REFUGEEHEALTH TECHNICAL ASSISTANCE CENTER

Audience Questions and Answers
Operationalizing the RHS-15 webinar

During the *Operationalizing the RHS-15* webinar, participants had the opportunity to submit questions to the presenters. Due to time constraints, not all questions were answered during the webinar. Questions and responses are provided here for those questions that were not covered during the webinar. The webinar can be viewed on the Refugee Health Technical Assistance Center (RHTAC) website www.refugeehealthta.org. For further questions or comments, please contact RHTAC by email at refugeehealthTA@jsi.com.

Will the RHS-15 be translated into French?
We hope to translate the RHS-15 into other languages as funding permits. We may collaborate with others interested to replicate the participatory translation process and are in discussion with two partners to do this. French would be the next language for us to target after Farsi, Kiswahili and Tigrinya. We would want to make careful note in the translation process to address any differences between French spoken in Central and West Africa, versus traditional French. Depending on the community consensus, more than one French translation may be needed.

Will the RHS-15 be translated into Chin?
We do not currently have plans to translate the RHS-15 into Chin. During our pilot phase we found that many Chin speakers understand written or spoken Burmese.

Do you have any information or resources on Mental Health training for interpreters?
There is very little in the way of training for interpreters in mental health. See http://www.ncihc.org/mc/page.do?sitePageId=87551 for some helpful information.

We partnered with a trauma expert to provide individualized and customized trainings for interpreters and bi-cultural workers who administer the RHS-15. Specifically these trainings cover the following content:

- How mental health is described in the United States
- What mental health means in different communities
- How to offer non-stigmatizing referrals
- Your role as an interpreter
- Resources for self-care
- Interpreting trauma

An example in the Seattle community is Harborview Medical Center, Interpreter Services Program which hosts monthly meetings between interpreters and mental health providers. Topics include how mental health encounters can differ from other encounters, differing perceptions about mental health across cultures, how to keep

interpreters safe in the locked units, how to interpret for group sessions, compassion fatigue and self-care for interpreters and providers, and how to work with interpreters.

In your experience has the RHS-15 been administered to each family [member] individually without the presence of the other family members? Some health screenings are done all at once with the whole family together.
Many refugees come from family contexts in which the collective is valued over the individual. Given how health screenings are typically delivered, the RHS-15 or any other mental health screening can be incorporated like any other component of the health visit. Most clients self-administer the RHS-15 and so being in the same room as their family members typically does not present any problems.

If there are instances where creating individual space is deemed an important factor, we recommend that steps are taken to offer this. While a private additional room was available for families completing the RHS-15- we did not find a need for using this space.

Where does the funding for the mental health coordinator come from?
This is a reference specifically to the Refugee Mental Health Coordinator position in Louisville, Kentucky. The Mental Health Coordinator serves to triage cases, engages in appointment scheduling, provides some casework and offers referral to the provider network. The Coordinator also functions as the point person and frequently checks in on clients through ongoing outreach and providing necessary linkages.

The State Refugee Coordinator, Luta Garbat-Welch was instrumental in garnering a Targeted Assistance Grant (TAG) through the Office of Refugee Resettlement (ORR). This allows the State to cover mental health services as it relates to overall employability outcomes. The primary rationale for this was to define the main barriers to employment and self-sufficiency and make the case that if there is poor mental health, people will not be able to get work or stay employed. In King County, Washington some TAG dollars are used for those refugees who have benefits end at 8 months post-settlement.

What is "RMA" and is it available in all states? Please discuss the RMA funding through which states can purchase private insurance.
RMA refers to "Refugee Medical Assistance" and is available to states that provide refugee resettlement services. RMA covers the cost of health services for refugees not eligible for Medicaid for the first 8 months from their date of arrival in the U.S.

Each state has its own program for RMA and in most states RMA is provided through the Medicaid system. However, Kentucky, Nevada, Tennessee and Alaska are Wilson-Fish states which are 100% privatized. This means that the state government is not involved in the administration of refugee services. These 4 states use RMA funding to purchase private insurance for refugees not eligible for Medicaid (classified as RMA clients) – all four states together form an 'insurance pool' which thus helps to lower the monthly premium costs. More information on the WF program can be found here:

http://www.acf.hhs.gov/programs/orr/programs/wilson_fish_prg.htm. In Kentucky, administration is provided through Catholic Charities of Louisville, Kentucky Office for Refugees.

Can you give any advice on how to begin outreach with local mental health providers/organizations to participate in accepting referrals?
One good step is to provide some education on the refugee experience and its connection to emotional distress. In addition to basic education, if capacity and resources are available, one could provide ongoing training and consultation to mainstream providers who may be interested in serving refugee populations. Here are some helpful topics to include in a provider training:

- Best practices in working with interpreters
- Refugee mental health beliefs and tips on reducing stigma
- Cross-cultural diagnosis and treatment planning

Could you please discuss a bit further the reasons the questionnaire is generally self-administrated? Why would this be preferable to being provider-administered (assuming the provider has been appropriately trained, and appropriate interpretation is available)? A corollary question: what resources are available to help staff become competent in administering the questionnaire? Who currently provides the at least one-hour trainings that you have recommended?

The RHS-15 can be either self-administered or interpreter assisted. Because many refugees are literate in their own language, we felt strongly as a project that literate refugees would be more likely to complete a questionnaire in their native language and stigma may be reduced. When screening a literate patient, a provider may chose to provide the patient with an orientation on the instructions and scale of the questionnaire, being sure to ask if there are any questions. This way a patient can make an informed choice to either complete it individually or with the assistance of an interpreter.

Sasha Verbillis-Kolp has designed a one hour training for interpreters on how to administer the RHS-15 and the role of the interpreter. This training is being peer reviewed and we invite interested parties to contact her directly for customized training at Sasha Verbilliskolp [sverbilliskolp@lcsnw.org].