Refugee Health Screener-15 (RHS-15)
REPLICATION PACKET
HISTORY

In King County, WA refugee service providers, resettlement agencies and community leaders, meet regularly to discuss issues and share resources. Over the years, the conversation frequently turned to refugee mental health. Given the trauma and loss refugees experience it was not surprising that many people around the table were seeing unmet needs in their clients and in their community, specifically around depression and traumatic stress. In 2009, a coalition formed between Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield to develop a system-wide effort to better address the mental health needs of refugees.

As the critical subject of refugee mental health continued to be discussed, there was a consensus that:

- Refugees with high distress needed to be found early before they were in crisis
- Any screening needed to take into account the particular cultural understanding of mental health
- Whatever was developed should be rigorously evaluated so that it would provide a firm foundation for evidenced-based practice

Thus, *Pathways to Wellness*: Integrating Refugee Health and Well-Being was created, with the vision of providing early screening and detection of emotional distress for newly arrived refugees. *Pathways* created a culturally competent, short screening tool, The Refugee Health
Screener-15 (RHS-15), that detects symptoms of anxiety and depression in refugee populations from different countries. Through collaboration with Public Health, the project utilized an existing central entry point for refugees. The screening tool was incorporated into the refugee physical health screening program at Public Health where every newly arrived refugee in King County is screened. Clients who screened significant for emotional distress were then referred to appropriate mental health services.

After a rigorous year-long evaluation, the RHS-15 was empirically proven to be reliable and effective, with 30% of people showing significant distress. The tool is now fully integrated into the physical health screening program at Public Health. This model enabled early intervention through the primary healthcare system and focused on holistically meeting the needs of refugees.

Pathways is incredibly appreciative of our funders for their continued support. Their investment in this project helped to change the system of care for refugees in King County. Refugees now receive screening for emotional distress and subsequent support as a standard part of resettlement. With the combination of community-based participatory research and rigorous scientific evidence, Pathways was able to raise the standard of culturally competent mental health screening and care for newly arrived refugees. In addition, Pathways created a replicable model of service and a validated screener that is now being used in other cities across the country. The support from our funders allowed Pathways not only to institute change in the system of caring for the refugees in our county, but has provided an avenue to stimulate change across the country for all refugees entering the United States.
CREATING PATHWAYS FOR REFUGEE SURVIVORS TO HEAL

"IT IS SO SIMPLE, BUT IT MAKES SUCH A HUGE DIFFERENCE."
Lisa Buckner, Registered Nurse

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 cannot 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.

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Lisa Buckner, Registered Nurse
"IT IS SO SIMPLE, BUT IT MAKES SUCH A HUGE DIFFERENCE."

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

Developed by the Pathways to Wellness project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

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Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The Pathways Project at 206-816-3253 or pathways@lcsnw.org.
Refugee Health Screener-15 (RHS-15)

Development and Use

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.
DEVELOPMENT AND USE

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 health3-11 that are associated with stressful events in a dose-dependent manner.6,12-14

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
(NMRSC-121), which was developed to assess the broad range of distressing physical and emotional symptoms in refugees, 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. 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.

Items used as a basis for developing an efficient screening instrument for emotional distress 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 (NMRSC-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. The NMRSC-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, and has transcultural validity. 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 >1.75 for each scale predict “clinically significant” anxiety and depression in general U.S. and refugee samples and are valid as diagnostic proxies.

- The Posttraumatic Symptom Scale-Self Report (PSS-SR) is a reliable predictor of the PTSD diagnosis in U.S. populations. 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, 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
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.
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

<table>
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<tr>
<th>Items selected by BAY</th>
<th>PSS-SR &gt;16</th>
<th>PTSD Diagnosis</th>
<th>HSCL-25 Anxiety</th>
<th>HSCL-25 Depression</th>
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<tr>
<td>NMS_1</td>
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<td>NMS_22</td>
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<td>“Coping”</td>
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<td>PSS 3</td>
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<td>PSS 5</td>
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<td>PSS 11</td>
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<td>HSCL 10</td>
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<td>HSCL 11</td>
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<td>1.00</td>
<td>1.00</td>
<td>0.96</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>0.94</td>
<td>0.83</td>
<td>0.91</td>
<td>0.93</td>
<td>0.86</td>
</tr>
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</table>

“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

Table. Item selected for the RHS-15 by final Bayesian analysis
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 >12) or higher is 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 of 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 is also considered a positive screen. Thus, our current recommendation is that a score of > 12 OR a distress thermometer score of > 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

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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.
REFERENCES

Refugee Health Screener-15 (RHS-15)

Fact Sheet
COMMUNITY BASED PROJECT

Pathways to Wellness: Integrating Refugee Health and Well-being developed as a collaborative response to an unmet need in the Seattle-metro area (King County, WA). Project collaborators noted a lack of mental health services, lack of knowledge of the refugee experience among mental health providers, and dearth of culturally relevant, validated screening tools to effectively identify refugees experiencing emotional distress. Because mental health screening is not a standard practice in refugee resettlement programs, the project targeted the development of an evidence-based tool that could be adapted to other resettlement locales. The project believes that integrating early detection and support for mental health problems into refugee resettlement, combined with culturally appropriate and effective treatment, reduces resettlement stress and accelerates healing.

PURPOSE AND DESIGN

Pathways field-tested an evidenced-based screener that is easily used in healthcare settings. The Refugee Health Screener-15 (RHS-15) was designed to be short (15 questions) with neutral language that does not directly address violence, torture, or trauma.

UNIQUE TRANSLATION PROCESS

The RHS-15 was translated with community focus group participation to ensure that questions were asked in the appropriate way according to language and culture. Pathways utilized a rigorous, iterative back-and-forth participatory consensus process that ensured relevant language-specific semantics yielding accuracy and clarity of meaning. The screener was professionally translated, and then community focus groups were held to discuss the meaning of words and the appropriate translation for each question. Changes were made upon recommendation by the focus group, and then a ‘blind’ reader from the community back-translated to English to ensure a match with the original questions. The project believes that this process is a best practice for ensuring the appropriate translation of assessments and screeners, given that the language equivalence is not always possible.

Available translations: Arabic (Iraqi), Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya and Swahili.

In development: Spanish
RESEARCH APPROACH

Twenty-seven NMRSC-121 items (each scored on a 0 to 4 severity scale) that are most predictive of anxiety, depression, and PTSD were utilized as a primary screening instrument. The HSCL-25 and the PSS-SR were used as diagnostic proxies to evaluate the validity of items that would comprise the RHS-15. Three statistical methods were then used and compared to establish the most useful and efficient set of symptom items to form the screener. Multiple exploratory methods were used during analysis, including correlations and general linear models using t-tests and analysis of variance. The items selected for the RHS-15 are composed of fourteen items (selected from the NMRSC-15, HSCL-15, and the PSS-SR) that showed significance for classifying by at least one of the 5 diagnostic proxies with sensitivity of .89 and specificity of .83.

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 Karrnni and Chin ethnic groups) coming for health screening at Seattle and King County Public Health (PHSKC) between April 2010 and November 2010. Those screened were administered the diagnostic proxies (DPS) within 2 weeks of screening. Roughly 30% of those screened during the pilot screened significant with an average 70% incident referral rate.

Post-hoc analyses of the developed RHS-15 showed good sensitivity (range .81 to .95) and specificity (range .86 to .89) to DPS in two of three ethnic groups. Of 77 screen positive cases, 74% accepted treatment services and 5% were in services at screening. Of those, 79% started treatment, all with a primary psychiatric diagnosis, and all but 8% stayed in treatment for longer than 3 months.

RESOURCES

CLINICAL USE

The Refugee Health Screener-15 validated tool has been integrated into standard physical health screenings that newly arrived refugees undergo at Public Health Seattle & King County and in several other places across the country. The RHS-15 may be self- or clinician-administered with assistance from trained interpreters. The average time of administration is between 4 and 12 minutes. It is not known if type of administration biases case identification, which has been shown to be a potential bias. With training and logistical support in rolling out the RHS-15, feedback from clinic staff has been very positive after concerns about time, workload, and possible adverse effects on patients are addressed.

The RHS-15 is a valid screener for common mental disorders in refugees presenting to public health. The screening method appears to be effective, but further prospective research is required to further validate the tool.

NATIONAL IMPACT AND PARTNERSHIP

In 2011, the RHS-15 was profiled as an emerging best practice by the Refugee Health Technical Assistance Center. Clinical implementation of the RHS-15 is occurring across the nation. States, such as New Mexico, Kentucky, Maryland, Utah, Idaho, Virginia and Arizona are working to integrate the RHS-15 into standard physical health screenings for newly arrived refugees. The Pathways team recommends the use of the RHS-15 in settings where there are adequate resources to conduct screening and appropriate services, and to develop a source and method of referral for further diagnosis and appropriate treatment. Pathways hopes that the tool reaches the hands of those serving refugees so that more refugees can get the care they need to heal and begin again in their new home in the United States.
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.
REPLICATION GUIDELINES

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.

We want to hear from you! Please consider reporting information to our Pathways team so we can continue to improve.
Refugee Health Screener-15 (RHS-15) Utilization Agreement

Developed by the Pathways to Wellness project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

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## UTILIZATION AGREEMENT

### INSTRUCTIONS
*Please complete the fields below*

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<th>Name:</th>
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### Where did you hear about the RHS-15?
- In a journal (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:

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<th>Age Range:</th>
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<td>14–21</td>
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<td>21–64</td>
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### Context:
- Refugees
- Asylum seekers
- Validity for Screening
- Comparison to another instrument

### How many refugees do you screen a year?
- 25–50
- 51–100
- 100–200
- 200+

### 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
- Other (please specify):

### Is there other pertinent information about how your organization will utilize the RHS-15?
This document may help you implement the Refugee Health Screening (RHS-15) in your health clinic.

**HOW THE RHS-15 IS INTRODUCED/EXPLAINED TO REFUGEE PATIENTS:**

At the beginning of each health screening visit, the worker should explain what will happen during the visit, including any medical history review, heights and weights, blood draws, immunizations, etc. The health worker should add that the last part of the visit also involves questions about how they are doing both in their body and in their mind. These questions are about sadness, worries, body aches and pain, and other symptoms that some people get that are related to bad experiences, stress at home, or travel to a new country.

It is important that this portion is seen as another part of the overall medical screening.

After immunizations have been administered, the worker hands out the RHS-15, and reminds the family that this is the last part of the visit and tells them that he would like each person (over 14 years of age) to answer the questions.

**RHS-15 INTRODUCTION:** (Suggested Script)

“Some refugees have mind and body symptoms because of the difficult things they have been through, and because it is very stressful to move to a new country. The questions we are asking help us find people who are having a hard time and who might need extra support. Your answers are not shared with employers, USCIS, teachers, etc.”

The healthcare worker reminds everyone that each person will answer the questions by themselves, but that they can ask for help from the interpreter if they cannot read them or find the answers confusing. The healthcare worker explains how to answer the questions (only pick one number for example) and encourages everyone again to ask for help if they need it.

It is hoped that this approach puts the family at ease and normalizes the screening tool as a regular component to their overall health-screening visit.
Clinical Considerations: RHS-15 Referral

TIMING:
Referral for more support is offered directly after the health worker has completed the scoring of the RHS-15. If a patient has screened at or above the cut-off scores as indicated on the RHS-15, we recommend proceeding directly to completing a referral.

REFERRAL OFFER: (Suggested Script)
“From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counselor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?”

IF CLIENT AGREES TO SERVICES: (Suggested Script)
“Can we take a couple of minutes to complete our referral form? I will refer you to an agency and they will be contacting you, is this okay with you. Someone will call you in your language and describe the type of support they can offer you. They will call you in the next few days to give you the appointment date and location of the appointment so you can find out if it is the right service for you.”

NOTES FROM CONVERSATION

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Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The Pathways Project at 206-816-3253 or pathways@lcsnw.org.