Community Access to Childhood Health (CATCH)

Final Report
June 30, 2004

This project sponsored by:

- American Academy of Pediatrics
- Otto Bremer Foundation

Project Conducted by:

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- John K. Blood
- Mådii Institute
Executive Summary

The American Academy of Pediatrics awarded the Northwest Hennepin Family Services Collaborative (NWHFSC) and Dr. Charles Ober of Hennepin County Medical Center a Community Access to Child Health community resource mapping/needs assessment grant. The Otto Bremer Foundation awarded the Collaborative an additional grant to fund a broader survey of community support services and to involve additional cultural groups in the process.

NWHFSC is a regional collaborative serving the cities of Brooklyn Center, Brooklyn Park, Osseo, Maple Grove, Dayton, Champlin, Corcoran, Ward 1 of Plymouth, and part of Hassan in the three school districts of Osseo Area Schools District 279, Brooklyn Center School District 286 and the Hennepin County portion of Anoka-Hennepin School District 11. This area has seen remarkable changes in its population and in its growth. Communities are becoming much more diverse with a quickly changing population that includes thousands of immigrants, refugees and asylees from four continents.

The purpose of this project was to conduct a maternal and child health disparities study among refugees, immigrants, people of color, and low-income residents in these communities. The results assisted the Collaborative in identifying existing gaps, barriers and related cultural needs for providing adequate medical, dental, and mental health services to underinsured and uninsured children and families in the Northwest Hennepin Area. NWHFSC is in the process of developing a Family Center, a ‘One Stop Shop’, that will provide medical services and comprehensive support services.

NWHFSC contracted with the Máádí Institute to create the study methodology, identify community resources and possible participants, conduct the interviews, manage the course of the study, and report the findings. This study was designed to identify referrers, providers, and consumers of health-related services. It specifically included hard-to-reach populations for which there is little or no information, especially families and community members who are difficult to reach because of culture, beliefs, language and fear of revealing personal information. There were 117 respondents from 23 cultural/ethnic groups out of the 305 contacts made. Respondents included families in the community; providers of culturally-based social and health services; school nurses, social workers, guidance counselors, cultural liaisons and family coordinators; community social service agencies; health care providers and places of worship.

In questions asking if medical, dental and mental health services are available, accessible and affordable in these Northwest Hennepin communities, there seemed to be wide agreement among the respondents. Approximately 60% said ‘no’ or ‘only somewhat.’

Respondents from all cultures and community/school service providers mentioned that “Most groups, unfortunately, are not having their needs met.” Health care needs are more complex, with increased demands on the limited number of resources in this area. Many service providers explained, “We are doing the best we can with what we have.”

Top barriers to meeting these needs, as identified by cultural providers and community members, included language, poverty and insurance issues. Service providers identified language, transportation and lack of insurance as top barriers.

Asked to identify the essential services needed in this area, all respondents listed mental health services as the top issue, followed by culturally and linguistically appropriate services and affordable health care.

When asked to identify their first priority for changes in services to improve the health of children and the broader community, participants from all groups identified a ‘one stop shop’ Family Resource Center with medical and mental health services as the first priority, followed by improved transportation and more mental health services.

All respondents were asked to identify what families and children need to participate more fully in the community and school life. Community members and service providers identified these priorities: transportation, child care, interpreters, time (many are working multiple jobs) and knowledge of available resources and of the ‘system.’ Community members also gave several suggestions for addressing cultural concerns.

Respondents were asked to suggest education and communication strategies for reaching the broader, diverse community. Many respondents replied, “That’s the million dollar question!” One comment summarized it as, “Communication is very important. It must be more direct and gradual.” Good advice given was, “Try to explain things at a level that a greater number of people can understand, but do not talk down to us—that’s rude and offensive.” Strategies suggested person-to-person communication, video and audio communication, and using existing gathering points and people who are connection points including schools, places of worship and community gatherings.

One of the most difficult things to remember is that a community of people is filled with strengths – strengths that all-too-often lie hidden and unappreciated. Refugees, immigrants, people of color, and low-income residents in our communities offer many amazing strengths. Among the strengths identified by respondents were: determination to succeed, resiliency, resourcefulness, hopefulness, the strength of family ties and pride in community.

Information gathered through this study was presented to 55 people from more than 12 cultures in northwest Hennepin County communities at a community meeting on February 19, 2004. This meeting engaged participants from a cross-section of the region in discussion about the health of their communities. The participants broke into small groups, facilitated by diverse community members, to begin work on an initial set of community-wide strategies for addressing the findings. This information was compiled and used by the NW Hennepin Family Services Collaborative in preparing its blueprint for the next three years and in developing the Family Center.
Introduction

Purpose of the CATCH Community Resource Mapping/Assessment

The American Academy of Pediatrics awarded the Northwest Hennepin Family Services Collaborative (NWHFSC) and Dr. Charles Oberg of Hennepin County Medical Center a Community Access to Child Health community resource mapping/needs assessment grant. The Otto Bremer Foundation awarded the Collaborative an additional grant to fund a broader survey of community support services and involve additional cultural groups in the process.

The purpose of this project was to conduct a maternal and child health disparities study among refugees, immigrants, people of color, and low-income residents in the region of northwest Hennepin County served by the NWHFSC to inform planning for the Collaborative. The goal of the study was to provide information to assist in:

1. Identifying the gaps and barriers that exist to providing adequate medical, dental, and mental health services to underinsured and uninsured children and families in the Northwest Hennepin Area;
2. Identifying cultural needs as they relate to medical, dental, and mental health service delivery that exist among the participating populations; and,
3. Developing a Family Center, a ‘One Stop Shop’, that will provide medical services and comprehensive support services.

Why is this mapping/assessment needed?

There is a great deal of data that has been collected, but it either is not relevant, or depends on inaccurate census data, or is tied to Hennepin County as a whole or to Minneapolis, not to each local community. The lack of information, and lack of services, for these communities were underscored during this study.

Specifically, the intention of this study was to include hard-to-reach populations for which there is little or no information, especially families and community members who are difficult to reach because of culture, beliefs, language and fear of revealing personal information.

Further, in requesting interviews with county services, two responses illustrate the importance of this assessment. One county service declined to be interviewed because “people we serve are not tracked by geographic area. The focus is on downtown where most people are. I can’t identify who of the staff is working with people in NW Hennepin communities.” Another agency, which has a contract from the county to provide services throughout the county, had erroneous information about which cities they should be serving. “We work only in Hennepin County, and some of those cities are in Anoka County, for example Champlin and Dayton.” When service providers do not know which cities are included in their service area, people living in these cities are not getting the needed services for which they qualify.

Project Methods

NWHFSC contracted with the Mádii Institute to create the study methodology, identify community resources and possible participants, conduct the interviews, manage the course of the study, and report the findings. The community study team included Dr. Charles Oberg of Hennepin County Medical Center, John Blood and Susan Blood of the Mádii Institute, Jonette Zuercer of Northwest Hennepin Family Services Collaborative, Deon LaBathe of Anoka-Hennepin School District Early Childhood Family Education and Dale Anderson of the Family Center Project. Work on these two projects began simultaneously in May 2003 when the first funding was received.

Study methods were based on a participatory model of strengths-based cultural knowledge mapping developed by the Mádii Institute.

The survey instrument was developed with the study team. Variations of the same instrument were used with the identified target populations. The majority of the information was gathered through in-person conversational interviews. A few respondents preferred to be interviewed over the telephone or to complete the surveys via e-mail or in writing themselves. In addition, one focus group interview was conducted at the Dayton Trailer Park.

Geographic Region

NWHFSC is a regional collaborative serving the cities of: Brooklyn Center, Brooklyn Park, Osseo, Maple Grove, Dayton, Champlin, Corcoran, Ward 1 of Plymouth, and part of Hassan in the three school districts of Osseo Area Schools District 279, Brooklyn Center School District 286 and the Hennepin County portion of Anoka-Hennepin School District 11. See Figure 1.
This portion of the Twin Cities Metropolitan Area has seen remarkable changes in its population and in its growth. As the population has changed, research has not been done to keep up with the changing needs and situations of the region’s inhabitants.

The region of northwest Hennepin County is characterized as having a quickly changing population shifting from older adults and younger families of predominantly European-American backgrounds to communities becoming more diverse with more African-American and Native American families as well as large numbers of immigrants, refugees and asylees from West Africa, East Africa, Southeast Asia, Central Asia, Central America, and Eastern Europe. Contrary to beliefs among county and local government planners, many of the immigrants settling in the region are making the suburbs their first home in the U.S.

The October 2003 enrollment data collected by Minnesota school districts and reported to the Minnesota Department of Education provide a glimpse into the demographic make-up of the school districts and communities in the Collaborative.

Attempting to collect population statistics for immigrant, refugee and asylee (IR&A) populations is difficult. Therefore, we were not able to fix accurate population counts by ethnicity. However, a look at statistics reported by the school districts themselves for students enrolled as of October 2003, does provide a momentary picture of the demographic make-up of these school districts.

**Figure 2, Students Enrolled in Limited English Proficiency (LEP) Programs**

<table>
<thead>
<tr>
<th>Rank in Metro</th>
<th>District</th>
<th>Count</th>
<th>% Of Total Enrollment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>St. Paul</td>
<td>14799</td>
<td>35.3</td>
</tr>
<tr>
<td>2</td>
<td>Minneapolis</td>
<td>11121</td>
<td>26.0</td>
</tr>
<tr>
<td>3</td>
<td>Anoka-Hennepin</td>
<td>1868</td>
<td>4.6</td>
</tr>
<tr>
<td>4</td>
<td>Osseo</td>
<td>1733</td>
<td>8.0</td>
</tr>
<tr>
<td>17</td>
<td>Brooklyn Center</td>
<td>364</td>
<td>21.2</td>
</tr>
</tbody>
</table>

**Figure 3, Students Speaking Languages Other than English at Home**

<table>
<thead>
<tr>
<th>Rank in Metro</th>
<th>District</th>
<th>Count</th>
<th>% Of Total Enrollment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>St. Paul</td>
<td>17902</td>
<td>41.2</td>
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<tr>
<td>2</td>
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<td>13959</td>
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<td>3</td>
<td>Osseo</td>
<td>2783</td>
<td>12.9</td>
</tr>
<tr>
<td>4</td>
<td>Anoka-Hennepin</td>
<td>2778</td>
<td>6.8</td>
</tr>
<tr>
<td>19</td>
<td>Brooklyn Center</td>
<td>495</td>
<td>28.7</td>
</tr>
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</table>

It is important to note that this statistical table would likely omit those from Liberia and other African IR&A people who come from countries where English is the official language. As such, given the high West African population in this region of Hennepin County, this data would not be a reliable way to determine foreign-born ethnicity.

Turning from ethnicity to accepted measures of poverty, many experts say that enrollment in Free/Reduced Meals programs is an acceptable indicator of poverty in a school population. Figure 4 shows Free and Reduced Cost Meal program enrollment, again showing that these three school districts stand out from other regions of the state. Please note Brooklyn Center’s rank would change if percent of total student enrollment is considered, as is shown below.

**Figure 4, Students Enrolled in Free/Reduced Meals Programs**

<table>
<thead>
<tr>
<th>Rank in Metro</th>
<th>District</th>
<th>Count</th>
<th>% Of Total Enrollment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minneapolis</td>
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<tr>
<td>2</td>
<td>St. Paul</td>
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<tr>
<td>3</td>
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<td>4</td>
<td>Osseo</td>
<td>5042</td>
<td>23.5</td>
</tr>
<tr>
<td>17</td>
<td>Brooklyn Center</td>
<td>967</td>
<td>56.3</td>
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</tbody>
</table>

It is important to note that the US decennial census, although considered highly accurate by state officials, may be mostly correct in terms of proportion of population being foreign-born, but is likely inaccurate as far as count. Still, when the most detailed demographic data sets are reviewed for this region in comparison to inner-city Minneapolis and St. Paul, we see that the highest density of East Africans is located in Minneapolis, while the highest density of West Africans is located in south western Brooklyn Park and north western Brooklyn Center, centered around the intersection of Interstate 694 and Zane Avenue.

According to Barbara Ronningen, the state demographer monitoring IR&A demographics, foreign-born African populations are difficult to count through Census data because of false reporting during the census-taking period, reluctance of residents to report their household data, and several other factors.

This project strove to engage people from as many different ethnicities in the communities as possible, as can be seen by looking at the ethnicity and demographic figures for the project.
Who Participated in the Project?

This study was designed to identify referrers, providers, and consumers of health-related services. There were 117 respondents, from 23 cultural or ethnic groups, out of the 305 contacts made. See the tables below and figure 5, at right.

The Sample Group

117 People from:
- 44 Families
- 19 Providers of Culturally-Based Social and Health Services
- 15 School Social Workers/Guidance Counselors/Cultural Liaisons/Family Coordinators
- 10 Social Service Agencies
- 8 Places of Worship
- 5 Healthcare Providers
- 3 School Nursing Programs

Many Cultures Participated

- African: Cameroon, Ethiopia, Kenya, Kono, Liberia, Nigeria, Oromo, Sierra Leone, Somali, Sudan
- African-American
- Central Asian
- Indian
- Eastern European: Bosnia and Russia
- European-American
- Hispanic/Latino: Guatemala, Honduras, Mexico
- Native American
- Southeast Asian: Cambodian, Hmong, Lao, Vietnamese

The major requirement for participation was geographic location of direct services or residency in the eight communities. There are many agencies and organizations in Minneapolis and St. Paul that may serve individuals and families in the Northwest Hennepin region, but there are relatively few that provide direct service in the service region of the Collaborative. Only a sampling of agencies directly offering services in the service area of the Collaborative were included in the survey. Likewise, only families living in the Collaborative’s service area participated. The goal was to include representation of diverse cultures, ethnicities and faiths in this area.

Initial interviews were conducted with school staff, cultural liaisons, social services agencies and places of worship as key informants. These key informants, particularly from the schools and cultural liaisons, identified families who were willing to be interviewed.

Key Findings

Availability, Accessibility and Affordability of Services

Three key questions were asked regarding the availability, the accessibility and the affordability of medical services, dental services and mental health services in these Northwest Hennepin communities.

Are medical services, dental services, and mental health services in these Northwest Hennepin communities available?

<table>
<thead>
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<th></th>
<th>Count*</th>
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<tbody>
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<tr>
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<td>17</td>
</tr>
<tr>
<td>Don’t Know/No Answer</td>
<td>19</td>
</tr>
</tbody>
</table>

*Discrepancy in total respondent count due to multiple members in some family units.

Fifty-nine percent of the respondents thought that services are not, or only somewhat, available. Only 15 percent believed these services are available while 16 percent did not know or did not answer this question.

Many respondents qualified their answer by saying, “It depends on insurance. If you have insurance and, if you do have insurance, where you are allowed to go.” Others reported that Medical Assistance families have a hard time finding clinics in this area that will take them, especially after the first three months of the year.

Respondents were unanimous that “Low-income dental services are practically non-existent.” Both key informants and families repeatedly said, “Mental health services are not adequately available, affordable or accessible.”
Are medical services, dental services, and mental health services in these Northwest Hennepin communities accessible?

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<th>Count*</th>
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<tr>
<td>No/Somewhat</td>
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<tr>
<td>Yes</td>
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<tr>
<td>Don’t Know/No Answer</td>
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</tbody>
</table>

*Discrepancy in total respondent count due to multiple members in some family units.

Fifty-seven percent of the respondents believe that services are not, or only somewhat, accessible. Only 9 percent believe that these services are accessible while 23 percent either did not know or did not answer this question.

Two major reasons limiting accessibility are transportation and cultural practices. Simply getting to these services is a barrier for many because of the limitations of the bus routes and schedules in this region, which serve commuters going to and from work in the city. Then families encounter cultural barriers.

Better transportation is one of the biggest obstacles to accessibility for all respondents. There is no bus service between communities. For example, riders must go to Minneapolis and transfer to another bus line to visit a service provider in a neighboring suburb. It is not possible to cross the suburban area by bus. Buses into Minneapolis run only at work commute times in the early morning and the late afternoon. “The closest bus service is four blocks away, and to lead a blind person and push a four-year-old in a wheel chair is very difficult,” one respondent reported.

“Cultural practices are a problem – there is no understanding” was a common observation from African-Americans, Native Americans, immigrants and refugees as well as from providers. Respondents from all of the cultural/ethnic groups mentioned the need for a culturally sensitive medical center. An observation from one mainstream family respondent reflected the frustration voiced by many others in noting, “…the way doctors are now is like going to Target. You can’t build a relationship with a cashier (or a doctor) because there is always a different one.”

Are medical services, dental services, and mental health services in these Northwest Hennepin communities affordable?

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<thead>
<tr>
<th>Count*</th>
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<tbody>
<tr>
<td>No/Somewhat</td>
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<tr>
<td>Yes</td>
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<tr>
<td>Don’t Know/No Answer</td>
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*Discrepancy in total respondent count due to multiple members in some family units.

Sixty-two percent of the respondents answered that services are not, or only somewhat, affordable. Only 3 percent believed that services are affordable while 24 percent either did not know or did not answer.

Affordability is an increasing concern not only among low-income families but also for middle class families who may have a family member with a chronic/terminal illness or a disability. High insurance premiums, high deductibles, exclusionary conditions, loss of employment that translates into loss of insurance coverage are of concern to numerous respondents. “There is an increasingly higher number of people without insurance who don’t qualify for insurance and can’t afford care,” noted one key informant while another observed that “Families are using school screening or education services as a substitute for medical care.”

The state of the economy and its effects on families in the community are particularly noticed by the two food shelves in the area. Directors of each food shelf made the very same remark, “People who donate to our organization are now using the food shelf. What will we do now that our donors are becoming our clients?” A respondent from one of the churches in the area pointed out that they have no food to donate to the food shelves for the first time in 10 years because of the needs of their own congregation and those who come to them seeking help.

Medical Home

One of the important elements of health care is having a medical home. Of the 44 families interviewed, 25% go to the same clinic for care. About 25% do not go to the same place because of insurance reasons, or clinic hours or they cannot get an appointment when someone is sick and needs to see a doctor that day. Another 25% said they primarily used Urgent Care, often because the clinics are not open extended hours when they get home from work. Twenty percent said they use the Emergency Room for care and that is only when they get really sick. Five percent said they do not go to a doctor.

About 25% go to the same doctor every time. And, another 25% try to see the same doctor every time but report frustration because there are very few appointments, or their insurance changes, or they or their doctor have moved. One respondent noted, “The doctor says ‘Make an appointment to see a doctor in two weeks,’ not ‘Make an appointment to see me in two weeks.’” One immigrant family expressed dismay over discovering that their doctor is scheduled at other clinics during the week rather than at the same clinic every day. They wondered, “why clinics hadn’t thought of that solution.”

Health Issues

All of the respondents, both professionals and families, were asked to respond to questions regarding specific health disparities they see (professionals) or experience (families) with opportunities to add ‘other’ to the list. In addition, families were first asked an open-ended question regarding what health concerns they have, with a follow-up question asking if they have other health concerns. Both groups were asked to rank the health issues they see most frequently (asked of professionals) or are of most concern (asked of families).

All of the health disparities/health concerns listed on the survey instrument were mentioned in responses.

The most frequently ranked health problems/concerns were general mental health, followed by ‘system navigation’, depression or anxiety, family conflicts, school issues and cultural conflicts.

It must be noted that trauma and torture were frequent responses among the large numbers of West Africans and also some of the Eastern Europeans (e.g. Bosnians). Schools reported many West African children have either been soldiers (boys) or sex slaves (girls) from very young ages and are acting out in classrooms as young as fifth grade because of their experiences. Trauma and torture also affect adults and families in numerous health and mental health problems. Post-Traumatic Stress Syndrome was noted as a serious concern among those respondents who have lived through war situations in their home areas, including Hmong families. One professional described it as being “both an individual and a generational issue that is contributing to the increase in domestic violence.”
Groups or Populations Identified as Having Needs Not Being Met

Respondents from all cultures and community/school service providers mentioned that “Most groups, unfortunately, are not having their needs met.” Health care needs are more complex and there are increased demands on the limited number of resources in this area. Many service providers explained, “We are doing the best we can with what we have.”

The groups most frequently mentioned included:

- Children from all ethnic groups with mental health issues. There are more emotional disorders at younger ages, and there is a need for day treatment and residential treatment for high-need children.
- Many cultural groups have concerns and unmet needs, especially immigrant and refugee families. All cultural groups interviewed in this project were repeatedly identified as having unmet needs. Immigrants and immigrant youth who have been traumatized and/or tortured were specifically mentioned as well as teens with mental health issues. Other concerns were expressed regarding “the way we work with the Hmong community needs to be different” and “African groups other than Somali may not find themselves represented in the discussion about services.”
- Seniors are experiencing isolation, depression, poor nutrition, and difficulties in finding services that they need including small services such as personal grooming (e.g. clipping nails, putting support hose on each morning, etc.)
- The working poor have no time to get health care when they are working two-three jobs and they could lose a job if they take time off from work. Family members face lack of health care when a working parent’s insurance will not cover the family.
- Single parents have many unmet needs, especially immigrant pregnant teens.
- Teens and youth have many unmet needs in mental health, chemical health, medical care, family issues and school issues that many respondents felt were being ignored.
- Entire Dayton Trailer Park, because of its isolation and its increasing Spanish-speaking population, was mentioned frequently as having numerous unmet needs.

Barriers to Meeting Needs

The barriers to meeting needs most frequently identified by cultural providers and community members (in rank order) included: language; poverty; insurance issues such as no insurance, high deductible, co-pays unaffordable, or no coverage of certain conditions; lack of transportation; hours of operation; a lack of information and lack of knowledge of resources and of the systems; services and programs not being communicated in a way that reaches the communities as well as cultural issues and lack of understanding.

Service providers most frequently identified the following barriers (in rank order): language; transportation; no insurance; cultural differences; communication; not enough time to meet needs; clients/patients who wait too long to ask for help and government policies.

Essential Services Needed

Essential services needed were identified by all respondents in the following rank order:

- Mental health services, both emotional and behavioral, including children and youth; culturally specific mental health services; trauma; both individual and generational post-traumatic stress disorder; and offering mental health and chemical health services together.
- Cultural needs for culturally and linguistically appropriate services; trained medical interpreters who understand and can explain medical terms; education about prevention for those who come from a curative system; materials translated into their own languages; cultural respect and understanding.
- Affordable health care including more free clinics and culturally appropriate services.
- One-stop Family center with all services and connection to community resources.
- Improved transportation.
- Basic medical services, especially affordable and accessible for children, and urgent care and preventative services.
- Dental services, both preventative and treatment, especially for children and have a sliding fee.
- Affordable housing.
- Recognize that this is a community of working poor and extend the hours of operation.
- A welcoming community structure that engages people in learning what services are available and how to access them.
- Services for middle-income people who cannot afford co-pays or deductibles but who do not qualify for medical assistance.

First Priority for Changes in Services

When asked to identify their first priority for changes in services to improve the health of children and the broader community, participants from all groups suggested the following (in rank order):

- One stop shop with medical clinic, a Family Resource Center with medical and mental health services, located in school(s) would be ideal with outreach and mobile van.
- Improved transportation, including the ability to travel on bus throughout the day, and to actually be able to travel from one service area to another, even in different cities, without having to travel to Minneapolis and back or to another hub. Bus schedules simply are not adequate for the needs of the community.
- More mental health services, especially for children under 12. The needs are real and relate to survival issues, not self-esteem issues. This is especially true with children who have been victims of torture, witnesses to torture, or who have been child warriors engaged in gun and personal combat battles in their countries of origin.
- More local accessibility to services including extended hours and multiple locations. Many community members are working two, three, and sometimes more, jobs to support themselves and provide for their families. Many low-income people are working second and third shifts.
- Increase services in schools including more hours and more social workers, nurses and counseling staff for those who are not part of special education; more ELL social workers; decrease student to counselor ratio [it is as high as 1 worker to 2558 students, the average is 1 worker to 994 students].
What Families and Children Need to Participate in Community and School Life

All respondents were asked to identify what families and children need to participate more fully in the community and school life. Community members and service providers identified the same elements, which follow in rank order:

- Transportation. Families have a hard time getting to and from places.
- Child care. Parents working multiple shifts and single parents alike said having child care available at support groups, community meetings is critical.
- Interpreters, including interpreters for any child care that is provided for specific cultural groups.
- Time. Keeping up with job demands (overtime or multiple shifts), evening homework expectations for children in school, taking care of children with special needs, or simply trying to spend time with their children all make it difficult to go out to community or school activities.
- “Too many of us have three and four jobs so we don’t participate in community programs. First, we need to feel part of the community. We need some direction about why we should go to the meeting, how important the meeting is to us. We ask if this meeting is for us or are we just invited,” explained one respondent.
- Knowledge of resources available and of the ‘system.’ “Families need to know the ‘system’ is there for them to go to to work problems out,” was a frequent response from providers and school staff.
- If child has problems, help families understand this is not a negative—show them it is not an embarrassment. “Hispanics and Asians are real focused on respect and how they present themselves so we are embarrassed when our children have problems,” shared one family respondent.
- People connections—encouragement from people to people. “Invite them. Have a plan to do this, to ask people personally. Do not just publish in newsletters or newspapers, put announcements on the radio, or put up posters,” explained several families.
- Stability in basic needs. “Families need to have a job, a place to live, basic needs met (food and clothing), and financial stability. People function better when there are fewer stressors in life. If they are in coping mode every day, they can’t participate fully,” observed one of the school staff members.
- Focus on communicate, communicate, communicate. Getting correct information is critical.
- Housing stability to be able to stay in one school throughout a school year. There is a high turnover in student population. For example, one-third (1/3) of the student population at Northview Jr. High turns over during the school year.

Comments about Cultural Concerns from Community Members

- Please have someone of our own kind in the system, not just a machine—a real person at school. Do not limit what the person can do—from bottom to top, anything we need help with we can go to this person.
- Treat everybody equally in the schools. Some teachers tend to be racist.
- America 101 lessons—what we need to know to live here.
- Must utilize African talent. These are not substandard talents. There are many highly educated, experienced professionals who could work in health care, social work, and education. There must be a commitment to hiring us, including us.
- Make rules the same for everyone, not just for Somali. There are many, many Africans here but we do not see ourselves represented in language requirements for public services, employment opportunities, and in many ways.
- City Council should make its way to West Africans. The mayor should be thinking. ‘There are many people who are not like me—30% of the people. I don’t see these people or hear their voices.’ Find out what people are like, their cultures.
- Cultural respect and adaptation goes both ways. We are not forced to swallow American culture but, at the same time, the community does not condone other cultures, so we have to change.
- Intergenerational opportunities. Extended families are the norm, but services are not typically organized with this in mind.
- Culturally appropriate organizational services. We need help establishing them here.

Ideas for Activities Suggested by Community Members

- Events at schools: Family nights, turkey bingo, and social events.
- Immigrant Families Day at school. Activities that are ceremonial—bring dish from your country. Make it their day, ask them what they want to do, they plan it. Not professionals sitting down and deciding it.
- Time to share traditions—Native art or Hispanic art show at community center. Celebrations and positive things so the community wouldn’t look at them all as failures. Our neighbors have values, traditions, and stories that can enrich the community.
- More family gatherings of diverse cultures—rather than just one culture at a time at school, celebrate other cultures, too. That’s how children learn to appreciate others.
- Low-cost after school programs, tutoring, cultural activities.
Education Strategies, Communication Channels Suggested by Community

Cultural providers, families and service providers were asked for suggestions for education strategies and how to communicate best with the broader, diverse community. Many respondents replied, “That’s the million dollar question!” One comment summarized it as, “Communication is very important. It must be more direct and gradual.” Good advice to remember is, “Try to explain things at a level that a greater number of people can understand, but do not talk down to us--that’s rude and offensive.”

Responses included:

Person to Person
- Word of mouth, people talking to people.
- Start at grass roots. Just like now--you are talking to me and if it is of interest to me I will talk to others. Churches, mosques, wherever people gather, businesses owned by this community.
- Small informal neighborhood meetings, where people who look like us are running things in a way that is comfortable and appropriate for us.
- One important thing has to be done: go see them, do not just call.
- Students serve as cultural brokers, they are more skilled than we realize. Be sure they have good info they are passing back and forth.
- Develop a relationship with the ethnic communities.

Video and Audio Communication
- We don’t do a lot of reading. Most people learn by illustrations and communicating directly rather than by newspaper and other publications.
- No time to read. Printed information is for nothing.
- Local NW television--have shows in our languages. TV stations/programs already existing: Oromo, Somali.
- Need to do verbal translation – recordings, cassette tapes.
- Advertising campaign (buses, TV, radio) with ONE number to call with questions and concerns.

Use Gathering Points and People Who are Connection Points
- Circulated through community agencies and school contacts - people on staff, bulletin boards, screenings and immunizations, ECFE, C.R.O.S.S., C.E.A.P
- Family advocate program is a good, strong one.

School Communication
- Connect with schools to experience it as a common place, view it as safe place in community.
- More school activities.
- Through wonderful brown Wednesday envelopes.
- Booth on parent-teacher night.

Places of worship
- Announcing it -- 5-minute spiel during worship services.
- Bulletins and newsletters.
- Educate the faith leaders so they bring it to their communities.

Community gatherings
- Town Hall meeting with brochures, show pictures and have direct communication.
- Free, easy and convenient classes close to home.
- Workshops or seminars that are family friendly gatherings on available resources and how to access them – with child care, activities for kids and elders attending, too, including social part with musicians. Food is important for people to come.

Put information that is user friendly, translated into languages, in:
- Apartment complexes
- Libraries
- Willow Lane Early Childhood Center
- Clinics and doctor’s offices
- Grocery stores

Strengths Available in These Communities

One of the most difficult things to remember is that a community of people is filled with strengths – strengths that all-too-often lie hidden and unappreciated. The cultural and low-income groups in our communities offer many amazing strengths that respondents shared:

- We have information that could help community be healthy--not just physically but as whole person.
- We are survivors. We have a lot of experience in life itself, lived under harsh conditions.
- Education, experience, commitment, strong determination. We may have been political, academic, business, medical and social services leaders at home.
- Determined to provide and succeed, e.g. to go find a job, hard working, family-oriented.
- Genuinely care about people but we are afraid to extend friendship because we don’t know if we will be accepted.
- Resiliency and courage, because it so difficult to navigate systems and yet we are still surviving it. Stretch resources incredibly far. Creativeness.
- Determination to have hope--trying to figure things out and be successful.
- Perseverance, high resilience--still going to school, maintaining jobs, even though they may not know where they may be living next week.
- Family ties are strong and give us strength.
- We sacrifice our own health care for our kids and home.
- Teens are smarter than people think.
- Good heart, push toward equity for everyone with compassion, willingness to help others.
- We understand that people’s value is not measured by their wealth.
- We are very spiritual.
- Peaceful, not violent.
• Working hard to be productive members of the community, often working 2-3 jobs.
• Pride in our community.
• A lot of these kids are good at finding resources.
• Our strength would be each other. We seek each other out and build relationships and community with each other.

Community Meeting

Information gathered from community members, community service providers, and school districts was presented to 55 people from more than 12 cultures in northwest Hennepin County communities on February 19 to engage participants from a cross-section of the region in discussion about the health of their communities. This information identified gaps, barriers, essential services needed as well as strategies and strengths identified by the respondents.

The participants broke into small groups facilitated by diverse community members to begin work on an initial set of community-wide strategies for addressing the findings. The small groups first reflected on the CATCH report findings and then each group chose one or two Health and Family Support service points to address. They identified additional local resources, any additional gaps and barriers and then suggested key local strategies for addressing these points. Finally, each group chose two or three local strategies to present to the whole group, based on the discussion at their table.

This information was compiled and used by the NW Hennepin Family Services Collaborative in preparing its blueprint for the next three years. A list of services was generated that would be helpful in addressing the gaps and barriers identified in the following areas: cultural diversity, race/ethnicity, literacy, lack of services, health issues, transportation, employment, child care, economics of financing needed services, housing, youth, schools, library, and media.

Strategies to address these gaps included:
• ‘One stop shop’ with transportation and a blend of services and activities;
• Unify the leadership of ethnic groups around issues;
• Increase the diversity of agencies and employ residents of the communities they serve bringing services to the people, not just people to the services;
• Continue building stronger literacy skills;
• Provide opportunities for families to build trust with each other and with schools and agencies;
• Grass roots legislative activity and voting; and,
• Community meetings to discuss these issues on a regular basis that city council members will attend.

Summary

A community of people is filled with strengths – strengths that all-too-often lie hidden and unappreciated. Refugees, immigrants, people of color, and low-income residents in our communities offer many amazing strengths. Among the strengths identified by respondents are: determination to succeed, resiliency, resourcefulness, hopefulness, the strength of family ties and pride in community.

The challenge for the Northwest Hennepin Family Services Collaborative, for the communities, for the school districts, for service providers, and for the region as a whole will be to best utilize the strengths of all people while building communities that work for all. At the community meeting participants from many cultures expressed their desire to work with the Collaborative toward building a healthier, more resilient community. This report offers a picture of the state of these communities now, the ‘before’ picture. The work that follows will contribute to the ‘after’ picture.