

Connections

An information service of Immigration & Refugee Services of America's
National Alliance for Multicultural Mental Health

VOLUME I, NUMBER I

JUNE 2000

Welcome to the first issue of *Connections*, a publication of IRSA's *National Alliance for Multicultural Mental Health*. This edition is an outgrowth of IRSA's mission to protect and promote the rights of the displaced—including access to services and programs in the country of resettlement that enhance adjustment and self-sufficiency. Since the early 1900s, IRSA has resettled refugees in the United States through an extensive national network of agencies. Through this experience, IRSA knows that refugees are indeed survivors who bring with them a wealth of personal and cultural strengths that benefit our country over the long run. At the same time, resettlement providers are well aware of the tremendous process of adjustment that refugees undergo—sometimes compounded by past experiences of torture and severe trauma—and the lack of appropriate support services available to them.

While resettlement providers are challenged to serve those refugees who may have more difficulty adjusting, mainstream providers struggle to serve those arriving from a very different cultural context, whose concept and experience of "mental health" may be radically different from their own. What is needed is technical assistance by cross-cultural mental health professionals to both types of providers—to resettlement workers on practice and programming that enhances the mental health of those they resettle, and to mainstream providers on the special strengths, needs, and cultural contexts of refugees. Through appropriate programming, much distress experienced by refugees can be diminished, more serious problems prevented, and those in need of more extensive support services will have access to services that are culturally appropriate and effective.

To this end, the *National Alliance for Multicultural Mental Health* was founded in 1996 by IRSA and three leading refugee mental health agencies—Heartland Alliance for Human Needs and Human Rights, the Center for Multicultural Human Services, and the Center for Victims of Torture—with support from the Office of Refugee Resettlement. In 1999, the Alliance grew to six agencies, with *Solace* of Victim Services, the International Institute of Boston, and the International Institute of New Jersey joining the collaborative. The Alliance serves refugee providers—including agency and program directors, caseworkers, ESL teach-

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This publication is made possible by support from the Office of Refugee Resettlement through ACF Grant number 90 RM 0033. The views expressed herein are those of the authors and do not reflect the official position of the Office of Refugee Resettlement.

ers, job developers—and mainstream providers—from the health, mental health, and education sectors—across the United States through:

- ◆ on-site training and consultation, crafted to the specific needs of the requesting agency
- ◆ annual training conferences
- ◆ a website (www.refugeesusa.org) providing centralized information and resources
- ◆ **Connections**, a bi-annual electronic and hard copy publication, including informative articles and descriptions of “best practices” in cross-cultural mental health

Connections supports the overall goal of the Alliance to link a diverse array of service providers with information and resources and with each other. There are many ongoing creative and innovative efforts across the country that—if shared—can benefit providers and those they serve tremendously. This publication aims to document and disseminate some of these “best practices.”

This first issue is debuting very close to June 26—United Nations International Day in Support of Victims of Torture—and, for this reason, we are highlighting the issue of torture. Many governments throughout the world routinely practice some type of torture, usually aimed to silence those who speak out against them and to maintain political dominance through terror. Those who are targeted are often the very people who are forced to leave their country and become refugees. Estimates of the number of refugees living in the United States who have endured some form of torture range from 5 percent to 35 percent. The needs of many of these refugees are quite complex, requiring comprehensive medical, psychological, legal, and social services. And, as described in the following articles, some of the most important needs are for reconnecting with others and regaining a sense of control over one’s life—basic human abilities that torture aims to destroy.

In the first article, Mary Fabri from Heartland Alliance for Human Needs and Human Rights in Chicago, describes a Bosnian women’s group that has helped women reconnect with each other and find strength in their traditions. Next, Ernest Duff describes his experience developing the *Solace* program of Victim Services with an approach that builds upon the resilience inherent in refugees and their communities and that emphasizes collaboration with other regional programs. Evelyn Lennon describes the efforts of a rural community in Minnesota to rally around and support a refugee survivor with the assistance of an innovative community-building and outreach project at the Center for Victims of Torture. We have included two policy pieces, to inform you of ongoing efforts at the macro level that affect both refugees and service providers. John Salzberg, Washington Representative for the Center for Victims of Torture, describes the tremendous effort undertaken

to strengthen U.S. support for survivors of torture, resulting in victories including the Torture Victims Relief Act that will provide \$7.5M in funding for torture-treatment centers in the year 2001 alone. Finally, Melanie Nezer, IRSA, discusses the Convention Against Torture in the United States and the obstacles to protecting those under threat of torture from deportation to their countries of origin.

We hope that you find these articles informative and useful. At the end of this publication are announcements, including information on our recent publications on refugee mental health, our training conference taking place in the Los Angeles area next month, and more detailed contact information

for the *National Alliance for Multicultural Mental Health*. We welcome your comments and look forward to hearing from you.

Sincerely,



Lyn Morland, MSW, ABD (PhD)
Senior Program Officer
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Group Therapy As an Intervention with Refugees

**By Mary Fabri, Psy. D.,
Heartland Alliance for Human Needs
And Human Rights**

Isolation is a persistent and pervasive complaint among refugees. The loss of homeland and the inability to communicate freely have profound effects on interpersonal interactions. Group therapy can be an effective intervention when the membership is designed in a thoughtful manner.

The Bosnian Mental Health Program, part of Heartland Alliance for Human Needs & Human Rights, in Chicago, Illinois, has been running groups for Bosnian refugees for more than four years. In the development of therapy groups the diverse ethnic, religious, and regional differences of Bosnians, as well as the range of experiences endured during the war, were taken into consideration. Groups were formed along homogenous lines of age, class, and region. The intention was to bring together individuals who would have some shared life experiences that could facilitate a sense of commonality and then, trust. The groups were meant to help the participants to recreate a feeling of community, an extremely important aspect of Bosnian life. The groups were not intended to be an arena for political discussion or resolution of ethnic or religious differences between members. The wish was for group members to come together to share a common interest, develop trust and relationships, and discuss their experiences at a pace determined by the group members.

The first group that was formed was called the "Grandmothers' Group." The eight women in the group were all fifty-five years or older, from a rural area, and living with an adult child's family. An art therapist, a clinical therapist, and an interpreter facilitated the group. The women were agreeable to meeting, but declared that they did not want to talk about the war. Handcrafts, such as crocheting, knitting, and needlepoint had been a part of these women's lives prior to the war. They all insisted, however, that they could no longer do these crafts, stating "I cannot concentrate," "I do not have the patience," or "I do not have the motivation." It was decided to have the women meet for two hours a week to share conversation, drink coffee, and work on handcrafts, to reclaim a part of their lives that existed before the war.

At the first group meeting, the art therapist provided each woman with a large square of fabric, threads, yarns, needles, and the other needed supplies to create a familiar craft piece. Although there was some mild protesting about being unable to do it, the group leaders gently encouraged and reassured the women. So over the following weeks, the women met, drank coffee, and talked while working. The art therapist lent assistance with the handwork while the therapist and interpreter facilitated the conversation as the women shared about their lives before, during, and after the war. The women cried and supported each other. They worked together, each creating their square: an embroidered repre-

sensation of the Muslim symbol of the crescent moon and star; a needlepoint scene of broken homes and blood in the river; a crocheted doily; a knitted scarf. Whatever was made was either created as part of the fabric or mounted on the fabric. Upon the completion of their individual work, the women then put each individual square together to create a panel, two squares wide and four squares long. They collaborated on adding a border to the panel. When it was completed, the women looked at what they had done, and one commented, "We can do better!"

Since that time, the group leaders have changed, but the women continue to meet. Sometimes they create individual works, sometimes collaborative efforts. They have gone on to make a beautiful quilt with panels depicting scenes from Bosnia, some from their war experiences, some from their life before the war. Their first work was exhibited in an art show at a women's gallery. Beside their work was displayed a translation of words they had composed.

We are women from Bosnia. Our mothers and grandmothers handed down to us the tradition of these crafts. The war in Bosnia took our homes away from us. We will find strength in our traditions.

The Bosnian Mental Health Program currently has four women's and one men's group meeting on a regular basis. The Grandmothers' Group is just one example of the value group therapy can have for refugees. Whether bringing together individuals to work on a project or to talk over coffee, the process of creating a sense of relationship between group members leads to developing trust and a feeling of belonging. It can break the pattern of isolation.

For more information, contact Mary Fabri at the Kovler Center for Survivors of Torture, Heartland Alliance for Human Needs and Human Rights, Tel: 773-271-1073; Fax: 773-271-0601. ■

Reflections on a Community Model Of Refugee Mental Health Work

**By Ernest Duff, MA,
Solace, Victim Services, New York City**

Three years and some months ago I funded myself to go to a one-week short course at the Refugee Studies Programme at Oxford University in the United Kingdom. The course was called "Re-thinking Psychosocial Interventions," and I remember how intrigued I was by the emphasis it had on taking a critical look at the rise of the psychosocial intervention internationally. I had worked for over nine years in resettlement of refugees, first at the local level for Episcopal Migration Ministries and Church World Service and again at the national level for the Church World Service Immigration and Refugee Program, where I coordinated their affiliate network. In all those years, I remember noting over and over again that many of the refugees I was having contact with had come out of nightmarish situations that often left them with a shattered and fragmented sense of self, as well as a tortured memory, but that at the same time they inevitably evinced that strength of spirit that could only be termed resilience.

Then there were all of the convoluted and maddening bureaucratic mazes that each refugee had to

face, made exponentially worse by the experience of massive ongoing trauma and cultural misapprehension. It seemed that the general consensus among the more mainstream mental health providers at the time was that this population was statistically insignificant—that those of us who chose to advocate for them had to prove that they even existed—and that we then had to take the long road toward trying to argue for why there should be preventive mental health services for refugees at all. All of this, in turn, had to occur in the presence of bureaucracies that defined the need for mental health work in terms of *chronic* mental illness for the most part, terms that were only applicable to a very small percentage of the refugee population.

So, with many of these vexing images in my head, I went off to Oxford and came back nine days later with a new conception of what I wanted to do. During the weeklong course, individuals from all over the world discussed the relative merits of psychosocial work on a worldwide basis. The clear relationship between the donor-driven nature of many psychosocial programs, and the strategic political interests (or lack of them) that drove decisions to fund many programs was an eye-opener for me. The

course also focused on the paucity of true consultation with the local populations and refugees, local NGOs and governments, in the countries that were to receive psychosocial services. Largely influenced by the work of Oxfam, as well as by their many years of working amidst refugees, the leaders of the course, Dr. Derrick Summerfield of the Medical Foundation for the Care of Victims of Torture in London, and Dr. Alistair Ager of Queen Margaret College in Edinburgh, made the case for why we should seek to *participate* with groups we would want to work with, particularly when approaching them with our northern and western perspective on mental health.

I was studying psychology at the time, and I was immersed in the statistically-based, cognitive/behavioral legacy of Eurocentrism, while my experience as a result of working with refugees was of a different caliber—multi-cultural, multi-faith, and multi-racial. And while I had always had an interest in post-traumatic stress, largely as a result of my Vietnam-era upbringing, there was something larger on the horizon that I sensed when looking at the refugee mental health issue.

That something, it turned out, was the sheer complexity of culture applied to *both* stress and resilience across a spectrum, coupled with a realization that no one I knew, particularly not the “experts,” really had the answers on how to work within this complexity, or how to respond to needs in appropriate and culturally competent ways.

I came back to the States resolved to bring the international lessons I had learned to bear on work right here, and as luck would have it, the opportunity to do psychosocial work became a reality barely four months later. In 1997, I helped to found *Solace*, a Program for Survivors of Torture and Refugee Trauma. Today, three years plus later, we are one of the members of the *National Alliance for Multicultural Mental Health*, as well as one of the 15 or so torture treatment centers in the United States. We are all bi-cultural, former re-fugees, with the exception of myself, and most of us are not mental health professionals, with the exception of myself. We do a lot of supportive counseling and other concrete services that help to re-build the sense of family and the needed connection to community that so many refugees have lost. We link, in a very decentralized and “resettlement-like” way, to clinicians in mental health and primary health care services through

out the City of New York. So far we have worked with people from 39 different countries.

Every time I think that we need to get more “sophisticated” about our approach, I reflect on what participation and dialogue really mean, and about how little we know about different world-views, spirituality, conceptions of the self and the other, the meaning of traumatic events, and the language with which to express them. I am finding that, in working with the community by doing outreach and needs assessment, we also need to see family systems at work within that community—along with the face of each individual—and *we* must endeavor to show them our *own* communities, families, and individualities. This is leading, I now know, to a paradigm that is radically different than the so-called “mental health” system in this country. In fact, this work lies largely outside of that system, informing that system about where it can learn and adjust to serve those from radically different backgrounds and multifaceted perspectives.

We are moving ahead at *Solace* with a community development effort that seeks to gather advice from refugee leaders, train them to do their own psychosocial needs assessments, meet their families in settings outside of the clinic, incorporate their traditional healing beliefs into the service plan, and bring healing into focus through the arts. We are also continuing to provide decentralized clinical services, capacity-building for providers and ethnographic evaluation, which allows us to hear from refugees about what they consider to be successful. We don’t do this alone; we are in consortium with others. In fact, I don’t believe anyone can do this alone; we are fundamentally interdependent when it comes to this particular concern, that is, the collective and individual health of our communities, of which refugees are a critical part.

The community and participatory approach requires extra effort, but the payoffs are tangible. More people are served as a result of an entrepreneurial and imaginative spirit, coupled with resettlement *and* clinical expertise, and refugees are not stigmatized in the process. Instead, they continue in their roles as students and teachers in our ever-evolving cultural milieu.

For more information, Ernest Duff can be reached at 718-899-1233, Ext. 101; Fax: 718-457-6071; Email: eduff@victimservices.org ■

Center for Victims of Torture Assists Rural Community As It Rallies Around Healing And Support for Refugees

By Evelyn Lennon, MSW, MA,
Center for Victims of Torture

Towns in rural Minnesota have suffered greatly from the farm crisis and the overall rural decline of the 1980's. Small communities have further confronted change in the last two decades as refugees, asylees, and immigrants have arrived to take jobs in regional factories and to find affordable housing.

Rapid change has been forced on the long-time residents of these towns, as it has been forced upon the new arrivals. Challenges to the existing systems include the introduction of non-English-speaking children and adults to classrooms; the initial need for resources by newcomers; and new cultural expressions. Challenges for refugees of war have been immense, as they have struggled to learn a new language and a new culture while coping with the deep effects of war trauma.

Samira O. (pseudonym) moved to a small city in outstate Minnesota in 1998 from her initial resettlement in Minneapolis. She came to find work in NewTown (pseudonym) with her five children and a sister. A group of refugees from Somalia already resided in a small housing complex near Main Street. Samira's husband had been killed and her sister raped and beaten by soldiers in their home country.

Samira's family received the assistance of school and social services workers soon after their arrival in NewTown. Local caregivers contacted the Center for Victims of Torture in Minneapolis for consultation, as additional resources became necessary for Samira's sister who suffered symptoms of post-traumatic stress disorder.

In response to requests for education and resources from the community, the Training Team from The Center for Victims of Torture held an all-day conference in NewTown for 100 professionals from the area. Workshops enlightened the participants on the subjects of the possible long-term effects of torture and war trauma, appropriate mental health interventions, and strategies for effective cross-cul-

tural work. Clinical staff from the Center for Victims of Torture worked with their counterparts in NewTown using case studies, role playing, and discussion groups.

Evaluations from the conference revealed the strong impact of the workshops. Medical, social services, and mental health workers learned "best practices" for working with war trauma survivors. Partnerships were developed among agencies in NewTown. A worker from the Center for Victims of Torture will return to the community to help organize a monthly refugee mental health consortium.

NewTown residents were appalled to learn about the widespread practice of torture throughout the world—and the deep and long-lasting wounds it inflicts upon individuals, families, and their communities. Many participants were deeply moved when Samira, as a member of a refugee panel in the plenary session, shared from the podium her family's tale of exile and suffering. Samira wept as people from her new community thanked her for sharing her story.

When the effects of torture and war violence are understood, steps can be taken to counter their effects. Communities like NewTown develop strong support for Samira and other new members, meaningful community structures, and the means to support change for all residents.

The Center for Victims of Torture provides training and consultation, upon request, to all who work with refugees and asylees. Clinical services are provided to survivors of torture in Minneapolis-St. Paul.

This is a true story with identifying details changed to protect the privacy and confidentiality of the refugee. For more information, contact Evelyn Lennon at Center for Victims of Torture, Tel: 612-627-4272; Email: elennon@cvt.org ■

The Torture Victims Relief Act: Congress Deserves the Credit

By **John Salzberg, PhD,**
Center for Victims of Torture

In 1992 the Minneapolis-based Center for Victims of Torture decided to hire a full-time Washington Representative on public policy and to undertake a concerted effort to strengthen U.S. support for survivors of torture. At the time the only concrete financial support by the United States Government was a \$100,000 annual contribution to the United Nations Voluntary Fund for Victims of Torture. And, for four years that contribution was pledged, but not contributed. Fortunately we have come a long way since those days.

In 2000 the United States contributed \$5 million to the UN Voluntary Fund for Victims of Torture. The Department of Health and Human Services, through the Office of Refugee Resettlement, is granting more than \$7 million to U.S. treatment programs for victims of torture. The Agency for International Development (AID) has just issued a \$1.5 million grant program to assist foreign treatment centers for victims of torture.

How did all this come about? Any political success is necessarily the result of the combined effort of many dedicated people and organizations. Refugee organizations, human rights groups, and service providers collaborated to draw attention to the critical need for this legislation. The Clinton Administration fought hard to get this legislation passed. Lavinia Limón, Director of the Office of Refugee Resettlement, was active throughout the process, and opened the door to appropriation of authorized funds through her agency. And, last but not least, strong congressional support from a few key Members of Congress made it possible. The remainder of this article is a tribute to these Members and their long-term dedication and strong support.

In 1994 Senator Dave Durenberger (R-MN) introduced the first Torture Victims Relief Act (TVRA). In 1995 Senators Durenberger and Paul Wellstone (R-MN) and Congressmen Christopher Smith (R-NJ) and Tom Lantos (D-CA) introduced TVRA, and in 1997 Senators Wellstone and Rod Grams (R-MN) and Representatives Smith and Lantos submitted TVRA.

In 1998 TVRA (PL 105-320) was adopted, providing, as indicated earlier, authorization for funding U.S. and foreign treatment centers through ORR and AID,

and a contribution to the UN Fund (which assists centers worldwide including U.S. centers). The above mentioned House and Senate Members were key to getting the authorization legislation through Congress. TVRA authorized funds for Fiscal year 1999 and 2000. In 1999 with the same sponsors the Torture Victims Relief Reauthorization Act of 1999 (PL 106-87) authorized increased funding for fiscal years 2001, 2002, and 2003.

Since no funding can be provided without appropriations, certain members of the Appropriations Committees were invaluable. In the House it was John Porter (R-IL) who chairs the Subcommittee that appropriates funds for the Department of Health and Human Services and who also sits on the Foreign Operations Subcommittee as well. Congressman Martin Sabo (D-MN) who also sits on the latter subcommittee provided key leadership particularly with AID. In the Senate, Senators Arlen Specter (R-PA), Tom Harkin (D-Iowa), and Patrick Leahy (D-VT) were very helpful.

The legislation has helped and been helped by the development of a U.S. Consortium of Treatment Centers for Victims of Torture. Now more than 15 in number, they are located from New York to California and from Minneapolis to Dallas. TVRA will help to support their work and help to develop additional centers around the United States. Most communities are not being served or are under-served in terms of care of their survivors of torture. With treatment many can become contributing members of their communities. Consortium members have also alerted their Members of Congress about the importance of assisting victims of torture.

There are now well over 200 treatment centers around the world, with many functioning in countries where human rights are fragile if not repressed. These centers need our support and with TVRA they will be getting more support. While efforts must also be strengthened to prevent the practice of torture, we can not forget the effects on those who have been tortured and their need for assistance. Moreover, by uncovering the magnitude of the problem, we help apply pressure on foreign government officials to desist in the use of torture.

For more information on the TVRA, contact John Salzberg at 202-484-0099; Email: dcenter@aol.com ■

The Convention Against Torture in the United States

**By Melanie Nezer, Esq.,
Immigration and Refugee Services of America**

At no time has the world been free of the use of torture as a means of political repression. Still, it wasn't until relatively recently—after World War II—that the international community began to take a stand against torture and formally declare that it would not be tolerated. In 1948, after the scope of Germany's brutality during the war had been fully revealed, the United Nations General Assembly declared simply and strongly: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

Of course, the use of torture did not end with World War II. Recognizing this, in 1975 the United Nations issued the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In 1981, the United Nations established the UN Voluntary Fund for Victims of Torture, and in 1984 the United Nations adopted the Convention Against Torture and Other Cruel, Inhuman or De-grading Treatment or Punishment ("the Convention Against Torture"). The Convention Against Torture has since been signed and ratified by 119 countries.

Convention Against Torture protections have been part of U.S. law since 1998. In February 1999, the United States Immigration and Naturalization Service (INS) and Department of State established rules and procedures for those who wish to request protection under the Convention.

Article 3 of the Convention Against Torture prohibits the United States from removing "any person to a country in which there are substantial grounds for believing the person would be in danger of being subjected to torture, regardless of whether the person is physically present in the United States." It provides protection for individuals who fear persecution but cannot qualify for asylum or withholding of removal because the persecution they fear is not on account of race, religion, nationality, membership in a particular social group, or political opinion.

The Convention Against Torture also provides protection for those who are excluded from applying for asylum, such as individuals with certain criminal convictions. For these populations, the Convention Against Torture may provide the only protection from removal to countries where they face torture.

While the United States clearly recognizes that the Convention Against Torture creates an absolute bar to deporting anyone who will be tortured, the U.S. government has placed some restrictions on Convention Against Torture protection. One controversial aspect of the regulations is a provision which permits the return of an individual who qualifies for relief under the Convention Against Torture if the Secretary of State obtains "assurances from the government of a specific country that an alien would not be tortured there if the alien were removed to that country." What concerns advocates is the possibility that the United States will negotiate with governments who have been found to persecute and torture. Morton Sklar, the director of the World Organization Against Torture, is concerned that "allowing the State Department to make inquiries with other governments destroys the concept of confidentiality in refugee cases" and could "subject an applicant or his family and friends in the persecuting country to grave danger."

Another threat to victims of persecution is the U.S. government's policy of "interdicting" migrants at sea. Interdiction—stopping boats carrying unauthorized migrants outside U.S. territorial waters and returning them to their country of origin—particularly the of Chinese in the Pacific and Haitians and Cubans in the Caribbean, has meant that victims of persecution may be sent back to their countries of origin without sufficient inquiry as to whether they may face torture if returned.

A third obstacle to protection is the recent sweeping changes to U.S. immigration law, which seriously threaten a refugee's right not to be returned to a place where he or she faces the threat of torture. Expedited removal, enacted in 1996, allows U.S. immigration inspectors to return individuals attempting to enter the U.S. with false or no

documents to their countries without hearing or review. Since victims of persecution often flee their countries without proper documents, they are especially vulnerable under these summary removal procedures. To help assure that victims of persecution are not sent back to their torturers, Senators Patrick Leahy, a Democrat from Vermont, and Sam Brownback, a Republican from Kansas, recently introduced the "Refugee Protection Act" (S. 1940), a

bill to effectively repeal expedited removal, limiting its use to emergency situations.

For more information about Convention Against Torture policies and practices in the United States, visit the website of the World Organization Against Torture at www.woatusa.org ■

Announcements

- ◆ **Future Directions in Refugee Mental Health conference in July!** IRSA's *National Alliance for Multicultural Mental Health* will hold its sixth regional training conference on July 24-26, 2000, in Burbank, California. Plenaries, panel discussions and workshops will address Refugee Mental Health Programming, Mental Health Practice, and Cross-Cultural Approaches to Mental Health. Presentations include *Stress Management for Caseworkers, Building and Integrating Services for Refugees, Indigenous Approaches to Healing, Community Outreach, and The Expressive Arts and Working with Survivors of Torture and Extreme Trauma*. For more information and registration, please contact Madelyn Leeke, IRSA Training Center, 202-797-2105; Email: mleeke@irsa-uscr.org
- ◆ **IRSA publications available for free download!** IRSA now has two publications on refugee mental health available for free download from our website at www.refugeesusa.org/store. The first, an update of our 1986 edition of *Preventive Mental Health in the ESL Classroom*, was produced by the original authors at the International Institute of Boston and is entitled *Mental Health and the ESL Classroom: A Guide for Teachers Working with Refugees*. The second publication is a collection of best practices by our founding *National Alliance for Multicultural Mental*

Health members entitled *Lessons from the Field: Issues and Resources in Refugee Mental Health*.

- ◆ **TASSC (The Torture Abolition and Survivors Support Coalition)** is in charge of organizing events the week of June 26 in the United States to increase awareness of the ongoing use of torture and its impact on those who survive. See their website at www.torture-free-world.org for more information on events this week or contact Harold Nelson at 202-529-6599; Email: hnelson@ghrc-usa.org
- ◆ **Please be patient!** Our website is still under construction. At the end of this month, start looking for the *National Alliance for Multicultural Mental Health* at www.refugeesusa.org. In the meantime, please contact Lyn Morland, IRSA, at 202-797-2105; Email: lmorland@irsa-uscr.org for more information on IRSA's refugee mental health initiatives.

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The *National Alliance for Multicultural Mental Health* offers expert technical assistance through:

On-Site Training and Consultations tailored to each agency's needs. Topics have included:

- Refugee mental health
- Cultural backgrounds of newly arrived groups
- Integrating resettlement and mental health services
- Innovative approaches to working with special populations:
 - Children and adolescents
 - Refugee women
 - Older refugees
 - Survivors of torture and extreme trauma
- Addressing family conflict
- Models for using interpreters
- Working with the schools
- Community approaches to mental health
- Working with natural support systems and indigenous healers
- Creative therapeutic approaches using the arts and media
- Spirituality and mental health
- Stress management and self-care for service providers

Community Workshops aim to increase communication and coordination among refugee-serving agencies in communities. IRSA and its partners will work closely with your agency to organize a workshop, tailoring it to agency and community needs.

National Training Conferences—Local and national service providers and experts in the field offer sessions crafted to participant needs. These gatherings have proved an excellent opportunity for networking, sharing experiences, and learning from one another. Comments from participants include:

"Presenters were clear and focused, provided valuable information..."

"I believe the two days have affected me so deeply that it is likely to change my career and my life."

"GREAT CONFERENCE! Honestly and truly... I will attend the next one."