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Supporting Immigrant and Refugee Families through Infant and Early Childhood Mental Health Services

ISSUE BRIEF

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Executive Summary

Infant and early childhood mental health (IECMH) is increasingly understood as an important facet of all young children's healthy development. It encompasses children's developing capacity to form relationships, experience emotions, explore their environment, and learn. For many children in immigrant families—who comprise one-fourth of all children ages 0–5 in the United States—IECMH support is a beneficial way to promote healthy development in the context of their foundational relationships with their caregivers.

Children in immigrant families, many of whom are U.S.-born citizens, often encounter particular risks as a result of interactions with migration and integration processes. Families can have adverse experiences related to acculturation, discrimination, and economic stress, potentially affecting young children during a critical developmental period. Refugees have experienced persecution and often witnessed or been victims of violence, while other humanitarian and immigrant populations may experience trauma related to the threat of deportation or family separation. Recent immigration trends, including the creation of new admissions pathways as well as increases in arrivals through longstanding ones (such as refugee resettlement), make attending to the healthy socioemotional and mental health and development of young children in immigrant and refugee families a critical, timely issue.

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Migration-related trauma can have long-lasting negative impacts for young children, yet access to IECMH services for this group is limited. Within the refugee resettlement sector, no processes or assessments are in place to identify or address IECMH needs for young children. The only existing mental health assessment designed for refugees is not validated for use with children under the age of 14. In addition, 18 percent of immigrants in the United States did not have health insurance as of 2022, compared to 7 percent of the U.S.-born population, making immigrants less likely to attend regular pediatric visits that would otherwise provide opportunities for assessments and referrals. Some immigrant families may also be hesitant to use services even when they are eligible, due to fears related to their immigration status (such as fear of arrest and

deportation, or of the potential negative impacts of benefits use on their long-term immigration prospects).

Data are scarce on immigrant families' access to IECMH supports, but they may be less likely to access such services than other families due to gaps in promotion, prevention, screening, and treatment. IECMH *promotion* efforts are less likely to reach immigrant families due to cultural and language barriers, reducing the likelihood that they will have the systems and cultural knowledge to navigate the complex U.S. health-care landscape and seek services when needed. Immigrant families are also less likely to be enrolled in *preventative* services such as early learning or home visiting, limiting their interaction with programs that can connect them to IECMH supports. *Screening* tools that are translated into appropriate languages and validated for use across cultures are limited in availability and seldom regularly used. And for families who are able to access IECMH *treatments*, culturally relevant interventions and linguistically and culturally competent clinicians are similarly scarce.

Policymakers, program administrators, researchers, and other stakeholders have several opportunities to improve the accessibility and relevance of IECMH services for immigrant and refugee families, including the following:

- The Centers for Disease Control and Prevention and the Office of Refugee Resettlement should consider developing joint guidance establishing standardized mental health screenings for refugee children and youth, including those under age 5.
- Policymakers can improve the accessibility of IECMH consultations delivered by professional consultants with mental health expertise by broadening policy and funding parameters to support consultations not only in center-based early childhood programs but also in family, friend, and neighbor care settings, on which a large proportion of immigrant families rely.
- Pediatric care providers can use targeted strategies to connect immigrant and refugee families with IECMH services, including the use of team-based models of care, colocation of resources, hiring of cultural brokers and family navigators, and tracking successful referrals as a key equity measure.
- Health-care, early childhood, and other service providers should consider the use of assessment tools that have been translated and validated for use with diverse cultural and linguistic groups, such as the Parents' Evaluation of Development Status and the Survey of Well-Being of Young Children.
- States and counties can support IECMH for immigrant and refugee families through home visiting programs that are tailored for this purpose, such as the Baby TALK model being used in partnership with RefugeeOne in Illinois.
- Policymakers can prioritize diversification of the IECMH workforce at all levels and appropriately incentivize the employment of cultural brokers and family navigators who possess the skills and lived experience to bridge both linguistic and cultural gaps between families and care providers.
- Government and philanthropic funders should create incentives for researchers to build empirical knowledge of culturally specific IECMH interventions and assessments for children of immigrants and refugees.

These strategies can help lay the foundation for the healthy development, well-being, and improved long-term outcomes of children in immigrant and

refugee families. Thus, prioritizing the accessibility and relevance of IECMH services for these families is imperative for both ensuring the healthy socioemotional development of their young children and promoting the resilience of the communities in which they live.

1 Introduction

Infant and early childhood mental health (IECMH) is increasingly recognized as an important lens through which young children's well-being can be understood and improved in ways that profoundly influence their future trajectories. For immigrant and refugee families who have been exposed to trauma and stressors related to migration and acculturation experiences, mental health resources and services that reach children at an early age can be particularly impactful. However, these families are less likely to have access to such supports due in part to their lower participation in formal child care, home visiting, and other programs that can connect families to the mental health services they need.[1]

Immigrant-serving systems and organizations such as refugee resettlement agencies are often disconnected from early childhood services, moreover, creating gaps in service alignment and communication. A lack of cultural responsiveness and awareness in the early childhood field overall can also contribute to lower levels of connection to mental health services in both clinical and nonclinical settings, such as through IECMH consultation. Finally, even after a successful referral has been made, IECMH practitioners are not always trained to work effectively with families whose language, outlook, and orientation toward parenting, child development, and mental health differ in important ways from the culturally dominant approach.

With one-fourth of all children age 5 or younger in the United States living in an immigrant family as of 2021,[2] addressing these gaps is a critical part of supporting the healthy development of the country's children. These young children's families come from a wide range of cultures and countries of origin, and face different challenges related to their immigration experiences. Given this reality, there is a clear need for policies, strategies, and program approaches that recognize and respond effectively to the diverse needs of immigrant families with young children, in order to shape systems that promote equitable outcomes for all.

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This issue brief describes the importance of IECMH services for immigrant and refugee families, and identifies gaps in IECMH promotion, prevention, screening, and treatment that affect these families' access to and use of such services. The brief concludes by identifying opportunities for policymakers and practitioners to improve access to and the relevance of IECMH services for this population.

2 The Importance of IECMH

IECMH refers to the developing capacity of children age 5 or younger to form relationships, experience emotions, explore their environment, and learn, within the context of family, community, and culture.[3] Successful development of these capacities is synonymous with healthy socioemotional development, and significantly contributes to long-term well-being during childhood and into adult life.[4] Central to a child's sense of well-being, as well as

their emotional, behavioral, and cognitive development, is the quality of the relationship with their main caregivers. For children to have sound mental health, their caregivers need support to decrease stress and enable them to be emotionally available. Accordingly, well-designed IECMH services support the relationship between children and their primary caregivers, recognizing that this connection sets the stage for social and emotional learning.[5]

In short, sound mental health provides a stable foundation for a child's development. However, when a child experiences toxic stress, this can damage this foundation and create an unstable environment. Many factors can cause instability, and identifying these factors is the first step toward mitigating their harm. Early signs that a child may need help can be detected through a continuum of mental health services: promotion, prevention, screening, and treatment. Many mental health problems can be prevented altogether, or prevented from becoming more serious, if they receive an appropriate intervention early on. Mental health services provide an opportunity for infants and young children and their parents to get help from trained health-care professionals to reduce conflict, restore balance to the child's environment, and in turn promote improved emotional regulation and the ability to understand and manage one's own feelings, behaviors, and actions.[6]

3 IECMH Needs among Immigrant and Refugee Families

IECMH services can be particularly beneficial for young children in immigrant and refugee families, due to specific risks they may encounter to their socioemotional and mental health. Many migrants have gone through stressful or traumatic experiences—from the factors that drove them to leave their home country, to the difficulties of their journey, to the challenges of gaining admission and settling in the United States. Immigrants in the United States have entered the country through different pathways and hold a wide variety of legal statuses, lived experiences, and integration trajectories, all of which can influence the type of mental health and other services they and their family members need and have access to.

Alongside renewed immigration of various kinds following the early-pandemic slowdown, the United States has seen an increase in arrivals by certain humanitarian migrants since 2021. The Biden administration has also raised refugee resettlement numbers, after record low admissions ceilings under the Trump administration, and created several new admissions pathways for groups in need of protection. For example, in fiscal year 2023 alone, communities across the United States received 240,000 parolees through new processes for Cubans, Haitians, Nicaraguans, and Venezuelans; 60,000 resettled refugees; and 113,000 unaccompanied children released to sponsors while they await the outcome of their immigration proceedings.[7] In addition, there were at least 2 million asylum cases in the immigration courts' backlog as of November 2023.[8] Many refugees, asylum seekers, and other humanitarian migrants have been displaced by armed conflict and other forms of violence, natural disasters, identity-based persecution, political turbulence, and economic collapse. Certain populations are at a heightened risk of exploitation as they make their way to the United States, some with no guarantee of formal protection upon arrival after long, dangerous journeys. The detrimental impact on mental health of displacement under distressing circumstances can be longstanding, especially for young children.[9]

Upon arrival in the United States, all migrants may face further stress and trauma due to difficulties arising from their legal status, social and economic hardships, rigid immigration policies, and demands

to integrate quickly. Immigrants are also at risk of discrimination and marginalization, particularly in an increasingly politicized and, in certain communities, volatile social climate.[10] Challenges such as abrupt cultural shifts, language barriers, and socioeconomic hurdles can lead to feelings of grief, anxiety, and isolation, which may be further exacerbated by the fear of deportation or family separation at any point during the process of admission to or re-establishment in the United States. Research indicates that the perpetual fear of losing their parents to deportation or other immigration enforcement mechanisms can lead to chronic stress and mental health disorders in children, inflicting long-term emotional damage.[11]

Due to the stress experienced before, during, and after migration, there is a high prevalence of anxiety, depression, traumatic stress, and other mental disorders amongst forcibly displaced and unauthorized immigrant populations.[12] However, few support structures exist to effectively address their unique mental health needs, particularly for younger children. Migration-related trauma can affect immigrants at any age, but the consequences for young children are distinct. Research shows that young children are exceptionally vulnerable to the short- and long-term effects of trauma that they experience personally (known as direct trauma),[13] and that the effects of trauma can be transmitted across generations (intergenerational trauma) or through a child's community (historical trauma).[14]

4 Gaps in Mainstream Benefits' and ORR Services' Support for Immigrant Children

Though awareness of trauma and its impacts on young children continues to grow, immigrant and refugee children in need of IECMH services are often overlooked by policymakers and service providers. At the same time, the refugee resettlement network and other systems dedicated to immigrant populations typically focus on employment and education and lack the institutional infrastructure to adequately address IECMH needs.

One of the most important factors in meeting IECMH needs is access to means-tested safety net benefits, such as the Supplemental Nutrition Assistance Program (SNAP or "food stamps"), Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and Medicaid. Eligibility for these and other public assistance programs can provide a newcomer family with access to material support that eases the process of integration and fosters self-sufficiency.

Immigrants' legal status affects the type of federally funded services and benefits they are eligible for (see this brief's Appendix for an overview). There are numerous variations and stipulations to consider when determining an immigrant's eligibility on the basis of status. For example, refugees and Ukrainian humanitarian parolees are immediately eligible for benefits upon admission; lawful permanent residents are only eligible after five years and if they meet certain work qualifications; and asylum seekers and Temporary Protected Status beneficiaries are categorically ineligible.[15] Many exceptions are made to eligibility restrictions for children, meaning that some families with children may have access to certain forms of support while other families and adults with the same status do not. And even for families who are legally entitled to access such programs, linguistically and culturally appropriate support is often limited.

While programs supporting nutrition and child care are valuable touchpoints in reaching young children, access to affordable health-care coverage has a considerable impact on whether families are

able to seek support for IECMH needs. Immigrants are significantly less likely than U.S.-born citizens to be insured (18 percent of immigrants did not have health insurance as of 2022, compared to 7 percent of the U.S. born[16]), and noncitizen families without insurance are limited in the health-care services they can access without bearing the full cost out of pocket. Public health insurance programs, such as Medicaid and the Children's Health Insurance Program (CHIP), play a vital role in helping low-income individuals and families access physical and mental health services. However, the eligibility criteria for these federally funded, means-tested programs mean that while some groups (many of which are admitted on humanitarian grounds, such as refugees) have access to these programs on the basis of their status, many others are ineligible (including lawful permanent residents within the first five years in that status as well as unauthorized immigrants).[17] This leaves many low-income immigrant families reliant on community-based organizations, grassroots service providers, and their community networks for resources and support.

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Depending on where they live, some immigrants who are ineligible for federally funded benefits can access health care through state public health coverage or expansions of Medicaid and CHIP. Some states use their own funds to offer health-care benefits to low-income families and/or children regardless of their immigration status, and others have opted to extend Medicaid and CHIP eligibility to certain lawful permanent residents, lawfully residing immigrants, and other noncitizens through an optional provision in the 2009 *Children's Health Insurance Program Reauthorization Act*.[18] Although an increasing number of states have expanded coverage through these channels, the Migration Policy Institute found that in 2019, 40 percent of the 2.3 million income-eligible immigrant children in the United States were barred from accessing Medicaid or CHIP based on their immigration status (an estimated 909,000 children).[19] In the absence of state or federally funded coverage, medically underserved immigrant families may access affordable care through federally qualified health-care centers, which includes mental health services on site or by referral.[20]

However, immigrants who fear interacting with any government-funded or subsidized services may not access or use such services, even if they qualify to do so. Such fears are often rooted in status insecurity, anxieties related to federal detection and deportation, and/or concerns that accessing benefits could have a negative impact on an individual's long-term immigration prospects. The 2019 public charge rule, which has since been overturned, imposed negative consequences on certain immigrants if they had received any of a list of specified mainstream benefits, including nonemergency Medicaid, during the green-card application process. Although this rule is no longer in force, its effects on immigrants' perceptions of benefits persist, causing reduced rates of participation in mainstream federal programs by immigrants for fear of negative immigration consequences. Such anxieties may be present even if children in immigrant families are eligible for certain means-tested benefits, as is often the case for U.S.-born children with foreign-born parents and, more generally, for children under the age of 18, who may be eligible for federal programs regardless of their immigration status (see the Appendix for details).[21] Therefore, immigrant children can be adversely affected when their parents are ineligible and/or fearful of accessing mainstream benefits, as well as when they lack information about their child's eligibility and how it may differ from their own.

Some young children are eligible for integration services through the Office of Refugee Resettlement (ORR) and the refugee resettlement network; however, these needs are generally a lower priority than the Reception and Placement program's primary goal of helping newly arrived refugee and humanitarian migrant families quickly achieve economic self-sufficiency and employment. This is illustrated by the lack of federally required mental health screening for young children who receive ORR-funded services and the sparse appropriation of resources specifically to mental health support services.[22] By the time many resettlement agencies are able to dedicate time and resources to IECMH issues, the ideal window of opportunity for early intervention has likely elapsed or the family has exceeded the 90-day period during which newcomers are eligible for Reception and Placement services. In addition, most refugee resettlement organizations do not have the resources or the training to provide IECMH services and must look to leverage existing programs within local communities, such as those offered by pediatric health-care providers and community-based organizations.

5 Gaps across the IECMH Spectrum of Support

Gaps in access to and participation in relevant IECMH services also exist within early childhood and health services. Immigrant families are too often underserved and overlooked across all aspects of mainstream IECMH services—promotion, prevention, screening, and treatment—and bridging these gaps is critical to effectively serving children in these families.

A. *Promotion*

IECMH promotion services—a combination of policy advocacy, public outreach, and education—aim to encourage healthy development in all children and should be widely available to the general public. Providing information on basic mental health concepts and available services, in a destigmatized way, can plant a critical seed that could ease a family's access to beneficial programs and treatments when a need arises. In the absence of promotional services, families may not know how to seek help or may be hesitant to do so. IECMH promotion occurs at the policy level through public campaigns and education, at the population level through awareness campaigns targeted to specific communities, at the program level through promotion of a particular initiative, and at the individual level through, for example, parent education.[23]

Mental health promotion, and particularly IECMH promotion, can be especially important for immigrant and refugee families who have minimal experience interacting with the U.S. health-care system, leading to limited "health literacy" in the U.S. context. Health literacy is the ability to understand and use information to make decisions about one's health and wellness. Research indicates that limited health literacy is particularly prevalent among immigrants, with less than 15 percent of the population as a whole confident in navigating the complexities of the U.S. health-care system.[24] Limited health literacy can also be exacerbated by cultural differences, especially among immigrants accustomed to non-Western health-care practices or health-related beliefs and stigmas.

Limited health literacy and cultural differences can lead to misunderstandings between patients and providers and the mismanagement of physical and mental health conditions. Consequently, some families may avoid preventative care, or care altogether, due to intimidation or distrust of an unfamiliar medical system. For example, some medical professionals suggested in interviews that one of the most significant barriers in designing and providing mental health services for new immigrant parents and their

young children is the absence of a shared understanding between practitioners and their immigrant clients of how perinatal mental health is understood and treated in an American context. Several practitioners noted that many parents do not perceive children under the age of 5 as having complex mental health needs, with one describing the provision of IECMH services as "trying to hang a coat on a hook that isn't there."[25] In short, it is difficult to expand and enhance IECMH programming when caregivers are not versed in the basics of infant and early childhood mental health and do not have a shared language with health-care providers. This cultural gap is particularly difficult to address when individuals have limited access to educational materials in their own language or are influenced by cultural stigmas regarding mental illness.

Cultural barriers, including stigmas around mental health issues and treatment, are known to be an important factor in limiting immigrant communities' participation in mental health services.[26] IECMH promotion strategies that are designed to reach the general population and rely on written and spoken communication are often not developed with these cultural barriers in mind. Moreover, campaigns that are primarily disseminated in English through mainstream media are less likely to reach and be understood by immigrant and refugee families who speak languages other than English and consume culturally specific media.

B. Prevention

IECMH prevention services address potential challenges that could negatively affect child development. Similarly to promotion, they are designed to nurture the caregiver–child relationship to prevent difficulties that could cause increased mental health issues in the future.[27] Examples of prevention strategies include high-quality early childhood education and care programs; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and other home visiting initiatives; regular access to health care; and early childhood mental health consultations.[28] These services are not direct treatment for mental health issues but support the well-being of children and their caregivers holistically, which in turn helps prevent mental health issues from developing.

Children of immigrants are also over-represented in family, friend, and neighbor care and other home-based child-care settings that rarely offer IECMH consulting or other preventative mental health supports.

Although evidence shows that high-quality early childhood programs can be disproportionately beneficial for immigrant and refugee families, they are less likely to participate in them. The National Academy of Sciences found that Dual Language Learners—young children with at least one parent who speaks a language other than English in the home, the vast majority of whom are children in immigrant families—access MIECHV programs at lower rates than their peers.[29] Children of immigrants are also over-represented in family, friend, and neighbor (FFN) care and other home-based child-care settings that rarely offer IECMH consulting or other preventative mental health supports.[30] Recent studies estimate that up to 60 percent of children in the United States participate in FFN care,[31] and immigrant families disproportionately rely on this type of care for many reasons, including preference, affordability, and availability.[32] Meanwhile, children of immigrants who are enrolled in center-based early childhood programs may be less likely to be successfully referred for IECMH consulting than their peers due to language and cultural barriers between program staff and parents.[33]

C. Screening

IECMH screenings aim to identify when a child may benefit from additional support.[34] Indicators that a child may need to be screened for mental health include poor sleep patterns, difficulties with feeding, lack of weight gain, and failure to meet developmental milestones.[35] Screening tools used by professionals to assess children's needs include the Early Childhood Screening Assessment, the Ages and Stages Questionnaire (ASQ) Social-Emotional screening tool, the Brief Infant-Toddler Social and Emotional Assessment, and the Survey of Well-Being of Young Children.[36] Based on the results of screenings, families may be referred to organizations such as Help Me Grow, which can connect them to appropriate resources.[37] If the results show a need for more intensive support, children and their families may be referred to treatment services.

The existing screening system does not always adequately identify young children in immigrant and refugee families who could benefit from services, for two reasons: lack of access to the health-care settings where the screenings are usually administered and lack of appropriate screening tools. The American Academy of Pediatrics recommends that all young children be screened five times for developmental health by the time they are 3 years old.[38] It similarly recommends screening for perinatal mental health conditions across pediatric visits in the first postpartum year,[39] pointing to the importance of pediatric offices in connecting families with young children to important resources. However, some immigrant and refugee families face systemic barriers to regular well-child pediatric care, including lack of insurance, fears related to their immigration status, difficulty navigating the health-care system, and a lack of language services.[40]

Moreover, commonly used screening tools such as the ASQ-3 (a set of questions about child development) and ASQ-SE-2 (questions focused on social-emotional development) are not specifically validated for use with immigrant and refugee families.[41] The ASQ-3 is only available in a few languages other than English, and even those are not always offered to the families who could benefit from them.[42] More broadly, many assessments are merely translated, not culturally adapted or validated to ensure content equivalence or cultural congruence.[43]

Mental health screenings for parents of young children are also critical to ensure that parents receive the mental health support they need to in turn support their young children's well-being. This is particularly true for postpartum mental health, which is an essential part of IECMH support. The Edinburgh Postnatal Depression Scale is one of the most widely used screening tools globally and has been translated and validated for use in several languages.[44] However, there is some dispute as to its cultural adaptation and validation for immigrant populations, due to challenges in translating key concepts and to cultural differences in how depression is viewed, which can lead some patients to be hesitant to disclose personal information to professionals.[45]

Many assessments are merely translated, not culturally adapted or validated to ensure content equivalence or cultural congruence.

The primary instrument used to assess recently arrived refugees' mental health, the Refugee Health Screener 15, is validated for use only with individuals age 14 and above.[46] Refugee resettlement agencies are not required or resourced to systematically screen young children or to screen for perinatal mental health issues.

D. Treatment

IECMH treatments are delivered by early childhood mental health professionals and are designed to support the emotional needs of children and the child–caregiver relationship.[47] The treatments are often dyadic (a form of therapy that treats children and parents together)[48] and can help parents respond to their child's needs, promoting a healthy, nurturing relationship. Evidence-based models of dyadic treatments include Child–Parent Psychotherapy and Attachment and Biobehavioral Catch-Up.[49]

For several reasons—gaps in promotion, prevention, and screening services; limited public funding and support for IECMH treatment for immigrant and refugee families; and lack of health insurance—many young children in this population are unable to access beneficial treatments. Even when families are able to connect with providers, language and cultural barriers can impede relevant and effective services. One IECMH professional interviewed as part of this study also pointed to the limited availability of interpretation services for clinicians, a shortfall exacerbated by the COVID-19 pandemic.[50] In general, research indicates that immigrants access mental health services at lower rates than non-immigrants despite their greater need.[51]

Moreover, there is limited empirical evidence on how effective mental health interventions commonly used with young children—such as Trauma-Focused Cognitive Behavioral Therapy, Child-Centered Play Therapy, and Parent–Child Interaction Therapy—are specifically with young children in immigrant and refugee families.[52] Indeed, most evidence-based IECMH services are developed for and tested with middle-class White Americans.[53] And while culturally specific interventions are known to produce significantly better outcomes for minority populations,[54] few targeted IECMH interventions designed for culturally diverse populations exist.

6 Policy Recommendations

Increased awareness of the unique challenges immigrant families face in connecting with IECMH services can promote more inclusive approaches to all aspects of those services—promotion, prevention, screening, and treatment. Policymakers, program administrators, and researchers in early childhood, mental health, refugee resettlement, and other fields have many opportunities, at the program and policy levels, to improve immigrant families' access to IECMH services and to expand the knowledge base needed to develop more relevant services for them. Opportunities include the following:

1. **Expand awareness of and promote screening for IECMH issues within refugee resettlement services.**

There is limited guidance or systematized means of integrating infant and early childhood considerations into the broader spectrum of refugee services, including health and wellness services. One important way in which IECMH could be integrated into these services is through the initial health screenings that are required for all refugees during their first 90 days in the United States. These screenings are also available to other ORR-eligible populations, such as asylees.

The initial health screening is a comprehensive assessment comprising up to three clinical visits conducted at the local health department and its partner sites. It examines all members of the household for physical and mental health issues to identify any acute or chronic health need, including communicable diseases. The assessment is particularly important because it is, in many cases, refugees' first opportunity to connect with the U.S. health-care system and be referred to specialized care if needed.

Some components of the health screening, such as tuberculosis testing, are required by ORR, and others are strongly endorsed by ORR as a part of the guidelines developed by the Centers for Disease Control and Prevention (CDC).[55] The means of screening and assessment are at the discretion of the state refugee health coordinator and local jurisdictions. For the mental health component of the screening, some state refugee health coordinators report widespread use of the Refugee Health Screener-15. However, this assessment tool has only been validated for children over the age of 14, and CDC guidance for young children is extremely limited.[56]

The CDC and ORR should consider developing joint guidance for mental health screenings for refugees and other ORR-eligible populations that establishes a standard of practice for screening children and youth, including those under age 5. Creating a standard would leverage existing systems and resources to ensure that these young children are being screened for free at the earliest opportunity. The CDC should also consider evaluating the utility of the Refugee Health Screener-15 for detecting mental health issues in young children, as well as developing more robust guidelines and appropriate tools as needed for screening and assessing this demographic, in coordination with clinicians and early childhood providers.

2 Improve the accessibility and cultural and linguistic responsiveness of IECMH consultation initiatives for immigrant and refugee families.

IECMH consultation is an intervention used to promote social-emotional development through support provided by professionals with mental health expertise to caregivers such as early childhood educators and/or family members. It is an important strategy that can reach young children in the context of their early learning programs, leveraging an existing touchpoint to identify and help address challenges they face. However, because children of immigrants and refugees access formal early learning programs at lower rates than their peers and are more likely to be in FFN care and other home-based care settings, they are less likely to receive beneficial mental health supports in the settings where they receive care. A study conducted by Georgetown University's Center for Child and Human Development found that IECMH consultation, similar to other supports, is not accessible by or designed for FFN providers, and that it is primarily geared toward licensed and center-based providers. The study also revealed the many mental health concerns faced by FFN providers that could potentially be eased by access to services.[57]

Broadening federal and state early childhood policy and funding parameters to include FFN providers could improve access to IECMH consultation for immigrant and refugee families and support a healthy socioemotional environment for their young children. Outside that formal system, increasing the availability of peer supports for FFN providers through existing networks and community-based organizations could also significantly improve provider well-being, contributing to the emotional support they are able to provide the children in their care.

FFN providers from culturally and linguistically diverse backgrounds can offer valuable, authentic connections to immigrant and refugee families. But some hesitate to access supports, including mental health supports, if they see them as part of a larger system that does not welcome or accept their approaches to child care.[58] To overcome this hesitation, organizations and networks that have trusted relationships and a shared cultural foundation with FFN providers can serve as brokers to connect them to these supports. Immigrant-serving organizations that offer early childhood and mental health services can create a touchpoint for immigrant and refugee families to demystify and destigmatize mental

health issues and lower the hurdles to accessing IECMH services.[59]

3 Recruit pediatric health-care providers to serve as an IECMH touchpoint for families who do not have access to many other early childhood services.

Immigrant and refugee families do not always have access to early childhood services, such as home visiting initiatives and early childhood education and care programs. Access to pediatric care is more common, and this could be an opportunity to provide IECMH services in a non-stigmatized environment.

Given the complex nature of mental health issues, primary pediatric physicians are not always equipped to provide adequate IECMH care without the help of specialists.[60] Collaborative, multidisciplinary, team-based pediatric care—such as the patient-centered medical home model and colocation of resources[61]—can help ensure that IECMH support is available as part of refugee and immigrant families' pediatric care plan. Zero to Three's HealthySteps model is a promising approach that pairs child development specialists with pediatric primary care providers, increasing access to comprehensive services for those who need them most. One of HealthySteps' sites, the Lowry Family Health Center in Denver, Colorado, serves a large population of newly arrived refugees and other immigrants, and successfully enrolls many of these families in higher-intensity care programs, increasing opportunities for families to connect with services and building trust-based relationships conducive to identification of and intervention in IECMH issues.[62]

Collaborative, multidisciplinary, team-based pediatric care... can help ensure that IECMH support is available as part of refugee and immigrant families' pediatric care plan.

Pediatric care providers can also consider targeted strategies to improve the likelihood that immigrant families will be connected to beneficial services once referred. For example, the Pediatric Clinic at Harborview Medical Center in Seattle, Washington, makes an effort to conduct screenings through bilingual and bicultural family navigators at every wellness visit, going beyond the American Academy of Pediatrics' recommended screenings, in response to the risks facing the immigrant communities the center serves.[63] This clinic also tracks the success rate of referrals as a key equity outcome, encouraging warm hand-offs between professionals and follow-through for patients who require multiple touchpoints and check-ins to achieve connection to services—policies rooted in recognition that the standard markers for engagement do not always lead to equity for this group.[64] Research shows that youth who are Black, Indigenous, or people of color are less likely than their White peers to access psychiatric support through pediatric care, indicating a need for strategies of this kind to reduce gaps in connection and access to services.[65]

4 Consider the use of assessment tools that have been translated and validated for use with a diverse immigrant and refugee population.

To provide accurate and appropriate assessments for immigrant and refugee populations, professionals should consider using tools that have been translated and validated for use with diverse populations, such as the Parents' Evaluation of Development Status (PEDS) and the Survey of Well-Being of Young Children (SWYC). While there is no universal or perfect tool available for mental health assessments of young children, and more research is needed to develop and disseminate assessment tools made specifically for immigrant and refugee populations, several developers have taken steps to provide culturally appropriate assessments.

The SWYC is brief and easy to read and provides instructions on how further translations can be created with no additional licensing fee,[66] which can encourage further translations to the benefit of speakers of less common languages. This is in contrast to the more widely used ASQ-3, for which additional translated versions and licenses are available at an additional cost.[67] The PEDS, which has several licensed translations, has the added benefit of creating a partnership between practitioners and parents, as part of the assessment is filled out by parents themselves. This recognizes parents as the experts on their own children and acknowledges their ability to provide information across linguistic and cultural contexts that practitioners cannot always observe during formal testing.[68]

5 Leverage home visiting services as an effective two-generation, relational approach to improve IECMH access for children and parents in immigrant families.

Home visiting is an effective two-generation service that can support the well-being of both parents and children. It also has the potential to support immigrant and refugee families' successful access to IECMH services. Promising practices such as Baby TALK (Teaching Activities for Learning and Knowledge) in Illinois have shown the potential of home visiting to support trauma-exposed refugee and immigrant families. Baby TALK is a community-based early intervention model that emphasizes a relational approach, utilizes effective communication strategies that honor culture, and approaches families with respect and curiosity.[69]

Working with RefugeeOne, the largest refugee resettlement organization in Illinois, Baby TALK has been able to reach out to refugee families directly, creating a clear link between refugee services and home visiting services. Families receive one-on-one support from home visitors from a similar cultural and linguistic background, many of whom are themselves refugees. Families who have participated have seen a positive impact on their children's language and social-emotional development, decreased stress and trauma symptoms for parents, increased access to referrals, improved economic self-sufficiency, and a positive impact on parenting practices.[70] Home visitors can also provide resources and connect families to additional services, such as mental health and general health screenings and appropriate child-care services. Through these referrals, families can access mental health treatments with medical professionals.

The MIECHV program, which is federally funded and administered by the Health Resources and Services Administration in collaboration with the Administration for Children and Families, continually evaluates the effectiveness of home-visiting models based on rigorous research studies.[71] Most research and evaluations of MIECHV-approved home visiting models, however, have not accounted for the needs and experiences of diverse communities.[72] States and counties should recognize the importance of serving immigrant and refugee families and consider the use of emerging models that are developed for specific cultural groups but not yet classified as evidence-based by MIECHV.

6 In efforts to address the shortage of IECMH care providers, prioritize workforce diversification and appropriately reward the critically important skills of cultural brokers and family navigators.

Promoting cultural and linguistic diversity within the IECMH workforce is an important strategy to improve the relevance and quality of services for immigrant and refugee families, as research highlights the importance of linguistic and cultural competence.[73] The mental health workforce overall in the United States is not keeping pace with the increasing diversity of the U.S. population, and practitioners are predominantly White.[74] The same likely

holds true for the IECMH clinical workforce, though data regarding the racial and ethnic composition of professionals in this field are scarce. In recognition of this disparity, several initiatives are underway to address the need for a more diverse and culturally competent IECMH workforce.

One example of a local effort to diversify staff is an initiative launched in 2023 by Best Starts for Kids (a community program in King County, Washington) to provide an accessible Infant Mental Health Certificate program that offers foundational training and qualification to a racially and ethnically diverse group of providers, interpreted in a wide range of languages. The inaugural cohort included child-care providers, home visitors, nurses, and social workers.[75] The Supporting Immigrant Families Learning Collaborative Project in Boston, by the Erikson Institute and Boston Medical Center, is another effort that offers resources, training, and support to IECMH staff working directly with mixed-status and unauthorized immigrant families to promote their well-being and sustainability, addressing critical issues of burnout and secondary trauma.[76]

In interviews, health-care administrators and providers highlighted the invaluable skills of family navigators and cultural brokers.

Supporting, resourcing, and retaining diverse workers across the early childhood and mental health fields is also a critical part of improving promotion and prevention efforts and connecting immigrant and refugee families with needed mental health services. In interviews, health-care administrators and providers highlighted the invaluable skills of family navigators and cultural brokers. These staff, who are hired from within the community they serve, act as trusted messengers who bridge both linguistic and cultural gaps between families and care providers—and in doing so, increase families' access to and participation in regular appointments as well as follow-up services and referrals. Funding opportunities that support such staff positions have the potential to reduce gaps in outcomes and dropped referrals for immigrant and refugee families who are considered hard to reach.[77] The family specialists employed in the DULCE (Developmental Understanding and Legal Collaboration for Everyone) program in Orange County, California—which serves predominately Hispanic families, many of them non-English-speaking—are an example of how the trusting relationships that bilingual and bicultural staff develop can increase uptake and retention.[78]

7 **Promote research into best practices for culturally specific IECMH assessments and interventions among refugees and immigrants.**

Despite the evident need for mental health interventions for young immigrant and refugee children, there is a limited body of empirical support for culturally specific interventions and assessments for this population. For example, only a few studies have tested both the psychometric properties and cultural fit of mental health assessments for immigrant and refugee youth, and even fewer for children under age 5.[79] These studies have significant variation in the measurement tools, evaluation methods, and frameworks employed in assessing and addressing mental health concerns, resulting in a dearth of empirical support for any one approach.[80]

The high level of need for mental health services among migrant children often leads clinicians to use any tool available, regardless of validity and without consideration of cultural context—risking inadequate assessment, under- or over-diagnosis, and inappropriate treatment.[81] Research suggests that culturally specific interventions result in significantly better outcomes for cultural minority groups.[82] Thus, government and philanthropic funders and research institutions should invest in growing this knowledge

base needed to improve the relevance of tools and services for children in immigrant and refugee families.

8 Employ a ground-up collaborative approach to intervention development and adaptation that is informed by cultural context and community needs.

Cultural adaptations of mental health interventions and assessments often use a top-down approach, modifying an existing tool or technique developed for one group for use with another.[83] This approach privileges mainstream conceptualizations of mental distress and healing, often formed within Western contexts.[84] Yet perceptions of mental health vary across cultures, as groups hold different beliefs and express distress, well-being, and healing in different ways.[85] Ideally, interventions should be developed within a specific cultural context from the ground up, making the targeted group the primary point of reference. However, adapting existing interventions for cultural fit can at times be less costly and more practical.[86] In this case, it is critical that researchers understand the specific community and cultural contexts of risk and resilience that may affect mental health and the effectiveness of an intervention or assessment.[87]

Researchers should collaborate with local organizations and mental health providers to center the unique needs of a community in intervention development, as well as to evaluate existing community-based approaches to supporting young children in refugee and immigrant families.[88] Adaptations should go beyond translation, as translating a tool from one language to another does not necessarily lead to cultural congruence.[89]

Diagnostic criteria for mental health disorders, as dictated by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V)—and, specifically for young children, the *Diagnostic Classification of*

BOX 1
Community Participation in Building Cultural Competency: Promoting First Relationships

Promoting First Relationships (PFR) is an evidence-based training program targeting social-emotional development and the healthy attachment of caregivers and their children ages 0–5. Established at the Barnard Center at the University of Washington, the program offers training to child-care providers and other direct service professionals on consultation and intervention strategies to support the well-being of caregivers and young children. PFR is delivered as a curriculum-based training across Washington State through a variety of programs and services, including organizations that target refugees and immigrants.

The Barnard Center has taken proactive steps to center cultural competency. In response to the growing use of PFR among diverse populations, particularly in King County, the Center ran focus groups among community organizations to develop the knowledge and tools needed to effectively engage with providers and parents from diverse backgrounds, including refugees and immigrants. The Center developed reflection tools to incorporate into the training curriculum that ask participants to think about how culture, background, and past experiences affect parenting.

PFR materials are available in English, Spanish, and Somali, reflecting the needs of ethnically diverse communities in Washington. The translation process for the Spanish and Somali versions involved working closely with native speakers from PFR community providers and families to ensure that the language was tied to culturally specific concepts. The Barnard Center has received a grant to translate the training into 25 new languages and is training providers who speak languages other than English to better serve the needs of diverse refugee and immigrant communities.

Source: author interview with Jennifer Reese, University of Washington Barnard Center, Washington, July 31, 2023.

Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)—were developed in a Western context, so it is critical that interventions appropriately address culturally specific symptomologies.[90] It is also imperative that researchers and practitioners identify and address their own racial or cultural biases, as these may influence the design, implementation, and evaluation of interventions and assessments.[91]

7 Conclusion

The intersection of early childhood, mental health, and immigrant and refugee services is an area that is often overlooked, given its position at the convergence of fields that each continues to struggle to gain visibility and sufficient resources. Yet the potential positive impact of culturally relevant, high-quality, and readily accessible IECMH services for underserved immigrant and refugee families demands that government agencies, immigrant-serving organizations, early childhood programs, and physical and mental health providers work collaboratively to address the compounding obstacles that many of these families face. Working to include often-marginalized groups in IECMH systems and programs is an essential part of helping families build a foundation for their young children's socioemotional wellness.

Working to include often-marginalized groups in IECMH systems and programs is an essential part of helping families build a foundation for their young children's socioemotional wellness.

Appendix

TABLE A–1

Immigrant Populations in the United States and Their Eligibility for Integration Services and Federal Means-Tested Benefits on the Basis of Immigration Status

Population	Integration Services and Benefits Eligibility
Humanitarian Populations	
Refugees are individuals who are outside of their country of origin and unable or unwilling to return because of persecution or a well-founded fear of persecution on the basis of race, religion, nationality, political opinion, or membership in a particular social group. A small percentage of refugees registered globally are referred to the U.S. Department of State's Reception and Placement (R&P) program and admitted to the United States. **Special Immigrant Visa (SIV) holders** are Iraqi and Afghan individuals who worked for the U.S. government or military during a prescribed time period and who have experienced or are experiencing threats because of their U.S. affiliation. Like refugees, they are admitted to the United States through the U.S. Department of State's R&P program.	In their first 90 days in the United States, refugees and SIV holders receive a host of federally funded integration services, such as support with school and welfare enrollment, housing, and employment support. The Office of Refugee Resettlement (ORR), part of the U.S. Department of Health and Human Services, provides funding to support the long-term integration of these and other humanitarian populations eligible for ORR-funded resettlement services with specialized funding streams such as Refugee Support Services, the Refugee School Impact grant, and the Preferred Communities grant, which support integration services for populations with special needs. All refugees and SIV holders are also immediately eligible for all mainstream federal means-tested programs for low-income individuals (such as Temporary Assistance for Needy Families [TANF], the Supplemental Nutrition Assistance Program [SNAP], Medicaid and the Children's Health Insurance Program [CHIP], and Supplemental Security Income [SSI]) on the basis of their status.
Asylees are individuals who, like refugees, are unable or unwilling to return to their country of origin because they have a well-founded fear of persecution. But unlike refugees, who are outside the United States when screened for resettlement, asylees are granted that status after seeking protection within the country or at a U.S. port of entry.	From the time asylum is granted, asylees are eligible for mainstream federal means-tested programs on the basis of their status as well as the same ORR-funded benefits and services as refugees. Unlike refugees, there is no federal mechanism to inform asylees of their eligibility for these benefits or to connect them with a resettlement agency that would provide a range of core integration-related services.
Asylum seekers are individuals awaiting a decision on their asylum case, having sought protection either at a U.S. port of entry or from within the country. With a backlog of approximately 2 million asylum cases as of November 2023, many asylum seekers wait for three to six years for a decision.	There are no federal programs dedicated to asylum seekers' integration, and they are categorically ineligible for ORR-funded benefits and services and most mainstream federal means-tested programs. If an individual is granted asylum (and thus becomes an asylee), that status comes with expanded service eligibility, as described above.

TABLE A–1 (cont.)

Immigrant Populations in the United States and Their Eligibility for Integration Services and Federal Means-Tested Benefits on the Basis of Immigration Status

Population	Integration Services and Benefits Eligibility
Cuban and Haitian entrants are individuals from Cuba or Haiti who have been granted parole or are awaiting asylum and/or removal proceedings and who do not have an enforceable, unappealable order of removal.	Cuban and Haitian entrants, like refugees and asylees, are eligible for ORR-funded resettlement and integration services. They are also immediately eligible for mainstream federal means-tested benefits and services to the same extent as other ORR-eligible humanitarian populations.
Unaccompanied children are children and youth under age 18 who arrive or are detected in the United States without lawful immigration status and without a parent or legal guardian in the United States who is able to take physical custody of them. After these children have been identified by a federal agency (typically, U.S. Customs and Border Protection) as unaccompanied, they are referred to ORR's program for unaccompanied children.	A significant number of unaccompanied children referred to ORR are released to sponsors in U.S. communities while they await immigration proceedings, but some remain in federal custody until they age out of ORR's unaccompanied children program at age 18. ORR provides various forms of support and integration services during their time in federal custody, and some receive ongoing integration support following their release to a sponsor (known as post-release services). Unaccompanied children released to sponsors are subject to the standard status-related eligibility restrictions for federal means-tested programs. By definition, unaccompanied children do not have lawful status in the United States and thus are considered categorically ineligible for those benefits programs until a lawful status (e.g., asylum, Special Immigrant Juvenile status) is conferred, if one is conferred. Exemptions to restrictions may be made for unaccompanied children on the basis of age.
Survivors of trafficking are individuals in the United States without lawful status who have experienced sex or labor trafficking. Formal status is conferred if an individual has been certified as such by ORR and/or holds a T visa, and it can also be held by family members eligible for derivative status.	T visa holders, like refugees and asylees, are eligible for ORR-funded resettlement and integration services. Once formal status has been conferred, they are also immediately eligible for mainstream federal means-tested benefits and services to the same extent as other ORR-eligible humanitarian populations.
Humanitarian parolees and recipients of other types of parole are granted temporary admission into the United States for a period determined by the federal government. Parole is granted for reasons of public benefit and/or humanitarian benefit through a designated program (e.g., the Cubans, Haitians, Nicaraguans, and Venezuelans [CHNV] program) or at a U.S. port of entry.	Parolees are eligible for most mainstream federal means-tested benefits if their parole period exceeds one year. Certain humanitarian and other parolees (e.g., Afghans, Ukrainians, Cubans, and Haitians) are immediately eligible for mainstream federal means-tested benefits and ORR-funded benefits and services.

TABLE A–1 (cont.)

Immigrant Populations in the United States and Their Eligibility for Integration Services and Federal Means-Tested Benefits on the Basis of Immigration Status

Population	Integration Services and Benefits Eligibility
Other Populations	
Lawful permanent residents (also known as green-card holders) have been granted the right to reside permanently in the United States. This can be the result of family ties, through employment, humanitarian channels (e.g., adjusting from refugee or asylee status), or the Diversity Visa lottery.	Some lawful permanent residents are admitted to the country through programs with dedicated integration services (such as those initially admitted as refugees). Lawful permanent residents who have held that status for five years and meet other program-specific eligibility criteria qualify for mainstream federal means-tested programs. However, those who adjust from humanitarian statuses that make them immediately eligible for mainstream benefits may qualify sooner on the basis of that prior status and eligibility period.
Nonimmigrants are individuals who enter the United States on a temporary basis for reasons such as tourism (e.g., B-2 visas), study (e.g., F-1 visas), business (e.g., B-1 visas), labor (e.g., H-2A visas for agricultural workers), or diplomacy (e.g., G-4 visas for international organization personnel).	Nonimmigrants do not receive any federally systematized integration services and are categorically ineligible for federal means-tested programs.
Unauthorized immigrants are present in the United States without authorization from the federal government. Some have entered the country without permission, while others have overstayed a visa or some other lawful status.	Unauthorized immigrants are categorically ineligible for most federal means-tested programs. U.S.-born children with unauthorized immigrant parents can qualify for such programs on par with other U.S.-citizen children. Certain federal means-tested programs (such as Head Start and the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) do not limit participation based on immigration status.

Note: This table shows those immigration status categories with the greatest relevance to young children, given this brief's focus on that population. For a more in-depth examination of immigrants' eligibility for public benefits based on their status, see Valerie Lacarte, Julia Gelatt, and Ashley Podplesky, *Immigrants' Eligibility for U.S. Public Benefits: A Primer* (Washington, DC: Migration Policy Institute, 2024).

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