

# **Mental Health Screening Recommendations for Newly Arrived Refugees in Minnesota**

Final Report

Prepared by Minnesota Department of Health Refugee Health Program

**April 15, 2014**

For more information contact:  
Refugee Health Program  
Minnesota Department of Health  
625 Robert St. N.  
P. O. Box 64975  
St. Paul, MN 55164-0975

Phone: 651-201-5414  
[www.health.state.mn/refugee](http://www.health.state.mn/refugee)



*Protecting, maintaining and improving the health of all Minnesotans*

---

## Table of Contents

---

Acknowledgments.....	3
Working Group Members.....	3
Executive Summary.....	5
Background.....	7
Four Initial Guiding Recommendations.....	8
Final Recommended Screening Questions.....	16
Bibliography.....	17

---

## Acknowledgments

---

The Minnesota Department of Health Refugee Health Program convened a working group of health care professionals to develop the Mental Health Screening Recommendations for Refugees in Minnesota. We wish to extend our gratitude to the following individuals for their constant engagement, suggestions, feedback, and edits. Special acknowledgments to Susan Dicker and Ann O’Fallon for leading the working group, and to Greg Vinson and Patricia Shannon for sharing their findings from the *Minnesota Screeners Project* and providing extensive technical consultation on validating mental health screening instruments throughout the year-long project.

### Working Group Members

**Jocelyn Ancheta**

Blue Cross Blue Shield of Minnesota

**Carol Berg**

UCare

**Mary Bradmiller, PhD**

Hennepin County Medical Center Medicine Clinic

**Rob Carlson, PA**

HealthPartners Center for International Health

**Anna Carpenter**

University of Minnesota, School of Social Work  
Graduate student

**Tonya Cook**

University of Minnesota, School of Social Work  
Graduate student

**Malini Desilva, MD**

University of Minnesota, Department of Medicine and  
Pediatrics

**Susan Dicker, MS, MPH**

Minnesota Department of Health  
Refugee Health Program

**Eh Taw Dwe**

St. Paul-Ramsey County Department of Public Health

**Bruce Field, MD**

HealthPartners Center for International Health

**Marge Higgins, LSW**

Minnesota Department of Health  
Refugee Health Program

**Neal Holtan, MD**

St. Paul-Ramsey County Department of Public Health

**Nancy Houlton, LICSW**

Behavioral Health, UCare Minnesota

**Sue Johnston, MSW, LICSW**

Private Counselor, Consultant

**Georgi Kroupin, MA, LP**

HealthPartners Center for International Health

**Richard Lee, PhD, LP**

University of Minnesota, Department of Psychology

**Ev Lennon, MA, MSW**

The Center for Victims of Torture

**Jim Letts, MD**

HealthEast Roselawn Clinic

**Karen Lloyd, PhD, LP**

Behavioral Health, HealthPartners

**Blain Mamo, MPH**

Minnesota Department of Health  
Refugee Health Program

**Christine May, CNP**

Hennepin County Public Health Clinic

**Steven Miles, MD**

University of Minnesota, Department of Medicine,  
Center for Bioethics

**Jeanne Nelson, MSN, PHN**

Olmsted County Public Health Services

**Andrea Northwood, PhD, LP**

The Center for Victims of Torture

**Ann O’Fallon, RN, MA, LP**

Consultant

**Doug Pryce, MD**  
Hennepin County Medical Center  
Internal Medicine Clinic and International Clinic

**Cheryl Robertson, PhD, MPH, RN, FAAN**  
University of Minnesota, School of Nursing

**Ann Settgest, MD, DTM&H**  
HealthPartners Center for International Health

**Marjorie Sigel, MSW, LICSW**  
Jewish Family Service

**Patricia Shannon, PhD, LP**  
University of Minnesota, School of Social Work

**Chhabi Sharma, MD**  
HealthPartners Center for International Health

**Shana Sniffen, MD**  
HealthEast Roselawn Clinic

**Bill Stauffer, MD, MSPH, DTM&H**  
University of Minnesota/ Division of Infectious  
Disease & International Medicine,  
Departments of Medicine & Pediatrics, HealthPartners  
Center for International Health

**Carol Stauffer, LICSW, MPH**  
St. Paul Public Schools  
HealthPartners Center for International Health

**Sally Trippel, MD**  
Olmsted County Public Health Services, Mayo Clinic

**Dean Tsukayama, MD**  
Hennepin County Medical Center  
Infectious Diseases Clinics

**Greg Vinson, PhD**  
The Center for Victims of Torture

**Lori Wald, RN**  
St. Paul-Ramsey County Department of Public Health,  
Refugee Health Program

**Patricia Walker, MD, DTM&H**  
University of Minnesota / Division of Infectious  
Disease & International Medicine, Department of  
Medicine, HealthPartners Center for International  
Health

**Quanah Walker, MSW, LICSW**  
HealthPartners / Behavioral Health

**Mike Westerhaus**  
HealthPartners Center for International Health

**Elizabeth Wieling, PhD, LMFT**  
University of Minnesota, College of Education &  
Human Development

**Cary Zahrbock, MSW, LICSW**  
Medica Behavioral Health

# Mental Health Screening Recommendations for Newly Arrived Refugees in Minnesota

---

## Executive Summary

---

The Minnesota Department of Health (MDH) Refugee Health Program (RHP) convened an expert mental health working group between September 2012 and September 2013 to advise the state on developing a mental health screening process for newly arrived refugees. Group members included experts in refugee mental health, refugee screening clinicians, policy makers, and other professionals in the field of international health.

At the time the working group was convened, the Minnesota Refugee Health Screening Protocol included brief and general guidance for assessing signs of post-traumatic stress and acute psychiatric disorders. In March 2011, the Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine released guidelines recommending mental health screening during the domestic medical examination in order to identify and triage refugees in need of mental health treatment. Based upon this recommendation, the RHP sought expert advice on how to incorporate this guidance within Minnesota.

The RHP asked the working group to recommend tools that could be used to identify individuals with chronic, serious, or acute mental illness to refer them for immediate psychiatric evaluation and treatment. The working group was also asked to identify individuals with mental illness who are not an immediate danger to themselves or others and are not gravely disabled by their illness, but whose ability to function is impaired, requiring appropriate referral to mental health specialists. If no such tool currently exists, the working group was asked to make recommendations for a new tool.

The working group met three times to evaluate current screening tools, develop common assumptions, and make recommendations. The group agreed that a new screening tool must be developed with a focus on identifying those refugees whose ability to function was impaired. A subset of the group held a fourth meeting to finalize the questions to be included in the mental health screening.

The working group recommended that the RHP undertake a pilot project with a select number of screening clinics across the state. Each participating clinic will incorporate the recommended mental health screening tool as part of the existing refugee screening process. These clinics will receive training prior to initiating the new protocol and on-going support for the duration of the pilot program. The RHP will address concerns and make modifications during the pilot project. Following the pilot phase, the mental health screening will be implemented for all refugee arrivals to Minnesota.

A series of five structured yes/no questions were recommended by the working group. The questions are largely based upon research completed by the Minnesota Center for Victims of Torture (CVT) and the

School of Social Work at the University of Minnesota (UMN). The *Minnesota Screeners Project*\* interviewed over 250 newly arrived refugees and screened them for mental health concerns. The questions most valid for tracking post-traumatic stress disorder (PTSD) and depression across cultures were selected for the pilot. All clinics participating in the pilot will report the responses to MDH and also document any referrals made.

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

---

\* The *Minnesota Screeners Project* was undertaken by the Minnesota Center for Victims of Torture and the School of Social Work at the University of Minnesota (May 2011- May 2013). A long questionnaire with 28 items, reflective of common mental and physical health concepts in various refugee populations, was developed to identify symptoms of PTSD and depression allowing for an appropriate referral. The tool was administered to 257 newly arrived adult refugees during their initial health assessment; participants provided responses using a four-point Likert scale. The goal of this effort was to identify unique questions that function similarly across groups and also lend themselves to a reliable score. Analysis of the data indicated that there are four questions among the 28 were “decently reliable” for both Karen and Somali refugees.

---

## Background

---

The working group was convened to review existing recommended guidelines to generate Minnesota's mental health screening protocol. Reviewed guidelines and tools included:

- Minnesota's current recommended guidelines for mental health screening, which were found to be very brief and too general.
- Recommendations from the CDC to include mental health screening during the domestic medical examination (March 2011):  
[www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html](http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html).
- Emerging mental health screening tools for diverse populations, including the RHS-15.

The charge of the working group was to evaluate and make recommendations to:

- Address mental health concerns during the initial refugee health screening, within the first 90 days after arrival.
- Improve the identification and referral of new arrivals who have mental health needs\*.
  - \* *Mental health needs are described as any mental health issues interfering or likely to interfere with the refugee's ability to engage in necessary activities of adjustment and resettlement.*
- Include existing validated screening tools that would be appropriate for in-state recommendations.

The working group agreed upon certain assumptions as the basis for considering recommendations:

- Mental health needs can impede new refugee arrivals' ability to successfully engage in necessary resettlement tasks.
- Mental health is an important health concern and should be integrated in the initial refugee health assessment to ensure that providers consistently address this area of health.
- The initial refugee health screening presents an ideal opportunity to address mental health needs and this timing is consistent with CDC guidelines for mental health screening of refugees.
  - *The initial refugee health screening is typically completed within 90 days of arrival to Minnesota.*
  - *Minnesota's yearly health screening rate is between 97-99 percent among eligible refugees.*
- A validated refugee mental health screening tool that meets the criteria of "gold standard" for this work does not currently exist.
  - *Development of a screening tool requires comparing results to a determined diagnosis using rigorous methodology such as structured clinical interviews like the Structured Clinical Interview for DSM Disorders (SCID), Child/Adolescent Psychiatry Screen (CAPS), etc., rather than diagnostic proxies.<sup>1</sup>*
  - *Need to assess the strengths and limitations of existing screening tools (e.g., RHS-15) for use in Minnesota.*
- Newly arrived refugees are eligible to receive mental health services through their state health insurance plan. However, significant barriers may prevent meaningful access to care. These

---

<sup>1</sup> Vinson, Greg, Shannon, Patricia. "Refugee Mental Health Screening: Research Progress in MN." PowerPoint presentation. Minnesota Department of Health, Mental Health Working Group, St. Paul, MN. 25 Sept 2012.

barriers include system barriers, scarcity of clinicians and staff trained in cultural competence, waits of weeks or months for mental health appointments, cultural stigma, and a lack of appropriate assistance for refugees to access these resources. The logistics of navigating unfamiliar transportation and health care systems and limited understanding of the western model of mental health services are complicating factors.

- Time constraints are a valid concern within the context of the initial refugee health assessment.

---

## Four Initial Guiding Recommendations

---

Within the first several meetings, the working group endorsed four recommendations. Significant discussion points are included to clarify the thinking of the group.

<b>First Recommendation</b>	
<b>Endorse the general points of the CDC Guidelines for the U.S. Domestic Medical Examination for Newly Arriving Refugees to include a mental health screening as part of the initial health assessment.</b>	
Rationale	<p>“Studies have shown a high prevalence of depression, post-traumatic stress disorder (PTSD), panic attacks, and somatization, and traumatic brain injuries in refugees.<sup>1-10</sup> Depression and PTSD are prevalent in refugees who are not in clinical care for mental health, in addition to those identified for mental health interventions.<sup>5, 7-14,”</sup></p> <p>(<a href="http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html">www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html</a>)</p>
	<p>Mental health is an important health concern and should be specifically integrated as part of the initial refugee health assessment to assure providers consistently address this area of health. Minnesota’s recommended state screening guidelines (<a href="http://www.health.state.mn.us/divs/idepc/refugee/assesfrm.pdf">www.health.state.mn.us/divs/idepc/refugee/assesfrm.pdf</a>) provide a consistent framework for assessing and reporting back on health conditions of significance.</p>

<b>Second Recommendation</b>	
<b>Expand state screening guidance to include three to four* mental health screening questions to be used as a basis for referral for a formal and comprehensive mental health assessment.</b>	
Rationale	Time constraints were one of the most cited reasons for not incorporating the mental health assessment into the existing screening process. Keeping the mental health screening tool brief addresses this need for time conservation. The lack of a culturally validated screening tool was also mentioned as a barrier for completing the mental health assessment. A triage model, with limited and targeted screening questions, would allow providers flexibility to conduct a limited or more extensive assessment as needed.
	The RHP will keep abreast of progress in the area of culturally validated screening tools for newly arrived refugees. MDH does not endorse a specific, existing mental health screening tool for the purposes of the initial refugee health assessment at this point.
	The capacity to implement a mental health screening assessment will vary by clinic setting. Factors include the availability of mental health resources within the clinic as well as the clinic's capacity to follow up on referrals after screening: <ul style="list-style-type: none"> <li>• <i>Primary care screening site:</i> A refugee may continue care at this site or go elsewhere. Follow up on referrals is a challenge.</li> <li>• <i>Public health clinic setting:</i> These settings offer only screening services; all other care is referred out. Follow up on referrals is a challenge.</li> </ul>

\*The working group initially suggested three to four questions; upon further discussion, the workgroup agreed on five screening questions.

Given the context for a mental health screening in a clinic setting, the screening tool must be both effective and efficient. It must maximize the limited time and resources of both the provider and the refugee patient. The screening tool is used as a quick way to help allocate resources for those who need them most. Once the screening has been administered, refugees with a high level of distress or a low ability to function can be referred for further assessment and treatment. It should be noted that this screening tool is not diagnostic for mental illness and it is not a tool for ascertaining a history of torture. Essential criteria for the mental health screening tool are listed in the table below.

<b>Mental health screening tool should be valid</b>
It should <i>measure subjective perception</i> of: <ul style="list-style-type: none"> <li>• Emotional distress</li> <li>• Ability to function</li> </ul>
<b>Mental health screening tool should be short</b>
<ul style="list-style-type: none"> <li>• Short measures can be reasonably valid</li> </ul>

<b>Mental health screening tool should be worded in lay language</b>
<ul style="list-style-type: none"> <li>• Use of psychiatric jargon (e.g., depression) is confusing</li> <li>• Psychiatric labels may be stigmatizing</li> <li>• Use of lay concepts or symptoms normalizes patient experience</li> <li>• Simple wording reflects patient’s experience</li> <li>• Easy language helps the patient understand the condition or purpose for referral of future mental health evaluation or treatment</li> <li>• Simple wording elicits more emotions</li> </ul>
<b>Mental health screening tool should be administered by a physician, nurse practitioner, or physician assistant</b>
<ul style="list-style-type: none"> <li>• Do not defer this part of the screening to another physician, continuity of care is critical</li> <li>• Somatic symptoms will be evaluated for physical and mental health sources</li> <li>• Physician’s clinical impression will supplement the findings of the screening</li> </ul>
<b>Mental health screening tool should elicit “yes” or “no” answers</b>
<ul style="list-style-type: none"> <li>• Use of scales is often confusing, requires explanation and training for patients</li> <li>• Disadvantage is getting only four discrete values across four question items, likely increasing errors</li> </ul>
<b>Mental health screening tool should involve patient’s subjective assessment</b>
<ul style="list-style-type: none"> <li>• Moves conversation into patient’s self-assessment Elicits patient’s motivation</li> <li>• Engages the person to ease the referral process and further mental evaluation or treatment</li> </ul>

### Limitations of a Brief Screening Tool

Validity and reliability are important features of a screening tool; in addition, it is affected by cut-scores and base rate (prevalence) of the health condition. Brief screening tools have some propensity toward false positives and false negatives and are often less reliable and valid than a longer tool. (*False positives: people selected for further assessment without the condition. False negatives: people not selected for further assessment but who actually do have the condition*). While longer screening measures have the stated advantages, they are impractical for refugee health screening sites in Minnesota.

Less valid measures will result in a screening tool that makes more errors (i.e., more false positives and negatives). In work with refugees, the validity of a measure is often judged simply by whether items or a set of items look effective or seem to make sense to providers. This is known as face validity by those in the measurement field (Crocker and Algina, 2006). While it is likely helpful for items to appear relevant to those using a measure (and this is the starting point for measure development), face validity has been

known for decades to have many shortcomings (Cronbach and Meehl, 1955; Mosier, 1947). Many professionals do not include it as a type of validity at all (McDonald, 1999). While the technical aspects of measure development are beyond the scope of this document, it is worth noting that a technical process, with a set of procedures involving systematic data and evidence collection exists to inform the development of a screening instrument.

When working with new populations or differing cultures, it is especially pertinent to consider how existing measures or question items may be working in “today’s situation” even if they had worked well in a different setting, or in the past. With a new population, the same measures or question items can function differently for that group, introducing errors into the measure’s use (i.e., screening decisions) as well as introducing biases against some populations (Heppner, Wampold, and Kivlighan, 2008). For example, at the CVT in Minneapolis, data from an earlier mental health screening effort revealed that a subset of typical mental health screening questions would be biased against some refugee populations. Based upon this finding, for subsequent screening recommendations, CVT adjusted the screening effort accordingly and included only those questions that did not have this bias in any screening recommendations (Vinson and Shannon, 2012). At a minimum, it is imperative to get the demographic information and item-level information for those screened at the test sites. This way, within practical constraints of the testing, those items can be examined in keeping with professional measurement practices to ensure valid and fair screenings.

### **Focus on Functionality**

The working group felt strongly that the screening questions should focus on ‘functionality’ as the basis for referral for a formal mental health assessment. Functionality, in this context, is defined as the ability of a newly arrived refugee to engage in necessary resettlement tasks during the initial 90-day resettlement period. During working group discussions, there was debate about whether to ask directly about torture and trauma, with the final recommendation not to include these items in a short mental health screening tool. To focus on functionality, the working group recommended:

- a. Using a maximum of three questions to address functionality to keep the process brief and allow for follow up with appropriate referrals. These questions will help identify “red flags” concerning the patient’s ability to engage in daily life and the necessary tasks of resettlement now or in the immediate future.
- b. Including three core areas of inquiry related to functionality: avoidance, nightmares/lack of sleep, and “thinking too much.”

<b>Avoidance (avoiding social contact/isolating)</b>	
	<i>Can you tell me what you have done in the last 3 weeks? Can you tell me what kinds of things you did?</i>
	<p>If prompting is needed:</p> <ul style="list-style-type: none"> <li>• <i>Have you left your apartment in order to do anything?</i></li> <li>• <i>Have you gone to appointments with your resettlement (VOLAG) case manager?</i></li> <li>• <i>Have you been over to a relative's apartment?</i></li> <li>• <i>Have you tried taking the bus to go on errands?</i></li> </ul>
<b>Nightmares/lack of sleep</b>	
	<ul style="list-style-type: none"> <li>• <i>Have you had trouble sleeping?</i></li> <li>• <i>Have you had bad or scary dreams?</i></li> </ul>
<b>“Thinking too much”</b>	
	<ul style="list-style-type: none"> <li>• <i>Have you been thinking too much about the past, even if you did not want to, or about other things that worry you?</i></li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>• <i>Have you been thinking too much about the things that happened in the village or camp, even if you did not want to?</i></li> </ul>

### **Important Caveats and Considerations for Providers**

The working group proposed an additional question for consideration: ***why did you leave your country?*** The rationale for including this question is that it allows the patient to give a context in which to answer the three questions related to functionality. The question allows the patient to provide as much or as little detail and context as they want, if he or she so chooses. This may be very powerful in building trust between provider and patient. In the experience of the *Minnesota Screeners Project\**, this question was important; feedback from refugees indicated that refugees do not just want to answer questions without talking about context—they want to talk about their experiences to explain their current situation. However, the recommendation at this point is to discourage asking the “Why did you leave your country” question during the mental health screening process. Providers may choose to ask this question as a part of the overall documentation of the person’s past history.

- a. It is unclear how the response to “why did you leave your country?” would get factored into a decision for further assessment or referral. Inconsistent utilization is undesirable during screenings. Since it does not elicit a yes/no answer, it is also unclear how the response to this open-ended question will be scored. This may result in assumptions and bias, which may increase referrals for people who do not need them. In essence, if the answer seems of significant concern to the provider, which depends on the provider’s familiarity with refugee populations, a referral will be made. It is a safe assumption that many refugees have negative experiences but are functioning within normal limits. If we care most about functioning, the most direct questions

about those issues would work better than extrapolating from experiences that may or may not be related to mental health issues.

- b. If this question is used and the patient reveals traumatic experiences, the clinician must be prepared to listen and support the patient. There were different perspectives on whether or not to include this question because of its open-ended nature and the potential time conflict to offer attentive listening. There was some discussion about whether this question will reveal torture and trauma.
- c. There was also discussion on where and when this question might be asked in the context of the initial health assessment. For instance, perhaps the question could be incorporated as part of the initial set of questions while reviewing past medical history, or as part of a cluster of questions about avoidance, sleep, and “thinking too much.” Experienced interviewers said patients are confused if the question is asked later in an interview as this question sets the stage for everything that follows.
- d. This document acknowledges that refugees may strongly prefer (and be more comfortable) telling their story of leaving their homeland and expressing their experience in more detail. Some refugees may consider being asked many pointed questions by a stranger as rude and rather incomprehensible. The recommended screening tool offers a compromise for this while capturing the information needed to generate a mental health referral. Ideally, the refugee will have the opportunity for full expression at the mental health referral site and, over time, with the medical provider offering long term care.

<b>Third Recommendation</b>	
<b>Expand MDH RHP’s guidance to screening providers:</b>	
<ul style="list-style-type: none"> <li>• <b>Include training options for referral to mental health resources and services.</b></li> <li>• <b>Strengthen linkage to available mental health resources.</b></li> </ul>	
<b>Rationale</b>	While mental health resources are available to newly-arrived refugees in Minnesota, significant barriers exist. Refugee health screening providers could benefit from training to perform reliable screenings. A listing of recommended available mental health services and resources in their community would also help facilitate effective referrals.

Training will be provided for medical providers at participating pilot clinics. Training will also be available to clinicians at mental health agencies who agree to receive referrals from pilot site clinics. Professionals experienced in screening newly-arrived refugees for mental health issues will provide the trainings.

**General Guidance for Training:**

- Only ask identified questions.
  - Additional questions can be discussed, but only utilized at provider’s discretion.
  - Open-ended questions are discouraged.

- Ask about how patient came to this country only if willing to listen to the answer. Optimal for primary care settings, where personal relationships can be established between clinician and patient.
- Training content will include:
  - Discussion of validation process done at CVT/UMN.
  - How to ask the questions, as well as discussion of provider discomfort in asking these questions.
  - Prompts for each screening question to be used as needed.
  - Tips on basic psycho-education, which should be done if a referral is indicated.
  - Tips for working with an interpreter (if indicated).
  - Techniques for opening and closing a potentially vulnerable conversation in a respectful and timely manner.
  - Review of PTSD/depression symptoms to enhance identifying these in answers to screening questions.
  - Discussion of unique issues of screening only or primary care settings.
  - Best practices in refugee mental health interventions for medical and mental health providers.

On-going support and evaluation will be available to all clinics over the pilot period. This may take the form of a facilitated discussion or discussion forum among engaged providers. Limited one-on-one consultation will also be available throughout the pilot period.

#### **Additional Elements for Training:**

- Develop interpreter training in mental health and cultural competence, which is equally as important as training for health care providers. Acknowledge the challenge of various dialects, inter-generational translation, and language variations by age groups.
- Explore the challenges in asking about substance abuse and domestic abuse.
- Explore strategies to address/diminish the stigma attached to mental health and substance abuse.
- Discuss with providers and interpreters the potential for fears of deportation if mental health issues are revealed.
- Consider a “forum for discussion” regarding the mental health screening instead of, or as a compliment to, formal training. It could be done via an Internet forum or webinars and be held quarterly or semi-annually.
- Work collaboratively with the health plans so they can assist with matching mental health providers based upon their expertise and experience working with refugees.
- Find culturally appropriate programs or explore strategies for successful chemical dependency referrals; it can be challenging to implement due to limited service providers.

The MDH RHP will work with each participating pilot clinic site to identify options for mental health referrals; these sites will be engaged to actively ensure referral and track the final outcome. The sites may be internal within a health system or external in the greater community. Clinics will utilize systems currently in place to initiate the referral.

In the pilot, mental health service agencies will be identified and established as an appropriate referral source. A protocol for referral between the clinic and the mental health service provider will be



---

## Final Recommended Screening Questions

---

Taking into account all discussion and concerns, five questions are recommended for inclusion in the MDH RHP pilot project. It is recommended that all questions be asked to generate a “yes/no” response. The responses to each question will be recorded on the MDH Initial Refugee Health Assessment form. The form will also reflect whether a referral was made for follow-up mental health/social services.

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

### Rationale

Limiting the number of questions included in the Minnesota Health Assessment process is a practical approach as the entire screening is time consuming and is done in a busy clinical setting. At minimum, these five questions increase the sensitivity of the mental health screening tool without compromising provider time and compliance concerns. Asking “yes/no” questions also makes administration of the screening easier.

---

## Bibliography

---

### Mental Health Screening Process

- Crosby, S. (2013) Primary care management of non-English-speaking refugees who have experienced trauma: A clinical review. *Journal of the American Medical Association*, 310(5): 519-528. doi: 10.1001/jama.2013.8788
- Centers for Disease Control. (2012). Guidelines for mental health screening during the domestic medical examination for newly arrived refugees. Retrieved March 24, 2014 from <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html>.
- Miles, S., & Garcia-Peltoniemi, R. (2012). Torture survivors: What to ask, how to document. *Journal of Family Practice*, 61(4), E1-4.
- Eisenman D.P., Keller A.S., & Kim, G. (2000) Survivors of torture in a general medical setting: How often have patients been tortured, and how often is it missed? *Western Journal of Medicine*, 172(5), 301-4.
- Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health*, 34(6), 529-536.

### Screening Tools

- Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E., Woldehaimanot, T., Yamazaki, J., & SooHoo, J. (2013). The Refugee Health Screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General Hospital Psychiatry*, 35(2), 202-209.
- Lee, V., Wong, T., & Lau, C. (2006). Three-item screening tool for geriatric depression. *Hong Kong Journal of Emergency Medicine*, 13(1), 17-23.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care*, 41(11), 1284-1292.
- Mollica, R., Caspi-Yavin, Y., Bollini, P., Truong, R., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous & Mental Disease*, 180(2), 11-16.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees. *Journal of the American Medical Association*, 288(5), 611-621.
- Westermeyer, J., Campbell, R., Lien, R., Spring, M., Johnson, D., Butcher, J., ... Jaranson, J. M. (2010). HADStress: A somatic symptom screen for posttraumatic stress among Somali refugees. *Psychiatric Services*, 61(11), 1132-1137.

### Screening Tool Validity

- Cronbach, L., & Meehl, P. (1955). Construct validity in psychological tests. *Psychological Bulletin*, 52, 281-302.
- Crocker, L., & Algina, J. (2006). *Introduction into classical and modern test theory*. Belmont, CA: Wadsworth Publishing.
- Heppner, P., Wampold, B., & Kivlighan. (2008). *Research design in counseling*. Belmont, CA:

Thomson Brooks/Cole.

McDonald, R. (1999). *Test theory: A unified treatment*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Mosier, C. (1947). A critical examination of the concept of face validity. *Educational and Psychological Measurement*, 7, 191-205.

## Understanding Refugee Mental Health

Refugee Health Technical Assistance Center. (n.d.). *Mental Health*. Retrieved from <http://refugeehealthta.org/physical-mental-health/mental-health>.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, 365(9467), 1309-1314.

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, 70(1), 7-16.

Porter, M., & Haslam, N. (2009). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *Journal of the American Medical Association*, 294(5), 602-612.

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.

## Special Populations

### *Iraqi Refugees*

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*, 1-8.

### *Somali and Oromo Refugees*

Carroll, J. K. (2004). Murug, Waali, and Gini: Expressions of distress in refugees from Somalia. *Primary Care Companion to the Journal of Clinical Psychiatry*, 6(3), 119.

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(4), 591.

### *Nepali Bhutanese Refugees*

Kohrt, B.A., & Hruschka, D. J. (2010). Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine, and Psychiatry*, 34(2), 322-352.

Schininà, G., Sharma, S., Gorbacheva, O., & Mishra, A. K. (2012). Who am I? Assessment of psychosocial needs and suicide risk factors among Bhutanese refugees in Nepal and after third country resettlement. *International Organization for Migration*. Retrieved from [www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Mental-Health-Assessment-Nepal\\_Final\\_11March.pdf](http://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Mental-Health-Assessment-Nepal_Final_11March.pdf).

- Thapa, S. B., Van Ommeren, M., Sharma, B., de Jong, J. T., & Hauff, E. (2003). Psychiatric disability among tortured Bhutanese refugees in Nepal. *American Journal of Psychiatry*, *160*(11), 2032-2037.
- Tol, W. A., Kohrt, B. A., Jordans, M. J., Thapa, S. B., Pettigrew, J., Upadhaya, N., & de Jong, J. T. (2010). Political violence and mental health: A multi-disciplinary review of the literature on Nepal. *Social Science & Medicine*, *70*(1), 35-44.
- Van Ommeren, M., Sharma, B., Sharma, G. K., Komproe, I., Cardena, E., & de Jong, J. T. (2002). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress*, *15*(5), 415-421.

### ***Karen/Burmese Refugees***

- 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.