GUIDELINES FOR MENTAL HEALTH SCREENING DURING THE DOMESTIC MEDICAL EXAMINATION FOR NEWLY ARRIVED REFUGEES

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Background and Goal

Long-distance journeys and resettlement entail a set of engulfing life events (losses, changes, conflicts, and demands) that, although varying widely in kind and degree, may severely test a refugee's emotional resilience. Resettlement in a new country can produce profound psychological distress, even among the best prepared and most motivated. Given the nature of life-threatening experiences prior to and during flight from their home countries or (country of asylum/host country), as well as the difficult circumstances of existence in exile, refugees may be at particularly high risk for psychiatric symptoms.

Risk factors that may predispose refugees and asylum seekers to psychiatric symptoms and disorders include: exposure to war, state-sponsored violence and oppression, including torture, internment in refugee camps, human trafficking, physical displacement outside one's home country, loss of family members and prolonged separation, the stress of adapting to a new culture, low socioeconomic status, and unemployment.[1,2] Studies have shown a high prevalence of depression, post-traumatic stress disorder (PTSD), panic attacks, somatization, and traumatic brain injuries in refugees.[1-10] 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.[5,7-14] Significant psychiatric symptoms may be present during the first few months following arrival to the United States.[8,15] Various factors, including language, culture, religion, stigma, lack of transportation, work conflicts, and lack of child care, may constitute barriers for refugees accepting mental health diagnosis and/or treatment. However, reports suggest that early intervention may be helpful, despite cultural and other barriers to mental health treatment for refugees.[15,16]

For most refugees, the domestic medical screening evaluation is the first interaction with the U.S. health-care system. As such, it presents an opportunity to educate them about mental health issues, discuss expected stress responses, and also acts as an opportunity to provide mental health resources. The goal of mental health screening during the domestic medical examination is to identify and triage refugees in need of mental health treatment. In the extreme, these mental health issues may be life-threatening. However, even when the problem is not an immediate threat, when identified and treated, improved mental health hygiene may assist refugees to integrate and live more productive lives in their new homeland. Addressing mental health issues in newly arrived refugees presents tremendous challenges to the care provider and the U.S. health-care system. Although this document cannot provide solutions to these challenges, it provides suggestions and resources for primary clinicians for mental health screening during the initial domestic medical examination. The recommendations provided must be tailored to a specific clinic's abilities and time, community referral resources, and the health system's ability to address issues identified.

General Points About Refugee Mental Health Screening

- Health clinics providing screening should have a good working relationship with refugee resettlement agencies. These agencies often provide transportation to and from health screening appointments and may facilitate ongoing primary care and consultation. Additionally, refugee resettlement case workers may have important observations or information that may be informative to clinicians regarding individual refugees.
- Acute psychiatric emergencies (e.g., suicidal/homicidal ideation) are seen infrequently during the domestic refugee examination, but do occasionally occur. In such cases,

patients may not be able to wait for outpatient referral and formal psychiatric evaluation and hospitalization may be necessary. Clinical facilities conducting the domestic medical examination should have a mechanism in place for expedited referral for psychiatric evaluation in urgent situations.

- Clinicians performing the evaluations should attempt to educate themselves about the history and cultural beliefs of the refugee populations they serve. The Cultural Orientation Resource Center Website may be useful to clinicians trying to familiarize themselves with new cultures of populations resettling to the United States. (www.cal.org/co/overseas/prog_high_archive.html).
- Medically trained interpreters should be used during patient interviews whenever possible. Bicultural interpreters are preferred. If an interpreter is not available in person, telephone interpreter services can be utilized. In addition, medical staff should be trained in how to use interpreter services.
- Mental health screening may be different in each resettlement location, depending on both staffing of the particular health screening clinic and availability of local mental health services for referral.
- Refugees may not volunteer or admit symptoms at initial screening, but symptoms may emerge several months or years after resettlement. Therefore, follow-up primary care referral for on-going health care is imperative. Ideally, primary care clinicians should be familiar with refugee care, including diagnosis and treatment (and/or referral) of commonly encountered mental health conditions.
- Clinicians should be aware that many refugees, particularly those from cultures with stigmas against acknowledging psychiatric symptoms, may present with stress-related somatic symptoms. Refugees with unexplained somatic symptoms such as headaches, stomachaches, or back pain may benefit from referral to a mental health professional.

Impairment-related Action Plans

Based on severity of symptoms and ability to function in daily life, three major actions plans should be considered during screening, corresponding to the following three groups:

I. Refugees with chronic, serious, or acute mental illness requiring immediate or rapid follow-up.

- Upon arrival, a small number of refugees with major mental illnesses may present with symptoms such as suicidal or homicidal ideation or severe limitations in ability to function (e.g., go to school/work, perform necessary activities of daily living such as dressing and feeding oneself) that require immediate attention. This group may include refugees with schizophrenia, bipolar disorder, major depression, traumatic brain injury, or PTSD.
- All refugee health screening clinics should attempt to identify these individuals with the objective to refer for immediate psychiatric evaluation and treatment.

II. Refugees with less acute mental illness or psychiatric symptoms requiring routine follow-up.

- Refugees with known or identified mental illnesses who are not an immediate danger to themselves or others, are not gravely disabled by their illness, but whose ability to function is impaired.

- Screening clinics should attempt to identify more severely affected individuals for referral to appropriate mental health specialists when available.
- Although all refugees should receive referral for primary care, additional assurances should be put in place that follow-up mental health care is available for refugees with mental illness.
- Severity and nature of symptoms, local availability of mental health services, and refugee preference are all variables that effect referral patterns preferences.

III. Refugees without identified mental illness or significant symptoms.

- All refugees have suffered directly or indirectly as a result of crisis, trauma or loss. The great majority of refugees are not in need of clinical mental health services.
- The objective for this group is to ensure that all refugees have access to primary prevention activities (e.g., assuring adequate nutrition, providing prenatal care, access to primary care, access to community services, and supports).
- Local resettlement and social service agencies may implement preventive mental health interventions, such as facilitating school entry, bolstering social support, and assisting with employment opportunities.

Mental Health-Related Components of the Health Screening Evaluation

Suggested components of the Mental Health Screening Evaluation described below are designed to help clinicians decide whether immediate or routine specialty referral is needed (Groups I, II above) or if referral to primary care is adequate (Groups II, III).

1) Review of records from overseas:

The overseas medical examination of refugees applying for refugee status does include an evaluation for physical and mental disorders with associated harmful behaviors and substance-related disorders. The Technical Instructions for Medical Examination of Aliens (TIs) provide the requirements for this evaluation. The TI component for physical and mental disorders with associated harmful behaviors and substance-related disorders was last revised in 2010. The TIs require that the examining physician determine whether an alien has a physical or mental disorder with associated harmful behavior, either current or history, which is judged likely to recur and which may or is likely to pose a threat to the property, safety, or welfare of the alien or others. The TIs also require that the examining physician determine whether an alien has substance abuse or addiction (dependence).[17] Refugees are classified as Class A if they have been diagnosed with a mental disorder based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, and with current associated harmful behavior or a history of associated harmful behavior judged likely to recur. A Class A refugee needs an approved waiver for travel. The waiver ensures that an approved U.S. health-care provider is identified for the refugee. When a Class A refugee arrives in the United States, he or she must report promptly to the identified U.S health-care provider. The same process should be followed for a refugee who meets the DSM-IV criteria for substance abuse or dependence and was assigned to Class A based on substance abuse or addiction (dependence). Refugees diagnosed with a mental disorder with no current associated harmful behavior or a history of associated harmful behavior judged not likely to recur are classified as Class B. Refugees with a Class B mental disorder do not require a waiver but will generally benefit from evaluation by a mental health specialist.

2) History and physical examination related to mental health

For full history and physical examination guidelines see:
www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html

- The following should be solicited during the history portion of the examination:
    - head trauma, loss of consciousness or seizures, the presence of which raises suspicion for conditions such as traumatic brain injury (TBI).
    - known psychiatric conditions or past evaluations or treatments.
    - history of exposure to traumatic events (see Screening for PTSD section below).
    - alcohol and/or drug use, including use of traditional herbal substances such as khat (East Africa).
    - for children, ask caregivers about the patterns of child development [e.g., whether each child has been developing normally; whether they have attended school, to what level, and whether learning difficulties have been noted (see Growth and Development section: www.placeholder).
- During the physical examination, special attention should be paid to the following:
    - signs of maltreatment such as scars and other deformities (see history and physical examination section: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html). The clinician serving refugees should be able to differentiate traditional medical or cultural practices, which may resemble non-accidental trauma (e.g., burn sticks, scarification), from other types of maltreatment.
    - unexplained somatic symptoms that may be related to psychological distress (i.e., unexplained headaches, backaches, or abdominal pain).

3) Mental status examination:

The mental status examination is generally informal and may be carried out by clinicians throughout the routine screening.

- During the routine screening process, the clinicians should pay close attention to:
    - tone of voice, body language and behavior that may indicate higher levels of anxiety or depression than expected. If level of anxiety or depression appears especially high, examiners may pay particular attention to mental health-specific questions below.
    - the refugee's ability to communicate thoughts in a coherent fashion (this determination may require input from an interpreter).
    - symptoms such as paranoia, delusions, or hallucinations that become apparent during the interview. Such symptoms indicate the need for immediate referral.
    - suicidal ideation during depression assessment (below).
    - homicidal ideation.

4) Screening for depression and PTSD

Clients over the age of 16 should be screened for symptoms of major depression and PTSD, the most common disorders seen in refugees. Although symptoms of depression and PTSD do occur in children, this cutoff age is suggested because the process of interviewing children, especially those who cannot read a translated questionnaire, can be very time-consuming and requires skills not generally available in the screening environment. In addition, because improved mental

health of parents can result in improved mental health of their children, screening adults in this setting is a priority.[18,19]

Before the clinicians or screeners ask specific questions relating to symptoms, refugees should be prepared by being presented a brief introduction such as the following:

"Many refugees may not be aware that stressful life situations and events they may have experienced can have lasting effects on their health. Most refugees will experience short-term psychological and social difficulties simply as a result of resettlement. This is normal and should be expected. If you feel these symptoms are excessive and are interfering with your life or if you have thoughts of hurting yourself or others, you can always come back to our clinic and ask for help."

Additional educational information aimed at raising awareness of common issues and symptoms experienced by refugees may be useful (See the appendix for sample). Optimally, this educational information may be translated into the refugees' native languages and given in a format appropriate to the literacy level and learning style of the refugee for future reference.

Screening for Depression

Clinicians should be familiar with the symptoms and diagnosis of depression described in the Diagnostic and Statistical Manual (DSM-IV), published by the American Psychiatric Association. For refugees who are literate in their own language, administering questionnaires in translated, written format can be effective and more time efficient than having interpreters translate each question. Tools are available that experts in refugee mental health use to screen for depression based on the DSM-IVcriteria. One such tool is the PRIME-MD PHQ-9, which is brief, has been used with a variety of cultural groups in the primary care setting, and is available online (http://steppingup.washington.edu/keys/documents/phq-9.pdf [PDF - 42 KB]). The depression section of the Hopkins symptom checklist is also available and has been used in refugee populations.

Screening for PTSD

Clinicians should be familiar with the three symptom clusters of PTSD as listed in the DSM-IV (re-experiencing, avoidance, and hyperarousal), although actual diagnosis of PTSD may be difficult during the short time available in the health screening setting. An example of a screening question for PTSD often used with refugees is as follows:[20]

In this clinic we see many patients who have been forced to leave their countries because of violence or threats to the health and safety of themselves and their families. I am going to ask you a question about these types of situations.

Were you ever a victim of violence in your former country? ____yes ____no

Clients who answer "yes" to this question should be asked whether they would like to describe what happened to them. If clients agree to describe what happened, practitioners should be ready to listen to a brief recounting. On the other hand, clients who do not wish to talk about these events should not be coerced. Coerced or forced discussion may traumatize patients further, especially if they have been interrogated or tortured in the past. After a brief recounting, specific symptoms of PTSD can be assessed.

Tools that may assist the clinician in screening for PTSD include the open-source PCL-C-17 (http://ctc.georgetown.edu/pdf/ptsdchecklistPCL_C.doc [DOC - 51 KB]) for PTSD or questions 1-16 of the PTSD portion of the Harvard Trauma Questionnaire checklist.

Mild or moderately impaired persons with depression and/or PTSD may be referred for routine follow-up, while severely impaired persons may require immediate referral.

Note: Psychological assessment instruments should not be the sole criteria for making psychiatric diagnoses. Anyone meeting criteria for depression or PTSD on a screening instrument should be referred to a mental health professional for further evaluation.

5) Referral for Refugees Considered at Significant Risk

If significant positive findings emerge from history, clinical observations, and/or relevant information provided by resettlement agencies, clinical judgment and availability of services will determine whether emergency or routine follow-up care is needed and how quickly these services need to be accessed. If symptoms of depression or PTSD affect daily function, more urgent follow-up care is recommended. The presence of suicidal or homicidal ideation should prompt referral for emergency follow-up. When PTSD symptoms are severe, it is optimal for the refugee to be referred to an agency with special expertise in working with refugee mental health issues, including torture.

When referring a patient primarily for mental health evaluation and treatment, the clinician can reassure the refugee by describing what to expect on the initial mental health evaluation. For children, information regarding histories of learning problems or poor school attendance must be relayed to the school systems they will be attending.

Appendix

Sample educational session

Refugees should be informed that:

- Many refugees have experienced persecution, war, or trauma.
- It is normal for people to miss family members and loved ones who are still in their home country.
- Many people have difficulties because they do not read, speak, or understand English.
- Many people have difficulties adjusting to American customs, people, food, and climate.
- Most people have difficulties understanding the American educational, health care, and legal systems.

Because of the many difficulties faced by refugees, they may:

- Feel sad, experience changes in their appetite, have difficulty sleeping, cry often, and lose interest in doing things that they once enjoyed.
- Worry about their jobs, their health, or life in the United States.
- Suffer from physical symptoms, such as headaches, dizziness, or restlessness.
- Experience nightmares about war or trauma.
- Have difficulty keeping bad memories out of their minds.
- Try to avoid things that remind them of the terrible things they saw or experienced.

The interviewer should emphasize that these symptoms do not reflect weakness in the person, but are normal reactions to past stressful and traumatic experiences. While experiencing some of these symptoms is normal, if the symptoms are very disturbing and cause significant difficulties in functioning, then the client or family should be encouraged to discuss them with a health provider.

Additional Resources

- Coping with a disaster or traumatic event: http://www.bt.cdc.gov/mentalhealth/
- Coping with a disaster or traumatic event: Information for Health Care Providers: http://www.bt.cdc.gov/mentalhealth/info_health_prof.asp

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