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Supporting Immigrant and Refugee Populations

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Introduction

Occupational therapists in various practice settings are likely to encounter immigrant and refugee clients, families, and populations. In addition, immigrants and refugees are more likely than the general population to face hurdles around both ADL and IADL participation. This population is particularly vulnerable to traumatic experiences as a result of deportation threats, difficulty acclimating to societal norms, obtaining safe housing for themselves and their family, and struggling to find gainful employment. Since occupational therapists are likely to treat individuals who are immigrants, refugees, or have some relation to these populations, it is important that providers are aware of the contextual factors that may impede clients' abilities to access healthcare services. Health management, health maintenance, and social participation are just some intervention areas that occupational therapists can help this population access.

Section 1: Background and Definitions

References: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11

There are various terms therapists should understand when working with immigrants, refugees, and other individuals in similar situations. The term refugee is used to describe any person who unwillingly and spontaneously flees their home country due to feeling unsafe there. Many refugees leave their country as a result of violence, intense persecution, war, and similar threats. Refugees apply for protection through the resettlement program in their country of destination. Once their application is accepted, refugees then enter their new country. This gives them a legal right to be in the country they flee to, as they are protected by international laws such as the Universal Declaration of Human Rights and the 1951 Refugee Convention and organizations such as the United Nations High

Commissioner for Refugees. The U.S. sets a yearly ceiling on refugee admittance, which causes variation in how many individuals are accepted from year to year. In 2023, the U.S. admitted just over 60,000 refugees, which is more than double the number from 2022 (around 25,000). Since 1975, the United States has accepted more than 3 million refugees.

Refugees may be confused with asylum seekers, who similarly flee their home countries without warning due to fear of imminent harm. The main difference between refugees and asylum seekers is the timing of when they apply for legal protection in their new country and when they enter that country. Refugees only enter the country after their application is accepted. Asylum seekers go to their country of destination before their application has been processed, which is why a large number of these individuals may come through unverified borders. This is due in large part to the exorbitant wait times for asylum seekers. As of 2024, there was a backlog of over 2 million asylum claims. More than half of these claims were held up in U.S. immigration courts. Even still, asylum seekers have legal protections of their own. They are not protected under the resettlement program as refugees are, but asylum seekers can remain in their new country due to the international non-refoulement law. This law prevents any country from returning a person to a place where they were subjected to or had a real risk of experiencing serious harm. This also entitles them to certain benefits in their new country as well as the ability to petition for their family members to enter the country. Individuals whose asylum has been granted are known as asylees. After one year of being in the United States and being formally granted asylum, asylees are eligible to apply for a green card.

Immigrants are individuals who plan and prepare to leave their home country and move to a new country for the foreseeable future. While not all immigrants end up becoming citizens and/or permanent residents of their new country, many do. The immigrant population in the United States is quite large, at 47.8 million

people as of 2023. However, this is because the term immigrants is inclusive of three classes of people – those who have undergone the full citizenship process, those who have been authorized to come to the U.S. via a work visa or other legal permit, and undocumented residents. As of 2024, immigrants make up over 19% of the United States workforce, which amounts to around 32 million people. This percentage is the highest it has ever been with immigrant workers now entering the U.S. workforce at a higher rate than U.S.-born workers.

Immigrant is a term that may be used interchangeably with migrant, though the two are different in their permanency. Migrant is a term that describes people who move between places to find work. Migrants may move to different parts of their own country or even across international borders to look for seasonal work. Since these individuals are overwhelmingly working in the agricultural industry, they are commonly referred to as migrant and seasonal agricultural workers, or MSAWs. Due to the transient nature of this population and their lack of documentation, it is difficult to know exactly how many MSAWs are in the United States. Estimates suggest there are anywhere from 1 to 3 million MSAWs working in the U.S. The majority of MSAWs (85%) are seasonal workers who come and go every few months between the U.S. and their country of origin. The remaining 15% of these individuals are true migrant workers who spend longer periods of time working in the U.S. Migrants are similar to immigrants in that there is intention and planning behind each of their moves. Both migrants and immigrants undertake such moves to seek new and, oftentimes, better opportunities for themselves and their families.

Section 1 Personal Reflection

What role might OT have in treating migrant and seasonal agricultural workers?

Section 1 Key Words

Asylee - Someone who spontaneously flees their country due to imminent fear of danger, applies for asylum in a new country, and enters that country once the application has been approved; asylees are protected under international non-refoulement laws and can apply for a green card after one year of living in the United States

Asylum seeker - Someone who spontaneously flees their country due to imminent fear of danger, applies for asylum in a new country, and enters that country before the application has been approved; asylum seekers are protected under international non-refoulement laws

Country of destination - The country or territory that an immigrant, refugee, or asylum seeker plans to make their new residence

Country of origin - The country or territory where an immigrant, refugee, or asylum seeker most recently came from

Immigrant - An individual who plans and prepares to leave their home country and move to a new country for the foreseeable future to access better opportunities; immigrants may or may not become permanent citizens of their country of destination

Migrant - Someone who moves between different parts of the same country or across international borders to find work; the majority of migrant workers are seasonal workers, particularly those in the agricultural sector

Refugee - Someone who spontaneously flees their country due to imminent fear of danger, applies to enter a new country, and enters that new country once their application has been approved; refugees are protected under the U.S. resettlement program

Section 2: Intersection of Immigrants & Refugees with Occupational Therapy and Human Rights

References: 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30

Due to the circumstances surrounding the departure from their country of origin, refugees, asylum seekers, and immigrants may face a range of barriers. These can include but are not limited to:

- Physical and psychological effects of trauma stemming from exposure to persecution, war, violence, and other forms of conflict and abuse
- Psychosocial concerns such as isolation, disorientation, difficulty adjusting, and more due to grief, loss, and displacement from familiar surroundings
- Inhospitable and sometimes even unsanitary travel conditions during their journey to a new country
    - Refugees and immigrants may be exposed to infectious diseases and medically unsafe situations during their journey, especially if they are taking lesser-traveled routes and passing through multiple countries via unverified borders.
    - Furthermore, refugees and immigrants with chronic and acute health conditions may have difficulty with health management tasks such as taking medications, getting enough rest, eating a well-balanced diet, and more during such a large transition.
- Fear of or threats from smugglers, human traffickers, and others who exploit vulnerable people
    - This may be a barrier refugees and immigrants face as they travel to a new country and even once they reach their destination.

- Language barriers and cultural differences can cause difficulty accessing employment, education, and healthcare services as well as integrating into social settings
    - Individuals who speak languages such as Spanish or French may not have as many difficulties in this area as people whose only language is less commonly spoken.
- Financial insecurity is a known barrier for those who do not have work and living arrangements planned out ahead of time
- Social integration, IADLs, employment, and other community tasks may be impacted by the effects of xenophobia, which can lead to isolation, financial instability, and additional mental health challenges
- Difficulty navigating the asylum and citizenship procedures as well as any that accompany them, such as applications for housing, health insurance, vehicle licensure, and more
    - This does not just refer to refugees and immigrants who speak other languages, as such processes are known to be lengthy and complex even for those whose first language is English.
- Fear of seeking social, legal, and medical services in their new country, especially if their immigration status is still pending
    - This can result in preventable medical conditions and can also lead to complications from existing health conditions.

Each of these barriers stands to negatively impact the lives of refugees and immigrants. The causes attributed to each barrier vary. Some – such as mental health concerns arising from difficulty adjusting to their country of destination – are individual in nature. The majority of barriers this population experiences,

however, are systemic. This means they pertain to legislation, government processes, and similar large-scale causes that affect the way immigrants and refugees assimilate into their new country.

As you may recall from the list, access to healthcare is considered a barrier for this population. Access to healthcare is unique in that it may be both individual and systemic in nature depending on the person. If individual barriers prevent someone from accessing healthcare, this may stem from cultural differences or a fear of persecution and mistreatment due to these differences. Systemic barriers that prevent immigrants and refugees from obtaining healthcare include high fees associated with medical services, low health literacy, stigma, poor or absent education regarding how to navigate the healthcare system (along with insufficient amounts of related support to remedy this concern), lack of interpreter availability, and fear of deportation.

Immigrants & Refugees' Right to Healthcare

We discussed some legal rights held by immigrants, refugees, and related populations. It is also important to recognize access to healthcare services as another right these populations possess. While this is a very basic human right, the process of accessing said healthcare services is somewhat complex.

Firstly, immigrants who are not officially documented do not have access to health insurance provided via federal funding. This means they cannot seek coverage through Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). However, undocumented immigrants may receive coverage through emergency Medicaid, which is utilized solely for the treatment of emergency medical conditions. Emergency Medicaid is allowable under the Emergency Medical Treatment and Labor Act (EMTALA). This federal legislation requires all hospitals that accept Medicare or Medicaid to evaluate anyone who is seeking any type of

emergency medical care. This allows any individual (regardless of their insurance coverage or ability to self-pay) to receive immediate and urgent medical attention for any condition that leads to a serious impairment of bodily functions, results in serious dysfunction of an organ or another body part, and places the individual's health at serious risk. In order for an undocumented immigrant to qualify for emergency Medicaid coverage, they must meet all other non-immigration-related Medicaid requirements set forth by the Centers for Medicare and Medicaid Services. To be covered under emergency Medicaid, the emergency medical services:

- Must be delivered in an acute care hospital emergency room or an acute care inpatient hospital
- Cannot include organ transplants
- Do not encompass any services provided before or after the emergency medical services (e.g. related or unrelated visits that are non-urgent in nature and occur before the emergency services, follow-up visits subsequent to emergency medical services)
- Cannot include routine prenatal or post-partum care
- Cannot include long-term care
- Cannot include rehabilitation services, including physical therapy, occupational therapy, and speech therapy

Exclusion from traditional, more comprehensive federal programs does leave immigrants and refugees with fewer insurance options. However, these groups are able to receive routine, non-urgent care through state-funded healthcare organizations. This includes non-profit hospitals, public hospitals, migrant health centers, and federally qualified community health centers (FQHCs).

Immigrants and refugees with the appropriate documentation, on the other hand, have a right to healthcare under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This legislation states that qualified people are able to access federal and state public health benefits, such as Medicaid. The PRWORA defines the following individuals as qualified persons:

- American Indians who were born in Canada
- Any victims of human trafficking along with their children, spouses, siblings, or parents, as long as they have a pending application for a victim of trafficking visa
- Anyone paroled into the United States for more than 1 year
    - Immigration parole is a temporary, discretionary status issued by the government. This is offered to individuals doing urgent humanitarian work or engaged in other efforts that significantly benefit the public. Immigration parolees are protected by the Immigration and Nationality Act (INA).
- Anyone who has been granted withholding of removal, also known as withholding of deportation
    - This refers to anyone the government cannot deport because their freedom, life, and other basic rights would be threatened in their country of origin on the basis of political affiliation, nationality, race, religion, or social group membership. Individuals granted withholding of removal are protected under an international human rights treaty called the United Nations Convention against Torture (UNCAT).
- Anyone who has been issued an administrative order staying removal by the Department of Homeland Security

    - This is defined as a temporary pause in proceedings for deportation that protect a person from being removed from the country. Due to its temporary nature, someone can use this time to appeal their deportation and/or fill out applications in an effort to change their permanent residence.

- Asylees
- Citizens of the Marshall Islands, Palau, and Micronesia who live in any U.S. state or territory
    - These individuals are also known as Compact of Free Association (COFA) migrants.
- Conditional entrants that were granted lawful permanent resident status before 1980
- Cuban or Haitian entrants
- Individuals who have Deferred Action Status
    - This status is granted by federal immigration judges or the United States Citizenship and Immigration Services, and allows someone to work and live in the U.S. for a specific period of time. Deferred Action Status is temporary and does not offer a pathway to citizenship.
    - For the sake of PRWORA, the only type of Deferred Action Status that does not qualify for health insurance coverage is those with Deferred Action for Childhood Arrivals (DACA).
- Individuals who have been granted Deferred Enforced Departure (DED)
    - This is a non-application-based status granted by the President of the United States that allows someone to work and live in the U.S. for a

specific period of time. Deferred Enforced Departure is temporary and does not offer a pathway to citizenship.

- Individuals who have Temporary Protected Status (TPE)
    - This is granted to individuals from certain countries who the U.S. deems it temporarily unsafe to return to as a result of natural disasters, active and armed conflict, and other extraordinary conditions.
    - TPE not only protects someone from deportation, but also grants them authorization to work.
- Lawful permanent residents, also known as green card holders or LPRs
- Lawful temporary residents, such as those with non-immigrant status who hold student visas, worker visas, U-visas, and any other type of visa
- Members of a federally-recognized Indian tribe
- Refugees
- Residents of American Samoa
- Victims of domestic violence who are attempting to become lawful permanent residents along with their children, parents, or spouses

Lawful permanent residents of the United States qualify to receive coverage through the Affordable Care Act's healthcare marketplace. In addition, individuals who meet this criteria can also receive tax credits to offset the cost of their insurance premiums. Typically, newly immigrated individuals must be in the United States for five years before they can register for Medicaid or CHIP services. However, this five-year waiting period is waived for certain immigrant groups, including:

- Active-duty military or veterans along with unmarried dependents or spouses (dependents or spouses must be considered qualified non-citizens)
- Amerasian immigrants
    - These are mixed race individuals who were born to Asian mothers in Asian countries and have fathers who were in the U.S. military around the time of their birth.
- Anyone who has been granted withholding of removal or withholding of deportation
- Asylees
- Entrants from Cuba or Haiti
- Iraqi and Afghani parolees and special immigrants
- Refugees
- Select lawful permanent residents
- Victims of human trafficking along with their children, spouses, siblings, or parents

In the event a refugee is not eligible for Medicaid for whatever reason, they can receive short-term medical coverage through the Refugee Medical Assistance (RMA) program. This program offers up to one full year of coverage to non-citizens who fall under the category of refugees according to the Immigration and Naturalization Act. The RMA is funded by the U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement. Refugees covered under RMA are connected with benefits close to those of Medicaid. They are given a medical screening upon their arrival in the United States. These take place at local public and private health clinics who are contracted with replacement designees

(RDs) that reimburse for the cost of evaluation. Replacement designees are entities outside of the state government who are charged with some or all responsibilities associated with the Refugee Resettlement Program in their state.

Occupational Injustices Impacting Immigrant and Refugee Populations

There are many occupational concerns that affect immigrants, refugees, and related populations. According to the American Occupational Therapy Association's Occupational Therapy Code of Ethics, all occupational therapy providers must maintain a commitment to the promotion of well-being, safety, inclusion, empowerment, and participation for all individuals. This extends to people in any phase of illness, health, or life. As part of an OT's scope of practice, therapists must uplift their patients in service to meet each of their occupational needs. In addition, there is no distinction that therapists must only help individuals, as they are equally qualified and capable of offering services to communities, populations, groups, families, organizations, and more. This verbiage in AOTA-created documents highlights just how well-suited OT providers are to treat immigrants and refugees.

Occupational apartheid is one of the most prevailing forms of injustice in this realm, as refugees, immigrants, and others in similar circumstances are all at risk of experiencing segregation in cultural, political, social, economic, and systemic ways. This type of injustice is on the basis of a person's innate characteristics, such as their nationality, ethnicity, race, gender, age, and/or social status. Any form of segregation – along with discrimination and prejudice – stands to bar these individuals from accessing equal opportunities and engaging in meaningful activities. Occupational apartheid is so significant in refugee and immigrant

populations that these individuals are entirely excluded from the aforementioned realms. This has a largely negative effect on their quality-of-life.

Refugees and immigrants who are subject to occupational marginalization have experiences akin to those of occupational apartheid, though not to the same extent. Many refugees and immigrants have unequal degrees of access to social services, medical care, employment opportunities, housing accommodations, leisure, and leveling up their social status/class. Individuals who experience occupational marginalization have *some* level of opportunity and ability to function in these areas. However, systemic barriers cause refugees and immigrants to have far fewer and less enticing opportunities than the general population has access to. In addition to lacking potential for these pivotal opportunities, occupational marginalization also manifests as not having agency over one's life and lacking the ability to make decisions. Similarly, these adverse effects originate from systemic barriers, but may be exacerbated by language barriers and cultural barriers.

Occupational alienation is another form of occupational injustice that has a much stronger emotional component. Historically, refugee and immigrant populations primarily have access to activities and opportunities that lack meaning to them. Therefore, they are at a greater risk of experiencing negative emotions such as isolation, lack of fulfillment, disconnectedness from their surroundings, lack of community, and emotional emptiness. In many cases, occupational alienation in these populations may stem from not having friends and family with them, but it may also be due to lack of acceptance from people around them.

Occupational imbalance is when someone has poor alignment with the activities they spend the most time doing. When someone focuses almost entirely on one area of their life, the others tend to suffer. If immigrant and refugee populations are not allowed to engage in the diverse range of occupations that other

individuals can (due to the lack of access characteristic of other forms of injustice), they are more likely to spend an excess of time doing the same activities. In some cases, the aforementioned activities don't have much meaning to them, which is why occupational alienation and occupational imbalance can be closely related. Occupational imbalance also involves a large disruption to someone's routines, rituals, and roles, which are so personal to someone. This is a key area to explore, as OT providers can play a large part in helping immigrants, refugees, and related populations who experience occupational imbalance.

Lastly, occupational deprivation tends to arise from many of the same causes we discussed earlier. Someone experiences occupational deprivation when they are unable to engage in certain occupations due to causes beyond their control. In the case of immigrants and refugees, these causes may be systemic, economic, cultural, political, and/or social in nature. There may be a period of time (sometimes extended, which is often the case for those who are undocumented or encounter smugglers/traffickers on their journey) when they are unable to obtain secure housing and have their basic needs met. In this case, they may be deprived of participation in ADLs, IADLs, and community integration. This can have a major influence on someone, regardless of whether or not those occupational areas were particularly valuable roles and activities for them.

As you can see, OT is well-suited to assist immigrant and refugee populations who experience a range of occupational injustices. We will discuss the ways in which occupational therapists can do this in upcoming sections.

Section 2 Personal Reflection

If a lawful permanent resident with all the proper documentation comes from Eastern Europe to the United States, is that person at risk of occupational

injustices? If so, which ones might they experience and how might that impact their day-to-day life?

Section 3: Population-Level Services for Immigrant and Refugee Populations

References: 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55

In order to understand how to best help immigrant and refugee populations from a population standpoint, therapists must understand the trauma they face. There are various stages of the transition between countries (often called resettlement) that OT providers should be aware of:

- **Pre-resettlement:** This is the preparatory phase that occurs before an immigrant or refugee makes a new country their residence. During this time, individuals go through medical screenings, security screenings, and a lot of paperwork as part of the application process.
    - Therapists working with individuals in the pre-resettlement phase should be aware of the impact that someone's education level and socioeconomic status have on their lives and the lives of their family. In addition, therapists should make considerations for the individual's sociopolitical context and the geographical location where they currently live.
- **Resettlement:** This phase consists of someone's journey to their country of origin, and is also associated with interviews, paperwork, and other requirements that allow them to enter this new country.

    - Some of the same therapeutic considerations apply to someone in this stage, as they are likely still dealing with the effects of trauma from experiences in their country of origin. Therapists should also factor in the effects of various modes of travel, traumatic events that take place during someone's travel journey, unsafe conditions they may be exposed to, and other environmental concerns.

- **Post-resettlement:** During this time, someone is settling into their new country and learning the basics about its culture, language, financial system, employment, housing, their local community, and more.
    - Therapists are especially equipped to help individuals during this phase as they are acclimating to many new situations and experiences. Therapists may also assist individuals with pending legal statuses, if their residence is still being processed, and handling various sociocultural barriers.

Refugees are at risk of experiencing various categories of stress. **Traumatic stress** is perhaps the most notable form and its sources serve as causal factors to a refugee fleeing their country. Traumatic stressors include persecution, community violence, family violence, war, home displacement, poverty, and migration, most of which take place in a refugee's country of origin. **Resettlement stress** is another type of strain that occurs once someone reaches their country of destination. This stems from refugees experiencing difficulties meeting their basic needs and can include poor access to resources, insufficient transportation options, lack of community support, difficulty finding safe and accessible housing, difficulty securing gainful employment, and any financial stressors that may result from the aforementioned causes. In a similar vein, refugees may also experience acculturation stress that is more interpersonal in nature. **Acculturation stress** can be caused by a continual need for translation services, difficulties fitting in at

school or in work environments, conflicts with new peers due to cultural differences, an inability to shift one's identity to include their culture along with that of their new residence, and potential clashes among family members regarding old and new cultural perspectives. Lastly, **isolation stress** can result in immigrants and refugees who feel the strain of their minority status through concerns such as discrimination, low social standing, lack of belonging, distrust from peers, harassment, prejudice, and feelings of loneliness.

Services for Immigrants and Refugees

Any population-level services provided to immigrants and refugees should be designed and implemented with strong consideration given to emotional well-being. Because occupational therapists understand the distinct impact of mental health concerns (either temporary or more lasting) on functional performance, it is crucial for these providers to be involved in the creation of such programming. The manner in which such services are provided is also important, which is why cultural competence should be a large part of professional development for anyone providing services to immigrants and refugees. In fact, cultural competence has crucial applications for therapists working with any and every population. For this reason, the American Occupational Therapy Association created the Educator's Guide for Addressing Cultural Awareness, Humility, and Dexterity in Occupational Therapy Curricula. This guide takes an intentional and effective approach to curriculum design by offering strategies, resources, and information to guide professors in building each OT students' skills, knowledge, and attitudes. Therapists working with immigrant and refugee populations should use this resource to guide treatment, achieve optimal health outcomes, and follow best practice. Other good resources are those that teach cultural humility, which is defined as ongoing self-reflection and self-awareness in order to recognize your own cultural biases and assumptions. Cultural humility paired with

cultural competence is one of the best ways to effectively meet the needs of patients from all backgrounds.

There are many population-level services that can benefit immigrant and refugee populations. These include but are not limited to:

- Free health clinics
    - Since many individuals who have just come to a new country may not qualify for or have immediate access to health insurance, they are at risk of going without medical care. If they do seek medical care at all, it is likely to be through free community health clinics in their area. Therapists and other clinicians in these settings can offer coaching to assist with health promotion and chronic disease management. If therapists encounter immigrants and refugees in need of free or low-cost medical care, they can utilize the directory through the National Association of Free & Charitable Clinics to locate clinics in their area.
- Vocational training
    - While some immigrants may come to a new country for a specific job, this is not the case for all immigrants and refugees. Therapists can work with these individuals in several ways. They can help individuals use their existing skills in a way that allows them to seek gainful employment. Alternatively, they can train them to develop new skills that prepare them for a job of their choosing. Therapists can connect patients with relevant resources such as the American Job Center or the Employment and Training Administration through the U.S. Department of Labor.
- Welfare and other social services

    - OTs can help immigrants and refugees get connected with welfare and other social service programs. This may be especially critical for pregnant women and families with young children. The Office of Refugee Resettlement operates under the Administration for Children & Families, which is responsible for some of the programs we discussed earlier such as Refugee Medical Assistance and related programs called Refugee Cash Assistance (RCA) and Refugee Support Services (RSS).

- Translation services
    - Immigrants and refugees whose first language is not English should have access to translation services. In many cases, therapists may focus on this as an initial referral or treatment goal, as this can assist patients with many other skill areas and resources. Therapists working at nonprofit organizations may help connect individuals with translators through Translators Without Borders. The Refugee Translation Project is another nonprofit organization that may be of assistance.

- Legal services
    - As mentioned earlier, immigrants and refugees may be in need of legal assistance but may also experience financial barriers to seeking this help. If that is the case, therapists may be able to direct patients to the directory of Pro Bono Legal Service Providers through the Executive Office for Immigration Review. Other resources in this arena include the Asylum Seeker Advocacy Project, which helps individuals seeking asylum with finding immigration lawyers while also offering assistance in other areas. The U.S. Committee for

Refugees and Immigrants also offers Humanitarian Legal Services across the country.

- Social participation and community integration
    - Social participation and community integration are two occupational areas that OT providers are experienced in addressing. Socialization is an important aspect of mental health and well-being that must be addressed with immigrants and refugees. In addition, community integration is essential to offer this population a sense of belonging and connection. The exact ways in which occupational therapists address these skills areas will depend on the practice setting where their patients are seen. Ideally, treatment centered around these areas should incorporate some form of community outings to be most effective.

Section 3 Personal Reflection

What role might an OT play in helping an immigrant and their family get a college education?

Section 3 Key Words

Acculturation stress - The physiological and psychological effects of stress related to entering and adapting to a new culture

Cultural humility - The ongoing act of self-reflection, self-awareness, and the ability to critique one's cultural biases and assumptions; in order to effectively convey diversity, equity, and inclusion, cultural humility should be paired with other skills such as cultural competence

Isolation stress - The physiological and psychological effects of stress from living as a minority who is not connected to the community around them

Resettlement stress - The physiological and psychological effects of stress from relocating to a new country and having difficulty meeting one's basic needs

Traumatic stress - The physiological and psychological after effects of traumatic events; in the lens of immigrant and refugee health, these events may include war, violence, persecution, poverty, migration, and displacement

Section 4: Occupational Therapy Evaluation of Risk Factors, Barriers, and Performance for Immigrants & Refugees

References: 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69

There are a variety of assessments that can be used during the OT evaluation process for immigrants and refugees. In addition, there are some targeted tools that allow therapists to glean the proper information to aid in treatment planning for this population. One example is the Refugees and Asylum Seekers Occupational Satisfaction (RASOS) Assessment Tool. Psychouli et al. (2023) looked into the development process for this outcome measure, and discovered that the RASOS was helpful in unearthing both environmental and personal factors that may lead someone to perceive low satisfaction in their most frequented activities and tasks.

Yazici & Akyurek (2025) researched the development of another OT-specific tool for this population, called the Occupational Justice Scale for Refugees (OJS-R). This was found to be both valid and reliable in the assessment of various forms of justice experienced by refugees. Historically, there has been a lack of assessment

tools to explore occupational justice in any individuals. Therefore, this measure can be used by OT providers to sufficiently identify any injustices and address them within their scope of practice.

In terms of therapy frameworks, Lord & Muñoz (2023) performed research that supports the use of a person-centered evaluation approach particularly when working with refugees who are children and teens. Each individual in this study reported mental health challenges, loss of meaningful roles, a history of trauma, and acculturation stress. This demonstrates the importance of therapists building rapport, forming a strong therapeutic alliance, and being mindful of cultural relevancy when selecting any evaluation tools.

As we mentioned earlier, mental health is an important area to address with immigrants and refugees due to the high occurrence of trauma in these populations. In particular, resiliency and coping mechanisms are an area of need for many immigrants and refugees. Fang et al. (2021) found that many first-generation immigrants demonstrate avoidant behaviors in response to stress, especially those with higher annual household incomes. In addition, first-generation immigrants who demonstrate resilience were noted to have an increased amount of positive coping strategies and fewer negative coping strategies as compared to first-generation immigrants with lower resiliency.

Mkoma et al. (2023) explored stroke treatment options and the continuum of medical services provided to immigrants in Denmark. Overall, they discovered immigrants were less likely to be admitted to the hospital's stroke unit early in relation to the onset of their condition. Individuals surveyed also reported receiving fewer preventive and therapeutic modalities in the early stages of their stroke rehabilitation. These modalities included screening for dysphagia and assessments/treatment from occupational and physical therapy professionals. Researchers also found that these disparities were more likely to be present in

immigrants with lower socioeconomic status. In general, these findings can help inform the practices of U.S.-based occupational therapists, as there are likely to be similar disparities present.

Research conducted by two OTs delved into the facilitators and barriers that impacted functional performance for several immigrants who were also musicians. Muriithi & Muriithi (2023) found that five factors played a large part in their ability to continue playing music. These included having a sense of identity as a musician, acknowledging the benefits associated with music, feeling a sense of appreciation from individuals and groups who enjoyed their music, adopting a positive outlook on their ability and willingness to adapt to a new environment, and being part of communities that created opportunities for them to perform in (though sparingly). Barriers included differences in music styles, a clash of languages, limited financial resources, and limited access to recording equipment, studio space, and media broadcasting.

Another piece of OT research from Fabianek et al. (2023) explored occupational disruption in first-generation Palestinian refugees living in Jordan. This qualitative study found that participants had a large amount of pride in their heritage and country of origin, but they had a largely traumatic experience by leaving that country. Other themes that emerged included internalized feelings of prejudice and feeling challenged by living in a country with a different culture. Results also showed that social participation was the occupational area most affected for these individuals. Therapists can use this information to guide their assessment and treatment of social interaction for immigrants and refugees.

Alvarez et al. (2021) looked into the common occupations and functional engagement of individuals in Sahrawi refugee camps. This study utilized the World Health Organization Disability Assessment Schedule (WHODAS 2.0) to measure each individual's participation in mobility, self-care, social activities, community

engagement, and cognition. Results showed that nearly all participants had difficulties in the aforementioned areas, particularly social engagement. In addition, the WHODAS proved to be an effective measure for tracking occupational difficulties of a wide variety. This global, inclusive tool can be advantageous for occupational therapists to utilize with this population.

Section 4 Personal Reflection

What aspects of cultural competence should a therapist be adept at when evaluating immigrants and refugees?

Section 4 Key Words

Internalized prejudice - Unexpressed feelings held by marginalized groups and minority individuals that coincide with societal stereotypes and other negative beliefs; internalized prejudice has the potential to lead to poor self-esteem, anxiety, depression, and even destructive habits

Resiliency - A trait that allows someone to recover quickly, efficiently in the face of hardships and other life difficulties

Section 5: Occupational Therapy Intervention for Immigrants and Refugees

References: 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84

We've already discussed the occupational injustices these populations face, but we haven't discussed the action steps OTs can use to tackle these issues. Therapists are encouraged to rely heavily on advocacy and health promotion in order to tackle systemic injustices for these individuals. There are several

frameworks and theoretical approaches that can be used in these efforts. Some of the research in the last section discussed the benefits of using a person-centered approach when working with immigrants and refugees, particularly with younger patients. Therefore, the Model of Human Occupation (MOHO) is an excellent starting point, as are similar frameworks such as Occupational Adaptation, Occupational Behavior, and the Person-Environment-Occupation Performance (PEOP) model. Some less common person-centered approaches that can be used with immigrants and refugees include:

- Framework of Occupational Justice (FOJ)
    - This framework allows therapists to look at the close relationship between structural and contextual factors that affect various forms of occupational injustice and, therefore, occupational outcomes. In particular, the FOJ focuses on occupational rights, including choice, balance, meaning, and participation. The FOJ emphasizes societal accountability, institutional changes, and inclusive programming for those with mental health concerns.
- Life Balance Model (LBM)
    - This model focuses on using a person's needs to structure their everyday activities. LBM's assumptions include basic needs for health and safety, empowering and rewarding relationships with peers, and having feelings of competency, and engagement. This model allows therapists to address the needs of immigrants and refugees who experience occupational alienation and occupational imbalance.
- Model of Occupational Empowerment
    - Therapists using the Model of Occupational Empowerment are able to make a connection between a person's maladaptive habits and a

disempowering environment. This dynamic can lead to learned helplessness, which reinforces the behaviors and causes a decline in someone's health. Therapists can use the Model of Occupational Empowerment to remediate these skills and help immigrants and refugees engage in exercise, educational opportunities of any kind, hobbies, activities, groups, self-directed projects, and more. Therapists may pair these interventions with home management training, assertive communication techniques, self-esteem building, lifestyle redesign, and vocational training, among others.

- Model of Occupational Spin-Off
    - This model outlines four levels of occupational engagement that are used as a means to improve someone's mental health. Through (1) affirmation, (2) environmental competency, (3) confidence in one's achievements, and (4) anticipation of ongoing engagement, occupational therapists can encourage an occupational spin-off. An occupational spin-off is defined as the subjective experience of well-being and self-actualization through occupational engagement. Therapists can use this model to help immigrants and refugees independently sustain long-term well-being.
- Model of Occupational Wholeness
    - This model relies on the intersectionality of four key components of occupation that contribute to health and well-being: becoming, belonging, doing, and being. The creators of the Model of Occupational Wholeness, Yazdani & Bonsaksen, posit that someone achieves the basic needs of becoming, being, and belonging by doing, which further enhances the codependence of each factor. Therapists can explore each of these needs and determine what is required to

meet them by analyzing someone's life patterns. The Model of Occupational Wholeness notes that deficiencies in any of these areas can lead to a decline in quality-of-life and long-term health outcomes. Therefore, this model can be used to address occupational imbalance and other forms of social injustice that immigrants and refugees may experience.

- Model of Seven-Level Hierarchy of Family-Therapist Involvement
    - Therapists working with youth immigrants and refugees may find this model helpful in meeting the needs of those with varying levels of family support. The Model of Seven-Level Hierarchy of Family-Therapist Involvement labels a child as having no family involvement, family serving as informants (passive information sources), family serving as assistants (helping the therapist meet treatment goals), family serving as co-clients (the child is viewed as a distinct part of the family unit), family serving as consultants (input from family members is a core part of the treatment plan), family serving as team collaborators (family is recognized for their ability to propose problems and solutions), and family acting as service director (supervising all coordinators involved in the child's care). When therapists identify the classification that applies to the child they are treating, they can better structure comprehensive, effective services for them. Youth who are part of immigrant or refugee families – especially children who have been temporarily or permanently separated from their parents and other relatives and may be experiencing complex mental health concerns such as attachment issues – would benefit from therapy using this model.
- Participatory Occupational Justice Framework (POJF)

    - Developed in 2005 by Townsend & Whiteford, the POJF is intended to encourage reflection and collaborative action as a means to remedy occupational injustice. The POJF uses a critical epistemology that ensures any providers using the framework are educated on the power dynamics and multiple layers of contextual factors that underlie many occupational injustices. This framework is unique in that social inclusion is one of its main end goals rather than more measurable outcomes therapists are used to working toward. Therefore, it is an excellent fit for use with immigrants and refugees, since social participation is a large occupation many of these individuals have deficits in.

- Recognize Privilege, Acknowledge Injustice, and Reframe Perspective to Reach Equity (PAIRE) Model
    - As the name suggests, the PAIRE Model has a high degree of crossover with treatment for immigrant and refugee populations. Therapists can use the PAIRE Model to address societal inequities and other systemic influences that affect the therapy process. In particular, this model helps therapists achieve occupational equity for their patients via intersectional and reciprocal impacts.

- Social Participation Frame of Reference
    - As we mentioned earlier, research shows that social participation is a large skill concern for immigrants and refugees. This frame of reference can help therapists address this meaningful occupation in youth, as it was designed for that age group. The Social Participation Frame of Reference helps therapists hone in on seven areas of functional performance: emotion regulation, family habits/routines, temperament adaptation, environmental supports, contexts for peer

interaction, peer interaction itself, and social participation at school. Each of these areas is crucial, especially given the mental health concerns immigrant and refugee children may display.

- Theory of Occupational Reconstructions
    - This theory has strong roots in the field of occupational science, as it explores the ways in which people interact within groups, especially in the face of conflict and problem solving. The theory of occupational reconstructions applies heavily to immigrants and refugees, regardless of whether or not they come to their country of destination with family. Immigrants and refugees may create social groups with relatives they made the journey with. However, they may also find community in spending time with people from their own culture. Either way, any occupational concerns related to someone's interactions (or lack thereof) within these contexts can be addressed using this theory base.
- The Canadian Model of Client-Centered Enablement (CMCE)
    - This model places enablement skills at the heart of OT and encompasses the use of various skills in this realm, including engaging, educating, specializing, collaborating, coaching, advocating, consulting, coordinating, adapting, and designing. OTs can use each of these skills to engage patients in shared decision-making. In order to understand the culture and specific needs of any immigrants and refugees they work with, OTs must utilize a highly collaborative approach.

Legal Protections and Processes for Healthcare Providers and Immigrant/Refugee Patients

In addition to utilizing advocacy and health promotion to address occupational injustices, occupational therapists working with immigrant and refugee populations should understand how to protect themselves and their patients. This includes following all regulations set forth by the Health Insurance Portability and Accountability Act (HIPAA), which makes it illegal to share, use, or disclose personal health information without consent from the patient. There are some exceptions to this, such as when healthcare providers are communicating about treatment of a shared patient. Another exception is when patient health information is requested by law enforcement personnel for the sole purpose of law enforcement. However, it is important to note that this is only permissible under some circumstances and the release of such information is largely not a requirement. In the event a patient's immigration status is collected as part of demographic information at a hospital, clinic, or other healthcare organization, this information would be protected under HIPAA laws.

There are various ways therapists can assist patients who are at risk of deportation or are concerned about U.S. Immigration and Customs Enforcement (ICE) raids. These include:

- **Creating clear policies and signage that differentiate public from private areas:** These written policies can help limit access to patient care areas to only those receiving care or parents of those receiving care. A similar practice that can also help is restricting private areas to medical staff only outside of business hours. A great way to do this is by forming written policies as well as making/posting clear signage and creating visual separation (distinct rooms with doors, areas sectioned off with room dividers, curtains, or other physical barriers) between areas with different

levels of access. A good example of these policies in practice is making a sign/policy that denotes the waiting room is open to the public and a sign/policy that mentions any non-medical professionals must be invited into patient care areas by staff. Another variation of these policies includes making the waiting room accessible only to patients and parents/guardians or others that may accompany patients, and making areas outside and near the medical clinic's building open to the public.

- **Be mindful of shielding information from the public:** In accordance with HIPAA and to maintain patient safety, medical staff should take steps to protect information from inadvertent viewing by the public. A good way to do this is by using privacy protectors on all computer screens, positioning screens in a way that prevents easy access by people standing in public spaces, closing doors or reception windows when medical staff are exchanging patient information over the phone or in person, and storing or shielding printed paperwork with patient information in files or cabinets.

- **Take measures to protect information regarding immigration status:** If at all possible, try to avoid collecting patients' immigration status as part of demographic information. In the event this data is required for Medicaid enrollment or other practical purposes, keep each patient's responses separate from their medical records and billing paperwork.

- **Create and disseminate educational materials:** These materials should aim to educate patients about their legal and health rights. Materials should be created with very simple, concise language. The subject matter should discuss three crucial areas: (1) describing a patient's right to refuse speaking to immigration agents or law enforcement, (2) outlining a patient's right to request a lawyer before speaking to immigration agents or law enforcement, and (3) instructing patients to never run or attempt to escape

from custody of police or immigration agents, as this gives any officer probable cause for an arrest. It would be most helpful to have this information in large signage posted in medical areas as well as in smaller formats (postcards, wallet-sized cards, pamphlets, etc.) for patients to take with them. In some geographic areas, those being questioned by police or immigration agents may be required to give officers their name while still retaining the right to not answer any questions. Medical staff creating these documents should first verify if their organization falls in one of these jurisdictions and include this information on the materials, if needed.

- **Run practice drills and develop emergency response plans:** In order to be prepared for these concerns – which is especially crucial for organizations in large cities or rural communities – medical practices should role play situations and offer training on what to do if and when immigration raids occur. This will help staff gain confidence in their responses during what will likely be a difficult time. In the same vein, organizations should designate staff leads (and a back-up in the event the main lead is not present) to handle all contact with law enforcement officers. No staff should allow law enforcement officers to enter the premises without a warrant, and staff members should explicitly verbalize this in response to entry requests from officers. All staff should be trained to direct law enforcement officers to that lead staff so they can review warrants and/or consent to entry. All medical staff should decline to offer any information to officers unless they are told they can do so by the lead staff.
- **Review any warrants or other presenting documentation carefully:** If officers do present a warrant before attempting to search the premises, therapists should ensure it is valid. The best way to do this is by finding documentation on the warrant from a judge or magistrate. If this is in place,

the officers are legally allowed to question anyone who is present and enter private spaces.

- **Documentation is essential:** Just as in patient care scenarios, therapists should be sure to document any interactions with law enforcement officers for the purpose of immigration-related detainments, searches, etc. This includes writing detailed notes of the names of all officers and staff who were present, all events that took place, responses from all parties, and photographs.
- **Seek out information from a local immigration lawyer:** It is beneficial to have a conversation with someone in such a role to learn if there are additional measures you can take for the protection of your patients. If budget and availability allow, organizations can ideally partner with such lawyers by having them on their board of directors or consulting with them in an advisory capacity, especially if the organization has a high immigrant population. This will not only help protect your patients, but also make you feel more comfortable in your ability to effectively and legally address any problems that might arise.
- **Offer comfort and reassurance to patients who are worried:** Therapists should be sure to comfort and encourage patients in the face of these concerns. This may include offering information about patient information being protected by both state and federal laws. Therapists may also want to remind patients of their individual mission and their organization's mission to preserve patient well-being and safety in any circumstance.

While traditional legislation may change at any time, therapists should remember that the aforementioned information is backed by constitutional rights, which do **not** change. Therefore, following the above steps to inform your responses to immigration-related concerns is the best strategy to have.

Section 5 Personal Reflection

How might an occupational therapist support their patients' rights when working in a hospital versus a non-profit medical clinic?

Section 5 Key Words

Critical epistemology - A concept that entails in-depth education on the continual influence of power dynamics along with the social and political factors that often skew many societal processes

Occupational science - A field of study that involves analyzing human occupation by exploring the meaning, patterns, and overall impact of each of a person's chosen activities on their life; occupational science also has roots in sociology, as it looks at the ways occupation affects individuals, communities, groups, and even larger populations

Section 6: Case Study #1

An occupational therapist is working in a community-based clinic that follows the clubhouse model. With the help of translator services, the OT completed an intake for a 41-year-old woman who entered the clinic as a drop-in. Earlier in the day, the woman tried to seek assistance at the domestic violence shelter located a few blocks down the street. After speaking with her briefly and learning about what she was looking for, they told her to come to the clinic.

The woman is a refugee from Ukraine who traveled to the United States two weeks ago. When asked about any health conditions she has, this patient told the OT that she has depression, cardiomyopathy, osteoporosis, and diabetes. She also mentioned being concerned about not having any medications with her. While she came to the U.S. legally, the current state of the community in her country of

origin prevented her from taking any essentials with her. She mentioned being very grateful for having a safe place to come to, but that she has been having a lot of difficulty getting connected with services here. She appeared despondent, citing some feelings of helplessness and a lack of purpose as well as concern for loved ones who are still in the Ukraine.

1. What is the most appropriate referral for the OT to initially make?
2. Does this woman qualify for services at this clubhouse clinic?
3. Does it sound like the concerns this woman is experiencing are the result of serious mental illness (SMI), trauma response, or potentially both?
4. What skill areas should the OT focus her assessment on?
5. What frame(s) of reference might be the most useful when structuring intervention for this woman?

Section 7: Case Study #1 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the most appropriate referral for the OT to initially make?

   Since this patient reports having several chronic conditions, it is essential to get her connected with primary care services. It is possible that this will be enough for her to receive medications and other services needed to manage these conditions. If not, the primary care provider can refer the patient to specialists who can manage her diabetes and depression before she experiences any major complications. Either way, primary care services

are essential to treating and monitoring each of her conditions, so they should be the therapist's priority for the time being.

2. Does this woman qualify for services at this clubhouse clinic?

   Yes. This woman has a depressive disorder, which is a Serious Mental Illness. The target population for clubhouse model clinics is those with SMI, so she is an ideal member.

3. Does it sound like the concerns this woman is experiencing are the result of Serious Mental Illness (SMI), trauma response, or potentially both?

   It is difficult for the therapist to tell exactly what the root of this woman's concerns are. However, it is very possible that her current presentation is due to both a trauma response and an SMI exacerbation due to lack of medication. The therapist should proceed as if the patient is having both an SMI exacerbation and a trauma response. Therefore, she should utilize a trauma-informed, culturally competent approach with her to ensure she does further traumatize her or injure their rapport during the early stages of treatment.

4. What skill areas should the OT focus her assessment on?

   Since the clubhouse model entails member-structured leisure programming and social participation, that is the main area this OT should focus on. If her clinic allows her the ability to cover other occupational skills, then the therapist should do so. If that is the case, the therapist should evaluate this woman's health literacy, the accessibility of her home environment (if she currently has a permanent home), her ability to perform IADLs – specifically grocery shopping and medication management, and community navigation skills. These are the most crucial for this woman to meet her basic needs.

5. What frame(s) of reference might be the most useful when structuring intervention for this woman?

   This woman reported feelings of helplessness. While this can stem from her diagnosis of depression, they can also undoubtedly be attributed to the difficulties she has experienced during her time as a refugee so far. Either way, the Model of Occupational Empowerment would be a good fit for her. In addition, the Social Participation Frame of Reference and Theory of Occupational Reconstructions mesh well with the programming offered at the clubhouse, so these should also be explored.

Section 8: Case Study #2

A 6-year-old child presents with his grandmother (who is his legal guardian) and 16-year-old brother to an outpatient clinic. They are there for an OT evaluation and were referred by the child's pediatrician, who recently diagnosed him with Autism Spectrum Disorder (ASD). The family (consisting of 7 total members) are all immigrants from Mexico who got here 3 months ago. The family's primary language is Spanish and the patient does not speak very much at all due to a speech delay. His 16-year-old brother came to today's visit because he is fluent in English and can serve as the translator for his grandmother . In addition, the patient's older brother often takes care of the child so he is familiar with the OT-related needs that will be discussed during the evaluation. Each of the family members appeared uneasy during the evaluation. As the OT spoke more with them, she picked up on concerns they have regarding deportation, as they are not documented immigrants. The family also mentioned having some problems with their insurance, and the 16-year-old brother gave some details about his grandmother initially qualifying for Medicaid for herself due to being over the age of 65 and having a disability. She was under the impression this insurance would

also offer coverage for her family, since she is the guardian for several of her grandchildren. However, they recently learned this is not the case.

1. According to the Health Insurance Portability and Accountability Act (HIPAA), can the child's 16-year-old brother serve as the translator for his family?
2. What can the therapist do to make the clinic setting more comfortable and safe for this family?
3. What referrals might benefit the child and his family, if any?
4. What frame(s) of reference are best suited for structuring treatment with this child?

Section 9: Case Study #2 Review

This section will review the case studies that were previously presented. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. According to the Health Insurance Portability and Accountability Act (HIPAA), can the child's 16-year-old brother serve as the translator for his family?

   Under HIPAA, there are no concerns with family members translating for one another as long as the patient or their guardian verbally identifies their translator and they sign a consent form. However, it is important to note that best practice involves a healthcare provider connecting any non-English speaking patients with a trained translator. This prevents any miscommunication or confusion that may arise from the use of clinical

language or other lesser-known terminology that may not otherwise translate well between languages.

2. What can the therapist do to make the clinic setting more comfortable and safe for this family?

   Since there is clear distress over potential deportation, the therapist can make a few changes to the clinic to put this family at greater ease. Initially, the best way to handle this is to speak with the family and inform them of their rights. The therapist should tell each of the family members that no one in the clinic can give any information to immigration agents or law enforcement officers about them – either related to health, their immigration status, or otherwise. The therapist should also do a once-over in the clinic space to ensure that all patient care areas are marked as such as visually private from public spaces such as waiting areas. If this is not the case, the therapist should discuss her concerns with her supervisor and advocate for some changes to make any immigrants and refugees feel safer there.

3. What referrals might benefit the child and his family, if any?

   There appears to be some concerns related to insurance coverage. It seems like their grandmother may have been talking about Emergency Medicaid for herself, which does not constitute standard health coverage nor does it cover family members. Therefore, the therapist should make a referral to a local free health clinic so the rest of the family can receive care, if needed. In light of this family likely not having coverage for the services that will be provided at this outpatient clinic, the family may need to seek other options. While this is not a referral, the therapist should inform them to seek OT services through the child's school. All children – regardless of immigration status – are entitled to free public school education from

grades K to 12. As part of this education, children are entitled to accommodations, whether that be PT, OT, SLP, or otherwise.

4. What frame(s) of reference are best suited for structuring treatment with this child?

   When this child does receive treatment, there are a few frames of reference that are ideal. Firstly, due to the closeness of the family unit, the Model of Seven-Level Hierarchy of Family-Therapist Involvement is an ideal way to capitalize on that support. The Social Participation Frame of Reference would also be fitting, as social participation is a known deficit for children with ASD. The Framework of Occupational Justice (FOJ) can also help this family overcome the systemic concerns that are preventing them from meeting their basic needs – chiefly, healthcare and safety in their direct environment.

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