

REFUGEE MENTAL HEALTH SCREENING

Patricia Shannon, Ph.D., L.P., Associate Professor
University of Minnesota School of Social Work
James Letts, M.D., Family Practice Physician
Healtheast Roselawn Clinic

Presenter Background



Patricia
Shannon,
Ph.D., L.P.

- Earned Ph.D. in Clinical Psychology at University of Michigan
- Postdoctoral Training on Treatment of Trauma, 1996-98
- Center for Victims of Torture, 1999-2009
- Associate Professor, U. of Minnesota, published on mental health screening and refugee trauma survivors.



James Letts,
M.D.

- Earned M.D. at University of Minnesota
- Residency at United Family Medicine
- Provider in family medicine at HealthEast Roselawn Clinic, 2001 – Present
- Leader in collaborations to improve access and health care for immigrant and refugee communities



Objectives

- Background
 - Why address mental health
 - Development of screening protocol
 - Evidence of trauma and mental health disorders in refugee populations
- The mental health screening component
 - Using the mental health screening questions
 - Conversations about mental health
 - Providing psychoeducation about refugee mental health
- Implementing MH screening in a primary care clinic
- Managing mental health symptoms in primary care
- Case examples



Why address mental health at refugee health screening?

- Impact on patient well-being
- Impact on clinic flow
- Impact on community



Development of MN Screening Protocol

- National context
 - Centers for Disease Control and Prevention “Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees,” 2011¹
- State context
 - MDH and partners seeing impact of unaddressed mental health needs
 - Ongoing discussion and collaboration

MDH Workgroup (2012-2013)

- Multi-disciplinary
 - Health professions, mental health providers, social workers, interpreters
- Multiple sectors
 - Representatives from Minnesota Health Plans, MN Department of Health, voluntary resettlement agencies, clinics, University of MN
- Expertise
 - “Front-line” experience
 - Grounded in research and best practices

MDH Screening Protocol

- Screening protocol developed, 2014
 - Development of 5 questions
 - Designed to be a component of the existing refugee health screening
- See full report from working group at:
<http://www.health.state.mn.us/divs/idepc/refugee/guide/mhguidelines14.pdf>
 - Based on research with Minnesota refugees
 - Informed by working group process
 - Informed by published studies of refugee health

Context of Refugee Mental Health: Exposure to War Trauma and Torture

- Refugees are commonly exposed to traumatic experiences in home countries, in flight, and in refugee camps²
- Refugees are also systematically targeted and tortured³
- United States definition of torture⁴
 - “an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control”



Sample Rates of Torture in Largest Groups

- Historical estimates between 5 and 35%.³

Somali (n=622)	36%	(Jaranson et al., 2004)
Oromo (n=512)	55-69%	(Jaranson et al., 2004)
Karen (n=178)	52%	(Shannon et al., 2014) ⁶
Iraqi (n=497)	56%	(Willard et al., 2013)
Bhutanese (n=810)	51%	(VanOmmeran et al., 2001)

MN Study: Karen Refugee Trauma Exposure

- 179 screened at Roselawn Healthcare, May 2011-2013
 - Lived in refugee camps for 13.47 years ($SD = 5.00$)
 - Lived in the U.S. for 37 days ($SD = 23.26$)
- Torture Prevalence
 - Primary Torture 27%
 - Secondary Torture 51%
- War Trauma
 - Primary War Trauma 86%
 - Secondary 83%

Torture Reported by Primary Survivors⁹

- Forced portering, forced labor, forced to be a soldier, forced to be a landmine sweep
- Beating
- Wounding, maiming or breaking bones
- Immobilization (being bound or tied up)
- Degradation
- Threats, death threats
- Torture as witness
- Forced to bury body of family member who died from torture

War Trauma Experiences

- Destruction/burning of houses, churches, schools, villages
- Destruction/burning of crops, food supply, animals
- Lost property or belongings
- Harassment by authorities
- Forced relocation
- Combat situation
- Extortion or bribery
- Witnessing others killed
- Landmine amputee
- Restricted movement
- Orphaned
- Child soldier recruitment
- Fear of deportation in Thailand



Prevalence of Psychiatric Disorders

- Exposure to trauma does not equal mental health disorders.
- Meta-analysis of 181 surveys of over 80,000 refugees from 40 different countries¹⁰
- Prevalence rates of 30% for PTSD and depression (highly co-morbid)
- Weighted prevalence rate of PTSD, 13% to 25%
- Torture experiences and cumulative exposure to trauma were the strongest factors associated with PTSD



Sample Rates of Refugee PTSD

Somali (n=622)	25%	(Jaranson et al., 2004)
Oromo (n=512)	25%	(Jaranson et al., 2004)
Karen (n=180)	8%	(Shannon et al., 2014)
Iraqi (n=497)	30%	(Willard et al., 2013)
Bhutanese (n=810)	43%	(Van Ommeran et al., 2001)



Sample Rates of Other MH Disorders

- Karen
 - 36% depression
 - 37% somatization symptoms; 20% anxiety (n=70) (Schweitzer, 2011)
 - 12.8% major depressive disorder (n=180) (Shannon et al., 2013)
- Bhutanese
 - 51% somatoform pain disorder
 - 18% dissociative disorder (Van Ommeran, 2001)
 - High rates of suicide (CDC study)
- Iraqi
 - 50% depression (Williard et al., 2013)



CDC-ORR Study, 2012¹²

- 16 suicides in Bhutanese community between 2009-2012
- Post mortem study revealed:
 - Language barriers (77%)
 - Worries about family back home (57%)
 - Separation from family (43%)
 - Difficulty maintaining cultural and religious traditions (43%)
- Community-based cross sectional survey of 423 resettled refugees
 - Anxiety (19%)
 - Depression (21%)
 - Distress (17%)



CDC-ORR Study, 2012¹² (cont.)

- Risk factors included
 - Not being a provider of the family
 - Having low perceived social support
 - Screening positive for anxiety, depression, and distress
 - Increased family conflict after resettlement

Long-term Effects

- While some people improve over time, many serious trauma survivors do not
- One study examined group of Cambodians two decades after resettling¹³
 - Indicated high rates of PTSD (62%) and depression (51%)

Health Effects of Untreated PTSD and Depression¹⁴

- Hypertension
- Coronary vascular disease
- Metabolic syndrome
- Diabetes mellitus
- Chronic pain

Minnesota Research Process

- 13 focus groups, 112 refugees, suggested questions
 - Oromo, Somali, Karen, Bhutanese
- Mental health screening of 257 refugees
 - Included all groups in Hennepin and Ramsey Counties
- Analysis of reliability of translated questions was $>.80$
- Identification of questions answered by all groups
- Validation of screening questions with structured clinical interview for DSM-IV diagnoses: PTSD, MDD with 180 Karen refugees (U of M Physicians Clinic, Bethesda)
- Ongoing research

Common Symptoms Across Focus Groups¹⁵

- Trouble sleeping
- Bad or scary dreams
- Too many thoughts
- Bad memories that come back
- Worry about family and friends back home
- Worry about more loss in the future
- Worry about children
- Feelings of fear from the past are still with me today
- Feeling hopeless about the future
- Losing parts of memory
- Trouble concentrating
- Feeling angry
- Spending time alone, keeping alone
- Trouble eating
- Stomach aches
- Headaches

Mental Health Screening Questions

Final Recommended Screening Questions

1. In the past month, have you had many **bad dreams or nightmares** that remind you of things that happened in your country or refugee camp?
2. In the past month, have you felt **very sad**?
3. In the past month, have you been **thinking too much** about the past even if you did not want to?
4. In the past month, have you **avoided situations that remind you of the past**?
(PROMPT: Do you turn off the radio or TV if the program is disturbing?)
5. Do any of these problems make it **difficult to do what you need to do on a daily basis**?
(PROMPT: Are you able to take care of yourself and your family?)

Response Format and Referral Criteria

- Yes-no response option
 - Functional question replaces scaled score
 - Practical reasons-time
 - Even with translation, it takes about two minutes to administer the mental health screen
- General referral guideline
 - Yes response to two or more questions indicates referral for further assessment
 - Consider question 5, interference with functioning
 - Screeners are not diagnostic
 - False positives versus false negatives

Refugees' Advice on How to Ask¹⁶

- Make refugees comfortable
- Initiate direct questions about mental health in historical context
 - Refugees defer to physician's authority
- Provide psychoeducation
- Use trained interpreters
- Use family as ally
- Interview some children separately

Provide Psychoeducation¹⁷

- Validate traumatic nature of refugee experiences
- Provide education about mental health effects and treatment of trauma
 - Explain that PTSD and depression can be normal response to traumatic experiences
 - Explain the common symptoms of PTSD and depression
 - Explain the potential health effects associated with mental health distress
 - Explain that these conditions are treatable
- Make referral for further mental health assessment
 - Details on how to refer will be covered in an upcoming webinar



Implementing Mental Health Screening in a Primary Care Clinic - Process

- The provider gives context to the questions.
 - “We know many people coming from the refugee camps have been through very difficult things in the past. We ask these questions of all new refugees at our clinic.”
- The screening questions will be translated into 5 most common refugee languages. Interpreters will be provided with the questions in the target language to ensure they are being asked consistently.

Implementing Mental Health Screening in a Primary Care Clinic - Process

- If the patient answers all questions with “No” there is no further evaluation.
 - The document is scanned into the electronic health record.
- If the patient answers “Yes” to one question, a follow-up or clarifying question is usually asked by the provider.
- If a patient answers “Yes” to two or more questions, the screen is considered positive.

Implementing Mental Health Screening in a Primary Care Clinic – Learning Curve

- Prior to implementation, there is a brief training for providers, nurses, medical assistants and interpreters that do refugee screening.
- Process is different and sometimes forgotten at first but it quickly becomes as much a part of the refugee screening as reviewing lab results or updating immunizations.
- Simply by asking the screening questions, patients seem reassured that we understand something about the struggles of the refugee experience.
- Never has a patient seemed offended by the mental health screening process or refused to participate.

Implementing Mental Health Screening in a Primary Care Clinic

- For most patients, little time or complexity is added to the refugee screening visit by the mental health screening.
- For patients that screen positive, the complexity and time demands of the refugee screening visit are increased.
 - However, it is no different than a patient that screens positive for hepatitis B or hypertension.
- Some initial education is done, sometimes treatment is initiated, sometimes referrals are made.
 - Almost always, close primary care follow-up is arranged for.
 - Often, treatment decisions are not made until the follow-up appointment.

Why Screen? A primary care providers' perspective

- If a patient has depression or PTSD, a primary care provider experienced in working with refugees may be the best person to treat that diagnosis.
 - Arranging for follow-up and ongoing care or monitoring at the primary care clinic
 - Prescribing SSRIs
 - Referral to any available psychotherapy, group therapy, community resources
 - Referral to psychiatry when available and accessible
 - Treating insomnia, chemical abuse, other manifestations of these illnesses

Why Screen? A primary care providers' perspective

- As their primary care clinician, we need to know if a refugee has mental health issues.
 - Monitor for worsening at future visits.
 - Complication of management of chronic diseases.
 - Consideration before doing invasive exams such as PAP, rectal exams, etc.
 - Consideration before referring for intimidating procedures and tests such as MRI, colonoscopy, endoscopy, injections.

Why Screen? A primary care providers' perspective

- It needs to be in the problem list and in the EHR.
 - Our partners need to know if a patient they are seeing for the first time has PTSD or depression.
 - Specialists may have very little knowledge of the background and experiences of refugee communities.
 - They do have the medical education that tells them they may need to spend more time explaining before doing to a patient with PTSD on the problem list.

Case Example #1

Managing subclinical/minor symptoms in the primary care clinic setting.

- 27 year old Karen female seen for refugee screening.
 - Two “Yes” answers on the screen.
 - On further evaluation at the screening visit she is determined to have sadness, stress, and isolation issues but no PTSD or depression.
 - The remainder of her refugee health screening is completed.
 - She is counseled on how to follow-up at the clinic if she develops worsening symptoms and routine follow-up is scheduled for 8 weeks.
 - At the 8 week visit, she is adjusting to resettlement very well and feeling less sadness and isolation. She has enrolled in English classes and is living with a cousin and feels hopeful for the future.
 - She is instructed to follow-up as needed and for health maintenance.

Case Example #2 Management of a psychiatric diagnosis in the primary care clinic setting

- 59 year old Karen male in clinic for refugee screening.
 - Answers “Yes” to 3 questions.
 - On further history, he has struggled with depression in the past. He often becomes overwhelmed with anxiety. He has vivid invasive memories of the killing of his son by the Burmese military. He sleeps poorly and has difficulty concentrating.
 - He acknowledges these problems are disruptive to his daily life and would like to discuss treatment options. After a review of his options, he is started on an SSRI. Because of his work schedule, he is not interested in seeing a psychologist. “Probable PTSD” is added to his problem list.
 - His refugee health screen is completed and close follow-up in the clinic in 4 weeks is arranged.

Case Example #3 Acute mental illness as the primary issue during a screening visit.

- 44 year old Karen female in clinic for refugee screening.
 - She answers “Yes” to all of the questions on the mental health screening.
 - On further history, she is feeling very depressed and thinks about dying a lot but has no suicidal intent or plan. She feels hopeless and afraid. Part of her family is still in the camp and she has no idea when she will see them again. She becomes tearful at times. Her sleep and appetite are poor and she has no interest in things she used to enjoy.
 - The other components of the refugee health screen are not done, they are rescheduled for another visit. The remainder of this visit is spent completing an evaluation of her depression and discussing the diagnosis and treatment options with her.
 - She is referred to a Karen women’s group and to a psychologist for therapy. Our clinic care guide is enlisted to enroll her in our healthcare home and help her navigate to the women’s group and psychologist. He also helps her arrange follow-up here in 1 week. He works with the patient and the provider to develop an emergency plan for the patient were she to become suicidal.

References

1. <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html>
2. Adams, K. M. (2004). Healthcare challenges from the developing world: Postimmigration refugee medicine. *British Medical Journal*, 328, 1548–1552.
Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association*, 294, 602–609.
3. Baker, R. (1992). Psychosocial consequences for tortured refugees seeking asylum and refugee status in Europe. In M. Basoglo (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 83–106). Cambridge, UK: Cambridge University Press.
4. 18 U.S.C. § 234, section 2340
5. Jaranson, J. M., Butcher, J., Halcon, L., Johnson, D. R., Robertson, C., Savik, K., & Westermeyer, J. (2004). Somali and Oromo refugees: Correlates of torture and trauma history. *American Journal of Public Health*, 94, 591–598.
6. Shannon, P. J., Cook, T., Vinson, G. A., Wieling, E., & Letts, J. (2014). Torture, War Trauma and Mental Health Symptoms of Newly Arrived Karen Refugees. *Journal of Loss and Trauma*, (just-accepted). DOI:10.1080/15325024.2014.965971
7. Willard, C. L., Rabin, M., & Lawless, M. (2013). The prevalence of torture and associated symptoms in United States Iraqi refugees. *Journal of Immigrant and Minority Health*. Advance Online Publication. Retrieved October 29, 2014. doi:10.1007/s10903-013-9817-5.
8. Van Ommeren, M., de Jong, J. T., Sharma, B., Komproe, I., Thapa, S. B., & Cardena, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry*, 58(5), 475–482.
9. Cook, T. L., Shannon, P. J., Vinson, G. A., Letts, J. P., & Dwee, E. (2015). War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study. *BMC international health and human rights*, 15(1), 8.
10. Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. *Journal of the American Medical Association*, 302(5), 537–549.
11. Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry*, 45(4), 299–307.

References (cont.)

12. Ao, T., Taylor, E., Lankau, E., Sivilli, T. I., Blanton, C., Shetty, S., & Lopes-Cardozo, B. (2012). An Investigation into Suicides among Bhutanese Refugees in the US 2009–2012 Stakeholders Report. *Center for Disease Control and Prevention*.
13. Marshal, G., Schell, T., Elliot, M., Berthold, S., & Chun, C. A. (2005). Mental health of Cambodian refugees two decades after resettlement in the United States. *Journal of the American Medical Association*, 294(5), 571–591.
14. Ahmadi N, et al. Post-traumatic stress disorder, coronary atherosclerosis and mortality. *Am J Card*. 2011;108(1):29–33.
Crosby, S. S. (2013). Primary care management of non–English-speaking refugees who have experienced trauma: a clinical review. *JAMA*, 310(5), 519-528.
Dedert EA, et al. Posttraumatic stress disorder, cardiovascular, and metabolic disease: a review of the evidence. *Ann Behav Med*. 2010;39(1):61–78.
Kibler JL, et al. Hypertension in relation to posttraumatic stress disorder and depression in the US national comorbidity survey. *Behav Med*. 2009;34(4):125–32.
Willard, C. L., Rabin, M., & Lawless, M. (2014). The prevalence of torture and associated symptoms in United States Iraqi refugees. *Journal of Immigrant and Minority Health*, 16(6), 1069-1076.
15. Shannon, P. J., Wieling, E., McCleary, J. S., & Becher, E. (2014). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative health research*, 1049732314549475.
16. Shannon, P. J. (2014). Refugees' advice to physicians: how to ask about mental health. *Family practice*, cmu017.
Shannon, P., O'Dougherty, M., & Mehta, E. (2012). Refugees' perspectives on barriers to communication about trauma histories in primary care. *Mental health in family medicine*, 9(1), 47.
17. Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (Eds.). (2008). *Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies*. Guilford Press.