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REFUGEE  
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# Policy Guide: Improving Access to Mental Healthcare for Refugees and Other Displaced People in the United States





*Featured Image: A family who arrived as refugees from Liberia are seen at their new home in Delaware during a meeting with a social worker. All refugee families should have access to culturally competent behavioral health care as they work to rebuild their lives in their new communities. Photo by UNHCR/Ashley Le.*

# Table of Contents

<a href="#"><u>Executive Summary</u></a>	4
<a href="#"><u>From Policy to Action - Using this Guide</u></a>	7
<a href="#"><u>A. Models of Mental Health Services for Refugees</u></a>	9
<a href="#"><u>B. Overview: The Mental Health Infrastructure for Refugees and Other Displaced People</u></a>	10
<a href="#"><u>I. ORR-funded Mental Health Resources and Services</u></a>	10
<a href="#"><u>a. The Refugee Mental Health Initiative (ReMHI)</u></a>	11
<a href="#"><u>b. ORR Survivors of Torture Program</u></a>	12
<a href="#"><u>II. Other Federal and State Funded Programs</u></a>	13
<a href="#"><u>a. Medicaid and CHIP</u></a>	13
<a href="#"><u>b. SAMHSA</u></a>	14
<a href="#"><u>C. State-Level Policies and Practices Advancing Mental Health Access for Refugees</u></a>	16
<a href="#"><u>I. Statewide Mental Health Policies for Refugees</u></a>	16
<a href="#"><u>II. Behavioral Health Equity Policies</u></a>	18
<a href="#"><u>III. Mental Health Studies, Task Forces, and Working Groups</u></a>	20
<a href="#"><u>IV. Language Access and Services</u></a>	21
<a href="#"><u>V. Mental Health Workforce Development and Licensure Barriers</u></a>	22
<a href="#"><u>VI. State-Funded Health Insurance for Displaced Trauma Survivors</u></a>	25
<a href="#"><u>VII. Community Healthcare Workers/Navigators</u></a>	25
<a href="#"><u>D. Conclusion</u></a>	26
<a href="#"><u>Acknowledgements</u></a>	27

## Executive Summary

While refugees and other forcibly displaced people experience mental health conditions at the same or greater rates than the general population in the United States,<sup>1</sup> they face significantly more barriers to accessing mental health services.<sup>2</sup> By definition, refugees are people who must flee their homes due to war, violence, or persecution – traumatic events which can have a lasting impact on mental health. This is further compounded by the long years often spent in poor living conditions in refugee camps or under-served urban areas in displacement. For those who are resettled, life in a new country can present its own mental health challenges, with some research suggesting that post-migration stressors can be more damaging than pre-migration trauma.<sup>3</sup> Yet, once refugees arrive in the United States, cultural, language, cost, and other systemic barriers can stand in the way of treatment and support.<sup>4</sup>

In a recent [report](#) surveying forcibly displaced people in the United States, access to mental healthcare ranked in the top five issues highlighted as being a key determinant of successful integration. Although access to mental health services has improved over the past few decades thanks to federal reforms,<sup>5</sup> inequities remain for underserved communities, including refugees and immigrants. The COVID-19 pandemic brought many of these disparities to the forefront, leading federal, state, and local officials to increasingly recognize the need for greater investments in mental health related services and resources.

The U.S. refugee resettlement program currently lacks a consistent and cohesive mental health strategy to address existing gaps in the provision of mental health services for refugees and other forcibly displaced people. It is primarily left to states and individual resettlement agencies to coordinate mental health screenings and resource support, if they choose to at all. Even in states that have implemented screening and referral processes, a shortage of culturally competent mental healthcare professionals, funding, and other resources often prevents meaningful access to care.

This policy guide provides an overview of the existing mental healthcare infrastructure currently available to refugees and other displaced people and highlights poten-

1 Rebecca Blackmore et al., “The Prevalence of Mental Illness in Refugees and Asylum Seekers: A Systematic Review and Meta-analysis,” *PLoS medicine*, (September 21, 2021), <https://doi.org/10.1371/journal.pmed.1003337>.

2 A.S. Derr, “Mental Health Service Use Among Immigrants in the United States: A Systematic Review,” *Psychiatric Services*, no. 67 (3) (2016): 265-274, <https://doi.org/10.1176/appi.ps.201500004>.

3 Susan S. Y. Li, Belinda J. Liddell, & Angela Nickerson, “The relationship between post-migration stress and psychological disorders in refugees and asylum seekers,” *Current Psychiatry Reports*, 18(82), (July 2016): <http://dx.doi.org/10.1007/s11920-016-0723-0>.

4 A.S. Derr, “Mental Health Service Use Among Immigrants in the United States: A Systematic Review.”

5 For example, passage of the Mental Health Parity Act of 1996 and the Affordable Care Act.

tial opportunities to advance policies at the local, state, and federal levels to improve access to care. While it is challenging to comprehensively capture every policy option, the intent of this guide is to serve as a primer for refugee advocates seeking to familiarize themselves with the refugee mental health landscape and explore opportunities for advocacy.

Based on our research, some potential opportunities for policy advocacy include:

### Calling on the federal government to:

- **Lead and implement a nationwide, cross-sectoral strategy to incorporate comprehensive, trauma-informed, and culturally and linguistically responsive mental health service provision** – by qualified providers – within resettlement programs and beyond to address gaps for refugees and other displaced people navigating mainstream behavioral health systems. This should also include long-term and consistent investments of funding by Congress, and in turn, relevant federal agencies (especially the Office of Refugee Resettlement).
- **Identify refugees and other displaced people as priority populations** in Substance Abuse and Mental Health Services Administration (SAMHSA) and other federally funded programs addressing mental health disparities for underserved populations.
- **Ensure that as many refugees and other displaced people as possible are eligible for federal health-related benefits and services** notwithstanding their immigration status.
- **Invest in workforce development programs** to improve the cultural and linguistic diversity of the mental health workforce and work with states to reduce licensing barriers for foreign-trained practitioners.

### Calling on state and local governments to:

- **Develop a statewide (or county/citywide) cross-sectoral refugee mental health strategy** that is comprehensive, trauma-informed, and culturally and linguistically responsive to address gaps and needs within the system of care. This includes facilitating collaboration between state behavioral health authorities, Offices for New Americans, state refugee coordinators, community organizations, refugee leaders, service providers, and practitioners to improve coordination and address gaps in needs. This should also include consistent and integrated funding structures, as opposed to periodic grants.
- **Identify refugees and other displaced populations for targeted programming** meant to address disparities in mental health outcomes for underserved popula-

tions. Many states identify specific populations for targeted services. Refugees and displaced people have unique needs that call for a similar approach.

- **Address shortages of culturally and linguistically competent practitioners** by investing in training, reducing licensing barriers for foreign-trained practitioners, and relaxing restrictions on interstate/virtual practice.
- **Ensure that refugees and forcibly displaced people have access to trauma-informed mental health screenings and referral processes** that are incorporated into resettlement programs and mainstream behavioral health services throughout the state, including in underserved geographical areas.
- **Ensure access to care extends beyond the initial resettlement phase** (i.e. beyond the first year post-resettlement).
- **Utilize Medicaid dollars and other federal funding to roll out innovative mental wellness programs**, such as funding community health navigators or wellness groups, to help address barriers to mental health access.
- **Invest in high quality interpretation and improved language accessibility**, including developing clearer guidelines on what constitutes “culturally and linguistically responsive” services.
- **Improve representation from refugee and immigrant populations** on state/regional/local mental health planning councils, task forces, and other government-convened entities.

## From Policy to Action - Using this Guide

This guide is designed for refugee advocates seeking to learn more about the refugee mental health policy landscape and potential opportunities for advocacy they can pursue within their own states or local communities. In determining what policies to pursue, the below checklist can assist in thinking about the relevant advocacy considerations:

### *Stage 1: Informing Your Advocacy*

- Find out what advocacy networks may already exist that are focused on mental health, including any groups focused specifically on healthcare for refugees or other underserved communities, and assess whether it makes sense to join existing efforts.
  - If no such networks are available, seek out other relevant potential partners such as Mental Health America affiliates or the National Alliance on Mental Illness to elevate the needs of refugee/displaced populations.
- Assess whether there is adequate representation of the needs of refugees and other displaced communities within existing state entities, such as Behavioral/Mental Health Planning Councils or other government-convened bodies.
- Convene meetings with interested stakeholders, such as refugee leaders, community-based organizations, resettlement agencies, schools, behavioral health practitioners, and ethnic-based organizations to discuss gaps and needs in mental health services.
- With input from all relevant stakeholders, identify your policy advocacy priorities. When assessing priorities, consider your political context and the feasibility of achieving these priorities.
  - Determine your end goal: Would these policies be best achieved through local, state, or federal legislation, administrative action, or through the budget process? Would this issue be best addressed through mutual aid or by building other community networks?

### *Stage 2: Organizing and Mobilizing*

- Build your movement: Organize in collaboration with local refugee leaders and other impacted community members. It is also important to engage behavioral health practitioners and providers who work with refugee and immigrant populations as both subject-matter experts and allies.
  - Consider your targets (the general public, the media, your local elected leaders,

government agencies, etc.).

- Representation matters. Advocate for refugee and immigrant representation on local, regional, or state-level behavioral health councils or other bodies to ensure existing programming addresses the needs of this population. If representation is not possible, seek out other avenues (e.g. providing outreach/educational opportunities) to elevate the needs of refugee/displaced populations within the work of such bodies.
- Determine your advocacy strategy and methods with your local/state political context in mind. In states where behavioral health for refugee and immigrant populations is not a priority, it might make sense to start with achievable policy goals, such as requiring a study assessing mental health system gaps or requiring representation/prioritization of refugee mental health in existing programs.

### ***Stage 3: Share Successes and Challenges***

If you are pursuing inclusive policies in your state, please let the Refugee Advocacy Lab know. We can help elevate your work to a nationwide network of advocates and share best practices. We are also available to provide technical assistance/support or connect you with resources. Please reach out to the Refugee Advocacy Lab at [info@refugeeadvocacylab.org](mailto:info@refugeeadvocacylab.org) to learn more. For specific questions about this resource, please contact Balqees Mihirig at [bmihirig@refugeerights.org](mailto:bmihirig@refugeerights.org).



## A. Models of Mental Health Services for Refugees

For those wishing to engage in mental health policy advocacy, it is helpful to be aware of the various models of refugee mental healthcare and the concurrent levels of services that should ideally be made available to refugees and other displaced people. Academics and practitioners in this space have proposed various mental healthcare models, and while it is beyond the scope of this guide to summarize them all, a key theme of such models is recognition that such care ought to be multi-level, cross-sectoral, and interdisciplinary.<sup>6</sup> For example, one such “multilevel model” proposes three tiers of services: safety and stabilization, community-based mental health programs, and specialized mental health treatment.”<sup>7</sup>

- **Level One – Safety and Stabilization:** These include services that are designed to ensure basic needs are met (such as employment, housing, access to healthcare, and access to education) and incorporating trauma-informed mental health education and strategies into the provision of such services. **Examples** include the refugee cash and medical assistance programs.
- **Level Two – Community-based Mental Health Prevention:** This level includes services delivered in accessible community settings that prevent escalation of symptoms and strengthen protective resources important for coping and adjustment. **Examples** include family and school-based mental health programs and trauma-informed refugee mental health literacy and leadership training.
- **Level Three – Specialized Mental Health Treatment:** Specialized care for those with more serious mental health conditions or families with identified and diagnosed problems. **Examples** include Cognitive Behavioral Therapy, Narrative Exposure Therapy, and Trauma Systems Therapy for Refugees.<sup>8</sup>

A successful model of mental health provision would ideally include several levels of services offered concurrently as needed to address individual, family, and community needs.<sup>9</sup> Additionally, a coordinated system of care requires that those who regularly

6 Hyojin Im, Cecily Rodriguez, and Jill M Grumbine, “A multitier model of refugee mental health and psychosocial support in resettlement: Toward trauma-informed and culture-informed systems of care,” *Psychological Services*, 18(3), (2021): 345–364, <https://doi.org/10.1037/ser0000412>.

7 Mary Bunn et al., “Rethinking Mental Healthcare for Refugees,” *SSM - Mental Health*, no. 3 (2023), <https://doi.org/10.1016/j.ssmmh.2023.100196>.

8 Bunn et al., “Rethinking Mental Healthcare for Refugees.”

9 Bunn et al.

interact with refugees are trained in trauma-informed care and have access to the necessary tools and training to ensure services are linguistically accessible and culturally responsive.<sup>10</sup>

## B. Overview: The Mental Health Infrastructure for Refugees and Other Displaced People

Mental health infrastructure for refugees in most countries, including the United States, often falls far short of the need. There is growing recognition of this fact, and some countries have started to address this need in a systematic way.<sup>11</sup> Efforts in the United States still lag behind, although there have been some advances in recent years. In this section, we outline some of the current infrastructure and programs available to refugees and other displaced people. While this overview is not comprehensive, it provides a broad introduction to federal or joint state/federal programs that are available in most states.

### I. ORR-funded Mental Health Resources and Services

The U.S. refugee resettlement program has traditionally prioritized self-sufficiency within the early months post-arrival. The Office of Refugee Resettlement (ORR) funds refugee resettlement agencies to provide assistance<sup>12</sup> to refugees who have arrived in the United States through the U.S Refugee Admissions Program (USRAP) – as well as to certain other displaced people – with obtaining housing, employment, and other basic services during their first 90 days.<sup>13</sup> After this initial period ends, funding ceases, although there is additional federal support for eight months for refugees who meet the income-eligibility requirements through ORR-funded refugee cash assistance (RCA) and refugee medical assistance programs (RMA).<sup>14</sup> Depending on the state and provider, RMA coverage can sometimes include access to mental health services.<sup>15</sup>

<sup>10</sup> Bunn et al.

<sup>11</sup> Branka Agic et al., “Supporting the Mental Health of Refugees to Canada,” Mental Health Commission of Canada, January 2016, accessed May 15, 2023, [https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-01-25\\_refugee\\_mental\\_health\\_backgrounder\\_0.pdf](https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-01-25_refugee_mental_health_backgrounder_0.pdf).

<sup>12</sup> Office of Refugee Resettlement, Summary of ORR Benefits and Services to Eligible Populations, accessed May 9, 2023, [https://www.acf.hhs.gov/sites/default/files/documents/orr/orr\\_fact\\_sheet\\_benefits\\_at\\_a\\_glance.pdf](https://www.acf.hhs.gov/sites/default/files/documents/orr/orr_fact_sheet_benefits_at_a_glance.pdf).

<sup>13</sup> “The U.S. Refugee Resettlement Program - an Overview,” Office of Refugee Resettlement, last modified October 4, 2021, <https://www.acf.hhs.gov/orr/policy-guidance/us-refugee-resettlement-program-overview>.

<sup>14</sup> “Refugee and Entrant Assistance - State Administered Programs,” accessed April 17, 2023, <https://www.benefits.gov/benefit/620>.

<sup>15</sup> “Refugee Medical Assistance (RMA) Health Assessment Program,” New York State Department of Health, accessed April 17, 2023, <https://www.health.ny.gov/funding/rfa/inactive/rma/>.

For up to five years post-arrival, refugees may also be eligible for other integration programs funded through ORR such as employment preparation and placement, English-language training, and other services, including community wellness.<sup>16</sup> ORR also administers, or has a role in administering, programs for survivors of torture (discussed below) and victims of trafficking.<sup>17</sup>

### **a. The Refugee Mental Health Initiative (ReMHI)**

Recognizing the gap in mental health services, ORR has recently begun to take steps to address the need. In October 2021, ORR announced the Refugee Mental Health Initiative (ReMHI) within the Refugee Health Promotion (RHP) program.<sup>18</sup> The goal of the program is “to build capacity within communities to address the mental health needs of refugee populations, including help overcoming stigmas associated with mental health care and creating opportunities for social engagement to reduce isolation.”<sup>19</sup> The program provides states with funding proportionate to resettlement numbers from 2019 and 2020.<sup>20</sup> The total funding received by states ranges from \$173,900 to \$582,529.<sup>21</sup> Based on these allocations, states can use the funds to support training and programming that enhances mental health access, including, for example, sponsoring certification training fees for Mental Health First Aid instructors or medical interpretation training.

Due to the relatively recent introduction of this program, it remains unclear how long ReMHI funds will continue. Given that current funding is based on resettlement numbers from 2019 and 2020 – the lowest in the history of the program – it likely falls far short of the existing need. Some states awarded the funding to community organizations via a competitive Request for Proposal (RFP) process.<sup>22</sup> It would appear that most of the funding has been directed towards education/outreach and navigation

16 “Ethnic Community Self-Help,” Office of Refugee Resettlement, accessed April 17, 2023, <https://www.acf.hhs.gov/orr/programs/refugees/ethnic-community-self-help>.

17 Office of Refugee Resettlement, Eligibility for ORR Benefits and Services – Victims of Human Trafficking, accessed May 9, 2023, [https://www.acf.hhs.gov/sites/default/files/documents/orr/orr\\_fact\\_sheet\\_victim\\_of\\_trafficking.pdf](https://www.acf.hhs.gov/sites/default/files/documents/orr/orr_fact_sheet_victim_of_trafficking.pdf).

18 Office of Refugee Resettlement, Refugee Mental Health Initiative within the Refugee Health Promotion Refugee Support Services Set-Aside: FY 2022 Funding Dear Colleague Letter 22-08, published October 25, 2021, <https://www.acf.hhs.gov/sites/default/files/documents/orr/orr-dcl-22-08-refugee-health-promotion-mental-health-fy2022-funding.pdf>.

19 Office of Refugee Resettlement, Refugee Mental Health Initiative within the Refugee Health Promotion Program, last modified December 8, 2021, <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>.

20 Office of Refugee Resettlement, Refugee Mental Health Initiative within the Refugee Health Promotion Refugee Support Services Set-Aside: FY 2022 Funding Dear Colleague Letter 22-08.

21 Office of Refugee Resettlement, Refugee Mental Health Initiative within the Refugee Health Promotion Refugee Support Services Set-Aside.

22 Michigan Department of Labor and Economic Opportunity, Office of Global Michigan, Request for Proposal: Refugee Mental Health Initiative, accessed April 17, 2023, <https://www.michigan.gov/ogm/-/media/Project/Websites/ogm/Request-for-Proposals/RMHI-23-9901-RFP.pdf>.

services and group wellness programs.

### Advocacy Opportunities:

- While a step in the right direction, Congress needs to provide ORR with significantly more funding to establish adequate mental health-related support for refugees and other ORR-eligible populations. Such investment should be accompanied by a nationwide strategy to incorporate mental health access within resettlement programs and beyond, to properly address gaps in mainstream health systems.
- States that receive ORR funding (or other federal funding) should be transparent on how such funds are allocated and provide an opportunity for impacted communities and other relevant stakeholders to give input on how funds should be prioritized.

### b. ORR Survivors of Torture Program

The Center for Victims of Torture (CVT) estimates that as many as 44 percent of the several million refugees, asylees, and asylum seekers living in the United States have experienced torture.<sup>23</sup> Since 2000, ORR's Survivors of Torture (SOT) program has funded programs that provide rehabilitative services to people tortured outside the United States who are now residents of the United States. While refugees and asylum seekers comprise most SOT program clients, the services are available regardless of immigration status, and there is no time limit to receiving such services. In 2023, ORR funded 35 organizations located in 24 states<sup>24</sup> to treat the physical and psychological effects of torture on refugees and other survivors. These grants are on a five-year cycle. There is also one technical assistance grant that aims to build the capacity of programs providing direct services.<sup>25</sup>

SOT programs together serve approximately 10,000 survivors each year: a fraction of those who need SOT services.<sup>26</sup> In 1998, CVT organized domestic centers into the [National Consortium of Torture Treatment Programs](#) (NCTTP) and provided training on advocacy and constituency-building. In addition, CVT, NCTTP, and [Refugee Coun-](#)

23 The Center for Victims of Torture, Updating the Estimate of Refugees Resettled in the United States Who Have Suffered Torture, September 2015, [https://www.cvt.org/sites/default/files/SurvivorNumberMetaAnalysis\\_Sept2015\\_0.pdf](https://www.cvt.org/sites/default/files/SurvivorNumberMetaAnalysis_Sept2015_0.pdf).

24 "Get Support in your Area," Heal Torture, accessed April 27, 2023, <https://healtorture.org/healing-centers/>.

25 "Services for Survivors of Torture," Office of Refugee Resettlement, last modified November 17, 2022, <https://www.acf.hhs.gov/orr/programs/refugees/services-survivors-torture>.

26 "U.S. Home to Far More Refugee Torture Survivors than Previously Believed," Center for Victims of Torture, September 29, 2015, <https://docs.google.com/document/d/1e7R8aMSd0z9WhZZ8NUIr5OIAuc61Y2dgczaslAgpxzQ/edit>.



[cil USA](#) advocate for Congress to increase SOT program funding.<sup>27</sup>

**Advocacy Opportunity:** CVT, NCTTP, and other national organizations within the Refugee Council USA coalition have been advocating for increased funding for ORR’s SOT program, which, if sufficient, would allow for the creation of more rehabilitation services in more states. Congress has increased funding to the SOT program for each of the last five years but not by enough. State funds can also be used to establish new SOT programs.

## II. Other Federal and State Funded Programs

### *a. Medicaid and CHIP*

Medicaid is a state-administered health insurance program for low-income adults in the United States that is jointly funded by the federal government and states. Separately, the Children’s Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

Both Medicaid and CHIP cover behavioral health services for serious mental illnesses in adults and children. Coverage for behavioral health services is generally more expansive for children than adults. Federal law requires Medicaid and federally funded CHIP plans to provide the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to screen for behavioral health issues and provide effective prevention or treatment.<sup>28</sup> EPSDT services for children include physician and clinic services, federally qualified health center and rural health clinic services, inpatient and outpatient hospital services, rehabilitative and preventive services, and services of other licensed practitioners. These services must be provided pursuant to EPSDT when necessary to treat an identified behavioral health condition.<sup>29</sup>

Many states have also taken the initiative to expand and fund mental health services beyond federal requirements. For example, some states have utilized Section 1115 Medicaid waivers, which offer states an avenue to deviate from federal restrictions and test new innovative approaches. Several states have used Section 1115 waivers to expand behavioral health services, address health disparities, advance whole-person care, and utilize non-licensed providers such as community health workers (de-

<sup>27</sup> National Consortium of Torture Treatment Programs, Appropriations Request Letter, March 1, 2023, [https://www.cvt.org/sites/default/files/attachments/u93/downloads/fy24\\_appropriations\\_request\\_letter.pdf](https://www.cvt.org/sites/default/files/attachments/u93/downloads/fy24_appropriations_request_letter.pdf).

<sup>28</sup> Center for Medicaid and CHIP Services, CMCS Informational Bulletin, published August 18, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>.

<sup>29</sup> Center for Medicaid and CHIP Services, CMCS Informational Bulletin.

tailed in later sections of this report).<sup>30</sup>

**Advocacy Opportunity:** Per existing federal law and through the Section 1115 waiver process, states have significant flexibility to utilize Medicaid dollars towards innovative programs that address social determinants of mental health.<sup>31</sup> Advocating that states utilize Medicaid dollars towards this purpose can be an important source of funding and an opportunity to test out innovative models of mental healthcare.<sup>32</sup>

## b. SAMHSA

While the Substance Abuse and Mental Health Services Administration (SAMHSA) does not have any programming specifically focused on refugees, providing culturally responsive services is a strategic priority for the agency over the next four years.<sup>33</sup> As part of this strategy, SAMHSA aims to increase the diversity of the mental health workforce through training, technical assistance, telehealth, and increasing support personnel such as paraprofessionals and peer counselors.<sup>34</sup>

SAMHSA provides several types of grants meant to supplement mental health services in states. SAMHSA block grants are intended to supplement Medicaid and Medicare and to fill gaps not covered by private insurance providers.<sup>35</sup> These grants are awarded to state entities such as state mental health authorities or health departments.<sup>36</sup> One type of block grant is the Community Mental Health Services Block grant (MHBG), which targets adults and children with serious mental health illnesses. As a condition<sup>37</sup> of this grant, a state grantee must establish a Mental Health Planning Council made up of the relevant government agencies, and 51 percent of such council must include consumers of such services and family members. The role of these planning councils is to provide input on programming funded by MHBG and to en-

30 “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” KFF, published March 2, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#:~:text=Section%201115%20waivers%20generally%20reflect,one%20presidential%20administration%20to%20another>.

31 “How States Are Utilizing Managed Care to Address Social Determinants of Health,” The VBP Blog, April 13, 2023, <https://www.thevbpblog.com/how-states-are-utilizing-managed-care-to-address-social-determinants-of-health/>.

32 See e.g. Oregon and Minnesota utilizing Medicaid dollars to fund community health workers to improve access to mental health services; Richard C. Boldt and Eleanor T. Chung, “Community Health Workers and Behavioral Health Care,” 23 J. Health Care L. & Pol’y 1 (2020), <https://digitalcommons.law.umaryland.edu/jhclp/vol23/iss1/2>.

33 Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Services Administration Interim Strategic Plan, published November 2022, <https://www.samhsa.gov/sites/default/files/samhsa-interim-strategic-plan.pdf>.

34 Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Services Administration Interim Strategic Plan, 6.

35 “Substance Abuse and Mental Health Block Grants,” Substance Abuse and Mental Health Services Administration, accessed April 17, 2022, <https://www.samhsa.gov/grants/block-grants>.

36 Substance Abuse and Mental Health Services Administration, “Substance Abuse and Mental Health Block Grants.”

37 42 USC Sec. 300x-3 requires states to establish a Mental Health Planning and Advisory Council if they receive funding through the Community Mental Health Services Block Grant (45 CFR Part 96).

sure such programming is responsive to community needs.<sup>38</sup> Some planning councils have adopted Culturally Linguistically Appropriate Service (CLAS) standards to ensure programming in their states is accessible to immigrant and refugee communities.<sup>39</sup> SAMHSA also provides discretionary funding to eligible community organizations that provide mental health services. Refugee-serving organizations are eligible to apply for such grants, and some have utilized them for services targeting refugees and other displaced people. For example, the Association of Africans Living in Vermont received a grant to implement Trauma Systems Therapy for Refugees by embedding multilingual clinician and cultural broker teams in middle and high schools with high numbers of refugees and immigrants.<sup>40</sup>

In addition, SAMHSA established the Office of Behavioral Health Equity (OBHE) to address disparities in behavioral health outcomes for underserved communities.<sup>41</sup> Notably, refugees are not identified as a group, although some may fall under other categories. The OBHE aims to advance more equitable behavioral health outcomes through data collection, policy development, quality practice, and workforce development. The OBHE also sponsors the National Network to Eliminate Disparities in Behavioral Health (NNED). The NNED is composed of community-based organizations across the United States focused on mental health and substance abuse. The network supports information sharing, training, and technical assistance as it relates to improving behavioral health outcomes for underserved communities.<sup>42</sup>

**Advocacy Opportunity:** Despite the fact that all states receive SAMHSA block grants and often additional discretionary funding, few states have utilized such funds towards addressing the unique behavioral health needs of refugees and other displaced people. Seeking representation on state mental health planning councils could be one way to address these concerns. National coalitions can also work with SAMHSA and other relevant federal offices to ensure refugees and displaced people are not left behind by calling for funding conditioned on mandatory reporting demonstrating that such funding is being used equitably to address the needs of refugees/displaced people and other underserved populations.

38 Substance Abuse and Mental Health Services Administration, “Substance Abuse and Mental Health Block Grants.”

39 “Addictions and Mental Health Planning and Advisory Council, About Us”, Oregon Health Authority, accessed April 17, 2023, <https://www.oregon.gov/oha/HSD/AMHPAC/Pages/About-Us.aspx>.

40 “VT Discretionary Funding Fiscal Year 2021”, Substance Abuse and Mental Health Services Administration, accessed April 17, 2023, <https://www.samhsa.gov/grants-awards-by-state/VT/discretionary/2021/details>.

41 Substance Abuse and Mental Health Services Administration, “Behavioral Health Equity,” accessed May 15, 2023, <https://www.samhsa.gov/behavioral-health-equity>; Identified groups include “Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.”

42 “Quality Practice and Workforce Development, Office of Behavioral Health Equity,” Substance Abuse and Mental Health Services Administration, <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>.

## C. State-Level Policies and Practices Advancing Mental Health Access for Refugees

Several states have implemented policies, passed legislation, or created partnerships to improve mental health access within communities. Some of the examples shared below are focused on refugees and other displaced populations, and others adopt a broader equity lens to improve accessibility for all underserved groups such as BIPOC and LGBTQI+ populations. While such a broad approach is important, refugee mental health needs are complex and often poorly assessed and studied.<sup>43</sup> The cumulative trauma experienced by refugees and other displaced people in the pre- and post-migration process, coupled with the cultural and linguistic barriers, requires its own approach that may differ from other underserved populations.<sup>44</sup> There is a great need for a statewide, cross-sectoral, community-based refugee mental health approach that provides training and linkages between resettlement services, mainstream health providers, and community organizations.

The following section summarizes policies implemented at the state level. While this summary is by no means comprehensive, the intent is to highlight notable examples that could serve as models that advocates and policymakers may examine as they assess needs within their own communities.

### I. Statewide Mental Health Policies for Refugees

In many states, there is often a gap in knowledge and capacity among both resettlement programs and mainstream mental health service providers. While resettlement programs offer rich culturally and linguistically responsive services to refugees, staff often do not have the knowledge or training to address mental health needs. Similarly, mainstream mental health providers often lack culturally and linguistically responsive tools to address the needs of newly arriving populations. To that end, some state refugee offices or health/mental health departments have taken steps to improve the integration of mental health services within their resettlement program through statewide approaches.

<sup>43</sup> Hyojin Im, Cecily Rodriguez, and Jill M Grumbine, "A multitier model of refugee mental health and psychosocial support in resettlement: Toward trauma-informed and culture-informed systems of care," *Psychological Services*, 18(3), (2021): 345–364, <https://doi.org/10.1037/ser0000412>.

<sup>44</sup> Hyojin Im, Cecily Rodriguez, and Jill M Grumbine, "A multitier model of refugee mental health and psychosocial support in resettlement: Toward trauma-informed and culture-informed systems of care."



In 2013, **Virginia** launched the Refugee Healing Partnership (RHP), which is a collaboration among the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Social Services (DSS), the Virginia Department of Health (VDH), varied providers, and refugee communities throughout the state. The partnership seeks to “promote positive mental health and cultural adjustment in the refugee community, create linkages between provider communities and the refugee communities, and provide opportunities for trauma-informed education at the community level and culture-informed education at the provider level.”<sup>45</sup> The partnership provided statewide resources and capacity-building programming such as trainings, conferences, community worker credentialing, and publications. It also established local Mental Health Councils in cities and counties with large refugee populations to coordinate local collaborations, and resources.<sup>46</sup> While the collaboration has since been rolled into the wider activities of the Office of Behavioral Health Wellness (OBHW) within DBHDS, refugee-focused programming remains integral to its operations.<sup>47</sup>

Though not quite as focused on mental health, other states have undertaken similar efforts to streamline mental health access within resettlement programs through uniform implementation of mental health screenings and referrals processes to culturally/linguistically responsive services, a recommended best practice by ORR and the CDC.<sup>48</sup> To facilitate screenings, some states provide support and funding to local health practitioners, county public health departments, or community clinics. Some states also include mental health-related information in refugee health promotion campaigns or educational outreach work. Examples of state offices that include mental health screening and referral programs in their general refugee health programming include [California](#), [Colorado](#), [Maryland](#), [Minnesota](#), and [Massachusetts](#).

45 “Health Equity,” Virginia Department of Behavioral Health and Developmental Services, accessed April 27, 2023, <https://dbhds.virginia.gov/human-resource-development-and-management/health-equity/>.

46 FY16 Refugee Healing Partnership – Program Report, Final Report to Virginia Department of Health – Newcomer Health Program, accessed April 27, 2023, <https://dbhds.virginia.gov/library/cultural%20and%20linguistic%20competence/refugee/fy16rhprep.pdf>.

47 “Office of Behavioral Health Wellness (OBHW),” Virginia Department of Behavioral Health and Developmental Services, accessed April 27, 2023, <https://dbhds.virginia.gov/behavioral-health/behavioral-health-wellness/>.

48 “Guidance for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees,” Centers for Disease Control and Prevention, last updated March 24, 2022, <https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html>; “Revised Medical Screening Guidelines for Newly Arriving Refugees,” Office of Refugee Resettlement, last updated March 21, 2022, <https://www.acf.hhs.gov/orr/policy-guidance/revised-medical-screening-guidelines-newly-arriving-refugees>.

**Advocacy Opportunities:**

- A cross-sectoral statewide collaboration led by state health/behavioral health authorities or other relevant state agencies in partnership with resettlement agencies, service providers, and refugee-led or community-based organizations is an important first step towards identifying and addressing key gaps and disparities within the system of care.
- When advocating for state funding for behavioral health programs for refugees, it is important to simultaneously push back against eligibility requirements that are too onerous for refugee-led organizations to meet. While accountability matters, states and advocates must reflect thoughtfully about supporting and capacitating refugee-led organizations to do this work.

**II. Behavioral Health Equity Policies**

Most states have established offices of health equity to address health and mental health disparities in access, quality, and treatment outcomes for marginalized populations. For example, the [California](#) Office of Health Equity explicitly identifies refugees as a population affected by health and mental health disparities. The purpose of the office is to facilitate cross-sectoral partnerships, including community-based organizations and local government agencies, while establishing larger health equity strategic plans.<sup>49</sup> Since 2009, the office has been overseeing the California Reducing Disparities Project, which targets mental health disparities in five population categories (African Americans, Asians and Pacific Islanders (API), Latinos, LGBTQI+ populations, and Native Americans) with an initial research phase and a current community partnership/grant phase.<sup>50</sup> While not specific to refugees, refugee populations can fall within intersections of these target populations. This project may serve as a template for similar projects specific to refugee populations.

Established in 2004 through the successful passage of Proposition 63, **California's** Mental Health Services Oversight and Accountability Commission (MHSOAC) was created to bring about transformational change across the state's mental health system through public and private partnerships at all levels. Among its mandated priorities, MHSOAC aims to ensure that mental health services are culturally responsive,

49 California Department of Public Health, Office of Health Equity, An Update on the Portrait of Promise: Demographic Report on Health and Mental Health Equity in California: A Report to the Legislature and the People of California by the Office of Health Equity, published February 2020, <https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/OHE%20Demographic%20Report%20Approved%20by%20CHHS%20Feb%202020%20Final%202.26.20.pdf>.

50 "California Reducing Disparities Project," California Department of Public Health, accessed April 28, 2023, <https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx>.

prioritizing culturally and linguistically responsive efforts that address “underserved cultural populations” (including “ethnically or racially diverse communities”).<sup>51</sup> Seats are also reserved on the Commission for impacted communities to ensure the decision-making process is driven by stakeholders. In 2019, MHSOAC chose to prioritize immigrant and refugee populations in its funding and utilized its budget to contract five mental health organizations across different regions of California that engage with specific immigrant and refugee populations. According to the commission, this funding is intended to support “advocacy, training, education, and outreach” as well as “statewide and local community-led events which highlight mental health services.”<sup>52</sup>

Similarly, some state legislatures have passed bills requiring state health departments to provide culturally specific/responsive behavioral health services. For example, **Nevada’s S.B. 341** (2021) required the Division of Public and Behavioral Health and other Department of Health offices to reduce disparities in health and behavioral health outcomes by applying for grants, setting up a Minority Health and Equity Account fund, and requiring all managed care organizations providing Medicaid services to develop a plan to provide culturally competent services to underserved communities including immigrants and those with another primary language.

**Oregon’s H.B. 2086** (2021) requires the Oregon Health Authority to “[e]stablish programs that are peer and community-driven that ensure access to culturally specific and culturally responsive behavioral health services for people of color, tribal communities, and people of lived experience.” Similar reforms have been adopted in **Colorado** to improve the availability of culturally competent services and create space in the system for trained peer supporters with lived experience to work with impacted individuals.<sup>53</sup> While not necessarily specific to refugees, culturally responsive behavioral health systems are in a better position to address the needs of forcibly displaced people.

51 CA Proposition 63 (2004).

52 “Community Engagement and Advocacy,” California Mental Health Services Oversight and Accountability Commission, accessed April 25, 2023, <https://mhsoac.ca.gov/connect/community-advocacy/>.

53 CO HB 21-1021 (2021); CO H.B. 22-1278 (2022).

**Advocacy Opportunities:**

- Advocating for the establishment of a behavioral health equity/cultural competence/disparity elimination office or a dedicated role within a state behavioral/health agency in states that still do not have one is a strategic first step.
- In states that have prioritized behavioral health equity, refugees and other displaced people are not always identified as a group in need of specialized programming. Ensuring that refugees and other displaced people are identified as a priority population within state behavioral health equity strategies is key.

**III. Mental Health Studies, Task Forces, and Working Groups**

One way that states and localities have started to address the needs of refugees and other forcibly displaced people is by establishing task forces and/or commissioning mental health studies on the needs and gaps in services. While focused more broadly on BIPOC populations, **Minnesota** recently established a task force to make recommendations on:

1. recruiting mental health providers from diverse racial and ethnic communities;
2. training all mental health providers on cultural competency and cultural humility;
3. assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and
4. increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, and/or people of color.<sup>54</sup>

While more specific to undocumented immigrant populations, the **District of Columbia's** [Law 22-141](#) (2018) may also serve as a model for future studies on mental health access in refugee and forcibly displaced communities. The Act requires the Department of Behavioral Health to conduct a study with institutions that provide health services to immigrant communities in order to evaluate the mental health impact of the “threat of imminent action by the federal government to remove immigrant(s) from the District,” as well as evaluate the immigrant community’s access to/use of mental health services, the availability of mental health educational services, and any barriers impeding access; identify mental health needs; and identify financial resources to maintain mental and physical health services for immigrants.<sup>55</sup> Some states have taken on the facilitator role, regularly convening health/mental health

<sup>54</sup> MN ST § 245.4902 (2022).

<sup>55</sup> D.C. Law 22-141 (2018).



system stakeholders to identify gaps and share best practices. For example, the Minnesota Department of Health coordinates [the Minnesota Immigrant and Refugee Health network](#), which brings together “health professionals, social service workers, students, community members and others interested in refugee and immigrant health issues” for monthly meetings to create dialogue and linkages in the field.

While not specific to mental health, state programming of this kind can facilitate necessary community partnerships.

**Advocacy Opportunity:** Identifying gaps and needs in systems of care is often the very first step in any state, county, or local strategy seeking to address the behavioral health needs of refugees and other displaced people. Advocating for a study of existing needs and gaps is an important first step and one that is often politically feasible to achieve in most contexts.

#### IV. Language Access and Services

Language access in the mental health services context varies significantly by state. Providers who receive federal funds to provide Medicaid/CHIP services must make language services available to Limited English Proficient (LEP) individuals under Title VI of the Civil Rights Act and Section 504 of the Rehab Act of 1973. However, language interpretation services are not classified as mandatory services. While a combination of federal and state laws mandate language access and translation/interpretation in certain healthcare settings or for required disclosures or hearings, comprehensive access to linguistically responsive mental health services is often much more limited.<sup>56</sup> Even in states that require linguistically responsive mental health services to be made available, few states specify requirements that service providers must meet.<sup>57</sup> Thus, the level of language access or services made available to consumers can vary greatly.

Some states, like **New York** and **California**, have implemented language access plans and requirements for state mental health agencies and medicaid providers. California, for example, requires<sup>58</sup> each Medicaid mental health plan to comply with cultural and

<sup>56</sup> Mara Youdelman, “Summary of State Law Requirements Addressing Language Needs in Health Care,” National Health Law Program, April 2019, <https://healthlaw.org/wp-content/uploads/2019/04/Language-Access-NHeLP-50StateSurvey.pdf>.

<sup>57</sup> Youdelman, “Summary of State Law Requirements Addressing Language Needs in Health Care.”

<sup>58</sup> Cultural and Linguistic Requirements, Cal. Code Regs. Tit. 9, § 1810.410.

linguistic requirements through varied means.<sup>59</sup>

New York’s Office of Mental Health provides a myriad of language access and interpretation services to LEP individuals admitted to their facilities or programs at no cost to the recipient.<sup>60</sup> Information about the availability of these services is made readily available in the top 12 spoken languages, with an ongoing assessment of whether materials and resources should be made available in additional languages.<sup>61</sup>

Many states have also implemented language access provisions relating to complaint processes and procedures regarding mental health services. For example, the **Georgia H.B. 1013** (2021) Mental Health Parity Act (which implements federal law requiring insurance providers to treat claim processing for both physical and mental health services in the same manner) requires that the materials involved in accessing the complaint process are “culturally and linguistically sensitive.”<sup>62</sup> This would allow LEP individuals to access the new parity enforcement/complaint process and compel their insurers to cover their mental health claims equitably.

Some states are also expanding language access requirements to telemedicine, a hugely important change due to mental health practitioner shortages. For example, **New Hampshire** recently passed **H.B. 1390** (2022), which directs licensed health care facilities required to provide meaningful language access to limited-English proficient speakers and deaf or hard of hearing individuals to provide such access when services are provided through telemedicine.

Even where interpretation is available, training and education of interpreters is necessary to ensure stigmatizing language is avoided in translation. To that end, some states have sponsored free training and support for interpreters.<sup>63</sup>

## V. Mental Health Workforce Development and Licensure Barriers

Both federal and state mental health agencies have long recognized the need for improving the diversity of mental health practitioners in the field. As mentioned earlier,

59 These include: development and implementation of a cultural competence plan; a statewide toll free telephone number 24 hours per day, 7 days per week available in all languages spoken by beneficiaries of the plan; interpreter services in threshold languages, at key points of contact; policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the specialty mental health services or related services available through that key point of contact; and general program literature in threshold languages in the county as whole.

60 N.Y. Office of Mental Health, Language Access Plan for Limited English Proficiency Individuals, October 1, 2022, <https://ogs.ny.gov/system/files/documents/2022/09/omh-lap-2022.pdf>.

61 N.Y. Office of Mental Health, Language Access Plan for Limited English Proficiency Individuals.

62 GA H.B. 1013, (2021-2022).

63 Virginia Refugee Healing Partnership, Free Online Interpreter Training Course, accessed May 15, 2023, <https://www.eventbrite.com/e/free-behavioral-health-interpreter-training-pre-registration-only-tickets-387463843787>.

one of SAMHSA's current strategic priorities is to improve cultural competency and diversity of the mental health workforce. To that end, SAMHSA has implemented various programs such as the [Minority Fellowship Program](#), which aims to improve behavioral health outcomes for racial and ethnic populations by diversifying the mental health workforce.

Some states have also taken steps to address the lack of diversity in the mental health workforce by conducting studies or removing unnecessary barriers to licensing requirements. **Vermont** has taken several important steps towards recognizing foreign-trained mental health practitioners. In November 2021, the Vermont Office of Professional Regulation (OPR), which licenses certain categories of mental health practitioners, implemented [rules](#) to streamline the process for recognizing foreign-trained professionals.<sup>64</sup> For other mental health license categories, Vermont recently passed legislation ([H. 661](#) (2022))<sup>65</sup> requiring OPR to conduct a study on streamlining mental health licensing into one license with endorsements for certain practice areas and examining barriers to entry faced by various disadvantaged groups.<sup>66</sup>

Modeled off Vermont and Minnesota,<sup>67</sup> a similar effort is underway in **Georgia** with [H.B. 520](#) (2023), which requires the state's Department of Behavioral Health to conduct a study to identify pathways for foreign-trained practitioners to gain licensure through an endorsement or temporary licensure process pending final licensure.

Similar to **Colorado** with [S.B. 22-181](#) (2022), **Oregon** recently passed a comprehensive bill, [H.B. 2949](#) (2021), addressing mental health workforce diversity. Among its provisions, Oregon's [H.B. 2949](#):

- Establishes programs that provide scholarships, stipends, and loan forgiveness (up to \$15,000 in mental health shortage areas), and retention activities.
- Provides funding to BIPOC and immigrant communities to ensure access to mental health care.
- Creates a Task Force on Expanding the Mental Health Workforce.
- Reduces the number of hours of supervised clinic experience required for professional counselor or marriage and family therapist licensure.

64 Vermont Office of Professional Regulation, "Foreign Trained Professionals, New Americans and Refugees," accessed April 17, 2023, <https://sos.vermont.gov/opr/regulatory/reducing-barriers/new-americans/>.

65 VT H.661, Act 117, (2022).

66 These groups include "Black, Indigenous, or Persons of Color (BIPOC), refugees and new Americans, LGBTQ individuals, individuals with low income, individuals with disabilities, and those individuals with lived mental health and substance use experience entering mental health professions."

67 MN ST § 245.49062 (2022); MN HF33 (2021).

**Illinois** took a slightly different approach through [the Behavioral Health Workforce Education Center of Illinois Act](#), which seeks to expand and diversify the mental health workforce by partnering with institutions of higher education to serve as coordination hubs to create a pipeline of mental health practitioners.<sup>68</sup>

In **Utah**, [H.B. 250](#) (2023) recently passed, which reduces barriers for communities of color seeking social worker licenses. The bill removed a redundant examination requirement for social workers and provided for greater accommodations for LEP individuals undergoing the licensure process, such as extensions of time to take the examination.<sup>69</sup>

An important aspect of understanding and tracking progress on diversifying the mental healthcare workforce is data collection. Georgia's [H.B. 520](#) (2023) mentioned above included provisions requiring the Department of Behavioral Health and Developmental Disabilities and the state licensing boards to collect data on the cultural and linguistic competencies of the existing workforce and whether they adequately serve the needs of the state's refugee and immigrant populations. The provisions are modeled off the Department's Office of Deaf Services, which collects data on the number of Georgians requiring American Sign Language (ASL) interpretation, and the number who receive support services, including counseling and mental health services with ASL interpretation.<sup>70</sup> The importance of data cannot be understated, since the needs of refugee and immigrant populations are essentially invisible without data to support advocacy efforts. Of course, any efforts to collect data should exclude any identifying information that could be abused by administrations hostile to immigrant populations.

**Advocacy Opportunity:** Reducing barriers to licensure and supporting alternative pathways to re-credentialing for foreign-trained behavioral health workers can be transformational for refugee and displaced communities. It allows foreign-credentialed workers to realize their full potential, while improving access to culturally and linguistically responsive services. Given nationwide shortages of behavioral health workers, these policies also tend to gain bipartisan support.

68 "Gov. Pritzker Announces New Behavioral Health Workforce Education Center," Illinois Office of Governor JB Pritzker, March 8, 2023, <https://www.illinois.gov/news/press-release.26148.html>.

69 "ASWB: End Discriminatory Social Work Licensing Exams (Petition)," Change.org, published August 2023, <https://www.change.org/p/aswb-end-discriminatory-social-work-licensing-exams>.

70 "Deaf Services," Georgia Department of Behavioral Health and Developmental Disabilities, accessed May 10, 2023, <https://dbhdd.georgia.gov/be-dbhdd/deaf-services>.

## VI. State-Funded Health Insurance for Displaced Trauma Survivors

There have also been efforts to supplement ORR funding with state dollars for other non-eligible displaced populations who require mental health services. To address this gap in services, organizations like the Center for Victims of Torture have advocated for state-funded trauma services. In 2003, [legislation](#) was passed in **Minnesota** expanding state-funded health insurance to people receiving rehabilitation services from a non-profit organization established to provide care to survivors of torture. The law establishes eligibility of this population for primary, mental health, and dental care benefits.<sup>71</sup> In a similar vein, **Colorado's** [HB 22-1094](#) (2022) was introduced to grant survivors of torture receiving care and rehabilitation services from a rehabilitative service provider eligibility for medical assistance without federal financial participation.

## VII. Community Healthcare Workers/Navigators

Community healthcare workers/navigators can play a vital role in facilitating access to mental health services for refugees and other displaced people. Community healthcare workers (CHWs) are individuals with relevant lived experience and cultural/language/community connection to the community they serve. They function as intermediaries between individual patients, these patients' communities, and healthcare/social service providers, building peer-to-peer relationships, facilitating trust, informing individuals of preventative care, and addressing social determinants of health.

Several states have passed legislation recognizing and legitimizing the role of CHWs in facilitating mental healthcare.<sup>72</sup> As previously mentioned, **Colorado** has made legislative reforms to allow for peer-support and peer-led organizations within the mental health system as an evidence-based practice that improves mental health outcomes and creates savings by reducing the need for crisis services.<sup>73</sup>

Some states require CHWs to be formally trained and certified, while others, to facilitate access to CHW roles, have no such requirements. For example, **New Mexico's** [S.B. 58](#) (2021) created a voluntary certification procedure for CHWs, allowing the Office of Community Health Workers (OCHW) to certify CHWs and mandating that at least three CHWs sit on the certification board.<sup>74</sup> Neither U.S. citizenship nor state residency was made a requirement for certification. New Mexico's model of volun-

<sup>71</sup> MN ST § 256B.06.

<sup>72</sup> Richard C. Boldt, and Eleanor T. Chung, "Community Health Workers and Behavioral Health Care," 23 J. Health Care L. & Pol'y 1 (2020), <https://digitalcommons.law.umaryland.edu/jhclp/vol23/iss1/2>.

<sup>73</sup> CO HB 10-1021 (2021).

<sup>74</sup> NM SB 58 (2014).



tary certification is notable in that the practice did not aim to exclude or limit access to the CHW profession but was instead meant to legitimize the work already being done by CHWs.<sup>75</sup>

States have also made it easier for CHW services to be covered by health plans. For example, **California's** [AB 2697](#) (2022) allows for general coverage of services offered by community healthcare workers under state healthcare plans. The bill also requires Medi-Cal managed plans to educate enrollees, in a “culturally and linguistically appropriate” manner. Similarly, [Minnesota](#) allows for direct Medicaid reimbursement for CHW services.<sup>76</sup>

## D. Conclusion

Investment in national and state mental health strategies for refugees and other displaced people can be life-changing for newly arriving families. Incorporating a national strategy into the resettlement program and other humanitarian pathways with partnerships from states, resettlement agencies, refugee communities, behavioral health practitioners, and community-based organizations can help address systemic gaps in the system of care.

States in particular stand to play an outsized role in ensuring refugees are not left behind through investments and common-sense policy reforms within their behavioral health systems. States can assume a leadership role by bringing stakeholders together and advocating for inclusive policies that address issues like workforce and licensing barriers, language access services, training, and other common challenges to mental healthcare access. States are also best positioned to assess geographical gaps in services for those resettled in rural areas or mental healthcare deserts. Cities and counties are also well positioned to facilitate linkages between providers and communities and bring state resources to where there is the greatest need for training and services.

Thoughtful policies and investments that permeate through federal, state, and local systems of care for refugees and other displaced people have the potential not only to be life-saving for newcomers but also to represent a great return on investment by enabling new Americans to realize their full potential and thrive in their new home.

<sup>75</sup> Boldt and Chung, “Community Health Workers and Behavioral Health Care.”

<sup>76</sup> MN Sec. 256B.0625.

## Acknowledgements

This policy brief was written and researched by Balqees Mihirig, Senior Policy Counsel at IRAP and Policy Advisor to the Refugee Advocacy Lab, and Nastaran Far, IRAP Policy Assistant, with input and support from Rose Lokwang, Refugee Congress Delegate for Ohio, Darlene Lynch, Head of External Relations at CVT Georgia and Alison Beckman, CVT Senior Clinical Consultant & Senior Clinician for External Relations.

Additional research assistance was provided by Ameerah Siddiqi, IRAP Policy Assistant, and University of California, Berkeley Law students Gabriella Lanzas and Cecilia Echaiz Guevara.



The Center for Victims of Torture works toward a future in which torture ceases to exist and its victims have hope for a new life. We are an international nonprofit dedicated to healing survivors of torture and violent conflict. We provide direct care for those who have been tortured, train partners around the world who can prevent and treat torture, and advocate for human rights and an end to torture.



IRAP is a global legal aid and advocacy organization working to create a world where refugees and all people seeking safety are empowered to claim their right to freedom of movement and a path to lasting refuge. Everyone should have a safe place to live and a safe way to get there.



The Refugee Advocacy Lab is an initiative hosted at Refugees International and co-founded with the International Refugee Assistance Project (IRAP), International Rescue Committee (IRC) and Refugee Congress to grow the movement for U.S. leadership on the protection and inclusion of forcibly displaced people. Centered in the perspective and leadership of displaced people themselves, we seek to support the advocacy community by developing strategic communications resources, championing inclusive policies, and building capacity for the field.