Pathways to Wellness

Integrating Refugee Health and Well-Being

Creating pathways for refugee survivors to heal

REFUGEE HEALTH SCREENER - 15 (RHS-15)

UTILIZATION REQUEST AND AGREEMENT

Date of Request:	**Name:**
Institution:	
Department (if applicable):	
Your Position:	
Address 1:	
Address 2:	

City:	**State:**	**Zip:**
Country:	**Email:**	
Phone Number:		

INSTRUCTIONS **Please complete the fields below**			
Where did you hear about the RHS-15?	☐ In a journal publication *List:* ____	☐ From a colleague	☐ Other (please specify): ____
What is your intended use of the RHS-15?	☐ Clinical assessment	☐ Research	☐ Other (please specify): ____

If you plan to use the RHS-15 for research, please briefly describe your research or use:	Ethnic and/or language group(s): ☐ Arabic ☐ Russian ☐ Nepali ☐ Spanish ☐ Karen ☐ Somali ☐ Burmese	Age range ☐ 14-21 ☐ 21-64 ☐ 65-older	Context: (check all that apply) ☐ Refugees ☐ Asylum seekers ☐ Validity for Screening ☐ Comparison to another instrument

How many refugees do you screen a year?	☐ 25-50	☐ 50-100	☐ 100-200	☐ 200 or more
What is the setting for administering the RHS-15?	Health setting ☐ Primary care ☐ Public health	☐ Resettlement agency	☐ CBO	☐ Other (please specify)
Funding source?	☐ Federal grant	☐ Foundation	☐ Intramural grant	☐ None

Is there other pertinent information about how your organization will utilize the RHS-15?	

Statement of Agreement

I understand that the purpose of this agreement is to improve the use and dissemination of the Refugee Health Screener – 15 (RHS-15). Any and all shared information and data between myself, or my institution, and *Pathways to Wellness* partners is to be utilized to improve the RHS-15. I also understand that I, and/or my institution, may negotiate with *Pathways to Wellness* partners how shared information and data will be used for institutional and/or scientific reports. I agree to utilize the Refugee Health Screener – 15 (RHS-15) in its current form and for its intended use unless otherwise specified in subsequent agreements.

(Please check the box that reflects your desired use of the RHS-15)

☐ I and/or my institution will use the RHS-15 for clinical purposes only. We do not have the capacity to engage in research, but agree to a qualitative interview to discuss challenges and successes with the RHS-15 so the tool can be further developed.

☐ I and/or my institution will use the RHS-15 for clinical purposes only. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

1. **The number of screenings conducted.**

2. **Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**

3. **Age, gender, and ethnic/language group, and screening score of participants screened.**

☐ I and/or my institution are interested in partnering with *Pathways to Wellness* partners on further evaluative projects about the RHS-15 and/or subsequent versions of the RHS-15. I/we understand that I/we will negotiate with *Pathways* how to proceed in such projects regarding lead, institutional review board approvals, data collection and management, and authoring of scientific reports. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

1. **The number of screenings conducted.**

2. **Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**

3. **Age, gender, and ethnic/language group, and screening score of participants screened.**

4. **Clinical information regarding 1) the number of those screened referred to care, 2) the number of positive screened persons that went to care, and 3) treatment outcomes.**

5. **A summary of any other qualitative or quantitative evaluations about the utility of the RHS-15 (negotiable on execution of the agreement).**

Requestors' signature: _____**Date:** _____

Requestor's printed name: _____

Thank you for your interest in utilizing the Refugee Health Screener-15 (RHS-15). We are interested in your findings, recommendations for further use and development, and collaboration on research and development.

Please return the form to: *Pathways to Wellness*
Beth Farmer, MSW
International Counseling & Community Services
4040 S 188th St., #200
Seattle, WA 98188
206-816-3252

You may fax to: **206-838-2680**

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REFUGEE HEALTH SCREENER - 15

Development and Use of the RHS-15

Early screening and intervention for emotional distress among newly arrived refugees is rarely conducted. Existing instruments are not designed for refugees or may be cumbersome to administer in health care settings. The RHS-15 was developed in a community public health setting to be an efficient and effective way to sensitively detect the range of emotional distress common across refugee groups.

Background

The United Nations High Commissioner for Refugees lists 16 million refugees and asylum seekers and 26 million internally displaced persons in the world as of mid-2009.[1] Over 1.8 million reside in the United States.[2] All refugees have experienced extremely stressful events related to war, oppression, migration, and resettlement. The best evidence shows that a large minority of refugees experience multiple, distressing somatic and psychological symptoms and poor mental health[3-11] that are associated with stressful events in a dose-dependent manner.[8,12-14]

Because this high burden of combined emotional and physical distress is often symptomatic of pre-existing or developing mental disorders, screening upon arrival in the host country is important. However, screening for mental disorders is not currently a standard practice in the majority of refugee resettlement programs in the U.S. Barriers to screening include time, cost, follow-up, refugees' health seeking behaviors, accessibility and availability of services, language, and cultural or conceptual differences in perceptions of health.[15] Another challenge to screening is that symptoms in refugees are most often not characteristic of single, western-defined psychiatric disorders.[16-26] Hence, instruments that effectively screen for distress in general, i.e., predictive of prevalent common mental disorders, have not been developed and tested in refugee populations. The value of such screening has also not been definitively established. Ovitt and colleagues examined refugee perceptions of a culturally-sensitive mental health screening in eight Bosnian refugees in the United States and suggested that screening is a necessary component of refugee resettlement.[15] Savin and colleagues (2005) analyzed data from the Colorado Refugee Services Program in Denver, and found that nearly 14% of the 1,058 refugees over the age of 18 screened positive for a psychiatric disorder using an instrument developed by an expert consensus process. Of those offered mental health services, 37% received such services and the remaining 63% declined.[26]

Developing an efficient and effective screening instrument

A screening instrument for refugees needs to be efficient and sensitive to a range of common psychiatric diagnoses. The two instruments that have been developed in refugee populations and could be considered screening instruments, the Harvard Trauma Questionnaire (HTQ) and the Vietnamese Depression Scale (VDS), are specific to posttraumatic stress disorder (PTSD) and depression, respectively.[27,28] The New Mexico Refugee Symptom Checklist-121 (NMRSCL-121), which was developed to assess the broad range of distressing physical and emotional symptoms in refugees,[5] is a reliable and a valid predictor of traumatic

events and mental health symptoms. However, it is long and comprehensive and was not intended to be a screening instrument.

Other scales developed for specific illness states in western populations have been adapted for use with refugees. For example, the Hopkins Symptom Checklist-25 (HSCL-25) has been adapted for several populations including Indochinese and Bosnian.[15,29] However, the HSCL-25 assesses clinically significant anxiety and depression, not PTSD, and was not intended for screening. A standard instrument that is effective and efficient in screening for emotional distress that is a common marker across psychiatric diagnoses in many ethnic groups would be helpful for resettled refugees.

<u>Items used as a basis for developing an efficient screening instrument for emotional distress</u>

PTSD, anxiety, and depression symptoms are the most common mental symptoms in refugees. Psychotic illnesses are relatively easy to detect by non-psychiatric providers. Thus, initial screening programs in two locales in the U.S. utilized instruments that have the best empirical support for assessing relevant symptoms. These included:

- *The New Mexico Refugee Symptoms Checklist-121 (NMRSCL-121)* assesses the broad range of persistently distressing somatic and psychological symptoms in refugees, and is reliable and a valid predictor of traumatic experiences, PTSD, anxiety and depression in both Kurdish and Vietnamese refugees.[5] The NMRSCL-121 is formatted for possible responses from 0 (not at all) to 4 (extremely), and may be scored as a sum or an item average.

- *The Hopkins Symptom Checklist-25 (HSCL-25)* assesses anxiety and depression symptoms, is valid for the general U.S. population and for Indochinese refugees,[30,31] and has transcultural validity.[32,33] The HSCL-25 is formatted for possible responses from 0 (not at all) to 4 (extremely), and is scored as an item average. Item-average cutoff scores of $\geq$1.75 for each scale predict "clinically significant" anxiety and depression in general U.S. and refugee samples and are valid as diagnostic proxies.[30,31]

- *The Posttraumatic Symptom Scale-Self Report (PSS-SR)* is a reliable predictor of the PTSD diagnosis in U.S. populations.[34] The 17 items on the scale, each scored from 0 to 3 for symptom frequency, are essentially DSM-IV PTSD diagnostic items. PSS-SR continuous scores and the diagnostic proxy were highly correlated with war-related trauma and anxiety and

depression in Kurdish and Vietnamese refugees,[13] and Cronbach's alpha in these samples was 0.95. The dichotomous proxy and the cutoff score were used for the current analyses.

The process of screening and assessing diagnostic proxies

For development of the Refugee Health Screener 15 (RHS-15), twenty-seven NMRSCL-121 items (each scored on a 0 to 4 severity scale) that were found to be most predictive of anxiety, depression, and PTSD in a refugee cohort were collectively utilized as the primary screening instrument. Six items were added to this screening based on clinical experience and empirical data about assessing emotional distress, including questions about family psychiatric history, personal psychiatric history, stress reactivity, coping capacity, and a distress thermometer. The HSCL-25 and the PSS-SR were used as diagnostic proxies to evaluate items that would comprise the RHS-15.

All instruments were translated into four languages using a rigorous, iterative back-and-forth participatory consensus process with refugees from each language group. This process ensured relevant language-specific semantics yielding accuracy and clarity of meaning. This phase of development is critical to obtain culturally-responsive items in each language. The four language groups were chosen because they are spoken by the highest number of refugees currently being resettled in King County, as well as in the United States.

Two-hundred fifty-one refugees 14 years or older in these four groups (93 Iraqi, 75 Nepali Bhutanese, 36 Karen, and 45 Burmese Speaking (including Karenni and Chin ethnic groups) coming for health screening at Public Health Seattle and King County (Public Health SKC) between April 2010 and November 2010 were screened by the *Pathways to Wellness* evaluation coordinator. Those screened were administered the diagnostic proxies usually within 2 weeks of screening. One hundred and ninety persons were administered the proxies. Those missed were due to shortage in available interpreters, out-migration, and other reasons (i.e. during time of diagnostic assessment, some participants had other medical concerns that warranted immediate attention). It is important to note that the development of the RHS-15 was an integral part of the overall *Pathways* mission, which included the integration of health services, outreach and education about refugee health, and an evaluation component. Stand-alone screening for emotional distress may not be useful if treatment services are not available or accessible.

Methods for evaluating the most valid set of items for screening

To establish the RHS-15, all items from the screening instrument and diagnostic proxy instruments (N=75 items) were analyzed together to improve on validity and efficiency of the initial screening instrument. Multiple exploratory methods were used, including initial correlations and general linear models using t-tests and analysis of variance. Three methods were then used and compared to establish the most useful and efficient set of items that would classify persons as most likely to have diagnostic proxy level anxiety, depression, or PTSD: discriminant analysis (DA), naïve Bayesian classification (BAY), and chi-square (CHI) for each item by diagnostic proxy. Diagnostic proxies used were (1) clinically significant anxiety, (2) clinically significant depression, (3) PSS-SR diagnostic PTSD, (4) moderate-severe PTSD or greater, and (5) any of the four previous diagnostic entities on Bayesian analysis.

Results of analyses

Most of the 75 items were significantly correlated with diagnostic proxies, reflecting their usefulness in the extant instruments. Some of the same and some different items were found to classify by diagnostic proxy when using each of the three classification methods. To establish the items that had the highest chance of correctly classifying a refugee with a likely diagnostic proxy, a grid of strength of association of item by classification method was constructed. Items that were high for classifying persons by at least 2 of the 3 methods were then subjected to BAY to maximize for classification sensitivity. Fourteen items were important for classifying by at least one of the 5 diagnostic proxies with sensitivity of at least .89 and specificity of at least .83. The table shows items included by BAY for each diagnostic proxy and the sensitivity and specificity of each item-group by proxy diagnosis. One item, HSCL 9 was not significant in other linear analyses, so was dropped from the final screening instrument. One item, HSCL 4 was significant in other BAY and CHI analyses so was added to the final instrument. Another item, HSCL 13, was significant in all 3 prior methods so was added to the final instrument. The distress thermometer was a significant predictor of each diagnostic proxy.

Table. Items selected for the RHS-15 by final Bayesian analysis

Items selected by BAY	PSS-SR ≥16	PTSD diagnosis	HSCL-25 Anxiety	HSCL-25 Depression	Any Proxy
NM 5_1	X		X	X	
NM 5_12				X	
NM 5_19				X	
NM 5_22					X
"Coping"			X		
PSS 3	X				
PSS 5				X	
PSS 11	X	X	X		X
PSS 17				X	
HSCL 1		X	X	X	X
HSCL 3			X		
HSCL 9	X				
HSCL 10	X				
HSCL 11				X	
Sensitivity	1.00	0.89	1.00	1.00	0.96
Specificity	0.94	0.83	0.91	0.93	0.86

"NM" is an item from the New Mexico Refugee Symptom Checklist
"PSS" is an item from the Posttraumatic Stress Symptoms-Self-Report
"HSCL" is an item from the Hopkins Symptom Checklist
The sensitivity and specificity values assume optimal scores to proxy diagnoses in BAY analyses

Current Recommendations for Scoring and Using the RHS-15

Past analyses of the initial screening instrument consisting mostly of NMRSCL-121 items determined that an item-average of 0.88 or greater was optimally associated with significant emotional distress (i.e., diagnostic level distress on proxy instruments). However, the RHS-15 now includes items from 3 different instruments, which had different instructions, response scales, and scoring. In particular, the PSS-SR items are rated more by frequency than severity on a scale from 0 to 3. The NMRSCL-121 and the HSCL-25 both have items rated from 0 to 4, but the instructions specify a different time frame of the symptoms. We have constructed the RHS-15 so that each item has the same response possibilities from 0 (not at all) to 4 (extremely).

Post-hoc analyses of the RHS-15 with items standardized to the current scoring scale were conducted to determine the optimal cut-off score to predict a positive case. One assumption of such analysis is that future

samples will score similar to our initial sample on the RHS-15 items and the diagnostic proxies. These analyses showed that an item-average of 1.18 may result in the most optimal sensitivity and specificity. However, a screening instrument is generally utilized to be highly sensitive, in order to identify all cases, particularly when missing any case would result in a significantly adverse outcome. An item-average of 0.88 and 1.18 on the 14 RHS-15 items translates to a total score of 12.32 and 16.52, respectively. Our data suggest that using the former cut score will result in identifying approximately 38% of refugees as positive for emotional distress. The latter cut score has not been tested in a separate or split sample, but we estimate it will result in identifying between 25% and 33% of refugees as positive for emotional distress. For now, we recommend that the item average of 0.88 (total $\geq$12) or higher be used to identify a positive case. Further evaluation is necessary to determine the sensitivity and specificity of the RHS-15 at various cut-off scores to find significant emotional distress, as well as other outcome measures that have yet to be investigated.

In the current analyses, a distress thermometer score of 5 or greater was 85% specific for being positive on any of the diagnostic proxies. The sensitivity of this cut score was .87, .85, and .66 for PTSD, depression, and anxiety, respectively. If a cut score of 6 or greater was used, then specificity increased to .93, but the sensitivity was below .50 for the three diagnostic proxies. Thus, to optimize for sensitivity and include cases that may be missed by the 13 symptom items plus the coping item, we recommend that a distress thermometer score of 5 or greater be considered a positive screen. Thus, our current recommendation is that a score of $\geq$ 12 OR a distress thermometer score of $\geq$ 5 is considered a positive case. We believe that the best process will eventually be to utilize the RHS-15 as a highly sensitive first screen, with intermediate scores (e.g., 12 to 16) warranting a second level, more specific screen. Early results from our second phase where the RHS-15 is integrated into routine health screening at Public Health SKC indicates that the administration time is approximately 5 minutes for those who are literate and self-administer the RHS-15, and up to 15 minutes for those who are administered the instrument regardless of literacy level. Public Health SKC has been forward-looking and innovative as a *Pathways* partner and by advocating for a pay-line for the time to administer the RHS-15.

We highly recommend the use of the RHS-15 in settings where there are adequate resources to conduct and score the screening, and to develop a source and method of referral for further diagnosis and treatment. Another decision point is about when in the course of resettlement is the best time to administer the RHS-15. While our premise is that it should be administered early in the course of resettlement, it is also clear in our work and from other studies that a significant proportion of newly arrived refugees will have a delayed onset of emotional distress. We are currently working on better understanding the proportion of refugees with distress on arrival, delayed distress, and factors that predict each.

Finally, the *Pathways* project invites collaborative work with other groups who wish to use and/or evaluate the effectiveness of the RHS-15. It is expected that the form and method of screening may vary from locale to locale, dependent on the health care setting, the population served, and the resources available. As of September 2011, the RHS-15 is available in English, Arabic, Burmese, Karen, Russian and Nepali (Bhutanese), with a Somali version soon available. We are beginning the process to have the RHS-15 also available in Spanish. Current development and evaluation of the RHS-15 has had institutional review board (IRB) approval and oversight at The Pacific Institute for Research and Evaluation. Any further collaborative evaluation and/or research will necessarily involve a discussion about how and where to obtain IRB approval to proceed with the work.

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ENGLISH VERSION

DEMOGRAPHIC INFORMATION

NAME: _____   DATE OF BIRTH: _____

ADMINSTERED BY: _____   DATE OF SCREEN: _____

DATE OF ARRIVAL: _____   GENDER: _____   HEALTH ID #: _____

REFUGEE HEALTH SCREENER (RHS-15)

Instructions: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you <u>over the past month</u>. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODER- ATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

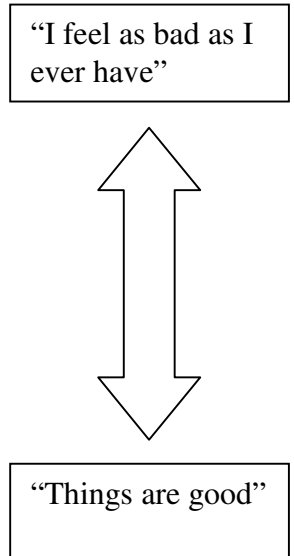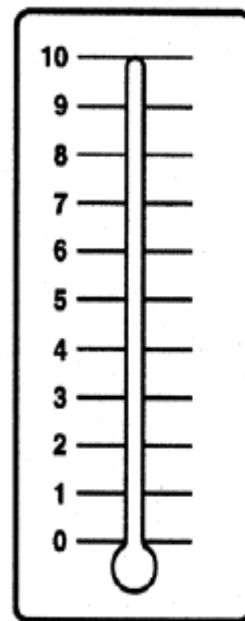|	NOT AT ALL	A LITTLE BIT	MODER- ATELY	QUITE A BIT	EXTREMELY
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

14. Generally over your life, do you feel that you are:

    Able to handle (cope with) anything that comes your way 0

    Able to handle (cope with) most things that come your way 1

    Able to handle (cope with) some things, but not able to cope with other things...................2

    Unable to cope with most things...3

    Unable to cope with anything 4

15.

Distress Thermometer

FIRST: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

10	Extreme distress
9	
8	
7	
6	
5	
4	
3	
2	
1	
0	No distress

"I feel as bad as I ever have"

"Things are good"

ADD TOTAL SCORE OF ITEMS 1-14: ___

SCORING

Screening is POSITIVE

    1. **If Items 1-14 is ≥ 12 OR**

    2. **Distress Thermometer is ≥ 5**

Self administered: _____

Not self administered:_____

CIRCLE ONE: **SCREEN NEGATIVE**   **SCREEN POSITIVE**

                                                                   REFER FOR SERVICES

Refugee Health Screener-15 (RHS-15)
REPLICATION GUIDELINES

Counties and states resettling refugees differ in their approach to refugee health screening. The RHS-15 is best suited for communities that have mental health resources available to refugees or potential for building that capacity.

When adapting the RHS-15 for use in your community:

- **Identify who will be screened using the RHS-15 and consider demographics**
  - · Which ethnic population(s)?
  - · What age(s) to target?
  - · Literacy, gender, etc.
  - · At what point in time during resettlement?

In King County, the RHS-15 was administered to newly arrived refugees age 14 years and older (among 4 ethnic groups) during their 1st month of resettlement and again at 12-16 months during the limited Civil Surgeon visit.

- **Identify the refugee health screening entity in your community and consider the screening setting**
  - · Public health department
  - · Primary care clinic
  - · Resettlement agency

In King County, health screening for refugees occurs at the public health department. Refugee clients are referred for ongoing care to primary care clinics. If a refugee client screens significant for emotional distress they are referred to a central referral source.

- **Consider the capacity of community mental health providers and build capacity if needed**
  - · Are there mental health agencies that can effectively serve refugees?
  - · What additional education, training or support do mainstream providers need to serve the population?
  - · Expect referral rates to be 10-15 % of those screened per month
  - · The cut off score can be based on your local conditions * (*See "Development and Use" paper for more discussion*)

In King County, while piloting the RHS-15 the average rate for screening positive was 25% of total screened per month. The project had a robust outreach component to build provider capacity.

- **Innovate a better continuum of care for refugees and consider local conditions**
  - · What does the structure of healthcare delivery look like in your community?
  - · How can this system be improved to better serve refugees?
  - · Where are the gaps in service?

- **Convene stakeholders to implement the RHS-15**
  - · Primary care doctors, refugee health-screening entity, and resettlement agencies can oversee the implementation and adaptation of the RHS-15 in your community.
  - · Document your results and share with health, resettlement and social service communities.

Pathways to Wellness
Integrating Refugee Health & Well Being

Creating pathways for refugee survivors to heal

A program of:

Michael Hollifield, M.D.
Psychiatrist, Family Practice
Pacific Institute for Research & Evaluation

Lutheran Community Services

ACRS ASIAN COUNSELING & REFERRAL SERVICE

Public Health
Seattle & King County

We want to hear from you! Please consider reporting information to our *Pathways* team so we can continue to improve.

Contact Information:

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"It is so simple, but it makes such a huge difference."
~ Lisa Buckner, Registered Nurse

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Pem came from a small country in Asia.

As a young mother, Pem fled her village when civil war broke out and soldiers began burning and looting homes. She spent over a month walking with her infant daughter to safety. For the next 13 years, Pem languished in a refugee camp. Fortunately, she was one of the lucky few that received an opportunity to come to the United States. When she arrived, Pem was given a required health screening that also looked for signs of depression and anxiety. Pem admitted to not being able to sleep at night and crying on an almost daily basis. Her body hurt, she said. "Too many thoughts. So many thoughts, I can not think well." Pem was immediately connected to support to help her with these symptoms, and is now thriving with a new job and new hope. Pem's assessment took less than 10 minutes, but it is not happening for most refugees.

Pathways to Wellness is a new approach to finding depression, anxiety, and traumatic stress in refugees and connecting them to the care they need to heal. We provide training for mental health providers to effectively deliver services to refugee populations, and partner with refugee communities to better understand and address mental health issues. *Pathways* is working with other cities across the United States to duplicate its success.

No refugee should suffer any more than they already have. Contact us to get more information on how *Pathways* can benefit your community.

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Pathways to Wellness is a partnership project between Lutheran Community Services NW, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield of the Pacific Institute for Research and Evaluation.