March 28-31, 2017
Sydneyo.

The *STAR-MH* screening tool for identifying mental disorders in asylum seekers and new refugees

Dr Debbie Hocking[1,2,3], Prof Suresh Sundram[2,3,4] , Dr Sam Mancuso[4]

1. Cabrini Institute
2. Molecular Psychopharmacology, Florey Institute of Neuroscience & Mental Health
3. Monash University, Psychiatry Department, Monash Health School of Clinical Sciences
4. Department of Psychiatry, University of Melbourne

Background

Prevalence of clinical disorders (% caseness)
in asylum seekers & refugees

	Depression	PTSD
Asylum seekers	**61.1****	**52.1***
Refugees	**30.3**	**27.3**

*$p < 0.01$, ** $p < 0.05$

(Hocking, Kennedy & Sundram, 2012)

	Depression	PTSD
General pop. **(12-mth)**	**4.1**	**6.4**

(Australian Bureau of Statistics, 2007)

Inadequacy of extant screening tools for mental disorders in Asylum Seekers

❑ Sector consultation

- ***Australia*** (FASST services, Hotham Mission, AMES, Red Cross)
- ***International*** (UK, i.e. *Traumatic Stress Service, Maudsley Hospital*; USA i.e., *Program for Torture Victims*, CA; *Survivors of Torture International*, CA; *Refugee Mental Health Program,* CO)

❑ Literature review

- ***K10*** – not validated in culturally diverse settings; poor X-cultural predictive validity; no established cut-off for depression/anxiety disorders
- ***RHS-15*** – not developed for AS populations; detects distress not disorder; no predictive validity
- ***DASS*** – does not identify PTSD
- ***GHQ-12*** – does not identify PTSD; measures general distress; poor predictive validity (Ouimette *et al*., 2008)
- ***PHQ-9*** – does not identify PTSD; not suitable for low literacy (Ali *et al.,* 2016)
- ***SRQ-20*** – too long.

The need for an asylum seeker-specific mental health screening tool

Mental health screening of asylum-seekers is important for 4 reasons:

a) To facilitate appropriate and timely treatment

b) To expedite the resolution of refugee status determination and maximise the individual's ability to credibly present their case *

c) To replace *ad hoc* and subjective mental health evaluations with a validated tool that can be applied uniformly by a range of workers in the field

d) To provide an objective measure to advocate for greater support throughout the refugee determination process where relevant.

* Aron, 1992; Cleveland, 2008; Cummins, 2013; Herlihy & Stuart, 2006; Steel, Frommer & Silove, 2004; Tay et al., 2013

Aim:

To develop a mental health screening tool for non-health workers

- ❑ Brief and easily administered
- ❑ Sensitive
- ❑ Simple

3 phases:

1. Tool development
2. Pilot process (iterative)
3. Qualitative feedback concerning length, interpretation, fidelity

Inter-correlation of symptoms

	Depression	Anxiety	PTSD	Demoralisation
Depression	-	.77*	.80*	.72*
Anxiety	-	-	.74*	.61*
PTSD	-	-	-	.68*

Method: Phase I: Tool Development

Item derivation

- An initial 12-item STAR-MH was derived from a questionnaire-based study
- All questionnaire items entered into chi-square analyses → sensitivity (SN) and specificity (SP) against MINI PTSD and/or MDD. High SN &/or high predictive accuracy items retained.
- Duplicated items removed
- 'Immediate screen-in' items included on clinical grounds (e.g. previous mental health treatment)
- 12-item version assessed in a test sample of asylum seekers at the ASRC (Asylum Seeker Resource Centre)
- ROC Curve and Classification and Regression Trees (CART) analyses performed
- 10-item version assessed in a validation sample of asylum seekers and new refugees

<u>1st version</u>* 12-item scale (including 3 'screen in' items)

<u>2nd version</u>** 10-item scale (including with 2 'screen in' items)

**   ASRC sample*
*** ASRC & Monash Health Refugee Health Clinic sample*

Method: Phase II - Pilot process (v.1 & v.2)

Exclusion criteria:

1. < 18 years old
2. Refugees < 12 months
3. Diagnosed with a mental disorder since being in Australia; currently seeing a psychiatrist.

Process:

- Screening tool administered by a range of non-health or non-mental health workers
- Diagnostically evaluated (M.I.N.I. 6.0 structured psychiatric interview) subsequently and blind to the participant's STAR-MH screening results.

Feedback & referral:

- Written feedback from administrators (built into STAR-MH pilot form)
- Onward referral

Method: Phase II – Administration outcomes (v.2)

- N=28 administrators → caseworkers, GPs, nurses, university students, bicultural workers, interpreters
- Diagnostically evaluated (validation interview) within 5.5 days of screening (IQR 0-9)
- Time taken to administer: Md 6 mins (IQR 5-7 mins) → with or without an interpreter

Feedback to clients & referral:

- Psychoeducation given
- 84% (*n*=53) of diagnosed accepted referral (uptake unknown)
- 5% (*n*=9) of diagnosed declined treatment.

Results (1)

Participant profile – v.2

- ***N*=192** from 36 countries; 65% required English language interpreter
- 70% Male; 60% partnered; 54% arrived by boat
- 19-82 years (*Md*=33 yrs, *IQR*=28-43)

Pre-arrival

- 15% refugee camp
- 6% mental disorder

Post-arrival

- 55% Australian immigration detention
- ***RDP stage:*** 73% Primary stage; 20% appeal
- ***Time since application:*** 5–175 weeks (*Md* =113; *IQR*= *62-143*)
- ***Work:*** 57% on welfare; 16% work
- ***Health***: 16% without Medicare
- 4% diagnosed mental disorder (in Australia)

Results (2)

Mental disorder prevalence (v.2)

- MDD: 30%
- PTSD: 20%
- PTSD &/or MDD: 32%
- 54% comorbidity (PTSD & MDD) – those who met criteria for a mental disorder
- Other: suicidality 7%; GAD 3%; panic disorder 2%; SUD 1.5%; psychosis 1%; OCD 0.5%; agoraphobia 0.5%

  → 99% comorbid with either MDD or PTSD (*n*=190)

  - ***Only 27% of those with a mental disorder had received treatment in Australia***
  - ***77% of those who met criteria had a GP (family doctor)***

Results (3)

Predictive accuracy; sensitivity & specificity

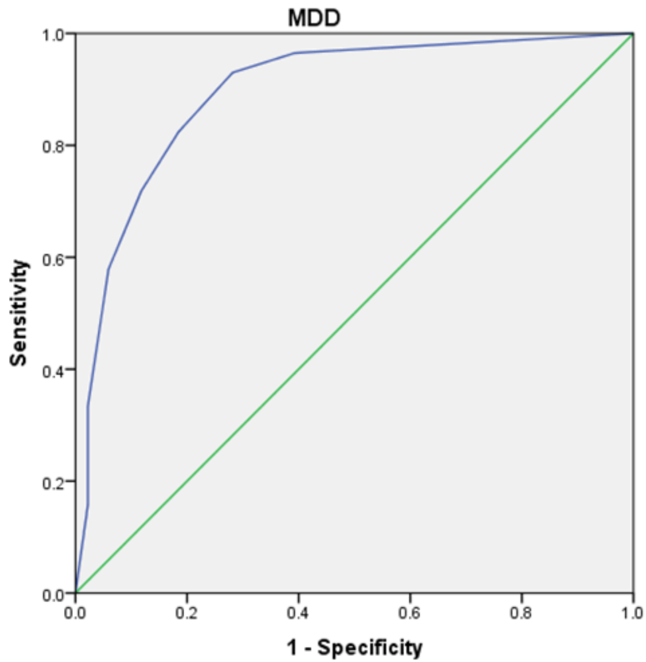
(9-item scale version: 7 + 2 ‘screen in’ items)

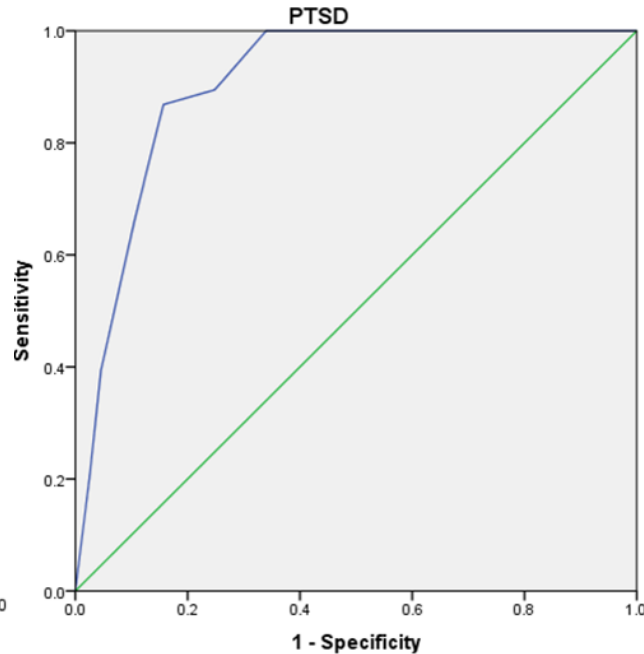
≥ 2 ‘Yes’	SN (%)	SP (%)	Area Under Curve	95% C.I.	Predictive accuracy
MDD	**93.0**	**71.9**	**.90***	**.85 – .94**	**72.9%**
PTSD	**100**	**66.7**	**.91***	**.87 – .95**	**78.1%**
MDD &/or PTSD	**93.5**	**74.6**	**.91***	**.87 – .96**	**80.7%**

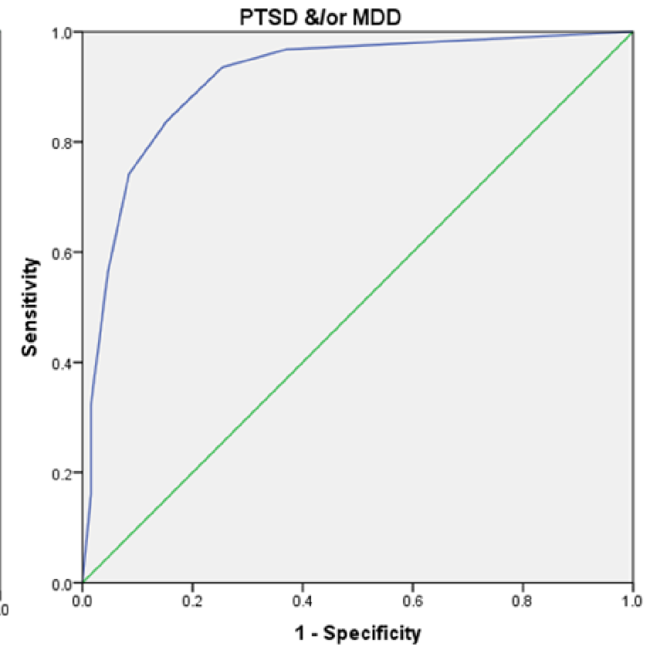
* $p < .0001$

Results (4)

Area Under the Curve (ROC curve)







Conclusions

- High rates of unrecognised MDD & PTSD in asylum-seeker populations
- A final 9-item version of the STAR-MH was derived which demonstrated good predictive validity (PTSD & MDD) to distinguish distress from disorder
- Identifying PTSD &/or major depression will likely capture other co-morbid mental disorders in this population
- The *STAR-MH* is a simple, efficient screening tool to facilitate mental health referrals by non-health workers for asylum-seekers & new refugees at the agency of their first presentation.

Acknowledgements

Asylum seeker and refugee participants

ASRC casework program and Monash Health Refugee Health Clinic

Supported by *B B & A Miller Fund* via**:**

Australian
Communities
Foundation

If interested in potentially being involved in the field study roll-out of the *STAR-MH*, contact:

Debbie Hocking debbie.hocking@florey.edu.au

Suresh Sundram suresh.sundram@monash.edu