Mental Health Screening and Barriers to Care of Refugees in the Triangle Area of North Carolina: a Community Survey & Program Intervention Approach

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Abstract
Numerous studies have found a high prevalence of psychopathology in refugees. This vulnerable population faces a unique trifold of stressors from the climate in their country of origin, the migration to their country of asylum and adaption to their new environment (Birma et al., 2005). Without strong coping strategies or the presence of mental health interventions, these stressful and traumatic situations often manifest into severe mental illnesses (Duckworth & Shelton, 2012). Though we have become increasingly aware of the presence of mental health illnesses in refugees, communities still face a variety of barriers in being able to offer their services to this unique population. This paper will serve to examine the history of the presence of refugee populations in North Carolina, barriers to mental health screening throughout the relocation process, as well as barriers to mental health care access in refugees and the methods in which trauma can impact an individual from a behavioral and physiological approach. The community-based survey will assist as an analysis of trends in mental health illnesses among various cultural populations of refugees living in the triangle area of North Carolina. This analysis will guide suggestions for mental health screening implementations, which will hopefully lead to increased resources and services intended to aid refugee mental health access. The aim of this paper is to provide research that will better serve the distinctive mental health needs of refugees in the triangle and function as a model for other communities to replicate.
History of North Carolina Refugee Populations

For the majority of North Carolina’s history, the yearly net emigration was substantially higher than immigration. Looking back in the early 1800’s with hundreds of thousands of European Americans exiting to the late 1800s with the departure of over 380,000 African Americans to as recent as the 1970’s when 94,000 people emigrated. A huge change occurred between 1980-1990 when the state saw its first immigration of 374,354 people (Stuart & Baum, 2005). With this growing change of immigration, appear a number of statuses under which these individuals and families arrive; this particular paper is most concerned with the refugee status. The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as a person who has fled their country due to persecution, violence or war. The refugee must have a rational fear associated with persecution for membership in a specific social group, nationality, political opinion, race or religion. Most refugees are afraid to return to their home country or cannot for the aforementioned reasons. Currently, the primary reasons for refugees fleeing their home country are associated with ethnic and tribal, religious and war violence (UNHRC, 2012).

Yearly, the United States has seen trends in the sub-groups of refugees arriving owing to the worldwide political climate and our own nation’s involvement. Some past examples of migration movements include South Vietnamese fleeing after America withdrew from the Vietnam War in 1975, the arrival of Cambodians in the USA during the Khmer Rouge and Cubans seeking refugee status in the 1960’s leaving behind the socialist revolution (Stuart & Baum, 2005). These trends and the number of refugee arrivals are greatly influenced by the United States Congress and the amended Immigration and Nationality Act under Section 207 (8 U.S.C. 1157). During each fiscal year, the President releases a quota of refugees that will be authorized for admissions to the United States. At the commencement of the 2012 Fiscal Year, 76,000 Refugees were authorized for admittance with the following regional break down of the overall total: 12,000 Africa, 18,000 East Asia, 2,000 Europe and Central Asia, 5,500 Latin America/Caribbean, 35,500 Near East/South Asia, and 3,000 Unallocated Reserve (Federal Register, 2011).

For the United States 2011 Fiscal Year, North Carolina had the 10th largest grand total of refugees accepted for resettlement, up from 12th largest in 2010 (see Appendix A). Among the grand total, the largest sub-groups included Burma (916 persons), Bhutan (569), Iraq (128), Eritrea (123), and Somalia (90) (US Department of Health & Human Services, 2012) (see Appendix B). Refugees are resettled within states based on the availability of a refugee resettlement organization. In North Carolina, these organizations can be found in Charlotte, Durham, Greensboro, High Point, New Bern and Raleigh (Refugee Works, 2012). With Raleigh and Durham being only 25 miles away from one another and having many surrounding communities connecting them, the Triangle area (the Piedmont area of Durham, Raleigh and Chapel Hill) is placed in a unique position to collaborate with a vast majority of refugees being resettled in North Carolina.

As increasing numbers of refugees resettle in North Carolina, we have become progressively more aware of their wide range of health needs. One area within health that has seen a lack of resources and programs is mental health of refugees, particularly children, who tend to be the most vulnerable.
Barriers to Mental Health Access

Researchers indicate up to 40% of refugees have an unmet need of mental health care services for psychiatric disorders in the United States (Ehntholt & Yule, 2006). There are a number of obstacles for refugees, resettlement agencies and other community organizations that work with refugees in offering and utilizing mental health services. The most common among these obstacles include transportation, interpreter services, health knowledge and cultural competency (Chang-Muy & Congress, 2009).

Arriving in North Carolina, refugees can face many impediments with navigating our transportation system. For those who walk or use non-motor vehicle forms of transportation, housing complexes are often too far to access their health care needs. Public transportation can frequently be difficult to navigate when stops are far from housing complexes, additional language barriers persist to comprehending routes and schedules, bus routes that require multiple switches and/or lack of available buses to a health care provider (Bridging Refugee Youth, 2006). Further barriers are inherent for those who seek to pass the North Carolina Drivers License test. As previously mentioned, the highest numbers of refugees in North Carolina come from Burma and Bhutan with most speaking Burmese, Karen, Chin, Dzongkha or Nepali. The North Carolina drivers permit test accommodates a number of languages, however these are limited to: English, Spanish, Chinese, Japanese, Russian, German, Korean, Arabic and Vietnamese (NC DMV, 2009). Refugees may be able to access an interpreter during these transportation circumstances, but even then challenges continue. The interpreter challenges will be discussed in regard to mental health services.

Federal Law under Title VI of the 1964 Civil Rights Act requires hospitals to provide interpreters for patients, including any mental health providers who bill Medicaid. There are however no federal standards governing mental health interpreters. Without the presence of certified interpreters, mental health professionals run the risk of miscommunication. Unqualified interpreters create further dangers for refugees and their mental health access; examples of these dangers include omitting vital information, blurring ethical lines when family members or friends stand in as an interpreter or individuals who are not highly fluent or culturally competent in the refugee’s native language or culture (Chen et al., 2007).

Adding to the possible lack of cultural proficiency of interpreters, many health care professionals have not been trained in cultural proficiency. More than just understanding the client’s language, the clinician must understand the perspective of how the client views and values their own culture and how this culture guides their behavior. Understanding the culture of a refugee can allow a clinician to examine their mental health beliefs, influences upon their health and practices and what interventions will produce successful outcomes. Cultural proficiency can further allow an understanding of what interrupts the effective utilization of health care services (Chang-Muy & Congress, 2009).

Basic health care knowledge of refugees represents another challenge. Refugees may not know their rights to health care or have knowledge of when and where to seek
the available care. Much of North Carolina’s refugee health knowledge resources concentrate on hygiene and healthy home environments (Walker, 2007). Few resources or programming for mental health concerns have been provided by resettlement agencies greatly due to the way in which they receive funding. Resettlement agencies generally receiving grant funding through the Office of Refugee Resettlement (ORR), which was created through the Refugee Act of 1980. The ORR awards grant funds by way of the state to community resettlement agencies that demonstrate their clients have reached economic self-sufficiency. With the significant emphasis on employment through this grant, few organizations have the resources or time to confront the mental health of their clients (Simmelink & Shannon, 2012).

In addition to the lack of resources and funding, resettlement organizations are on a strict timeline that they must adhere to, leaving case managers and other providers with little time to spare for mental health care. In the first month of arrival, a resettlement agency must provide the following for refugees: airport pickup, housing orientation, general orientation to America, bus orientation, bank and food shopping, social security card application process, clothing and housing donations, assignment of volunteers or sponsors, English classes, Matching Grant or Refugee Assistance Program, Social Services application and if applicable WIC: Women, Infant and Children (Refugee Transitions, 2012). Each of these tasks takes a great deal of time and effort to navigate, especially when deciding which program is best for a refugee. Bear in mind that case managers have multiple individuals and families on their caseloads with most of their clients arriving with little advance notice to prepare for the resettlement process.

From one to four months, case managers then assist refugees either through the Match Grant (MG) or Refugee Assistance Program (RAP). With Match Grant, the goal is for refugees to be economically self-sufficient within six months and without support from public cash assistance. A refugee resettlement agency must provide case management, cash allowance, employment services, food subsidies, housing and transportation during this 180-day period (North Carolina Department of Health and Human Services, 2012). After this 180-day period, if a refugee has not become economically self-sufficient they may be eligible for programs, such as RAP. Refugees who have been in the US more than 30 days, but less than 5 years and are not yet economically self-sufficient may be eligible for RAP. In this program, the resettlement agency provides case management, employment services and assistance in enrolling in public cash assistance (RCA/TANF). RAP is funded through the previously mentioned Department of Health and Human Services’ Office of Refugee Resettlement (Church World Service, 2012). The push for economic self-sufficiency early on is further evident by the loan agreement with the International Organization for Migration (IOM) that requires refugees to begin paying back their plane ticket cost to the United States within five months of their arrival. Accumulating to this extensive timeline is the fact that public benefits including cash assistance, food stamps and Medicaid for refugees ends eight months after their arrival in the United States (Refugee Transitions, 2012).

Though the US Government’s refugee timeline is important in assisting refugees’ transition, it solely focuses on their immediate needs of employment and hinders
resettlement agencies from assisting clients beyond this scope. With the employment and economic self-sufficiency focus, communities are inclined to forget to focus on refugees’ issues during transit and even before migration (Chang-Muy & Congress, 2009). Studies show an individual with a mental illness can be negatively impacted in their ability to engage in economic activities, literacy opportunities and may make them prone to dysfunctional families and addictive behaviors, such as substance abuse (Unite for Site, 2007). The focus of employment without regard to mental health services fails to address the connection between the two.

The Impact of Trauma

Refugees are exposed to trauma in three separate ways: stressors in their country of origin, their flight to safety and during resettlement into their refuge country (Birma et al., 2005). Due to the stressors they have been exposed to, refugees are at an extremely high risk for the development of emotional and behavioral complications. The stressors many refugees have witnessed or experienced often involve torture or violence. They may have lost a family member or as a child, may be under the watch of one who is too stressed themselves to focus on the child’s emotional needs (Unite for Site, 2011). The most recurrent diagnoses of refugees with mental illnesses are post-traumatic stress disorder (PTSD), depression and anxiety with additional sleep disorders. A study demonstrated the prevalence of refugee children with anxiety disorders to be at a proportion of 49%-69% and those with PTSD at a proportion of 40% (Fazel & Stein, 2002). Another study showed that children aged 0-6 exposed to trauma were prone to showing excessive displays of anger, demanding of attention through negative behaviors, displaying regressive behaviors, startle easily, fear adults who remind them of the traumatic event, show excessive irritability and sadness, exhibit attachment disorders and act withdrawn (National Child & Traumatic Stress Network, 2010).

Though many guardians feel children are too young to comprehend traumatic events, research shows that children who experience trauma, especially young children (aged 0-6) are at increased risk for complications in brain development (National Child & Traumatic Stress Network, 2010). The human brain rapidly develops early from newborn to 2 years old, creating increased neuron connections and growth in cell size (Blackwell, 2002). A reduced size in the human brain cortex, which has been shown in children exposed to trauma can lead to obstructions in attention span, consciousness, languages, memory, perception, and thinking. In addition, a brain cortex that does not develop to its potential size may be associated with an individual’s IQ and their capability of regulating emotions. Children in these traumatic situations are more likely to have digestive problems, headaches, wet the bed or themselves and have sleep difficulties (National Child & Traumatic Stress Network, 2010).

A high level of stress frequently produces adrenaline. This response is vital to our survival and allows the body to efficiently deal with stress, as it assembles energy stores and modifies blood flow. In the same way, our bodies also produce cortisol during stress to help us cope. However, prolonged release of adrenaline and cortisol in an individual’s body creates destructive effects. Cortisol will subdue immune responses and control gene expression within neural circuits that are associated with emotion and memory. Having an
increased activation of adrenaline and cortisol can severely harm brain development well beyond the actual exposure of stress. Additionally, researchers have seen damage to the hippocampus region of the brain in children and adults due to sustained high-level releases of cortisol; a damaged hippocampus can harm an individual’s ability to learn, retain memories and cope with stress. All of these scientific findings suggest that individuals affected by trauma and left without access to mental health care resources will continue to experience the negative effects of stress well into the future (Harvard Center of the Developing Child, 2005). Many of the physiological brain development symptoms share the same or similar signs of the most common mental illnesses found in refugees.

**Available Mental Health Screening Tool**

Currently the most highly regarded mental health screening tool for refugees is the Refugee Health Screener 15 (RHS-15). The RHS-15 utilizes 121 items that have been found to be the best indicator of anxiety, depression and PTSD among refugee populations. This instrument has gained the best practices from previous surveys, allowing for an efficient and effective screening process that is both culturally sensitive and has been rigorously translated into various languages. The RHS-15 was available in seven different languages in early 2012 including Arabic, Burmese, English, Karen, Nepali (Bhutanese), Russian and Somali with future plans of expanding to African French, Farsi, Ki-Swahili, Spanish and Tigrinya. This questionnaire would appropriately serve all of the dominant languages found in refugee groups across North Carolina and has the ability to be used for all other languages with the aid of an interpreter. Furthermore, the RHS-15 has approval from the Institutional Review Board (IRB) allowing for applicable use in research projects upon consent (Pathways to Wellness, 2011). Therefore, the RHS-15 is the screening tool we expect to use throughout this research survey.

**Utilization, Barriers and Results of RHS-15**

Utilizing the RHS-15 or a similar questionnaire is vital for connecting refugees to mental health services that this population rarely receives. The RHS-15 screening tool can also serve to normalize mental health services, which have different meanings across cultures and are often highly stigmatized in refugee communities. Habitually using this survey in the resettlement process alongside other services could benefit the receptiveness to mental health services and break down some of the stigmas surrounding mental healthcare.

Pathways to Wellness (PTW) have done extensive research on the utilization, barriers and results surrounding the RHS-15. Though certain aspects of their data will be county and state specific, organizations can gather a fair amount of knowledge and support from their work. PTW noted across counties, local refugee resettlement agencies observed clients experiencing emotional distress with little to no follow-up care to assist with their distress. Their vision was to provide early mental health screening that would improve the resettlement process and increase access to mental health providers. Moreover, they wanted to provide evidence-based tools to reduce the burden and barriers on healthcare providers while providing culturally appropriate materials to refugee
communities. After a year of modeling and field-testing the RHS-15 in King County, Michigan, PTW had great success with the survey and county support. The RHS-15 fulfilled their vision and has been adapted in a variety of ways, dependent on individual counties’ healthcare systems.

Before implementing the RHS-15, PTW recommends an hour-long training at minimum to help normalize mental health not only within the refugee community, but also with interpreters and all administrators of the screening. This training would provide the opportunity to educate RHS-15 administrators on mental health, trauma, defining perceptions of mental health and access to care while standardizing it among other health programs. Furthermore, training would provide administrators with suggestions for sensitive language and behavior that could potentially increase the chance of referral acceptance among refugees, bridging one of the barriers to mental health services.

Organizations who have begun implementing the RHS-15 into their programs listed a previous inability to test for mental health illnesses in a culturally sensitive manner as a major barrier; the RHS-15 is capable of doing this after going through a process of rigorous examination of languages from the perspective of native speakers. Since it is a predictive survey and not a diagnostic one, it can be administered by an assortment of individuals from health workers, interpreters and other individuals involved in patient care. This allows for a great deal of flexibility in the way states have established managing the RHS-15; from King County in Michigan administering the RHS-15 through the health department to Louisville, Kentucky administering it through their resettlement agencies. Due to the nature of the questionnaires’ cultural sensitivity, it can be self-administered if clients are literate and easily navigable by interpreters if the clients are pre-literate. On average, the survey took 10 minutes to complete and clients who received the RHS-15 expressed relief in being asked these questions. The ease, flexibility and lack of large time commitment for executing the RHS-15 is extremely beneficial to an overtaxed case manager.

The simple scoring system associated with the RHS-15 further allows for ease in implementation for resettlement agencies. The RHS-15 has an easy to interpret, predictive analysis that guides the scorer as to when a referral should be provided. Individuals scoring 12 or higher on items 1-14 or scoring 5 or higher on the distress thermometer show a significant relation to emotional distress, whether that be depression or anxiety symptoms (see Appendix C). The RHS-15 even provides a referral script that allows providers to lessen the stigma surrounding mental health and provide refugees the opportunity to accept a referral. In their field study, PTW found that those scoring close to the cut off value of 12 and 5 were less likely to accept referrals, whereas those scoring higher than 12 on the survey were very willing to receive support. Their research showed 31% of their clients displayed signs of distress and about 70% accepted referrals. Though it was very rare for clients to decompensate, PTW suggests having crisis referrals available should this difficulty arise.

Still barriers persist in regards to the availability of insurance coverage for mental health services. Across states, refugees are guaranteed access to Medicaid for the first eight months following their arrival, making it best for the RHS-15 to be implemented early in the resettlement process. Early implementation allows for quicker connection to
providers providing early intervention and prevention of future mental health concerns while still working within the Medicaid window. With adequate data on the refugee communities’ needs, the King county field study was able to collaborate with mental health professionals who were willing to bill Medicaid and in some cases do pro-bono work.

Beyond providing and scoring the RHS-15, resettlement agencies would be able to assist with setting up initial appointments to mental health providers and deliver transportation to primary appointments. These are both actions resettlement agencies characteristically take toward physical health appointments and would further normalize mental health by providing equal services. Assisting with initial transportation could also contribute to the likelihood of referral acceptance and return to additional appointments. Any transportation past the first appointment is not recommended by PTW due to client confidentiality reasons.

Even with all of these above-mentioned strategies in practice, many barriers are still evident en route to quality mental health care for refugees. These barriers include, but are not limited to continued access to transportation, cultural sensitivity of providers and availability of mental health counselors willing to accept referrals. However, it is imperative to begin this first step of implementing the RHS-15 and having data available on the unmet need of refugees; the screening tool will serve as a positive step and the foundation to providing quality mental health services. Several counties throughout the United States have implemented the RHS-15 in a variety of ways that align with their individual state’s healthcare systems. North Carolina has the ability to learn from the methods these counties have found successful and strategize ways to avoid barriers that previous organizations faced in implementing the RHS-15 (Pathways to Wellness, 2011).

**Intervention: Implementing Culturally Appropriate Screening**

The proposed intervention is the implementation of the RHS-15 at a local resettlement agency in the Triangle area of North Carolina. Resettlement organizations work directly with individuals and families from their initial arrival, allowing for the ability to implement the RHS-15 during the orientation period and provide referrals within the eight-month Medicaid window period. Several resettlement agencies across the United States are currently connecting refugees to mental health providers permitting best practice collaboration across these agencies. With limited funding and time available, the RHS-15 is ideal in that it can be self-administered in 10 minutes and has no fees beyond printing associated with it. The success of one agency implementing the RHS-15 could cause a ripple effect among agencies and increase data on the unmet need of refugees. A diverse group of resettlement agencies working on this intervention would allow a wider network of access to mental healthcare providers willing to connect with agencies. With a strong data set and evaluation in place, resettlement agencies could advocate for local health departments to take over the implementation of RHS-15 with the potential of further normalizing mental health. The intervention below is divided into four steps to assist in successfully implementing the RHS-15.
Stage One: Planning

In this stage, staff will be presented with the need for the proposed intervention. The proposal presentation and planning phase will be instrumental in providing an active learning environment for staff to become promoters of mental health access for refugees. An appropriate activity to accompany this presentation could be the use of a logic model or SMART (Smart, Measurable, Attainable, Realistic, Time-bound) goal sheets to express how the implementation of the screening tool can help the organization as a whole reach their broader goals. With a full understanding of the importance of mental health and the knowledge of the ease in which screening can be implemented, staff will be able to relay this information to clients and the general community. Furthermore, the intervention proposal will allow staff that work directly with refugee clients and have a strong understanding of their needs to present their own concerns and suggestions for improvement when administering the RHS-15. This presentation would additionally serve as an educational piece by explaining how implementation has worked for other counties, using the King County and Louisville examples. This is also an appropriate time to poll staff on where in the orientation process they feel the RHS-15 would be best integrated. The request paperwork for the RHS-15 from PTW would then need to be completed by the supervisor of this organization (Appendix D).

Stage Two: Collaboration (Develop Program & Promote)

As suggested by PTW, an additional meeting approximately an hour in length will need to be setup with staff members and interpreters who will be administering the RHS-15. This meeting will be used as training for administering the RHS-15 and also to further dispel any stigmas surrounding mental health. Interpreters at resettlement agencies often were former clients of the organization themselves, though these individuals are an extremely valuable resource, they can also bring some of the same cultural stigmas against mental health services. It is important that all individuals involved with administering are supportive of the RHS-15 and understand its importance in order to increase clients’ comfort level with the screening and likelihood of accepting referrals. As previously mentioned, any clients who were literate will be able to self-administer the RHS-15, but staff and interpreters will still need to introduce them to the screening tool and in a supportive manner, explaining the importance of being honest on each question. Upon completion of the RHS-15, staff and interpreters will need to be comfortable with the scoring component and referral process, which will be included in this training.

This stage of implementing the RHS-15 will also include advocating for mental health access among refugees and networking with local mental health providers. These providers will need to be willing to accept referrals, bill Medicaid and open to the sensitive needs of refugees. Organizations will need to recruit crisis support for the rare case that refugees decompensate; suggestions include the ER and crisis hotlines (Pathways to Wellness, 2011). The collaboration between resettlement agencies and referral accepting mental healthcare providers could be a difficult process for case managers with a heavy caseload so recruiting volunteers familiar with the organization may be the best choice for this procedure. In the Triangle area, many university organizations are involved with resettlement agencies, such as UNC Refugee Health Initiative and Kenan Institute for Ethics at Duke University. Including students in the...
training piece and making them aware of refugee mental health care needs could motivate these students to take on presentations to mental health providers and building alliances. Several resettlement agencies also have AmeriCorps VISTA volunteers who would be suited to take on this roll as well (Church World Service, 2012).

Stage Three: Delivery

Once staff members have been trained, several collaborations have been made with local mental health counselors and the RHS-15 has become available to the resettlement agency through PTW, it is an appropriate time to move forward with delivering the screening tool. The RHS-15 should be administered within the first two weeks of arrival, which is the same requirement for physical health screening tools. This will allow normalizing the RHS-15 alongside physical health, as well as provide intervention in an early stage that could prevent further mental health concerns. Those clients receiving a score in the ‘at risk’ range should be immediately supplied a referral upon completion of the survey. If the client wishes to accept the referral, an appointment should be scheduled with a mental health counselor directly following their screening. Though the time frame in which clients will be able to see a counselor may vary widely depending on availability, case managers should arrange for the earliest possible appointment to increase sessions available during the Medicaid window. As with physical health appointments, resettlement agencies should provide not only scheduling, but also transportation to the initial mental healthcare appointment. Any scheduling and transportation beyond the initial appointment may be considered a breech in confidentiality and go against resettlement agencies views on empowering clients. For this reason, it will be important to have clear bus maps and directions available in efforts to overcome transportation barriers (Pathways to Wellness, 2011).

Stage Four: Evaluating

Collecting assorted data throughout the implementation process will be extremely important for a variety of reasons. For resettlement agencies, data should include suggestions from staff on improvement and managing screening amidst other resettlement tasks. This will help to implement the RHS-15 in the most efficient way providing a positive environment for staff, which will need to be advocates of the integration of mental health screening into their services. In requesting the RHS-15 through PTW, they also require at minimum a follow-up interview. If possible, additional data is extremely helpful for improving the RHS-15 and mental health services. Suggestions for data include: number of screenings conducted, when in the implementation process screening is conducted, basic client information (age, gender, ethnic/language group), screening scores of recipients, number of recipients referred to care, positive screens that went to care and treatment outcomes. Data from mental health providers would also benefit the implementation process. Without breaking confidentiality, this data could include mental health counselor’s receptiveness to referrals, ability to provide complete services and barriers experienced within providing services (Pathways to Wellness, 2011). Input on the strengths, weaknesses and raw data numbers of clients served will allow for further improvement of screening and could pave the way for additional services, such as cultural competency training for mental health
providers, additional funding, transportation vouchers, group therapy programs, increased insurance coverage, etc.

**Identified organization**

This intervention will be proposed to Church World Service-RDU located in Durham, NC. Church World Service is a global organization with numerous smaller branches positioned throughout the United States. On a global scale, Church World Service claims the mission statement of “working with partners to eradicate hunger and poverty and to promote peace and justice around the world”. Their work is divided into three components of humanitarian assistance and development (42.8%), refugee assistance and resettlement (53.9%) and education, advocacy and partnership (3.3%). With the larger portion of their work going towards refugee assistance and resettlement, their work is carried out internationally at refugee camps and locally at resettlement organizations in host countries (Church World Service, 2011).

Church World Service-RDU (CWS) serves refugees and immigrants resettling in the Triangle. Clients served by this organization live in the cities of Durham, Raleigh, Chapel Hill and Carrboro. The organization connects clients to community resources that are able to assist their immediate needs, as well as reach their long-term needs in acclimating to their new culture and achieving self-sufficiency. Clients are provided with a variety of resources from case management services, employment assistance, English classes and immigration legal services. The staff at CWS consists of AmeriCorps members, case managers, community resource coordinators, a director, employment specialists, and an ESL instructor and immigration services coordinator.

Implementing the RHS-15 at CWS is beneficial for its alignment to their mission and philosophies. CWS ties all of their programs to the four philosophies of empowerment, acceptance, sustainability and confidentiality. These philosophies help foster self-sufficiency rather than dependency among the clients they serve. Providing the RHS-15 can clearly be used to empower refugees to tend to their health needs and connect to community resources. It promotes acceptance of struggles in an individual’s past, as well as the current challenges in a way that is positive rather than debilitating. The screening tool is sustainable in its ease of implementation and accessibility to a variety of languages. Finally, the RHS-15 connects clients to confidential services that could positively impact their transition into a new culture and goal of self-sufficiency.

CWS reaches clients in a broad area across Raleigh-Durham rather than staying connected to one specific location. This assists them with connecting to a wider range of refugees, collaborating with mental health providers across the Triangle and leading the way for other refugee resettlement organizations in the Triangle. In this past year, CWS resettled refugees from the countries of Sudan, Bhutan, Burma, Congo, Eritrea, Iran and Iraq (Appendix E). The languages found in these countries are either all already available on the RHS-15 or are one of the languages that PTW is currently working on and expected to release for the RHS-15 within the next year. This allows CWS to provide the screening tool to all of their clients and provide input to PTW on potential strengths and weakness on the latest language editions of the RHS-15 (Church World Service, 2012).

Upon initially suggesting these positive elements of the RHS-15 to a few case managers at CWS, they were very aware of the mental health needs and receptive to the idea of the RHS-15. There were misconceptions that a licensed psychologist was needed to
administer the RHS-15, which may have been one of the inhibitors for why these intervention steps have not been previously taken. With their input, a proposed timeline was created below for the hopeful implementation of the RHS-15 at CWS.

**January 2013**

- Present Proposal to CWS Director
- Host meeting with all CWS staff to discuss mental health needs of refugees, implementation of RHS-15, staff concerns and proposed timeline
- Apply for use of the RHS-15 through PTW
- Recruit individuals outside of case managers (volunteers, students, community members…) willing to work on agenda needed to complete implementation
- Begin creating training for RHS-15 for staff who will be administering

**February 2013**

- Complete training design for RHS-15 for staff who will be administering
- Collaborate with AmeriCorps members, volunteers and university organizations
  - Host refugee mental health needs education presentations to mental health providers
  - Secure mental health providers willing to accept referrals
  - Recruit crises support resources
- Begin designing data tracking/evaluation forms

**March 2013**

- Complete data tracking and evaluation forms
- Continue recruiting mental health providers
- Fine-tune entire timeline of implementation process (when the screening will be implemented, how referrals will work, securing transportation, meeting with all involved individuals about concerns)

**April 2013**

- Host RHS-15 training with all staff and interpreters involved with administering
- Implement RHS-15 into orientation process
- Implement evaluation and data tracking
- Continue recruiting mental health providers

**May 2013**

- Review evaluation data for strengths and weaknesses
- Meet with staff members to discuss areas for improvement, concerns with how implementation is proceeding thus far
- Evaluating ways to continue improving RHS-15 implementation and how program will be self-sufficient within orientation process
Appendix A

2011 FY Arrivals by State

Office of Refugee Resettlement

Appendix B

Refugee Populations in North Carolina

US Department of Health & Human Services
Appendix C

Distress Thermometer

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

I feel as bad as I ever have

Things are good

ADD TOTAL SCORE OF ITEMS 1-14: ___

| SCORING | | |
| --- | --- | |
| Screening is POSITIVE | Self administered: ___ | |
| 1. If Items 1-14 is ≥ 12 OR | Not self administered: ___ | |
| 2. Distress Thermometer is ≥ 5 | | |

Appendix D
## UTILIZATION REQUEST AND AGREEMENT

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### INSTRUCTIONS

Please complete the fields below

Where did you hear about the RHS-15?

- [ ] In a journal publication
  - Ex: ______
- [ ] 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:

<table>
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<th>Ethnic and/or language group(s):</th>
<th>Age range</th>
<th>Context: (check all that apply)</th>
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<tr>
<td>Arabic</td>
<td>14-21</td>
<td>□ Refugees</td>
</tr>
<tr>
<td>Russian</td>
<td>21-64</td>
<td>□ Asylum seekers</td>
</tr>
<tr>
<td>Nepali</td>
<td>65-older</td>
<td>□ Validity for Screening</td>
</tr>
<tr>
<td>Spanish</td>
<td></td>
<td>□ Comparison to another instrument</td>
</tr>
<tr>
<td>Karen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somali</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burmese</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many refugees do you screen a year?

- [ ] 25-50
- [ ] 50-100
- [ ] 100-200
- [ ] 200 or more

What is the setting for administering the RHS-15?

- [ ] Health setting
  - Public health
  - Primary care
- [ ] Resettlement agency
- [ ] CBO
- [ ] Other (please specify)

Funding source?

- [ ] Federal grant
- [ ] Foundation
- [ ] Intramural grant
- [ ] None

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

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UTILITY REQUEST AND AGREEMENT

Statement of Agreement

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

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

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

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

1. The number of screenings conducted.

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

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

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

1. The number of screenings conducted.

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

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

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

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

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Appendix E

Annotated Bibliography


This article expresses the need for reproductive health services specialized at specific groups, such as refugees and IDPs. These populations tend to have higher levels of health inequalities not always seen by the general population—gender-based violence, unsafe abortions, lack of family planning care. The research in this article brings together evidence and work from esteemed members of the United Nations and NGOs working on the ground to collaboratively present a work of best practice. Lack of reproductive rights and dangers associated can lead to severe mental health illnesses.


This article exams the many stresses and exposure to trauma of refugee children from their host country, migration and settling in their country of origin. In addition, it details the need for trans-disciplinary services with research on the unique needs of refugee children rather than clumping them into a group with children from the US who have experience trauma. The evidence and suggestions from this article would be useful to a variety of health professionals and case managers who serve refugee children and their families.

This manual is extremely useful to a variety of individuals working with LGBT refugees from case workers, health providers, educators, community members, etc... It clearly outlines terminology and myths surrounding LGBT refugees. In addition it provides health needs, especially mental health of this community and the detrimental affects that can happen without appropriate services. The manual is most useful in explaining beneficial ways to creating safe and sensitive services that advocate for LGBT refugees. The appendix includes useful materials to address the comfort level of a LGBT client, risk assessments and action plans for increasing the strength of safe spaces.


This article addresses the concern that cultural competency cannot be an acquired skill with an endpoint, but rather an on-going learning process for providers working across cultures. The researchers present a model to aid cultural sensitivity and to working with individuals in an empowering manner that involves six steps called the Explanatory Models Approach. This model is patient focused and centers around what is at stake for the patient if they are not receiving culturally appropriate care.


This article discusses the high levels of stress and prevalence of mental illnesses that are present in immigrant and refugee children, along with providing educational workers the tools to recognize and address them. Along with their resources, the researchers provide tools for family involvement and discuss the deep important of family and group support. The article goes into further depth provide ways educational and health workers who directly collaborate with refugee and immigrant families can help engage the entire family and providing meaningful support.

**References**


Pathways to Wellness (2011). Integrating Refugee Health and Well-Being: Creating


