"Refugee Mental Health Screening: Best Practices for Mental Health Referrals"

A training webinar from Minnesota Department of Health

Hosted by Dr. Patricia Shannon (University of Minnesota-Twin Cities School of Social Work)

October 28, 2015

Q&A Summary

Q: I noticed that the referrals highlighted in this webinar were made by a range of providers and professionals, which also makes sense given the different clinical contexts of refugee health screenings at public health or primary care clinics. For those providers who might have a short time with patients (at screening only clinics for example) it makes sense to lean toward "trusting your gut" and making a referral if you have concerns. Could you speak to how much time making a referral needs to take?

A: (Dr. Shannon) I would open this up for discussion between providers as well. These screening questions were picked because both Somali and Karen refugees who were having problems endorsed them during the research, but the fact is that most of your patients will not endorse them. Based on the number of items a patient says "yes" to, you may have a conversation with them. The first webinar [available on the MDH website: http://www.health.state.mn.us/divs/idepc/refugee/guide/10mentalhealth.html#pilot] contains three examples from Dr. Letts based on his experiences of what this might look like in mild, moderate, and serious cases. In serious cases, he recommends redirecting the appointment toward the mental health concern as the primary problem. He notes that this is normal within clinical care, and the same as what would be expected with any new and serious concern, such as significantly elevated blood glucose for example. This training time is a good opportunity to think within your specific clinical context of how that would work. Certainly, there may be cases in which you need to take significant time and that will be apparent, but it will not be the majority.

Q (from screening provider): I am thinking about a case that I worked with when I was not satisfied with the referral I made. It was an Iraqi family that I had come to know; the mom and some of the children identified mental health concerns. I felt they would have been responsive to care, but I couldn't make it happen. I looked for a referral resource, which was challenging as they were in the suburbs, and talked with them about options, but I wanted to something more direct. When I saw them back for their adjustment of status, they seemed to be doing better but had not connect to mental health care. Also, I saw the father, who said that they were all fine, but that may not be accurate! I'm hearing about some more tools here; it is very challenging to do "warm hand-offs" at a screening-only clinic.

A: (Marge Higgins, MDH) I believe I remember the family you are referring to, and MDH, the resettlement agency, and primary care were all made aware of the situation, which is very helpful! The family was made aware of options but decided not to seek care. It is a good example of the importance

of readiness to seek help, as well as showing the importance of the relationship between screening and referral-accepting providers that you discussed.

(Dr. Shannon): In some culture, the family head will speak for everyone, so this also reminds us of the importance of talking with family members individually in some cases, as the family head may not be aware that some members of the family are suffering. Also, this webinar really highlighted success stories, which gives a distorted view of some of the challenges in this work. There were also examples of referral attempts that were not successful for many reasons. One reason for unsuccessful referrals was culture, and/or families refusing to seek care despite the provider's efforts. I personally have had cases of working with Iraqi families who needed home visits multiple times to seek care with me. Sometimes everyone's best efforts do not lead to a connection.

(Ellen Frerich, MDH): Always, and especially during this pilot process, we encourage the pilot clinics to communicate with us about their concerns with a specific case or with the screening/referral process in general. As with other health concerns, some referrals lead to an immediate improved outcome, and some referrals do not. Continuing the example of the diabetic patient, sometimes the connection with an endocrinologist and diabetes educator works and yields an improved outcome, but sometimes the patient refuses or continues to have struggles. We hope that this screening and referral process improves the health and outcomes for some of our new arrivals in need.