Implementation of Standardized Refugee Mental Health Screening in Minnesota

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Learning Objectives

- Identify key stakeholders in the development and implementation of a refugee mental health screening pilot
- Discuss successes and limitations in Minnesota's training process
- Consider opportunities to address common provider concerns during pilot training process

“Landscape” in Minnesota

- Decentralized refugee health system (multiple clinics, counties, models)

yet still…

- Well-connected refugee health stakeholders and partners
- Divergent mental health assessment/referral practices among clinics
- Managed care environment
- Known mental health care needs among refugee arrivals
  - 43 cases of mental health needs indicated on overseas paperwork in 2013-2014
  - Cases of mental health care accessed through Emergency Department/Crisis Line

Development of Pilot

http://www.health.state.mn.us/divs/idepc/refugee/guide/10mentalhealth.html#pilot

- MDH Refugee Mental Health Workgroup (2012-2013)
  - Expertise that is multi-disciplinary and involves multiple sectors
- Identification of pilot clinics
  - Interest/capacity
  - Diversity: Clinic models, geography, patients
- On-going discussion
  - Desired “Threshold”
  - Referral and training needs

The Questions

In the past month…
… have you felt very sad?
… have you been worrying/thinking too much?
… have you had many bad dreams or nightmares?
… have you avoided situations that remind you of the past?

Do any of these problems stop you from doing things you need to do every day?

Training Structure: Webinars

Three webinars offered:

1) Minnesota Refugee Mental Health Screening: The Measure
2) Building Trust and a Working Relationship
3) Best Practices for Making Mental Health Referrals for Refugees

Evaluation: Webinars

- Ongoing resource
- Incomplete data
- Indications of some knowledge/confidence gains
- Limited attendance
  - Unable to track online usage
  - Registration for “Live” events ranged from 7 to 19 participants (attendance somewhat lower than registration)

Training Structure: In-person Seminar

Three key areas:

- Conducting the screening: Demonstration and small group exercise

- Interpreting the screening: Presentation and discussion

- Making the referral: Demonstration and small group exercise

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“Hands on” Component

- Vignettes drawn from real situations
- Interpreter pairs (Somali, Karen, and Arabic speaking, based on Minnesota arrival demographics); “pre-trained”
- Opportunity to work through the screening and referral in a realistic way
- Feedback
  - From “interpreter”
  - From “patient”
  - From peers

Evaluation: In-person Seminar

- 37 attenders total at 2 seminars
- Evaluation structure: Matched anonymous pre-test and post-test, additional form with contact info to request further feed-back and availability for future follow-up
- Majority had not attended any webinar.
- Participants reported increased comfort in talking to refugees about mental health and increased confidence in screening refugees for mental health, providing psychoeducation, and providing a mental health referral ($p<.001$)

Lessons Learned

- Offering or referring to subject matter training as requested, without “reinventing the wheel”
- Importance of interaction among stakeholders and participants on on-going basis
- Strong commonality of concerns and questions
- Strength from multiple perspectives
- Impact of staff/provider turn-over

Next Steps…

- (Current implementation)
- Survey of providers and staff
- Ongoing reinforcement of referral mechanisms
- Ongoing data analysis
- Potential addition of a pilot location
- Exploration of evaluation/validation possibilities
  - Funding
  - Timing
  - Data privacy
  - Collaboration