

San Diego Refugee Forum
General Meeting Minutes – March 18, 2007

Call to order at 10:22 am

Hamse Warfaa

Present: Diana Ross, Bob Montgomery, Ryan Florence Clark, Hamse Warfaa, Janice Stucke, Blake Tye, Kushbinder Lally, Jeff Zlotnik, Shahla A-Sepah, Kathi Anderson, Dilkhwaz Ahmed, Samantha Hurst, Tiana Reinhardt, Juana Duenas, Dung Le, Robert Lopez, Jennifer Tracy, Sid Voorakkara, Mohamed Mohamud, Ana Quinonez, Kelly Henwood, Debbie Rull

I. Call to Order 10:30am

Introductions

II. Approval of Minutes

- Motion to approve minutes: Ana Quinonez, Second: Jennifer Tracy
- All approved, no nays, no abstentions

III. Bylaw Vote

- Tabled for discussion regarding membership recommendations from outreach committee

IV. County of San Diego: Kelly Henwood

- Part of the Prop. 63 Community Input Process
- Prop. 63 is a 1% tax on millionaires (\$ amount subject to macroeconomic conditions)
- Treatment piece was facilitated last year this piece is the “prevention and early intervention piece” (PEI)
- Two sections: universal (includes general pop, reduction of stigma, and youth) and targeted (predisposed/indicators)
- What would culturally relevant services look like? How would you create trust?
- 51% of funds earmarked for youth
- There are two levels to consider: macro systematic access issues and micro individual intervention strategies
- Next step is to look at successful models and research, please let us know if you have any
- Idea Strategy:
 - Bio-medicine and mental health do not have a good understanding of values and cultural understanding of mental health from a various cultural perspectives
 - There is a loss of connection between medical and mental health issues, many headaches, backaches are symptoms of mental health related issues but doctors don refer or recognize the connections to mental health. This integration needs to happen with the medical community
 - Mental Health issues are very complex for immigrants and refugees. These needs are different, and you also need to differentiate those who have been in the US for less than 2 years and more than 5 years. MHSA needs to examine these needs
 - Mental, emotional and physical perspectives and definitions of health, with many refugee and immigrants cultures, are different than US perspectives, this needs to be taken into account

- Welfare to Work mental health just lost funding and services (provided through UPAC) and providers are now seeing that many of these clients do not feel comfortable accessing what is currently available
- Staff need to represent the communities that they serve
- clients need to be encouraged to use their community strengths, treatment and services must take into account family and community systems
- MHSA needs to give flexibility to use strengths and assets of the community in the delivery of services, including where and who delivers services (for example at temples, churches, etc)
- County needs to support cultural competence through trainings and conferences, one example is to have healers involved in a training
- Culture must be broadly defined not just linguistically but also an understanding of the fear that different cultures have regarding mental health issues and how this fear permeates through out the lives of people and their community (an example was given regarding the southeaster perspective when a family member is "sick" and how it has employment, economic and social consequences for the whole family)
- Look at the Catholic Charities program as an example "Parents as Teachers" which provides outreach, home visits to engage parents
- An example of a program that has done a good job with this is King County Washington
- Would like to see the County concentrate on system efforts
- Confidentiality is a challenge for refugee communities, because they are close knit, and instead of getting care people chose to not access services
- More services need to focus on the "Self" and allow people to connect with self through meditation and other modes, to help them interface with the community (see example of program for youth experiencing trauma)
- Services must intentionally create culturally and linguistically relevant atmospheres
- Services and the County needs to look at the terms used for mental health, these are mostly western based, and do not translate
- The notion of "individualized" services and case plans lose meaning in immigrant and refugee cultures where community and family systems are strong
- African refugee community and others who have experienced trauma need an opportunity to "harvest secrets" via home visiting, building relationships, etc with those who don't have to re-create, re-live, their own trauma to provide support, a safe supportive person who has not shared these same traumas is often helpful
- Self care needs to given to providers, those who take care of others need to take care of themselves
- PTSD resiliency and growth provide an opportunity to "re-frame" issues and an approach to services in a strength based way to view trauma and tragedy
- Services need to include asylum seekers
- Services are needed for second generation immigrants and refugees as well
- A workforce strategy for mental health professionals should consider the "pipeline" of K-12 , college and professionals. See California Endowment for program ideas and research
- Workforce needs to take into consideration the long term promotion of diversity with in the mental health sector

- What needs to be improved with current county system
- County needs to stop trying to fit people into what exists and build services around needs instead
- A suggestion was made to analyze "no show" rates of different populations, including refugees and immigrants and use this data to adjust approaches to working with these populations
- Insurance is complicated and with so many components, the knowledge of intake specialists need to be improved. It seems that if a clients responses are not framed "just right", no one helps to figure out options
- Customer service at the county needs to be expanded
- 1-800 & hotline numbers don't easily lead to live or local people
- There are not enough interpreters and interpreters need to be bettered trained regarding medical terminology and confidentiality issues. See other models of curriculum including one in Seattle for Somalia interpreters. See California Endowment work on standards for interpreters, local, state and national support for standardization and professionalization of interpreters. See California Healthcare Interpreters Association (CHIA)

V. State and Provider Updates

- Bob M. reported that the refugee summit will be in Sept in Manhattan Beach, he is on the planning committee and is looking for ideas on presentations and speakers
- Bob M. also reported on behalf of the VOLAGS, arrivals are slow right now, extremely well below expectations, very concerned about the Iraqis- expecting 12k but getting closer to 6K, in East Africa turbulence in Kenya has slowed or stopped the processing, expecting big 4th quarter arrivals, largest populations from Burma, Iraq and Somalia

VI. Public Announcements

- Juana Duenas asked the forum to submit questions for next month's presentation on MediCal eligibility – please submit your questions directly to Juana Duenas at juana.duenas@sdcounty.ca.gov by the first week of April
- Debbie Rull discussed the problem gambling program at UPAC
- Jeff Zlotnik introduced dharmabums meditation as a prevention program for mental health issues, this model has been used at Crawford and King-Chavez, he can be reached at (858) 922-8811 or google "dharmabum center"

VII. Financial Report

- Hamse Warfaa reported we have \$ 1,450.09, most recent transaction is AAA's membership

VIII. Next Meeting

Tuesday, April 15, at 10:30 am