

**Tools and Strategies for Refugee Mental Health Screening, Introducing the RHS-15  
January 25th RHTAC webinar**

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the webinar on tools and strategies for refugee mental health screening. 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 the star followed by the zero. As a reminder, this conference is being recorded. Wednesday, January 25, 2012. It is now my pleasure to turn the conference over to Mr. Paul Geltman. Please go ahead, sir.

Paul Geltman: Hi. Good afternoon everybody. This is Dr. Paul Geltman. I'm the medical director of the Refugee and Immigrant Health Program and the Refugee Health Technical Assistance Center at the Massachusetts Department of Public Health. I want to welcome you to our presentation today and to our series of webinars on refugee health. I have a few introductory remarks to make and then I'll introduce our speaker for today, Dr. Michael Hollifield. So I just want to ask you to bear with us—this is our first time using a new webinar format. And I'm hoping it's going to go smoothly for us.

The first slide that you should be seeing now should say Webinar Overview. We're going to hear our presentation by Dr. Hollifield, which we anticipate, will be roughly fifty to sixty minutes and hopefully that will leave us at least twenty minutes for question and answer at the end. The slides, a webinar recording, a transcription of questions and answers as well as some additional resources will be posted at least within a day or two after our—after the webinar on our Refugee Health Technical Assistance Center website—<http://refugeehealthta.org>. It sometimes takes us a little while to get the question and answer response up, but the other resources as well as the webinar recording and slides will be up very quickly.

If you do have any questions, you can also e-mail us at [refugeehealthta@jsi.com](mailto:refugeehealthta@jsi.com). In addition we'll be having a quick survey which will appear immediately after the webinar conclusion. Lastly I just want to note that we hope to continue the conversation with a new feature that we've just started this month on our website called community dialogs. At the end of the webinar presentation, before we go to the question and answer session, I will show you some screen shots, so you'll know what to look for where we hope to get people's input around best practices, questions, tips and anything that people want to contribute to the discussion about mental health screening. Currently we have one community dialog that started. People have already looked at that, and this one will follow after the webinar.

So I'm going to go onto the next slide. We are excited that for the first time we're able to offer continuing education credits. For those of you who are eligible and need and want them, I hope you already registered, because it had to be done through a separate registration system which is now closed. For those who did register for educational credits with Bay State Community Continuing Education, please expect another evolution specific to that process to come from them via e-mail on January 26.

Okay. So today our objectives are to describe the tools available for screening and assessing mental health in refugees, to explain how to use the new refugee health screener fifteen item questionnaires in the care of your patients. Identify the primary and secondary obstacles to

screening for mental health in refugees. Describe strategies to overcome obstacles to the provision of optimal care for these patients.

Lastly, I just want to give you a little idea of who's among you out there listening in. We have a variety of health and mental health care providers. We have refugee health coordinators from public health departments as well as staff. We have refugee resettlement coordinators and staff. Literally dozens of organizations in Canada, Switzerland, Thailand and forty states around the country, we had well over 600 registrants for this webinar. With that introduction, I'm going to quickly introduce our speaker. Dr. Hollifield—Michael Hollifield received his medical degree from the University of Washington in Seattle and then completed a dual residency, training in family medicine and psychiatry at the university of New Mexico. He's an accomplished researcher in anxiety disorders and trauma. And has been working for a number of years now to develop screening questionnaires for mental health, specifically for refugees. Currently Dr. Hollifield works with the program for traumatic stress at the veteran's administration Long beach Healthcare System. He's also with PIRE—the Pathways to Wellness project out of Albuquerque and Seattle.

As I mentioned this is our first time using this new system and we've had slight technical glitch with Dr. Hollifield's connection, so this is his cue to see if he can advance the slides and then he's going to pick up the presentation.

And if he can't he's going to tell me.

Michael Hollifield: Thank you, Dr. Geltman, and I want to thank the Refugee Health Technical Assistance Center for inviting me today. It looks to me like advancing the slides for me isn't really working well—

MH: I appreciate the work of Allison, Judith, Dr. Geltman, and to invite me as mentioned and also Pathways to Wellness team, Beth Farmer, [Junko Hermusaki] and Annette Holland at the Seattle King County Public Health and Tsegaba Woldheimenot and Sasha Verbillis-Kolp. This project has been one that is grown out of other projects we've done trying to move towards better screening and better care for refugees. Some of the material I used today is also been created by this Pathways to Wellness team and Pat Gorsky at Harvard U. Medical Center at the University of Washington.

Next slide, please.

PG: Before I forget I do want to just thank the US office for Refugee Resettlement who funds the Technical Assistance Center and we always like to acknowledge that and make users that people are aware that this presentation is brought to them by ORR. So moving ahead to your screening for emotional distress in refugees goals slide,

MH: Great. So we—Dr. Geltman described the goals from today. We'd like to talk about identifying the need for screening. I describe the development of the refugee health screener fifteen and then to communicate the importance of the process also during screening, referral and treatment. And not just the screening tool itself or any screening tool for that matter.

Next slide, please.

MH: The New Mexico Refugee project is where we began some of our early work for screening for refugees and an NIH grant was provided to us, 1998 to 2002. And I'm going to be presenting

from my slides only on my screen, Paul, and I ask you to continue the slides for the participants. The goal of the New Mexico Refugee project was to improve the assessment of trauma and health. We developed instruments including the comprehensive trauma inventory 104; the New Mexico refugee symptom checklist 101 and the goals of these were really to describe the full range of trauma and health outcomes including symptoms and refugees towards beginning a screener for use in public health. Next slide.

The Pathways to Wellness project has really helped to forward this mission. Project partners of the Pathways to Wellness are listed: Lutheran Community Services Northwest; Asian Counseling and Referral Services; Public Health Seattle in King County; myself. All under the direction of Beth Farmer as the project director. Next slide, please.

PG: The next slide, Michael is the first poll.

MH: Great.

PG: So I'm going to read this to people. So and we're going to have a few of these poll questions sprinkled in for you during the presentation. This is our first poll question. The question is: *Somatic presentation of emotional distress occurs in what percentage of people?* So for people who aren't healthcare practitioners, somatic presentation means physical symptoms like headaches, stomach aches, things like that. You have three choices. A is *greater than 50% from developing nations*, B is *less than 50% from more developed nations*. C is *greater than 50% of people who grew up either in developing or more developed nations*. I hope you guys can see the difference. I'm going to count to ten and then we're going to skip to the results so click quickly. 10. 9. 8. 7. 6. 5. 4. 3. 2. 1. Okay. Poll is being closed. So the results that we have for choice A which was greater than 50% of people who were from developing nations. 27.8% chose that. For choice B which is less than 50% of people from developed nations. 8.3% chose that and for choice— So the final tally for A was 28.4. For B it was 9.5% and for C which was over 50% of people who grow up in either developing or more developed nations is 66.2% So I'm going to go to the next slide, Michael and you can respond to that.

MH: Yeah. For the whole participant group. That is actually the best answer is C. Sometimes it is discussed that people in developing nations have a higher rate of somatic presentation of emotional distress, but it really isn't true. The ticket into care is often somatic stress when people are going into physicians. But whether you look at this in Seattle Washington, New York City, Latutu Africa, Kenya, or our refugee populations. Somatic presentation is the most common presentation of emotional distress.

I'd like to start with this case as illustrative of our refugee population and screening. So Khem is an eighteen year old Napoli Bhutanese who comes to King County for our help who comes with his family for health screening. He seems nervous but bad to be in the US. He mentions some intermittent neck and chest pain. This was already assessed in the refugee camp and not thought to be a problem. His other has no record of illness, although currently some nausea, mild intermittent pain in her chest but denies any pain with activity or any other GI complaints. His father is quiet, and had cholera a long time ago. His nine year old sister is quiet and without complaints.

Next slide, please.

So as we would do, in resettlement, the family undergoes health screening, initial immunizations and initial laboratories. Then the family is provided a list of medical clinics in South King County and encouraged to establish care and follow-up on the rest—immunization and labs as soon as possible, care clinic near their home. Next slide, please.

So as you all know who are in resettlement of refugees, often what happens is people come into the agency, attain their cultural orientation and basic services, etc, and are often either sent to a screening clinic or to primary care clinic but usually things are not identified in terms of health needs at that point be they “physical or mental”. Next slide, please.

So Khem was given a primary care clinic appointment to establish and four months later he and his mother go to the primary care clinic that was identified to him to establish care. Next slide, please.

The goals at this first clinic visit are very complicated. It is the goal of the primary care physician to build rapport, address current concerns as a patient, have an orientation, discuss the initial two to three visits, conduct evaluation and diagnostic services and then decide what service are necessary for the patient and the patient’s family.

MH: Absolutely. so that’s the issue is it’s a very busy clinic to do everything that needs to be done and generally in the primary care setting the issues that are for most are about the orientation, the rapport. Again, getting clinical services started. So it becomes a very difficult place to screen for mental health or any other issues besides what is already conducted in the first clinical visit.

Next slide, please.

PG: Okay. So this is our next poll question. And the question is *the prevalence of PTSD, that’s Post Traumatic Stress Disorder and depression in refugees is between five and twelve percent. This is just a true/false question.* So again, click very quickly. This isn’t scientific. Nobody needs to really stress about getting the right or wrong answer. I’m going to count down from ten again and then close the poll. 10. 9. 8. 7. 6. 5. 4. 3. 2. 1. Closing the poll now. Okay. So— 27.4% said true 72.6% said false.

MH: I don’t know what people mean when they say these are trick questions, but this kind of thing may be kind of a trick question. For those of you who work in this field, you all know that a high percentage have symptomatology. A high percentage have emotional distress. But as I’ll show in a few slides, the actual diagnosis and prevalence of PTSD and depression is probably between five and 10 percent. So Khem’s acute visit, five months later Khem and his mom come to the clinic for an acute care visit. Now this is nine or ten months into resettlement after some services for new refugees have already expired. Through an interpreter, Khem reports he has been sick and not able to attend school for weeks. Again, noting chest and neck pain and problems with digestion. Mother is also having problems with back pain, abdominal discomfort and fatigue.

Next slide please. Only after a long dialog, using the community interpreter and so you all that have that work in these settings, you know how long this takes and how much resources and time it takes, does it become clear that his mother had witnessed the killing of her father before coming to the refugee camp and she is exhibiting symptoms of PTSD. Khem had symptoms of depression in the camp and is now having problems adjusting to his new school and home. So the question is could both Khem and his mother’s risk for mental health problems

have been identified and managed earlier? What are the benefits and obstacles to integrating mental health assessment into refugee screening at resettlement. Next slide, please.

PG: Michael, just before you go to the next slide, we're still getting people now and then putting in a query about not being able to hear you very well. But I actually just want to say that I don't think it's you because I can hear you quite well. So I just want to ask everybody who's out there listening on their computer speakers to make sure that both the speaker volume is turned up as well as the volume settings on your computers control that control the output to the speakers on your computer. Sorry. Go ahead, Michael.

MH: So the Pathways to Wellness vision was a very clear vision and I was extremely pleased to be asked to work with pathways to wellness. The questions are if we conduct early mental health screening while refugees still have resources, could we prevent refugees being in crisis? Could we lower emotional distress and could we improve adjustment? In order to do that, it's important to do the following two arrow bullets. One is to build capacity for refugee mental health, that is increased access and do so by decreasing stigma and the other is to design evidence based and validated tools that actually provide effective approaches to reduce the burden of mental illness and to offer tools to other resettlement areas for replication.

Next slide please. The challenges to early screening and intervention are many and again, for those of you who work directly in this field, you know what they are. There are cultural, logistic and effectiveness issues about screening. As we've been talking about western construct of mind body separation sometimes don't seem to apply to refugees, but it's why I put that question in about the somatic presentation. I think, often, it doesn't apply to many health care systems here in the United States. We expect people to come in saying exactly what's wrong when they often use a somatic presentation and we can't get to the mental health issue.

The cost, the time, the follow-up is very challenging in refugees, particularly getting interpreter services and having people who do this work, who like to do this work and have the ability to work trans-culturally. Then there is the issue of the perceived versus the actual potential burden. It really depends on who you are. If you're a healthcare administrator who is holding the purse strings, I think the actual and potential burden of these illnesses are lower than if you're the person in the trenches actually hearing the patient's story.

Another challenge is to really build up community mental health capacity. And I think it's a major, major problem with current funding and issues about that capacity. I once was told be careful to turn over any given rock you might be worried what you find under there. I think it's one of the major biases and problems and obstacles to providing screening for mental health for refugees because there really isn't the capacity to serve what we find. As you know, there's individual and community stigma and how to speak about mental health in refugees, which, by the way, I don't think is necessarily always a lot different than speaking about mental health to farmers who live in Iowa. The other obstacles are how will refugees seek help in their new land. They're very busy, also trying to get their lives going and trying to decide what are important issues to seek and what aren't. Lastly, what we found from our early work is to really get appropriate and efficient instruments in the same issue. I'm going to spend most of the rest of the talk about efficient instruments and what we've done to develop the RHS-15.

Next slide, please. Whenever you construct an instrument, you really need to understand what the purpose is. Everyone knows there are lots of instruments out there that have been

developed. I've developed some myself that are simply totally inappropriate as screening instruments.

Next slide, please. The purpose for a screening instrument during early resettlement really is needed because emotional distress in refugees is highly prevalent. The other reason it's needed is that integrating mental health into public health and primary care is important since the initial visits for refugees are in these settings. We think by integrating this early, it would help alter the current process and enhance both secondary prevention and early tertiary care. Those of you who work with refugees know that's very important to get going in the first months while people still have resources and before they often lose their resources. Next slide. So here are the data that are confusing about and why the question was kind of a trick question about the prevalence of anxiety and depression. Early clinical samples show that PTSD and depression symptoms were between fifty and ninety percent. Although one study early on showed a much lower in the Vietnamese. There is always the issue about whether different populations have different prevalence's and how they manifest those and those are very important issues some of which we won't touch on today. In non-representative community samples the prevalence's have been all over the board, from four to fifty percent for PTSD and five to thirty one percent for major depression. You see the same thing in representative community samples. Now the one in Cambodians using a structured interview showed a twelve percent incidence of PTSD. That was closest to I think the best study so far by Menofasal and group in England. A Meta analysis showing that PTSD is about a ten percent rate and depression is five to seven percent in community refugee samples. They also showed which is really interesting, that those rates are affected by methodology. So if you have a non-random sample, those rates are higher if assessments are done through interpreters, those rates are different. If you have a small sample size and if you have clinical assessment those rates are different. So I really rely on that meta analysis data of Menofasal to say that actual diagnosed PTSD and depression ranges between five and ten percent. But the symptoms are a different thing in probably forty to sixty percent of people have symptoms. The question is who should we intervene with and when. Many studies in the trauma field have shown that if we intervene too early, it may actually be a bad thing to do. Critical incident debriefing and PTSD early thought to be a good thing, has shown to be harmful. So that's a really central question to our folks during resettlement. Who and when and I think it really is kind of a linchpin to the question of screening and further assessment.

Next slide, please. So the current options are, I think for screening, there are many tools on the market, but for actual screening there's a Vietnamese depression scale by Kinsey et al which is a fifteen item scale and is a very good, well validated scale for depression. There's the Harvard Trauma Questionnaire by Richard Malika et al that has four sections, some of which are thirty items, symptom sections for PTSD and depression. Hopkins symptoms checklist twenty five. We think that's a very good questionnaire for refugees and we've used that in our research and validated it in refugees to some degree. Twenty five items. PSSSR by Edna Thoa which screens for PTSD and is actually a proxy diagnosis for PTSD is seven items. We developed the New Mexico Refugee Symptom checklist, but it's way too long. It's a comprehensive checklist of refugee's health and it really does pull out all important symptoms that refugees are having. But these options in my view are either too long, too specific or have not been tested across ethnic populations. Other instruments such as the PHQ 9 have not been developed or tested in refugees. PHQ9 is a very good questionnaire for depression in American populations and may well work in refugee populations, but has not been tested.

Some of our anecdotal experience in the pathways to wellness project is that the PHQ9 is not being favored in some settings.

Next slide, please. The next issue when you construct an instrument is about the definition of the instrument. You want to define it as exactly as possible what you want to assess. In a screening instrument should be just that. It is not a diagnostic instrument. It's just like a TB test. You put a TB test into someone's skin. It reads whether or not they are likely to have TB, but it is not diagnostic. It is faster. It is cheaper. It is less intrusive than chest x-rays and other tests. That's why we do them. The same is true with cardiac disease, getting EKG's. They are not diagnostic. They're screening. We think that the same should be true in refugee mental health. We should have screening instruments that get as close to diagnosis but further follow-up will be necessarily.

Next slide, please. So the RHS15 is a screener for distressing symptoms of anxiety and depression including PTSD in refugees. It is predictive of these disorders. And I will show you data about that later. It is not a diagnostic evaluation. But it is highly sensitive and specific for anxiety, depression and PTSD. We think it is a mechanism to route people who need care into treatment and we know it is now integrated into standard refugee health screening that the public health, Seattle and King County and is becoming integrated in at least three other venues. The next issue about constructing an instrument is about the design of the instrument and I'm going to show you that later towards the end of the presentation. Basically it's a very important issue to describe and figure out what it will look like and for what purpose. And I'm very pleased to say that Sasha on our project, Beth and other people involved with this tool have done an excellent job in really over and over working on how to design this so that it's appropriate for various refugee populations.

Next slide, please. The development should be described about an instrument. You know to really understand how it's developed and if it really fits the purpose and the definition.

Next slide, please. So previous efforts at developing screening have been conducted. Ovid et al have published on Bosnian refugees and suggested that in fact brief screenings looked to be doable and looked to be acceptable to refugees and looked to be useful in detecting emotional distress and mental health problems that were not detectable if you didn't have them in place. Dr. Dan Savin in Colorado have published really the only good study of a screener which is a little bit long and the only down side to that screener is it hasn't been as well measured. It's a fabulous effort showing a very significant prevalence of symptoms of depression and anxiety, including PTSD in Colorado. In that study, when they conducted screening and then gave a referral to their mental health resources, approximately 37% of people went to follow-up with those resources. And that's important for later on when we talk about the connection part of the screen that screening alone is not enough and not acceptable enough. We previously started conducting work in New Mexico and in Kentucky with public health and resettlement agencies. We have developed a New Mexico Refugee Screening checklist 121 and from that we culled down to 27 items that we thought were more appropriate screening instrument and that were shown to be more highly predictive of diagnostic levels of anxiety and depression. All of these early data point to the need for a brief and effective screen. What we have found in our previous work is again the thing that really, really impairs the effort is not having an integrated system to really work on screening you know connection, getting mental health resources in place.

Next slide, please. So initial screenings in New Mexico and Kentucky that we've done utilize instruments that have had the best empirical support for assessing relevant symptoms. In

New Mexico, refugee symptom checklist, the HSCL25 and the PSFFR. I want to stop there for a moment and say that I know there are really a lot of other very good efforts around this country and elsewhere in trying to conduct screening for refugees. Los Angeles County has a big effort going on to conduct screening for refugees using an instrument that they're developing. A few groups in Minnesota are doing exceptional work on looking at how to screen for refugees and contending with very difficult questions such as when you conduct screenings should you ask about suicidal ideations at screening or should you not. What should you include when you're screening and what shouldn't you include. These groups around the country and including Paul Bolken who works in Uganda out of Hopkins are doing really exceptional work. So for the development of the RHS-15 we utilized those twenty seven items that I've already spoken about as an initial screening instrument. And we wanted to see how good those items were to predict diagnostic proxies of anxiety and depression on the HSCL 25 and post traumatic stress on the PSSSR. And in our previous work, again, we have found those two instruments to be really good as diagnostic proxies in lieu of the ability to do a long standard diagnostic interview.

Next slide, please. This is from our earlier work in New Mexico in our NIH funded study just to show that when we conducted in depth interviews with refugees compared to a symptom checklist, the difference you get in what comes out in terms of symptoms. So whenever you have structured clinical assessment like an SCL. This was previous efforts that had been done. You know it will not pick up the same number of and type of emotional or physical symptoms that refugees are having. The in-depth interviews you see on the left hand column, those symptoms are what we use to develop the New Mexico screening instrument and the twenty seven items that ended up as our initial screener to develop the RHS15. You can see that they range across various body symptoms and organ systems and our analysis show that most of all of these physical symptoms were highly related also to emotional symptoms.

Next slide, please. So further development of the RHS15—initially instruments have been translated into four languages, key components to cultural responsiveness in this translation is to make sure that when the translation is happening that there are language specific semantics that yield accuracy and clarity of meaning. So this always comes up. Aren't there different items for different ethnic groups? Aren't different populations more likely to manifest through cardiac symptoms or respiratory symptoms or GI symptoms. It may be true, although in our early research we found that ethnicity only accounted for 10% of the variance in scores on the New Mexico symptom checklist. We think that a key component is to really have good language specific semantics that yield more accuracy and then a good screening instrument will actually pick up whether or not people have anxiety or depression. This phase of development is critical to obtain culturally responsive items in each language group. New language groups are being instituted as we speak including Russian and Somali, and more are on the way.

So our initial work in developing the RHS15, we conducted this screening with 250 refugees, fourteen years or older in the four groups screened. You can see those groups. They were Iraqi, Nepali Bhutanese, Korean and Burmese speaking Korean ethnic groups. Of those 251, 190 of those were administered the diagnostic process within two weeks of screening. Some were missed due to shortage of available interpreters, migration and for other reasons.

Next slide, please. We used three methods to compare and establish the set of items that best classified persons as most likely to have diagnostic process two level anxiety, depression or PTSD. I'm not going to bore us all with a lot of discussion about these techniques, but we did use a number of them to come up with the current RHS15. We used discriminate analysis to look at items that discriminated. We used naïve Bayesian classification which is a very interesting



approach that throws everything into the hopper and basically says which combination of these questions are going to best predict a given construct; like depression, anxiety or PTSD or all of them. And we used a Chi-squared method for each item, by each diagnostic proxy, anxiety, depression and PTSD. Items that were high for classifying persons by at least two of the three methods were then subjected to the final Bayesian classification to maximize for classification sensitivity.

Next slide, please. Well, this is the results of the final Bayesian analysis and basically what it shows is these are the items that ended up in the RHS15. The Bayesian analysis showed that you can see the PSSSR 16, there are five items that best predicted having diagnostic level or greater than a sixteen score on the PSSSR with potentially 1.0 sensitivity and a .94 specificity. For the PTSD diagnosis, the anxiety cutoff score, the clinically significant depression, different items came out as being potentially the best in terms of classifying those patients by those diagnosis. And then finally we asked the question, what items best come out to classify refugees as having any of these diagnostic proxy's and you can see there were three items that came out with potential sensitivity of .96 and specificity of .86. Well, that's a chart that doesn't mean much in terms of what the final result was, so next slide.

I'm going to show now a little bit further of the metric testing which really is the final stage of instrument construction to evaluate the validity and reliability of an instrument before it should be put in the field. And the RHS15 now has a range of scores from 0 to 54. We have looked at the cutoff scores for the RHS15 to predict the proxy diagnosis that you see on the left hand column. So in our sample of 190 patients, refugees who were screened at Seattle King County Public health sixty four had proxy level diagnostic PTSD, which, by the way, is higher than ten percent. Fifty eight percent had depression, clinically significant depression. Fifty three had anxiety. Seventy nine of these refugees had any of those diagnostic proxies and thirty eight refugees had all of those diagnostic proxies. If you look at the cut scores. If you would use nine of the cutoff score, fifty eight of the sixty four would be classified. So it was 90% sensitive if you use nine. If you use ten, it's 85% sensitive. If you use eleven, it's 85% sensitive and so on. This shows essentially what cut scores would be best for what diagnostic proxies. And if you really want to—if you have a lot of resources, and you have as many mental health providers as you want, then a cut score of nine is best. At nine you're going to pick up most sensitively most refugees that have any of these diagnostic proxies, as you can see. And you will pick up everybody who has all of these diagnostic proxies. If on the other hand, you're resource poor or don't think you have as much capacity then you can actually move the cut score higher and you know exactly what the sensitivity is and specificity for any of these diagnostic proxies.

Next slide please.

PG: Michael, I'm just going to back up one, because we had it out of order. We had the third poll question if you want me to go to that.

MH: Please.

PG: Okay. So third question from Dr. Hollifield for you is that *screening for mental health in refugees should be conducted in all refugee resettlement settings, used in settings where there are appropriate services, c, used if it results in improved outcomes only. D both b and c.* So go ahead and make your choices. And I'm just going to wait a moment. I'm going to count quietly to myself this time. Okay. Three. Two. One. Zero. I'm closing the poll now. So we have

36.4% said that screening for mental health in refugees should be done universally in all settings. 13% said only those settings where there are appropriate services. 1.3% said it should be done if it results in improved health outcomes and 49.4% said both b and c. Appropriate settings and if it results in improved outcomes.

MH: Thank you, Paul. So I don't think there's a known correct answer for this one. So I get accused of another trick question. There it is. We know because of the high rate of symptoms that many of us believe A. All refugees should be screened. I don't know the correct answer yet because many people say that a screening test should only be employed if two things happen. If A you get people to appropriate services so that B they have the chance of having improved outcomes. Some people say that screening should only occur if you've demonstrated that it improves outcomes. Otherwise it's a waste of time and money. So that really is the essential question that continues to be on the table for screening refugees for mental health is if we do so universally are we going to improve outcomes and have appropriate services to do so. So the best answer for this is probably B, but I think there's no right answer.

Are we on the slide now that shows the number and percent with diagnosis with different cut scores?

PG: No. We're on the slide with the cover of the questionnaire, but if you want I'll go to a different one.

MH: Go back one, please.

PG: This is sensitivity and specificity to diagnostic process.

MH: Thank you.

PG: At various cut scores.

MH: Great, so this shows, again, depending on how you think of this poll question. If it's an issue of how many people you should capture or if you think we should screen everybody and pick up the—be the most sensitive in picking up who should go onto care, then you would use a nine for a cut score. If you look across these cut scores on the RHS 15, the best overall cut score that has the best combination of sensitivity and specificity is probably twelve. And we have recommended twelve currently as a cutoff score to refer people for mental health services.

Next slide. So this is now the design of the RHS15. We have designed it as you see to have a cover slide. This is the English version. There are other versions that we can post on the website for people to see afterwards. It's nice in that it has a---it's used as a standalone. It can be used with this cover sheet for filing, getting the demographic information of the refugee, who administered it, etc.

PG: Michael, if I could just interrupt you for a second. We just got a good question, which I think probably is one that's worth interrupting you for.

MH: Sure.

PG: I don't think everybody in fact; maybe a majority of those who are listening know what sensitivity and specificity are. If you could just very quickly explain that to people and why it's important.

MH: Yes. So again, I think it's one of the major reasons why screening has been impairment in getting screened going in these populations, because we don't really know with the instruments on the market are we really finding the people who we need to find. And are we not sending to care people who don't have the illnesses. So sensitivity is that the screening instrument would pick up everybody that has the illnesses. So everybody who would have the PTSD, Anxiety and Depression if this screener were 100% sensitive, it would pick up all of those. It would identify all of those people. Specificity, on the other hand is to identify people who don't have it as being negative on a screening instrument. So an instrument is highly specific if it tosses out people who it should toss out. That is who don't have anxiety and depression and PTSD. That's the real challenge of a screening instrument. You always misclassify some people. Some people tend to score high on these questionnaires when they really don't have the full blown disorder. And so they would really be classified falsely. And some people tend to score low when they do have these disorders because they don't report symptoms as much. So they would be missed and they would be outside of being sensitive. So if the cutoff score were twelve and somebody scored a nine, you wouldn't say that they had anxiety or depression or PTSD and you wouldn't send them for services, but in fact, they may really have it. They may have PTSD, they just score low on these things. And that's why this questionnaire thus wouldn't be highly sensitive, because you would miss that percentage on that end of the spectrum. I hope that helps.

PG: And another quick question, a technical question. What do you mean by proxy diagnosis?

MH: So there's a debate about what the best way is to diagnose mental disorders and that's not just in refugees, although it's more prominent in refugees. Is the DSM IV diagnostic criteria conducted in a clinical interview; is that the best way to diagnose people? That is currently the gold standard of diagnosis, to sit down face to face, do a clinical interview, and go through all the diagnostic criteria and the symptoms and make a diagnosis for one of those disorders. The instruments we use as proxies they have been found to be very sensitive and specific to clinical diagnostic interviews. Therefore, they're thought of as being very good diagnostic proxies. They're good proxies for diagnosis. So the PSSSR and the HSCL25 are fairly reliably used to be diagnostic proxies and we used them in this research to understand how well the RHS15 performed.

So I'm going to move, if we could, Paul to the second page of the RHS15.

PG: Okay. There was a second metrics slide. Did you want to skip over that?

MH: We talked about that.

PG: Okay.

MH: In sensitivity and specificity.

PG: I'm on the slide now that has the grid of the symptoms.

MH: Good. These were, when all was said and done and we did all those analysis that I discussed, these were the symptoms that came out to be very sensitive and specific. I showed on the grid the sensitivity and specificity. This is the RHS15 as it now looks. So the instructions are to ask the refugees—to indicate the degree to which it's—the symptom bothersome to them over the past month. It's a critical part of the questionnaire in terms of how long a symptomatology you ask for. Some questionnaires ask for only the past couple of days or weeks. Some ask for longer than that, but we believe this has been found to be kind of the best way to refugees who are screening during resettlement. You can see the items that came out as being significant predictors as a combination of items of anxiety, depression and PTSD. So some of them are somatic symptoms like muscle, bone and joint pains. Faintness, dizziness and weakness, number six. Feeling restless which is kind of a combination of a somatic symptom and a psychological symptom and other came straight out of some emotional sorts of questions which is feeling down, sad or blue, helpless. Too many thoughts. Crying easily. Number ten through thirteen were items from the post traumatic symptoms scale self-report. Excuse me. When we through all of those, these items came out as being the most predictive. Numbers ten through thirteen are straight from the PSSSR and are very sensitive to predict post traumatic stress disorder in refugees. We found very interesting one of the items we found to be the most predictive of either anxiety, depression or PTSD is number eleven on this scale—I'm sorry—number twelve. Feeling emotionally numb. For example, feeling sad but can't cry. Unable to have loving feelings.

Next slide, please. The fourteenth question, which was very significant, is an item of coping. So the symptoms and the coping items. Those are all added up to get your total score. So item—as you can see at the bottom of this questionnaire, we think screening is positive if items one through fourteen is greater than twelve score or the distress thermometer is greater or equal to five. On that one item you see here the distress thermometer. If somebody circles five, six or seven to that question of you know how bad do you feel today on a scale of zero to ten. I feel as bad as I ever had or things are good. If they score above five, they're 85% likely to have PTSD, anxiety or depression. Currently that's what we believe the best scoring of this is, is a 12 on item 1-4 or a five or above on the distress thermometer.

Next slide.

PG: Michael, before we move ahead from this, we've gotten at least three or four questions about some of the technical side of administering this that I want to pose to you now rather than wait. First of all, people want to know who can administer this. Can the patient? There was a question about people who can't read? So can people complete this themselves or have it asked of them as a questionnaire? Does it have to be a mental health professional? And then the other question is one that harkens back to the first conversation you and I had about this which is your use of the term feeling blue. And how does that carry over in multicultural setting.

MH: Very good questions. I'm going to start to answer those and then I think in that Annette Holland from Seattle King County Public health may be on the line and it would be a good time for her to weigh in on this issue too. It's a great question and essential. As you can see in the scoring box, if you're still on that final page of the RHS15, there's a box to say whether it's self-administered or not self-administered. So this can be self-administered for people who are literate and choose to do this. It can be self-administered. For people who aren't then it would

have to be administered to them. That's an issue that is kind of dependant on your own locale, and how you can do it if you have interpreter services to help those who cannot administer itself. It is intended to be a self-administered questionnaire for those who can so that it is more efficient in the public health or primary care settings. The second question—oh. And we don't believe that somebody that's a trained mental health professional would have to be the one to administer this because we believe the items are now good enough and it's been tested with people self-administering, that they could do that on their own and it could be scored easily by anybody in the primary care/public health setting. The question comes up about if somebody gets distressed by doing this, who do you need around? The good news is that that really has not happened much at all. So the concern—one of the main concerns about it being administered is turning over a rock that has to be addressed right away. And if Annette is on the line, I'll let her speak to that a little bit.

AH: Hi. This is Annette from Public Health in King County. And we have found that the majority of our refugee clients are able to self-administer the tool. Those that are not able to have the assistance of a trained interpreter. The interpreters that we use in our refugee health screening program were all trained by the pathways project and they understand the project and why we're doing what we're doing and they are very experienced. So they're able to guide any refugee clients who are not literate or not able to understand what we're asking them to do through the process and that works really well.

MH: Thanks Annette. And, Annette, tell us how is it in terms of that other fear that it's going to cause emotional distress that is going to be a problem in the public health setting?

AH: Yes. We had a lot of reticence ... We have an RN administer the health screening. We don't have a physician and so the RN felt initially that they weren't the right people to be administering this tool. They were very concerned about lifting the lid or turning the rock and it was really only once that Dr. Hollifield and the pathways project director Beth Farmer had done an in-session, training session with them they were able to voice all their fears, ask a lot of questions and they were reassured, basically that this is not what's going to happen. They're not going to be lifting the lid and creating mayhem with the refugees who have gone through trauma. It's very rare, in fact that we've seen any negative reaction to the questions, and as you pointed out earlier, it's not a diagnostic tool. And we did meet the equation between doing the refugee—doing the admission and screening tool and administering a skin test for TB. If you get a positive skin test for TB, you don't worry about an outbreak. You don't worry about the person being infectious. You simply refer them to the professionals, the experts which would be the TB clinic or a primary care physician. Now we're able to reassure the nurses that they're simply helping to administer this tool but they are not responsible for the making the referral to a professional in the mental health field. I think another barrier was the lack of resources, or the perceived lack of resources for mental health in the refugee community and once we explained to the nurses and the staff in the refugee screening program that at the same time as piloting the tool we have been building capacity out in the community, so that there were good resources to refer people to, they felt more confident and more able to administer the tool. I think all in all, they are very glad that they went through this process. They were very reluctant but now are celebrating the fact that it seems to be a tool that works and has managed to improve the health outcome for many of our clients.

MH: Thanks Annette and we're extremely grateful to Annette and Seattle King County public health for going along on this ride and overcoming those sorts of issues and barriers and seeing how it works, so Annette will be with us in the question session if there are further issues about this in the public health setting. I want to address the issue of the item blue. That comes from the English version and many Americans don't really feel sadness as blue. And in other countries there are other colors that are used for what sadness or down is. Yellow. Sometimes green. But others but sometimes colors not at all. so this is back to the issue of the key when you are doing the translation is to capture the actual meaning of the term and have the other ethnic group and language group really describe in their language what the meaning of that term is and have it translated appropriately so that it's known that it would mean sadness, down, or is there a color in your language that means that. Sasha—I don't know if Sasha is on the phone with us—if she is she can describe that process, briefly and maybe any words or any conflicts that came up, other than blue when doing these translations.

MH: I think Sasha isn't with us, so let's move on. And we'll have time to discuss that in the Q&A session as well. Again, it's critical regardless of what you're doing in translation is that you do it for meaning, symbiosis and the translation process is critical in getting this correct in all of the languages that we utilize. Next slide, please.

PG: Michael, a lot of questions are coming through that are sort of how to questions. The process of administering it and we'll—I'll try to bundle those when we get to the question answer section rather than continue on that vein now. So you can get through your presentation. However, I just want to say to the listeners, we will take every single question that is submitted and either Dr. Hollifield or I, but most likely it will be he will provide a written answer and we will post them on our website [refugeehealthta.org](http://refugeehealthta.org) usually within about two weeks from today. So if you put in a question, even if we don't respond to you in the chat immediately, or during the question and answer session, we will have a written response for you on the website within probably about two weeks at the most. Go ahead Michael.

MH: Great. I just have a few more slides and then we'll get to those very important questions. You know that really becomes the meat and potatoes of this issue if this instrument or any instrument is going to be used in the appropriate settings and so I think they're obviously the questions that need to be discussed. So here's another scenario for Khem using this instrument. A public health nurse or a tech screens three of the family members using the RHF15 and it takes on the average about two to five minutes for somebody to administer it themselves. It takes maybe ten minutes that needs it self-administered and finds Khem to score high. The nurse offers a referral. Khem usually—and this is really from our experience in this project, Khem asks how did you know I was having tense muscles and headaches. All of these questions are exactly how I'm feeling? And we really believe that this questionnaire has hit on these issue because of the analysis that we did, some of which are very technical and some of which we've gone through but we really have come up with some of the items that are the most prevalent, the most prominent and that do in fact predict anxiety and depression and PTSD the best. So the refugees have really embraced this questionnaire and said those are really important questions. That's how I've been feeling. The mother also has a significant score and is offered referral. And it is stated to her, it appears you have some problems with crying a lot and stress or too

much thinking. Many refugees experience these symptoms. I will refer you to somebody who would be able to help you more. You notice what we don't say here is it appears you have depression. It appears you have mental illness. It appears you have emotional distress. We want to treat these screaming items as Annette was saying very much like a TB test. It appears you have some issues here, let's get you to the right people.

Next slide, please. The family accepts services. The nurse provides copies of medical reports, screening forms, provider notes, language ID cards and a toolkit folder for the family to bring to their PCP. This is an important statement. In addition to the RHS15, the pathways to wellness project, partnering with community partners have developed a toolkit folder that refugees can take to their PCP that have these sorts of reports that really helps in that initial intake in the primary care service or in the mental health service so that there's a connection between this screening and the follow-up service. In our study, because of these connected capacities, 73% of our people went for follow-up care for mental health services. That was in contrast to the 37% in the Sabin study where they did a great job screening for people and offer services and didn't have as many connected capacities at that time. Right now, by the way, Colorado has some of the best services and the most connections of anywhere in this country. At the time they were doing that not as much. Khem and his mother are eventually seen by a clinician who is part of an outreach referral system for refugees. The clinician then provides further diagnosis, treatment and resource support for the family to cope with a new environment. Next slide, please.

So this is where kind of now moving into the Q&A session with these last two slides. What is the effective use of the RHS15? So we believe it should be used in public health or primary care or other health screening sites early on in the resettlement process when people still have services. We believe it's best to be used where there are mental health services available to refugees or as a way to help develop them. Really critical now is that this kind of screening is incorporated into other health screenings and there's no need to identify it as separate from health screening. It's not a mental health issue. It's not an emotional issue. Certainly if the refugee asked about this, those, that language is used. We don't think it's appropriate where there are no resources to support treatment of refugees identified. Next slide.

Last comment and then we'll move to Q&A. We do believe that this instrument requires further validation. That is does it get people to care and when they go to care, do they get better. We are looking towards dissemination now in to five to six states with public health divisions. We believe that policy needs to be identified about mental health screening so that it gets into our systems of care and funding should then follow. Next slide, please.

Thank you. Comments will be appreciated. And I wonder if Beth Farmer might be on the line to talk about the issue of that connecting where there are resources and what has happened in the pathways project where people have gotten the care and we can move onto questions and answers.

Beth Farmer: This is Beth and I am on the line. You know we found when people came in to our clinic for care, is the clinicians were really surprised that people hadn't noticed how distressed they were. And we were at least as far as how—did it really pick up significant depression or PTSD—it's been our anecdotal experience that absolutely it did. And that people have gotten more stabilized being connected to services. Whether they—there's been some symptom reduction but because of the—they're still fairly new in the resettlement process and in fact one of the biggest outcomes, especially since resettlement is only thirty to ninety days is that

they are connected to a place and as they get more stable, that they can continue to work on these issues over time.

MH: Thank you, Beth. I wanted to say again, Beth has been a fabulous director of this project and the success has been largely due to her leadership and everyone else on this project. We're done and if we have questions and answers that I can field or others. That's great.

PG: Before we wrap up the formal part of the presentation, we have one last poll question. We want to know how you're going to use this information. Are you going to use it with your refugee clients or patients? Share it with colleagues or coworkers, maybe conducted a training for colleagues who couldn't participate today? Or you don't know. Perhaps you have some other ideas. So if people could go ahead and give us a response quickly, I'm just going to pause for a moment, and while the poll is open, let me just say that the questions are rolling in so fast in my chat box that there's no way we can keep up with them or answer them all today. I've been trying to get a little gist of what's coming in and I've got some themes written down and I think what I'm going to try to do is take some of the question themes and try to have a little conversation with Michael around them which hopefully will answer many of the questions. So I'm going to close the poll in three seconds. Three. Two. One. Closing it now.

This is what we got. Almost half of you said you're going to use it directly with your refugee clients and patients which is great. 77% said that you're going to share it with colleagues and coworkers. And I'll remind you that the recording of the webinar will be available almost immediately on our website, <http://refugeehealthta.org> as well as other resources and the instrument itself. Asking where can you get it? It will be on our website and we'll probably have links to Dr. Hollifield's website as well. It will be available to you. A good place to start is [refugeehealthta.org](http://refugeehealthta.org). Sixteen percent said you're going to actually train your colleagues, which is wonderful. Eight percent said you weren't sure and 12.7% said you've got other ideas. So I want to pursue that other ideas option right now before we try to get into handling some of the other questions and answers. So we want to continue the conversation. Did this raise more questions for you, things that we can't answer today? Perhaps you have resources, case studies or promising approaches in how you do a mental health screening in the real world. We want to continue the conversation so we're very excited that just this month we've started our community dialog section on our website, again it's shown right here. [www.refugeehealthta.org](http://www.refugeehealthta.org).

And you see it's circled on the screen, there's a menu for community dialog and then when you go to that, this is what you see and the current one you can see is a follow-up on our previous webinar from December about domestic health orientation and we had three categories in which you could comment. That one is still open if anybody is interested in taking a look at it, but what you will see very soon—I'm not quite sure how soon—but very soon we will have a community dialog open to follow up on this webinar as well. And we hope you'll really take advantage of that and share your thoughts with us. Now I'm going to start with some questions now for Dr. Hollifield and as some of you may know and Dr. Hollifield knows the I'm a pediatrician and this is one of the questions I asked him is about the validation age only going down to mid adolescence, and so quite a few people have said, well Dr. Hollifield, what are we supposed to do about the kids? And are there instruments that we can use for kids? Or what about validating yours for younger ages?



MH: That's a great question and you know Beth could pipe in here, too. One reason for doing this had to do a lot with the pragmatics and logistics. In the state of Washington, people fourteen and older can consent themselves for mental health assessments and it made this project feasible to start there, to start with fourteen and older. We're now looking at the data that to see if between fourteen and sixteen is different than adults. Older than that, we don't have a large population in that group, so I think the question is a great question and it is one that there are multiple partners of ours that are interested in and want to conduct more evaluation with younger groups to see. There are items for kids. The intrusion experience of scale is one IES. It is a question about PTSD and trauma that has been validated for children and that can be used currently for kids and is really good. It's on—actually—Dr. Geltman, it's on slide fifty seven.

PG: All right. Let's see if I can go to that. My slide 57 is the twelve instruments developed in refugee populations. Is that the one you wanted?

MH: It's actually the goodness of instrument construction and access.

BF: I was going to say from the project director side of this, I know that people were very much concerned about the children. We were concerned we would have to have multiple instruments to include in this study if we did much lower age groups because of course the verbalness of the question wouldn't hit all the developmental ages. Where we compromised was we figured if the parent screened significant we would go ahead and refer the entire family in. And talk about the entire family getting care. Even with the adolescents fourteen and older who did screen significant, the parents were very emphatic that they not go get care and the family structure is much more collective than here so people—the adolescents didn't feel that it was necessary their independent choice whether to get care or not. I think that one of the things that we learned as the parents who weren't really familiar with counseling or mental health care wanted to try it out first and see what it was all about, see if it helped and after they'd been in six months, nine months a year then we started to see other members of the family trickle in. So there are a lot of different answers to this question. We will probably need multiple instruments to screen lower, two we didn't get a lot of adolescent accepting services even when they screened significant and three they tended to come in naturally later on as well as the fact that when parents do get better the kids tend to improve anyway, so that's kind of our patchwork approach.

MH: Thank you, Beth. I want to reiterate two things. On the slide you're currently looking at, this is from our article in the Journal of the American Medical Association in 2002. If you get that article, you will see at that point and not much has changed except the work we've done with the RHS15 and the New Mexico symptom checklist since then, but those were a good overview of all the instruments of the time and the IES is in the lower half of the slide and it's a very well constructed instrument and there is a child version of the IES that looks at trauma and intrusive symptoms relevant to PTSD. That's one of the best instruments now. There are other diagnostic instruments for kids like the kiddie sats and others. They aren't good screening instruments. That's that. Finally the follow up on what Beth said, there was another article in the Journal of the American Medical Association the past year on maternal depression and child depression and it showed exactly what Beth just said. If the mother and in this case the mother, is treated successfully for depression, children get better. So that may be one answer that may

become a best practice, I think, in many settings. But having said that, we are working with some colleagues also to think about validating this, or looking at validating this to lower ages.

PG: I'll just jump in. You know there is an instrument that's commonly used in pediatrics that's about a thirty five question screening questionnaire about behavioral health. It's not specific for these types of conditions but it's called the pediatric symptom checklist. It comes in multiple languages, but again, unlike this, it's a little longer and it's not at all validated specific to refugee populations. But it does come in multiple languages and is available for free out of the Mass. General Hospital Child Psychiatry department. You can go to their website and download it for free. I don't think you'll find anything like the refugee health screener that we're hearing about today. So Michael I want to move on. We also got a lot of kind of questions that are as I mentioned earlier, how to questions. Questions can it be—can or should it be used as a needs assessment tool to justify trying to promote or develop services? Can it be used like—or should it be used like a screening through ESL type classes or job training classes? When should it be done? Do you worry about if you do it too early refugees might be in that kind of post resettlement sort of honeymoon period or if they conversely are just having a particularly bad day for whatever reason and they score over five on the distress thermometer, how does that affect things? Can you talk about this theme of questioning?

MH: Given the fact that we don't think that it is harmful and I think Annette—I'll ask Annette to say a word in a minute, certainly if one wants to use it as a needs assessment, knowing it's not diagnostic, knowing it's a screening tool, it would be an appropriate use of this tool to collect information interagency or for your own agency about the percentage of symptoms in your own populations and we will have different versions and different languages coming out in the near future. I think nine are now slated to be done. Eight or nine. I'm not sure about it being used at ESL or other—I know that's where refugees go a lot, but at this point, I think of it as being done in the healthcare setting. We have talked a lot about that and that's an ongoing discussion about where it is best utilized. Again, I think at this point, the general answer to that is it's best utilized where people will incorporate it in health screening and have the ability to connect people with outreach to other services. The issue of too early or too late is a good one. We're currently looking at our data to look at the issue of early distress, delayed distress and chronic distress. We are actually providing this at intake when people are coming through public health and also a year later at the civil surgeon evaluation. Annette can you comment on how that's going in terms of offering it at two different times at Seattle King County Public health?

AH: Yes. We started last year offering it for a second time at the civil surgeon visit which will happen anytime between twelve and sixteen months after a refugee's arrival here in King County. So we just started that at the end of last year. We don't have any data yet to show how that changes things. Sasha, if she was on the line would be able to speak to that a little better, but it may be too early to come up with any final conclusions, but obviously we want to measure whether the intervention when we screened when refugees first came to us has had any impact, have improved their health, but what we found is that people are willing to take the assessment a second time. There's no barrier to them actually filling out the same questionnaire again and it will be very interesting to see if the intervention at that early stage was better than at a later stage or vice versa.

MH: We are just now completing that data collection. Our early look at it honestly and it's a look and no better suggest that as we know in this field that there are some people who have early. Some people have delayed distress and they'd be better picked up eight months down the road and some people have chronic distress. I think personally that the standard of care is going to be that people ought to be screened early and there ought to be a screening down the road at some point, too. Especially for those who identified with some form of problem of distress.

Sasha Verbillis-Kolp: This is Sasha Verbillis-Kolp. I did want to chime in there on the second time in administering the RH15 for the civil physician exam and what we found as Annette had just mentioned was that many refugees were also able to talk about their sense of gratitude for having been referred on for treatment for those who had screened positive a year prior and that was an interesting learning I think for some of the nurses involved in being able to meet with people a year later and hearing how grateful or just perhaps what their experience had been like having gone to treatment.

BF: This is Beth and I'll second that. I think what we've found all different parts of the question is that if people had just had a bad day when we follow-up on referral, they self-select out. They will say, I just had a bad day. I'm feeling better. We are not finding people are improving people at a year super significantly even when they've been in services and their symptoms are reduced and their lives have stabilized. that first year of life in the United States—and that second year as well, but especially that first year is extremely difficult and we're retesting that civil surgeon at right about—not long after they've lost benefits and it's a very stressful time. So you've got a second stressful time there. I think the big takeaway from testing multiple times is because resettlement is so short, it's those who are truly having symptoms are not connected to another service agency they are really poised to fall through the cracks at the end of their resettlement period.

PG: So the questions continue to roll in. As I said, we've got about five minutes left and they're just far, far too many for us to answer live, but we will post answers to all the questions on the website, hopefully within a couple of weeks. I know from some of the comments that people are already going to the website and looking for things. Just be patient with us. We generally don't post things before the webinar so you will see things, but just give us a little time. Within a day or two things should start appearing on the website. Again its [refugeehealthta.org](http://refugeehealthta.org) and I just want to say there's a question about the pediatric symptom checklist for younger kids. I rush through it quickly, but if you go to the website of the Massachusetts General Hospital which you can start at the parent organization which is [partners.org](http://partners.org) I don't have the exact website in front of me. We'll try to post it, but you should go to the child psychiatry page within Mass. General Hospital and you should be able to find a link pretty easily to the pediatric symptom checklist, or if you just go to Google and type pediatric symptom checklist, I guarantee you will find it very easily. Also Michael, just so you know, people want to know if you've published about the RHS15 specifically and in general, we can provide links or the citations for Dr. Hollifield's publications about previous versions, but have you published anything yet about this one?

MH: We have written up a paper that can go along with the current RHS15 that describes its development and that paper is now being worked for publication. We plan to submit this for publication within the next month and we expect there should be a number of publications

coming out about it over the next year. We are grateful for the technical assistance center and will provide the link to the pathways website as well, so that people can and attain these instruments and a current description of this prior to publication as an open access issue.

PG: I sort of feel like I'm the old style television newscaster with the breaking news being handed to me. One of my colleagues here in Massachusetts handed me a note that says that in fact the refugee mental health topic is open and live on our community dialog page within the [refugeehealthta.org](http://refugeehealthta.org) website. So people can really continue this conversation immediately if you'd like. And we would really love to hear from. Something—I'll go back to it. Michael on your very last slide, of the presentation, you said thank you. And collaborations encouraged. And we've gotten a couple of questions from state coordinators who are interested in maybe getting a refugee health assessment clinics using this and whether there needs to be any specific protocol or permissions that—copyrighted and whether you know there's any formalities that need to be addressed?

MH: So we can send—if people refer those questions to us at Pathways, and we'll put that link up on the technical assistance center. We do have a utilization form. We currently have ten states and agencies that are partnering with us to look at data collection in their own locals. In a clinical setting to see how useful it is and we're interested in collaborating with folks on that issue. This is an open access document. As being funded by Robert Wood Johnson and some other funders Boeing and Bill and Melina Gates listed on the—the first United Way listed on the first slide. It was requested that it be open access and we are very happy that it is open access. so we can provide people with a tool, the description of the tool, with the utilization form that is only meant for us to track who wants to utilize it, how they will utilize it and if they want to participate with us in data collection of any kind. It is copyrighted because we just don't want multiple versions to get altered and changed out there before we fully test it in collaboration with our partners.

PG: Okay. It is just about 2:30, so we're going to wrap up. I want to thank Dr. Hollifield and his colleagues for their excellent presentation. I think this instrument is something that a lot of us in refugee health have been waiting a long time to see. Keep sending questions in. We'll get to them. Anything that you submit through the chat while the webinar is still live we will respond to as mentioned earlier. You can also continue these questions, the more general questions on the community dialog on our website. And we'd encourage you to do so to get some engagement and conversations going. One thing I just want to remind you about is when we stop the webinar momentarily—when we end the presentation, please don't immediately shut down your browser because your evaluation is going to pop up on your screen and sometimes there's a momentary delay. So again, I want to thank everybody and I want to acknowledge the folks here at the technical assistance center who has been working behind the scenes to make sure that everything goes smoothly and also again our funders from the office of refugee resettlement without whose support and assistance none of this would be possible. So again, I want to reiterate a chat message that just went out, that if you are signed up for continuing education credit; you will also receive in your e-mail another evaluation which you must do to get your credits. So just be alert for that. Don't automatically delete it by accident. Again, thank you everybody. I think at this point we're going to stop the webinar and I direct you to follow up on our website. Have a great afternoon.

Operator: Ladies and gentlemen, that does conclude the webinar for today. We thank you for your participation and ask that you please disconnect your line. Have a great day everyone.

[Music]

**[End of Recording]**