Stakeholder Perspectives Report: November 09, 2018 Focus Group Findings on Migrant Legal-Mental Health Intersectionality

Part of the project *Transforming Refugee Mental Health: Improving Legal Assessment of Credibility* seed funded by University of California, Davis, Office of Global Affairs

Raquel Aldana, JD | Patrick Marius Koga, MD, MPH

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BACKGROUND

In spring 2018, the UC Davis Office of Global Affairs awarded a seed grant to Raquel Aldana, PhD, Associate Vice Chancellor for Academic Diversity, Professor, UC Davis School of Law, and Patrick Marius Koga, MD, MPH, Director, Refugee Health Research, Dept. of Public Health Sciences, UC Davis School of Medicine for their proposed project "*Transforming Refugee Mental Health: Improving Legal Assessment of Credibility through Science."* The project aimed to address the mental needs of refugees and other vulnerable migrant populations by bringing together mental health and legal experts to produce recommendations on best practices for interviewing, documenting, and adjudicating legal claims seeking legal redress. While focusing initially on Northern California, the project is intricately embedded in the larger, international collaborative project *"Transforming Refugee Mental Health" (TRMH)* of University of California Davis Arab Region Consortium (UCDAR), with the longer view of enhancing mental health research and clinical service capacity in Lebanon, West Bank/Palestine, and Egypt, for traumatized Arab refugee populations. TRMH has begun to consider how to include the important intersections of mental health services and legal remedies, especially in refugee cases, both in the Arab Region and in the Arab refugee populations of California. While some Arab countries provide advanced therapies (Murad & Gordon, 2002), and have a modern legal framework for mental health services (e.g. Sudan, Jordan, Oman), in others, the therapy of the psychiatric patients includes cautery, exorcism, and physical violence (Pridmore & Iqbal Pasha, 2004). While in Egypt, Morocco, and Syria the corresponding legal framework for mental health is out of date (Tzeferakos & Douzenis, 2017), Yemen, Saudi Arabia, United Arab Emirates, and Bahrain don't even have a specific legislation for mental health (Gharabih, 2008).

The seed grant project started on November 09, 2018 with a daylong *First Forum on Refugee Legal-Mental Health Intersectionality*. The day also included a Focus Group Study. Featured in the UC Davis media https://law.ucdavis.edu/news/news.aspx?id=9178 the study had eight focus groups involving refugee organizations, media, immigration lawyers, mental health providers, neuroscientists, academics, researchers, global/refugee health, medical associations, refugee resettlement agencies, NGOs, advocates who came together to identify policy recommendations on the asylum adjudication and treatment of trauma associated with all stages of the forced migration journey. A *Second Forum on Migrant Legal-Mental Health Intersectionality* is scheduled for October 25, 2019 to conclude this project. The forum will include panel discussion with immigration lawyers, policy makers, and neuroscientists. The findings of the November 2018 Focus groups presented here only in summary form are intended to be used to inform policy changes, to close interprofessional education and practice gaps in work with asylum seekers, immigrants, and refugees, to shape programs that are tailored to the migrant communities served, and to improve the overall legal and mental health of all people in forced migration.

The seed grant project has generated an NIH R21 grant proposal titled "*A Gendered and Cultural Framework for Mental Health Assessments in Refugee and Vulnerable Arab Communities "* (Arab GCF Project). Led by PI Suad Joseph, this R21 application aims to develop, test, and validate a Gendered and Cultural Framework (Arab GCF) that may be hold more meaning and acceptance for mental health assessments with Arab and other vulnerable populations in Lebanon, West Bank/Palestine, and Egypt. The project thus may hold a better potential to inform legal and health frameworks and policies to reduce malpractice, suffering, ovemedicalization, treatment gaps and mental health disparities not only in the Arab Region but also in Arab populations in California. Lastly, but not in the least, the legal-mental health intersection lessons may apply not only to refuges but also to all categories of migrants in the United States and worldwide.

INTRODUCTION

Migrants encounter trauma along a continuum of pre-, peri-, and postmigration experiences. This is especially true for migrants forced to leave their home and/or who do so as irregular migrants. The trauma begins with the circumstances that provoked their migration and their rupture from home and family. The trauma continues with the suffering endured in the oft-treacherous journey toward their final destination. The confrontation with legal systems along the way or upon arrival wields new, or exacerbate old traumas, inflicted upon migrants intentionally or accidentally. Trauma is also present in the discomfort and pain associated with settling into new lives where identities and culture must be reshaped for survival. At their new destination, a plethora of legal and social vulnerabilities put migrants at greater risk of becoming victims of crime. Traumatized migrants who manage to arrive to the United States encounter both health and legal professionals, either voluntarily when seeking health services or legal protection, or mandatorily when facing removal, often while in detention. It is likely that health professionals are aware of and even perhaps equipped to address trauma's effects on the mental and overall health of migrants. It is however, less likely that different types of health professionals are aware of how their work within different healthcare services could be strengthened if they knew more about each other's research and best practices. Moreover, it is even less likely that these same health professionals understand the ways in which legal systems subject immigrants seeking legal protection to additional trauma, except perhaps in obvious cases of prolonged detentions and other types of ill treatment. Similarly, health professionals likely ignore how their good faith efforts to treat trauma could both harm their patients' legal proceedings or benefit their legal claims.

Legal professionals are usually well aware that forced and irregular migrants, especially refugees and asylum seekers, have experienced trauma. Indeed, the presence of trauma provoking forced flight – the well-founded persecution – is the foundation of a strong legal claim for refugee or asylum protection (Johnson, K., Aldana, R., Hing, B., Saucedo, L., Trucios-Haynes, E., 2019). The same is true human trafficking or crime victims who seek legal protection based on their victimization. Legal advocates are also starting to recognize how efforts to document a client's story of trauma to prove the legal case can trigger strong emotional responses and re-traumatize clients. However, legal professionals are usually quite unaware of how trauma affects memory or the ability to recall facts and narrate consistent stories. They are also less aware to how their good faith efforts to document in writing their client's trauma with specificity and chronological logic can end up adversely affecting the adjudicator's subsequent assessment of the client's credibility when the client is unable to perform their story as written. They usually lack training; moreover, on how to manage their client's trauma, or their own vicarious trauma, or on how medical evidence could help them corroborate the veracity of their client's experiences with trauma. Scientific knowledge about trauma should inform not only how legal and health professionals partner to better serve migrant communities but ultimately also the types of legal reforms needed to help bridge the gap between scientific knowledge and law. The legal community has started to document these gaps, such as recognizing the ways in which credibility assessments in refugee and asylum cases diverge significantly from what science teaches us about how trauma affects memory retrieval and story-telling. Yet, this recognition has yet to make a dent in promoting the urgently needed legal reforms that could actually improve law's objective: the ability to accurately and humanely identify the petitioners who have a right to protection under the law.

This project aims to start this important conversation and partnership between legal and health

professionals who serve traumatized migrants. Our aim is to improve our mutual understanding of how trauma affects many migrants, especially refugee and asylum seekers, and how we can best work together not only to ameliorate posttraumatic physical and psychological ill effects, but also to improve the legal systems' efficiency and ability to fairly adjudicate their claims. We considered it important that these multidisciplinary efforts should be led by research universities with strong programs in science and law, in partnership with practitioners and policy makers in both law and health fields, who are best equipped to inform the issues and the priorities.

METHODS

Research Design and Participant recruitment

Using a community-based participatory research approach, we conducted a qualitative research study with eight audio-recorded focus groups with professional and cultural experts in asylum, immigrant, and refugee services. Focus group topics centered on interprofessional education, practice, and service gaps in legal and mental health services for asylum seekers, immigrants and refugees in Northern California. A team of four investigators analyzed all transcripts in full before reducing data to codes through consensus. Broader themes were created to encompass multiple codes and emerging subthemes. For our focus study, we used an expert sampling (a subtype of nonprobability purposive sampling) with the objective to produce a sample that can be logically assumed to be representative of population with a high degree of knowledge about our study area, refugee mental health and law intersections. "Expert" here meant not only participants with JD, MD, PhD, Psy.D and other terminal degrees, but also migration cultural experts, individuals who embody of a certain set of characteristics. As Kitamaya & Cohen put it (2010, p.212) the term means "…the people most immersed in, most competent in, or who most embody a culture in it's "pure" form." These migration cultural experts were resettlement agency workers, state and county refuge agencies, refugee community based organizations and refugees, immigrants and asylum seekers themselves.

Findings presented in this Report are based on data from eight focus groups of experts belonging to five stakeholder groups: (I) refugee/immigrant organizations, media; (II) immigration lawyers; (III) mental health providers; (IV) academics, researchers, global/refugee health, medical associations; and V) refugee resettlement agencies, NGOs, CDPH, advocates, and refugees, that explored interprofessional gaps in their awareness, knowledge, training, and skills in working with refugees, immigrants, and asylum seekers. The focus groups were conducted on November 09, 2018 in partnership with these organizations that identified mental health as a major health concern. Participant recruitment: we have reached out via email and phone to 192 experts representative of five refugee stakeholder groups in the Greater Sacramento and San Francisco areas who could influence or be affected by policy changes. We have personally invited each person to the focus groups, and explained the purpose and the process. Forty-nine participants have been recruited giving us a return rate 25.52%. Seven more participants have been added through snowballing bringing the N to 56. (See Figure 1 for a list of stakeholder organizations). Finally, 46 participants filled up all the demographic information of present study and actually participated in the focus group discussions.

Figure 1

Stakeholder Group I Refugees; Immigrants; community based organizations (CBOs); media *n: 9*	**Stakeholder Group II** Immigration Lawyers & Law Educators; legal agencies *n: 14*	**Stakeholder Group III** Mental Health Professionals (MD; PhD; Psy.D; LMFT) *n: 8*	**Stakeholder Group IV** Researchers; Academics Neuroscientists; Global/Refugee Health; Medical Associations *n: 9*	**Stakeholder Group V** Refugees resettlement agencies; CDPH; Sacramento County; social agencies; advocates, politicians *n: 9*
Afghan refugees / Special Immigrant Visa (SIV) holders	UC Davis School of Law and UC Davis Immigration Law Clinic	UC Davis Dept. of Psychiatry and Behavioral Science	UC Davis Department of Public Health Sciences / Ulysses Refugee Health Research Program	California Department of Public health (CDPH)/Office of Refugee Health
Iraqi refugees Special Immigrant Visa (SIV) holders	University of the Pacific - McGeorge School of Law, Sacramento, Victims of Crime Resource Center in Sacramento	California Psychiatric Association	UC Davis Center for Reducing Health Disparities	Sacramento County Department of Health
Iranian refugees and asylum seekers	UC Hastings College of the Law, San Francisco	Sacramento County Department of Health / Services Adult Psychiatric Support Service Clinic	Office for Equity, Diversity and Inclusion, UC Davis	Opening Doors, Inc. Sacramento
Egyptian immigrants	International Human Rights Clinic, Berkeley Law	UC Davis RESTART Program: Resilience, Education and Supportive Tools for Adults Recovering from Trauma	UC Davis Betty Irene Moore School of Nursing	Sacramento Food Bank & Family Services
Turkish asylum seekers	Southern California Immigration Project (SCIP)	Alliant University Int'l, San Francisco	Refugee and Asylum seeker Health Initiative (RAHI) at UCSF School of Medicine	TESOL International Association (formerly Teachers of English to Speakers of Other Languages)
Afghan Community of Sacramento	Legal Services for Children (LSC), San Francisco	Holistic Therapy for the Heart and Soul, San Francisco	UC Davis, Department of Asian American Studies	San Francisco Coalition for Asylee, Immigrant and Refugee Services (SF-CAIRS)
Former Veteran, Immigrant, and	Equal Justice Works, Washington, DC	Former VIRTIS Refugee Clinic,	Loma Linda University	

Refugee Trauma Institute of Sacramento (VIRTIS)		Sacramento		
	Garcia & Anderson, LLC, Sacramento		San Mateo County Medical Association	
	Immigrant Legal Resource Center (ILRC), San Francisco			
	Sacramento FUEL Network Removal Defense Program at California Rural Legal Assistance Foundation (CRLA Foundation)			

Demographic Characteristics of Focus Group Participants

Forty-six participants filled up all the demographic information of present study. This section was divided into demographic characteristics and work information of participants, as shown in Table 1. The highest incidence of participant age group was observed with those aged 38-47 years (37%), followed by those aged 28-37 years (32.6%). Participants of Caucasian/White ethnicity had the highest incidence (23.9%), followed by Southeast Asian (21.7%), Hispanic/Latino (15.2%) and Middle East North Africa Region (13%). The female (76.1%) to male (21.7%) participant ratio in this study was 3.5/1. Almost half of participants had doctoral degrees (47.8%), followed by Master's degrees (34.8%). Colleges/universities had the highest institutional representation in the study (28.3%), followed by community-based organizations (21.7%), and resettlement agencies (15.2%). Profession-wise, lawyers had the highest incidence of participation (28.3%), followed by physicians and researchers (13% each). The immigrant's field/type of experience observed was highest with immigrants (67.4%), followed by refugees (60.9%) and asylum seekers (39.1%). Participants with a work experience of 6-10 years had the highest incidence (39.1%), followed by those with 3-5 years (34.8%). Participants born in United States had highest participation (45.7%), followed closely by former asylees/immigrants/refugees (37%) and naturalized US citizen (21.7%).

Table 1 Demographic characteristics and work information of participants

Demographic/Work information		no.	%
Age (years)	18-27	1	2.2
	28-37	15	32.6
	38-47	17	37.0
	48-57	6	13.0
	58-67	7	15.2
Race & ethnicity	African	1	2.2
	African American	1	2.2
	Caucasian/White	11	23.9
	Central Asian	1	2.2
	Hispanic or Latino	7	15.2
	Indian subcontinent	3	6.5
	Middle East North Africa Region (MENA)	6	13.0

	Native American or Alaskan	1	2.2
	Southeast Asian	10	21.7
	Western Asian	3	6.5
	I prefer not to disclose	2	4.4
Gender	Male	10	21.7
	Female	35	76.1
	I prefer not to disclose	1	2.2
Education	No degree	2	4.4
	Bachelor's degree	5	10.9
	Master's degree	16	34.8
	Doctoral degree	22	47.8
	Other degrees	1	2.2
Affiliation	College/university faculty	13	28.3
	College/university staff	4	8.7
	CA State or County staff	4	8.7
	Community-based org.; Refugees	10	21.7
	Legal agencies	5	10.9
	Media	1	2.2
	Medical society	2	4.4
	Resettlement or social agency	7	15.2
Profession	Advocate	5	10.9
	Consultant	1	2.2
	Executive/administrator	2	4.3
	Lawyer	13	28.3
	LMFT Therapist	3	6.5
	Physician	6	13.0
	Psychiatrist	2	4.3
	Psychologist	2	4.3
	Public Health	5	10.9
	Researcher	6	13.0
	Social worker	1	2.2
Professional experience of migrants types	Asylum	18	39.1
	Immigrants	31	67.4
	Refugees	28	60.9
	SIVs	9	19.6
	IDPs	1	2.2
Years of professional experience	1 -2 years	2	4.4
	3 – 5 years	16	34.8
	6-10 years	18	39.1
	More than 10 years	10	21.7
Personal immigration experience	Currently asylum seeker	4	8.7
	Currently SIV	4	8.7
	Former asylee/immigrant/refugee	17	37.0
	Legal Permanent Resident	7	15.2
	Naturalized US citizen	10	21.7
	Born US citizen	21	45.7

	Parents are refuges/immigrants	9	19.6

The focus groups were facilitated in English at UC Davis Medical Education Building, Sacramento, CA, by five experts and lasted for approximately 90 minutes. A semi-structured guide was used, which covered topics including participant experiences with and perspectives on mental health and mental illness, both generally and related to their specific community, as well as recommendations for promoting improved mental health. Participants were asked to complete a brief Demographic Questionnaire at the start of the group to gather basic sociodemographic information. The focus group questions followed a *3E* sequential process of Engagement, Exploration, and Exit:

I. Engagement question: introducing participants to the topic of discussion

1. What is your work (or your personal) experience with vulnerable migrant (refugees, immigrants, and asylum seekers) populations? (15 min)

II. Exploratory questions: having participants talk about the main topic

2. What gaps, if any, in your own professional awareness, knowledge, skills, and training in work with vulnerable migrants, if any, have you noticed? (15 min)
3. What gaps, if any, in the awareness, knowledge, skills, and training of other stakeholders relevant to your work, have you noticed? (15 min)
4. What do you like and/or dislike about the idea of mandatory interprofessional training (i.e. CEUs) in work with (15 min)

III. Exit question: checking to see if anything was missed in the discussion.

5. What other policy changes would you suggest to reduce/close gaps and better integrate interprofessional stakeholders' work with vulnerable migrants? (15 min)

Post-focus groups discussion and Data Analysis

The facilitators gave a short summary of the main themes they have heard and asked the participants: have we correctly described what has been said? Afterwards all participants returned to the Lecture Hall to discuss the themes that have emerged. Focus groups were audio recorded by eight UCD medical and public health students and the groups were professionally transcribed. Transcripts and summaries were managed and coded using NVivo, a software package for qualitative data analysis. A coding scheme (with definitions) was developed that included pre-identified and emergent themes. Data analysis was conduced by Hadeer Akram Al-Ani, PhD, Assistant Clinical Professor in the Dept. of Public Health Sciences at UCD School of Medicine, and by Claudia Patricia Escobar, PhD candidate in the School Organization and Education Policy emphasis area, and a former researcher and policy analyst for the University of California's Office of the President.

FINDINGS

Data Analysis: Emerging Themes and Subthemes

I. GAP THEMES

Six curricular, service, practice, challenges, cultural competence, and research themes have emerged about perceived gaps in the education and training of legal, medical, social, and resettlement professionals working with migrant populations. Twenty-seven associated subthemes have been identified in the data analysis.

II. POLICY IDEA THEMES

Four themes have emerged in the areas of interprofessional education (IPE) and interprofessional practice (IPP) training, the provision, monitoring and performance evaluation of services, a two-way cultural competence and humility, and a better use, alignment, and expansion of resources. Fourteen associated subthemes have been identified in the data analysis.

THEME 1
Curricular Gaps
in trauma-informed medical and legal education & training and migrant populations

Subtheme 1.1. Medical, nursing, and psychology curricula are deficient in immigrant and refugee historical, sociopolitical, and cultural backgrounds and determinants of migration and health

Subtheme 1.2 Legal curricula are deficient in trauma-informed migrant and refuge health topics including the Resilience Model and lack self-care to prevent secondary traumatization and burnout

THEME 2
Knowledge & Practice Gaps
trauma-informed medical, legal, and resettlement services

Subtheme 2.1 Lack of knowledge and poor public understanding of law and immigration. Courtrooms have inadequate knowledge of refugee languages and lack translators

Subtheme 2.2 Adversarial process and no right to counsel

Subtheme 2.3 Insufficient mental health support and care for asylum seekers and other vulnerable migrants in traumatizing adjudication proceedings, no guarantees of confidentiality, poor support for caretakers

Subtheme 2.4 Medical malpractice of immigrants in detention

Subtheme 2.5 Poor longitudinal follow-up on refugee mental health status beyond the 90-day post arrival initial assessments at the county refugee clinic

Subtheme 2.6 Refugee/migrant charities and NGOs show insufficient knowledge of their scope of work

Subtheme 2.7 Many doctors and lawyers come from privileged backgrounds with little personal experience to inform empathy for their underprivileged & traumatized patients/clients

Subtheme 2.8 Attorneys and resettlement workers insufficiently knowledgeable about client trauma and retraumatizing clients

THEME 3
Interprofessional Service Gaps
in the provision, awareness, access, and navigation of systems, services, and networks

Subtheme 3.1. Insufficient interprofessional collaboration generally

Subtheme 3.2. Shortage and poor continuity of legal, mental health, translation, and social services for asylum seekers, immigrants, and refugees. No timely and effective training in how to navigate social systems, secure gainful employment, file taxes

Subtheme 3.3. Refugees not included in interprofessional practice networks, some feel being "siloed" and disempowered.
Subtheme 3.4. Refugee IPP network databases in need of adequate compilation, wider dissemination, easier access, and constant updating
Subtheme 3.5. Insufficient knowledge of service systems and resources from the part of social agencies; medical doctors can seldom connect refugee patients with social services.

THEME 4
Resettlement Challenges in communication, translation, sociocultural orientation, & engagement

Subtheme 4.1. Belated, poor, ineffective socio-cultural orientation, ESL classes, employment and professional reentry training provided to newly arriving clients
Subtheme 4.2. Refugee women are left behind because of a lack of a gendered, and culturally congruent approach to orientation, training, and assistance.
Subtheme 4.3. Resettlement agencies and the society at large, often ignore/exclude refugee views, expertise, and professional capital. Needless and neglectful "brain waste" of refugee medical doctors, especially Afghans and Arabs.
Subtheme 4.4. Unsustainable reliance on unpaid volunteers and unrealistic expectations to have unemployed refugees, too, do volunteer work.
Subtheme 4.5. Lack of migrant knowledge of cross-cultural challenges; some refugees are perceived as having unrealistic job expectations, a sense of entitlement, and archaic, domineering, patriarchal attitudes towards women.

THEME 5
Cultural Competence Challenges in Trauma-Informed Practice

Subtheme 5.1. Social stigma of mental illness in refugee communities
Subtheme 5.2. Loss of refugee male employment, social capital, and dignity produces shame and frustration that sometimes leads to domestic violence
Subtheme 5.3. Current US legal approach to domestic violence in refuge families not in alignment or even conflicting with cultural competence
Subtheme 5.4. Mental health provider and translator, cultural, and procedural gaps in trauma-informed practice
Subtheme 5.5. Clients prefer culturally-congruent translators and providers but not from the same community out of fear of poor confidentiality

THEME 6
Research Gaps in migrant trauma & disconnect between research & practice

Subtheme 6.1. Status adjudication process not informed yet by trauma research and neuroscience
Subtheme 6.2. Insufficient research funding for refugee and immigrant relevant studies (e.g. epidemiological, ethnographic, anthropological; traditional indigenous, culturally congruent interventions)

THEME 7
Policy Change Ideas in interprofessional education & interprofessional practice

Subtheme 7.1. Mandate Interprofessional education (IPE) and practice (IPP) training to overcome the isolation and poor effectiveness of silo work.
Subtheme 7.2. IPE and IPP training should be a personalized process of a refugee-informed, refugee-centered and refugee-driven IPP community-making which engages, not wastes, refugee brain, expertise, talent, and aspiration to integrate productively in their new society.
Subtheme 7.3. Connect practitioners to IPP networks instead of only to individual peers; multisite partnerships between refugee stakeholders should become the norm of refugee interprofessional practice (IPP).

Subtheme 7.4. Learn from the migration policy experience of other countries and perhaps rethink and extend the definition of "refugee".

THEME 8
Policy Change
Ideas in the Provision, Monitoring and Performance Evaluation of Services

Subtheme 8.1. Start refugee resettlement orientation long prior to departure, in the country of origin or transit and extend the refugee post-arrival resettlement assistance and orientation beyond the current short time (3-9 months)

Subtheme 8.2. Accountability and oversight of service providers. The performance of resettlement agencies should be improved, standardized, monitored and evaluated.

Subtheme 8.3. The current reduction in governmental programs for immigrants, refugees and asylum seekers needs to be redressed and reevaluate the current policy of grant asylum seekers work authorization only after a six months wait.

Subtheme 8.4. Medical ethics advocacy and policy changes urgently needed for children held in traumatizing immigration detention with no confidential psychiatric or counseling services.

THEME 9
Policy Change
Ideas for a Two-Way Cultural Competence and Humility

Subtheme 9.1. Cultural ignorance, bias, and Islamophobia need to be replaced with cultural competence, if not with cultural humility. Neither cultural assimilation nor overpathologization should be imposed on immigrants who may find better inner strength for healing within their own identity, frameworks, and community.

Subtheme 9.2. Refugees, too, need to change and adjust some unrealistic expectations, and archaic cultural attitudes, like men's patriarchal domineering and/or disempowerment of women, or the women's poor literacy, English and employment skills.

THEME 10
Policy Change
Ideas for a better use, alignment, and expansion of resources

Subtheme 10.1. Continuity of care or wrap-around services

Subtheme 10.2. Relying on resettled refugees/asylees as cultural resources

Subtheme 10.3. Funding increases; use Mental Health Services Act (MHSA) funds to close refugee IPP training gaps.

Subtheme 10.4. Expand educational, vocational, professional reentry, and social integration opportunities

DISCUSSION, CONCLUSIONS, & POLICY RECOMMENDATIONS

To be compiled after the October 25, 2019 Forum.

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