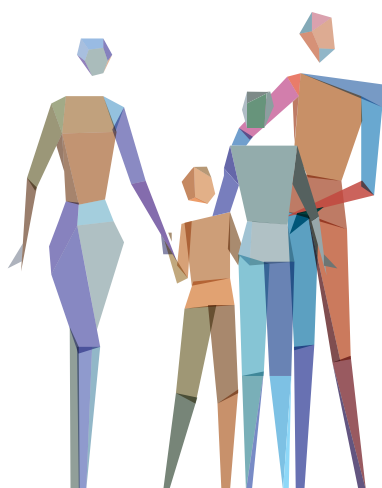




Advancing Equity

Refugee and Ethnic Mental Health



nileSisters
DEVELOPMENT INITIATIVE

Nile Sisters Development Initiative (NSDI) is a community-based organization that provides vital services to refugees and immigrants in the San Diego region. The NSDI mission is to educate, support, and offer training to refugee and immigrant women and their families to help them overcome barriers to social and economic self-reliance. Founded in 2001, NSDI assists refugees and immigrants to assimilate a new language, customs, and systems that are inherent to the American way of life. NSDI is committed to mitigating health disparities afflicting refugee and immigrant communities by offering family advocacy and education services. These include programs to raise awareness of sexual and reproductive health, mental health, oral health, and chronic diseases.

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Advancing Equity

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Executive Summary

Nile Sisters Development Initiative (NSDI) believes that access to culturally and linguistically sensitive health and wellness programs is necessary for our community members to reach their full potential and to thrive. A designated Live Well San Diego partner, NSDI proudly shares the County of San Diego vision of “Building Better Health, Living Safely and Thriving.” [1] In collaboration with like-minded partners, NSDI seeks to address health disparities afflicting refugee and immigrant women and their families.

Mental health is widely acknowledged as a priority health issue across refugee community members and stakeholders in San Diego County. [2] A 2012 study of more than 200 resettled African refugees revealed that 83% of participants reported traumatic experiences. Over 75% of participants reported enduring three or more traumatic events, and 85% had at least one symptom of post traumatic stress disorder (PTSD). [3] Current literature on the mental health of resettled refugees indicates the prevalence of anxiety, dependency syndrome, depression, somatization, and PTSD. [4] [5]

This initiative was developed in response to a roundtable discussion on mental health held October 5, 2016, with ethnic-, faith- and community-based leaders in the San Diego refugee community. At the roundtable, community leaders expressed concerns regarding the unmet mental health needs of resettled refugees. This initial discussion prompted a two-part community dialogue series, on October 17, 2016 and November 18, 2016, during which stakeholders engaged in further discussion of mental health concerns in refugee and ethnic communities.

This report will highlight key themes that emerged in the roundtable discussions and subsequent community dialogues. The dialogues were designed to explore perceptions, attitudes, knowledge, and beliefs regarding mental health. In addition, participants discussed promising practices, evidence-based interventions, and recommendations to improve knowledge, awareness, and utilization of mental health services.

Background

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity.” WHO declares that health is a fundamental right, which requires the active engagement of populations to ensure access to essential medical and psychological related information. [6] The United States Department of Health and Human Services (HHS) affirms this definition, emphasizing the importance of a wellness approach to mental health. This approach ensures that individuals are able to realize their full potential, cope with daily stressors, work productively, and make meaningful contributions to their communities. [7] The Substance Abuse and Mental Health Services Administration (SAMHSA) is a branch within HHS responsible for leading national public health efforts to improve the accessibility of mental health information, services, and research. SAMHSA believes that behavioral health is essential to health and seeks to reduce the impact of substance abuse and mental illness on American communities. [8]

The United Nations 1951 Convention on the Status of Refugees defines a refugee as someone who is unable or unwilling to return to a country of origin, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. [9] Historically, the United States has resettled the greatest number of refugees in the world. In 2016, the US admitted 84,995 refugees, the most since 1999. [10] Of these, 7,908 were resettled in California, and 3,100 of those resettled in San Diego County. [11]

Refugees are widely exposed to risk factors for developing mental health disorders. The term *triple trauma paradigm* describes the three major phases of traumatic stress experienced by refugees during forced migration. This requires a shift in the approach, on behalf of providers, to acknowledge that resettled refugees are “in the midst of a chronological interaction of three distinct traumatic

periods.” [12] During the pre-migration phase, refugees endure physical and emotional trauma as a result of forced displacement. They travel long distances and often endure inexplicable violence before even arriving in a refugee camp. From there, an average of seventeen years is spent waiting for repatriation or resettlement in a host country. [13] Trauma and grief associated with forced displacement often go unaddressed, due to barriers to accessing healthcare services in the resettlement camp. Even after resettlement, refugees continue to face unique stressors during readjustment in a host country. These include post-migration stressors related to cultural, linguistic and structural barriers to self-sufficiency.

Under the Refugee Act of 1980, the United States government recognizes the provision of mental health services for refugees as a national public health priority. [14] Prior to resettlement, refugees undergo a medical examination to identify physical or mental illnesses or disabilities. Upon resettlement, the Centers for Disease Control (CDC) provide the appropriate state public health authorities the details of the overseas medical evaluation. During the first 90 days after resettlement, refugees also undergo a domestic medical screening; however, the mental health assessment is not mandatory. [15] While the CDC recommends routine mental health screening for newly arrived refugees, barriers have impeded the ability to ensure access to and utilization of services. The early detection of mental health issues during the arrival screening is critical for ensuring coverage by Medi-Cal benefits (the California version of Medicaid).

Many refugees arrive from countries with underdeveloped health systems, where access to basic healthcare services is limited, and mental health services are almost non-existent. Therefore, the concept of preventative care is not fully understood, and there is a lack of knowledge of available services and treatment options. In addition, stakeholders have expressed a need to understand the social and cultural factors contributing to low utilization rates. Perceptions of mental health greatly differ across cultures and contexts. Cultural attitudes such as stigma and views of mental health as a spiritual or religious issue pose significant barriers to care for refugee populations.

Project Summary

On October 5, 2016, NSDI convened a roundtable discussion with ethnic- and faith-based organization leaders from the refugee community to address growing concerns about the mental health needs of the large and rapidly growing refugee and ethnic populations. Two follow-up community dialogues were held: October 17 and November 18, 2016. Open to the public, these dialogues assessed community members’ perceptions of mental health, service utilization, and the prevalence of unmet mental health needs.

In alignment with principles of community-based participatory research (CBPR), NSDI supported community leaders from refugee and ethnic populations in convening stakeholders across sectors. CBPR principles differ from traditional research approaches in that community members are partners in all aspects of the decision-making process. This approach is based on the premise that through shared knowledge and expertise, all stakeholders can be empowered to improve the health and well-being of the entire community. Furthermore, CBPR seeks to build upon existing community assets, such as resources and relationships, to address health issues.

The roundtable discussion and the two community dialogues had the following desired outcomes:

- Expand the voices of refugee and ethnic communities in San Diego County, including constituents, ethnic- and faith-based leaders
- Provide a platform for ethnic-, faith- and community-based organizations to liaise with formal institutions and partners
- Improve sharing knowledge of existing mental health programs and services in San Diego County that target refugee and ethnic populations
- Identify the priority mental health needs and concerns of refugees and ethnic individuals / families, as well as opportunities for partnerships to address them

- Identify protective resources within refugee families, schools, communities and social environments to prevent and address mental and behavioral illnesses

Methodology

On October 5, 2016, NSDI convened a roundtable discussion with ethnic- and faith-based organization leaders from the refugee community to address growing concerns about the mental health needs of the large and rapidly growing refugee and ethnic populations. Two follow-up community dialogues were held: October 17 and November 18, 2016. Open to the public, these dialogues assessed community members' perceptions of mental health, service utilization, and the prevalence of unmet mental health needs.

Emergent Themes

Cultural Sensitivity During the dialogue, participants engaged in a discussion regarding cultural perceptions of mental and behavioral health disorders. Upon resettlement, refugees struggle with making sense of a new or different culture, which then compounds existing migration trauma and increases vulnerability to mental illness. It was expressed that resettled refugees do not always have the appropriate terminology in their languages to express mental health concerns. Therefore, it is critical to define mental wellness and develop interventions based upon the unique customs and beliefs of an ethnic or cultural group. Also, participants emphasized the importance of increasing provider awareness of the customs, traditions, rules of etiquette and moral values that define each culture.

In addition, community stakeholders discussed the concepts of illness and wellness. The medical model of illness is based on external sources of influence. It is designed in response to existing illness in hopes of maintaining, instead of healing. Whereas a wellness approach is comprehensive in that it views health as more than just the absence of illness. It is based on how well an individual is able to function in the world. In terms of the refugee experience, the wellness model accounts for aspects of culture that serve as a barrier to effective functioning in a new society. In alignment with international and national standards of health, mental wellness should be defined within the context of each ethnic community, to ensure appropriate messaging. [17]

Mental illness in refugee and ethnic communities is heavily stigmatized, and discussion of the topic is taboo. The shame and guilt associated with mental illness often prevent individuals in the community from discussing issues. When an individual in the community displays symptoms of a mental health disorder, he or she is often the last person to find out until it reaches a degree of severity, which can no longer be managed by family members. Currently, when there is a mental health-related emergency in the community, someone calls the Psychiatric Emergency Response Team (PERT). PERT clinicians work with law enforcement officials whose presence in a response can trigger conflict within communities. Often times, involvement with law enforcement is looked down upon and can lead to labeling or isolation.

Language Access Language concerns expressed by community members aligned closely with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) recommendations. [18] In terms of communication and language assistance, community dialogue participants highlighted that accessing translation services and interpreters that speak the same dialect can be very difficult. There is a significant need for interpreters, as well as culturally and linguistically diverse mental health clinicians.

It was acknowledged that many refugees utilize a family member or acquaintance as an interpreter, which can lead to misinterpretation. Among recently resettled adult refugees, it was noted that individuals often use children or younger family members because they learn the English language much faster. Also, patients often express confidentiality concerns with interpreters from their

community and are reluctant to discuss sensitive issues, which can impede with treatment. The providers that participated noted that many aspects of the treatment get lost in translation when the interpreter is not trained and messages aren't fully conveyed both ways. Untrained interpreters that speak the same languages often have their own trauma and grief that is unresolved, which can disrupt treatment.

Service Delivery Many refugees and ethnic populations come from cultures where membership to a community is of the utmost importance. This contrasts with Western emphasis on the individual and the tendency of Western mental health practitioners to deliver treatment in a one-on-one setting. This isolation can have adverse effects on the mental health and well-being of a refugee or ethnic minority. Healthcare practitioners from refugee communities and community members agreed that interventions aimed at the individual might not yield as successful results as community interventions. In particular, when serving refugee populations who have lost familial and social support networks, simulating a community may be useful in alleviating migration stressors and sense of isolation. There was unanimous agreement that community-level interventions were needed in order to provide education and treatment.

In addition, participants expressed the need to invest in the training of healthcare professionals from refugee and other ethnic communities. Despite the emerging demand for entry-level and advanced healthcare workers, there is a limited supply of culturally and linguistically appropriate healthcare professionals who can assume the occupations available in the region. Several zip codes within Mid-City, specifically 92105 and 92115, are federally designated health professional shortage areas (HPSA) and medically underserved areas / populations (MUA/P). [19]

Evaluation and Data Beyond the initial medical screening and any resulting referrals, limited data and information are available regarding the long-term health status of refugees.[20] Community members expressed the importance of a comprehensive needs-assessment to strengthen the evidence base regarding the mental and behavioral health needs of ethnic and refugee populations in San Diego County. This will be utilized to inform interventions to identify and combat the priority mental health concerns of San Diego's ethnic and refugee communities.

Currently, limited data is available about the prevalence and utilization of mental health services among refugees. Participants noted that, while current healthcare reporting standards provide critical insight into racial health disparities, ethnic data that is vital for understanding differences in health outcomes between foreign-born Africans and African Americans is missing. It is widely understood that foreign-born Africans and African Americans have significant differences in physical and mental outcomes. Therefore, examining ethnicity and disaggregated data will allow community stakeholders to address the social and environmental factors influencing the health and well-being of each ethnic group.

Community Outreach and Education Community dialogue participants expressed the need to explore how varying levels of the community could be leveraged for outreach and education efforts. This included ethnic / tribal affiliations, neighborhood, and city interventions. Discussion included the strength of social cohesion based on trauma, shared experiences, and resilience, in contrast to the dominant culture. A strong need to leverage existing community assets to improve the mental health status of ethnic and refugee communities also exist, especially in working with ethnic-, faith-, and community-based organizations to normalize mental health, and increase the utilization of mental health services among refugees. Eighty-nine (89%) of participants agreed that a mental health forum was needed for refugee-serving agencies, healthcare providers, and community stakeholders. Creating linkages with refugee-serving agencies across sectors, stakeholders could improve knowledge sharing and referrals of clients via *warm handoffs*.

Recommendations

Disaggregated Data Between 2000 to 2013, the foreign-born population from Africa in the US more than doubled from 881,000 to 1.8 million. At a minimum, it is estimated that 30,000 individuals from East African countries reside in City Heights.^[21] The high concentration of foreign-born individuals from sub-Saharan African countries in City Heights warrants the need for disaggregated data to ensure that accurate information is being provided for the public, policymakers, and the press. This data would be essential for understanding the prevalence of mental health disorders and service utilization rates, in order to address disparities.

Screening Tools Participants noted the need to operationalize evidence-based and validated assessment tools, which are culturally appropriate and incorporate the worldviews of diverse refugee and ethnic communities. The RHS 15 (refugee health screener 15) is validated in 11 languages to screen refugees for symptoms of anxiety and depression, including PTSD (post-traumatic stress disorder). It is currently available in the following languages: Arabic, Burmese, Farsi, Karen, Kiswahili, Nepali, Russian, Somali, and Tigrinya. It has proven to be reliable and effective because of its universal implementation questions. It can be administered by health workers, interpreters, and various stakeholders involved in patient care.

Technical Training and Capacity Building In order to assist community stakeholders in providing services, the community dialogue participants reinforced the need for technical assistance. Members of ethnic-, faith-, and community-based organizations expressed the need for mental health training sessions to increase capacity to identify and refer community members to appropriate services. This would ensure that all ethnic groups have access to basic mental health education and allow community members to address gaps in service delivery. Furthermore, programs and interventions need to be led by members of the target population with common life experiences and in familiar settings. Community stakeholders expressed the importance of centralizing services in geographic areas with high density of refugees and other underserved populations.

Community Health Outreach Worker Model Community-based healthcare models have rapidly become the preferred means of improving access to care for underserved populations. Community health outreach workers (CHOW) are an essential component for public sector initiatives who are unable to meet the needs of medically underserved populations. CHOWs can provide a mental health component in the community through health education, case identification, and referrals to mental health providers. They would undergo a minimum of eight hours of training to acquire proficiency in identifying the signs and symptoms of mental health issues, prevention strategies, needs and risk assessment, trauma, family dynamics, and crisis management. Furthermore, they would be gatekeepers or cultural brokers, because they identify with the target communities. They not only would speak the languages but would be intricately aware of the unique cultural and social norms of their target population.

Ethnic and Cultural Resource Guides Participants expressed a strong desire to create a cultural resource guide on each of the major ethnic refugee groups. This would be utilized across sectors to inform stakeholders about the population's history, culture, religion, education, language, resettlement needs and offer brief demographic information. It would highlight the core cultural concepts for consideration when working with this population. These free printed resources could be housed in the offices of the County of San Diego, Health and Human Services Agency, Public Health Services, and Tuberculosis Control and Refugee Health Program, and could be offered from the San Diego Refugee Forum resource web page, as well as by the web sites of relevant departments at academic institutions.

Refugee Wellness Hub / Center This hub or central location could be a welcoming center that acknowledges the unique identities and cultures of target population. In using the ecological model, the hub could serve as a bridge to integrate critical preventative

health services and support through program activities and as an information outlet with on-site resources attached. It would not only provide mental health interventions but address the social determinants of health, such as education and employment, which impact overall health and well-being.

Peer-Support Groups Peer-support services would be provided by individuals from the target population who have lived experiences similar to the people that they are serving. SAMHSA has recognized the importance of social support in promoting a positive lifestyle and behavior change. Peers can serve in a variety of capacities, providing one-on-one motivation and encouragement each step of the way through recovery. Peer-support leaders also could facilitate support groups and educational activities to build healthy social networks.^[22]

Educational Groups Social support is widely considered to be a preventative factor for mental health. Under circumstances where mental health services are unavailable or limited, support groups offer a solution for engaging hard-to-reach populations. Furthermore, they reduce the stigma associated with mental health by promoting dialogue, serve as a prevention tool, and serve as a platform for education, resource-sharing, and activities.^[23] Non-clinical support groups also strengthen family relations and community by promoting trust and safety and rebuilding social fabric torn by forced migration.

Appendix

Guidelines for Dialogue Participants

- Respect thoughts and opinions of others
- Share time equally to ensure participation of all attendees
- Listen carefully, and avoid interrupting
- Be open-minded and open to learning
- Focus on solving problems rather than reiterating existing problems

Mental Health Brief

Background It is widely understood that refugees are at greater risk of developing mental and behavioral health disorders. They endure long-distance journeys, often suffering through inexplicable violence and trauma before arriving in a refugee camp. From there, a significant amount of their lives is spent waiting for repatriation or resettlement in a host country. The disruption of familial and social networks combined with limitations to resources often lead to the development of acute and chronic diseases. After resettlement, refugees continue to face unique stressors during readjustment in a host country. The psychological impact and subsequent effects on the health and well-being of these individuals are undoubtedly hard to measure. In order to understand the health needs of this population, it is critical to apply a whole-person model that accounts for the mental, physical, and social factors which influence health.

Demographics San Diego County is the largest refugee resettlement site in the State of California.^[24] Approximately, 150,000 refugees reside in the region.^[25] Many refugees reside in the central region, mainly in the community of City Heights, one of six nationally sponsored resettlement communities.^[26]

- Forty-two percent (42%) of City Heights residents are foreign-born^[27]
- Seventy-three percent (73%) of City Heights residents have limited English proficiency^[28]
- Primary languages spoken include Amharic, Arabic, Burmese, Creole, French, Haitian, Somali, and Swahili

Key Findings

- Mental health is a top-three priority issue among refugees living in San Diego County
- Healthcare providers acknowledge mental health as the largest unmet need for the San Diego refugee population
- Lack of interpretation services and limited availability of translated health information is a barrier to accessing preventative services^[29]

NSDI Recommendations

- Develop a comprehensive plan to identify and combat the priority mental health concerns of the San Diego refugee and immigrant community
- Increase access to culturally and linguistically appropriate mental health services
- Collaborate with ECBOs (ethnic community-based organizations) to increase utilization of mental health services among refugees

Questions Posed at First Community Dialogue

1. What are your reactions to the information presented in the brief Mental Health of Refugees in San Diego County?
2. From your professional or personal experiences, what are the greatest barriers to accessing mental health services for refugee populations in San Diego County?

3. What are key assets or protective factors for mental health in the refugee community?
4. What existing programs or strategies are in place to improve the mental health of refugees in San Diego County?
5. How can existing programs better align with these cultural understandings of mental illness?
6. How does mental health impact refugee populations differently? For example, how do the issues adolescents face differ from those of adults or the elderly?
7. What do you believe to be the challenges that prevent our communities from developing a common understanding and consensus on the next steps to improve the mental health and well-being of the refugee community?

Questions Posed at Second Community Dialogue

1. In your opinion, what is the single greatest barrier refugees / immigrants face in accessing mental and behavioral health services?
2. What are key assets or protective factors for mental health in the refugee community?
3. What community attitudes and beliefs regarding mental / behavioral health are important to consider when designing programs and interventions?
4. How can existing programs and services align with diverse cultural understandings of mental health?
5. Which refugee sub-populations are disproportionately impacted by mental and behavioral health issues?
6. What promising strategies exist to promote the mental health of refugees and immigrants?
7. What are the most important lessons you have learned from working with refugee and immigrant communities?

Ethnic- and Community-Based Organization (ECBO) and Nonprofit Organization Participants

- American Bar Association, Immigrant Justice Project
- Nile Sisters Development Initiative (NSDI)
- Social Advocates for Youth (SAY) San Diego
- United Women of East Africa Support Team (UWEAST)

Faith-Based Organization Participants

- African and Caribbean Refugees Association
- Tabernacle African Caribbean Refugee Association

Mental and Behavioral Health Service Provider Participants

- La Maestra Community Health Centers
- Mental Health America of San Diego
- Psychological Emergency Response Team (PERT)
- Union of Pan Asian Communities (UPAC)

Academic Institution Participants

- San Diego State University (SDSU) Social Policy Institute
- San Diego Unified School District, Mental Health Intervention Team
- University of California San Diego (UCSD) Center for Community Health

Public Sector Participants

- San Diego County Community Action Partnership (CAP)
- San Diego County Department of Behavioral Health Services

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