**Adapting QPR Training to Incorporate Refugee Experiences**

**January 31, 2012 RHTAC webinar**

Operator: Ladies and gentlemen, thank you for standing by and welcome to the Refugee Experiences and Adapted QPR Training for Refugee Gatekeepers Webinar. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question and answer session. At that time, if you have a question, please press the 1 followed by the 4 on your telephone.

You may also ask a question during the presentation by using the chat feature located in the lower left corner of your screen. If you need to reach the operator at any time, please press star 0. As a reminder, this conference is being recorded Tuesday, January 31, 2012.

I would now like to turn the conference over to Charlot Lucien, coordinator of the Refugee Health Technical Assistance Center. Please go ahead.

Charlot Lucien: Thank you again for joining today's Webinar, and my name is Charlot Lucien, coordinator for the Refugee Health Technical Assistance Center, RHTAC. This project is based at the Refugee and Immigrant Health Program at the Department of Public Health of Massachusetts, and we are funded by the Office of Refugee Resettlement of the Department of Health and Human Services.

Now before we start, I want to give you quick background on the development of this Webinar. Through the Office of Refugee Resettlement, RHTAC was made aware of a number of suicides in the Bhutanese community, and we went through the process of researching what could be an adoptable suicide prevention model. We've reviewed a number of them, and all of them relevant to their intended populations, and we worked with the QPR Institute to adopt their model to integrate what we call the refugee experience.

Now QPR stands for question, persuade, and refer. So why are we doing it now? What we saw is this capacity to bring the refugee piece and make it available online to the large

network of QPR trainers. There are currently reported to be more than 4,000 in the US. So when we do that, local agencies reach out to them and we also saw an opportunity to facilitate greater in-person training in resettlement areas with these trainers. So I really want to take the time to thank the QPR trainers for joining us today.

I also want to thank Dr. Paul Quinnet. He's the President and CEO of the QPR Institute, and he's also on the line. And toward the end of the call as needed, he may help field some of the questions. We also want to acknowledge on this call our project officer Makda Belay, and our staff Tina Sang and Judy Chevarley who worked hard to help with this adaptation process. They are also available as well during the Q&A session toward the end.

Now speaking about questions, we understand that people may have questions during the presentation. We will take your calls live on the phone through our operator after Dr. Stewart's presentation. But in the meantime, you can also send your questions through the chat function, and that was explained to you earlier, and we will try to get to some of them at the end. Now if we don't go through all of them, we collect usually all questions and we post a summary document online after the Webinar.

A full list of all the resources that we have may be available in a few days, so we encourage you to also visit our site frequently. Again, that's www.refugeehealthta.org. As a final reminder, this Webinar is being recorded and everyone will receive an email with a link to the recording. So what are our objectives for today?

Our objectives are two-fold. We first have a part one presentation, and that's an introduction to refugee experiences and this is geared toward a number of you who have been trained as QPR gatekeepers and to other audiences, to clinical staff, resettlement providers, all of them with some suicide prevention background or experience. So anybody in this audience can also make use of these slides in the course of their work, because you are not all QPR certified trainers.

We also have - so the objectives would be literally to explain how a person becomes a refugee, to describe the refugee migration process, to understand the effects of migration and resettlement on refugee health and mental health, and to identify challenges during the integration process. A second part will be a brief presentation that will outline the added features of the two-hour QPR training for gatekeepers.

Again, I want to say that the full training slides will also be available online for the certified gatekeepers. So the specific objective for this one would be to review those key features of the adapted QPR training and the tools that will be available. So we have now a quick poll, if you want, and what will happen, you will take about ten seconds to answer these questions. Are you a QPR trainer? Again, it's yes and no, and I will count to ten, and then we will close the poll. Okay, we are closing the poll now, and let's see what we have. So, we have 41% who answered that they are QPR trainers, and there are 59% of you who are not QPR trainers. Again, the email block that went out went to a number of other agencies and programs that are not necessarily in the QPR training organization.

So let me say quickly that we are now going to introduce our speaker, Dr. Samantha Stewart, and Dr. Stewart is an attending psychiatrist at the Bellvue NYU Program for Survivors of Torture. She has authored several papers and reports on the issue of torture survivors' treatment and psychiatric care, and has conducted investigations on torture victims overseas, in Zimbabwe and South Africa. She is also a member of the leadership team of the Refugee Health Technical Assistance Center, and she has extensively reviewed the QPR suicide prevention model to help with its adaptation process. So now - I now want to turn it to Dr. tewart.

Dr. Samantha Stewart: Hello, everyone. Can you hear me?

Charlot Lucien: Yes.

Dr. Samantha Stewart: All right, great. I'm so happy to be here today, and it was interesting to see from the poll that it is approximately half and half people who may be coming from

refugee agencies and experienced QPR trainers. This presentation is really trying to assemble the kind of expertise that people who've thought a lot about how do you train people in suicide prevention with the expertise of people who've worked a lot with refugees, understanding that this is a very specific population, and that many resources often do have to be adapted to be effective at this - to be effective with this group.

So let's jump right in by starting with a general question for people in the audience. Answer to yourselves, but I want each of you to think in your own minds, what comes to mind when you think of a refugee. This is to give you a starting point, to say, okay, what do I know? What do I imagine? And then we'll have you reflect on that as we go forward and try to describe to you how someone becomes a refugee, and what that process is like, and why that process and that identity might actually affect somebody's suicide risk, and the way to go about instituting prevention.

Okay. So it's a bit of a trick question, because in reality, there - so I'm having a delay with slides. Let me just - okay. This is the slide we want to be in. Okay. Because in reality, refugees come from all walks of life and from a variety of different countries. There's no typical refugee experience, because they can come from large cities, small villages, modernized countries, developing countries, and each of these cultures has different levels of familiarity to Western culture, including Western views of health, health care, and mental health.

The following slide shows images - the top is a Somali father and son, and the bottom slide is some Bhutanese youth. The Somali refugees - their story of arriving to the United States as refugees begins with Somalian independence, at which point the Bantu began to be treated as a real second class citizen, very marginalized in politics, education, and in the professions. The government started some forced seizures of farms in the '80s, and then general violence broke out in the '90s.

At that point clans, war lords, bandits, were very prevalent, leading to many Somalis fleeing to refugee camps just across borders, including Kenya's. Now within the refugee

camps, the discrimination - again, the Bantu ethnicity reemerged, and many Bantu within the refugee camp were forced to live on the outskirts of refugee camps, which are often more dangerous areas in a camp community, with attacks from bandits trying to get UNHCR resources, and occasionally the hostility of people in the host country, particularly can be threatening to the - to women who go out into the nearby environment to collect firewood.

The Bhutanese story begins back in the 1800s when people of Nepali background moved to Bhutan, set up farms in the southern part of Bhutan, and really identified with Bhutan for many years. In the '80s, however, the government in Bhutan began a policy called Bhutanization, which likewise marginalized people of this Nepali background and specifically the Lhotshampa ethnic minority. This meant the children were not allowed to speak Nepali in school, and they couldn't get full citizenship.

Initially there were peaceful protests, but by the '90s, the government had begun to crack down on protesters, leading to some detentions and torture. Many families fled across the border at this point to Nepal, where refugee camps were set up, and those camps - and after living in those camps for practically 20 years, in the past few years, UNHCR has decided to offer resettlement to those refugees.

So in this case, the Bhutanese of Lhotshampa minority are now having the opportunity to move to other countries, but that's after spending lifetimes in the camps. So it's a big adjustment in this case. Refugees entering the US in recent years include those from Somalia, Democratic Republic of Congo, Urtrea, Cuba, Burma, Iraq, Palestine, Bhutan, Vietnam, Iran, and Afghanistan.

Now the formal definition of refugee is defined by the United Nations as a person who is outside his country of nationality and who is unable or unwilling to return to that country due to persecution or a well-founded fear of persecution based on one of five factors: race, religion, nationality, political opinions, and/or membership in a social group. The two previous examples, the issue was nationality.

But as we go through this presentation, you'll see images of people who've been - who've had problems in their home country based on other identities. There are an estimated 45 million people worldwide who leave their homes due to persecution, so that circumstance is not as rare as we would like it to be. The large majority of people fleeing their homes are called internally displaced people.

That means they move within their own home country, so they do not qualify for refugee status. You can see from this chart, there has been a second majority of refugees, but then that tiny - there's a tiny sliver - it's not even visible on my screen. It's less than 1% of those refugees that actually get resettled in a third country. Today for the most part we are talking about that small minority who have gone through the process of going to a - fleeing to a second country and then being resettled in a third country.

Now the next slide is to engage you once again, a little quiz. Which of the following famous people are refugees? We have Albert Einstein, a very well-known scientist, Alek Wek, a very well-known model, and Gloria Estefan, a very well-known singer, or D, all of the above. I think you have the chance to actually participate in a poll here, so go ahead and answer. I see the number rising where this doesn't - essentially you're all right, because it does turn out that every single one of those three people that are well-known to us are refugees.

Albert Einstein was a refugee from Nazi Germany based on his Jewish identity, ethnicity, religion. Same as well, (Alec West) from Sudan, based on ethnicity. Gloria Estefan from Cuba, political beliefs. And so we see that these - that they are refugees also.

We can expand our ideas of who they include, because once, if they have a healthy, successful integration into the host country, they can be very successful, contributing members of society. Now this slide is a simplified but important picture of the refugee migration process. You see somebody would begin in their home country, move to a host country, often the nearest place they can get a plane ticket to or walk to.

And then as we described, a small minority will be moved by UNHCR to a third country called resettlement. The movement to a third country in resettlement is done only after UNHCR determines that it is not possibly safe for the person to return to their home country or to safely integrate into the host country where they've initially fled. Now what we'll be discussing in the next few slides is that during this migration, these people in flight are often not able to meet basic needs.

You consider Mazwell's hierarchy, and if somebody doesn't have clear access to safety, food, clothing, or shelter, it is certainly very difficult to plan for the future, have sense of stability, build a support network, the things that we think lead to good health and mental health. Now let's focus on that first step. Flight from a home country is a decision that is made by refugees who live in fear in their home countries. They may have witnessed killings of loved ones, been tortured, raped, detained in prison, enslaved as child soldiers, forced to work in labor camps, or were afraid these and other types of atrocities would happen to them.

In addition, their homes and possessions may have been destroyed or forcibly taken away. The second key point is that the act of leaving is typically forced by violence and unbearable circumstances, and has an urgent, unplanned quality. When a refugee leaves with this type of urgency, they have to leave belongings behind. They often take risky journeys on a moment's notice without time to prepare. This traveling to a safer place may include long walks or journeys by boat, bus, or plane.

Many refugees are successful only after repeated attempts, and many others die during the attempt to reach safety. Again, this is something you want to keep in your mind in terms of if a QPR presentation is being given to gatekeepers of this community, this is the kind of background experience that people in those communities are arriving to the United States with. When we focus on the host country, the issue doesn't necessarily get much easier.

The host country, the image that many of you may bring to mind, is the image of refugee camps that you see in the media. It turns out more than half of refugees don't settle in refugee camps. They just try and find a place in a non-camp or urban setting in a host country that

may or may not recognize their documents, that may or may not share any linguistic background. And when they are in the non-camp or urban setting, they have little to - significantly less access to the resources UNHCR is providing to the camp.

We're going to look at some images of camps. These are Iraqi refugees. You can see that people may be living in tent conditions, and in not necessarily rich parts of the host country. Often when host countries permit camps, they have it in the outskirts or in places that do not have many resources. Host countries may also demand that services provided for refugees are no more than what's available to their local population.

So if people cross borders into similarly impoverished or countries in conflict, they may not - there may not be many resources to access, period. These are Congolese school children in a makeshift school so there is the attempt to recreate schools in the camps. Here are Somalians at the transit center. This is in order to get permission to come and go from camps, so the daily life involves a lot of bureaucracy, and doesn't have the quality of a fluid, flexible life that many people would be accompanied to - accustomed to in terms of accessing resources and building communities.

Now some images of some non-camp or urban settings. These are - no, these are not. These are Iraqi refugees in Syria. Looks like they found someplace that they can afford, but they're sleeping on the floor. Sudanese refugees in Egypt. The - it looks like the children have had the opportunity to get into school, but unclear what their relationship is in the schools. It's often described that host countries' own population feels very upset and conflicted by people from other countries coming and using any of their resources.

And here are Chin refugees in Malaysia. The refugee migration process is marked by displacement, loss, and upheaval. With each move to a different country or location, refugees must draw upon their resiliency and available resources to adapt and survive in a new and oftentimes unwelcoming environment. Refugees also face uncertainty regarding whether they will ever be able to return home, if they will be referred to resettlement, and how long the admissions process will take for third country resettlement.

As we move on to the final objective of this first portion of the talk, thinking about the impact of that refugee migration on physical and mental health, the - one of the key components is that extended period of instability where somebody is not - doesn't have resources, doesn't know when they are in a place where they can really begin to build a life once again and feel certain of their own safety.

Now thinking of pre-flight pressures that would impact the mental and physical health of a refugee, depending on the living countries in the country, refugees may have been exposed to diseases, experienced malnutrition, and have limited access to health care. That can affect their physical status. That can also affect their relationship with health care, their understanding about seeing a doctor and their willingness to see a doctor.

In the clinic where I worked, diseases like tuberculosis and hepatitis B are the norm. So other countries are coming with exposure to infectious diseases that we don't - that we aren't typically exposed to in the United States. Refugees most likely also experience significant stress such as loss of relationships, separation from family, and crumbling social support. It's these structures that often drive people to leave. In times of conflict, violence, and mass migration, there is a general worsening of government infrastructure, which weakens the home country's ability to provide health care and protection to its people.

Now many of the stressors of flight and living in a host country have over that, so primarily I want to direct your attention to the bottom four. That's the loss of status, discrimination, long wait, and anxiety over the future. This is when those issues really kick in. Frequently people do not feel welcome or safe in the host country. There can be a new set of discriminations in that they are refugees and not in their native countries.

And there's this - the long wait like you see in waiting for a line to see if you can get a pass to come and go from the refugee camp, but there's a long wait of trying to figure out is it the home country going to settle down and become safe again; am I going to be granted a third country resettlement? What does UNHCR plan for this camp? Many of the camps -

again, I think the image we have from the media is camps being something temporary, and that's the idea of them. But when we think of temporary, we think a few months, maybe a year. But in reality, many of these camps end up existing for many years.

At that point, people have this confusion of whether they are supposed to settle in or whether they should be prepared to move on at any point. And the last slide is one that we really want to pay attention to with the populations who we've developed these QPR trainings for, the resettlement stressors. Once refugees arrive in the United States, they may be disappointed by how their new lives in America do not match their high expectations.

Refugees often come to the US lacking the social support of family and friends who remain back in the home country or host country. Racism, low economic class, and the language barrier place refugees at disadvantage upon resettlement. These factors combine to isolate refugees from social support and the wider US society, so these are things that we want to keep in mind, both as risk factors for suicide, but in terms of thinking how might you approach somebody who's feeling that isolated, to persuade and refer to - refer for assistance.

Over time, refugees tend to develop a higher risk of chronic disease, due to Western diet and lifestyle. They may also have ongoing responses to trauma, including depressive, anxiety, and post-traumatic stress disorders. Interestingly, while they're still in flight, often there's no time to sense the degree of trauma they've experienced. Once they arrive at what they're told is their final destination, many times the emotional and traumatic response begins to set in.

Barriers such as lack of transportation, stigma, and unfamiliarity with Western medicine may make it difficult for refugees to access and use health and mental health services. Okay. When we think about adjustment to life in the United States, there - like, the key idea is people come in with a set of expectations and so much hope that they're going to be able to finally settle into a place and start a life.

In particular, the United States has a very weighty image in people's minds as a land of opportunity and money adjusting to that when you arrive with a different language, with or without your family, and with a short window of financial support that disappears quickly makes for a tremendous adjustment for many of our refugees. These images that follow are (unintelligible) refugee resettlement.

This is a Sudanese woman waving the American flag. This is a Bhutanese family that has all arrived together and has housing. And here is a Somali family that has their belongings. You see that's what your belongings get pared down to when you go through these many stages of transition, arriving at a refugee and immigration center. There's excitement there, but you can also, when you see the title you can imagine that there's also lots of uncertainty and bureaucracy and unfamiliarity ahead.

Seeing their coats reminds me of a frequent comment about new arrivals in New York City area, is absolutely never having had to wear a coat before and understanding the kind of cold that you can experience here. And this is a (unintelligible) family that's been resettled in Ireland. Now this slide is key. You see that we've inserted a reality phase which comes after arrival.

These previous slides show the anticipation and the hope. Reality is the phase in which the genuine conditions of daily life begin to settle in, and you see that there's this chart that demonstrates a fork in which integration and connection to resources can lead to adaptation and further integration, whereas isolation and alienation can lead to further marginalization for a variety of reasons.

Our efforts for refugee agencies and for QPR trainers who might be interested in working with these groups are to attend to and be able to identify those who might be heading toward alienation and marginalization. Issues such as unemployment, family dysfunction, lack of support system, certainly can increase a person's risk for suicide. The immediate goals of refugee resettlement are to bring refugees into a safe environment and give them an opportunity to rebuild their lives.

The ultimate goal is refugee integration into US society. Integration results from the long journey of successfully adapting to new surroundings. ORR, the Office of Refugee Resettlement, the federal government agency charged with helping refugees during the resettlement process, states its mission as providing people in need with critical resources to assist them in becoming integrated members of American society.

This slide defines integration: good psychological and social adjustment, self-sufficiency, self-confidence, sense of power and control, language competence, good social support systems, well-functioning family and children. Interference with any of those, again, can shift things in the other direction. Integration is a two-way street where refugees learn to adapt to their new environment and supports are provided to refugees by receiving communities.

There are many sources of support, and they all play a role in helping refugees cope with challenges and adapt to life in the US. We want to highlight these now, because some of them may be unfamiliar to QPR trainers, and they are important resources in terms of thinking how do you reconnect a marginalized refugee to a greater community. Some of the sources of support we think of are rest resettlement agencies, refugee communities, indigenous traditional healers, religious organizations, family, and friends.

Now those aren't the same list of sources of support that we would always think of for an American born citizen who has access to some of the more formalized support networks, so such as health and social services. Think of the barriers that may be there, educational and vocational training and community-based organizations.

Okay. The gatekeepers you will be training on QPR are affiliated with the groups listed previously. Refugee gatekeepers are defined as community members who are trusted by refugees and come into regular contact with refugees. Thus gatekeepers are in a unique position to spot suicide warning signs, intervene, and connect refugees to appropriate services.

Okay, here's our transition point. We're thinking of people who may have that familiarity with refugees as described by that definition of gatekeepers, and we're thinking of QPR trainers who have familiarity with training people in suicide prevention. We've collaborated to try and come up with an adaptation to a full-length presentation, how to make it more suitable for training gatekeepers so that gatekeepers can suitably use this information in their communities.

Today we only have a short time, so we just want to focus on the areas that we thought were important to adapt. The most important areas for adaptation is primarily how do you discuss suicide in a refugee community, and that requires figuring out how suicide is viewed in the refugee community. We couldn't make one presentation that suits every single refugee community.

So the idea here is during the training to be sorting this out with the community that you're training. The second area that is important to adapt is that the suicide risk factors actually shift, and we'll spend some more time on that. And then finally, thinking about how you would go about teaching the QPR steps. Okay. So as I began to say, suicide from a refugee's perspective is going to be as varied as the number of refugees.

So in a training, the idea would be to get the members of that specific community to work together to try to decide how is suicide viewed in that community. Are there specific words somebody would use? What is a respectful way to ask about it? In our minds, the best way to train a group in that will be to put that back to the group.

Have either small or large group discussions in which people describe the - their understanding of what relationship that community has with suicide. This entire presentation got generated by the fact that there has been an upsurge in suicide in the Bhutanese community. So certainly if you approached a Bhutanese community right now, it would be very much in people's minds.

We can imagine other communities where people would - their first reaction would be say - would be to say we don't commit suicide, or there may be certain - there may be specific language people use around it. People might say it's taboo, or people might have the idea that it's a noble way if you perceive yourself to be a burden.

Starting with forming a shared understanding for gatekeepers of that refugee community will help the QPR trainer to guide them toward useful conversations with people that they see as at risk for suicide. Okay. The second adaptations - set of adaptations have to do with highlighting some specific risk factors for suicide among refugees.

I like to think of the model that QPR trainers will be familiar with, that says the risk for suicide is driven by someone's capacity for suicide plus somebody's desire to die. This idea says that exposure to violence and death and trauma, exposure to an intense fear, often increase somebody's capacity for suicide, because with more exposure, the threshold for thinking that that act would be out of comprehension or out of the imagination is reduced.

In the first part of the presentation, we had a lot of description of how much violence and trauma a refugee is likely to have witnessed, either directly or indirectly, during the course of their migration. So that's something specifically to keep in mind. The second refugee specific risk factor lies in the resettlement challenges, and again thinking of the model of increased capacity plus desire to die, desire to die is often described as having two components: a perceived burdensomeness, and lost sense of community.

Now in a list of issues that come up during resettlement, we can imagine how both of those become significant potential psychological experiences for the refugee. Now how to address these during - I skipped one. How to address these during a training? Again, we like to turn to discussions within the gatekeeper refugee community. If it's small groups, they can report back to the trainer. If it's a large group, everyone gets to participate, and then you can compare what people come up with as resettlement stressors, and again, this way you'll find what are the specific salient stressors for that refugee community.

We've described a long list, but our general stressors that each community is going to have certain stressors that are more specific to them. You can compare what groups come up with, with the list that we've compiled. Here there's a summary of some of the resettlement challenges that were previously described, but we see - they're listed in ways that show how they really can interfere with the sense of community, this breakdown of community and loss of traditional support, feelings of isolation, new culture, new language, unrealistic expectations, decline in status, being labeled a refugee, as well as within the family, and that can really contribute to the perceived burdensomeness.

For many refugees, one of the commonly described problems is that on arrival, family dynamics get very disrupted. Often young people who have the most capacity to learn a new language are suddenly transferred to the - to leadership and powerful roles in the family that had traditionally looked to the elders both for - both as breadwinners and decision-makers. And when this gets switched, it's a significant stress on family life.

Young families can feel very overwhelmed by the increased responsibilities, and elderly can feel significant shame that they are no longer able to lead their family or provide financial support for their family. An additional stressor that refugees describe is the label itself. It can be an issue while they're in the host country, but then arriving to the United States with this label can also exacerbate feelings of being stigmatized, treated differently, low, unrespected, and inferior.

That, we can imagine as contributing to potential esteem issues and feelings of confidence about reaching out and integrating into the community. The final area which requires some adaptation is the teaching of QPR. I was thinking when Charlot introduced the talk, QPR is a riff on CPR. As such, it may not resonate with many refugee communities. So the very big deal, as it probably is in a standard community, is trying to work with a gatekeeper, with refugee gatekeepers, to think about how would you ask the suicide question with refugees.

This should involve both discussion as a group, but also role play, because we imagine that for many refugee communities, it would require significant practice for people to even conceive of bringing up this issue, because there might be so much taboo. A lot of the work should be spent role-playing trying to figure out what would be a respectful way to ask that question.

Would it be more appropriate to ask that question when somebody is alone, or with their family, which again is quite counter to what we would imagine from an American-born perspective, to consider asking this question in the presence of family members. And what word would you use to ask the question? There's probably a variety of words in different languages that can be more direct or less direct.

The persuade step - we think many of the same basic principles are true: listening to the problem, giving full attention, remembering suicide is not the problem, only a solution to the problem, not rushing to judgment, offering hope in any form, and the same issue of trying to help refugee gatekeepers not just rush in to solve the problem, but to actually be able to address the issue of the suicidality.

Again, because we think there will be community-specific ideas about what effective and safe ways to make connections with people, we would suggest doing a role play so that members of a specific refugee gatekeeper community can really think about what would be the culturally correct way to join with someone, to create the kind of connection that would allow that person to feel a little bit of hope with the gatekeeper.

And one of the major things that can come into play here would be trying to figure out if there's somebody else in the community who that person feels connected enough to that they should be present for the persuading discussion, or to accompany to any referrals, somebody who the refugee would trust enough to say, I'm willing to access or approach some of these resources that are very unfamiliar or frightening to me.

So again, the major point here is that practicing these conversations would be very important in a refugee gatekeeper training, as well as that group generating collectively what is best for that specific community. The referred steps - we want you to think back to our first part in which we elaborated on a refugee support network. It's not the same support network as for the - a typical American citizen.

So it will be important to approach any of these trainings by first trying to (suss) out what are the agencies, who are the important people, what are the resources in that community, so that you and the gatekeepers can really decide, which are the ones that would be useful. Key here is keeping track of informal resources as well as formal resources. There may be an elder in the community, or somebody who's been there the longest and speaks the language, that'll play crucial roles in assisting with referral.

So as the source, you want to make a commitment - get a commitment from the person in order to refer. The adaptation here is thinking very carefully about whether that person would be more likely to follow through with their referral if there's somebody to accompany them, if there's some way of decreasing language barrier, if there's some way of helping them feel connected to the refugee community as they approach a resource that may be unfamiliar.

Turning this into a discussion also helps this feel more understandable in the gatekeeper's mind. By training refugee gatekeepers about QPR, you are joining the wider network of people who care and support refugees, and we thank you for joining us today and hope that you'll continue the learning today by finding information about refugee groups who live in your communities, and as Charlot described we will have this slide show, an extended version, and several other important resources available via our Web site.

Charlot Lucien: Thank you very much, Dr. (Stewart). Again, so what you have on these slides are some resources that we invite you to visit. They are about refugee experiences. You can also learn more, again, about refugees, by visiting the resources that we put down here. And again, they'll be posted shortly after the Webinar.

So let's do something very quick. It's a very quick poll, and then we'll get to some of your questions. And the poll is about, do you plan to train refugee gatekeepers on QPR in a classroom setting? So it's a yes or no, and we'll take about seven seconds to get your responses. Okay. Good, closing the poll. Here we go. So we have, yes, 16%, and the question was do you plan to train refugee gatekeepers on QPR in a classroom setting, so yes, 16%, no, 43%, and maybe, 40%.

Again, this is perfectly normal. This is reflective of the fact that we are just getting started with this adaptation, so we invite you to again look at it more. Again, as I reminder, they'll be posted, the slides, both on the refugee health technical assistance center, and on the ORR site. So I would say no that if (Katrina) can help us, because we are ready for the Q&A. We'll take both live questions and we'll also take some of the chat questions that came through the chat function.

Operator: Certainly. Ladies and gentlemen, if you would like to register for a question, please press the one followed by the four on your telephone. You will hear a three-tone prompt to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. You may also use the chat feature located in the lower left corner of your screen.

One moment please for our first question.

Charlot Lucien: And again, if we have some questions that came through the chat line, we also...

(Jennifer Cochran): Charlot, this is (Jennifer Cochran) with Refugee Health Technical Assistance Center, and there is a question that came through the chat line. And this is for Dr. (Stewart). Are there any specific groups that may be at higher risk for suicide, such as women or elderly or teens? Are those data available as yet?

Dr. (Samantha Stewart): You know, this is one of the issues where the reality is there's not much data on suicide in refugee populations. And then there's the separate possibility that there's significantly different rates and risk factors for suicide within different populations.

I think during the discussion we highlighted that we do think there are times when elderly may be at increased risk because of the loss of their leadership, loss of their ability to provide and counsel their families. But we do think that there's an increased risk among the youth because of this significant increase in stress. Overall, the data isn't really there, so we go population by population.

(Jennifer Cochran): Thank you.

Charlot Lucien: Thank you, Dr. (Stewart).

Dr. (Samantha Stewart): We do - it's certainly similar risk factor to the common - to the general population, such as mental health issues do pose an increased risk factor, so identifying mental health issues among refugees is a big - a very important issue.

Charlot Lucien: Thank you, Dr. (Stewart). Again, there's a lot of question or are there other questions that we need to field? Chat line?

(Jennifer Cochran): Yes, I have another. I don't know if Dr. (Quinnet) is on the line today, but if he is, then he might answer this question. If he's not, then we will get a response from him. So this is from a participant on the Webinar to the QPR Institute. Can QPR master trainers include those who would like to train refugees in our QPR instructors training? If so, how do we ensure they have the information and resources to adapt their QPR training once they are trained?

Dr. (Paul Quinnet): Hi. Can you hear me?

(Jennifer Cochran): Yes.

Charlot Lucien: (Paul), yes. Thank you very much for joining.

Dr. (Paul Quinnet): Actually there's some construction going on where I am and it's very noisy, so I'm actually standing outside trying to get away from it. I'm not sure I totally understood your question about the - was this about master trainers being able to do - to train instructors to work in the refugee communities, or could you repeat the question?

(Jennifer Cochran): You know, it says - I will repeat - this is in the chat box, so...

Dr. (Paul Quinnet): I see. Okay.

(Jennifer Cochran): Oh, so she says yes. Yes. You have that.

Dr. (Paul Quinnet): Okay. We are preparing a set of guidelines actually working with the native aspirations center of excellence and illness prevention in the Indian community, or the Native American community here in the US, so we have a process guide in draft form now that will hopefully make it easier for people working with different groups and ethnic communities and so forth to do pre-approved as it were adaptations of QPR for those communities.

As you know we have a lot of research completed now, and so there's a need to maintain the fidelity of that research and its outcomes, but we're very much aware that some of these things need to be adjusted in such a way that the message gets across and we get the safety and caring message to the people surrounding that individual who may be at risk.

Charlot Lucien: Thank you, Dr. (Quinnet). For those of you who arrived a little bit late, Dr. (Paul Quinnet) is the president and CEO of the QPR Institute, and we are happy to have him join the call here. Do we have other questions?

(Jennifer Cochran): It's (Jennifer). If I could just follow up on Dr. (Quinnet)'s comment that on the Refugee Health Technical Assistance Web site we will be posting a full adapted slide set for QPR trainers to use, so not the master level trainer, but the two-hour training that will have also a facilitator's guide and some role plays that would be relevant for refugee gatekeepers as well. So those will be posted on the Web site.

Dr. (Samantha Stewart): It's interesting. In the poll I was thinking I didn't know if some people were saying no, or maybe, due to thinking is that - would a classroom be the best setting to meet with refugee gatekeepers. I think what we're encouraging is some creativity, that it may be a different setting that facilitates this kind of conversation in a given refugee community. So I don't know if people were thinking along those lines, but that's an interesting idea.

Charlot Lucien: Are there comments, because although we asked for questions, but if there are people who have comments and recommendations as well, we'll be happy to share them?

Operator: We do have a question from the phone line, so from the line of (Nuame Kikojima), please proceed with your question or comment.

(Nuame Kikojima): Yes. I work in refugee health at San Francisco General, and then now am a master trainer for QPR, and I did want to remind clinicians that they need to be aware that in - that general medical health - that people can be severely - have severe anemia, they could have thyroid problems, they could have diabetes, and reticent to get care.

And they may be thought of as having depression or amotivational, when really there is an underlying physical problem. And so those, you know, people need to make sure that they're screened for that as well.

Charlot Lucien: Thank you very much for these comments, and there are people asking for a training package to be sent. Again, we will be sending to all a follow-up email, and that will lead you to our Web site, where you'll be able to find the training materials. And we will

emphasize also that you are encouraged to visit the site from time to time, because we will continuously post new resources and materials.

Dr. (Paul Quinnet): All right. This is Dr. (Quinnet). We'll be posting those slides on the QPR site for certified instructors using their password access, and they'll be able to get those materials there as well.

Charlot Lucien: Thank you very much. And as an added piece, we will also be posting information on the ORR, the Office of Refugee Resettlement site, as well. So we are left with just a couple of minutes to conclude this Webinar, and I'm going to make two quick comments.

Firstly, right after the Webinar, if you can take the time to complete our evaluation, and in term of next steps, there are questions that we collected, and we will be posting a summary document with the responses online after the Webinar. We'll be also posting both the full set of slides for the refugee experience, the introduction to refugee experience that was the first part of this Webinar, and also the first - the full set of slides for the entire adaptive QPR training.

So check on the Web site and we'll have this. We have your email addresses, so we'll be able to reach out to you for the correspondence about for how to be in touch with some resettlement agencies in your area or in your state, or also how to connect with the QPR Institute so that if you're a gatekeeper trainer, if you're a QPR trainer, they can also know in which state you are, and they'll be able to refer agencies or programs that conduct (unintelligible) about suicide prevention training.

So once again please take the time to complete the evaluation, and we thank you very much for joining this Webinar.

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