Integrating Refugee Youth Mental Health Screenings into the Domestic Refugee Medical Examination

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Executive Summary

Refugees are people displaced from their native countries and unable to return due to a fear of persecution. Refugees often experience cumulative stressors during the pre-flight, flight, and resettlement periods. Refugees of all ages have considerable risks for the development of mental distress. A high proportion of refugee youth experience mental health disorders, particularly posttraumatic stress disorder and depression. The tool currently used in Utah to screen for mental health concerns during the domestic refugee medical examination (DRME) is validated for refugees age 14 and older. The Utah Refugee Mental Health Subcommittee has recognized the need to identify a tool to screen for mental health concerns in refugees under the age of 14.

The purpose of this project was to determine the practicality and provider acceptability of a tool to screen for mental health concerns in refugee patients under the age of 14. Four primary objectives were designed to meet this purpose: 1) identify a tool, 2) assist two clinics to implement a pilot test of the identified tool, 3) evaluate the use and outcomes of the tool; and 4) disseminate the findings.

The Strengths and Difficulties Questionnaire (SDQ) was chosen as an appropriate tool. Meetings with the key stakeholders at the pilot clinics were held to identify concerns and assist in the development of a suitable clinic process flow. Five providers involved in the pilot were surveyed using a new questionnaire designed to identify barriers and supports for the project. Education was delivered to providers based on information from the stakeholder meetings and the identified barriers and supports.

A six-week pilot test of the SDQ was conducted tool use and mental health referrals were monitored. Out of the 41 children who presented for a DRME during the pilot period, nine children were screened using the SDQ. Of the nine children screened, two had positive SDQ scores and were offered referrals for mental health services (compared to 0 referrals during the same range of dates in 2014). At pilot conclusion, the involved providers were surveyed using a newly developed questionnaire designed to measure provider satisfaction with the SDQ and clinic process flow as well as perceived parent reception. Providers were neutral about continued tool use and identified the SDQ questions and increased ability to identify children who would benefit from mental health services as positive features of the SDQ. Concerns with the tool included length, time required for completion, cumbersome scoring, and interpretation difficulties. Results from the pilot were shared with members of the State Refugee Health Advisory Committee, Refugee Mental Health Subcommittee, and the pilot clinics who have determined they will extend the pilot. The University of Utah and Utah Department of Health Institutional Review Boards approved this project.

A standard procedure to screen refugee youth under the age of 14 for mental health concerns did not exist in Utah prior to this project. This project served as an initial pilot test to determine the practicality and provider acceptability of the SDQ to screen for mental health concerns in refugee youth under the age of 14 in Utah. Ultimately, this project will contribute to improved health and wellness of refugee youth under the age of 14 due to early identification of mental health concerns and timely referral to appropriate services.

The supervisory committee for this project included Julie Balk DNP, APRN, FNP-BC, CNE and Barbara Wilson PhD, RNC, Associate Dean, Academic Programs. The project chair was Jane Dyer CNM, FNP, MBA, PhD, FACNM. Amelia Self, MSW, Brent Pace, LCSW, and Rachel Weir, MD, served as content experts.

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Thousands of refugees arrive in the United States for resettlement each year (ORR, n.d.). These refugees have spent months to years displaced from their homes, and many have experienced either primary or secondary trauma or torture. In accordance with the *1951 Convention Relating to the Status of Refugees*, a refugee is defined as any person who

> Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 2010, p. 14)

Inherent in this definition are multiple contributors to mental health disturbances; refugees have been persecuted, displaced, and are unable to return to their homes. While not all refugees will have mental illness related to these conditions, the likelihood of developing a mental health disturbance is significant, and if not identified and treated in a timely manner could have long term effects in all aspects of life.

Problem Statement

Upon arrival in the United States, refugees undergo a resettlement process that includes a Domestic Refugee Medical Examination (DRME) within 30-90 days of arrival (CDC, 2014b), or even sooner for people with certain medical conditions (known as class B conditions). The Centers for Disease Control and Prevention (CDC) have identified mental health screenings as an important component of the DRME (CDC, 2014a). Within the Salt Lake Valley, there are

three clinics that conduct DRME's, with two clinics responsible for the majority of the examinations. These clinics are currently using the Refugee Health Screener-15 (RHS-15) to screen for mental health issues (A. Self, personal communication, September 3, 2014); however, this screening tool is only validated for use in individuals aged 14 and older (Hollifield et al., 2013). The Refugee Mental Health Subcommittee, a subcommittee of the State Refugee Health Advisory Committee, has recognized the need to identify a mental health screening tool for refugees under the age of 14, but such a tool has not yet been selected or tested.

Clinical Significance and Policy Implications

Out of the 1,276 refugees resettled in Utah between October 1, 2012 and September 30, 2013, 418 were under the age of 14 (A. Self, personal communication, September 15, 2014). In the time period between October 1, 2013 and September 15, 2014, 1,237 refugees were resettled in Utah and 403 are under the age of 14 (A. Self, personal communication, September 15, 2014). Nearly one-third of all refugees resettled in Utah are under the age of 14, but only 2 - 3% (8/327 in 2013 and 7/237 in 2014) of documented refugee mental health service referrals are made for this youth population (A. Self, personal communication, September 15, 2014).

This project served to increase the identification of mental health concerns that require referral to mental health services for refugee youth under the age of 14 in Utah. Information gleaned from this project will be utilized by the UDOH to determine Utah's mental health screening policy for refugees under the age of 14. Ultimately, this project will contribute to improved health, wellness, and acculturation of refugee youth with mental health disorders by identifying concerns and connecting these youth with the necessary mental health services.

Objectives

The purpose of this project was to determine the practicality and provider acceptability of a tool to screen for mental health concerns in refugees under the age of 14. The following objectives served to meet this purpose:

1. Identify a tool that will be usable during the 40-60-minute DRME, is validated for use in individuals under the age of 14, and has been used previously with refugee populations.
2. Assist two of the clinics responsible for conducting DRMEs in Salt Lake City to implement a pilot test of the identified screening tool
3. Evaluate the use and outcomes of the identified mental health-screening tool.
4. Disseminate the findings to the Refugee Mental Health Subcommittee and the pilot clinics.

Literature Review

The refugee admissions program in the United States is steeped in a history of war and conflict. The first piece of refugee-related legislation was enacted following the end of World War II (ORR, n.d.). The Displaced Persons Act of 1948 permitted entry of 400,000 additional persons to the United States in addition to the 250,000 who had arrived prior to its enactment (BRYCS, 2014: ORR). With the end of the Vietnam War in 1975, hundreds of thousands of displaced people required resettlement. Many of these individuals were resettled through a temporary task force with temporary funding, until the Refugee Act of 1980 was enacted, which continues to guide refugee resettlement today (ORR).

Since 1975, over 3 million refugees have been resettled in the United States (U.S.) (ORR, n.d.). The majority of these refugees have arrived from the Indochinese region or from countries of the former Soviet Union (ORR), though increasing numbers of refugees are arriving from

African countries including Somalia and Sudan and Middle Eastern countries including Iraq and Iran (ORR, 2013). The five most common nativities resettled in Utah in 2013 included Iraqi, Somali, Bhutanese, Karen, and Burmese, representing 73.18% of all refugees resettled in Utah (UDOH, 2014). The most common languages spoken by refugees in Utah include Arabic, Somali, Nepali, Dari/Farsi and Karen (A. Self, personal communication, September 15, 2014). In 2015, resettlement of similar ethnic groups in Utah is expected with a possible increase in the number of refugees resettled from the Democratic Republic of the Congo and Syria (A. Self, personal communication, September 16, 2014).

Becoming a Refugee

While the life of each person who gains refugee status is unique, it is helpful to consider the lives of refugees collectively within a model known as the "triple trauma paradigm" (Beckman et al., 2005). This model divides the refugee experience into three distinct periods: pre-flight, flight, and resettlement. Each phase is characterized by circumstances that can have profound effects on the health and emotional well being of the refugee. The pre-flight phase includes the period of time (sometimes as long as several years) leading up to the decision to flee one's home. This period often includes a gradual increase in threat towards one's life or family's lives until the perceived threat becomes so great that the individual makes a decision to flee his or her homeland. This decision to flee leads to the flight period, wherein the individual spends days to years escaping his or her country of origin. Many individuals spend a portion of this flight time living in refugee camps. The third phase, or resettlement phase, is characterized by adaptation and a acculturation within a resettlement country

Individuals who have fled from their homes, are outside of their country of their origin, and are unable to return due to a real or perceived threat of persecution (UNHCR, 2010), are able

to apply for refugee status and resettlement. The resettlement process includes overseas processing (including an overseas medical exam within 6-12 months prior to arrival in the U.S. and a cultural orientation specific to the destination country), assignment to a voluntary agency (VOLAG), placement and arrival in a resettlement location, and referral to eligible programs in this new community (UDOH, 2014; Bishop et al., 2012; & Downes, 2011).

During the overseas medical examination, refugees are screened for "class A" conditions that preclude admission the U.S. and "class B" conditions that require close follow-up upon arrival in the U.S (Bishop et al., 2012; Downes, 2011). Mental health conditions are included within these constraints. Due to class A restrictions, refugees will not be permitted entry into the United States if they have active substance abuse or addiction or physical or mental disorders associated with harmful behavior (Bishop et al; Downes). However, refugees with full remission of substance addiction and well-controlled mental illness (class B conditions) are permitted entry into the U.S (Bishop et al.; Downes).

Contributors to Mental Illness

There are multiple stressors and experiences that can contribute to the development of mental ill health in refugee children throughout all phases of the triple trauma paradigm. A major contributor to mental health disturbances for refugee youth during the pre-flight and flight phases is an exposure to violence, torture, or trauma (Betancourt et al., 2012; Lustig et al., 2003). Traumatic exposures during the pre-flight phase include direct or indirect exposure to war and political upheavals, witnessed violence, forced combat experience, and personal exposure to violence (Betancourt et al.; Lustig et al.). During the flight phase, traumatic exposures include separation from caregivers, physical and sexual violence in refugee camps, lack of sufficient food or water, and placement in detention facilities or juvenile jails while awaiting immigration

decisions (especially for unaccompanied minors) (Lustig et al.; Dura-Vila et al., 2013; Measham et al., 2014). During the resettlement phase, refugee youth can be exposed to retraumatization through discrimination and bullying (Lustig, Dura-Vila et al.).

Once resettled in a host country, refugee youth experience new and challenging stressors. These stressors include family-level violence, low socioeconomic status, frequent relocations, language acquisition difficulties, social isolation, disruption of family relationships, difficult peer interactions, generational differences, role reversals, deterioration in family relationships, cultural bereavement, uncertainty regarding asylum status, and downward mobility (Betancourt et al., 2014; Measham et al., 2014; Fazel, Reed, Panter-Brick, & Stein, 2012; Crowley, 2009; Bronstein & Montgomery, 2011; Dura-Vila et al., 2013; Vostanis, 2014; Goosen, Stronks, & Kunst, 2014; Panter-Brick, Grimon, & Eggerman, 2014). Unaccompanied asylum seeking children (UASC) have significant increases in mental health disturbances within the resettlement country due to an interaction of traumatic experiences throughout all phases of the triple trauma paradigm and the loss of parents and caregivers (Sanchez-Cao, Kramer, & Hodes, 2013).

Caregiver mental illness has been shown to be a significant contributor to mental disturbances in refugee youth (Panter-Brick, Grimon, & Eggerman, 2014). In fact, caregiver psychopathology is such an important consideration that the CDC specifically recommends that mental health screenings during the DRME should focus primarily on adults because improving caregiver and parental mental illness will also lead to improved mental health for refugee youth (CDC, 2014a). However, it is clear that in Utah there are many refugee youth who would likely benefit from mental health services that are not currently offered referrals for these services.

Despite these significant contributors to mental illness, multiple studies have demonstrated that refugee youth can be quite resilient (Crowley, 2009: Fazel et al, 2012).

Moreover, there are important protective factors that can be beneficial for the mental health and well being of refugee youth. These protective factors include family cohesion and support, good parental mental health, perceptions of acceptance within the resettlement country, low peer violence and discrimination, perceived sense of safety and feelings of belonging at school, continued alignment with native culture while successfully integrating into the host country, acquisition of resettlement country language, religious participation, and good community networks (Fazel et al.; Betancourt et al., 2014)

Mental Health Disorders in Refugee Youth

In Arthur Kleinman's (1991) work *Rethinking Psychiatry: From Cultural Category to Personal Experience*, he expressed that "ethnographic studies demonstrate convincingly that concepts of emotions, self and body, and general illness categories differ so significantly in different cultures that it can be said that each culture's beliefs about normal and abnormal behavior are distinctive" (p. 49). An understanding of the important cultural and situational implications for refugee mental health is necessary prior to engaging in a discussion of mental health disorders in refugee youth. Crowley (2009) suggests that it is perhaps not appropriate to apply Western psychopathological diagnoses to children from non-Western cultures. Moreover, Crowley reasons that the typical responses of refugee youth to their horrendous and traumatic exposures are conceivably within the spectrum of normal rather than a representation of an underlying pathology. However, considering that untreated or undertreated mental health disturbances – whether normal or pathological – can lead to poorer health outcomes into adulthood and even affect the health and wellness of future generations (Fazel et al., 2012), it is important to identify those youth who would benefit from mental health services and connect

them with the appropriate resources (Crowley). In these situations, a diagnosed mental illness is often necessary in order to mobilize these resources.

With the above disclaimer in mind, the most commonly diagnosed psychological disorders in refugee youth include posttraumatic stress disorder (PTSD), depression, and anxiety disorders (Vostanis, 2014; Dura-Vila, Klasen, Makatini, Rahimi, & Hodes, 2013; Bronstein & Montgomery, 2011; Crowley, 2009; Measham et al., 2014; Betancourt et al., 2012). Refugee youth also demonstrate behavioral and conduct disorders (Dura Vila et al., Bronstein & Montgomery), substance abuse disorder (Crowley), and a number of psychological signs and symptoms including sleep disturbances, nightmares, inattention, withdrawal, somatic symptoms, self-harm, attachment problems, school and learning difficulties, and peer problems (Bronstein & Montgomery; Crowley; Measham et al.; Betancourt et al.). Prevalence data for mental health disturbances in refugee youth varies considerably based on the study and population. A systematic review by Bronstein & Montgomery revealed rates of PTSD and depression in refugee children from 19 to 54% and 3 to 30% respectively. A literature review by Crowley, however, found PTSD rates to be 20 to 70%, depression rates to be 15 to 47%, and one study mentioned anxiety rates at 23%. It is clear that data regarding prevalence of diagnosed or diagnosable mental health disorders in refugee youth varies substantially, but that diagnosable conditions do develop with considerable frequency.

Mental Health Screening for Refugee Youth

Screening tools. Some state Refugee Health Programs, such as the program in Colorado, do not use a formal mental health screening instrument for refugee youth (Savin, Seymour, Littleford, Bettridge, & Giese, 2005); moreover, the CDC (2014a) has specifically recommended that formal screening is only necessary for adult refugees. However, the UDOH Refugee Mental

Health Subcommittee believes that there is a gap between the number of refugee youth who could benefit from services in Utah and the number who are being referred for these services. Screening tools have been shown to be helpful in identifying mental health concerns of refugee youth (Crowley, 2009; Bronstein & Montgomery, 2011; Achenbach et al., 2008), leading to appropriate referrals and improved adjustment.

Few mental health screening tools have been developed specifically for refugees and none have been developed for use in refugees under the age of 14. The two tools that have been developed for refugee populations, the RHS-15 and the Hopkins Symptom Checklist-37 (HSCL-37) were not designed for and have not been tested in children under the age of 14 and 12 respectively (Hollifield et al., 2013; Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007). However, there are two tools—the Strengths and Difficulties Questionnaire (SDQ) and the Achenbach System of Empirically Based Assessment (ASEBA)—that have been validated for use in children under the age of 14 and have been tested in a variety of cultural contexts (Achenbach et al., 2008). While these tools have been used or recommended for use with refugee youth (Crowley, 2009; Bronstein & Montgomery, 2011; A. Green, Personal Communication, December 30, 2014), rigorous validation studies have never been conducted with refugee populations resettled in Western countries (Crowley; Vostanis, 2006). In addition, there is one tool currently in development by the National Child Traumatic Stress Network (NCTSN) with partnership from a local organization in Salt Lake City, the Children's Center (B. Pace, personal communication, September 26, 2014). This tool, the Traumatic Events Questionnaire (TEQ), has been designed specifically for children who have been exposed to trauma. The tool has not yet been thoroughly tested or validated. In addition, the tool would

likely not be the right fit for this project because its narrow focus might lead to missed mental health concerns in children who have not been victims of trauma.

ASEBA. There are three different tools that comprise the ASEBA system: The Child Behavior Checklist (CBCL), a parent-reported form; the Teacher's Report Form (TRF); and the Youth Self Report form (YSR) (Achenbach et al., 2008). The tools assess empirically based syndromes, Diagnostic Statistical Manual (DSM) scales, and internalizing and externalizing behaviors. Psychometric properties for all scales on all three forms have been substantial both in U.S. and non-Western societies.

SDQ. The SDQ instrument was developed in 1994, and has seen extensive testing in a variety of cultures since its introduction (Achenbach et al., 2008). The SDQ is currently available in over 75 different languages including three of the five most commonly spoken languages by refugees in Utah (Arabic, Somali, and Dari) (Youthinmind, 2009). Like the ASEBA, the SDQ has good psychometric properties in the U.S. (Achenbach et al.; Bourdon, Goodman, Rae, Simpson, & Koretz, 2005) and non-Western countries (Woerner et al., 2004; Vostanis, 2006), but also has the advantage of being available for free online (Crowley, 2009). The SDQ is comprised of at total of 25 questions across five subscales: pro-social, hyperactivity, emotional, conduct, and peer problems (Vostanis). The pro-social subscale increases the user friendliness of the tool because the pro-social items decrease the parent perception of judgment against their child (Vostanis). The instrument is available in English in both teacher and parent reported forms for children age 2-4, 4-10, and 11-17, and a self reported form for children age 11-17 (Vostanis). Many of the translated forms are only available in the teacher and parent reported versions for age 4-17.

Barriers. A qualitative study by Ellis, Miller, Baldwin, & Abdi (2011) was conducted to identify the barriers that exist in accessing mental health services for refugee youth. This study found that common barriers exist among refugee youth from different cultures. These barriers include distrust of authorities, stigma of mental illness, language and cultural barriers, and prioritization of needs. Refugee youth are not likely to access mental health services if more primary needs such as adequate food or shelter have not been met.

In some cases, refugee youth have learned that sharing personal information with strangers can place them at significant risk for violence, so are reluctant to share deeply personal and often traumatic information with a stranger within the resettlement country (Ellis, Miller, Baldwin, & Abdi). According to B. Pace (personal communication, September 26, 2014), mental health service providers in Utah have recognized that refugees who have arrived from Iraq demonstrate a particular stigmatization of mental illness. This is presumed to be due to mental health treatment in Iraq where formal psychiatric services are not offered except in cases of severe psychopathology (e.g. schizophrenia). In order to overcome this barrier, it is important to educate refugee youth and their families about mental health services, how they work, and what to expect when accessing these resources (Crowley, 2009). Ellis, Miller, Baldwin, & Abdi suggest that to overcome language and cultural barriers, mental health services should be provided with a medically-trained interpreter in the child and parent's native language and should consider the culture-specific explanations of mental illness and as well as the history of the country of origin and the child/family's reasons for fleeing their home country.

Theoretical Framework

The Ottawa Model for Research Use (OMRU) provided a conceptual framework to guide this scholarly project. The OMRU was created by Logan & Graham (1998) to help guide the

implementation of health care research in clinical practice. The OMRU framework consists of six key interactive elements: evidence-based innovation, potential adopters, practice environment, transfer strategies, adoption, and outcomes (Logan & Graham). These six elements are connected by a process of evaluation that involves assessing barriers, monitoring use, and evaluating outcomes (AME) at each stage of research transfer (Logan & Graham). Appendix A provides a visual representation of this model.

The evidence-based innovation integral to this project was the implementation of a tool to screen for mental health concerns in refugee youth under the age of fourteen. According to Logan & Graham (1998), the adoption of an innovation is highly influenced by the perceptions of the potential adopters. An innovation is most likely to be adopted if the developer is credible, if the adopters are involved in the implementation process, if the process is transparent, if there is evidence-based support, if it is user-friendly, and if it is testable. Other considerations within health care include the risk-benefit ratio for patients, ethical considerations, and the attractiveness of the tool (Logan & Graham).

The practice environment for this scholarly project included two pilot clinics that conduct DRMEs for refugee patients in the Salt Lake Valley. For successful implementation of an innovation, there must be consideration of the structural and social aspects of the practice environment as well as the patients that are seen within the environment (Logan & Graham, 1998). The decision-making structure, policies, physical structure, workload, resources, incentive system, politics and personalities, presence of advocates and champions, organizational culture, and patient preference are all important considerations regarding the practice environment.

The potential adopters in this scholarly project include the clinic managers, providers conducting DRMEs, and support staff at the two pilot clinics. In order to ensure successful adoption of an innovation, it is essential to view the innovation from the perspective of all the potential adopters (Logan & Graham, 1998). It is therefore necessary to identify perceptions of potential adopters prior to the implementation of an innovation in order to tailor the innovation to meet the needs of those people who will be responsible for its use.

The last three components of the OMRU include research transfer strategies, research adoption and use, and outcomes. The research transfer strategies are the methods used to disseminate the innovation into the practice environment and to the potential adopters (Logan & Graham, 1998). The most effective research transfer strategies are those that consider the barriers and supports within the practice environment. According to Logan & Graham, research adoption and use serves to evaluate the success of the transfer process by monitoring and evaluating the extent to which the innovation is used. The outcomes of the innovation relate to the impact of its implementation (Logan & Graham). In order to determine outcomes, information must be gathered about the impact of the intervention on the key stakeholders: providers at the pilot clinics, support staff, and patients.

Implementation

Objective 1: Identify a Tool

The first objective for this scholarly project was to identify a mental health screening tool. In order to accomplish this objective, a search for evidence-based innovations related to mental health screenings was conducted to identify tools that had been utilized and studied in refugees under the age of 14. In addition to searching the peer-reviewed literature, a representative of a local organization that works with refugees under the age of 14 was contacted

to determine if providers were currently using any tools with this population. The identified tools were evaluated for content, ease of administration (specifically number of questions and credentials necessary for administration), and the number of languages into which the tool had been translated and presented to the Refugee Mental Health Subcommittee for approval. The SDQ was chosen as the mental health screening tool for this project.

Objective 2: Implement the Tool

The second objective for this DNP scholarly project was to implement a pilot test of the mental health screening tool within two pilot clinics. As the OMRU clearly indicates that innovations are much more likely to be successful if there is participation and buy-in from the potential adopters, meetings were held with the key stakeholders at each of the pilot sites to identify barriers and supports within the practice setting and to develop a clinic flow protocol to integrate the mental health screening tool into the DRME. A paper survey for the involved providers was created with assistance from two representatives at the Study Design and Biostatistics Center (SDBC) at the University of Utah to further identify perceived barriers and supports of the providers (see Appendix E). This survey was reviewed for face and content validity by the SDBC representatives, the director of the UDOH Refugee Health Program, and the project chair. Additionally, a pediatrician in Vermont, Dr. Andrea Green, was contacted due to her experience using and studying the SDQ in her practice with refugee children. Information gained from the stakeholder meetings, surveys, and Dr. Green was used to tailor research transfer strategies and provider education (see Appendix H). An Institutional Review Board (IRB) application was submitted for this project to the University of Utah and the UDOH. The project was considered quality improvement in nature and was deemed exempt from IRB oversight by both the University of Utah and UDOH (See Appendix F). Following receipt of the IRB

decision, survey completion, and education of all involved providers, a six-week pilot test of the SDQ was conducted at the two pilot clinics.

Objective 3: Evaluate the Tool

The third objective for this scholarly project was to evaluate the use and outcomes of the identified mental health screening tool. In an effort to elucidate provider satisfaction with the clinic process flow and perceived parent reception of the SDQ, a post-implementation survey was created with assistance from the two representatives at the SDBC (see Appendix E). This survey was reviewed for face and content validity by the SDBC representatives, the director of the UDOH Refugee Health Program, and the project chair. The surveys were administered following the completion of the pilot. All five providers involved in the pilot were invited to complete a survey with an 80% response rate. In addition, mental health service referrals for refugees under the age of 14 in Utah from the equivalent six weeks during the year preceding the pilot (January 27, 2014, through March 7, 2014) were compared to the number of referrals made during the pilot. To evaluate use of the tool, the number of completed SDQ screenings was compared to the number of children who received DRMEs during the pilot period.

Objective 4: Disseminate Findings

The fourth objective of this scholarly project was to disseminate the findings. This objective was designed to promote the sustainability of the project. The provider satisfaction results, perceived parent reception, use (number of screenings completed compared to the number of children selected for inclusion in the pilot), and outcomes (referrals) of the project were shared with the State Refugee Health Advisory Committee, Refugee Mental Health Subcommittee, and the key stakeholders at the pilot sites.

Evaluation

All four objectives of this scholarly project were evaluated using met/not-met criteria. The objectives were considered "met" if all components were accomplished prior to the pre-stated completion dates (see Appendix B for the projected completion dates). Additionally, pre- and post-implementation questionnaires were reviewed for common themes and evaluated using descriptive statistics (see Appendix G).

Results

Objective 1: Identify a Tool

Through the literature search and phone conversation, the SDQ and ASEBA tools were identified as potential screening questionnaires for this project on October 3, 2014. The SDQ was chosen and presented to the director of the State Refugee Health Advisory Committee on October 8, 2014. The director of the State Refugee Health Advisory Committee approved the tool on October 27, 2014. This tool was selected for this project because it has been validated in numerous multicultural contexts (Achenbach et al., 2008), is available in over 75 languages (including three of the five most commonly spoken languages in Utah) for free online, and is user friendly due to the inclusion of positively worded items. This objective was met as all criteria were completed before the projected completion dates.

Objective 2: Implement the Tool

Pre-implementation questionnaires were created on October 14, 2014, and sent for review to the SDBC representatives, project chair, and director of the State Refugee Health Advisory Committee. The review was completed on October 27, 2014. Stakeholder meetings occurred on December 2, 2014, and December 8, 2014, at the two pilot clinics. These meetings clearly revealed that providers were concerned about their limited time. They were especially concerned

that it would be difficult to perform mental health screenings on an entire family if a single parent presented with multiple children. The providers also felt that the scoring of the questionnaire was too cumbersome. Additionally, there was a concern voiced about the validity of the SDQ when used with the refugee population. The previously mentioned pediatrician, Dr. Green, stressed the importance of educating interpreters prior to the DRME to ensure that all items on the form were clear and that the interpreters understood the rationale for the screening.

All five providers who conduct the DRMEs were contacted in person by the lead investigator and invited to participate in the pre-implementation survey. There was a 100% response rate, though one questionnaire was incomplete. Pre-implementation surveys were completed over a six-day period between January 6, 2015 and January 12, 2015. Results of the pre-implementation questionnaires can be found in Appendix G. Barriers identified from the Likert-style and open-ended questions on the pre-implementation questionnaire included time, perceived lack of need, and parental resistance. Identified supports included interpreters and support staff.

An educational presentation (see PowerPoint presentation in Appendix F) was offered to all providers following survey completion. This education was tailored to address the concerns, barriers, and supports previously identified by providers and other stakeholders. It was determined that only one child per family would by included in the pilot study. In order to facilitate interpreter education, it was decided that one child per family would be randomly pre-selected for inclusion in the pilot and that the director of the State Refugee Health Advisory Committee would coordinate interpreter education with the resettlement agencies prior to the DRME. To address concerns with scoring, two tools (one for the Arabic version of the instrument and one for all other languages) were created as a color-coded single-page quick

reference for providers (see Appendix I). The educational presentation also included information about the validity of the SDQ.

The pilot start date was delayed until January 26, 2015, in order to facilitate interpreter education and coordination with the resettlement agencies. The pilot occurred over a period of six weeks and concluded on March 6, 2015. All components of this objective were completed, but they were not completed prior to the projected completion dates. This objective, therefore, was met with conditions.

Objective 3: Evaluate the Tool

In accordance with the OMRU theoretical framework, use and outcomes of the SDQ were evaluated throughout and following the pilot period. Mental health referrals were used as the primary outcome measure for this project. During the pilot period, a total of 41 children under the age of 14 presented for their DRME and nine (21.95%) were screened for mental health concerns with the SDQ. These nine children were selected based on the scheduled DRME information from the State Refugee Health Advisory Committee. The intention was to include one child between the age of two and 14 per family encounter at one of the two pilot sites. If a family with more than one child between the age of two and 14 was scheduled for a DRME during a single clinic encounter, then the child selected for inclusion in the pilot was based on random number generation. Unfortunately, all eligible children were not included in the pilot due to scheduling and rescheduling issues and miscommunication between one of the pilot sites and the State Refugee Health Advisory Committee. One provider at one of the pilot sites saw five of the children included in the pilot and three providers at the second pilot site saw the additional four children.

Of the nine children included in the pilot, two (22.22%) had positive results on the SDQ and were offered referrals for mental health services. At pilot conclusion, the number of intra-pilot referrals was compared to the number of referrals that occurred during the equivalent range of dates in 2014. During January 27, 2014, through March 7, 2014, no children were referred for mental health services. Additionally, during the pilot period there were 32 children who received DRMEs but did not received mental health screenings with the SDQ. None of these children were referred for mental health services. Providers indicated that the mental disturbances experienced by the children who were referred for mental health services during this pilot period were not immediately apparent and they likely would not have been referred for services without the positive SDQ results. This pilot resulted in two more appropriate mental health service referrals than the equivalent range of dates in 2014. If the referral trend demonstrated in this project were to continue, it is possible that an additional seven children could have been identified and referred for mental health services if all children who presented for DRMEs during the pilot period had been screened for mental health concerns with the SDQ.

The primary purpose of this scholarly project was to determine the provider acceptability of a tool (the SDQ) to screen refugee youth under the age of 14 for mental health concerns. The post-implementation questionnaire that was developed to determine provider satisfaction with the tool and the clinic process flow as well as perceived parent reception of the tool was used to evaluate provider acceptability. Post-implementation questionnaires were completed over a period of four days between March 9, 2015, and March 12, 2015. Out of the five providers who completed the pre-implementation surveys, one provider did not complete any of the pilot mental health screenings and therefore declined to complete a post-implementation questionnaire. Results of the post-implementation questionnaire can be found in Appendix G. Providers were

generally neutral about continued use of the SDQ. Providers liked the questions on the SDQ and felt that it provided a resource to help identify mental health concerns in younger refugees. However, providers expressed concerns with the length of the tool, time required to complete, scoring, and interpretation difficulties. Providers did not perceive that parents were unwilling to complete the questionnaire, but parental literacy was a barrier to completion.

There was one subject who offered suggestions to improve the provider acceptability of the tool. This provider suggested that the tool would have greater acceptability if case managers or interpreters were trained to administer the tool prior to the office visit. Alternatively, the provider suggested creating a shorter tool to screen refugee youth under the age of 14 for mental health concerns. This objective was met as all components were completed by the projected completion date.

Objective 4: Disseminate Findings

The results from this project were presented to the State Refugee Health Advisory Committee, Refugee Mental Health Subcommittee, and the key stakeholders at the pilot sites at a Refugee Health Screening Coordination Meeting on March 18, 2015. Due to the small sample of children included in this pilot project, it was recommended that the pilot be extended to obtain a larger sample size, increase provider familiarity of the tool, and gain a better understanding of provider acceptability. The key stakeholders at the pilot sites agreed to an extended test of the tool, and the director of the State Refugee Health Advisory Committee identified an employee who would continue the pilot. To ensure success with this pilot extension, a summary document (see Appendix J) was presented to the director of the State Refugee Health Advisory Committee on March 23, 2015. The project was further disseminated at a University of Utah College of

Nursing poster session on March 27, 2015. This objective was met as all components were completed by the projected completion deadline.

Limitations

This project was limited by the small sample size included in the pilot test of the SDQ. Out of the five providers who were included in the pilot, one did not have the opportunity to screen any children with the SDQ during the pilot period, two of the providers only screened one child each, one provider screened two children, and one provider screened five children. The sample size was limited by the provider-directed restriction to only include one child per family. However, even with this restriction, there were 23 children who should have been eligible for inclusion in the pilot, but only nine were included. These additional 14 children were missed due to scheduling and rescheduling issues and limited communication between one of the pilot clinics and the director of the State Refugee Health Advisory Committee (who was coordinating interpreter education with the resettlement agencies).

Recommendations

This project demonstrated that potential of the SDQ to increase appropriate referrals for mental health services in refugees under the age of 14. Providers were neutral about continued tool use, but did believe that the SDQ contained good questions and that the tool likely would increase their ability to connect children who may be struggling with mental health disturbances with beneficial services. The concerns cited by providers – time, length, interpretation difficulties, and scoring – would likely become less troublesome with increased familiarity with the tool. Because of these findings, my primary recommendation is to extend the pilot in order to increased provider familiarity with the tool, gain a larger sample size, and develop a better impression of provider satisfaction with the tool. Moving forward, it would be beneficial to

include only those children who are from nativities for whom the tool has already been translated and to provide extensive education to interpreters who will be assisting with the completion of the tool (in the case of parental low literacy). Moreover, it would ultimately be worthwhile to translate the tool into additional languages commonly spoken by nativities resettled in Utah to limit the need for interpreter assistance completing the tool. Additionally, validation studies of the SDQ in refugee populations resettled in Western nations are lacking, so this is a great area for future research. If providers ultimately decide not to use the SDQ, then I recommend the development of a task force to create a shorter and easier to score tool to screen refugee children under the age of 14 for mental health concerns.

DNP Essentials

The Doctor of Nursing Practice (DNP) essentials identify the key competencies that must be contained within the curriculum for a DNP degree (Hathaway et al., 2006). The eight DNP essentials encompass the core competencies that are essential to any advanced nursing practice role. This project is influenced by six of these DNP essentials and demonstrates a synthesis of my DNP education. The essentials evident within this project include: I) The Scientific Underpinnings for Practice, II) Organizational and Systems Leadership for Quality Improvement and Systems Thinking, III) Clinical Scholarship and Analytical Methods for Evidence-Based Practice, V) Health Care Policy for Advocacy in Health Care, VI) Interprofessional Collaboration for Improving Patient Health Outcomes, and VII) Clinical Prevention and Population Health for Improving the Nation's Health (Hathaway et al.).

This project's purpose was based on the OMRU theoretical framework to formulate and evaluate a new clinical practice approach based on the patterning of human behavior in relation to the environment (Essential I). Essential II was evident in this project due to the development

of a care delivery approach to address the needs of the refugee youth population as identified by scientific studies. The thorough literature review conducted to identify tools appropriate for the project's target population provided evidence of Essential III. Health care policy (Essential V) was influenced through the dissemination of findings to the pilot clinics and the Refugee Mental Health Subcommittee to influence the mental health screening policy for refugees under the age of 14 at the involved screening clinics. Essential VI was accomplished by including multidisciplinary stakeholders in the development and implementation of the project (family practice physicians, nurse practitioners, physician's assistants, social workers, psychiatrists, psychologists, and medical clinic support staff). Lastly, this project was focused on improving the health of a vulnerable population within a local community, meeting the criteria for DNP Essential VII.

Conclusion

It is clear that refugee children can and do experience many contributors to mental health disturbances. Prior to this project, there was no standard method to screen children under the age of 14 for mental health concerns in Utah. This project sought to determine if the SDQ would be a practical and acceptable tool to screen this young refugee population for mental health concerns.

At the project conclusion, it is not known if the SDQ will be ultimately adopted as Utah's tool of choice to screen refugees under the age of 14 for mental health concerns. At the very least, this project served to increase provider awareness of the mental health issues experienced by refugees under the age of 14 in Utah. Moreover, this project has provided a firm foundation to further determine if the SDQ will be an acceptable tool for providers to screen for mental health disturbances in refugees under the age of 14. Ultimately, this project served to increase

the health and wellness of this young refugee population through a process of identification of children with mental disturbances and timely referral for mental health services.

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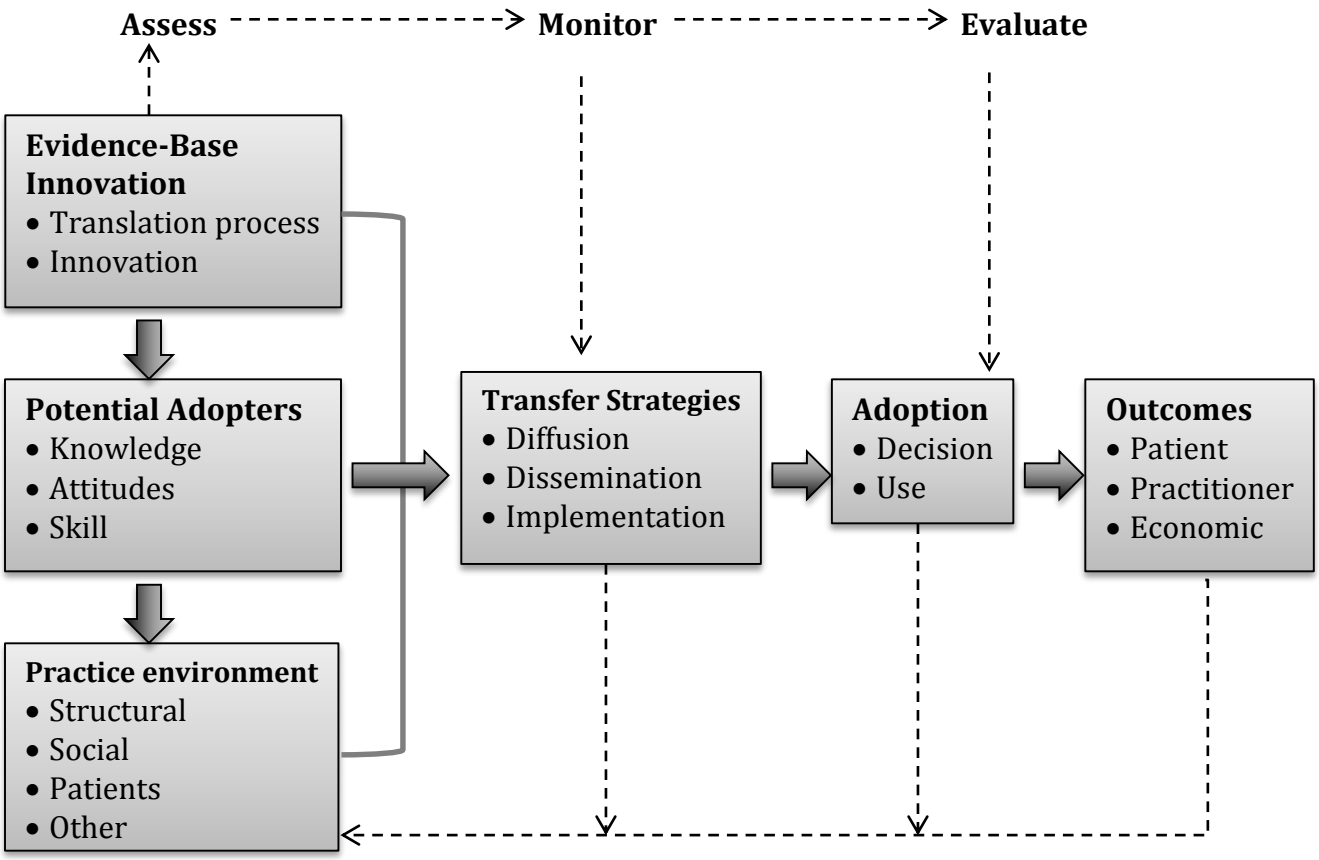
Appendix A
Ottawa Model of Research Use



Appendix B
Implementation and Evaluation Plan

Objective 1: Identify a tool that will be usable within the context of the 40-minute DRME, is validated for use in individuals under the age of 14, and has been used previously with refugee populations.	
Implementation	**Evaluation**
▪ Search for evidence-based innovations related to mental health screening tools for refugee youth under the age of 14 before October 1, 2014 ▪ Evaluate identified screening tools for content, ease of administration, and languages available ▪ Share the identified tool with the UDOH Refugee Mental Health Subcommittee for final approval	▪ Met/not met criteria ▪ Search completed by October 4, 2014 ▪ Evaluation and review by Refugee Mental Health Subcommittee by October 15, 2014
Objective 2: Implement the mental health screening tool within three pilot clinics.	
Implementation	**Evaluation**
▪ Meet with key stakeholders at each of the three clinic sites to assist in the development of a clinic flow protocol to integrate the mental health screening tool into the DRME ▪ Create, test, and administer pre-implementation surveys. ▪ Submit IRB applications ▪ Educate the providers at each of the pilot sites about refugee youth mental health concerns, appropriate use of the identified mental health screening tool, and referral process ▪ Administer the tool during the DRME to one refugee under the age of 14 per family screened at each pilot site for six weeks	▪ Met/not met criteria ▪ Meeting with stakeholders before December 12, 2014 ▪ Surveys created by October 15, 2014 ▪ Surveys tested by October 22, 2014 ▪ IRB applications submitted by October 31, 2014 ▪ Providers surveyed by December 19, 2014 ▪ Provider education completed by January 9, 2015 ▪ Pilot conducted from January 26, 2014 through March 6, 2015
Objective 3: Evaluate the use of the identified mental health-screening tool to determine provider satisfaction with the tool, congruence with provider mental health assessment, clinic process flow, perceived parent reception, and number of referrals using a pre/post-test design.	
Implementation	**Evaluation**
▪ Create, test, and administer post-implementation surveys ▪ Submit IRB applications ▪ Gather referral data ▪ Gather screening tool utilization data	▪ Met/not met criteria ▪ Survey created by October 15, 2014 ▪ Survey tested by October 22, 2014 ▪ IRB applications submitted by October 31, 2014 ▪ Referral data gathered throughout the pilot (January 26, 2015 through March 6, 2015) and compared to equivalent 2014 dates at pilot conclusion ▪ Screening tool use data gathered throughout the pilot (January 26, 2015 through March 6, 2015) ▪ Post-implementation surveys completed by March 13, 2015
Objective 4: Disseminate findings to Utah Department of Health Refugee Mental Health Subcommittee and the providers at the pilot clinics.	
Implementation	**Evaluation**
▪ Attend the Refugee Mental Health Subcommittee meeting and present results to the subcommittee ▪ Meet with the clinic directors at the pilot sites to present results	▪ Met/not met criteria ▪ Results presented to subcommittee and pilot sites by March 20, 2015

Appendix C
Proposal Defense PowerPoint

Integrating Refugee Youth Mental Health Screenings into the Domestic Refugee Medical Examination

Diane Kay Chapman, RN, BSN, CCRN

In partial fulfillment of the requirements for the Doctor of Nursing Practice degree
October 2, 2014

Background

- Domestic Refugee Medical Examination (DRME) within 30-90 days of resettlement (CDC, 2014)
- Mental health screenings should be included in the DRME (CDC, 2014)
- Three clinics in Salt Lake Valley conduct DRME's
- Refugee Health Screener-15 (RHS-15) used to screen for mental health concerns

Problem Statement

- RHS-15 is validated for use in refugees ≥ 14
- Refugee youth experience significant psychological distress (Bronstein & Montgomery, 2011)
- Mental health screening tool for refugees <14 has not been identified for use in Utah
- Purpose: To determine the practicality and provider acceptability of a tool to screen for mental health concerns in refugees under the age of 14 in Utah

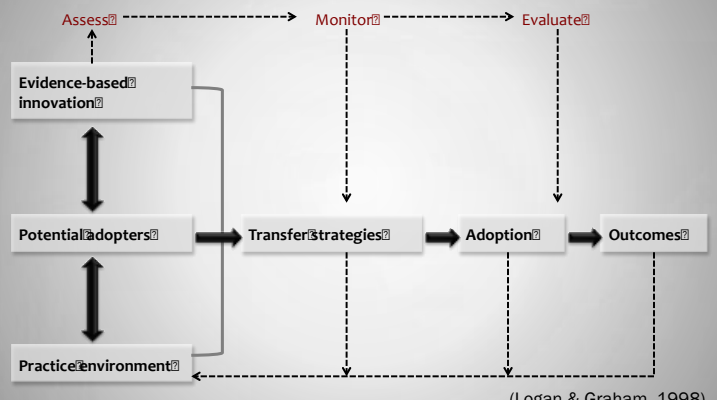
Significance & Policy Implications

- Roughly 1/3 of refugees resettled in Utah are <14 years of age. (A. Self, personal communication, September 15, 2014)
- 2-3% of refugee mental health referrals are <14 years of age. (A. Self, personal communication, September 15, 2014)
- Will help determine youth refugee mental health screening policy in Utah
- Timely referral → improved health, wellness, and acculturation

Objectives

1. Identify a mental health screening tool
2. Assist three pilot clinics to implement a pilot test of the identified screening tool
3. Evaluate the use and outcomes of the mental health screening tool
4. Disseminate the findings

Ottawa Model of Research Use



(Logan & Graham, 1998)

Literature Review

- Contributors to Mental Illness

(Dura-Vila et al., 2013; Jakobsen, Demott, Heir, 2014; Goosen, Stronks, & Kunst, 2013; Panter-Brick, Grimon, & Eggerman, 2014; Betancourt et al., 2012)

- Common disorders

(Crowley, 2009; Dura-Vila et al., 2013; Jakobsen, Demott, Heir, 2014)

- Barriers

(Ellis, Miller, Baldwin, & Abdi, 2011)

- Screening Tools

(Vostanis, 2006; Achenbach et al., 2008)

Implementation & Evaluation

Objectives	Implementation	Evaluation
1. Identify	• Review published articles and contact local mental health clinics • Evaluate identified tools • Share tool with UDOH for approval	• Tool identified (10/4/14) • Tool evaluated (10/15/14) • Tool shared with UDOH (10/15/14)
2. Implement	• Meet with stakeholders at clinics • Create, test, and administer pre-implementation survey • Submit IRB applications • Educate providers • Administer tool during DRME	• Meeting with stakeholders (12/12/14) • Survey created (10/15/14) and tested (10/22/14) • IRB applications submitted (10/31/14) • Providers surveyed (12/19/14) • Surveys analyzed (12/23/14) • Provider education completed (1/9/15) • Pilot conducted (1/12/15-3/6/15)

Implementation & Evaluation

Objectives	Implementation	Evaluation
3. Evaluate	• Create, test, administer, and analyze post-implementation survey • Submit IRB applications • Gather and analyze referral data • Gather and analyze screening tool use data	• Survey created (10/15/14) and tested (10/22/14) • IRB applications submitted (10/31/14) • Pre-implementation referral data gathered (1/12/15) • Referral data gathered throughout the pilot • Screening tool use data gathered throughout the pilot • Post-implementation surveys completed (3/13/15) • Post-implementation surveys, referral data, and screening tool use data analyzed (3/19/15)
4. Disseminate	• Share results at UDOH Refugee Mental Health Subcommittee meeting • Share results with key stakeholders at pilot sites	• Results shared with pilot sites and subcommittee (3/20/15)

Summary

- Refugee youth have significant mental health concerns, but are not routinely screened or referred for mental health services in Utah
- Pilot a standard process to screen refugees under the age of 14 for mental health concerns during the DRME
- Sustained by disseminating the findings to the UDOH Refugee Mental Health Subcommittee
- This project is guided by DNP essentials I, II, III, V, VI, and VII

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Committee

Project Chair: Jane Dyer, CNM, FNP, MBA, PhD, FACNM

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Appendix D
Consent Cover Letter

Consent Cover Letter

Integrating Refugee Youth Mental Health Screenings into the Domestic Refugee Medical Examination

The purpose of this project is to determine the practicality and provider acceptability of a tool to screen for mental health concerns in refugee children under the age of 14 during the domestic refugee medical examination. We are undertaking this study because we believe refugee children under the age of 14 would benefit from a standard screening process and connection with mental health services if indicated.

I would like to ask you to complete the enclosed questionnaire and return it to the principal investigator in the attached, unmarked envelope. There are no risks associated with completion of this questionnaire. However, you will benefit from completing the questionnaire, as it will provide you an opportunity to voice you opinion about the identified tool and the clinic process flow. You will not be compensated in any way for completing this questionnaire.

Completion of this questionnaire is completely anonymous, and your responses will remain confidential. In order to allow for the comparison of pre-implementation and post-implementation questionnaires while ensuring your anonymity, I am requesting that you write a unique, personal 4-digit number at the top right hand corner of the questionnaire (participant ID). Please choose a 4-digit number that you will remember so you can write the same code on the post-implementation questionnaire at the end of the pilot study. Completed questionnaires will be kept in a locked drawer and destroyed after the study completion. Only the principal investigator will view the collected data.

If you have any questions, complaints, or if you feel you have been harmed by your participation, please contact Diane Chapman, Doctor of Nursing Practice Student in the College of Nursing at the University of Utah, at (801) 787-2453.

This project has been submitted to the University of Utah and Utah Department of Health Institutional Review Boards. It has been deemed exempt from IRB oversight as it is quality improvement in nature.

It should take 10 minutes to complete the questionnaire. Completion is voluntary. You can choose not to take part. You can choose not to finish the questionnaire or omit any question you prefer not to answer without penalty or loss of benefits.

By returning this questionnaire, you are giving your consent to participate.

Thank you for your time. Your completion of this questionnaire is greatly appreciated.

Appendix E
Pre- and Post-Implementation Questionnaires

UNIVERSITY OF UTAH COLLEGE OF NURSING

Participant Number _____

Refugee Youth Mental Health Screening Pre-implementation Questionnaire

Practice specialty _____

Number of years in practice (round up to nearest year) _____

Experience level with refugee patients (please place a mark on the line to represent your experience level from novice to expert)

0 _____ 10
Novice Expert

How comfortable are you identifying and referring patients with mental health concerns? (please place a mark on the line to represent your comfort level on this continuum)

0 _____ 10
Not comfortable at all Very comfortable

1. I believe there are refugee children under the age of 14 who would benefit from mental health services (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments:

2. I think it would be helpful to have a questionnaire or survey to screen refugee children under the age of 14 for mental health concerns (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments:

3. I believe that a thorough history and physical examination are sufficient to identify mental health concerns in refugee children under the age of 14 (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments:

4. A tool to screen refugee youth under the age of 14 for mental health concerns would not be useful for my practice (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

5. I believe that the current mental health screening process for refugee children under the age of 14 years is insufficient to identify all children who would benefit from mental health services (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

6. There is sufficient time in the initial refugee medical examination to include a screening for mental health concerns for children under the age of 14 years (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

7. The clinical support staff would not be capable of assisting in the administration of a questionnaire to identify mental health concerns in refugee children under the age of 14 (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

8. When I identify a refugee child under the age of 14 with mental health concerns, I know where I can refer them for mental health services (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

9. Interpreters of the patient's native language are typically available during the initial medical examination for refugees (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

10. I feel comfortable screening for mental health concerns in refugee children under the age of 14 (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

11. What do you perceive to be barriers to administering a mental health questionnaire to refugee children under the age of 14 during the initial refugee medical examination?

12. What supportive factors for mental health screening of refugee children under the age of 14 are in place within your practice environment?

Please review the attached Strengths and Difficulties Questionnaire (SDQ) and then answer the following questions:

13. I feel that the SDQ would be useful in the initial mental health screening of refugees under the age of 14 (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

14. I believe that parents of refugee children under the age of 14 would generally be willing to complete the SDQ (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

15. Interpreters present for the initial refugee medical examination would be capable of assisting parents to complete the SDQ (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

16. Have you ever used a tool similar to the SDQ in your practice? Yes/No
If yes, what was your experience?

UNIVERSITY OF UTAH COLLEGE OF NURSING

Participant Number _____

Refugee Youth Mental Health Screening Post-implementation Questionnaire

Practice specialty _____

Number of years in practice (round up to nearest year) _____

1. Did you use the Strengths and Difficulties Questionnaire (SDQ) to screen refugee children under the age of 14 for mental health concerns during the pilot test between January 26, 2015 and March 6, 2015 (Check one)? ☐ **Yes** ☐ **No**
   If yes, then please answer the following 16 questions.
   If no, then please describe why you would or would not want to use this tool during the initial refugee screening examinations for children under the age of 14. You do not need to answer the subsequent questions if you did not use the tool during the pilot.

2. I would like to continue to use the Strengths and Difficulties Questionnaire (SDQ) to screen refugee children under the age of 14 years for mental health concerns (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

3. The SDQ did not increase my ability to recognize mental health concerns for refugee children under the age of 14 years (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

4. What do you like about the SDQ?

5. What do you dislike about the SDQ?

6. I referred more refugee children under the age of 14 years for mental health services due to use of the SDQ (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

7. The process to score the SDQ worked well (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

8. Scores of the SDQ were available or easy to calculate at the time I encountered the patient in the exam room (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

9. The clinical support staff was capable of assisting me with the screening process (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

10. What worked well with the clinic process flow for mental health screening of refugee children under the age of 14 years?

11. How might you suggest improving the use of the tool in your clinic?

12. I noticed that parents were uncomfortable with the SDQ (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

13. There were times when parents were unable to complete the SDQ due to lack of interpreter (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

14. Parental literacy levels were not a problem in the screening process (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

15. Parents were generally willing to complete the SDQ (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

16. The SDQ format seemed acceptable to parents (circle one).

Strongly disagree Disagree Neutral Agree Strongly Agree
Comments

17. Did you perceive that some parents were unwilling to complete the SDQ? If so, for what reasons?

Appendix F
University of Utah Institutional Review Board Decision

2/28/15, 11:35 PM

INSTITUTIONAL REVIEW BOARD
THE UNIVERSITY OF UTAH

75 South 2000 East Salt Lake City, UT 84112 | 801.581.3655 | IRB@utah.edu

IRB: IRB_00077500

PI: Diane Chapman

Title: Integrating Refugee Youth Mental Health Screenings into the Domestic Refugee Medical Examination

Thank you for submitting your request for approval of this project. The IRB has administratively reviewed your application and has determined on 11/26/2014 that your project does NOT meet the definitions of Human Subjects Research according to Federal regulations. Therefore, IRB oversight is not required or necessary for your project.

DETERMINATION JUSTIFICATION:
According to the guidance released in February 2010 by OHRP (see http://answers.hhs.gov/ohrp/categories/1569), this activity meets the description for a Quality Improvement (QI) activity and does not constitute human subjects research. This activity appears to be a quality improvement activity with the objective of providing recommendations for program development to improve services to a particular group. The project does not constitute a systematic investigation that is designed to develop or contribute to generalizable knowledge and does not involve an untested clinical intervention. It therefore, does not satisfy the definition of "research" under 45 CFR 46.102(d).

This determination of non-human subjects research only applies to the project as submitted to the IRB. Since this determination is not an approval, it does not expire or need renewal. Remember that all research involving human subjects must be approved or exempted by the IRB before the research is conducted.

If you have questions about this, please contact our office at 581-3655 and we will be happy to assist you. Thank you again for submitting your proposal.

Click IRB_00077500 to view the application.

Please take a moment to complete our customer service survey. We appreciate your opinions and feedback.

Appendix G
Pre- and Post-Implementation Questionnaire Results

Table 1

Pre-Implementation Provider Questionnaire

Question	Range	Median	Mean	SD
1. I believe there are refugee children under the age of 14 who would benefit from mental health services	(3,5)	4	4.2	0.84
2. I think it would be helpful to have a questionnaire to screen refugee children under the age of 14 for mental health concerns	(3,5)	4	4.2	0.84
3.I believe that a thorough history and physical examination are sufficient to identify mental health concerns in refugee children under the age of 14	(2,4)	3	3	1.00
4. A tool to screen refugee youth under the age of 14 for mental health concerns would not be useful for my practice	(2,4)	2	2.6	0.89
5. I believe that the current mental health screening process for refugee children under the age of 14 years is insufficient to identify all children who would benefit from mental health services	(1,4)	4	3.2	1.30
6. There is sufficient time in the initial refugee medical examination to include a screening for mental health concerns for children under the age of 14 years	(2,4)	2	2.8	1.10
7. The clinical support staff would not be capable of assisting in the administration of a questionnaire to identify mental health concerns in refugee children under the age of 14	(2,3)	2	2.4	0.55
8. When I identify a refugee child under the age of 14 with mental health concerns, I know where I can refer them for mental health services	(2,4)	4	3.4	0.89
9. Interpreters of the patient's native language are typically available during the initial medical examination for refugees	(4,5)	5	4.6	0.55
10. I feel comfortable screening for mental health concerns in refugee children under the age of 14	(2,4)	3	3	1.00
13. I feel that the SDQ would be useful in the initial mental health screening of refugees under the age of 14	(3,4)	3	3.25	0.50
14. I believe that parents of refugee children under the age of 14 would generally be willing to complete the SDQ	(2,4)	3.5	3.25	0.96
15. Interpreters present for the initial refugee medical examination would be capable of assisting parents to complete the SDQ	(3,4)	3.5	3.5	0.58

Table 2

Post-Implementation Provider Questionnaire

Questions	Range	Median	Mean	SD
2. I would like to continue to use the Strengths and Difficulties Questionnaire (SDQ) to screen refugee children under the age of 14 years for mental health concerns	(2,4)	3	3	0.82
3. The SDQ did not increase my ability to recognize mental health concerns for refugee children under the age of 14 years	(2,5)	3.5	3.5	1.73
6. I referred more refugee children under the age of 14 years for mental health services due to use of the SDQ	(1,4)	2	2.25	1.26
7 The process to score the SDQ worked well	(1,4)	2	2.25	1.26
8. Scores of the SDQ were available or easy to calculate at the time I encountered the patient in the exam room	(1,4)	2	2.25	1.26
9. The clinical support staff was capable of assisting me with the screening process	(2,4)	3.5	3.25	0.96
12. I noticed that parents were uncomfortable with the SDQ	(2,3)	2	2.25	0.50
13. There were times when parents were unable to complete the SDQ due to lack of interpreter	(1,4)	3	2.75	1.50
14. Parental literacy levels were not a problem in the screening process	(2,4)	2	2.5	1.00
15. Parents were generally willing to complete the SDQ	(2,5)	4	3.75	1.26
16. The SDQ format seemed acceptable to parents	(3,4)	4	3.75	0.50

Appendix H
Provider Education PowerPoint

Mental Health Screenings for Refugee Youth Under the Age of 14

Diane Chapman RN, BSN, CCRN, DNPs

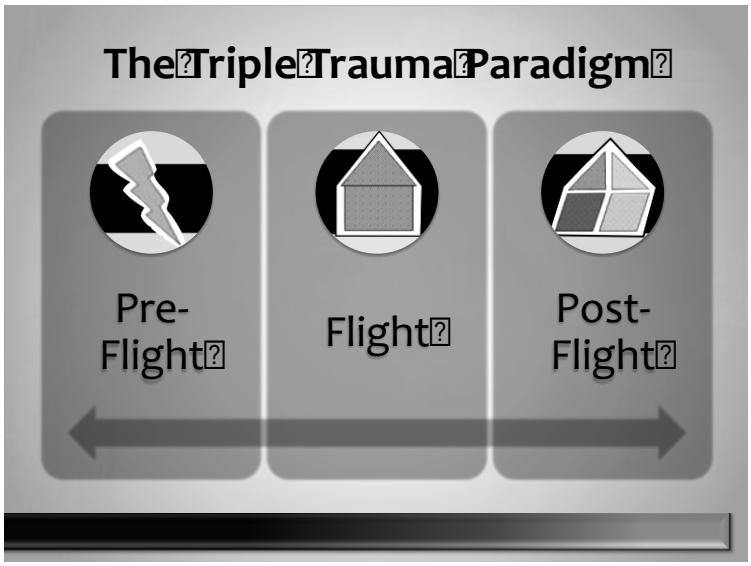
Objectives

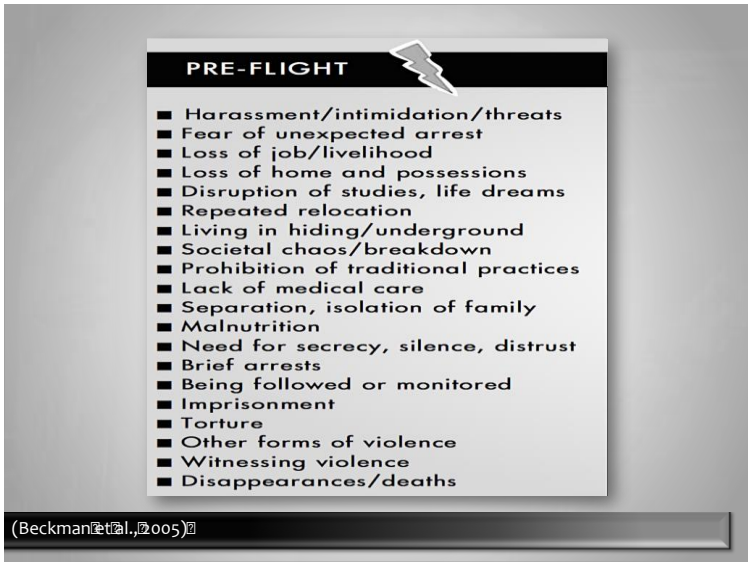
- Identify common contributors to mental illness and common mental health disorders experienced refugee youth
- Review the development and structure of the Strengths and Difficulties Questionnaire (SDQ)
- Examine psychometric properties of the SDQ
- Explain the administration process of the SDQ during the pilot study
- Discuss options for scoring the SDQ
- Review referral process

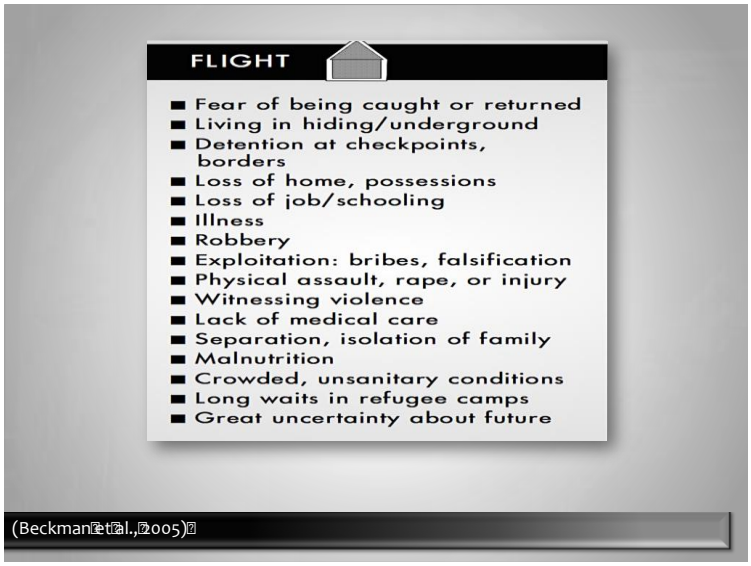
UNHCR Refugee Definition

Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

(UNHCR, 2010, p. 14)


The Triple Trauma Paradigm
Pre-Flight
Flight
Post-Flight


PRE-FLIGHT
Harassment/intimidation/threats
Fear of unexpected arrest
Loss of job/livelihood
Loss of home and possessions
Disruption of studies, life dreams
Repeated relocation
Living in hiding/underground
Societal chaos/breakdown
Prohibition of traditional practices
Lack of medical care
Separation, isolation of family
Malnutrition
Need for secrecy, silence, distrust
Brief arrests
Being followed or monitored
Imprisonment
Torture
Other forms of violence
Witnessing violence
Disappearances/deaths
(Beckman et al., 2005)


FLIGHT
Fear of being caught or returned
Living in hiding/underground
Detention at checkpoints, borders
Loss of home, possessions
Loss of job/schooling
Illness
Robbery
Exploitation: bribes, falsification
Physical assault, rape, or injury
Witnessing violence
Lack of medical care
Separation, isolation of family
Malnutrition
Crowded, unsanitary conditions
Long waits in refugee camps
Great uncertainty about future
(Beckman et al., 2005)

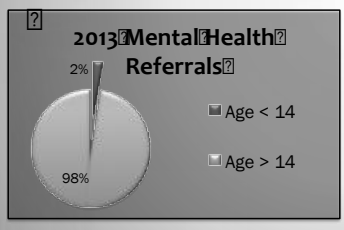
Common Mental Health Disorders

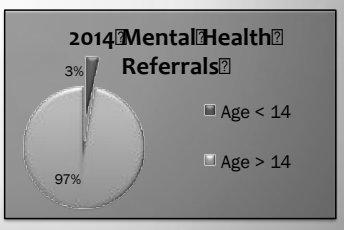
- Post-traumatic stress disorder
- Depression
- Anxiety disorders
- Behavioral and conduct disorders
- Substance abuse disorders
- Psychological signs and symptoms

(Vostanis, 2014; Dura-Vila, Klasen, Makatini, Rahimi, & Hodes, 2013; Bronstein & Montgomery, 2011; Crowley, 2009; Measham et al., 2014; Betancourt et al., 2012)

Project Rationale

- The RHS-15 is validated for age 14 and older
- There is concern that we are not identifying children in need of services
  - 2-3% of refugee mental health referrals in Utah





The Strengths and Difficulties Questionnaire

- Development first published in 1994
- 25 questions
  - 5 subscales: Emotional symptoms, conduct problems, hyperactivity, peer problems, pro-social behavior
- Available in 80 languages
  - Arabic
  - Somali
  - Dari
  - Farsi
- Parent/teacher forms for children age 2-4, 4-10, and 11-17
- Self-report form for children age 11-17

Validation

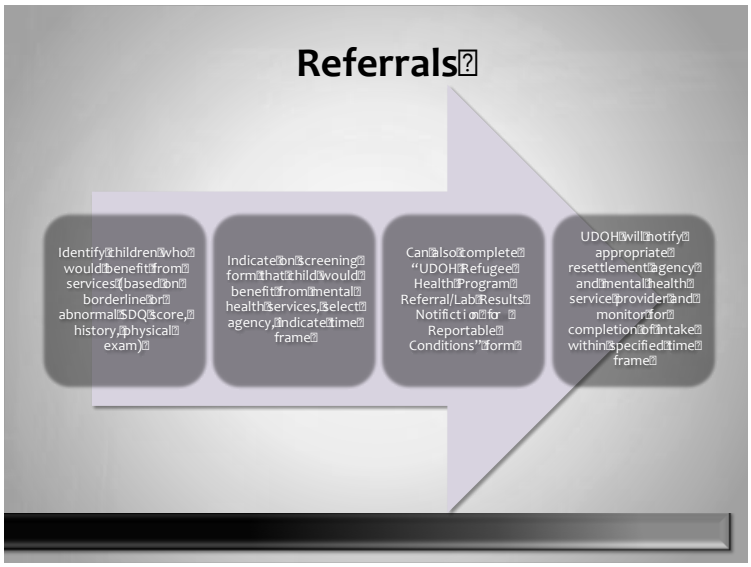
- Has been extensively studied in the U.S. and Western Europe
- Has demonstrated good psychometric properties in a variety of cultural contexts
  - Middle East (Yemen)
  - Asia (Pakistan, Bangladesh, Thailand)
  - Africa (Democratic Republic of Congo)
- Has been studied and used extensively in diverse populations
- Many studies of refugee youth have reported its use, but have not presented psychometric data
- Is currently being studied in refugee populations in the U.S.

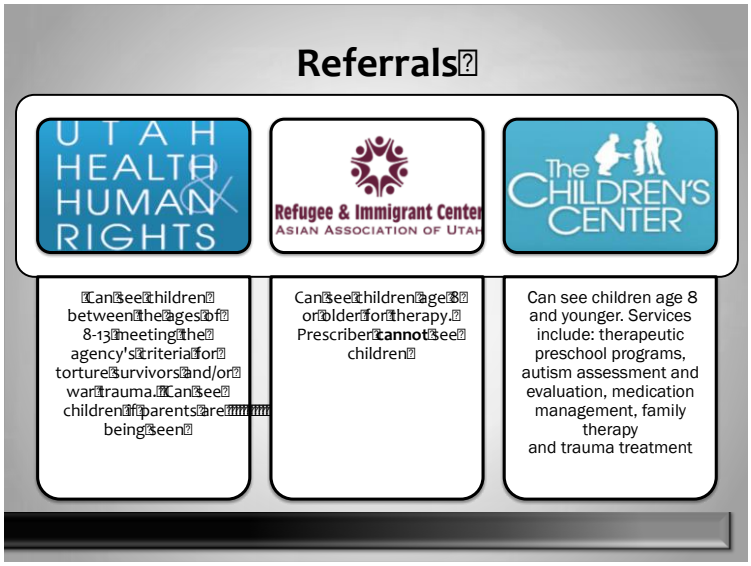
(Achenbach et al., 2008; Woerner et al., 2004; Vostanis, 2006; Leavey et al., 2004)

Administration

- Children in pilot will be pre-selected
- Interpreters will arrive for appointment with form
- Form will be completed while in the office and available for providers prior to examination


Scoring
Hard copy
English/most languages
Arabic
Online: http://www.sdqscore.org/Amber
Interpreting scores


Referrals
Identify children who would benefit from services (based on borderline or abnormal SDQ score, history, physical exam)
Indicate on screening form that child would benefit from mental health services, select agency, indicate time frame
Can also complete "UDOH Refugee Health Program Referral/Lab Results Notification for Reportable Conditions" form
UDOH will notify appropriate resettlement agency and mental health service provider and monitor for completion of intake within specified time frame


Referrals
UTAH HEALTH & HUMAN RIGHTS
Refugee & Immigrant Center
ASIAN ASSOCIATION OF UTAH
The CHILDREN'S CENTER
Can see children between the ages of 8-13 meeting the agency's criteria for torture survivors and/or war trauma. Can see children if parents are being seen
Can see children age 8 or older for therapy. Prescriber cannot see children
Can see children age 8 and younger. Services include: therapeutic preschool programs, autism assessment and evaluation, medication management, family therapy and trauma treatment

Summary

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Appendix I
Scoring Tools

Strengths and Difficulties Questionnaire

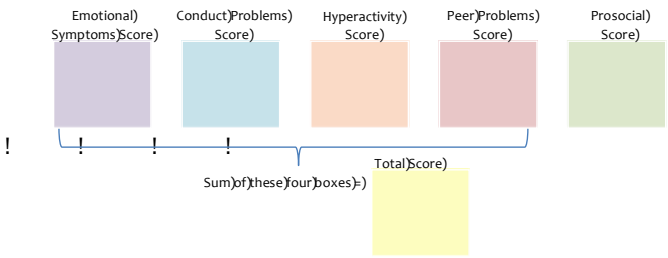
P or T [4-10]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	0"	1"	2"
Restless, overactive, cannot stay still for long	0"	1"	2"
Often complains of headaches, stomach-aches or sickness	0"	1"	2"
Shares readily with other children, for example toys, treats, pencils	0"	1"	2"
Often loses temper	0"	1"	2"
Rather solitary, prefers to play alone	0"	1"	2"
Generally well behaved, usually does what adults request	2"	1"	0"
Many worries or often seems worried	0"	1"	2"
Helpful if someone is hurt, upset or feeling ill	0"	1"	2"
Constantly fidgeting or squirming	0"	1"	2"
Has at least one good friend	2"	1"	0"
Often fights with other children or bullies them	0"	1"	2"
Often unhappy, depressed or tearful	0"	1"	2"
Generally liked by other children	2"	1"	0"
Easily distracted, concentration wanders	0"	1"	2"
Nervous or clingy in new situations, easily loses confidence	0"	1"	2"
Kind to younger children	0"	1"	2"
Often lies or cheats	0"	1"	2"
Picked on or bullied by other children	0"	1"	2"
Often offers to help others (parents, teachers, other children)	0"	1"	2"
Thinks things out before acting	2"	1"	0"
Steals from home, school or elsewhere	0"	1"	2"
Gets along better with adults than with other children	0"	1"	2"
Many fears, easily scared	0"	1"	2"
Good attention span, sees work through to the end	2"	1"	0"



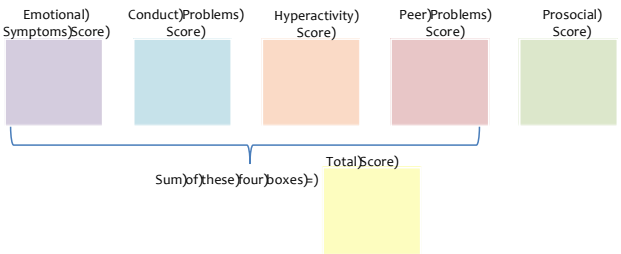
أستبيان مواطن القوة والصعوبة SDQ (4-17سنة)
للوالدين

يرجى الاجابة على كل بند بـ : غير صحيح, صحيح نوعا ما , او صحيح بالتأكيد بوضع علامه ☑ تحت الأجابة المناسبة . حاول ان تكون دقيقا فى إجاباتك. سوف يساعدنا كثيرا اذا اجبت على كل بند حتى وان كنت غير متأكد او ترى انه غير مناسب. يرجى ان تكون اجابتك حول سلوك الطفل خلال الستة الأشهر الأخيرة.

اسم الطفل: ..... ☐ ولد ☐ بنت

تاريخ الميلاد : .....

	غير صحيح	صحيح نوعا ما	صحيح بالتأكيد
يهتم بمشاعر الاخرين	0" ☐	1" ☐	2" ☐
لا يستطيع البقاء او الاستقرار فى مكان واحد . كثير الحركة	0" ☐	1" ☐	2" ☐
كثيرا ما يشكو من صداع او آلام فى البطن او الشعور بالغثيان	0" ☐	1" ☐	2" ☐
يشرك الاخرين بسهولة فيما يخصه{ لعب, أقلام, ألعاب, حلويات .....الخ}	0" ☐	1" ☐	2" ☐
كثيرا ما تنتابة نوبات من الغضب الشديد أ و سريع الغضب	0" ☐	1" ☐	2" ☐
يحب العزلة. يميل الى اللعب لوحدة	0" ☐	1" ☐	2" ☐
مطيع على وجه العموم. عادة يفعل ما يطلبه منه الكبار	2" ☐	1" ☐	0" ☐
يقلق من اشياء كثيرة. كثيرا ما يبدو عليه القلق	0" ☐	1" ☐	2" ☐
يساعد الاخرين اذا ما حدث لأحدهم مكروه	0" ☐	1" ☐	2" ☐
يتململ او يتلوى باستمرار{جسمه فى حركه مستمره اثناء جلوسه}	0" ☐	1" ☐	2" ☐
لديه على الاقل صديق واحد جيد	2" ☐	1" ☐	0" ☐
كثيرا ما يتعارك مع الاخرين من نفس سنه او يستأسد عليهم	0" ☐	1" ☐	2" ☐
كثيرا ما يكون غير سعيد, حزين او يبكى بسهوله	0" ☐	1" ☐	2" ☐
فى الغالب محبوب ممن هم فى سنه	2" ☐	1" ☐	0" ☐
يتشتت انتباهه بسرعه وقليل التركيز	0" ☐	1" ☐	2" ☐
عصبى او متشبث{متعلق} بالاخرين فى المواقف الجديدة. من السهل ان يفقد ثقته بنفسه	0" ☐	1" ☐	2" ☐
لطيف مع من هم أصغر منه	0" ☐	1" ☐	2" ☐
كثيرا ما يكذب , يخدع او يغش	0" ☐	1" ☐	2" ☐
يستهزأ منه او يستاسد عليه من هم فى سنه	0" ☐	1" ☐	2" ☐
كثيرا ما يتطوع لمساعدة الاخرين{الوالدين, المدرسين, الاطفال الاخرين}	0" ☐	1" ☐	2" ☐
يفكر قبل ان يتصرف	2" ☐	1" ☐	0" ☐
يسرق من البيت او المدرسة او من أماكن اخرى	0" ☐	1" ☐	2" ☐
ينسجم بشكل أفضل مع الكبار عنه مع الاطفال فى نفس سنه	0" ☐	1" ☐	2" ☐
يخاف من اشياء كثيره . من السهل تخويفه	0" ☐	1" ☐	2" ☐
يتابع اداء الواجبات حتى النهايه . لديه انتباه جيد	2" ☐	1" ☐	0" ☐



Appendix J
Summary Document

UNIVERSITY OF UTAH
COLLEGE OF NURSING

Integrating Refugee Youth Mental Health Screenings into the Domestic Refugee Medical Examination

Summary of Pilot Project: January 26, 2015m through March 6, 2015

Prepared by Diane Chapman BSN, RN, CCRN, DNP student

Introduction

Refugees have been displaced from their homes and are unable or unwilling to return due to a fear of persecution. Refugees often experience traumatic events in their homeland and during displacement. Cumulative stressors from the pre-flight, flight, and resettlement periods can be significant. Refugees of all ages have considerable risks for the development of mental illness. A high proportion of refugee youth experience mental health disorders, particularly posttraumatic stress disorder and depression. The tool currently used in Utah to screen for mental health concerns during the domestic refugee medical examination (DRME) is validated for refugees age 14 and older. The Utah Refugee Mental Health Subcommittee has recognized the need to identify a tool to screen for mental health concerns in refugees under the age of 14.

The purpose of this project was to determine the practicality and provider acceptability of a tool to screen for mental health concerns in refugee patients under the age of 14. Four primary objectives were designed to meet this purpose:

1) Identify a tool that would be usable within the context of the DRME, is validated for use in children under the age of 14, and has previously been used with refugees.
2) Assist the clinics conducting DRMEs in Utah to implement a pilot test of the tool.
3) Evaluate tool use and outcomes.
4) Disseminate the findings to Utah's Refugee Mental Health Subcommittee and the pilot clinics.

Summary of Results

The Strengths and Difficulties Questionnaire (SDQ) was selected as the screening tool for this pilot as it has been studied in numerous multicultural contexts, is available in multiple languages (particularly Arabic, Somali, and Dari/Farsi), and is accessible for free online (http://www.sdqinfo.org). While the SDQ has not been rigorously studied and validated in refugee populations in the West, it has been previously used with refugees and is currently under study in a refugee population at a pediatric clinic in Vermont. The SDQ is comprised of 25 questions over 5 subscales (pro-social, hyperactivity, emotional, conduct, and peer problems). Each subscale must be scored individually, and the four difficulties subscales (hyperactivity, emotional, conduct, and peer problems) can be summed to arrive at a total difficulties score (see tables in Appendix A for interpretation of scores). The SDQ website has various tools for scoring including transparent overlays and online scoring and report generation. The questionnaire is available for ages 2-17, though some of the language versions have only been translated for 4-17 year olds. For purposes of this pilot, it was recommended that all children with a positive result (borderline or high score in any

difficulty subscale or in the total difficulties score) be offered a referral for mental health services.

Stakeholder meetings were held with key representatives from each of the two pilot sites. The stakeholder meetings revealed provider concerns about the lack of validation studies of the tool in refugee populations in the U.S., time to administer the tool (particularly for large families who arrive together for screening), difficulties interpreting some of the verbiage on the tool (i.e. "fidgety"), and scoring. One clinic representative suggested that the providers at her clinic would prefer a single page scoring reference rather than the set of transparent overlays available online. Pre-implementation questionnaires were administered to providers to identify barriers and supports to the tool use. Identified barriers included limited time, possible parental resistance, and lack of need. Supports included the clinic staff and interpreters. Because providers were concerned about the time it would take to screen multiple children in a single family, it was determined that for purposes of this pilot, only one child per family visit would be included. A single color-coded scoring sheet was created to facilitate scoring (see Appendix B).

The pilot was conducted over a six-week period between January 26, 2015, and March 6, 2015. Twelve children were selected for inclusion in the pilot, though only 9 completed a mental health screening with the SDQ (two patients rescheduled and one cancelled because they did not yet have their Medicaid card). A single provider at one clinic site completed five of these screenings and three providers completed the additional four screenings at the other clinic site. A total of 23 children met eligibility criteria for inclusion (age 2-14, only one child per family). If a family with more than one child between the age of 2 and 14 was seen together for the DRME, then random number generation was utilized to select which child would be included.

During the pilot period, 41 children between the ages of 2 and 14 completed their initial health screening. Only 22% (9/41) of children between the age of 2 and 14 who received their initial health screening were included in the pilot. Out of the 9 children who were screened with the SDQ, 2 (22%) had positive SDQ scores and were offered referrals for mental health services. One child's parent accepted the referral and one declined. To provide context to the number of referrals that occurred during the pilot period, the number of intra-pilot referrals was compared to the number of referrals that occurred for children age 2-14 during the equivalent period in 2014 (January 27, 2014 through March 7, 2014). During this equivalent period, 22 children were screened, but none were referred for mental health services.

Following the conclusion of the pilot, a post-implementation questionnaire was administered to providers to determine provider satisfaction with the SDQ and the clinic process flow as well as perceived parent reception of the mental health screening. Providers were neutral about continuing to use the tool and continued to express concerns with the length of the questionnaire and the complexity of scoring. Providers reported that parents were generally willing to complete the SDQ and appeared to find the format acceptable, though parental literacy levels did present a barrier to questionnaire completion. One provider noted that there were occasions when the parent or interpreter completed the form incorrectly requiring a redo. There was one occasion when the interpreter started completing the form in front of the provider without translating the

questions for the parent. Providers suggested that it might be necessary to identify or create a shorter or simplified tool or to train caseworkers/interpreters to complete the form with the parent prior to arrival at the clinic.

Recommendations

It is clear that there could be significant benefit for children if a standard questionnaire-based mental health screening process was included during the DRME. More children were referred for mental health services during this pilot period than referred for services during the equivalent period in the year prior. However, as this pilot study was limited by a small sample size (only 9 children included), it is difficult to draw firm conclusions. Based on the results and findings from this pilot project, I would suggest the following recommendations:

- Extend the pilot to include additional children. It would be especially valuable to screen only those children from cultures for whom there is already a translated version of the SDQ. I would recommend continuing to limit inclusion criteria to only one child per family until the providers and interpreters become more familiar with the SDQ.
- While it is ideal to have parents complete the form independently, it is not always possible due to parental literacy levels. Those interpreters who assist parents in completing the form should have a thorough understanding of the tool and how to administer it. I recommend selecting 2-3 interpreters per available language (Arabic, Somali, Dari/Farsi) and using only these interpreters during pilot extension.
- Consider alternate methods for SDQ completion. As suggested by one of the providers, one alternative might be to train caseworkers or interpreters to administer the form at the patient's home prior to the clinic appointment. The form can also be completed by the child's teacher, though it is unknown if teachers would be willing to complete the form and this would also result in a significant delay in mental health screening.
- If the SDQ is selected as the screening tool for refugee children under the age of 14 in Utah, it would be valuable to conduct a large validation study in order to determine psychometric properties in refugee children in the West. This would be a major contribution to the literature as such validation studies are currently lacking.
- If it is determined that the SDQ is not the ideal tool to screen for mental health concerns in refugees under the age of 14 in Utah, then I suggest calling a task force to create a shorter tool with simplified scoring.

Appendix K
Project Defense Poster