



WORKING WITH REFUGEE CHILDREN AND FAMILIES: UPDATE FOR MENTAL HEALTH PROFESSIONALS

Produced by

2009 APA Task Force on the Psychosocial Effects of War on Children and Families Who
Are Refugees From Armed Conflict Residing in the United States

Each year, tens of thousands of refugees flee their war-torn countries and communities and enter the United States. More than 40% are children, many of whom have experienced profound loss and survived devastating events that can impact their development and long-term functioning. Their journeys from their home countries are often rife with violence and instability and characterized by long periods without the most basic childhood needs met (or fulfilled), such as proper nutrition, housing, and education. Despite the extreme adversity that they face, these children and their families demonstrate profound strength and resilience in their survival strategies, coping mechanisms, and abilities to adapt within what are often completely unfamiliar environments.

The field is only beginning to understand the full impact of armed conflict, displacement, and resettlement on children's development and overall well-being, however, the present literature indicates promising initiatives in individual treatment methods, family therapy, and group work in schools and other community settings. Psychologists in their roles as clinicians, researchers, educators, and advocates can be important resources in the lives of these refugee children and their families and can work to enhance society's understanding of their experiences and needs.

Defining “Refugee”

Under U.S. law, those who enter through the formal refugee resettlement system qualify for refugee status. The U.S. Immigration and Nationality Act defines a refugee as “a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in

a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution.”

The United States has a long history of providing asylum. More than 2.7 million refugees, driven from their homelands by war; political change; and social, religious, and ethnic oppression, have settled in the United States since 1975, with average admissions of 81,500 refugees annually. Rapid and often-unanticipated explosions of conflict and unrest around the globe and changes in U.S. public policy toward refugee resettlement have driven the dynamic trends in refugee admissions between 1975 and 2008. During the Cold War (1948-1980), the majority of refugees entering the United States came from Southeast Asia and Europe, particularly the former Soviet Union. From 1980-1992, there was an influx of refugees from the former Soviet Union and the former Yugoslavia. Since the late 1990s, refugees have arrived primarily from Somalia and Ethiopia in Africa and Iran, Iraq, and Afghanistan in the Middle East.

How Refugee Children Enter the United States

Children who travel to the United States from regions affected by armed conflict arrive through multiple pathways and with varying statuses: Most often, refugee children arrive in the United States with their parents or other guardian family members.

A much smaller subset of refugee children enter the United States as unaccompanied minors, arriving without parents or caregivers. While most unaccompanied minors are placed in licensed foster homes, other licensed care settings are used according to children’s needs, e.g., therapeutic foster care, group homes, residential treatment centers, and independent living programs.

Some children, fleeing violence or persecution, enter the United States and file for asylum once on U.S. soil. Children involved in the asylum process are either dependents of parents seeking refuge in the United States or unaccompanied minors. Seeking asylum involves an often lengthy, costly, and stressful legal process developed without specific attention to the needs and rights of children.

Following a conflict in their home country, some children, traveling neither with family nor as unaccompanied minors, are brought to the United States to reunite with family members, sometimes after long separations. Some are reuniting with a parent who moved to the United States prior to the onset of the violence. Others are reunited with parents or other relatives after separation during the war. Some children and parents presumed one another dead only to discover their loved ones living in the United States.

How War and Refugee Flight Affect Children and Families

A range of mental health and developmental consequences are associated with child and adolescent exposure to armed conflict, including elevated symptoms of posttraumatic

stress disorder (PTSD), depression, anxiety, somatic complaints, sleep problems, and behavioral problems. Studies find high rates of exposure to traumatic events and a cumulative effect of multiple traumas, often referred to as a “dose effect,” such that higher rates of trauma are often associated with higher rates of PTSD, depression, and behavior problems.

Specific Factors That Influence the Psychosocial Adjustment of Children Affected by Armed Conflict

Individual Factors

- **Development** is an important and complex consideration in understanding the needs of children who experience war at all ages and stages of their lives within cultures and communities with varying expectations, norms, and values. An environment of violence, unpredictability, and instability challenges children’s abilities to engage in age-appropriate tasks and achieve mastery over them.
- **Individual temperament** may be related to adjustment to trauma and personality characteristics, including flexibility, creativity, intelligence, and curiosity, and may be protective for children from war zones. Children with significant psychological problems that existed before the war may have more difficulty in the aftermath of the trauma they experienced.
- **Gender** may influence children’s war trauma experiences. Girls and women are more likely to experience sexual trauma. Boys are more likely to be exposed to direct nonsexual violence (e.g., shootings) during war, to experience a greater frequency of traumatic events, and to be involved in the conflict themselves as perpetrators or child soldiers.
- Little formal research addresses **sexual orientation and gender identity** and the unique needs of lesbian, gay, bisexual, and transgender (LGBT) refugee children. The International Gay and Lesbian Human Rights Commission (2007) found a high prevalence of persecution and significant variability in the legal rights accorded to LGBT individuals depending on country of origin.
- **Race and ethnicity** are aspects of the refugee child’s identity that can affect the adjustment and mental health of refugee children and families upon resettlement in the United States. After experiencing significant trauma and dislocation, war-affected children and their families may face additional stressors, such as discrimination, and cultural differences.
- **Acculturation** refers to the process of adaptation, or lack thereof, which occurs when two cultures come into contact with one another. The process of adaptation is one of the

central tasks for refugee children, and important markers include language(s) spoken, ethnic identity, and the degree to which individuals participate in cultural activities. Parents and children may acculturate at different rates.

- **Resilience** involves the positive adjustment of individuals under conditions of significant adversity. Several factors may contribute to resilience in refugee children living in conflict or postconflict settings, including individual factors (e.g., intelligence, coping, emotion regulation); attachment relationships and social support; caregiver mental health; access to child care and schools in war-affected regions; religious institutions and affiliations; and cultural values and practices. **Coping** with the traumatic and frightening events of war may tax and drain children's inner resources, resulting in a reliance on fewer and less-effective coping strategies. On the other hand, some children demonstrate remarkably high functioning after severe trauma, illustrating the protective power of individual coping strategies in the face of adversity.
- **Language acquisition** may serve as a protective factor for refugee children who acquire new language skills more quickly. However, there may be implications for children who demonstrate decreased fluency in their first language, as this may interfere with communication with family members who only speak the primary language and contribute to a loss of social support within the family setting.
- **Disabilities and medical needs** that children had before the war, as well as those that developed due to exposure to war, can affect refugee children's postmigration psychosocial adjustment. Refugee children with disabilities and medical problems require coordinated, interdisciplinary care in order to meet their multifaceted needs and facilitate their physical and psychological recovery.

Family Factors

The adjustment of refugee children is necessarily linked to the experiences, functioning, coping strategies, and adaptation of their families.

- Refugee families must learn to function in new cultures with the added burden of finding adequate resources for their **most basic needs**. This stressful process is linked to increased rates of depression and PTSD symptoms among children.
- Upon resettlement, adults who are highly educated or former professionals in their country of origin may face the difficult and sometimes humiliating experience of finding employment in a society that does not recognize their educational background or work experience. **A loss of status** may particularly affect families with unrealized expectations of a better life or elevated social standing in the United States. The psychological and economic stress of this transition not only affects adults, but also their children, who must live with these changed circumstances.

- **Differences in rates of acculturation** within resettled refugee families are common. Children often adapt to new language and cultural norms more quickly than their parents, leading to intergenerational misunderstandings, tensions between old and new cultures, and challenges to identity development.
- **Family members' mental and physical health** also impacts children's psychological health. For example, maternal mental health problems and adjustment difficulties are risk factors for increased internalizing and externalizing behaviors in children.
- One of the less-acknowledged stressors in resettled refugee families is secondary trauma of **domestic violence** and **child abuse/neglect**. Families under increased economic and social stress and living in social isolation are more vulnerable to incidents of violence in the home, which likely serve as another source of trauma and a reminder of war-related traumas. Witnessing threats and/or actual violence toward a parent puts children in these homes at increased risk for trauma-related sequelae, including an increase in feelings of insecurity, fear, and anxiety.
- Despite the multiple stressors on refugee families, research and clinical evidence indicate **remarkable resilience** in these families as they cope with the aftermath of war. Well-functioning families provide a protective function in the lives of their children. While poor parental functioning is linked to greater difficulties in refugee children, refugee parents model resilience to their children in many ways, including adapting to a new culture, providing for their families, and sending additional economic support to family members still living in their country of origin.

School Factors

- Some refugee children arrive in the United States with **limited or disrupted formal education**. Although access to public education may be seen as a resettlement benefit, children face multiple challenges once placed in the U.S. educational system, including adapting to a new culture and language while participating and functioning with same-age American peers. The parents of refugee children may be unfamiliar and uncomfortable attending school conferences and assisting with homework. Language, cultural, and socioeconomic barriers may further inhibit communication between parents and school professionals.
- The psychological difficulties that result from war-related experiences may affect **children's learning and school performance**. Poor behavioral or academic functioning at school may indicate that a child is struggling emotionally. Teachers, school psychologists, and guidance counselors are essential resources for refugee children's adjustment to school and the identification of learning or emotional difficulties. School psychologists can play a critical role in identifying refugee children in need of mental health services, evaluating educational or trauma-related needs, and consulting with school administration and staff regarding ways to promote acceptance of refugee

students. Schools may also provide a less stigmatizing setting for the provision of mental health screening and services. Nonetheless, in order to conduct valid and meaningful assessment of mental health issues, school-based practitioners must contend with the cross-cultural challenge of critically examining constructs developed in Western societies before applying them to children from non-Western countries now living in the United States.

Community Factors

- Resettlement communities in the United States are far from monolithic; they vary along a number of dimensions, including density of refugees already resettled, ethnic and racial diversity, job opportunities, community safety, attitudes toward immigrants and refugees, dominant religious beliefs, and availability of resources. **Living in an area with high concentrations of their own ethnic group** can shape the experience and adjustment of refugee children, although the direction of influence does vary.
- **The degree to which the dominant culture accepts newcomers of different cultural groups** is also an important factor in the culture of a community and may influence individuals' level of acculturation. Community psychologists with expertise in creating services for vulnerable populations not typically served in mental health settings may be particularly able to assist in needs assessment and development of community-based interventions for refugee families.

Mental Health Professionals and Other Care Providers Can Alleviate Distress and Encourage Resilience and Recovery in Refugee Children and Families

Various therapeutic models and techniques address the effects of exposure to war in children, including individual psychotherapy, family therapy, group treatment, and school-based services, and they represent a range of orientations and approaches, including psychodynamic, supportive, and cognitive-behavioral therapies. Many clinicians working in the field adapt and combine some of these interventions in order to provide effective clinical care to refugee children.

Individual Approaches

There is some general evidence of the effectiveness of individual treatment with a range of children affected by traumatic stress. A number of common factors that characterize effective practitioners, regardless of their training or technique, contribute significantly to good therapeutic outcomes, including a high degree of empathy, tolerance for strong emotions, capacity to gently confront clients when needed, and lack of defensiveness.

Cognitive-behavioral therapy (CBT), with its emphasis on mastering negative emotions, thoughts, and actions by addressing dysfunctional cognitions and behaviors, can be well suited to address fear, helplessness, and anxiety. CBT has been used with refugee children to strengthen their coping strategies using, for example, methods such as visual imagery and relaxation techniques. In CBT, as with all treatment approaches, practitioners must be sensitive to the fact that different cultural groups vary considerably in their views regarding psychological well-being, distress, and healing. In addition, constructs relating to cultural norms, including what are considered adaptive and maladaptive cognitions and behaviors, are dynamic and change over time, suggesting that the ongoing reassessment of these constructs is needed.

While there have been no controlled medication trials conducted on refugee children, there is evidence that supplementing therapeutic interventions for traumatized children with psychopharmacological treatment results in greater symptom reduction. Refugee parents may not be familiar or comfortable with medicalized treatments of psychological distress. Clinicians need to be aware of and attentive to the salience of these cultural differences.

Family Approaches

Family members who have lived through war together may have vastly different intrafamilial ways of remembering, processing, and dealing with these traumatic events. Family-based interventions targeted at improving the emotional functioning of refugee children and their families can address many aspects of the refugee family's experience, including bringing to the surface the family members' shared experiences and differing perspectives on the war, flight, and acculturation; identifying family patterns of coping and communication; and assisting in the process of making meaning of the family's history. Clinicians who work with refugee families may take on several tasks over the course of family therapy, such as restoring a sense of equilibrium and parental well-being, enhancing empathy between and among family members, and allowing opportunities for making meaning through shared expressive exercises.

School-Based and Community-Based Group Approaches

It is crucial that interventions for refugee children utilize the resources offered in the educational environment. Schools can provide a welcome contrast to the disruption that refugee children endured in their countries of origin and during their resettlement journey.

School personnel can be essential in identifying the mental health needs of refugee children and referring them for appropriate services, in some cases before psychosocial and mental health problems develop or worsen. School psychologists can provide direct interventions for this population, such as teaching effective ways to handle stress and providing support and guidance around issues of acculturation. Schools can also provide the setting for clinical services, such as group interventions and creative art and

expressive treatments, to reduce barriers to treatment access that refugee families might encounter when mental health interventions are only available in traditional clinical settings.

Although there is little systematic research on therapeutic group interventions used in schools and other community settings to facilitate the adjustment of refugee children, group work has the potential to foster hope, normalize experiences and reactions, impart information, create interpersonal learning opportunities, and allow for catharsis. In addition, group work can provide an opportunity to decrease the sense of alienation often created by war and create a sense of belonging and connection. However, therapists must carefully consider the composition of a school-based group when combining children or adolescents from different countries or even from different cultural backgrounds (ethnic, religious, tribal) within the same country. Basic geopolitical history may influence group interactions and ultimately, impact outcomes.

Three Basic Mental Health Care Principles for Working With Refugee Children

Three principles of mental health care are well documented in the research and clinical literature on the needs of refugee children and families: the necessity of comprehensive services, the importance of cultural competence in clinicians, and the need to integrate evidence-based practice with practice-based evidence.

1. Use Comprehensive, Community-Based Services

Comprehensive services are designed to address a broad range of needs in the population. Given the numerous stressors on individuals facing resettlement in a new country—including language, work, education, financial issues, and acculturation—it is important for clinicians working with refugee children and families to take a holistic approach by addressing daily life adaptation and problems, as opposed to focusing solely on mental health symptoms.

Since stressful environmental and social conditions can create and maintain psychological distress, interventions for refugee children must address and have an impact on these conditions. The use of a case manager or social worker, who focuses on the daily needs and concerns of a refugee family, may provide stability so that the family can later address its mental health needs with a trained clinician.

Comprehensive services are designed to increase service use by underserved populations. Creating outreach services for clients and providing supportive information or care in accessible and nonstigmatizing locations, such as a school or community center, facilitates service utilization. There are several models for service provision including (a) a “tier-based” model in which most members of the target population

receive services in broader, community- or school-based interventions with specific, trauma-focused treatment required for the most symptomatic and impaired members of the community; and (b) a “public health framework,” which focuses primarily on culturally competent, trauma-informed community and preventive interventions, in which psychoeducation and skill-building in relation to trauma sequelae are used. Trauma-specific treatment modalities are then used in the smaller number of cases where there is the most severe need.

2. Provide Culturally Competent Services

Clinical services for war-affected refugee populations must reflect cultural competence by offering services that effectively meet the needs of multicultural populations. Inherent in this notion of culturally competent care is the concept of identifying needs and creating clinical services consistent with a population’s values, beliefs, and practices. The development of culturally competent care with refugee populations entails more than a training module or collection of “facts” about an ethnic or racial group’s beliefs. An understanding of an individual’s or community’s views related to human development and social expectations allows a clinician to design interventions that integrate cultural beliefs and norms about well-being and health with Western approaches and techniques. A child’s acculturative level should be taken into consideration. Careful query regarding the cultural and faith-based beliefs, values, and rituals central to refugee families may provide openings for clinicians to integrate these beliefs and practices into treatment.

3. Integrate Evidence-Based Practice With Practice-Based Evidence

Evidence-based practice in psychology integrates the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. When working with children, an evidence-based orientation to practice consists of assessment, intervention, and ongoing monitoring. A clinician should conduct these three elements in a scientifically minded manner and informed by clinical expertise, as well as remain attentive to the developmental processes and contexts of care that are critical for children and adolescents.

When working with refugee children and their families, clinicians should use evidence-based treatments when possible. However, since few treatment effectiveness studies have been conducted with refugee children, it is necessary for psychology to examine and recognize the efforts of providers in the field working with this population. These caregivers can provide “practice-based evidence”—reports of clinical interventions and existing practices successful with refugee children and gleaned from real-world settings.

Clinicians must be flexible, utilizing evidence-based techniques and protocols when possible, while incorporating other methods developed to meet the unique needs of war-affected refugee children. This delicate balance requires creativity and rigor and, in

some cases, collaboration with others who have tackled similar issues. Clinicians who rigidly adhere to protocols and treatment plans devised for populations with very different cultural backgrounds, beliefs, and values may lose opportunities to intervene effectively with refugee children or families.

Ethical Issues and Other Considerations in Clinical Practice With Refugee Children and Families

Mental health care providers working with refugee children should follow the **principles of practice and ethical care** recommended in the psychological assessment and treatment of all children. There are, however, specific ethical issues that may arise in clinical practice with refugee children and families:

Relying on Western models: Assumptions underlying clinical practice come from theory and treatment models developed in wealthy countries and Western culture. It is imperative that they be critically examined in the care of culturally diverse refugee children and families. For example, the Western medical model frames adversity and suffering in terms of psychopathology rather than as a legitimate response to stress and upheaval. A clinician may experience pressure to emphasize vulnerability and victimization over resilience in the clinical formulation of a refugee client's condition in order to request other services or support an application for asylum. This kind of emphasis then suggests that the individual's reaction to war and organized violence is abnormal rather than an expected response to severe trauma.

Power differentials: Clinicians should be aware of the often substantial power differential that exists in a relationship between refugee clients and professionals and carefully monitor their own political and social inclinations in the context of their work with refugees who may have direct experiences with persecution, armed conflict, and/or torture.

Appropriate boundaries: Maintaining appropriate therapeutic boundaries is an important component of ethical practice, particularly in cases involving human rights violations and other atrocities that may evoke strong transference reactions of dependency and gratitude in clients as well as powerful countertransference reactions in clinicians. Conversely, individuals who experienced direct persecution or violations of their human rights may experience a stance of unwavering neutrality from a clinician as a minimization or denial of the injustice of what was done to them. The power of a therapist to bear witness to clients' suffering and take a stand as to the injustice and criminality of it cannot be underestimated.

Using interpreters: Refugee community members are often involved in outreach, interpreting, prevention, and mental health counseling to improve cultural competence in a clinical team. Ethical dilemmas can easily arise, for example, when the only available interpreter in a particular language is someone who has a personal relationship with the refugee child and family. Therefore, it is vital to ensure that community members

involved in the provision of clinical services uphold ethical practices, such as maintaining therapeutic boundaries and confidentiality in the context of a small or tight-knit refugee community.

Legal consent: As with other clients, when offering therapeutic services to refugee children and families, clinicians must obtain informed consent from parents or legal guardians. There may be barriers to effective communication regarding informed consent, such as cultural, educational, and linguistic differences between refugee clients and practitioners. Also, individuals who escaped situations of persecution or interrogation may fear the signing of legal forms and documents and the ramifications of not following the direction of an authority such as the therapist or evaluator.

Confidentiality: Clinicians must impart basic information to children and families about the risks and benefits of treatment, the limits of confidentiality, and the rights of the patient. Legally, the age of children or adolescents can become an important factor in determining who gives ultimate consent to treatment and to whom information can be released. For children from cultures in which exact age and birth date are not recorded, this kind of information may not be clear. Clinicians must follow state law and ethical guidelines to the fullest extent possible when grappling with these issues in a situation of consent with refugee children or adolescents.

Ethical relativism: A continuum exists between ethical relativism, which embraces all cultural values and practices, and ethical universalism, which holds that there are fundamental principles that all people, regardless of their culture, should follow. Clinicians may find themselves challenged by the practices or beliefs of clients from different cultures that are in opposition to their own values. When faced with these tensions, they are advised to seek supervision within the field and within their clients' cultural community to determine how to proceed in an ethical manner respectful of cultural differences and consistent with the field's standards of practice.

Secondary trauma: Psychologists and other professional care providers who work with refugee children face a particular risk often underemphasized in training in human service settings—that of secondary or vicarious traumatization. Stories of human atrocities and the violence that are often part of the experiences of war-affected refugee families may overwhelm, upset, and change clinicians' worldview. Compounding this, children are witnesses to and, in many cases, direct victims of this violence. Exposure to these stories can lead psychologists, even with the best clinical training, to feel angry, burned out, depressed, or in some cases, detached from their work. Without proper supervision and processing around this specific issue—the emotional toll of hearing stories from war zones and attempting to address war's human costs—clinicians are vulnerable to many overwhelming emotions and reactions. To minimize these difficulties, clinicians must learn self-care techniques during their training to work with refugee children. Furthermore, programs for war-affected children and families can also address this by integrating self-care and support into their staff development activities.

CONCLUSION

War and armed conflict affect millions of people around the world each year, sending thousands into flight from their homes and countries in the hope of escaping chaos and violence. In the midst of these refugees are thousands of children. In 2008, of the more than 60,000 refugees who came to the United States, about 21,000 of them were under the age of 18. Many of these children, who have experienced and survived devastating and profoundly stressful events, need supportive services to promote health and well-being after resettlement in the United States. Such services can address a range of needs, including basic daily living, education, and physical and mental health, across the numerous contexts in which these children function. Psychologists—in their roles as clinicians, researchers, educators, and advocates—have tremendous potential to assist the many children who arrive in the United States seeking safety after the violence and disruption of war.

RESOURCES

Mental Health Resources

APA Presidential Task Force on PTSD and Trauma in Children and Adolescents

<http://www.apa.org/pi/families/resources/task-force/child-trauma.aspx>

This task force produced a suite of products for mental health professionals and policymakers regarding the basics of trauma in children and adolescents, ways in which to help children and their families cope and recover, and pitfalls to avoid upon encountering trauma and PTSD in children and adolescents.

Bellevue/NYU Program for Survivors of Torture

www.survivorsoftorture.org

The Bellevue/NYU Program for Survivors of Torture provides comprehensive medical and mental health care and social and legal services to survivors of torture and war traumas and their family members.

Boston Center for Refugee Health and Human Rights

www.bcrhhr.org

The center provides comprehensive health care for refugees and survivors of torture and related trauma, coordinated with legal aid and social services. The center provides training to agencies and professionals to conduct clinical, epidemiological, and legal research and to advocate for the promotion of their health and human rights.

Center for Multicultural Human Services

www.cmhsweb.org

The center assists mental health workers in meeting the needs of clients who have a cultural and/or language barrier to treatment. The center is dedicated to bridging the gap between diverse client populations and mainstream mental health provider organizations.

Center for Victims of Torture (CVT)

www.cvt.org

The CVT offers national technical assistance through resources, training, and networking opportunities specifically targeted to specialized torture treatment centers. CVT also provides a series of publications for practitioners who work with refugees and survivors of torture.

Disaster Response Network (DRN)

<http://www.apa.org/practice/programs/drn/index.aspx>

APA's DRN is a national network of psychologists with training in disaster response who offer volunteer assistance to relief workers, victims, and victims' families after man-made or natural disasters in the United States and U.S. territories. DRN members use their professional judgment and training to help disaster victims cope with extremely stressful

and often tragic circumstances. Members help problem solve, make appropriate referrals to community resources, advocate for workers' and victims' needs, provide information, and listen. They also focus on providing general emotional support and helping people marshal their own successful coping skills.

Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings
http://itspnyc.org/perspectives_guidelines.pdf

The Task Force on International Trauma Training of the International Society for Traumatic Stress Studies developed consensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations in the international arena.

Harvard Program in Refugee Trauma (HPRT)
www.hpert-cambridge.org

The HPRT is a multidisciplinary program that has been pioneering the health and mental health care of traumatized refugees and civilians in areas of conflict/postconflict and natural disasters for over two decades.

Immigrant & Refugee Mental Health
<http://www.mcgill.ca/tcpsych/clinical/child>

This website provides research on the mental health of ethnocultural communities in Montreal. It is part of the Montreal Center of Excellence in Immigrant Studies, sponsored by Citizenship Canada and the Social Science Research Council of Canada.

National Child Traumatic Stress Network (NCTSN)
www.nctsn.org

The NCTSN is a SAMHSA-funded collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children (including refugee children) and their families across the United States.

SAMHSA Refugee Mental Health Program
www.refugeewell-being.samhsa.gov

This program provides refugee mental health consultation and technical assistance. SAMHSA also responds to refugee admissions emergencies and provides technical assistance to increase collaboration between refugee service agencies and mental health providers.

For a more comprehensive list of resources, please download the full report: *Resilience and Recovery After War: Refugee Children and Families in the United States* at www.apa.org/pi/families/refugees.aspx

Relevant APA Resolutions and Policy Statements

- Reaffirmation of the APA Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as “Enemy Combatants”— <http://www.apa.org/about/governance/council/policy/torture.aspx>
- Resolution Against Genocide— <http://www.apa.org/international/resources/Resolution.pdf>
- Resolution on Children’s Mental Health— <http://www.apa.org/about/governance/council/policy/child-mental-health.aspx>
- Resolution on Immigrant Children, Youth, and Families— <http://www.apa.org/about/governance/council/policy/immigrants.aspx>
- Resolution on the Psychological Needs of Children Exposed to Disasters— <http://www.apa.org/about/governance/council/policy/children.aspx>
- Resolution on UN Convention on the Rights of the Child— <http://www.apa.org/about/governance/council/policy/rights-child.aspx>
- Resolution on UN Convention on the Rights of the Child & Optional Protocols — <http://www.apa.org/about/governance/council/policy/child-rights.pdf>
- Resolution on Violence Against Children by Governments— <http://www.apa.org/about/governance/council/policy/governments.aspx>



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