Refugee Mental Health Screening & Care in the United States

Introduction

Everyone chases a dream. Several, however, chase safety. Across the world, while a few nations suffer from war, disease, and poverty, their people would attempt to flee to other countries that would promise a better life. Many manage this, but while they're physically in a better place, their minds could still be trapped in the horrors they may have recently escaped.

The mental health of refugees here in the United States should be as much of a concern to us as the mental health of the country's citizens. However, the reality of the situation dictates an urgent response to an otherwise hidden epidemic. In the United States, the prevalence of poor mental health outcomes in the refugee population is disproportionate to that within the citizen population. We suspect that this is because of cultural and structural barriers that are preventing refugees from receiving the care they need, following different circumstances that may leave them at risk.

The differences between refugee mental health outcomes compared to non-refugee mental health outcomes, based on various articles found in the literature, can be as high at 50% depending on the population, depending on where the individual migrated from, and the circumstances why they have done so (Barnes, 2001; Sangalang et. al., 2018). These numbers, of course, might be higher, as refugees have a much greater chance of not following up with their providers. And workable sampling methods for existing studies are limited in representability

(Seagle, 2019). Refugees moving into the United States are not faring as well as their neighbors, and poor mental health can lead to worse issues if not addressed.

The discrepancy in mental health care for our refugee population is unfortunately because of issues from the community, organizational, and policy levels of the social-ecological perspective. Interventions to address the mental health discrepancy between refugees and non-refugees will have to be community based to promote social integration. And change needs to happen to existing policies and infrastructure in the United States to help facilitate efforts to reduce the prevalence of mental illness amongst refugees, improve provider accountability, and ensure sustainability for community mental health programs.

For this paper, we will review the current prevalence of mental health disorders among refugees; the barriers they may face in accessing mental healthcare; the state of community programs and current screening tools for mental health being used; Electronic Medical Records; Meaningful Use; and how we can tie everything together to form a cohesive system for addressing mental health for the refugee population in the United States.

Prevalence Rate of Mental Health Disorder Among Refugees

When looking at the prevalence rate of mental health disorders among refugees, the literature stratifies the refugee population by sub-populations to better represent different migratory backgrounds. In almost all cases, we can see that refugees suffer from worse rates of mental health disorders, such as depression and PTSD, compared to non-refugees.

Amongst Asian and Latino refugee populations, we do not see a huge discrepancy but disproportionate rates regardless, with approximately 11% of the population suffering from a mental health condition such as depression, while only 6.7% of non-refugees have depression (Sangalang, 2018). Syrian refugees, by comparison, are faring much worse; as much as 58% of the Syrian refugee population suffers from major depressive disorder (Jancin, 2017).

It is surmised that these disproportionate rates of mental illness among refugees are possibly because of the circumstances why they had to migrate to the U.S. to begin with. A lot of individuals have likely fled from war and other related issues, such as food shortages, disease, torture, and prosecution (Asgary, 2011). Not that all refugees come to the United States with mental illness, but a combination of these historical events and culture shock may leave the individual at high risk of developing a mental illness or disorder that inhibits quality of life. Preventative measures at the community level may not be enough to help combat mental illness among refugees; organizational and policy level changes need to be made in order for those measures to be successful.

The Socio-Ecological Framework and Public Health Law

To better understand the issues we face in refugee mental health screening, and the effect our recommendations may have, we will address this subject from the perspective of the socio-ecological framework of public health and public health law.

The three levels of the social ecological model that we will look at for discussing different means of reducing the disparity of mental health outcomes in the refugee population are the community, organizational, and policy levels. Interventions at the community level involve

local organizations and commissions tied to specific communities. In this case, refugee populations and their sub-populations. Leaders are used to provide an opportunity for members of their community, and local groups dedicated to public health can act as advocates for more vulnerable members of their respective community (Golden, 2015). Efforts and interventions made at the organizational level help to empower those advocacy groups and provide them with better means to help community members (Golden, 2015). In our case, it would also revitalize patient and physician interaction in mental health care and continued follow-up.

Policy changes and public health law will need to be implemented in order to tackle the disparity of mental health outcomes among refugees as well. Policy change helps to ensure longevity of various public health programs and an autonomous interaction between all key groups. The lack of policy and guidelines creates a stagnation in advocacy that worsens outcomes overtime (Golden, 2015; Porter et al., 2018). This is, on most occasions, our most powerful means of ensuring public health changes are successful, and we have on record other victories in public health that use law, such as tobacco laws, seatbelt laws, and more.

Barriers to Refugee Mental Health Care

Something important to understand is the individual barriers a refugee or asylum seeker may face when trying to get access to mental health care, or why they may be hesitant to seek mental health care to begin with. While mental health is becoming a more acceptable topic in the United States to talk about, mental health and mental illness may still be topics of contention in other areas of the world where refugees may hail from. Our current systems in place to render these services may also not be enough to provide for refugee patients.

Many refugees may not identify what is mental illness and the symptoms of illness. Depending on where the individual is from, they may not recognize depression or anxiety as a medical problem and cannot convey these symptoms to their doctors. Alternatively, those who are from an area where mental illness is heavily stigmatized may not wish to disclose symptoms they are having, for fear of heavy ridicule from family or other community members (Asgary, 2011). These individuals are usually the ones to not be followed by their doctors or healthcare providers, as they won't report symptoms of mental illness. There may be a general fear or perception of discrimination from healthcare providers, resulting in a lack of trust necessary to report symptoms of depression, anxiety, or PTSD (Asgary, 2011). Better education and social support systems would both be useful for refugees and healthcare providers to identify and destigmatize mental illness.

There is also difficulty in navigating a new environment and developing a support system. Refugees may need time to adjust to a new work life, new monetary system, transport, etc. These new experiences may appear daunting to the individual and, depending on where they live, they may not receive help from a peer to navigate them. Perceptions of feeling alone may worsen symptoms of depression and anxiety, and prevent someone from willingly seeking help (Asgary, 2011). Community programs that focus on social networks for displaced populations would help the individual integrate into a new environment.

General affordability and accessibility of services is also a common barrier to mental healthcare for refugees. Often, refugees will have limited-time access to Medicaid services, assuming they're officially U.S. citizens, before they're left to navigate the system to reapply on their own. This proves difficult when families have to prioritize food, money, and shelter over

health services, as the process for reapplying to Medicaid is not made easy to them (Asgary, 2011). Refugees coming into the U.S. will usually receive their initial intake assessment but will not report in for follow-up because of other obligations that make healthcare unaffordable and unreachable.

For those who do follow-up with their providers and inquire about mental health services, the care their doctors provide them may not always be the best. While it is required to provide a health assessment for all refugees entering the U.S., mental health screenings are not always required per state; it is also not required for providers to follow-up with their patients regarding mental health outcomes, and because of this, referrals are often lost in the system - possibly 69% of the refugee population who has received assessments have unknown health outcomes (Seagle, 2019). There is unfortunately a poor patient-provider relationship between doctors and their refugee patient population, and doctors today are most often not trained to render culturally acceptable questionnaires and tests for refugees (Seagle, 2019). The study that produced these findings also appeared to be very limited, as it could not produce a representative sample of participating clinics because of the scarcity of those actually eligible to take part, having to opt for a county-level clustering sampling method instead. This suggests that clinics which take the time to assist their refugee patients with mental health referrals are few.

The CDC states that the first three months of refugee resettlement is a crucial period in their lives. Deemed the “Honeymoon Phase”, this is a time where someone establishes themselves in a new nation, culture, and system. It is also a phase where if they cannot meet their needs, they may be at increased risk of further hardship years later. That includes mental health outcomes. Establishing a plan of care during this phase is crucial to preventing mental illness, or

for preventing it from getting worse over time (CDC, 2019; Shannon, 2017). Better provider accountability would be extremely beneficial for refugees in order for them to successfully integrate with a new environment, and to prevent mental illness from either worsening or taking root.

We may not tackle these barriers to mental health care simultaneously, but there are tools that exist that might eliminate gaps in mental healthcare for patients who can see their physicians. Efforts to destigmatize mental illness among refugee communities would also go a long way to reduce the discrepancies in mental health among refugee sub-populations.

Refugee Community Programs

Community outreach and mental health programs are few for refugees in the United States. There is a need for services dedicated to the mental health of refugees, especially for refugees who have come from regions of conflict (Silove, 2004). Of those that exist, there is hesitation to receive services depending on where referrals come from. Data on referrals from clinical settings is inconclusive, as there is limited follow-up on these referrals and their outcomes from physician offices. Refugees who are referred from a clinic are less likely to attend a service compared to when they're referred from a non-clinic setting (Ballard-Kang, 2018). It could be surmised that this is possibly because of the aforementioned trust issues that exist with providers and or their lack of training in assisting refugees with diverse histories and circumstances of which they migrated to the U.S.

Those who do attend community programs receive multiple benefits for doing so, including better connections with neighbors, aid services, improved education and vocational

training, and support. Overall social integration and assurance of resources appears to be key for addressing mental health concerns (Priebe, 2016). Improving provider-patient trust and destigmatizing mental illness would produce more results on the effectiveness of community programs. As well, a policy level change that would help these community programs be maintained for the refugee population or jump started for a community in need would ensure sustainability.

The Refugee Health Screener - 15

There are several forms and tests in the literature designed to screen refugees on their mental health status. Using the DSM-V, these forms and tests have produced mixed results from clinicians and psychiatrists. One test called the Refugee Health Screener-15 (RHS-15 for short), however, was especially effective. The RHS-15 is a fifteen item questionnaire, thirteen items specific to testing for depression, anxiety, and PTSD, while the last two are focused on the ability to cope (Kaltenbach, 2017).

Clinical trials so far have produced good results across multiple populations, proving to be a valid and effective tool for screening mental illness among refugees (Stingl, 2017; Kaltenbach, 2017). The RHS-15 is specifically designed to be used across multiple refugee sub-populations, using pictures, semantics, and other universally understood questions that can be mildly adjusted to accommodate different cultures, as it was found that each culture responds differently to some questions on the RHS-15 (Kaltenbach, 2017). This shows that the RHS-15 appears to be flexible as a questionnaire for a population as diverse as the refugee population.

The RHS-15 also shows to be quite feasible. In test trials of the RHS-15, the majority of patients filling out the questionnaire had no issues filling it out, and it managed to screen 52% positive results while maintaining great persistence (Kaltenbach, 2017). All of this, while proving to be practicable, practical, economically friendly, and easily deployable (Stingl, 2017). As a method of testing for mental health illness amongst refugees, the RHS-15 appears to be the best test for doing so.

Electronic Medical Records & Meaningful Use

Since the 21st century, providers here in the United States have been required to use Electronic Medical Records (EMR). This transition from paper charts has made for more efficient record keeping and monitoring for many providers (barring user error). It has also made it easier for national surveillance systems to track the statistics of certain communicable and non-communicable diseases (Charney, 2012).

Several of these systems are becoming very advanced, especially as technology grows. Domain owners are usually able to implement various modules that build into EMR, and new things can be added per an office's request. With these systems however, there was concern for a time that the use of technology would distance providers from their patients. To address these concerns, the Centers for Medicare and Medicaid Services implemented a reimbursement system known as Meaningful Use.

For those who demonstrated Meaningful Use, they had to exhibit a set of obtained goals every year, which was staged over the course of 4 years three different times. Currently, the goals include maintenance of demographic information, routine vitals checks, smoking status,

provision of chart summaries, etc (Anumula, 2012). Several of these goals are very strict, with some goals requiring to be met with 80% of the provider's patient population.

Initially, providers who participated in this program received bonuses to the amounts they were paid by Medicare and Medicaid. For those who met all of their goals, they received bonuses of up to $44,000. This has changed recently however to a pay deduction now, and providers who now fail to meet these goals could see reductions of up to 5% (Anumula, 2012). Given that the majority of the patient population is insured either under Medicare or Medicaid, negligence on medical record and examination upkeep can rack up deductions very quickly, and makes for a good incentive to be diligent.

Keeping this in mind, meaningful use can be a benefit to refugees who obtain citizenship and can get insurance through Medicaid. Providers will be motivated to maintain quality record keeping and examinations on file for their refugee patient population. The Centers for Medicare and Medicaid Services review their goals for Meaningful Use annually and are likely to add more as the years go by. Seeing as how recent Medicaid expansions have been beneficial for mental healthcare providers, there is potential to see a new goal centered on the upkeep of mental health records for patients.

Recommendations

For the interests of reducing the overall prevalence rate of mental illness in refugee populations in the United States, and reducing the discrepancy of mental health between refugees and non-refugees, we recommend:

- Adding Mental Health Status and Last Update on Outcomes to the list of objectives for Meaningful Use.
- Implementing RHS-15 as a form bundled in electronic medical records for physicians to employ routinely, and tracks outgoing referrals to professionals.
- Adding community programs for mental health as a local, viable referral option for clinics and provider's offices.
- Imposing an 80% requirement for this new objective for Meaningful Use.

Office staff at provider's offices are already obligated to notify their doctors if there are any concerns with the mental health status of their patients. Adding mental health status and last update on outcomes on the list of objectives for Meaningful Use would make it a necessity for providers to keep tabs on their patients and check in on them. This would be especially beneficial for their refugee patients. With the 80% requirement to meet their goal as well, providers will need to be consistent with the vast majority of their patients in order to be reimbursed by the Center of Medicare and Medicaid services. Failure to meet that requirement would cause payment deductions of up to 5%.

To facilitate this objective, we propose the full scale implementation of the RHS-15 into electronic medical records and domains designed to maintain patient histories. This could be administered by either the provider or by the patient themself, but whatever the patient would score on the RHS-15 would be saved into the provider's system automatically and recommendations can be made based on those scores. Since this would be a modular add-on for electronic medical records, changing questions to better suit a refugee patient's cultural background would be as simple as selecting a country of origin from a drop menu. Along with

implementing the RHS-15, providers would receive additional training to administer the RHS-15 and to interact appropriately with diverse cultures and populations.

Successfully referring a refugee patient to mental healthcare does not have to be limited to the care of a psychologist or psychiatrist either. Local organizations and community programs that help refugees with their overall needs and health would be viable options for referral recipients, in the same way a physical therapist would be referred orthopedic patients who just had surgery. Making this change might help us address the disparity between mental outcomes of refugees and non-refugees in the United States.

Limitations

While these recommendations may help address some of the refugee population's mental health needs, there are a few limitations as far as who these policy changes to the health administration may actually help. Individual provider attitudes toward these changes and the thoroughness of their testing with the RHS-15 will always be subject to their own willingness. Those who do not routinely meet the criteria for Meaningful Use may not acknowledge the new mental health goal as a necessity. Those that do but are not always diligent in their record keeping or savvy with the technology may also not be able to service the refugee population to the best of their abilities.

These recommendations would also depend on whether there are mental health providers or community mental health and wellness programs in the patient's area. Rural communities, where the population is more spread out, may have difficulty in providing for any refugee patients or maintaining organizations to serve them. In more impoverished areas, community

programs may not be available for a referral system with local providers. The individual themself will probably need insurance and will need to be a U.S. citizen. Those who do not have Medicaid at the least would most likely not be able to see a provider for testing. They may also have to overcome the hurdle of finding a provider taking Medicaid patients, or who has opted into servicing Medicaid patients.

Patients also will have to seek help. Refugees who have come from areas where mental illness is heavily frowned upon will be less likely to confide in their doctors whether they are experiencing any symptoms of depression, anxiety, or PTSD.

Conclusion

Refugees in the United States suffer from disproportionately high rates of mental health illnesses, including depression, anxiety, and PTSD. These rates vary between sub-populations, but they are almost always higher than non-refugees. This is because of an existing lack in healthcare policy to strengthen programs that currently exist and to ensure their use.

Adding a new goal to Meaningful Use for required mental health outcomes and updates/ referrals would be useful for sustaining existing programs, creating new ones, and providing business for local psychologists and psychiatrists. A good quality of life is an essential human right. Good quality of life implies not only good physical health, but good mental health as well. These policy changes would strengthen the healthcare administration, the refugee community, and the individuals themselves.

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