Evaluating refugee mental health screening & follow up

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Objectives

Our aim is to improve mental health (MH) systems for arriving refugees. We are utilizing a community based participatory research framework to examine the following:

- ☐ Effectiveness of MH screening processes in identifying need for MH care follow up
- ☐ Effectiveness of MH follow up processes for successfully connecting arrivals with needed MH care
- ☐ Implementation of screening & follow up processes from provider & refugee patient perspectives
- ☐ Potential changes in MH symptoms reported during early resettlement

Mixed Methods Design

CBPR
- Organized a steering committee made up of cultural leaders representing each ethnic group, providers from each screening site, state government stakeholders and research partners to guide study implementation, measurement tools, interpretation & dissemination of findings.

QUAL
- In-depth, semi-structured interviews utilizing a focused ethnographic approach
- Explore emic perspectives on experiences of refugee patients and screening providers
- Compare & contrast themes emerging from providers & refugee patients' perspectives on screening & follow up

QUANT
- Examine potential variation in depression and PTSD symptoms across 3 time points in early resettlement
- Bivariate analysis and multinomial logistic regression to identify significant predictors of latent class membership
- Growth mixture modeling to identify shape of potential changes in symptoms over time and across ethnic groups

This project is conducted in partnership with Hennepin County Public Health Clinic (Minneapolis), HealthEast Roselawn Clinic (St. Paul), and Olmsted County Public Health Clinic (Rochester).
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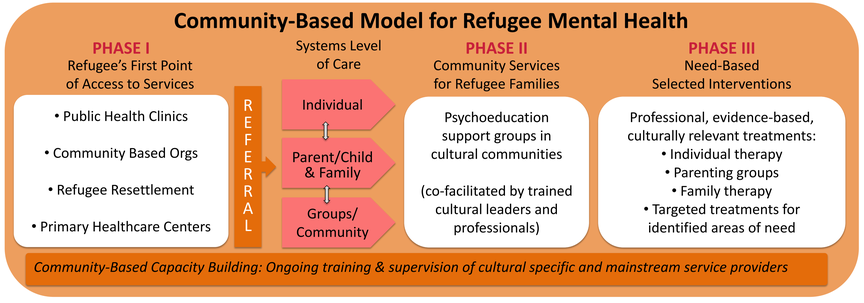
Project Background

In past decade, over 35,000 refugees have arrived in Minnesota from Somalia, Ethiopia, Burma, and Bhutan/Nepal. Research has suggested up to 30% of refugees are at increased risk for developing serious & persistent mental illness (SPMI) including depression and PTSD. Our preliminary research identified that new arrivals often face barriers related to language, culture, socioeconomic factors, stigma and lack of trust in health/MH care. Health providers reported discomfort in discussing MH & trauma histories with refugees, communication barriers, differing cultural beliefs about health/MH, and acculturation issues as challenges to identifying and caring for the MH needs of refugee patients. Providers also raised concerns about lack of efficient screening tools and MH resources available for refugees who need services.

UMN and CVT (2015) surveyed health coordinators from 43 states on how MH screening is approached. Results indicated nearly 60% do not screen for torture or war trauma and over 25% do not screen for MH symptoms. Of the states that do screen for MH, over half use informal conversation. Less than 16% of states utilized formal instruments for screening.



In response, Dr. Patty Shannon, CVT, and the Minnesota Department of Health (MDH) developed a 5-item screener discriminant of SPMI in refugees that is used in Minneapolis-St. Paul metro primary/public health clinics. Corresponding psychoeducation and training materials for screening providers were developed and implemented metro-wide.

Additional research is required to understand how well the MH system responds to cultural norms and trauma-related symptoms of refugee patients. Future research must examine the underlying factors for high utilization of healthcare services among refugee patients with undetected MH conditions and needs. Innovative solutions for overcoming systemic barriers to refugee patients' access and engagement with MH care are urgently needed.

Data Collection

- ☐ Partner with 3 screening clinics to recruit 50 arrivals who screened positive for follow up and 50 arrivals who screened negative for follow up
- ☐ Recruit arrivals representative of largest ethnic groups arriving in Minnesota (Somali, Oromo, Karen, and Bhutanese/Nepali) and providers/staff actively involved in screening & follow up at clinic sites
- ☐ Conduct semi-structured interviews at 3 time points (after initial screening; 6 months; 12 months)
- ☐ Conduct standardized assessments of depression (HSCL) and PTSD (PDS-V) at the same 3 time points

Implications

Throughout knowledge translation and dissemination, steering committee and community stakeholder reflections and recommendations will be integrated and utilized to improve MH screening & follow up processes for statewide implementation.

- ☐ Qualitative and quantitative findings will be presented to steering committee, key community stakeholders and screening clinics
- ☐ Study results will be shared through publications, professional presentations, and statewide training efforts
- ☐ Project learnings will be utilized to develop further research & funding applications related to evaluating MH screening, follow up and culturally responsive care for refugees in Minnesota and beyond