always.

But after that it's really up to the client on whether they want their resettlement agency included in other pieces of this. Because the regular client confidentiality will really apply at that point.

Knowing that they have an appointment or they need to go to appointment is one thing, being able to share information about the case or to coordinate care is really going to still fall under client confidentiality.

So now I'm going to turn it over to Sasha who's going to talk about what it looks like in Kentucky where it's been implemented as well and then we'll quickly talk about a community that's considering implementing it and what questions they're asking themselves. Sasha?

Sasha Verbillis-Kolp: Well thank you very much. In profiling Kentucky, I wanted to first share with you all that it's a state that on average resettles about 2000 refugees per year across the entire state.

You see the map here, you'll see how many counties the county has - or sorry the state has, Kentucky has over 120 counties which I think makes it a very interesting state for how we look at how healthcare services are delivered.

Refugees are dispersed throughout Louisville, Lexington, Bolling Green and Owensboro cities and to give you an idea of how big one of the cities is in Kentucky, Louisville is a city of about 750,000.

In a moment here I will invite the state refugee health coordinator to join me in talking about Kentucky. First of all I want to mention that the RHS 15 is currently being utilized in Louisville Kentucky through the work of resettlement agencies, it's not yet integrated into the health screening clinics but they are hoping to later roll that out across the entire state.

It is being used but it is being used in a different way that in King County. Following a similar formula or methodology that Beth had detailed in looking at some initial questions about King County we can look at Kentucky and see that in Louisville for example we know that there are two individual providers and one bigger mainstream mental health agency that has a history of working with refugees.

And that's kind of key to that specific city. But on a state wide level we can look at this and see while they anticipate up to 2000 refugee arrivals in one year, approximately 70% of these will be 14 and over and so we get a total number there of 1400.

Of that in a targeted languages of Arabic, Nepali, Burmese and Korean, we can anticipate about 980 folks that would likely be screened age 14 and over and of those languages.

Within that there may be up to 30% that screen significant so that's almost 300 folks and of that somewhere in that range that Beth had indicated about 30 to 70% will be likely to accept referral for more support, so that's anywhere from 80 to 200 annually.

I'm going to put up here the trail of Kentucky and all of the unique factors that we're talking about here today that are at play for these site specific considerations.

On the left of your screen you'll see the interplay of how funding the type of screening site one has, ultimately what that referral mechanism will look like and then what long term healthcare will look like for a community.

As you view here the funding structure in Kentucky we'll see that they have Medicaid as well as the state has purchased an additional insurance, private insurance for refugees. There's a third tier to their funding structure which some states have and in this case it is an ORR based targeted assistance grant.

In general we can see that Kentucky is well poised with a good amount of coverage to service refugees with mental health. The screening sites in the state vary, there are a series of federally qualified health centers and a couple of private providers.

For example in Louisville there are three different clinics that are conducting screening, that's key in terms of what we think about in terms of how they will move about adopting or integrating their RHS 15 specifically in Louisville.

And of those health clinics in Louisville there are both over the phone and in person interpretation. Going back to Louisville the resources that they have currently in terms of how the RHS 15 has been incorporated into the resettlement agencies is that they've hired a mental health coordinator who is administering the RHS 15 and then coordinating the referral to two different primary providers in the community.

Then ultimately in terms of their long term care, where will refugees go and continue to access their healthcare needs will depend on this infrastructure of the Medicaid or the private insurance.

Ultimately the hope is that the federally qualified health clinics or the private providers will continue to provide care. I'd ask (Luta) to offer some additional insight here on how this work is occurring in Kentucky paying in mind specifically the things that they are considering in looking at rolling out the RHS 15 across the entire state.

Luta: Hi this is Luta can you hear me?

Sasha Verbillis-Kolp: Yes.

Luta: Okay. Thank you for including us in this presentation. I think the key thing for Kentucky is we have spent several years trying to figure out what the mental health resources are available to refugees.

We've been working with originally we were solely working with one provider who provided mental health services for both Medicaid and RMA clients.

And as she did that, started training our main mental health Medicaid mental health provider on working cross culturally with refugees so that we could start streamlining refugees into mainstream services.

We have recently hired a mental health coordinator for Louisville, Louisville is our largest site and so where we are providing the first roll out of the RHS 15 and trying to learn through this process in our main city, and what she does is accepts referrals from the clinics and from the resettlement agencies.

And then uses the RHS 15 to determine if there is a need and coordinates those referrals to the appropriate health insurance provider. And we have seen a doubling of referrals since she has joined the team and part of that is she is on site at the resettlement agencies and so works with ESL classes and kind of is out and available and visible and we actually have started having self referrals.

And she's able to work with refugees for up to five years from their date of arrival. So we've been kind of watching her use the RHS 15 and we're looking at incorporating it into our health screenings, next fiscal year.

And one of the things that we are looking at now is where that would take place within our screening process, we have a two visit process and then who at each clinic would be working with those providing those RHS 15.

And again providing support to the interpreters and what that would look like in terms of usage.

Beth Farmer: Thank you so much Luta, I appreciate that. This is Beth again, I'm going to quickly look at Spokane Washington which has not implemented the RHS 15 yet and what questions they're going through.

And I'm going to move through it rather quickly so we can have time for people's questions. In Spokane which is a county in Spokane County is a county in eastern Washington, there's about 600 refugees that are approved for resettlement there every year.

The county itself has about a half a million people and refugees are dispersed throughout the county. As we look at moving towards implementation or looking at mental health for refugees in that county, we are really looking at some of the same questions that we spoke about earlier on in the webinar.

We need to find the number of refugees, given the number of people coming into Spokane, we look - we think it will be somewhere between 22 to 52 clients annually that might be entering services.

But we know that there are limited community mental health providers who have refugee mental health expertise and that's a pretty significant barrier.

This site profile, the funding, screening site, referral source and ongoing health care is that again in Washington state Medicaid is covered, PTSD and major depression are covered.

But in Spokane county there's not additional funding to cover people after that initial eight months. So unless they're on disability or on TANF, temporary aid for needy families that is going to be a critical consideration which is what's going to happen when their funding gets cut off at eight months.

The screening site is the local health department and they use brokered phone interpreters and that's something that we've been talking to public health about there that they've expressed as a concern which is will this work with phone interpretation?

The other thing is we don't have an agency yet that's willing to coordinate referrals and we don't have agencies that have a large amount of experience working with refugees.

So we're really looking at thinking about what's the next logical step? So you could screen and make sure the information is shared with their primary care provider because that allows the primary care provider to consider their mental health which is an important part of providing comprehensive care.

So that might be a first step. There is a wonderful sexual assault center in eastern Washington, could we build capacity there? Could we build capacity with the community mental health providers there?

‘ Are they interested? How many people are they willing to take? Have they ever worked with interpreters before, those are some questions that we need to be asking.

And their ongoing healthcare is that they're referred to numerous primary care providers based on where they actually get their apartment or are placed for housing.

This really differs in every locale, this kind of site profile will really differ and some places they have kind of a tower like setting where the same place that does the health screening is their primary care provider and they also have integrated behavioral health.

And then you kind of have the best possible scenario. In some places it's much more fractured and you're really going to have to kind of do that landscape analysis and coordination.

So we really - so the next question - or sorry, so that's kind of really the end of our presentation and time for questions. We'll be having some discussion questions afterwards.

Our Pathways to Wellness partners are listed here both from Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health and Dr. Hollifield who originally came up with the tool.

And I think all of us are incredibly invested in making sure that if refugees need care that they have a path to that care. And so we're happy to provide any sort of technical assistance to sites throughout the country to explore and make this possible.

Jennifer Cochran: Great, this is Jennifer again and I'm actually going to put it back to this one, I want to thank Beth and Sasha for really a very rich presentation here and I want to thank Annette and (Luta) for weighing in from your perspective around administering.

We do have a couple of questions that have come in and so I'm wondering if I pose them if you might share some thoughts. And one really follows this last piece that you were talking about Beth and that was where you talk about engaging community mental health agencies to find out about their capacity to receive referrals.

And you noted some agencies may not feel prepared to work with clients and that you discuss with them ways to provide necessary training and so the question was asked if you could expand on that some and the person typed in quite a full question here.

It says perhaps you could also address the related consideration that providers who have experience with culturally diverse clients don't necessarily have experience in working with refugees specifically.

And addressing the types of trauma and stress to which they have been exposed. She's interested or the person asking is interested in

knowing what resources are available to help mental health professionals, really gain necessary in depth competencies in working with refugees.

And in this area where the questioner is is a major resettlement area, she only knows of one short elective course that was offered a couple of years ago as part of a university mental health counseling program.

And that was only available to students who were enrolled so I'm just going to recap that a little bit, so if you could speak a little bit more about kind of building readiness or preparing mental health agencies to serve refugees or accept refugee referrals.

The second question about what if you have providers who do have experience serving culturally diverse clients but not with refugees specifically and then third any resources that you might be able to point us towards.

Beth Farmer: This is Beth and so I'll speak from my other hat as managing a community mental health agency that serves refugees.

I do think that this is a very overlooked field. If you look at the foreign born population in the United States it's really increasing and the way right now our mental health system is pretty much set up from a pretty western dominated paradigm and I think that's why you get such low utilization in other communities.

So I think overall just expanding from refugees to immigrants, it's a very overlooked field and I'm hoping that it will be included as more and more people get trained.

We developed our own training here and we're happy to share some of those resources with other people, you know we can look at even helping people with the webinar.

It's really a process I think in that providers need to understand who refugees are and the context that they come in, because the context that they come in, the resettlement process, what they're expected to do that very quick adaptation, the need to attain self sufficiency, the economic pressures, the cultural shock.

That's critical to really being able to serve them appropriately. Then beyond that I think they have to have some cultural awareness of the really western domination in our current mental health and the way we provide mental health services for agencies who are already providing services to people who are foreign borne, immigrants primarily.

I think they're going to have a leg up on this, they're already going to understand that the way people talk and view mental health is going to be different.

So understanding people's belief system around that and then some real practical solutions, what should you be asking on an intake? How do you talk about certain things differently, talking in symptoms instead of diagnosis?

How do you create a treatment plan that really promotes overall wellness of the context that they're in and have the other person really be on the same page.

So there's a lot of layers to it. For this piece we really worked with Asian Counseling Referral Service which is a wonderful - they've got a wonderful training history where they've done a lot of capacity building

all over the country, especially around serving the Asian Pacific islander community.

And so together we work to build trainings to work with people and then in some places like many things they do it imperfectly.

I know that some communities have pro bono people who are willing to take this on and they do their own research and they develop through time I think one of the things is there is no one perfect solution.

This whole process of starting to implement mental health for refugees is really a journey that each community is kind of on. And you often don't start out with the perfect case scenario.

It's kind of you build it over time.

Sasha Verbillis-Kolp: And with that Beth I wanted to add that there are other communities across the states that depending upon their capacity may have longer visits where a screening tool may not be what is chosen for the type of identifying refugees with distressing symptoms.

Perhaps they have an hour to two hour availability, I'm thinking of some colleagues that I've had the chance of working with in Colorado so every community will have a different resource capacity in their health screening site which can be that arena to identify refugees early and then connect them to care.

As Beth was speaking to the community outreach and provider outreach strategies that we took really were part of our service delivery model if you recall earlier on in that slide by integrating a way to intervene early by screening and referring and then getting people to treatment.

We've wrapped around that a wrap around model of having ongoing education to providers and then ongoing psycho education within refugee communities. And that work is critical and I know a lot of communities, a lot of people that are listening in here today have rich resources to that regard.

And that perhaps might be another opportunity for a webinar to share some best practices.

Beth Farmer: Yeah and actually I want to piggy back on that Sasha because we did not write the book on how to deliver mental health services to refugees.

If you look at the Harvard trauma center, if you look at the center for victims of torture, if you look at health and human rights in Utah, if you look at the Florida survivors of torture and I hope I said that name right, many states, even if it's not in your particular city, many states already have people who have a high capacity to work with refugees and (assiliees).

And they understand your state and they understand your public health system and they're a closer resource than we are. And they're a wonderful natural resource so I would also turn to those folks because they have tremendous knowledge to give that is on not only on treatment but also on your state's funding, on your state's capacity to serve these folks.

Jennifer Cochran: Great, thank you for such a rich answer. It's Jennifer and another question that came in is - maybe a little more straight forward is if you would be willing to describe the hour long training in a little bit more detail?

I know you talked too about kind of building that capacity and building an investment so if you would talk about that hour long training and who administers the training to health professionals and interpreters and I'm going to have - add in here the add on which may be if you wanted to say a little bit more about the ongoing education components that you just touched on for providers.

Beth Farmer: Sasha developed a PowerPoint for training nurses and the public health setting and we have shared that with sites and we're happy to look at posting that on the RHTAC site.

I think the concern is that a PowerPoint really isn't enough to train so you could use that PowerPoint as a base for maybe a webinar. And Sasha did you want to say anything about that?

Sasha Verbillis-Kolp: Yeah, it's two questions, one is training health professionals and then it's a second training specifically for working with interpreters with this type of mental health screening questionnaire.

And they are slightly different presentations that I've prepared and I'm more than willing to work and collaborate and offering to different communities if that's an interest.

The reason that they're different is that they are different roles I think that interpreters play in doing this work and it's important to talk about that.

And as I had spoke to earlier the fact that there is stigma present within refugee communities is I think it's really key to offer some one on one training with your bicultural workers if possible so that there's a

familiarity on why the tool was developed, what its rationale is and then how it can be delivered in your health site.

The last question Jennifer as I heard correctly was on provider education, is that right?

Jennifer Cochran: Yeah, just you had mentioned that you also continue ongoing education for at both the provider level and the community level.

Sasha Verbillis-Kolp: Sure, Beth did you want to speak to that?

Beth Farmer: Yeah, I mean right now our - we work with Asian Counseling Referral Service, we take speaker presentations. When we initially started this we also had quarterly presentations for community mental health providers.

And we've also been contracted by some of the larger community mental health agencies to provide training to their staff.

So it's both proactive and responsive training depending on what people would like and then also being proactive in reaching out and offering training to places where we know we need to build capacity.

Jennifer Cochran: Great, I'm going to pause for a moment and put up a series of - three discussion questions that you posed to the community at large that's on the webinar and the larger refugee resettlement communities.

Really for people to start thinking about so I'm going to read them off and then ask Sasha and Beth if you want to say a little bit more and then I'll introduce how you might continue this conversation online.

And the questions that you posed to us are what are the biggest barriers to offering mental health services to refugees in your community?

And I think you really have had us think quite a bit about who we are and where we're located. What would it take to overcome those barriers and what strengths currently exist in your community that you can leverage?

Beth Farmer: Yeah, I would just want to reemphasize that this really is a journey that most communities are on. And you start somewhere, you often don't start with the finished product where you can just add water and everything goes into place.

Some communities are blessed with that but most communities aren't. So figuring out with your community where can you start, even in a small way, even if you're not ready to implement screening.

Where can you start addressing this very critical need that not only on a personal level helps people build lives in the United States but on - really on a community level helps the adjustment process and people to become better integrated into their community and more successful here in the United States.

Jennifer Cochran: Great, thank you. So how...

Sasha Verbillis-Kolp: I wanted - if I still have a minute here there was somebody, I'm not sure how to use this chat box very well but somebody had asked about the timing, the when question of when to administer RHS 15 and I just wanted to speak real quickly to that.

That in King County and along with our research because our project was also - had a research driven approach to it, that we administered during the first 30 days when refugee new arrivals came in.

But we also retested a year to 16 months later post arrival so there was a question specifically about the fact that there might be delayed distress or hardships and difficulties that refugees may experience later on post arrival or during the resettlement.

So for that reason we had incorporated in King County two times at which we can administer the RHS 15 screener.

Jennifer Cochran: Great, thanks Sasha for picking that up. So I'm going to turn you now to think about how - engage in a discussion that involves your peers and people from across the country here.

And so we wanted to let you know that on the refugee health TA website there is a tab at the top called community dialogue and we have - we'll have ready to post today, I think it's already live health screening discussion thread.

And so we'll invite you to join in here, hear what you're doing, ask questions of people from across the country, we don't - although Sasha and Beth gave us a tremendous amount of information and a way to think about what we might - how we might approach these - the issue of mental health screening, mental health services in our own communities.

We have as much to learn from each other so we encourage you to go to the web, put your comments there and see who may help you think this through.

I'm also going to - I'm going to begin to wind down here and to remind you that for next steps we have collected questions. I think we got to most of them but if we didn't because they do kind of come in through the box over here, if we missed any questions we will respond to those and post them online.

And we'll put the resources and the PowerPoint up there for you to continue to review. And keep in mind that there is an evaluation as you level the webinar too. For many of you you're probably aware that the North American refugee healthcare conference is coming up at the end of June, it will be June 28 to 30 in Rochester New York.

If you haven't already heard about it go online and take a look, it looks to be just a fabulous conference that's coming up.

And then finally I want to leave you with our website and the email, feel free to email us at any time with questions or suggestions for future webinars as well as looking for information.

So thank you very much and let me again thank Sasha, Beth, (Luta) and Annette for giving us just a tremendous presentation today. Thank you.

Beth Farmer: Thank you.

END