

Resource Document on the Mental Health Response to Migration Emergencies

Approved by the Joint Reference Committee, October 2023

“The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors.” — *APA Operations Manual*

Prepared by the APA Cross-Council Work Group on Responding to Migration Emergencies: Council on International Psychiatry and Global Health: Pamela Collins, M.D. (co-lead), Alan Fung, M.D., James Griffith, M.D., Ali Haider, M.D., Giuseppe Raviola, M.D., Isaac Johnson, M.D.; Council on Children, Adolescents, and Their Families: Balkozar Adam, M.D., German Velez, M.D., Olivia Shadid, M.D.; Council on Geriatric Psychiatry: Badr Ratnakaran, M.D. (co-lead); Council on Advocacy and Government Relations: Veronica Searles Quick, M.D., Adam Chan, M.D., Omotola Ajibade, M.D., Nicholas Apping, M.D.; Council on Psychiatry and Law: Dhruv Gupta, M.D.; Caucus on Global Mental Health and Psychiatry: Mara Fiorentino, M.D., Ahmad Adi, M.D.; APA: Ricardo A. Juarez, M.S.

I. Introduction

- The ever-changing global landscape has made migration a central concern in the modern era, where millions of individuals and families are subject to displacement each year. As we find ourselves in the midst of climate change, political polarization, economic upheavals, and social transformations, migration emerges as a multifaceted phenomenon, touching every corner of the world. No one is exempt from the potential experience of uprooting, a reality that resonates across all societies and transcends all boundaries.
- Migration is propelled by numerous causes, each as diverse and complex as the individuals involved. From those seeking refuge from political unrest to those displaced by environmental factors, the reasons for migration are as varied as they are profound. Understanding these underlying causes is crucial not only to addressing the larger socioeconomic issues at play but also to the intimate and personal mental health response required to support those in the process of migration.
- Psychiatrists and mental health professionals find themselves at the forefront of this human experience. They are called upon to not only understand the multiple stages of migration but also to foster a sense of cultural humility, safety, and empathy. This requires a deep insight into the process of migration, recognizing that everyone’s journey is unique, shaped by their personal circumstances, cultural background, and the broader sociopolitical context.
- This guide is crafted with a sense of urgency and purpose to provide support to those engaged in mental healthcare for migrants. It is not merely theoretical but also a practical tool intended to serve as a guide and resource. It is designed to connect psychiatrists to other available tools and resources, helping them navigate the intricate web of mental health challenges associated with migration. Whether it be offering a framework for culturally sensitive therapy or providing links to community support systems, this guide seeks to be a comprehensive companion for professionals who are committed to offering compassionate, informed care.
- As you delve into the ensuing pages, you will discover insights, guidelines, and actionable strategies that encompass the broad spectrum of migration-related mental health issues. We believe this resource will play a vital role in strengthening the mental health response to migration emergencies and foster a more humane and empathetic approach to one of the most pressing global challenges of our time.

II. Migration and Mental Health

- Refugees and migrants often come from communities affected by war, conflict, natural disasters, environmental degradation or economic crisis. They undertake long, exhausting journeys with inadequate access to food and water, sanitation and other basic services, which increases their risk of communicable diseases, particularly measles, and food- and waterborne diseases and various noncommunicable diseases due to the migration experience³¹.
- Refugees and asylum seekers often have significant underlying physical and mental health problems caused by factors arising before, during and after migration. These include experiencing conflict, violence, danger, exploitation and loss, uncertainty around housing, finances and employment during the process of seeking asylum, challenges accessing care, and potential discrimination from healthcare professionals and the local community. All displaced people experience the loss, in some form, of their social structures, cultural values and community rituals²².
- Refugees and migrants may be at risk of poor mental health because of traumatic or stressful experiences and at more risk of mental disorders such as depression, anxiety and post-traumatic stress disorder (PTSD). Many experience feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability, anger or aches and pains³¹.
- Culture has an important role in the presentation of distress and illness, and cultural differences impact upon the diagnosis and treatment of migrant populations in part due to linguistic, religious and social variation from the clinician providing care².
- During the stages of migration, there may be factors that predispose individuals to mental disorders. Pre-migration factors include the personality structure of an individual, forced migration, and persecution, among others. Migration factors include cultural bereavement. Culture shock, a discrepancy between expectations and achievement, and acceptance by the new nation are potential post-migration factors².

A. Causes of Migration

- There are five primary macro level drivers of migration – economics, demographics, social, political and environmental. These provide a broad context in which people move from one location to another. In addition, there are micro level factors (such as age, gender and income level) that determine how the macro factors influence migration decisions at the personal or household (micro) level⁹.

[See visualization: "A conceptual framework for the drivers of migration."](#)

- The socioeconomic characteristics of families and individuals are one of the most important micro drivers of international migration. The very poorest of the poor tend not to be as mobile as others, largely because they lack the capital needed to successfully relocate⁹.
- With forced migration, socioeconomic characteristics may play a role in determining whether people will leave their home communities and where they go to find greater safety. Families measure the risks and benefits of staying in place against those of flight for each member. Risks vary depending on many personal factors including gender, age, sexual orientation, health, size and composition of the household as well as the nature of the threat⁹.
- The involuntarily immobile may be the most at risk, but the least able to flee due to pre-existing vulnerabilities. It is a mistake to think of migration as either forced or voluntary, as there are often elements of both. Facilitators and barriers to migration and immobility are systemic⁹.

B. The Migrant Journey

- The migration experience can lead to exposure to adverse events, such as witnessing or experiencing violence that negatively impacts mental health. The persistence and severity of psychiatric disorders among migrant populations can be attributed to a combination of factors, including the degree of severity of initial trauma exposures and clustering of trauma exposures during the migration process³⁷.
- Those residing in refugee camps in low-income countries show the highest prevalence of anxiety and depression, reflecting the highly stressful conditions typically encountered in the camps, with rates among high-income countries varying with prevalence tied to exposure to stressful events due to material and social conditions⁴⁰.
- Among asylum seekers, evidence suggests that the detention experience itself is a risk factor for adverse mental health, with studies documenting increases in prevalence of depression and PTSD over time among both adults and children after being detained³⁷.

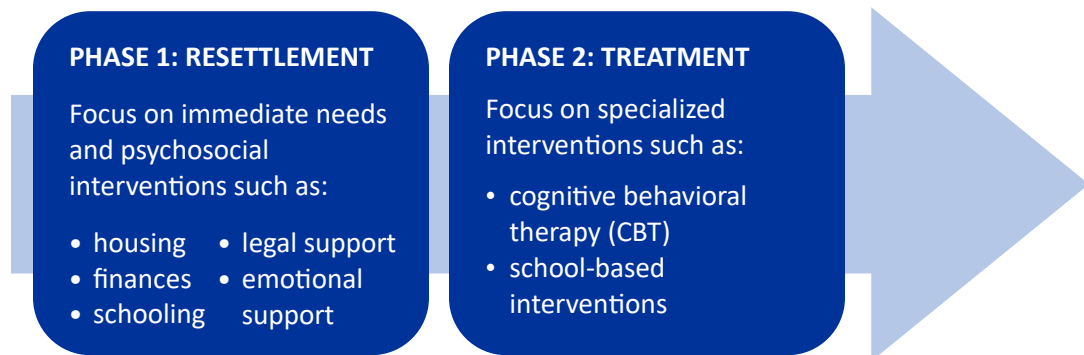
See visualization: “Risk and protective factors for migrant mental health.”

- When developing or providing mental health services for migrants and refugees, clinicians and administrators may consider the following broad issues³⁷:
 - accessibility
 - cultural adaptation of services, and
 - an ecological systemic and public health approach to address social and structural determinants of mental health

See visualization: “Considerations in mental health services for migrants.”

- A few guidelines propose a phased approach of refugee care: during the first phase, the emphasis is put on non-specific interventions to respond to the immediate needs of resettlement (housing, financial, schooling) and provide emotional support. During a second phase, if survival is no more at stake and symptoms persist, specialized interventions may be warranted³⁷.

Phases of Care for Refugees



C. Post-Migration

- Post-conflict conditions associated with the migration process, such as experiences of detention, extended insecure status, and restrictions on the ability to find employment and/or housing, can have a powerful impact on mental health⁴⁰. At the time of arrival, many refugees and asylum seekers may display acute stress symptoms that will disappear without treatment over time once a feeling of safety is established³⁷.
- The average length of displacement for those in protracted situations is over 20 years. Most of the millions of refugees who are forcibly displaced will remain so for most of their lives - 80% of them in low-income countries⁴⁰.
- An increased length of displacement is associated with poorer mental health outcomes, suggesting that the long-term mental health for refugees and asylum seekers may deteriorate because of resettlement into highly stressful settings⁴⁰.
- While they await the review of their claim, asylum seekers often face restrictions on access to employment, housing, education and other normal conditions of residence. They face complete restrictions on their freedom in the form of detention, often in conditions that have been found to be degrading, punitive, and inhumane⁴⁰.
- Exposure to secondary stressors after resettlement, such as poverty, unemployment and limited social support, also impact duration of mental illness and prevent recovery. Migrants with precarious legal status live under high stress and permanent uncertainties in their resettlement environment, which may have a negative impact on mental health³⁷.
- For vulnerable migrants who have a precarious migratory status, mostly asylum seekers and undocumented migrants - access to mental health services is also limited by the actual or perceived lack of entitlement to services. Studies show that migrants and refugees underutilize mental health services due to stigma around mental illness, linguistic obstacles, and lack of cultural sensitivity of service providers. Most migrants encounter difficulties stemming from the absence of knowledge about host country services and linguistic barriers. Using professional interpreters improves clinician–patient communication and supports the access to a range of more appropriate services³⁷.
- The social determinants of health include material variables that are shaped by social and policy forces, variables such as access to safe environments, adequate food and housing, high-quality health care, and appropriate employment. These material variables can have long-term and developmental effects in addition to the more obvious immediate risks⁴⁰.
- The social determinants of health also include interpersonal variables, like experiences of social exclusion, discrimination, and low social status. Both material and interpersonal social determinants influence health and mental health through psychological states such as stress, perceptions of control, and social networks, which in turn have effects through biological pathways including neuroendocrine, neuroimmune and epigenetic responses⁴⁰.

III. Responding to Migration Emergencies

A. International Organization for Migration (IOM)

1. [Migration Crisis Response](#)

The IOM is the leading United Nations agency working on migration. It provides inclusive and holistic responses to the mobility dimensions of crisis using the [Migration Crisis Operational Framework \(MCOF\)](#). MCOF is designed to uphold human rights and humanitarian principles and provide protection and assistance to crisis-affected populations through partnerships with states and international organizations.

2. [Mental Health and Psychosocial Support \(MHPSS\) in Emergencies and Displacement](#)

This manual provides guidance and tools to support the implementation of mental health and psychosocial assistance in the field, including the following areas:

- Psychosocial needs assessment in emergency displacement
- Camp coordination and management
- Community-based approaches
- Psychological first aid (PFA)

B. World Health Organization (WHO) Refugee and Migrant Mental Health

1. [Refugee and Migrant Mental Health Global Action Plan \(GAP\)](#)

The WHO *GAP – promoting the health of refugees and migrants* – is part of an international framework established by the United Nations to manage global migration using six priorities, including promoting public health interventions and quality healthcare, advocating for refugee and migrant mental health policies, enhancing capacity, and strengthening health monitoring and communication.

2. [Mental Health in Emergencies – Effective Emergency Response](#)

The WHO endorses interagency MHPSS guidelines to support effective response to emergencies, from basic services to clinical care. Clinical care for mental health should be provided by or under the supervision of mental health specialists such as psychiatric nurses, psychologists, or psychiatrists.

3. [Psychological First Aid Manual](#)

This manual is designed to orient helpers to offer first-line psychological first aid (PFA) to people following a serious crisis event. PFA involves humane, supportive, and practical assistance in ways that respect people’s dignity, culture, and abilities. It is an approach that can be learned by both professionals and nonprofessionals who are in a position to help people impacted by distressing events. It is not necessary for helpers to have a psychosocial or mental health background in order to offer PFA.

4. [mhGAP Humanitarian Intervention Guide \(mhGAP-HIG\): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies](#)

The WHO mhGAP-HIG contains first-line management recommendations for mental, neurological, and substance use conditions for non-specialist healthcare providers in humanitarian emergencies where access to specialists and treatment options is limited. The guide is available in nine languages and includes a training guide for facilitators to train non-specialist healthcare providers to manage mental, neurological, and substance use conditions in humanitarian emergency settings.

C. United Nations High Commissioner for Refugees (The UN Refugee Agency)

1. [Operational Guidance on Mental Health and Psychosocial Support \(MHPSS\)](#)

This guide, developed by the United Nations Refugee Agency or UNHCR provides practical tools to inform MHPSS activities, including:

- Community resilience
- Promoting mechanisms for social support
- Offering services to those with complex mental health needs

One of the key principles in the Operational Guidance aims at developing a multilayered system of MHPSS services, starting from actions that benefit all refugees – utilizing an MHPSS approach – and continuing to targeted MHPSS interventions, including:

- Social considerations in basic services and security
- Strengthening community and family support
- Focused psychosocial support
- Clinical services

[See visualization: “Intervention Pyramid.”](#)

2. [Global Trends Report](#)

Report including the latest official statistics on refugees, asylum seekers, internally displaced and stateless people, as well as the number of refugees who have returned home. The latest report, published in June 2023, states that at the end of 2022, 108.4 million people worldwide, or one in every 74 people on Earth, were forcibly displaced as a result of persecution, conflict, violence, human rights violations, or events seriously disturbing public order.

IV. Population Interventions

A. Children and Adolescents

Case Vignette

Maria is a 12-year-old girl from Honduras who migrated to the United States with her family. Maria's family lived in a rural community in Honduras, where they faced persistent violence and economic challenges. Her parents worked as farmers but struggled to make ends meet due to poor harvests and limited access to markets. Maria had experienced multiple incidents of violence in her community, including witnessing a shooting outside her home. During her migration journey, Maria and her family faced hunger, thirst, and exhaustion. They also encountered dangerous situations, including crossing rivers and traveling through harsh terrain. Upon arriving at the U.S. border, Maria's family sought asylum, but they faced delays and uncertainty in the immigration process. They were placed in a detention center for several weeks, where Maria experienced further stress and anxiety.

Interventions

Downstream:

- Culturally sensitive care and linguistic support: multilingual support, culturally relevant materials, interpreter services
- Education and school-based interventions including needs assessment, appropriate referrals, and support
- Legal support and advocacy: asylum application, family reunification
- Assessment of social determinants of mental health: basic needs, caregiver
Community integration to support belonging

Midstream:

- Emergency assistance: support at transit points, shelters
- Legal assistance: pro bono services, know-your-rights workshops to empower youth
- Access to healthcare: mobile health clinics, vaccination, hygiene kits
- Protection: protection protocols, safe spaces

Upstream:

- Addressing poverty and promoting economic empowerment
- Social protection programs
- Children's rights and protection from abuse, exploitation, and violence
- Protecting the health of children of immigrants by reducing disparities in federal, state, and local policies
Investing in neighborhoods and immigrant communities and resources

Resources

- [Towards a Child Rights-based Assessment Tool to Evaluate National Responses to Migrant and Refugee Children](#)
- [Field Handbook on Unaccompanied and Separated Children](#)
- [APA Immigration Toolkit: Displacement, Trauma, and Mental Health Among Migrant Youth and Their Families](#)
- [APA Resource Document on Social Determinants of Mental Health in Children and Youth](#)

- In recent times, there has been a proliferation of various guidance, guidelines, and good practice models that aim to promote a child rights-based approach to protect migrant and refugee children. However, the next crucial step is to consolidate these diverse guidance documents into a unified conceptual framework that can facilitate effective governance, accountability, and transparency in national responses. This framework should prioritize a comprehensive child rights-based approach to the protection of migrant and refugee children at all levels, ensuring their well-being and rights are safeguarded in a holistic and cohesive manner. The urgency of this need becomes apparent when we explore the profound impact that migration can have on the mental health of children, a process that begins as early as the perinatal period and continues to shape development through young adulthood. The stresses associated with migration, particularly if forced or undertaken in desperate circumstances, can have immediate effects on expectant mothers during the perinatal period, leading to preterm births or low birth weight. The anxiety and trauma often experienced by parents in these situations can further translate into attachment and developmental issues in infancy.
- In early childhood, a lack of stability and exposure to traumatic events can lead to delays in emotional and cognitive development. Children may experience feelings of insecurity and anxiety, struggling to cope with a rapidly changing environment. Adolescence is a critical period for mental health development, and migration can introduce unique challenges. Cultural adaptation, language barriers, discrimination, and the struggle to establish identity can lead to feelings of isolation, depression, and anxiety. As children transition into young adulthood, the accumulated effects of migration-related stresses can lead to persistent mental health challenges. The complexities of integrating into new cultures, pursuing education, and establishing careers may exacerbate existing mental health conditions, hindering overall well-being and life progression.
- In light of these complexities, the call to consolidate guidance into a unified conceptual framework is not only strategic but also deeply humane. The psychological well-being of migrant and refugee children is a multifaceted issue that demands a thorough, rights-based approach, one that recognizes the intricate interplay among physical, emotional, and social factors. By placing the mental health of children at the core of migration response strategies, we take a vital step toward a more compassionate and effective response to a global phenomenon that continues to shape the lives of millions.

International Agreements Pertaining to Child Migrants

1. [International Covenant on Civil and Political Rights](#)
2. [International Covenant on Economic, Social and Cultural Rights](#)
3. [Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment](#)
4. [Convention on the Rights of the Child](#)
5. [Convention on the Rights of Persons with Disabilities](#)
6. [International Convention on the Elimination of All Forms of Racial Discrimination](#)
7. [Convention on the Elimination of All Forms of Discrimination against Women](#)
8. [1951 Convention Relating to the Status of Refugees and Its 1967 Protocol](#)
9. [International Convention on the Protection of the Rights of All Migrant Workers](#)
10. [Global Compact for Safe, Orderly and Regular Migration](#)
11. [Convention on the Rights of the Child on the Sale of Children and Child Prostitution](#)
12. [Convention on the Rights of the Child on the Involvement of Children in Armed Conflict](#)
13. [International Labour Organization Convention 182 on the Worst Forms of Child Labour](#)
14. [United Nations Standard Minimum Rules for Administration of Juvenile Justice \(Beijing Rules\)](#)
15. [United Nations General Assembly resolution on guidelines for the alternative care of children](#)
16. [United Nations General Assembly resolution on children without parental care](#)

B. Adults

Case Vignette

Osman is a 28-year-old refugee who fled Somalia due to famine, drought, and civil war. He had faced sexual violence during the civil war and feared being ostracized by his family for being a rape victim. As he resettles in the United States, he works long hours to meet his needs financially and does not have time to attend classes to speak English. Due to his past sexual trauma, he feels hypervigilant around his male work colleagues and avoids venturing out of his house alone in the evenings. He feels depressed, worthless, and hopeless about leading a life in the United States. Even though he lives in a neighborhood consisting of members from the Somali community, he describes feeling detached from them and is not interested in social interactions with them.

Interventions

Downstream:

- Language assistance during encounters
- Assessing and addressing healthcare needs, including chronic illness, infection screening, and immunizations
- Addressing stigma of mental illness during encounters, including trauma and torture
- Watching for somatic symptoms associated with mental illness, including headache, muscle tension, fatigue, insomnia, changes in appetite
- Screening for substance use and suicidal ideations
- Making information and assistance available to help resettlement

Midstream:

- Information on safe shelters and transit points
- Providing resources to local culturally appropriate support systems and community events
- If the refugee or asylum seeker is a parent or a caregiver for a minor, providing appropriate support for the minor (see interventions for child refugees)
- Access to housing and job opportunities
- Addressing barriers to access to healthcare

Upstream:

- Addressing discrimination based on country, racism, poverty, ableism, and ageism in migration and health-related policies

C. Women

Case Vignette

Noor is a 34-year-old female refugee in the process of resettlement in the United States along with her 6-year-old daughter, Aisha. She had fled her home country of Syria following the civil unrest. She lost her husband and another daughter after their boat capsized in the Mediterranean Sea when they had initially fled to Greece from Syria via Turkey. Even though she feels relieved with the support systems provided with the resettlement process and is in contact with the Syrian community in the United States, Noor reports feeling depressed and having nightmares of losing immediate family members during her journey to the United States. She feels overwhelmed and detached from caring for her daughter, who is also grieving the death of her family members. She also alludes to having been sexually assaulted while in a refugee camp in Greece but does not want to talk about it. Even though Noor is college-educated and can speak fluent English, she worries about working and seeking healthcare due to cultural and linguistic differences that can occur during social interactions.

Interventions

Downstream:

- Language assistance during encounters
- Assessing and addressing healthcare needs of women refugees and asylum seekers, including management of pregnancy, sexual and reproductive healthcare, and hygiene products
- Addressing stigma of mental illness during encounters, including trauma
- Assessing for sex trafficking and torture, including sexual and gender violence
- Watching for somatic symptoms associated with mental illness, including headache, muscle tension, fatigue, insomnia, changes in appetite
- Screening for substance use and suicidal ideations
- Making information and assistance available to help resettlement

Midstream:

- Providing resources to local support systems for women
- Information on safe shelters and transit points
- If the refugee or asylum seeker is a parent or a caregiver for a minor, providing appropriate support for the minor (see interventions for child refugees)
- Providing resources to local culturally appropriate support systems and community events for women
- Access to housing and job opportunities
- Addressing barriers to access to healthcare, including sexual and reproductive health, contraception, and pregnancy care

Upstream:

- Addressing gender-based discrimination from employment and housing opportunities
- Advocating against gender-based social and healthcare disparities

Resources

- [Supporting Mental Health of Immigrant Women](#)
- [Migrant Women's Mental Health and Wellbeing](#)
- [Safeguarding Women and Girls in Times of Displacement](#)

D. Older Adults

Case Vignette

Syed is a 71-year-old refugee from Iraq. During a health checkup, the physician noticed he was malnourished, sad, and withdrawn. Syed describes having witnessed the abuse of his children and grandchildren during his escape from Iraq. Since his arrival in the United States, he has felt socially isolated and has no company of peers of his age and from his community. He feels that all his surroundings are very alien to him, and he is not sleeping or eating well. The physician also noticed memory problems during the encounter with Syed. Syed also reports not understanding what being depressed means as he says his community does not talk about mental illness.

Interventions

Downstream:

- Language assistance during encounters
- Assessing and addressing healthcare needs of older adults, including mental health, cognitive dysfunction, malnourishment, and frailty
- Addressing stigma of mental illness during encounters
- Making information and assistance available to help resettlement
- Watching for somatic symptoms associated with mental illness, including headache, muscle tension, fatigue, insomnia, and changes in appetite

Midstream:

- Providing case management or social work services
- Helping older adults find culturally relevant opportunities and recreational programs to help them adjust to their new surroundings
- Exploring employment opportunities
- Encouraging participation in local events
- Exploring culturally appropriate, long-term care if the older adult requires continuous assistance with independent activities of daily living

Upstream:

- Advocating for anti-poverty measures or income opportunities for older adults
- Advocating against discrimination of older adults in employment opportunities

Resources

- [Health of Older Refugees and Migrants](#)
- [Integration Handbook: Older Refugees](#)
- [Addressing the mental health needs of older adult refugees](#)
- [Barriers and facilitators of health among older adult immigrants in the United States](#)

E. LGBTQ+

Case Vignette

Selena is a 28-year-old male-to-female transgender person from El Salvador seeking asylum in the United States due to fear of persecution from gang violence. During her journey to the United States via the Mexican border, she faced sexual and gender-based violence. Upon reaching the United States, Selena has found that finding a job and shelter is difficult due to bias and discrimination of her transgender status. She finds integrating with other refugees and asylum seekers from El Salvador difficult due to their conservative religious beliefs. Because of these experiences, she fears and mistrusts social interactions and is reluctant to seek help for healthcare needs.

Interventions

Downstream:

- Language assistance during encounters
- Assessing and addressing healthcare needs of LGBTQ+ refugees and asylum seekers, including treatment of sexually transmitted disorders, gender-affirming care, and hygiene products
- Assessing for sex trafficking and torture, including sexual and gender-related violence
- Addressing stigma of mental illness during encounters, including trauma
- Watching for somatic symptoms associated with mental illness, including headache, muscle tension, fatigue, insomnia, and changes in appetite
- Screening for substance use and suicidal ideations
- Providing information and assistance available to help resettlement

Midstream:

- Information on safe shelters and transit points
- Providing resources to local LGBTQ+ support systems and community events
- Access to housing and job opportunities
- Addressing barriers to access to healthcare, including gender-affirming care, and sexual and reproductive healthcare

Upstream:

- Addressing gender-based discrimination from housing and employment opportunities
- Advocating against sexual and gender, minority-based social and healthcare disparities

Resources

- [LGBTQ Asylum Seekers: How Clinicians Can Help](#)
- [Migration and LGBTI People](#)
- [Sexual orientation and gender identity and the protection of forced migrants](#)

F. Climate Refugees

Case Vignette

After the 2021 severe flooding that struck parts of the Kurdistan region in Northern Iraq, Mona and her family migrated to the United States. They lived in a rural town where no one spoke their language or understood their culture. The school had never welcomed a refugee student before, and there was no translator who spoke her language. She was bullied at school for wearing a hijab and secondhand clothes that did not fit her. She frequently cried, had difficulty sleeping, struggled with concentration, and isolated herself. She worried about her cousin, who was her best friend, who was still in Iraq. She started crying after her peers tried to put food in her mouth on the first day of Ramadan.

Interventions

Downstream:

- Language assistance during encounters
- Assessing and addressing healthcare needs, including chronic illness, infection screening, and immunizations
- Addressing stigma of mental illness during encounters, including trauma and grief from the climate change-related event
- Watching for somatic symptoms associated with mental illness, including headache, muscle tension, fatigue, insomnia, and changes in appetite
- Making information and assistance available to help resettlement

Midstream:

- Information on food, safe shelters, and transit points
- Attempting to contact family members and friends who might have been displaced from the climate change-related event
- Providing resources to local culturally appropriate support systems and community events
- If the refugee or asylum seeker is a parent or a caregiver for a minor, providing appropriate support for the minor (see interventions for child refugees)
- Access to housing and job opportunities
- Addressing barriers to access to healthcare

Upstream:

- Addressing discrimination based on country, racism, poverty, ableism, and ageism in migration and health-related policies

Resources

- [Frequently asked questions on climate change and disaster displacement](#)
- [The Impact of Climate Change on Mental Health and Emotional Wellbeing](#)
- [Review of the Impact of Climate Change on the Global Demand for Psychiatric Services](#)
- [Climate change aggravating migration and health issues in the African context](#)

G. Human Trafficking

Case Vignette

Alejandra is a 24-year-old female living in Venezuela who lost her job as a hotel worker because of the COVID-19 pandemic. She has no family to support her and has become increasingly concerned about the gang violence in her town and considered migrating to the United States. After a male friend told her about a job working at a grocery store in Texas, Alejandra began the long journey to the United States with him. When they reached Mexico, he introduced her to a man who would help smuggle her into the United States. A few days later, that man handed over to another man who bought her and told her she needed to become a sex worker to pay off her debt to him. Shocked and terrified, she refused and asked to be sent back to Venezuela. She pleaded with him to let her go, but he said that would never happen and began to beat and torture her and starve her of food and water. She was repeatedly told that her only option to pay off the debt was through sex work so after time she succumbed to the pressure. By the time Alejandra crossed the border into the United States, she was depressed, suffering from recurring nightmares, experiencing guilt and hopelessness, had contracted an STD, and was now pregnant and scared.

Interventions

Downstream:

- Culture humility and culturally competent mental health care
- Translators and interpreters
- Connection with others from the Venezuelan community
- Medical care to address her needs
- Resources for resettlement and legal support

Midstream:

- Safe housing, employment, and food
- Case management to navigate the new setting
- Address barriers to health care

Upstream:

- Advocate and connect to supporting organizations (Examples: Stop Human Trafficking, Polaris Project, Coalition to Abolish Slavery)

Resources

- [Mental health and human trafficking: responding to survivors' needs](#)
- [Human trafficking and psychiatric education: a call to action](#)
- [Are we seeing the unseen of human trafficking?](#)
- [Health of men, women, and children in post-trafficking services](#)
- [Risk factors for mental disorders in women survivors of human trafficking](#)

H. Substance Use

Case Vignette

David is a 30-year-old male refugee from Guatemala who is in the resettlement process in the United States. He fled his home country three years ago due to poverty and fear of persecution from gang violence. He lives in subsidized housing and works as a daily wage worker at a construction site. After work, David describes that he is feeling lonely, sad, and homesick. He struggles with sleep and low energy, spending his after-work hours drinking three to four 16oz cans of beer per day for the last year. He does not report any withdrawal tremors, seizures, or confusion after he misses drinking beer. He denies consuming alcohol in the daytime or at work. On weekends, he smokes marijuana and experiments with cocaine to get past feelings of boredom and feel “better.”

Interventions

Downstream:

- Language assistance during encounters
- Assess and address healthcare needs including chronic illness, infection screening, and immunizations
- Screen for substance use and suicidal ideations
- Address stigma related to mental illness during encounters including trauma, intimate partner violence, and torture that might be contributing to substance use
- Educate about laws and regulations related to substance use, and ways how ongoing substance use and interactions with the legal system can jeopardize refugee/asylum seeker status
- If non-pharmacological management like motivational interview, contingency management, or coping skills training are used, they should be culturally adapted for the patient
- Assess for sex trafficking and torture including sexual and gender violence
- Watch for somatic symptoms associated with mental illness including headache, muscle tension, fatigue, insomnia, changes in appetite
- Provide information and assistance available to help resettlement

Midstream:

- Information on safe shelters and transit points
- Provide resources to local culturally appropriate support systems and community events to help with engagement with community
- Access to housing and job opportunities
- Address barriers to access to healthcare and resources to treatment for substance use that are culturally and linguistically appropriate for the patient

Upstream:

- Address discrimination based on country, racism, poverty, ableism, and ageism in migration and substance use treatment-related policies

I. Serious Mental Illness (SMI)

Case Vignette

Sultan is a 19-year-old male Rohingya refugee who migrated to the United States more than a year ago from Myanmar following a military coup in 2021. His brother Abdul took him to a clinic for a physical and mental health evaluation where he is observed to be disheveled, distracted, and mumbling to himself. The encounter is limited due to the lack of a Rohingya or Chittagonian language interpreter, though both Sultan and Abdul speak a basic level of Burmese and Abdul helps to communicate for Sultan. Abdul describes moving to the United States with Sultan due to a fear of persecution by the Myanmar military. Sultan becomes more withdrawn and begins talking to himself sharing that he is hearing voices and experiencing decreased self-care, appetite, and disorganized behavior since witnessing interpersonal violence and persecution of friends and family members by the military. He has never had a mental health evaluation or been treated for any psychiatric disorder. Abdul believes Sultan's symptoms are part of the traumatic experiences he experienced and may be due to bad omens or demons in their lives.

Interventions

Downstream:

- Language assistance during encounters. Match the language of the translator as much as possible to gain understanding of the psychopathology presented by the patient
- Consider differential diagnosis of various presentations of SMI including neuropsychiatric symptoms by medical disorders.
- Assess and address healthcare needs including chronic illness, infection screening, and immunizations
- Screen for substance use and suicidal ideations
- Assess for explanatory models of mental illness related to the patient's culture and expectations in management of mental illness
- Address stigma related to mental illness during encounters including trauma, intimate partner violence, and torture
- Assess for sex trafficking and torture including sexual and gender violence
- Watch for somatic symptoms associated with mental illness including headache, muscle tension, fatigue, insomnia, changes in appetite
- Provide information and assistance available to help resettlement

Midstream:

- Information on safe shelters and transit points
- Provide resources to local culturally appropriate support systems and community events to help with engagement with community
- Access to housing and job opportunities
- Address barriers to healthcare access and resources for treating substance use that are culturally and linguistically appropriate

Upstream:

- Address discrimination based on country, racism, poverty, ableism, and ageism in migration and substance use treatment-related policies

V. Engaging the Family as a Unit of Care in Refugee Mental Health

- For many refugee populations, a person's primary identity may be that of a family member or clan member rather than a person as an individual. Throughout history, strong families have protected vulnerable individuals, nurtured children, and gathered resources for the common good. As a social unit, the family often extends beyond the nuclear family to include the extended family with grandparents, aunts, uncles, and cousins^{10,11}.
- Families are often the most plentiful resource available to refugee agencies stretched thin for resources. Families can be major contributors to resilience against trauma and loss. A cultural readiness for family-centered care may exist within any population where family or clan identities predominate^{10,11}.
- Clinicians, case managers, and other social service providers need skills for conducting family meetings that engage family members as full participants in the planning and implementation of refugee services. These skills include^{10,11}:
 - Establishing a trustworthy relationship with each family member and the family as a whole
 - Eliciting fears, losses, traumatic experiences, and mental health concerns that may be immediate priorities, particularly those involving absent family members
 - Learning how family leadership, roles and responsibilities, and decision-making have traditionally operated and whether the family organization still functions effectively
 - Learning about family strengths and competencies that can be brought to bear on the family's priority of concerns
 - Organizing a family action plan in which each family member contributes to addressing the family's priority of concerns

Case Vignette

Ana, a 13-year-old girl from Guatemala, ran away from home with two older brothers after chronic physical abuse by their grandmother and her new boyfriend. Years earlier, she and her brothers had been left in the care of the grandmother when her mother emigrated to the United States. Ana and her brothers made their way north through Mexico toward the U.S. border, where they hoped to rejoin their mother. Ana was assaulted, raped, and impregnated in a village where they sought shelter. The three teenagers reached the border but were detained by the Immigration and Naturalization Service (INS). Weeks later, Ana and her two brothers were released to the custody of her mother. Ana had not seen her mother since age three. The mother now had a new family – a husband and two children, one of whom was developmentally disabled.

When Ana, due to her pregnancy, was referred to a social service agency, the agency psychotherapist and case manager engaged the whole family by establishing a trusting relationship with each family member, in addition to providing trauma-focused therapy for Ana. In family meetings, the therapist elicited the story of the three siblings' journey from their home country and their hopes and concerns as a whole family. Initially, the stepfather complained, "This house is too crowded. There are too many children." However, the therapist facilitated a plan for optimizing space and privacy while the case manager mobilized additional financial support for resettlement of the children. The therapist facilitated Ana's stepping into a new role of providing childcare for her developmentally disabled stepbrother. The therapist joined the family to celebrate the birth of Ana's new baby, then later, Ana's return to school while her mother cared for her baby at home. During subsequent months, family stressors and relational strains were manageable. A year later, none of the three children showed overt mood, anxiety, or post-traumatic symptoms despite their traumatic migration. Ana became an outstanding student in school.

VI. Mental Health Response Recommendations

A. Clinical Practice

1. Cultural Formulation Interview (CFI) Supplementary Modules

The CFI supplementary modules can help clinicians conduct a comprehensive cultural assessment by expanding on the following CFI subtopics:

- **Stressors and supports:** information on the individual's life context, focusing on resources, social supports, and resilience
- **Role of cultural identity:** information on the most salient elements of an individual's cultural identity
- **Past help-seeking:** information on various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, and other forms of traditional or alternative healing)
- **Barriers:** the role of social barriers to seeking help, access to care, and problems engaging in previous treatment

[See Cultural Formulation Interview \(CFI\).](#)

a. Supplementary module for immigrants and refugees

This module focuses on the specific needs of immigrants and refugees, providing clinicians with interview questions aimed at collecting information about the migration and resettlement experiences of immigrants and refugees, including the following:

- Premigration difficulties
- Migration-related losses and challenges
- Ongoing relationships with country of origin
- Resettlement and new life

Many refugees have experienced stressful interviews with officials or health professionals in their home country, during the migration process, and in the receiving country, so it may take longer than usual for the interviewee to feel comfortable with and trust the interview process. When patients and clinicians do not share a high level of fluency in a common language, accurate language translation is essential.

[See CFI Supplementary Module 11: "Immigrants and Refugees."](#)

b. Supplementary module on spirituality, religion, and moral traditions

This module focuses on clarifying the influence of spirituality, religion, and other moral or philosophical traditions on the individual's problems and related stresses. People may have multiple spiritual, moral, and religious affiliations or practices. Interview questions address the following:

- Spiritual, religious, and moral identity
- Role of spirituality, religion, and moral traditions
- Potential stresses or conflicts related to spirituality, religion, and moral traditions

If the individual reports having specific beliefs or practices, inquire about the level of involvement in that tradition and its impact on coping with the clinical problem. If the individual identifies more than one tradition, each can be explored.

[See CFI Supplementary Module 5: "Spirituality, Religion, and Moral Traditions."](#)

2. Trauma-Informed Care

The [APA Stress and Trauma Toolkit](#) helps providers understand the unique circumstances facing marginalized populations and includes specific guidelines for treating undocumented immigrants. The following are ten ways (adapted and revised from the toolkit) clinicians can provide trauma-informed care in migration emergencies:

a. Start from a place of cultural humility

- While it is nearly impossible to understand a person's intersection of their background and lived experiences, recognize and be sensitive to culturally specific concepts of distress and normative cultural factors. Be sensitive to culturally specific phenomena when treating patients, but also treat each patient as an individual and assess what their culture means to them.
- For example, in many Latino cultures, PTSD symptoms may be attributed to "susto" ("soul loss") instead of being recognized as a mental illness. The Cambodian language has no word for depression or anxiety, so these patients may present with complaints of "khyal attacks" or "wind attacks," which are described as dizziness, shortness of breath, and palpitations. At the same time, not all individuals from Latino and Cambodian cultures ascribe to these concepts, and practitioners should avoid making assumptions about one's beliefs based on culture of origin.
- Try using probing interview questions found in the **Cultural Formulation Interview (CFI)** linked in this resource document.

b. Consider protective factors

- Studies have shown that the most important protective factor for immigrants' mental health is whether they receive adequate social support.
- Other protective factors include pride in ethnicity, bilingualism and multilingualism, and spirituality.
- Encourage and advocate for the unification of patients with their families.
- Connect patients to resources. Emphasize the importance of social supports for the well-being and recovery of disenfranchised populations. Connections with resources can be just as important as receiving treatment.
- Provide consistent and accessible follow-up. Immigrants may distrust the healthcare system and may require more frequent and consistent follow-up to create a sense of trust. Collaborative decision-making and motivational interviewing can be helpful when culturally sensitive.
- Spirituality and faith should be assessed and incorporated into treatment planning if the patient desires.
- Minimize language barriers. Make an attempt to offer resources in patients' native languages. Provide opportunities to learn English if patients show an interest.
- Collaborate with community organizations that support immigrants in multiple facets of their lives, including family support.

c. Encourage clinicians to examine their own implicit and explicit biases

- As a structural intervention, suggest regular training that promotes reflective self-examination and awareness of implicit bias.
- Evaluate, challenge, and address structural and practice-level factors that perpetuate explicit bias, discrimination, and inequalities for immigrant and other vulnerable populations.

d. Consider the many external and internal factors that influence the course of a person's life

- Use a “sociocultural ecological framework” that considers the complex interplay among individual, relationship, community, cultural, and societal factors that influence mental health. Community-focused interventions that integrate school, community, and physical and mental healthcare, and faith-based organization providers can increase access to care and provide social support.
- Conduct psychiatric testing in a format that accommodates the individual's culture and/or language, or that applies to many cultures.

e. Combat psychosocial stressors

- Those affected by migration emergencies often experience a large variety and number of psychosocial stressors.
- Assess needs using standard instruments or assessments such as the **Brief Risk Overview survey** and take into consideration the possible effects of adverse childhood experiences (ACEs).
- Employ early assessment of psychosocial stressors, substance use, and barriers to care when treating undocumented immigrants.
- Identify accessible social services and supports for addressing psychosocial stressors in the lives of undocumented patients.
- Think about partnerships with organizations that offer trusted spaces within the specific community, including faith-based organizations, schools, or community centers.
- Consider increased follow-up and connecting patients to services such as peer navigators, health coaches, college resources, or legal assistance. Resourceful thinking can help bridge cultural or language gaps, such as advocating for testing in a different language for a child in school or using innovative but accessible technology.

f. Screen for trauma

- Given the high risk for trauma, especially among those affected by migration emergencies, consider screening for trauma and practicing trauma-informed care even if patients do not meet the criteria for PTSD.
- Screen for trauma exposure and symptoms, anxiety, depression, substance use disorders, and sleep disorders. Whenever available, use screening measures developed for the population the patient identifies with. For example, The Colonial Mentality Scale (CMS-I) has been validated for the Filipino American population for mental health and well-being.
- Recognize the impact of violence on development and coping, and identify recovery from trauma as a primary goal. An empowerment model maximizes patient control, collaboration, and a safe environment. This model also emphasizes resilience, minimizes retraumatization, and practices cultural competency and cultural humility.
- Consider early interventions for dual pathology of PTSD symptoms and alcohol or substance use disorder (AUD/SUD) in immigrants with trauma history, particularly for Latino immigrants, who are at high risk for comorbid PTSD and AUD/SUD.
- Since trauma-informed care involves both the individual treatment of a patient by a provider and the policies of systems-based practices, consider reexamining policies that may restrict access to social services and healthcare for the undocumented.

g. Inform patients of their rights

- Research indicates that fear of deportation is common among all immigrants; when those affected by migration emergencies understand their rights, they can use that information to advocate for themselves, decrease their chances of being separated from loved ones, and protect their mental health. Some examples of this include connecting patients with legal aid or providing appropriate language information to notify them of their rights. Victims of crime may be eligible for changes in immigration status if they help law enforcement investigate the crime.

h. Use narrative therapy and cognitive restructuring

- Allowing patients to tell their stories and recreate their narrative often helps those affected by migration emergencies process and prevent symptoms of depression, anxiety, and PTSD. Narratives allow people to access their stories in a less damaging and more therapeutic way. These strategies are known to help with issues related to identity and stress.

i. Encourage self-advocacy and empower patients

- Inform patients affected by migration emergencies of the legal rights they have. Provide links to legal and social services that can assist patients in learning how to practice self-advocacy and access resources they need for themselves and their families.

j. Continue learning

- Please see [“Suggested Assessment and Treatment Recommendations for Marginalized Populations”](#) from the APA Stress and Trauma Toolkit.

B. Community Response

1. Support Resettlement Efforts

There are different ways the United States supports migrants and refugees, including through resettlement. Resettlement organizations facilitate the successful resettlement of migrants and refugees by addressing specific areas, including the following:

- a. Get people resettled** through support with learning language, jobs (employment placement and workforce development), case management (housing, social services, food pantries), kids in school, etc.

[UNHCR List of U.S. Resettlement Partners](#)

Resettlement is a coordinated activity undertaken in partnership with UNHCR, U.S. government agencies, nongovernmental organizations, and other actors. It includes a variety of specific actions, from the identification of refugees in need of resettlement to screening, processing, and reception and integration of refugees in the United States.

Partner agencies and organizations include the following:

- **National and state government partners**
- **Nongovernmental partners and refugee advocacy organizations**
- **Resettlement agencies**
- **Intergovernmental partners**

b. Find resources in your state.

[U.S. Office of Refugee Resettlement \(ORR\) State Contacts](#)

The ORR provides new populations with access to critical resources to support them in becoming integrated members of American society. ORR provides an interactive map that can be used to identify resources and contacts in U.S. states, regions, and territories.

- c. Community support** can be informal and not limited to organizations that receive federal funding. Different community spaces and centers (churches, mosques, other houses of worship, etc.) can provide basic resources and services to refugees. It is important to consider a population's specific resettlement needs when thinking about patients' needs and potential opportunities for support.

8 Practical Ways to Help Refugees

- 1) Host refugees and asylum seekers in your home
- 2) Volunteer your specific skill
- 3) Help refugees integrate into a new culture
- 4) Encourage your university to offer refugee scholarships
- 5) Employ refugees
- 6) Offer opportunities for refugees to volunteer
- 7) Hold awareness and fundraising events
- 8) Donate

2. Support Asylum Cases

- Asylum seekers are at high risk for post-traumatic stress disorder (PTSD) with several studies estimating rates of PTSD to be 28% to 36% among the asylum-seeking population. Symptoms of PTSD, such as disordered memory, numbness, and reduced responsiveness to the outside world, can make it difficult for asylum seekers to be granted legal status³⁷.
- Asylum seekers are not entitled to an attorney and those who are unable to afford an attorney or secure one pro bono are severely disadvantaged against the U.S. government's attorney without representation or access to a psychological evaluation. Additionally, with a backlog of more than half a million cases, immigration courts are unable to deliver timely decisions to people seeking refuge³⁷.
- Psychiatrists can play an important role in asylum proceedings as psychological assessment can greatly help the odds that an individual will be granted asylum. Immigration courts often rely on psychiatric evaluation and testimony to help assess the veracity of the asylum seeker's claims. As expert witnesses, psychiatrists can provide context and corroboration for asylum seekers trauma, thus reinforcing the credibility of the asylum seeker, and explain how trauma and mental illness affects behavior³⁷. The [Physicians for Human Rights \(PHR\) Asylum Network](#) supports survivors of torture and ill-treatment seeking refuge and recovery in the United States. It is comprised of 2,000 members nationwide who are called upon to provide pro bono forensic medical and psychological evaluations as they align with their particular skills and expertise.

C. Organizational Response

1. Advocate for Increased Refugee Admissions

- Although historically, the United States has resettled more refugees than any other country, its resettlement program has not kept up with the increase in the global refugee population by about 50% over the past five years¹⁷.
- The refugee admission ceiling has fluctuated across U.S. administrations, with the lowest number of refugees resettled in the United States since the passage of the Refugee Act of 1980 occurring in FY 2021¹⁷.

Fiscal Year	Refugee Admission Cap	Refugees Admitted	Administration
FY 2023	125,000	-	Biden
FY 2022	125,000	25,465	Biden
FY 2021*	62,500	11,411	Biden
FY 2020	18,000	11,814	Trump
FY 2019	30,000	30,000	Trump
FY 2018	45,000	22,579	Trump
FY 2017**	50,000	53,716	Trump
FY 2016	85,000	84,944	Obama
FY 2015	70,000	69,993	Obama

*Trump Administration proposed a 15,000 refugee admission cap for FY 2021.

**Obama Administration proposed a 100,000 refugee admission cap for FY 2017.

- The U.S. president sets the number of refugees accepted into the United States in consultation with Congress before October 1 of each year¹⁷.
- The three primary U.S. federal government agencies involved in the refugee resettlement process are the Department of State (DOS), the Department of Homeland Security (DHS), and the Department of Health and Human Services (HHS)¹⁷.

2. Advocate for Increased Funding of Refugee Resettlement Services

- Refugee resettlement agencies provide services to assist refugees before, during, and after their arrival in the United States, including arranging for travel to the United States and providing housing, clothing, and food upon their arrival. Resettlement agencies also assist refugees with applying for a Social Security card, registering children in school, learning how to access shopping facilities, arranging medical appointments, and connecting them with social or language services.
- Refugee resettlement services are funded through the U.S. Department of State (DOS) and the U.S. Department of Health and Human Services (HHS)
 - **Migration and refugee assistance** ([DOS – Bureau of Population, Refugees, and Migration](#)): Provides funding for the protection and assistance of refugees, conflict victims, stateless persons, and vulnerable migrants worldwide.

- **Refugee programs** ([HHS - Office of Refugee Resettlement](#)): Provides eligible populations with critical benefits and services, including access to health and mental health services.

Recent Developments

In January 2023, the Biden Administration launched the [Welcome Corps](#), a new program that allows everyday Americans to directly sponsor refugees arriving through the [U.S. Refugee Admissions Program \(USRAP\)](#) to resettle in their communities. In July 2023, the Department of State introduced the **Welcome Corps on Campus**, a new targeted education sponsorship initiative that enables U.S. colleges and universities to play a leading role in resettling refugee students.

VII. Advocacy, Media, and Communications

A. Clinicians as Advocates

- In responding to migration crises, clinicians are often in a position to lend their voices and expertise to related advocacy efforts. When engaging in advocacy work, it is important to adhere to advocacy best practices. Given that a full guide to advocacy for clinicians is beyond the scope of this document, additional advocacy resources are provided pertaining to clinicians' roles as advocates, engaging in effective advocacy, and advocacy in working with populations impacted by migration crises. Advocacy best practices highlighted by these resources include:
 - **Assess readiness to engage** in advocacy and community partnerships, including resources available at the individual and/or organizational level, degree of cultural humility, knowledge gaps, and factors that may need to be addressed to effectively partner with the community impacted by a crisis.
 - **Work in collaboration with communities and prioritize community needs.** Meet with members and leaders of the communities impacted by a crisis to identify their concerns and goals. This helps ensure advocacy efforts are aligned with community needs and undertaken in a community-driven way.
 - **Identify the system(s) to be targeted.** Examples include institutional, state, or federal policy, as well as healthcare systems and individual and clinic-level interventions.
 - **Develop a strategic plan.** This may include identifying and recruiting allies, developing a clear mission statement for dissemination, meeting with stakeholders and lawmakers, and following the issue through the legislative process.
 - **Monitor efficacy by utilizing measurable outcomes.** Evaluate outcomes regularly and modify approaches being utilized if needed.
- Accurate terminology is especially important in advocacy work. We want to recognize that the term "migrant," which is not defined in international law, might not be the most inclusive term but is a common lay term. Therefore, the use of "migrant" in this document does not seek to disregard the legal status of those who are forcibly displaced as refugees or who seek political asylum. The term "migrant" is used here to refer to those who move away from their place of usual residence for a variety of reasons. Please refer to the migration terms section of this resource document for more information on terminology and its usage.

B. Media and Communications in Advocacy

- Communication with the media can be an important avenue for clinicians to discuss key points and challenges related to migration crises, provide recommendations for supporting individuals impacted by crises, and highlight resources available. Communication can take many forms, including interviews with journalists, opinion pieces in journals, letters to the editor, and social media posts.
- Journalists may directly reach out to clinicians to engage in interviews related to a crisis and to provide clinical expertise and interpretation. The [APA Psychiatrist's Guide to Media and Communications](#), which is available to APA members, provides a series of videos with guidance on communication with journalists and includes the following points:
 - **Being understood:** It is important to keep in mind that the points and ideas one is communicating from a clinical standpoint are often complex. Communicating points effectively requires setting the context of the conversation, understanding one's target audience, and having a sense of the level of expertise of the interviewer. Share that it is appropriate for them to request "check-backs" for you to provide clarification on any points, as the content can be complex.
 - **Utilizing teaching elements:** Effective media communication can be enhanced by incorporating the fundamentals of teaching. These include knowing the central points one wants to convey, the context of the communication – including the goals the journalist has for the interview, the terms one needs to define, anticipated barriers to understanding that may arise, and how the effective use of examples may improve understanding.
 - **Maintaining focus and addressing misquotation/misrepresentation/hostility:** Stay focused on the point at hand during an interview. Deviations from the intended topic should be made intentionally, and if it feels that a discussion is starting to veer off course, one may request to go off the record for a particular topic and then return to the record once returning to the topic of the interview. During and after an interview, the possibilities of misquotation, misrepresentation, misattribution of emphasis, and hostility by the interviewer are still possible; the likelihood of such is reduced by staying true to the focus and topic of the interview throughout the conversation.
 - **Balance:** When communicating with media, the intention of the interviewer may be to communicate a specific opinion or belief that may not always be aligned with the goals or opinions of the interviewee. Aim to incorporate balance into the statements made during an interview to reduce the risk of statements being used in an imbalanced fashion.
- During communication, one should avoid jargon whenever possible and utilize brief, clear statements that remain on target to the point one is aiming to communicate. If writing an opinion piece or letter to the editor, following key teaching principles, sticking to one or two key points, and utilizing effective examples can help ensure that the piece is understood as intended by the audience. Social media can be an effective venue via which to connect with journalists, lend your professional voice to support important issues, and disseminate information on resources available to community members.

Resources:

- [A Psychiatrist's Guide to Advocacy](#)
- [APA Resource Document on Advocating for Anti-Racist Mental Health Policies](#)

VIII. Migration Terms

Term: **Migrant**

- “Migrant” is not a defined term in international law. It traditionally refers to a person who moves across an international border in search of a better livelihood or to join family members already in the new country. This motivation stands in contrast to those who are forcibly displaced by threats or acts of violence.

Term: **Refugee**

- “Refugee” traditionally refers to any person who has fled their country of nationality due to a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.”¹ This broad definition of refugee is best captured by the term **“forcibly displaced person,”** since the term “refugee” has been given a more restricted legal definition. Refugees receive basic assistance and the same rights as any other foreigner who is a legal resident in the United States.
- According to U.S. immigration law, a refugee is someone who has been resettled in the United States through the U.S. resettlement program administered by the U.S. State Department. This program has been recently expanded, including new pathways for achieving refugee status.
- A non-citizen seeking refugee status must register, while still residing outside the United States, with the United Nations Refugee Agency. After passing an initial screening, applicants can be referred to one of seven U.S. State Department Resettlement Support Centers. After clearing security checks, the applicant can be cleared for entry into the U.S. This process generally takes 18 to 24 months to complete.
- Approval of an application for refugee status is based on whether the applicant:
 - Is of special humanitarian concern to the United States
 - Demonstrates that they have been persecuted or fears persecution due to race, religion, nationality, political opinion, or membership in a particular social group
 - Is not firmly resettled in another country
 - Is admissible to the United States
- Gender is not a protected social group under U.S. immigration law unless the local government can be shown to be unwilling or unable to protect from gender-related violence.

Resources:

- [Migrant and Refugee Frequently Asked Questions](#)
- [Forced Migration or Involuntary Displacement](#)
- [Refugee Resettlement Factsheet](#)
- [Council on Foreign Relations: Immigration and Migration](#)
- [U.S. Citizenship and Immigration Services: Guides for Refugees and Asylees](#)

Term: Asylum Seeker

- “Asylum” provides protection from deportation to a country where there exists a credible threat of persecution or violence. To apply for asylum, a person must be physically present in the United States and apply for asylum within one year of arrival. Establishing a physical presence has been the motivation for asylum seekers to cross the U.S.-Mexican or U.S.-Canadian border.
- There are two paths to seeking asylum:
 - **Affirmative asylum** can be sought proactively through U.S. Citizenship and Immigration Services.
 - **Defensive asylum** is sought by a person placed in removal proceedings but who seeks to block deportation. A person is in removal proceedings after being apprehended (taken into custody) within the United States or at a U.S. port of entry without proper legal documents or in violation of their immigration status. This includes those apprehended by U.S. Customs and Border Protection (CBP) trying to enter the United States without proper documentation, even if found by an asylum officer to have a credible fear of persecution or torture.
- In both the affirmative and defensive processes, asylum seekers have a right to a lawyer. However, unlike the criminal court system in the United States, the U.S. government does not provide lawyers for individuals in immigration court.
- Asylum law originated in the aftermath of the Holocaust to ensure that the United States would never again turn away people fleeing persecution; however, the refugee process and asylum process are different processes in U.S. immigration law.

Recent Developments

The asylum process has been the focus of political dispute during the Trump and Biden Administrations. In March 2020, U.S. President Trump issued under Title 42 an emergency health directive (to prevent the spread of COVID-19) that allowed U.S. officials at the U.S.-Mexican border to turn away asylum seekers without processing their claims. With the expiration of Title 42 on May 11, 2023, the Biden Administration implemented a complex program under the Title 8 section of U.S. immigration law that:

- Creates a new legal pathway for individuals from Columbia, El Salvador, Honduras, and Guatemala to reunite with family members in the United States.
- Allows 30,000 Haitians, Venezuelans, Nicaraguans, and Cubans per month who have U.S. sponsors to apply for humanitarian parole in the United States. Those who qualify will have U.S. work permits for two years.
- Issues \$50 to \$250 fines and 6-24 months in prison for each attempt to cross the U.S.-Mexican border without legal permission.
- Requires anyone who wants to apply for asylum to make an appointment through the CBP One phone app. The number of appointments available per day through the app is expanded to 1,000.
- Accepts asylum applications only from people who can show they applied for asylum in third countries en route to the United States and were rejected and that they tried to make appointments through CBP One.
- Increases the total number of asylum officers and immigration judges to reduce backlog.
- Opens processing centers in other countries where applications can be made for legal immigration to the United States.

Term: **Human Trafficking**

- Immigration relief is provided to eligible victims of human trafficking through:
 - **“T visa”** (T nonimmigrant status) protects victims of human trafficking. Victims can remain and work in the United States for up to four years and can apply for green cards.
 - **“U visa”** (U nonimmigrant status) protects victims of criminal activities that include domestic violence, sexual assault, hate crimes, human trafficking, involuntary servitude, and other serious offenses. Victims can remain and work in the United States for up to four years and can apply for green cards.
- Both T and U visas generally require the victim to assist or cooperate with law enforcement in the detection, investigation, or prosecution of human trafficking or qualifying criminal activity.

Term: **Torture Survivors**

- The 1985 World Medical Association defined torture in its Declaration of Tokyo: “The deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons, acting alone or on the orders of any authority, to force a person to yield information, make a confession, or for any other reason.”
- An estimated 44% of asylees and refugees in the United States have reported torture, currently totaling 1.3 million torture survivors.
- The 1998 Torture Victims Relief Act (TVRA) provides legal asylum, support for medical and psychiatric care, and other benefits administered by ORR in HHS. It also provides technical assistance to organizations providing direct services to victims of torture. However, an asylum seeker qualifies for these benefits only if torture was committed by persons acting under the color of law (police, military, or other governmental agents) with intent to inflict severe physical or mental pain or suffering. Rape or other sexual violence can meet TVRA eligibility criteria when committed under color of law, as by members of the police or military. However, other injuries from war violence or civil unrest do not meet TVRA criteria for torture.
- Torture survivors meeting TVRA criteria for torture occurring under color of law are eligible for legal asylum, which provides access to medical and psychiatric care and other social service benefits.

The [National Consortium of Torture Treatment Programs](#) (NCTTP) has 34 member programs that provide ORR-funded services for torture survivors and received the 2017 APA Human Rights Award.

Term: **Deferred Enforced Departure (DED)**

- DED is a program that is at the U.S. president’s discretion to authorize under his constitutional authority to conduct foreign relations.
- Individuals covered by DED are not subject to removal from the United States for a designated period of time.
- As of August 2023, only residents of Liberia and Hong Kong held DED status.

Term: **Temporary Protected Status (TPS)**

- TPS is a U.S. Department of Homeland Security program that allows citizens of designated countries to reside legally in the United States for a period of up to 18 months, which the U.S. government can renew indefinitely.
- TPS holders are eligible for employment and travel authorization and are protected from deportation.
- The program does not include a path to permanent residency or U.S. citizenship, but TPS recipients can apply for those designations separately.
- As of 2023, there were 355,000 TPS recipients from 16 countries afflicted by armed conflicts, environmental disasters, or other conditions that would render a country unsafe.

Term: **Unaccompanied Minors**

- Children and youth who cross the U.S. border without a parent or guardian meet the legal definition of an “unaccompanied minor” if the child:
 - has no lawful immigration status in the United States;
 - is less than 18 years of age; and
 - has no parent or legal guardian in the United States who is available to provide care and physical custody.
- When unaccompanied minors arrive at the U.S. border, they are transferred to the Unaccompanied Children (UC) Program, which is managed by the Office of Refugee Resettlement (ORR), which is administered by the U.S. Department of Health and Human Services (HHS). The ORR provides shelter and care for the unaccompanied minors while determining their most appropriate placement.
- Most unaccompanied minors are released to a parent or close relative. A small number are placed in long-term foster care under HHS custody. Unaccompanied minors with a sponsor or in long-term foster care have the same educational rights as other children while awaiting immigration proceedings.

Term: **Deferred Action for Childhood Arrival (DACA)**

- The DACA program was created to protect young adults brought to the United States as children from deportation.
- While the program also provides them work authorization for temporary, renewable periods, they remain ineligible for many federal programs, including health coverage through Medicaid, the Children’s Health Insurance Program, or the Affordable Care Act health insurance marketplaces.
- As of December 31, 2022, there were roughly 580,000 active DACA recipients from close to 200 different countries residing across the United States.

IX. Conclusion

- Sociopolitical changes, geopolitical unrest, and climate change-related extreme weather events have led to the migration of the human population.
- Refugees and asylum seekers have not only had to face forced displacement but also torture, interpersonal violence, and traumatic events during their escape from their home country.
- During the resettlement process, refugees and asylum seekers continue to face threats to their well-being due to poor social support, cultural and linguistic barriers, racism, discrimination, financial strain, and barriers to access to employment, housing, and healthcare. These traumatic experiences and daily stressors put refugees and asylum seekers at risk for mental illness, including depression, anxiety, suicide, PTSD, and substance abuse.
- Mental health professionals, including psychiatrists and trainees in psychiatry, should address the mental illness, provide culturally and linguistically appropriate care, and take necessary interventions to support the refugees and asylum seekers in their resettlement process.
- Psychological First Aid, Cultural Formulation Interview, and trauma-informed care during clinical encounters are essential non-pharmacological management strategies for refugees and asylum seekers.
- Considerations for local resources and support systems, migration policies, and advocacy efforts to address socioeconomic and healthcare disparities can further strengthen the well-being of refugees and asylum seekers during their journey to resettlement.

X. References

1. 1951 Refugee Convention. United Nations Office of the High Commissioner for Refugees. <https://www.unhcr.org/us/about-unhcr/who-we-are/1951-refugee-convention>
2. Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J.D., Kirkbride, J., Moussaoui, D., Nazroo, J., Qureshi, A., Stompe, T., Tribe, R. 2011. WPA guidance on mental health and mental health care in migrants. *World Psychiatry*. Feb;10(1):2-10. <https://doi.org/10.1002/j.2051-5545.2011.tb00002.x>
3. Black, J. 2021. Global Migration Indicators 2021. International Organization for Migration. Geneva. <https://publications.iom.int/books/global-migration-indicators-2021>
4. Chaplin, L., Ng, L., Katona, C. 2020. Refugee mental health research: challenges and policy implications. *British Journal of Psychiatry*. Vol. 6, Issue 5. Royal College of Psychiatrists. <https://doi.org/10.1192/bjo.2020.90>
5. COVID-19 and Mental Health Among People Who Are Forcibly Displaced: The Role of Socioeconomic Insecurity. 2022. *Psychiatric Services*. ps.psychiatryonline.org/doi/full/10.1176/appi.ps.202200052
6. Dangmann, C., Dybdahl, R., Solberg, Ø. 2022. Mental health in refugee children. In *Current Opinion in Psychology*. Vol. 48, p. 101460. Elsevier BV. <https://doi.org/10.1016/j.copsyc.2022.101460>
7. Derr, A.S. 2015. Mental Health Service Use Among Immigrants in the United States: A Systematic Review. *Psychiatric Services*. ps.psychiatryonline.org/doi/10.1176/appi.ps.201500004
8. Displacement, Trauma and Mental Health Among Migration Youth and Their Families. 2023. American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/diversity/education/immigration-toolkit>
9. Essentials of Migration Management 2.0 (EMM2.0) Handbook. 2021. International Organization for Migration. <https://emm.iom.int/handbooks>
10. Griffith, J.L., Keane, J. 2018. Where is the family in global mental health? Families, Systems, and Health. Vol. 36, Issue 2, pp. 144-147. American Psychological Association. <https://doi.org/10.1037/fsh0000361>
11. Griffith, J.L., Song, S.J. 2023. Family and couple therapy. *Tasman's Psychiatry*. Springer. doi.org/10.1007/978-3-030-42825-9_63-1
12. Hynie, M. 2018. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*. 63(5):297-303. journals.sagepub.com/doi/10.1177/0706743717746666
13. Immigrant, Refugee, Mental Health: Health Education and Communication Tools. Centers for Disease Control and Prevention. www.cdc.gov/immigrantrefugeehealth/resources/index.html
14. Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Professional Training Series No. 8/Rev. 2. 2022. United Nations Office of the High Commissioner for Human Rights. https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf
15. Jarvis, G.E., Kirmayer, L.J. 2023. Global migration: Moral, political and mental health challenges. *Transcultural Psychiatry*. Vol. 60, Issue 1, pp. 5-12. SAGE Publications. <https://doi.org/10.1177/13634615231162282>
16. Kamali, M., Edwards, J., Anderson, L.N., Duku, E., Georgiades, K. 2022. Social Disparities in Mental Health Service Use Among Children and Youth in Ontario: Evidence From a General, Population-

- Based Survey. The Canadian Journal of Psychiatry. Vol. 68, Issue 8, pp. 596-604. SAGE Publications. <https://doi.org/10.1177/07067437221144630>
17. Kobucista, C., McBride, J., Roy, D. 2023. How Does the U.S. Refugee System Work? Council on Foreign Relations. <https://www.cfr.org/background/how-does-us-refugee-system-work-trump-biden-afghanistan>
 18. Kronick, R., Jarvis, G.E., Kirmayer, L.J. 2021. Refugee mental health and human rights: A challenge for global mental health. Transcultural Psychiatry. Vol. 58, Issue 2, pp. 147-156. SAGE Publications. <https://doi.org/10.1177/13634615211002690>
 19. Mattar, S., Gellatly, R. 2022. Refugee mental health: Culturally relevant considerations. In Current Opinion in Psychology. Vol. 47, p. 101429. Elsevier BV. <https://doi.org/10.1016/j.copsyc.2022.101429>
 20. Mental health and psychosocial support for resettled refugees. 2021. International Organization for Migration. www.iom.int/resources/mental-health-and-psychosocial-support-resettled-refugees
 21. Mental Health Facts on Refugees, Asylum-Seekers, and Survivors of Forced Displacement. 2020. American Psychiatric Association. [https://www.psychiatry.org/File Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Refugees.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Refugees.pdf)
 22. Mental health of asylum seekers and refugees. The Royal College of Psychiatrists. www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health
 23. Mental health promotion and mental health care in refugees and migrants. World Health Organization. apps.who.int/iris/handle/10665/342277
 24. O'Brien, C.V., Charura, D. 2022. Refugees, asylum seekers, and practitioners' perspectives of embodied trauma: A comprehensive scoping review. Psychological Trauma: Theory, Research, Practice, and Policy. American Psychological Association. <https://doi.org/10.1037/tra0001342>
 25. Population-Based Survey. Canadian Journal of Psychiatry. Vol. 68, Issue 8, pp. 596-604. SAGE Publications. <https://doi.org/10.1177/07067437221144630>
 26. Position Statement on Immigration, Children, Adolescents, and Their Families. 2021. American Psychiatric Association. <https://www.psychiatry.org/getattachment/52f4041f-e375-4855-8065-7a406b2b2cc1/Position-Immigration-Children-Adolescents-and-their-Families.pdf>
 27. Position Statement on Mental Health Needs of Immigrants and People Affected by Forced Displacement. 2022. American Psychiatric Association. <https://www.psychiatry.org/getattachment/cff13d1c-a18a-470a-b890-1c0e49bf2d7f/Position-Mental-Health-Needs-of-Immigrants-Forced-Displacement.pdf>
 28. Position Statement on Sexual Abuse of Migrants in ICE Custody. 2020. American Psychiatric Association. <https://www.psychiatry.org/getattachment/7e36150b-d235-4815-a412-1d6069e62613/Position-Sexual-Abuse-ICE-Detention-Centers.pdf>
 29. Position Statement on Xenophobia, Immigration, and Mental Health. 2020. American Psychiatric Association. <https://www.psychiatry.org/getattachment/446455ae-046e-4f38-a3a6-7df2e4f439a8/Position-Xenophobia-Immigration-Mental-Health.pdf>
 30. Pumariega, A.J., Rothe, E., Mian, A., Carlisle, L., Toppelberg, C., Harris, T., Gogineni, R.R., Webb, S., Smith, J. 2013. Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 52, Issue 10, pp. 1101-1115. Elsevier BV. <https://doi.org/10.1016/j.jaac.2013.06.019>

31. Refugee and Migrant Mental Health. 2022. World Health Organization. www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health
32. Refugee Trauma. The National Child Traumatic Stress Network. www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma
33. Resource Document on Addressing the Migration Emergency and Human Rights of Haitians. 2022. American Psychiatric Association. <https://www.psychiatry.org/Psychiatrists/Search-Directories-Databases/Resource-Documents/2022/Addressing-the-Migration-Emergency-and-Human-Rights>
34. Resource Document on Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients. 2013. American Psychiatric Association. <https://www.psychiatry.org/Psychiatrists/Search-Directories-Databases/Resource-Documents/2013/Cultural-psychiatry-as-a-specific-field-of-study-r>
35. Resource Document on Mental Health and Climate Change. 2017. American Psychiatric Association. <https://www.psychiatry.org/Psychiatrists/Search-Directories-Databases/Resource-Documents/2017/Mental-Health-and-Climate-Change>
36. Resource Document on Xenophobia, Immigration, and Mental Health. 2010. American Psychiatric Association. <https://www.psychiatry.org/Psychiatrists/Search-Directories-Databases/Resource-Documents/2010/Xenophobia,-immigration-and-mental-health>
37. Rousseau, C., Frounfelker, R.L. 2019. Mental health needs and services for migrants: an overview for primary care providers. Journal of Travel Medicine. Volume 26, Issue 2. academic.oup.com/jtm/article/26/2/tay150/5251755
38. Saadi, A., Al-Rousan, T., Al Heresh, R. 2021. Refugee Mental Health—An Urgent Call for Research and Action. Journal of the American Medical Association. Vol. 4, Issue 3, p. e212543. <https://doi.org/10.1001/jamanetworkopen.2021.2543>
39. Salehi, B., Rolin, S.A., Dixon, L.B. 2022. Refugee Mental Health. Psychiatric Services. Vol. 73, Issue 10, pp. 1196-1196. American Psychiatric Association Publishing. <https://doi.org/10.1176/appi.ps.22073011>
40. The need for mental health and psychosocial support for migrants and refugees in Europe. 2016. Mental Health Europe. mhe-sme.org/wp-content/uploads/2019/01/Position-Paper-on-Mental-Health-and-Migration.pdf
41. The Role of Psychiatrists in the Growing Migrant and Refugee Crises. The American Journal of Psychiatry. July 1, 2017. <https://doi.org/10.1176/appi.ajp-rj.2017.120703>
42. Treating Immigrant and Refugee IPV Survivors. 2019. American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/diversity/education/intimate-partner-violence/immigrants-and-refugees>
43. Treating Undocumented Immigrants in a Changing Political and Social Environment. 2018. American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/diversity/education/stress-and-trauma/undocumented-immigrants>
44. Virupaksha, H.G., Kumar, A., Nirmala, B.P. 2014. Migration and mental health: An interface. Journal of Natural Science, Biology and Medicine. July 5(2):233-239. www.ncbi.nlm.nih.gov/pmc/articles/PMC4121889/
45. What immigrants and refugees need to know about the Affordable Care Act. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. www.samhsa.gov/sites/default/files/immigrants-refugees-affordable-care-act_0.pdf

46. Working with Refugee and Forced Displacement Patients. 2020. American Psychiatric Association. <https://www.psychiatry.org/Psychiatrists/Diversity/Education/Best-Practice-Highlights/Working-with-Refugee-and-Forced-Displacement-Patie>
47. World Migration Report 2022. International Organization for Migration. worldmigrationreport.iom.int/wmr-2022-interactive/

Appendix A. Guide for Responding to Migration Emergencies

Guide for Responding to Migration Emergencies			
<ul style="list-style-type: none"> Stay informed through reputable media outlets (e.g., newspapers, magazines, radio, television, websites) Track response and relief efforts by multilateral organizations (e.g., UNHCR provides regular updates for emergencies resulting in the large displacement of populations) Prioritize and support local area specialty organizations (e.g., local, national, regional organizations specializing in disaster response, trauma-informed care, psychiatry, and psychology, expatriate and diaspora community networks) 			
Fund Relief Efforts and Advocate	Prepare to Respond	Respond to the Emergency	After the Emergency
<ul style="list-style-type: none"> Contribute funds to reputable local, regional, national, and international relief organizations. Notify legislators about emergency and collect and share stories and first-hand accounts to stimulate a greater allocation of resources to support relief efforts. 	<p>Before emergencies:</p> <ul style="list-style-type: none"> Become trained and certified members of disaster mental health response teams for the International Federation of Red Cross and Red Crescent Societies (IFRC). Become trained on the evaluation of asylum seekers. (e.g., Physicians for Human Rights, APA Annual Meeting) 	<p>Facilitate credible information exchange:</p> <ul style="list-style-type: none"> Liaise with mental health experts and organizations in the area of the emergency to learn how to best support their efforts. <p>Utilize technical skills and expertise:</p> <ul style="list-style-type: none"> Utilize skills and expertise to provide virtual trainings and online resources for responders and relief workers near or at the emergency site. <p>Trained humanitarian responders:</p> <ul style="list-style-type: none"> Coordinate with humanitarian organizations to deliver medical services. (e.g., Médecins Sans Frontières, International Medical Corps, IFRC) 	<p>See section on “Mental Health Response Recommendations.”</p>