SSM - Mental Health 3 (2023) 100196

Contents lists available at ScienceDirect

SSM - Mental Health

journal homepage: www.journals.elsevier.com/ssm-mental-health

Rethinking mental healthcare for refugees

ARTICLE INFO

Handling Editor: Prof B Kohrt

Keywords
Multilevel
Forcibly displaced
Prevention
Treatment
Resettlement

ABSTRACT

After several years of downturn in new resettlement, the United States is projected to admit 125,000 refugees in the current fiscal year. Refugee communities have known risks of developing mental health problems due to high rates of exposure to war and conflict-related trauma and chronic stressors associated with displacement and resettlement. In this commentary, we examine limitations in the current system of mental health care available to newly arriving refugee communities and make recommendations for expanding and redesigning services to better meet the needs of culturally diverse refugee communities. This includes drawing on public health and prevention frameworks to implement a continuum of services including basic services and security, trauma-informed prevention services to meet the needs of individuals, families and communities and specialized clinical care for those that need it. Across all services, we recommend robust engagement and partnership with refugee community leaders to design and deliver programs.

The Biden Administration has taken steps to rebuild the role of the US in offering safety and protection to refugees and other forcibly displaced persons. This started with setting a target of 125,000 refugee arrivals through the Presidential Determination, up from 15,000. This was followed by granting humanitarian parole and other protections to over 95,000 Afghans and 120,000 Ukrainians in less than two years (Kessler, 2022; Montoya-Galvez, 2022). Most recently, special humanitarian parole programs have been announced for Cubans, Haitians, Nicaraguans and Venezuelans, which offers individuals and their families admission to the U.S for a period of temporary protection (U.S Citizenship and Immigration Services [USCIS], 2023). Following several years of a major downturn in resettlement due to the Trump administration's anti-refugee policies (Bolter et al., 2022), these are welcome steps which signal the U.S. government's renewal of our country's long-term commitment to those forced to flee their country and seek safety in the U.S. However, meeting the needs of refugees and similarly situated communities requires more than increasing the number of new admissions, and must also include changes that will better support the mental health and well-being of culturally diverse displaced populations. In this commentary, we briefly examine the mental health needs facing refugee communities, current challenges and limitations in the mental health system and outline recommendations for a multilevel system of stabilization, prevention, and treatment.

1. Background

Refugees and other forcibly displaced communities are at high risk for common mental health conditions and psychosocial problems due to violence and trauma experienced in the country of origin, during migration and compounded by displacement stressors. Several systematic reviews have identified high rates of depression, anxiety, and PTSD among refugee adults and children (Frounfelker et al., 2020; Nesterko et al., 2020). Growing evidence indicates that post-migration stressors such as English language proficiency, food and housing insecurity, unemployment and social exclusion highly influence mental health outcomes and accumulate with increased time of displacement (Hou et al., 2020). Forced migration also contributes to social losses due to family separation, change in family roles, and disruption in community connections (Bunn et al., in press; Wachter & Gulbas, 2018). These experiences often negatively impact relationships within families and can result in the breakdown of vital social networks (Sim et al., 2018; Weine, 2011). The above concerns have become even more pressing in the wake of the COVID-19 pandemic, which has been associated with increased adversity, stress, domestic violence, social isolation, and increased mental health symptoms (Júnior et al., 2020).

Despite the significant need, there are major gaps in the mental health service system available to refugee and forcibly displaced communities. Historically, the U.S. refugee resettlement program has emphasized self-sufficiency – learning English, getting to work, and becoming financially independent – and lacked formal initiatives to address the significant trauma and chronic stress that negatively impacts the mental health and future success of refugee individuals, children and families. Moreover, refugee communities face numerous barriers to accessing care (e.g., insurance, linguistic accessibility, transportation) and studies show that service use is low among refugee and forcibly displaced populations (Derr, 2016). While there are increasing efforts to screen and identify mental health conditions in refugees, meaningful referrals remain lacking because of these aforementioned issues and resource limitations in available services (Magwood et al., 2022; CDC, 2022). Furthermore, screening and referrals without attention to cultural understandings of symptoms or perceptions of mental health care are unlikely to lead to engagement in treatment, as many refugees are accustomed to seeking help through different channels such as family or religion (Ellis et al., 2010).

https://doi.org/10.1016/j.ssmmh.2023.100196
Received 16 November 2022; Received in revised form 10 February 2023; Accepted 11 February 2023
Available online 13 February 2023

Mental health programs that are available often focus on providing trauma-focused psychotherapy to individual refugees. Because these services are highly specialized, they often have waiting lists and often rely on providers who may not be familiar with the forced displacement context or how to work cross-culturally. Depending on the country of origin and culture, individual psychotherapy and psychiatric medication may also be highly stigmatized and inconsistent with one's worldview on healing (Schlechter et al., 2023). While access to specialized clinical care is essential, there is also a need to expand beyond this approach and emphasize community-based, community driven and psychosocial models that are responsive to the broader impacts of trauma and chronic adversity on refugee families and communities.

A number of new programs introduced by the Office of Refugee Resettlement take important steps in this direction and address long standing gaps in mental health services, with significant new funding available in areas of health promotion, mental health and family strengthening among others.[1–3] However, to maximize the potential of these new programs, and existing mental health best practices developed to date, there is a need to develop an overall vision and framework for mental health and psychosocial support for forcibly displaced populations in the United States.

2. A multilevel model of refugee mental health prevention and treatment

Drawing inspiration from models developed for other populations and settings (e.g., humanitarian settings, the recovery movement, harm reduction and substance use treatment, (Substance Abuse and Mental Health Service Administration [SAMHSA], 2022, Inter-Agency Standing Committee [IASC], 2007), mental health services for forcibly displaced populations in the U.S need to be based on a multilevel public health model and outline a spectrum of services from universal considerations to low intensity supports to treatment services for individuals with more severe mental health needs (see Table 1). These services are not intended to be sequential but offered concurrently, as needed, to address the real-world problems that refugees face and responsive to individual, family and community needs. Cutting across all levels of care are efforts to build the capacity of diverse practitioners and create neighborhoods and cities which are welcoming to refugees and conducive to recreating their life in a new culture and environment.

To promote stability, it is critical that we address the social determinants that negatively impact the mental health of refugee and forcibly displaced communities, and which accumulate with increased time in displacement (see level 1 in Table 1, Kemmak et al., 2021). Social determinants that contribute to mental health problems include access to safe neighborhoods, food and housing, quality healthcare, adequate income, language proficiency, social exclusion and discrimination (Hynie, 2018). Discrimination toward refugees stemming from anti-immigrant sentiment in the media and larger policy campaigns along with growing nationalism are large contributors to stress related to resettlement (Butler and Sheriff, 2021; Ellis et al., 2008; Jannesari et al., 2020).

Table 1
Multilevel model for Refugee mental health prevention and treatment.

Intervention	Purpose and Focus	Examples
Level 1: Safety and stabilization	Benefits and services designed to promote safety and ensure basic needs are met including employment, housing, access to healthcare & education. Integration of mental health education, trauma-informed care principles and mental health prevention strategies into basic services and benefits. Creating a welcoming city and community environment for newly arriving refugees.	• Multiple Office of Refugee Resettlement (ORR) programs including but not limited to Refugee Cash Assistance, Refugee Medical Assistance, Matching Grant, Refugee Support Services, and Preferred Communities (ORR, 2022). • Programs that promote social connections and adjustment through community and private sponsorship between US citizens and refugees (Welcome.US, 2023; Welcome Corps, 2023; Refugee Council USA, 2023).
Level 2: Community-based mental health prevention	Interventions and services delivered in accessible community settings that prevent escalation of symptoms and strengthen protective resources important for coping and adjustment. Community-based capacity building to empower communities through education and skill building. Coordination and collaboration with local non-profits and municipal governments.	• **Family-based mental health programs** to improve family processes and functioning (Bunn et al., 2022a). • **School based mental health programs** to improve socio-emotional functioning amongst youth (Bennouna et al., 2019). • **Refugee Mental Health Literacy and Leadership Training** to build capacity amongst community leaders to employ trauma-informed practices to address mental health concerns (Administration for Children and Families, 2018).
Level 3: Specialized mental health treatment	Specialized care for those with more serious mental health conditions or families with identified problems. Treatment that is specific to mental health disorders once presented and diagnosed.	• **Cognitive behavioral therapy** for treatment of PTSD amongst refugees (Hinton et al., 2012). • **Narrative exposure therapy** to treat the effects of trauma and anxiety (Wright et al., 2020)). • **Trauma Systems Therapy for Refugees** to address core stressors in the social environment and trauma-related emotional dysregulation (Ellis et al., 2012) • **Core clinical competencies** needed to deliver culturally responsive and effective therapeutic care (Joyce et al., 2012; Bunn et al., 2022c; SAMHSA, 2014). • **Psychiatric medications** to treat PTSD, depression, anxiety or other conditions (Sonne et al., 2017).

There are numerous initiatives through the Office of Refugee Resettlement that are designed to address social determinants including cash assistance benefits, English language programs, case management, employment support and investments in microfinance and small businesses among others (ORR, 2022). Currently, refugees receive either short term medical coverage through Refugee Medical Assistance or have access to Medicaid in states where they are eligible. These programs should be adequately funded, and medical coverage expanded to ensure newly arriving refugees have the safety and stability needed to focus on integration and recovery.

[1] Newly introduced ORR programs include Operation Allies Welcome - a federal initiative to coordinate support for the resettlement of Afghan refugees. More information can be found here: https://www.dhs.gov/allieswelcome.

[2] The Department of Health and Human Services launched Welcome Corps - a private sponsorship program for US citizens to support incoming refugees through raising funds, connecting to essential resources, and assisting with logistics such as housing and employment. More information found here: https://www.state.gov/launch-of-the-welcome-corps-private-sponsorship-of-refugees-2.

[3] The Refugee Mental Health Initiative within the Refugee Health Promotion program allocated funding through states to build capacity to address the mental health needs of refugee populations. https://www.acf.hhs.gov/sites/default/files/documents/orr/orr-pl-22-06-refugee-mental-health-initiative-within-the-refugee-health-promotion-program-2021-12-08.pdf.

These services can also be bolstered through capacity building efforts to ensure all resettlement workers receive training and support on how to deliver trauma-informed services and respond to mental health needs and by integrating trauma-informed care and mental health education and prevention strategies. Newly arriving communities will benefit, for example, from public information campaigns which normalize the need for mental health and aim to reduce stigma associated with assessing care. A core set of mental health and psychosocial support skills such as psychoeducation, coping skills and self-management strategies for emotional distress in adults and children could be integrated into delivery of practical services to better support health and wellbeing during the resettlement and adjustment process. Refugees' sense of safety and stability in their new home environment is also greatly shaped by the milieu where they live. Thus, part of level 1 efforts must also concentrate on preparing receiving communities and cultivating welcoming neighborhoods and city environments for newly arriving refugee individuals and families (Coffman, 2022). Organizations like Welcoming America lead initiatives and a global network of nonprofit organizations and governments striving for more inclusive and welcoming communities (Welcoming America, 2022). New community and private sponsorship models enable Americans to provide direct support and assistance in the resettlement and adjustment process (Welcome Corps, 2023; Welcome.US, 2023). While long-term evaluation is needed, this program has the potential to build greater awareness for Americans about the experiences and needs of forcibly displaced populations and foster a sense of welcome, inclusion and belonging for refugees.

In addition to services designed to promote safety and stability, community-based mental health prevention models are needed that are responsive to the broader impacts of trauma and chronic adversity on individuals, families and communities (see level 2, Table 1). These models can mitigate the development of mental health problems for populations with known risks and strengthen resources needed for coping and adjustment such as family and community relationships and access to formal and informal social support (Fazel and Betancourt, 2018; Wachter et al., 2022). Several promising universal, selective and indicated prevention models have been developed and tested for families, groups, school and community settings and can be delivered at diverse points across the resettlement and integration process (Bennouna et al., 2019; Bunn et al., 2022a; Bunn & Betancourt, 2022; Sullivan & Simonson, 2016; Tyrer & Fazel, 2014). This will require situating these and other evidence-based (e.g., interventions with consistent research findings showing improved outcomes) and evidence-informed (e.g., interventions informed by research outcomes, provider experience, recipient preferences, and situational circumstances) mental services in community and neighborhood settings such as home-based care, mutual aid organizations, schools, religious institutions and libraries. These settings are accessible and acceptable to newly arriving families and communities but infrequently included in training and dissemination of evidence-based services. Community-based care also requires more robust engagement with refugee community members with shared life experiences and similar cultural and linguistic backgrounds who can serve as vital partners, providers and leaders in planning, designing and delivering mental health services. For example, the International Rescue Committee is currently delivering Skills for Psychological Recovery (SPR), an evidence-informed mental health prevention program developed by the National Child Traumatic Stress Network and the National Center for PTSD to newly arrived Afghan community members in eight locations across the U.S. (Brymer et al., 2008; IRC, 2022). This program utilizes trained Afghan peer supporters who have been able to shape the SPR approach to be culturally responsive and linguistically accessible. This collaborative approach can be replicated with other, similar models and expanded moving forward.

Community level services should also involve training and capacity building with local nonprofits and municipal governments and with federally qualified health centers, community mental health centers and safety net hospitals so that mainstream providers have the knowledge, skills and attitudes to more effectively work with refugees who may need specialized care (Im et al., 2021). Efforts to conduct brief mental health screenings with adults and children should be integrated into these settings to provide opportunities for psychoeducation and to promote detection and early treatment. However, screenings are only useful as part of a coherent system of care where referral to services are available, linguistically accessible, and culturally responsive.

Even with robust community-based prevention, there will still be individuals and families who will need and benefit from specialized psychotherapeutic interventions and pharmacotherapy to alleviate symptoms of posttraumatic stress disorder, depression, anxiety, complicated grief and severe mental illness. There is an emerging evidence base on the effectiveness of dyadic trauma-focused interventions on symptoms of PTSD and depression (Chipalo, 2021, Hinton et al., 2012; Lambert and Alhassoon, 2015) and experimental research has demonstrated positive impacts of exposure-based interventions on prolonged grief disorder in refugee populations (Djelantik et al., 2020). Group-based therapy models can also be an effective, practical and cost-effective way to treat mental health conditions in settings where specialized resources are constrained. In addition to alleviating symptoms, groups are uniquely suited to addressing the social and interpersonal consequences of trauma and forced displacement (Bunn et al., 2016). Groups can result in the development of new relationships, reduce social isolation, and enable a sense of hope and social connection (Akinsulure-Smith and Smith, 2019; Bunn et al., 2022b; Drožđek and Bolwerk, 2010; Kira et al., 2010). There is also some evidence supporting the use of anti-depressents and some other sychiatric medications in treating PTSD and other common mental disorders in refugees (Sonne et al., 2017). Investments are needed to further evaluate these models and ensure adults and children have access to services.

For families where there are members with significant mental health conditions or histories of family trauma, abuse, interpersonal violence, long-term family separation and loss, family therapy models are beneficial to restore safety and reestablish meaningful and connected family relationships (De Haene et al., 2010). Much important work has been done in this area including models which have integrated the use of cultural brokers as part of an overall engagement and treatment approach. There is also room for further development of these treatment models, adapting existing approaches for use with culturally diverse families and the family systems issues common to refugees (De Haene et al., 2018; Utržan and Northwood, 2017). Mental health practitioners, in turn, need training and support to implement evidence-based models, and develop core clinical competencies for culturally responsive and effective care. Additional investments will also need to be made to ensure that these systems have access to reliable, quality interpretation support.

3. Conclusion

At this opportune moment for refugee resettlement in the U.S., it is imperative to not just restart but also rethink and redesign our country's approach to mental health service delivery. Many of the necessary components, such as health promotion programs and working with schools and community-based organizations, are already in place, but they lack sufficient resources, coordination, and integration into an overall vision and strategy for mental health prevention and treatment. In this piece, we have put forth a multilevel model that includes basic services, community-based prevention and specialized treatment services. To fully elaborate this model, however, we need the participation of diverse stakeholders engaged in work with refugee other forcibly displaced communities (e.g., clinicians, those with lived experiences, refugee service providers, researchers, policymakers, etc) to identify the range of mental health and psychosocial needs, best practice models and approaches, workforce requirements, target outcomes and strategies for effectively implementing services into community based and clinical settings. Then, we will not just admit new children and families into the U.S, but position our programs to better facilitate the health, wellbeing

and successful adjustment of newcomer communities.

Funding

Funding for this project is provided by the National Institute of Mental Health, grant number K01MH128524-01A1.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Administration for Children and Families. (2018). *Mental Health Capacity Building through Collaboration and Training for Refugee Community Leaders and Refugee-Serving Staff in the United States*. Health, Hope, and Wholeness 2018 Pennsylvania Refugee Health Consultation. https://www.dhs.pa.gov/refugeesinpa/Documents/Mental%20Health%20Capacity%20Building%20through%20Collaboration.pdf.

Akinsulure-Smith, A., & Smith, H. (2019). Re-creating family and community networks: group interventions with forced migrants. In M. Berthold, & K. Libal (Eds.), *Refugees and Asylum Seekers: Interdisciplinary and Comparative Perspectives* (pp. 182–201). ABC-CLIO.

Bennouna, C., Khauli, N., Basir, M., Allaf, C., Wessells, M., & Stark, L. (2019). School-based programs for supporting the mental health and psychosocial wellbeing of adolescent forced migrants in high-income countries: A scoping review. *Soc. Sci. Med., 239*, Article 112558. https://doi.org/10.1016/j.socscimed.2019.112558 (1982).

Bolter, J., Israel, E., & Pierce, S. (2022). *Four years of profound change: Immigration Policy during the Trump Administration*. Migration Policy Institute. https://www.migrationpolicy.org/research/four-years-change-immigration-trump.

Brymer, M. J., Steinberg, A. M., Sornborger, J., Layne, C. M., & Pynoos, R. S. (2008). Acute interventions for refugee children and families. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 625–640.

Bunn, M., & Betancourt, T. (2022). Strengthening mental health support services for refugee children resettled in the U.S. *Child Evidence Briefs, 16*.

Bunn, M., Goesel, C., Kinet, M., & Ray, F. (2016). Group treatment for survivors of torture and severe violence: A literature review. *Torture, 26*(1), 45–67. https://doi.org/10.7146/torture.v26i1.108062

Bunn, M., Zolman, N., Polutnik, C., Khanna, D., Betancourt, T., & Weine, S. (2022a). Family-based mental health interventions for refugees across themigration continuum: A systematic review. *SSM-Ment. Health, 2*, 100153. https://doi.org/10.1016/j.ssmmh.2022.100153

Bunn, M., Marsh, J., & Haidar, A. (2022b). Sharing stories eases pain: Core relational processes of a group intervention with Syrian refugees in Jordan. *J. Spec. Group Work, 47*(2), 110–132. https://doi.org/10.1080/01933922.2021.2000084

Bunn, M., Murakami, N., & Haidar, A. (2022c). Culture, trauma and loss: Integrative social work practice with refugees and asylum seekersN. Murakami, & M. Akilova (Eds.). . In *Clinical Social Work Practice with Displaced Persons (Chapter 12)*. Springer.

Bunn, M, Samuels, G., & Higson-Smith, C.. Ambiguous loss of home: Syrian refugees and the process of losing and remaking home. Wellbeing, Space and Society. (in press).

Butler, S., & Sheriff, N. (2021). *The Challenges of Addressing the Health Care Needs of Afghan Evacuees*. Brookings Institute. https://www.brookings.edu/blog/up-front/2021/10/14/the-challenge-of-addressing-the-healthcare-needs-of-afghan-evacuees/.

Centers for Disease Control and Prevention. (2022). *Guidance For Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees*. Centers for Disease Control and Prevention. https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html.

Chipalo, E. (2021). Is trauma focused-cognitive behavioral therapy (TF-CBT) effective in reducing trauma symptoms among traumatized refugee children? A systematic review. *J. Child Adolesc. Trauma, 14*(4), 545–558.

Coffman, M. (2022). In *Aurora, Colorado We Welcome Immigrants*. The Hill: Changing America. This is why your city should, too https://thehill.com/changing-america/opinion/521918-in-aurora-colorado-we-welcome-immigrants-this-is-why-your-city/.

De Haene, L., Grietens, H., & Verschueren, K. (2010). Adult attachment in the context of refugee traumatisation: The impact of organized violence and forced separation on parental states of mind regarding attachment. *Am. J. Bioeth., 12*(3), 249–264. https://doi.org/10.1080/14616731003759732

De Haene, L., Rousseau, C., Kevers, R., Deruddere, N., & Rober, P. (2018). Stories of trauma in family therapy with refugees: Supporting safe relational spaces of narration and silence. *Clin. Child Psychol. Psychiatr., 23*(2), 258–278.

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatr. Serv., 67*(3), 265–274. https://doi.org/10.1176/appi.ps.201500004

Djelantik, A. A. A. M. J., de Heus, A., Kuiper, D., Kleber, R. J., Boelen, P. A., & Smid, G. E. (2020). Post-migration stressors and their association with symptom reduction and non-completion during treatment for traumatic grief in refugees. *Front. Psychiatr., 11*(407). https://doi.org/10.3389/fpsyt.2020.00407

Drožđek, B., & Bolwerk, N. (2010). Group therapy with traumatized asylum seekers and refugees: For whom it works and for whom it does not. *Traumatology, 16*(4), 160–167. https://doi.org/10.1177/1534765610388299

Ellis, B., Lincoln, A., Charney, M., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Transcult. Psychiatr., 47*(5), 789–811.

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *J. Consult. Clin. Psychol., 76*(2), 184.

Fazel, M., & Betancourt, T. S. (2018). Preventive mental health interventions for refugee children and adolescents in high-income settings. *Lancet Child Adolescent Health, 2*(2), 121–132. https://doi.org/10.1016/S2352-4642(17)30147-5

Frounfelker, R. L., Miconi, D., Farrar, J., Brooks, M. A., Rousseau, C., & Betancourt, T. S. (2020). Mental health of refugee children and youth: Epidemiology, interventions, and future directions. *Annu. Rev. Publ. Health, 41*, 159–176. https://doi.org/10.1146/annurey-pubhealth-040119-094230

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcult. Psychiatr., 49*(2), 340–365. https://doi.org/10.1177/1363461512441595

Hou, W. K., Liu, H., Liang, L., Ho, J., Kim, H., Seong, E., … Hall, B. J. (2020). Everyday life experiences and mental health among conflict-affected forced migrants: A meta-analysis. *J. Affect. Disord., 264*, 50–68. https://doi.org/10.1016/j.jad.2019.11.165

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *Can. J. Psychiatr., 63*(5), 297–303.

Im, H., Rodriguez, C., & Grumbine, J. M. (2021). A multitier model of refugee mental health and psychosocial support in resettlement: Toward trauma-informed and culture-informed systems of care. *Psychol. Serv., 18*(3), 345.

Inter-Agency Standing Committee. (2007). Mental health and psychosocial support in emergency settings. In *IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings*. https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Guidelines%20on%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings%20%28English%29.pdf.

International Rescue Committee. (2022). *Salamati Roti: Helping Afghans build physical, mental and spiritual resilience*. International Rescue Committee. https://www.rescue.org/announcement/salamati-rohi-helping-afghans-build-physical-mental-and-spiritual-resilience.

Jannesari, S., Hatch, S., Prina, M., & Oram, S. (2020). Post-migration social–environmental factors associated with mental health problems among asylum seekers: A systematic review. *J. Immigr. Minority Health, 22*, 1055–1064.

Joyce, M., Bunn, M., & Engstrom, D (2012). Clinical practice with survivors of tortureE Congress, & M Gonzalez (Eds.). . In *Multicultural perspectives in social work practicewith families* (pp. 277–295). New York, NY: Springer Publishing Company.

Júnior, J. G., de Sales, J. P., Moreira, M. M., Pinheiro, W. R., Lima, C. K. T., & Neto, M. L. R. (2020). A crisis within the crisis: The mental health situation of refugees in the world during the 2019 coronavirus (2019-nCoV) outbreak. *Psychiatr. Res.*, Article 113000

Kemmak, A. R, Nargesi, S., & Saniee, N. (2021). Social determinant of mental health in immigrants and refugees: A systematic review. *Med. J. Islam. Repub. Iran, 35*, 196. https://doi.org/10.47176/mjiri.35.196

Kessler, G. (2022). *Numbers behind Afghanistan evacuation come into focus*. The Fact Checker https://www.washingtonpost.com/politics/2022/05/25/numbers-behind-afghan-evacuation-come-into-focus/.

Kira, I. A., Ahmed, A., Mahmoud, V., & Wasim, F. (2010). Group therapy model for refugee and torture survivors. *Torture, 20*(2), 108–113.

Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *J. Counsel. Psychol., 62*(1), 28. https://doi.org/10.1037/cou0000048

Magwood, O., Kassam, A., Mavedatnia, D., Mendonca, O., Saad, A., Hasan, H., … Pottie, K. (2022). Mental health screening approaches for resettling refugees and asylum seekers: A scoping review. *Int. J. Environ. Res. Publ. Health, 19*, Article 3549. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8953108/.

Montoya-Galvez, C. (2022). *U.S. admits 100,000 Ukranians in 5 months, Fulfilling Biden pledge*. CBS news. https://www.cbsnews.com/news/us-admits-100000-ukrainians-in-5-months-fulfilling-biden-pledge/.

Nesterko, Y., Jäckle, D., Friedrich, M., Holzapfel, L., & Glaesmer, H. (2020). Prevalence of post-traumatic stress disorder, depression and somatisation in recently arrived refugees in Germany: An epidemiological study. *Epidemiol. Psychiatr. Sci., 29*.

Office of Refugee Resettlement. Employer Engagement. (2023). *Office of Refugee Resettlement: An office for the administration of children and families*. https://www.acf.hhs.gov/orr/programs/refugees/employer-engagement.

Refugee Council USA. (2023). https://rcusa.org/.

Schlechter, P., Wagner, U., Morina, N., & Hellmann, J. H. (2023). Psychotherapy motivation in refugees: The role of alexithymia, stigmatization, self-esteem, and psychotherapy expectations. *Psychol. Trauma: Theory Res. Pract. Pol., 15*(2), 227–236. https://doi.org/10.1037/tra0001167

Sim, A., Bowes, L., & Gardner, F. (2018). Modeling the effects of war exposure and daily stressors on maternal mental health, parenting, and child psychosocial adjustment: A cross-sectional study with Syrian refugees in Lebanon. *Global Mental Health, 5*, Article e40. https://doi.org/10.1017/gmh.2018.33

Substance Abuse and Mental Health Services Administration. (2022). *Harm reduction. Substance abuse and mental health services administration*. https://www.samhsa.gov/find-help/harm-reduction.

Sonne, C., Carlsson, J., Bech, P., & Mortensen, E. L. (2017). Pharmacological treatment of refugees with trauma-related disorders: What do we know today? *Transcult. Psychiatr., 54*(2), 260–280. Chicago.

Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. Substance Abuse and Mental

Health Services Administration. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf.
Sullivan, A. L., & Simonson, G. R. (2016). A systematic review of school-based social-emotional interventions for refugee and war-traumatized youth. *Rev. Educ. Res., 86*(2), 503–530. https://doi.org/10.3102/0034654315609419
Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum-seeking children: a systematic review. *PLoS One, 9*(2), Article e89359. https://doi.org/10.1371/journal.pone.0089359
US Citizenship and Immigration Services. (2023). *Processes for Cubans, Haitians, Nicaraguans, and Venezuelans*. US Citizenship and Immigration Services. https://www.uscis.gov/CHNV.
Utržan, D. S., & Northwood, A. K. (2017). Broken promises and lost dreams: Navigating asylum in the United States. *J. Marital Fam. Ther., 43*(1), 3–15.
Wachter, K, Bunn, M, Schuster, RC, Boateng, GO, Cameli, K, & Johnson-Agbakwu, CE (2022). A scoping review of social support research among refugees in resettlement: implications for conceptual and empirical research. *J. Refug. Stud., 35*(1), 368–395. https://doi.org/10.1093/jrs/feab040
Wachter, K., & Gulbas, L. E. (2018). Social support under siege: An analysis of forced migration among women from the Democratic Republic of Congo. *Soc. Sci. Med., 208*, 107–116.
Weine, S. M. (2011). Developing preventive mental health interventions for refugee families in resettlement. *Fam. Process, 50*(3), 410–430. https://doi.org/10.1111/j.1545-5300.2011.01366.x
Welcoming America. (2022). *Initiatives. Welcoming America*. https://welcomingamerica.org/initiatives/.
Welcome.US. (2023). https://welcome.us/.
Welcome Corps. (2023). https://welcomecorps.org/.
Wright, A., Reisig, A., & Cullen, B. (2020). Efficacy and cultural adaptations of narrative exposure therapy for trauma-related outcomes in refugees/asylum-seekers: a systematic review and meta-analysis. *J. Behav. Cognit. Ther., 30*(4), 301–314.

Mary Bunn*
University of Illinois Chicago, Department of Psychiatry, United States

Deepika Khanna
University of Illinois Chicago, College of Medicine, United States

Elizabeth Farmer
International Rescue Committee, United States

Eleanor Esbrook
University of Illinois Chicago, College of Medicine, United States

Heidi Ellis
Boston Children's Hospital and Harvard Medical School, United States

Anne Richard
Freedom House, United States

Stevan Weine
University of Illinois Chicago, Department of Psychiatry, United States

* Corresponding author. Department of Psychiatry, University of Illinois at Chicago, 1601 W. Taylor Street, Chicago, IL, 60612, United States.
E-mail address: mbunn@uic.edu (M. Bunn).