Southwest Interdisciplinary Research Center

ARIZONA STATE UNIVERSITY

research in action

The Need for Mental Health Screening for Refugee Women

Refugee women account for 48% of all refugees in the United States, and Arizona ranks among the top 10 states for their resettlement with approximately 3,500 new arrivals annually[1]. Refugee women are often stigmatized or victimized as survivors of rape, abuse, and war-related violence. Refugees must learn to navigate a new community, language, and cultural system, while coping with the loss of homeland and family, social isolation, social stigma, and discrimination. However, too often local services or support networks may be inadequate to respond to members of this vulnerable group thereby further increasing their risk of trauma. While the U.S. Centers for Disease Control and Prevention has established guidelines for mental health screening of newly arrived refugees during domestic medical examination, universal screening for mental health conditions is not a consistent practice. A further challenge is the uneven availability and familiarity of practitioners with valid and reliable screening tools which are linguistically and culturally appropriate.

This study presents findings of the process of implementing the RHS-15 and rates of mental health conditions among newly arrived refugee women receiving routine obstetric and gynecologic care.

The Refugee Health Screener-15 (RHS-15) was developed by the *Pathways to Wellness: Integrating Community Health and Well-Being* program as a culturally responsive, efficient, validated screening instrument that detects symptoms of anxiety, depression, and posttraumatic stress disorder across multiple refugee populations[2]. The 15-question screener has been tested for use in public health and community settings, it requires limited training for staff, and adds only five to ten minutes to a patient's visit. It has been validated in: Amharic, Arabic, Burmese, Cuban Spanish, Farsi, French, Karen, Nepali, Russian, Somali, Swahili, and Tigrinya languages.

Methodology

Between April and October of 2012, women over the age of 18 receiving routine health care in the Refugee Women's Health Clinic were screened in their preferred language of choice—Arabic, Burmese, English, Karen, Nepali or Somali. Trained Cultural Health Navigators (CHNs) were an integral part of this screening process as they received cross cultural trainings, in partnership with Jewish Family and Children Services (JFCS), a local behavioral health agency. Subsequently, the CHNs verbally administered the RHS-15, with 221 refugee women eligible for screening. The RHS-15 consists of two sections. The first 14 questions are rated on a scale from zero (not at all) to four (extremely) using variably full jars of sand. A total score of 12 or more on the first 14 questions is a positive screen. Question 15 comprises the second section, which is a distress thermometer. Women can mark their distress from zero (no distress) to ten (extreme distress). A distress thermometer score of 5 or more is a positive screen. A woman only has to score positive on one of these two sections to be considered a positive screen.

[1] Arizona Department of Economic Security. Division of Aging and Adult Services: About Refugee Resettlement. Retrieved from https://www.azdes.gov/landing.aspx?id=7241#RA

[2] Pathways to Wellness. (2011). Refugee Health Screener-15: Development and use of the RHS-15. Retrieved from http://www.lcsnw.org/pathways/index.html

Results

The RHS-15 was completed by 112 (50.7%) women from the eligible sample. Twenty-six women (23%) scored positive on the RHS-15, of whom 14 (54%) were Iraqi, one (4%) was Burmese, and three (11.5%) were Somali. They were referred for further mental health evaluation at JFCS resulting in, eight (30.8%) receiving mental health services, and five (19.2%) awaiting scheduled appointments. Thirteen (50%) women were not enrolled in any mental health care because they either declined services (46.2%) or lacked insurance (53.8%).

There is a need for community-partnered, culturally-tailored interventions to provide health promotion education, dispel myths and reduce the stigma of mental health for refugees while accentuating asset-based, strength models of resiliency, community and social support. There is also a growing interest in the integration of primary care with behavioral health services to enhance mental health services as a best-practice model to improve the recognition of mental illness and quality of care.

Discussion and Conclusion

The described screening identified women with emotional distress who would not otherwise have been referred for a mental health assessment. It represents a partnership between an obstetrics and gynecology practice dedicated to caring for refugee women with a behavioral health agency. The initiative also provided an opportunity for providers to better understand mental health disparities and health equity across a vulnerable, medically complex population.

Providers caring for refugees need to be aware of the diverse cultural idioms by which suffering is expressed in addition to the social stigma associated with traumatic experiences and mental illness. Use of bi-cultural interpreters enhances patient-provider communication. Access to culturally, linguistically and gender appropriate care are key factors influencing help-seeking behavior. Important barriers for healthcare identified in this population include: lack of perceived need for mental health treatment, a perception that treatment could result in the loss of one's children or marital strain, and uncertainty about the role of government in healthcare which could compromise freedom or immigration status. In the majority of the cases, the assessments' results did not lead to treatment. Sufficient culturally appropriate behavioral health services and readily access to health insurance by refugee women are priority policy issues in need of immediate attention.

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