Hello everyone welcome to today's webinar, Creating Effective Refugee Community Partnerships: Two Perspectives. My name is Dawn Rudolph and I'm the UCEDD technical assistance director at the Association of University centers on disabilities or AUCD and I'm very pleased to moderate today's event for you. This webinar is presented by AUCD diversity and inclusion blueprint team and a supported by the administration on intellectual and developmental disabilities through the UCEDD resource Center.

Before we begin I would like to address a few logistical details. First we will provide a brief introduction of our speakers and then after both presentations there will be time for questions. Because of the number of participants, your phone lines and your computer microphones are going to be muted throughout the call however when it is time for Q&A if you are on the phone you will be up to request to be unmuted by hitting star pound if you have questions to ask. If you on the computer you can use the raise hand option and we will unmute you there. To ask questions at the end. We will do questions for both presenters we will hold all the questions until the end. You can also use the chat box in the Adobe connect, what you see on your monitor. You can submit questions through the chat box also and we will also answer as many of those as possible during the Q& A period. Please note that we might not be able to address every question. If there are too many questions, more than time allows, so we can end on time but if there are questions we cannot get to at the end then we can certainly follow up with the presenters and get you the answers afterwards. Also this entire webinar is being recorded and will be available on AUCD’s website following the webinar. At the end of the webinar there will be a short five question evaluation and if you could please take a moment at the very end to complete that, it should pop up in your browser and that will give us some feedback on the webinar will provide some suggestions for future topics. That will be helpful if you could help us out with that.

Without further delay I would like to introduce our speakers today. Dr. Jean Beatson is the training director for the Vermont leadership education and Neurodevelopmental disabilities program of the VT LEND program and is responsible for overseeing all program components. The VT LEND is a grant from the Maternal and Child Health Bureau and focuses on inter-professional collaboration, cultural competency, family and person centered care, autism and other neurodevelopmental disabilities and leadership in maternal and child health. In collaboration with the VT LEND faculty and staff, Dr. Beatson take the lead in curriculum and program development, interprofessional education, maintaining university and national program connections, mentoring trainees, fellows and new faculty, strategic planning and grant writing. She is the liaison between the Department of nursing and the VT LEND. She's a guest lecturer at the College of nursing and health sciences and a member of the graduate nursing students thesis and projects committees. Dr. Beatson has been faculty at the University of Vermont since 1996. Her research and scholarly writing includes cultural and linguistic competence, person and family centered care, refugee mothers raising children with disabilities and interprofessional education. Jean thank you so much for taking the time to present with us today. >> Dr. Hyojin Im is an assistant professor at Virginia Commonwealth University school of

social work or VCU school of social work, and she has extensive experience working with traumatized refugee communities both international and domestic. Dr. Im has led several community-based participatory research projects to improve mental health and social integration of refugees, partnering with multilateral stakeholders. working with the centers for victims of torture she has been involved in healing and partnership project to develop and implement culturally grounded screening for trauma related symptoms and build capacity of community for mental health referrals and services. Funded by the Annie E Casey foundation, she investigated how unique challenges that refugees face during migration and resettlement interact with social capital and community integration in the United States. She also developed and implemented multiple intervention and evaluation projects in refugee camps which led to a series of community-based refugee protection projects for displaced Somali refugees funded by USAID. She is currently working with Malaysia and local partners to integrate mental health services into primary care clinics and to build cross cultural competency in the host communities. While continuing her research agenda for urban refugee mental health and international settings, Dr. Im has built committee health partnerships and projects in Richmond Virginia, supported by the refugee mental health initiative of Virginia. Dr. Im developed a multitier refugee mental health care model and providing trauma informed cross-cultural psychoeducational training and intervention curricula that are currently adapted, culturally adapted to refugee communities. She is currently teaching clinical social work research and international social work practice at Virginia Commonwealth University and Dr. Im thank you as well for sharing your expertise with us today. Without any further ado I am happy to turn the presentation over to Dr. Im to share your knowledge with everyone today.

Thank you so much Dawn. Hello everyone thank you for joining today. I'm going to present today some of my projects for the refugee communities in the US and some in Kenya as well and share some thoughts about organizing refugee populations and building sustainable intervention programs in refugee communities. Let me start with the definition of refugee. I know many of you might be very familiar with this but a refugee is defined as a person forced to leave or exiled from their home country because of fear of persecution based on their race, religion, political opinions, ethnicity or social affiliation.

As we built in the definition refugees experience a unique and tremendous challenge which happens before, during and after migration. Because of the complex need of the refugee community, it is useful to divide refugee experiences into three common core phases. I have pre-migration, migration and post migration. Pre-migration is a period of time when refugees experience a diverse conditions in the home country that are the impetus behind their flight. In home countries many refugees face physical and emotional trauma, associated where they were, social conflict or organized violence. Culture and gender based biased are two of the most common violations that are in the refugees' home country. At this phase refugees suffer from numerous hardships including lack of political governance, and many don't have access to proper social support, health and education and multiple losses of family, property, home and in the community. In the migration phase, that is the transition

period. This is a time of the transition of instability. In fact the refugees have no permanent residency and are transitioning between countries. As refugees often live in transitional living conditions such as refugee camps, urban slums and even detention centers. This is also time when refugees have additional family roles or separation because of unstable legal, social and economic status. Refugees are often excluded from proper social protection, basic health care, education and social services. And discrimination and conflict from host community members which is a common experience. And also intense and prolonged process and no immediate solution or peace in the home country and it can increase marginalization in the population.

As to all of these challenges I do not know how many of you know that actually how many refugees get a resettlement opportunity. The numbers actually less than 1% in the world so only less than 1% of refugees can get better opportunity of resettlement in a third country. Or post migration phase is an ongoing process of culture and cultural adjustments and integration into the new culture. At this time refugees often struggle with multiple cultural and linguistic challenges as you perhaps know pretty well and lack of transportation, limited opportunities for employment, education, cultural education and also limited access to health care and other services. Acculturated stress, identity crisis, and intergenerational gap are some of the most well-known challenges because of the cultural transition. Refugee resettlement is one of the three solutions for refugee communities since 1976 US we settled more than 3 million refugees over almost 50 states. In 2014, according to refugee resettlement we had almost 70,000 refugees living in the US. I have some numbers here, the breakdown information of Virginia example. In Virginia for example there were 1,310 new arrivals in 2014 and we had Iraqis, currently one of the largest subgroups and the refugees from Bhutan, Ethiopia, Afghanistan and Burma are still growing as well.

Today I'm going to mostly explain the project what I did in Virginia. This is one of the models that we developed to address multiple and various refugee mental health issues in the community. It is a little bit intimidating that it is a lot of information but I have a link later that you can feel free to look at the details if you are interested later. These are the multitier model of mental health and psychosocial supports. As mentioned earlier refugees expense cumulative stressors and challenges. One reason is that is highly affected by the stressors his mental health. We wanted to develop this model to provide the guide stratified intervention model and capacity training for both refugee community and service providers. This model also aims to provide a properly and effective service efforts to the early stage of resettlement. At the bottom you can see the timeline when a refugee arrives in the US. In Virginia state and as I believe many other states as well, basic resettlement services is over until 90 days of the first arrival. Then Medicaid is only available up to eight months for most refugees and the refugees are just left out in that they have to survive on their own in most cases. On the right side of the model, I just wanted to mention these two pillars here. These models, act as the main principles of care and capacity training which is trauma informed and culture informed. Again since we don't have much time maybe Ican go to these details, if you're interested I can answer those

later if you have questions. The tier model is targeting different issues. The tier 1 is applicable to general population to address with social adjustment and integration issues. It is for the integrating to the existing services for a refugee community. Tier 2 is community-based training that is by extensively focusing on stress coping and social functioning. Tier 3 for our mostly for the specialized care or focused care so for example, Tier 3 to address trauma healing or trauma focused treatment is one example. Tier 4 is mostly for the specialized mental health treatment, psychiatry services or integrated care is involved. This is not the reason why I am actually presenting this and using this time but I just wanted to make sure that this is a guiding principle that we have and that the refugee healing partnership is embedded to this model here.

The refugee healing partnership is a collaborated effort initiated by three Virginia state offices. One is office of culture and linguistic competency, the newcomer health program, and we have office of newcomer services. These three offices came together to create a healing partnership so initially they actually started at the state level. The main outcomes that we're aiming for are positive mental health and cultural adjustment, a linkage between providers and the refugee communities and the last one is opportunities for trauma informed education at the community level and cultural informed education at the provider level.

The main focus that I wanted to have here is actually the parallel process of partnership building and intervention development. Other states guidance and support, actually developed some pilot intervention here to build some capacity in refugee leaders. Trauma influence cross cultural education training is designed for mental health professionals to engage with and build capacity in refugee community leaders for some community-based intervention. The trained leaders can provide some community health workshops and then afterwards we have another leader which is a support group, I will explain it later. But these pilot interventions were developed at the same time we tried to build a partnership which incurred three groups here. The refugee dialogue group, the refugee mental health Council and the refugee community leaders Council. Those three community organized entities meet together every month to discuss common issues in the community. Each has slightly different topical focus but still those are very much interconnected pieces. Try to address the common issues or the most urgent issues or in the current time or all together or individually. Those three groups consist of the local community partnerships. These models allowed us to develop partnership building and also the community intervention.

Let me explain the community intervention in a little more detail. After I started this model in Kenya we started training of the trainor because their setting has a very low capacity. They're not very many mental health providers. Even in the US, even though we have much greater facilities and resources but we don't have not many culturally and linguistically competent service providers in terms of mental health services. We wanted to train the community leaders for fair experience and very well regarded in the community, to build some capacity around

providing some health worship or education. We started with the training of the trainer in this case we used a trauma informed equipped culture psycho education in Virginia. In Kenya we used but still very similar kind of idea and then secondly the trained leaders provided community health worship embedded to communities existing services so for example, some in Kenya actually I provided in the clinic where we had parenting services and also youth programs so these workshops can be embedded in health services. In the US now we're trying to have those interventions in resettlement agencies as part of the cultural education program. This way we provide interventions to the refugee community and very culturally relevant and linguistically competent way and then the trained community members actually stayed in the group in more like a voluntary self contained support group. This is the model that we used in Kenya, very successfully now we're using it in Virginia and in Malaysia we are testing this model currently.

This is a picture that I wanted to share with you, this was the training, training intervention. We started with a community in Richmond which is one of the most active communities and the trained leaders as you saw in the previous slide, those leaders provided some community health workshops in the community and this is an intervention. I just wanted to show some pictures, this is a ceremony and also this is somatic symptoms that people after some training they had recognized and understand some impact of trauma on the body. Community health and partnership, I actually have a link yourself you want to better understand or learn more about the details you can feel free to use this link. Also if you have questions about it. Maybe I need to wrap up this presentation by emphasizing that sustainability and why it works. Developing a community-based intervention program takes much time and effort from both sides, providers and community members. The lack of communication and understanding or sometimes in the refugee community I think it’s maybe in the other communities as well but particularly in the refugee communities sometimes distrust or mistrust can become an obstacle to build this partnership. In refugee populations, especially additional layer challenge exists which is a cultural and linguistic barrier. I believe that the committee leaders are the backbone in almost any community initiatives for the refugees particularly because of many refugee communities are I think partly because refugee communities are mostly unified along the common values and goals of building and rebuilding communities and restoring cultural tradition. I don't think I was lucky to find some random people who are actually involved in this community building efforts. I believe refugee communities tend to have low regarded sometimes representative leaders either elder or young in their community. Their leadership I think often emerged through the community of diversity in the process of restoring the community either during or after migration. Leaders are often well trained and more, much experience to their previous professions before they are coming to the US. I know many leaders have been working with the UNHBR or other international NGOs in the camp. Some leaders I trained used the psycho education leader in before she came here. A lot of great examples actually and you perhaps find in your community your engagement leaders to be amazed by how much experience and how much educated the members are.

Training and retraining refugees and using nurture and interactive training format we do providers and refugee leaders are very powerful to mobilizing into that community I think. It is potentially very ideal to this effort to build culturally linguistically competent workforce development so that the programs and human resources can sustain its efforts. Maybe I can briefly mention some of the challenges. There are numerous challenges in this type of work. One of them is partly because partially because of the community research but a lot of ethical challenges and sometimes identification of leaders is very difficult. some communities in my experience is especially challenging to have some competent bilingual leaders or some communities like the people who are fairly highly educated perhaps the don't have a tradition meaning of leaders in the natural setting. You have to well identify and be careful about who you start working with. Also a lot of intercultural or multicultural competence issues and another thing was the funding so that is why I felt that some of the models worked very well, this is based on the community setting. Perhaps I can talk a lot but maybe you can actually ask me any questions after Jean is finsihed with her presentation. Thank you.

Dr. Im thank you so much for sharing so much of that information. It is so critical that the work that you do is connected in communities, building capacity in the communities. Very grassroots and very focused on helping the folks who have gone through the trauma to heal thank you for sharing that. We're going to move on now to Dr. Jean Beatson. I will switch to the next slide at hand it over to you Jean.

Thank you very much Dawn. I have lost connection twice so I'm going to proceed. Hopefully I will not lose connection again and thank you, Hi Jin that was very fascinating and I have a bunch of questions for you myself. Wonderful that this talk is after yours because we are going to be or I am going to become I say we because it has been such a collaborative effort in our Vermont LEND program but I will be talking with the role of partnering with refugee populations and diversifying LEND programs. The first and most important thing we do is set our vision. So our vision was we aim to become racially and ethnically diverse at every level of our LEND program, children, families, trainees, staff and faculty, LEND leadership, advisory Council. In order to do that, we had to address a lot of frequently heard comments within our own program and also we hear these comments everywhere even at the AUCD annual meeting in the fall when I was attending a lot of diversity offerings, a lot of these comments were there. These are almost at the level of nit but it is something I think is worth talking about.

One of them is we want to do some of these things but there just aren't any money out there. There are no grants. Later in my talk I will talk about how funding for these initiatives must come out of the base budget. Another is, we do not need cultural and linguistic competency training because we don't have that much diversity. We hear that a lot in Vermont, overall in the state Vermont is about 95% white and the premise behind that is cultural linguistic competency training is necessary for every person. It is not only necessary dependent upon what your diversity status or demographics are. The other one that is

similar to the first, we have no specific budget related to this. I don't know where to start someone said. We will just say that the amount of resources out there are phenomenal especially out of Georgetown, they're all over the country even professional literature.

How I incorporated program wide? I am hoping today you will learn a little bit of what we did. Because I'm a person of color, not me personally, they expect me to do everything. We grappled with this in our program also. One of the things that as faculty and staff, we all have really learned deeply is that it is everyone's responsibility to familiarize yourself with the literature and what needs to be done and to do as much as you can on your own to move the agenda forward. It is not about hiring one person who's going to do it all for you. Which is what a lot of people said. I wish I could find someone to come in and do it for us, have a consultant come in that you work with and then it is not nearly integrated into your persons or into your program. A lot of people have no diversity recruitment plan. Then, finally, we often hear particularly with disability organizations, disability is diversity so we have it covered. That is just disability is a function of diversity but we're talking now about racial ethnic diversity.

The literature tells us that culturally affected faculty have certain things in common. One is that we incorporate cultural linguistic competence into your professions. Such as doing self assessment on cultural linguistic competence, where do you stand as a profession, what your biases hidden or not hidden. Your motivations for change in growth, goal settings so that personal level of cultural linguistic competence, beyond cultural awareness is critical.

Another element of the cultural faculty is being able to observe an advocate in a cultural and linguistic confidence in organizations where you work. You have to learn how to see what is going on. Once you start seeing it and I have heard faculty in our program say this, once you start seeing it to see it everywhere. Joining committees, being active in your organization, seeing it as something that is a professional responsibility of yours and learning how to intervene when issues of bias arise and they will arise.

Working with and serving racially/ethnically diverse populations. Out reach to former refugee community for teaching, trainees and families. The way that we are doing this, we're partnering with former refugees in the Burlington, Vermont area and diversifying the LEND program this way and it is mutually beneficial. As faculty, we need to know the role of cultural linguistic competence in addressing health and health care disparities. As we all know, the health disparities undo different in morbidity and mortality, health care disparities are undo choices and services are received or accessed. Within our program we incorporate these principles into almost every class that we teach.

In our faculty, we have some professional development content, everybody participates in classes, faculty retreats, different places where this content is presented. The content must include racism, bias and micro aggressions, white privilege, systems of oppression, teaching diverse students and those who are English language learners and those

for whom English is not their primary language, including supporting academic writing. Health and health care disparities, the differences, what they are, what is happening in your own community. Family and person centered care and I will say that in, as a short aside in family centered care, a lot of organizations feel as though they really understand this, really understand what it is and that they're doing a good job with it. Some of the literature or the more recent literature is really demonstrating the fact that that is not true. We're really good at delivering personal family centered care properly for the middle class and upper middle class white people but when it comes to people living in low economic status, people who are Hispanic, people who are African-American and others were not taking the job at all. We just taught a class last week actually that really peels apart the differences between personal family centered care and cultural linguistic competence both interrelated concepts requiring different skill sets. Our training content of faculty also includes cultural and linguistic competence, in general often we use the maternal child health modules on health literacy. We talk about defensiveness, bias awareness and motivation, motivation to change, inner motivation, outer motiviation. Self-awareness and reflection and how to engage in culturally effective mentorship.

This again from literature comes from effective mentorship. Supporting trainees experiential learning and LENDS. How do you do that? Asking about personal or observed incidence of bias, stereotyping and micro-aggression. This year we actually changed our mentorship guide that all of our faculty used to include talking points along these lines. You are actually listening to stories from trainees and fellows. We have structured reflections in discourse with peers and faculty. We do this as large groups, small group work, and faculty mentoring. As I just mentioned the mentorship guide was created and followed by all faculty. I might also add that when disturbing instances bias are told then we also as a program have responsibility to respond and we have created a response protocol that is respectful of everyone but also works toward creating change in our communities. For our faculty we do mid and end of year mentorship evaluations by our mentees. They know that our faculty will eventually do that and it is to foster conversation about how we are doing.

You might be wondering, how did all of this get started . One of the first things we did a few years ago was hire a multicultural director and this was a way to start and create sustainable change. We created a staff position for multicultural director and she was also a program evaluator. We created a diverse person who is trusted in multiple communities. She was then able to target recruitment and former refugee communities and as my colleague Dr. Im noted in her talk , that in a former refugee communities there are many people who have lots of education, who are really wanting to get involved in LEND programs and other programs like this that develops capacity for them, it develops capacity for us.

Our multicultural director also raised awareness and did a lot of cultural linguistic competency training for our professional partnerships with title V, and academic studies and with in-state

leadership. Her role also include monitoring and collaborating with our program on our cultural linguistic competence curriculum, the recruitment plan and faculty and staff professional development and evaluation. Prior to us hiring her we were 100% white.

Here was our recruitment plan and some outcomes. In 2013, about three years after we set upon this plan, we had a target set for 30% racial/ethnic diversity of trainees and fellow. In 2014 we had 30% diversity we reached our goal that is this year. Next year, 2015/16, we have accepted more than 50% diverse trainees and fellows. A think we had 16 accepted and nine are racially and ethically diverse. We also are recruiting racially and ethnically diverse faculty and staff. So in this year, 2014/15 we have reached 30 percent diverse faculty and staff. Staff positions and faculty positions and when positions open up we prioritize talented people who are diverse and we have been able to find them and it has just been astonishing.

We are able to increase the racial/ethnic diversity of families involved in LEND. Our family faculty was a fellow in 2013/14. That is an example of a pipeline activity. She was a family fellow. This year, 70% of families match with our trainees are racially diverse. Our advisory Council is setting up a cultural competence and health disparities subcommittee with 90% racial/ethnic diverse community stakeholders. This is an interesting point, setting up a subcommittee for the advisory Council specifically to focus on health disparities, issues in the community and diversity is important because many of you may notice but people go quiet when they are in a room full of state leaders or people who may even be their boss. It is a conflict for people to really raise critical issues that are happening. You must create a safe environment in which to do that so we have a good communication plan between the subcommittee on our advisory Council all these members on the subcommittee are invited to come to the advisory Council but some real conversation happens in that subcommittee that won't necessarily happen at that same level in the advisory Council although that information will inform our strategic direction.

>> Sustaining change funds must come from a core budget. I promised you talk about money. How do we find new money in our budget? If you wait for grant, the grant will come and the grant will go and you will go back to the way you were. You must create the change within your core funding. When we calculate core faculty time, we use percentages. We decreased the training and clinical director percent time significantly. We also did new budget lines and spending priorities. If you do for your organization a cultural linguistic competence organizational assessment you will find all kinds of tools on the national center competence website out of Georgetown. This is one of the elements that you be looking at budgets and what do your budget lines tell you ? Is there anything in your budget line for interpretation or translation. We put some in. Budget line for consultant fees related to family practicum parents, $2800. We are prepared to add more staff clients. As with multicultural liaisons or things that come up that you want to do for our work. Unanticipated program savings are marked for diversity cost. We also put in money for child care and comprehensive fees pay for family fellows and summer

refugee trainings and fellows. Who by and large are financially struggling.

Integration at all levels. Realty follows intention. Like I said at the beginning of my talk first that your intention. Our current trainees are referring new trainees. This year we had three former refugee trainees next to her we will have seven. Targeted outreach for staff openings. Our subcommittee, our cultural linguistic competence, very diverse subcommittee, touching many of the communities around us. Diverse children and youth affected by disabilities and their families are involved in family connections, family faculty and these first two family connection and family faculty they have a teaching role in our clinical director does a lot of work in training them what this role is, getting a traininer director to meet them, and we paid them into back for the LEND program. The sustaining racial/ethnic diversity in LEND. Like we haven't mentioned leadership yet. Leadership succession beginning in 2015 we will have a new training director and she is a ethically diverse person and we are planning ahead and thinking ahead for our other management team positions, program Director, clinical director . Strategic planning. Let me back up by saying, in terms of leadership, we believe strongly that in order for the health disparities in healthcare disparities thqt exist in all of our communities, to be addressed effectively not only does the workforce need to be diversified but the leadership needs to be diversified. Strategic planning, we are shifting our program from a clinically-based program to a policy leadership program with the focus on diversification. We do CALC organizational assessments, cultural and linguistic competence organizational assessment, and we implement recommendation plan every three years as I said the creating the pipeline, we are committed to it and we're mentoring development across the board. We are evaluating our processes and doing annual reviews.

Here's a picture of this years trainees and fellows this is at the Vermont Statehouse just last week. We were there for a day at the legislature. Some of them to get their fact sheets in other communities, things our legislators really don't know too much about and the interest was really high. Our discourse, our conversation has completely changed. We are learning things now that we would have never known were not for our diverse trainees, faculty and staff. Issues of bias, care disparities these, access to our healthcare exchange, the list goes on and on. Every faculty staff trainee knows that what we're doing now is not only right but that we should have done it a long time ago and it is fair to say that we are on fire.

Here is my contact information. Please call or email me with any questions and I'm going to hand it back over to Dawn for questions.

Thanks so much Jean that was, I am almost speechless. That was really so comprehensive and really helping other folks in the network have a plan basically. You built a plan, you had fantastic outcomes and thank you for being so very concrete in how you explained all of that. I am going to open the floor for questions. Here is how to ask a question. If you are on the phone, I'm going to open up the queue on the phone lines so if you have a question you can press star pound on your phone and I

cannmute you one at a time in order of questions. If you are online, on the computer listening through your computer you can either type something in your chat box or you can use the feature to raise your hand and I can unmute you individually there as well. Hyojin and Jean are available to answer questions about either one of their presentations and you may even have questions for each other. Don't hesitate to ask any questions you might have. >> Right now I do not see anyone who is requesting the floor To ask questions. Jean, you said you might have had some questions for Hyojin about her presentation. Would you like to ask those?

Hyojin, I am curious in your wonderful work and I loved your presentation, the folks that become health navigators in your community, do they go on, do they continue doing that work for different organizations or what happens next for them?

Thank you for the question. That is one of the most exciting parts as well. Can I maybe go back to some of the slides that I had? I didn't really demonstrate that very fully but here one of the initiatives that states are now working on I'm actually developing this program also but cultural navigator quality education program. We are trying to focus on mental health first but eventually we want to move on to more general overall health worker the community health worker model. These community navigator programs though now actually started because last year we had some pilots and we are editing a series of trainings here that includes mental health, first aid training, to peer which is a suicide prevention, bilingual confident bilingual step training is more like a medical interpreter training. Then some of the trainings that we are adding now and a series of trainings after that. We are giving them a qualification or certificate and they are moving on to some other service areas. It is not just a mental health or health only but we're actually training for Department of Social Services, refugee resettlement agency. Even in school settings. It is very open right now but again it is very beginning stage right now so I do not have a potential outcome yet but we are making good progress. A lot of leaders from the local community Council, the refugee community leaders Council members. Many of them taking those cultural navigator qualification training right now. I wish I could actually have more outcomes but I'm very excited actually. It has been very well accepted by the community. >> Did that answer for you?

Yes, thank you.

There is a question on the phone I will unmute someone to ask their question.

My name is Jim I’m director of child advocacy at Lori Children's Hospital in Chicago. I am a new invited member to the Illinois childhood form a coalition ad hoc committee on refugee and integrating children and trauma. This is a newly formed committee and that is why I have been invited in. Specifically, there are two groups that have come up in discussion. One, the unaccompanied minors who have been coming in as you know from Latin America, Central America and second, refugees and immigrants who come in through the State Department and refugee

resettlement agencies. My question to Dr. Im is do you have any give me guidance or recommendations around how we might bridge the two as we develop community informed and trauma specific training?

Thank you so much for the question. Actually glad you about this question but I am not sure if I'm the best person to answer but to my best, unaccompanied minor I'm not actually working with but I know that the people are actually going, this is as you may know this is a program to the office of refugee resettlement. The two are slightly different although there are resettlement agencies that these agencies are a part of it but not exactly coming to the resettlement agencies. My experience to this population is very limited but the best part the refugee traditional to try to, especially in particular might be in Virginia we have a lot of people with special immigration visa so there are some different kinds of different in the actually within the refugee community having on that very well. I really wanting to start working with resettlement agencies at the beginning because I'm actually moving the slide to this model because it is an entry point first of all but I think the agencies and services they, the providers need to have more information and more collaboration. That is why we started the partnership with all the service providers including schoolteachers and even housing complex measures. These I think, this is one example in Virginia but I think, I believe many other communities have that kind of a refugee dialogue initiative. Some of them are actually mandatory so I think that partnership can be extended based on what is existing in your community. I'm sure that a lot of new interest actually I have been involved in some of the trauma informed care service providers who are not directly connected to refugee community but they have been serving the children in foster care system for example. There are slightly getting some more people actually including the people for unaccompanied minors, other programs they're getting to know or getting exposed to those people but some are not very well-connected to refugee resettlement service providers directly. I don't know if I have really announcer to question but I think the partnership extension is one of the key parts or at least the beginning effort of this kind of initiative.

One very brief request. I am also a volunteer tutor to an 11-year-old boy from Congo who was in a camp in Uganda for a number of years. With this training, you have various providers listed but I would really punctuate that we as volunteers also would benefit from this kind of training and orientation.

Yes. We started that iniative very recently] in my previous work has been quite a few years appears but the finalized two I think it is available in print so you could contact me. We're trying to build some more multicultural competency in that training module so that we really need to focus on one specific group and it is kind of an engaging group. It is a more interactive so it is not about one way information kind of dissemination. It is rather getting more voices to the committee so the participants can actually provide more input about culturing to mental health and others. It is not mental health treatment training so it is open for anybody who might be willing to work with refugee leaders or community members. I do not know if I missed something but my

connection was not the best but we can actually talk after maybe. Feel free to contact me, you have my contact information.

Thank you Dr. Im. There are two more questions in the chat box. One for Dr. Im and one for Dr. Beatson. I will give you a break in thinking here Dr. Im and I will start with Dr. Beatson. I will start , how important has been top leadership at the organizational level to create and support these changes in presented outcomes?

That is an interesting question and thank you for asking. I would say that it is essential for at least depending on what your model is that the leadership is fully behind that. That said, if you have a collaborative model like we have a management team and I would say some of us were in different places a few years ago and we all started to really come on board in different ways. If you have a very top-down model and at the very top of the leadership people aren't getting into it then I do not think that is not to do. I think your approach is going to have to say you will run into barriers and challenges all the time, within ourselves and withinin our organizations. Be professional, speak to the points that are important that are supported in the literature in the experience of the community and you will eventually win people over. In our program some people left because they weren't able to completely make some shifts that we were trying to make. Leadership buy-in makes it a lot easier even though it is hard to do.

Thank you. I know I have two clock on my clock but there is one question left if we could make a quick. Dr. Im it is in the chat box from Mary Alice. Where can we get more information on the refugee community leaders Council? Where is it housed or organized?

It is a local community initiative which I actually started as part of the Delti survey. I just created some small groups of leaders as a part of some intervention development process. Maybe I can check with you , we don't have much time right now but I can provide more information. It is not available on the website yet or there is nothing released but it is totally community-based and it is voluntary. The people meet every month voluntarily and we put some kind of agenda for the leaders to work on. I would love to talk with you more so feel free to let me know if you are interested in talking. That would be great.

Thank you so much to everyone for participating in this webinar today. I'm going to scroll through the slides all the way to the very end. If you have additional questions , you can contact the presenters directly, you can contact us at AUCD this is Dawn and my contact information is on the screen . Again, I really appreciate everyone's dissipation. As we close out the webinar, please do take a moment to complete the survey and Dr. Im and Dr. Beatson thank you so much for providing sharing such valuable information for everyone. We really appreciate it.

Have a great afternoon everyone.

Goodbye. >> [Event Concluded]