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REVIEW ARTICLE

Migrant Trauma and the Role of Healthcare Professionals and Systems in Enhancing Wellbeing

Jordan Greenbaum, MD,[1*] Ernesto Caffo, MD,[2,3]

[1]International Centre for Missing and Exploited Children, Alexandria, VA, USA
[2]University of Modena and Reggio Emilia, Modena, Italy
[3]SOS Il Telefono Azzurro Onlus and Fondazione Child, Modena, Italy

[*]jgreenbaum@icmec.org

ABSTRACT

Millions of children and adults are forcibly displaced from their homes each year, with a significant proportion seeking refuge in the European Union. Before, during and after their migration journey they may experience multiple trauma events that may lead to significant stress and complicate their adjustment to the host country. Physical, emotional and behavioral responses to adversity (the traumatic stress response) vary and are influenced by numerous factors, notably by cultural beliefs and norms. Culturally responsive healthcare professionals who serve migrant patients are in a unique position to recognize signs and symptoms of traumatic stress, and provide basic, practical interventions. Given the large number of migrant individuals at risk for significant behavioral health issues and the relatively limited number of mental health professionals available to treat them, resources are best allocated if the primary healthcare provider is equipped to offer formal or informal "screening" for traumatic stress (e.g., use a culturally adapted and validated clinical tool or 'screen' with open-ended questions about the migration experience, current patient wellbeing, and daily stressors). They may then offer a basic intervention for the majority of patients with mild-moderate symptoms of stress, while referring those with severe symptoms to trained mental health specialists. This article reviews the types of trauma often experienced by migrant families and the nature of the traumatic stress response. It explores how culture may impact manifestations of traumatic stress and influence discussions of trauma between patients/caregivers and healthcare professionals. Moreover, it outlines the roles of the primary healthcare professional and their organization in recognizing and responding to the needs of these vulnerable patients. Screening options, basic psychoeducation strategies and the importance of community resources are discussed. The need for clinical protocols and a trauma-informed healthcare facility, as well as staff education regarding migration-related health and behavioral health needs, cultural responsivity, and trauma-informed care is emphasized, and resources are provided.

Introduction:

Extreme poverty, armed conflict, climate-related adversity, persecution and violence drive millions of adults and children from their home communities each year, with individuals often crossing international borders to seek safety.[1] Per the United Nations High Commissioner for Refugees (UNHCR), approximately 108.4 million individuals were forcibly displaced by the end of 2022, of whom 53.2 million were designated as 'refugees' (individuals who have left their country of origin due to persecution, conflict, generalized violence or other crises that require international protection).[2] Migration of asylum-seekers (those who have left their home country and are applying for refugee status) to the European Union is on the rise, with 881,220 first-time applicants in 2022, representing an increase of 64% from 2021. The most common countries of origin for this group were Syria, Afghanistan, Venezuela and Turkey, while the most common destination countries within the EU were Germany, France, Spain and Austria.[3] 25.2% of first-time asylum seekers were children under the age of 18 years.[3]

Whether children and adults migrate due to fear of persecution, to escape climate-related events, to pursue educational or employment opportunities or reunite with family, many have experienced multiple traumatic events, before, during and after migration.[1,4,5] The physical and mental health consequences of these events may drive individuals to seek medical attention, and may provide healthcare professionals (HCPs) with a critical opportunity to intervene. Clinicians may offer basic guidance and support to manage the emotional aftermath of the migration, as well as referrals to organizations that provide holistic services to address practical and essential needs. In this article, we summarize the myriad needs of migrants and refugees ('newcomers'), focusing on migration-associated traumatic stress. We outline ways in which primary care medical providers may assist these families, especially in settings where there is a dearth of trained mental health professionals.

Prior to their journey newcomers may have survived extreme poverty, food insecurity, and unemployment, and/or emotional and physical violence, torture, sexual assault, or loss of loved ones.[6-9] Similar traumatic events may occur enroute to an individual's destination, along with exploitation, human trafficking, violent crime (e.g., robbery, kidnapping) and separation from family members and caregivers.[6,10] According to statistics from the International Organization for Migration (IOM) more than 17,900 people died or went missing in the Mediterranean between 2014 and 2018.[10] After arrival at their destination, newcomers may experience severe overcrowding; food insecurity and other privations; uncertainty about their future; as well as violence, abuse and exploitation while in detention centers, refugee camps, or other institutionalized settings (e.g., residential care for unaccompanied minors).[5,11]

Unaccompanied minors are at particularly high risk for violence and exploitation due to their age, lack of supervision and resources, immature brain development (e.g., incomplete development of executive functions) and lack of adult protection.[1,6,10] Many unaccompanied minors arriving to an EU country run away from shelters where they are placed, due to

deprivation, the urgent need to find work to pay off debts or to support family in the home country. Many continue their transit to another country; others may obtain work in the informal sector where they are exposed to exploitation and abuse.[10]

Newcomers who are not residing in large group settings also may be vulnerable to exploitation, trafficking, homelessness and unemployment due to limitations in resource accessibility, unfamiliarity with the new culture and with migrant services, language barriers, and fear of seeking help from authorities.[1] Exploiters may deceive migrants with offers of shelter and fraudulent job opportunities or migrants may join relatives or acquaintances who are being exploited, and hence become victims, themselves.[12] Severe economic challenges may necessitate residing in unsafe neighborhoods with gang or other community violence; facing chronic unstable housing; and experiencing forced labor and/or sexual exploitation. Discrimination from members of the host country may emanate from xenophobia and other biases commonly associated with migration such as intolerance of race/ethnicity, religion, culture and gender-based attitudes that foster repression of females.[13] Social isolation from would-be peers, lay persons, teachers, work colleagues and potential service providers all add to the post-migration stress and trauma experienced by migrants and refugees.[14]

In reaction to their trauma and the constant uncertainty of their future newcomers may develop a significant traumatic stress response[15-18] that can be disruptive to the individual and render them at increased risk for further adversity. The traumatic stress response—a normal reaction to abnormal events that threaten the safety and wellbeing of an individual[15]—may take a variety of forms (see Table 1). Many emotions, attitudes and behaviors are nonspecific, developing in response to a variety of stressors. In addition, those experiencing severe trauma may have none of the reactions delineated below. An individual's response to trauma is influenced by a number of factors, including time since event, perception of event, witness vs participant status, temperament, prior experience with trauma, age, developmental status, social support and attachment relationships.[19-22] For example, two children may experience the same traumatic event yet respond with different emotions and behaviors, with reactions that vary in severity, character and duration. Traumatic stress responses may appear suddenly or gradually and may become manifest soon after the trauma or only upon the onset of major changes in a person's life such as puberty, or loss of a loved one. Children may respond to stress according to their age and development, with young children showing regression in behaviors (e.g., bedwetting), fear of abandonment, hyperactivity and irritability, while older children/adolescents may develop social withdrawal, and high-risk behaviors such as substance use and self-harm.[15,16] Most traumatic stress responses may be seen in children and adults of any age, however.

Manifestations of a traumatic stress response vary with culture.[23] Idioms of distress (manifestations of distress that are shaped by local culture)[23] may or may not be included in Western diagnoses associated with trauma.[24] However, they are critical to understand as a practitioner assesses newcomer wellbeing.[25]

Nonjudgmental, open and respectful inquiry into the idioms most common to the patient, as well as their beliefs about the cause of physical and emotional signs/symptoms, explanations for prior trauma events (e.g., karma, external forces, punishment for moral transgressions), and the most appropriate treatment will assist the clinician in working with the individual to determine culturally acceptable ways to address symptoms of distress. Formal screening for signs and symptoms of traumatic stress can be helpful to the HCP but tools must be culturally adapted, with the input of cultural brokers, patients, families and others with personal knowledge of newcomer cultural and religious beliefs and practices.[23,26]

Table 1: Signs and Symptoms of a Traumatic Stress Response[15,16,23,24,27-29]

Physical	Emotional	Behavioral
Nightmares and sleep problems	Post-traumatic stress disorder symptoms	Refusal to separate from caregiver
Altered appetite and eating patterns	Depression and withdrawal	Hyperactivity, poor attention
Chronic pain complaints without organic cause	Anxiety or panic	High-risk behaviors
Exhaustion, fatigue	Numbness	Abrupt change in behavior or new fears
Nausea	Anger	Hyperarousal
Symptoms of irritable bowel syndrome	Confusion	Aggression/hostility
Dhat (semen loss in urine)	Guilt/self-blame	Regression of milestones (e.g., language)
"Khyal attacks" (wind attacks) (fear of death, dysregulation within the body when standing up, symptoms of panic attack)	Despair	Repetitive games or other activities, often re-enacting trauma events
"Hwa-Byung" (chronic anger leads to fire illness, with sensation of chest pressure, loss of control over anger)	Emotion dysregulation	"Thinking too much;" "brain fag," "ode ori"
"Nervios"-related conditions (range from intrusive thoughts, nervousness, to loss of behavioral control, dissociation, violence)	Distrust of strangers	Avoidance of people, situations that trigger trauma memories

Physical	Emotional	Behavioral
Shenjing shuairuo (neurasthenia, neurological weakness)	Fear (of abandonment, of certain people or situations, preoccupation regarding others' safety)	Dissociation
"Ulysses Syndrome" nervousness, fatigue, headaches in response to migratory grief arising from forced separation from family, a sense of hopelessness and despair and sense of being alone)		

For some newcomers the trauma response persists and may become debilitating with chronic signs and symptoms that are more or less consistent with the Western diagnoses of post-traumatic stress disorder (PTSD), depression, anxiety and others.[27] In a study of Syrian refugees in Lebanon and Jordan, the rate of PTSD was 45.6% among young people aged 7-18 years; with increased risk among those with higher rates of exposure to war atrocities, and those with coping styles that included avoidance, social withdrawal, and resignation.[27] In their study of psychopathology among forcibly displaced Syrian children and youth, Gormez et al found a rate of PTSD of 18.3%, while that for anxiety-related disorders was 69.0%, with death of an important person and male gender revealed as risk factors for PTSD, and exposure to cruelty or torture, and increasing duration of refuge associated with anxiety disorders.[30] Prevalence rates of mental distress among refugee children in the European Union member states vary across studies, with results ranging from 19-53% for PTSD; 10-33% for depression, 9-32% for anxiety and 20-35% for emotional and behavioral problems.[31,32] Although results are mixed, some studies have found elevated rates of attempted suicide among immigrants relative to the native population especially among migrant South Asian women.[33,34] For individuals with severe symptomatology referral to culturally-responsive mental health specialists may be offered by the HCP, if available.[18,35] However, for many migrants and refugees, trauma symptoms are less severe and improve over time, especially with strong family and social support, school connectedness and holistic services.[5,13,27,36] This group of individuals may benefit from culturally appropriate, basic psychoeducation and stress management strategies, with referrals to agencies/organizations that can address holistic needs, such as housing and immigration processing. HCPs are in a good position to talk with patients about their migration experiences, recognize signs of traumatic stress and provide this basic intervention, referring individuals with more severe symptoms to existing mental health specialists. This use of a relatively large work

force (healthcare personnel) to screen and counsel newcomer patients, and to refer a limited number to a small work force (mental health specialists) allows far more individuals and families to obtain the services they need and helps to ensure that psychologists and psychiatrists are available to treat patients with more severe symptomatology. Furthermore, HCPs can begin to address the social stigma that may be associated with mental health care, increasing the likelihood that those who need specialty care actually receive it.[37]

The Health Sector Role in Addressing Migrant Trauma and Improving Wellbeing

Migrant/refugee families and unaccompanied minors may have little knowledge of available resources and may distrust help from authorities and community professionals due to fear of deportation, arrest, or losing one's children to the state child welfare system. Discrimination by the public and by professionals may lead to social isolation and reduced help-seeking behaviors by newcomers, despite the availability of services in the area. Thus, individuals may have desperate needs and concerns that impact their health and wellbeing, yet minimal access to resources. This situation may lead to exacerbation of the traumatic stress response, which itself may hinder a person's ability to analyze problems, plan strategies for meeting environmental challenges, and implement actions to improve the wellbeing of oneself and dependents.[17]

The physical effects of migration-related trauma,[38] including injuries from assault or accident, sexually transmitted infections and unwanted pregnancies from sexual assault, malnutrition due to privation, exposure, and poorly controlled chronic conditions related to inaccessible health care enroute may lead to health-seeking behavior in the destination country. The plethora of behavioral health challenges associated with traumatic stress may also drive health-seeking behavior. HCPs serving adults and children, particularly those working in facilities that serve migrants and refugees, may be the first professionals to identify highly stressed and traumatized individuals, and may serve as liaisons for critical services. The trust accorded to HCPs because of their professional role may make it easier for patients and caregivers to share sensitive information about trauma and current psychosocial concerns related to their migrant status. Screening questions regarding physical and mental health may be more accepted when asked by primary care professionals than if posed by other authority figures, especially if they are embedded in a trauma-informed, patient-centered approach as described below. Pediatricians are versed in child development and in an ideal position to screen for trauma and identify stress as a major causal factor in presenting complaints such as regressive behavior, transient pain without organic cause, encopresis, inattention, emotional dysregulation and new high-risk behaviors. While providing ongoing care for pregnant girls and women, obstetricians/ gynecologists may build the trust needed to explore trauma stressors that negatively impact their patients. Accident and emergency medicine staff may be the first to recognize newcomer traumatic stress when they treat injuries from violence and exploitation, or acute mental health crises related to self-harm and suicidality. In some cases, they may be the only professionals to

interact with newcomers, and function as the sole potential bridge to essential services. HCPs and the health systems that support them need to recognize their critical role in supporting newcomer health and wellbeing.

The Role of the Clinician

To effectively recognize newcomer stress and offer appropriate resources, HCPs need education and training on migrant health needs and cross-cultural communication strategies,[18,25,39-44] as well as human trafficking and exploitation.[45,46] Knowledge of cultural, religious and spiritual beliefs and practices, as well as current sociopolitical and economic issues of the major migrant population is helpful in building trust and identifying specific patient stressors and needs.[47-51] Understanding a patient's (and caregiver's) views on the causes, implications and socially acceptable manifestations of physical and emotional distress helps practitioners recognize traumatic stress responses, and facilitate culturally appropriate conversations about the individual's previous experiences and current needs.[52]

Cultural and social taboos about mental health disorders and treatment require sensitive questions, respectful listening and open discussion,[37,53] with a goal of identifying potential interventions that are culturally acceptable to patient and family and that address the mental health concerns noted by the provider. Sexual taboos may make it extremely difficult for patients to discuss prior sexual violence and exploitation associated with their migration, and reluctant to report signs and symptoms of sexually transmitted infections.[49] Strict gender roles may inhibit boys and men from disclosing sexual victimization or discussing associated emotional distress[54-56] and care must be taken to acknowledge these views and facilitate the trust needed to allow patients the freedom to discuss their experiences. Reproductive and sexual health issues may be very important to newcomers, especially women of child-bearing age. Expectations and norms surrounding discussions of sexual topics, of practitioner gender, and of appropriate procedures for genital examinations may vary considerably with culture and religion, making cultural responsivity critical to obstetrician/gynecologists, adolescent medicine providers and pediatricians. Finally, cultural differences in communication styles may challenge the practitioner in their efforts to obtain and interpret information, determine current levels of distress, or engage a patient in shared-decision making.[57,58] Provider sensitivity to cross-cultural differences in issues of social hierarchy, comfort with expressing disagreement, and on the degree of nonverbal, implicit meaning embedded within conversations helps ensure that patients are able to voice their concerns and desires and that these are understood by practitioners.

On-site training regarding cultural and religious responsivity, and migrant health/behavioral health needs may be available from multiple sources, including university faculty in global health departments, staff at local nongovernmental organizations (NGOs) serving migrants and refugees, and local elders within a migrant community. Through collaborative efforts and funding initiatives, multiple global and EU organizations prioritize mental wellbeing,

recognizing the unique challenges faced by migrants. This commitment underscores a comprehensive approach integrating cultural responsivity, awareness, and accessibility to mental health services for migrants across EU Member States. Many of these organizations provide online information such as the World Health Organization (WHO; https://www.who.int/); UNESCO (https://www.unesco.org/en); Istituto degli Innocente (https://www.istitutodeglinnocenti.it/it); European Union Agency for Fundamental Rights (https://fra.europa.eu/en); Unicef (https://www.unicef.org/), UNHCR (https://www.unhcr.org/us/), International Organization on Migration (IOM; https://www.iom.int/), and International Labour Organization (ILO; https://www.ilo.org/), and numerous publications are available in the health/behavioral health literature and gray literature.[18,23,25,28,35,43,48-50,59-61]

To build trust and enable the clinician to understand current and prior migration-related stressors, as well as to provide support and a sense of hope, clinicians should use a patient-centered, strength-based, trauma-informed approach (TIA)[62] that acknowledges and respects fundamental human rights and the need to prioritize the best interest of the patient in all decisions affecting them.[39,63,64] A trauma-informed approach takes into account the potential impact of adversity on a patient's views of themselves and others, their perceptions of safety in the environment, their attitudes toward others and their behaviors. The trauma-informed provider responds in a nonjudgmental, calm and empathic manner. To avoid possible cultural stigma associated with the term, 'trauma' a HCP may use other terms such as, 'adversity' or, 'scary events.' The clinician explores how the individual experienced a given event (not assuming it was 'traumatic') and how they responded to it immediately and over time. Discussing the positive coping mechanisms used by the patient, the trauma-informed clinician emphasizes resilience and protective factors and helps the patient to identify potential future strategies for managing stress. The TIA emphasizes the importance of transparency in providing information to the patient, seeking informed consent, respecting confidentiality and privacy, building a sense of physical and emotional safety, and empowering the patient to engage in the care process and in decision-making.[62] Resources on trauma-informed, rights-based care are available for HCPs, in the form of on-site/online education and training (HEAL Trafficking; https://healtrafficking.org/), (International Centre for Missing and Exploited Children; https://www.icmec.org/healthportal-resources/), and are included in numerous publications and guidelines addressing the clinical management of specific issues, such as child sexual abuse. [39,40,46,65-77] Culturally appropriate and professional interpretive services are critical when working with newcomers and specific guidance on a linguistically responsive and trauma-informed approach is available for interpreters.[73]

Formal screening for traumatic stress may be accomplished using one of several tools that have been adapted and validated for use across multiple cultures.[78-84] However, in the absence of a screen that has been validated in a specific migrant population, open-ended questions about the migration experience,

current patient physical and emotional wellbeing, and important daily psychosocial and economic stressors may help the HCP to identify traumatic stress in a patient and clarify the need for specific resources. Brief psychoeducation about trauma and traumatic stress can be tailored to incorporate cultural beliefs and manifestations of distress. Important concepts to stress during psychoeducation include:[15,16,35,85]

- The stress response is a normal, extremely common and generally transient response to abnormal situations and is not a sign of 'madness' or 'bad character'
- It is important to view a patient's behaviors and attitudes through a 'trauma lens,' re-framing apparently 'maladaptive' behavior as an individual's response to extreme stress. Certain behaviors may have been adapted to cope with the stress (e.g., social withdrawal, hostility, and aggression) while others may be triggered by exposure to stimuli in the environment that remind the person of their trauma (e.g., panic attacks, hypervigilance, avoidant behavior). High-risk behavior, such as substance misuse may represent an effort by the individual to escape the anxiety and stress associated with prior trauma.
- Family members can assist the individual by reacting to trauma-related behaviors such as hostility, emotional lability and social withdrawal in a nonjudgmental, supportive and empathic manner.
- It is important to establish and maintain a daily routine so that family members, especially children, can feel in control of their environment and able to predict their immediate future.
- Patients and caregivers can learn to recognize 'trauma triggers' that remind an individual of prior distressing events and take steps to avoid them or mitigate their effect.
- Traumatic stress responses vary in severity, nature and duration but typically improve over time. If symptoms are severely disruptive to an individual's life, or persist for an extended period, the patient may benefit from formal mental health support.
- Periods of anxiety and emotional distress can be addressed through any of a variety of culturally relevant stress management techniques, including:
    - Deep breathing exercises
    - Progressive muscle relaxation
    - Meditation
    - Yoga
    - Tai Chi
    - Mentally repeating mantras, poems, songs, recalling myths/legends
    - Envisioning safe, comfortable, idyllic place
    - Writing in journal
    - Talking with trusted friend, confidant, family
    - Listening to music; dancing
    - Exercise

- When discussing stress management strategies, it is critical to encourage active input from the patient and caregiver(s), to be sure techniques identified are acceptable and feasible. The HCP should be aware of cross-cultural differences in communication styles and of the perceived power differential between provider and patient. Careful attention to body language and word choice are needed.

Migrant children and adults are at elevated risk of sex and labor trafficking and exploitation.[86] Providing universal education on the risk of exploitation may be very helpful. Basic information about risk factors, potential indicators, and resources for those in need helps to equip the family with necessary tools to recognize high-risk situations and potentially avoid trafficking and exploitation.[45]

Since the visit with the HCP may represent the first contact with community service providers it is helpful for the practitioner to be aware of relevant organizations and agencies that serve newcomers. This is best achieved with use of a comprehensive directory of local and national service providers. The clinician may also provide practical guidance on issues faced by patients and caregivers in their daily lives and help families navigate the health system. Referrals to external service providers are best accomplished through 'warm hand-offs' whereby contact with the organization is made prior to the patient/family leaving the medical facility.

Beyond individual and family patient care, HCPs can advocate for community services, legislation and policy changes that improve access of documented and undocumented migrants to health and mental health care, housing, culturally responsive education, employment opportunities and pro bono immigration assistance. They can work with the media to increase public awareness of the needs of newcomers, challenge xenophobic attitudes and policies, and support community organizations that serve migrants and refugees.

Role of Healthcare Organizations

To provide optimal care to newcomers HCPs must have strong support from their healthcare organization. A critical role of the organization is to provide education to staff and trainees regarding migrant health, cultural responsivity, traumatic stress and trauma-informed care.[77] This may take the form of educational presentations and discussions of case scenarios at staff meetings, weekly faculty academic sessions, or at conferences. Education may be offered via easily accessible online modules, using the resources discussed above. These training topics should be presented at least annually and built into orientation curricula for new staff and faculty. Inclusion of those with lived experience and those with detailed knowledge of relevant cultural beliefs and practices is important in ensuring that presentations are relevant, accurate and adequately represent the perspectives of newcomers.

HCPs are further supported by their organizations when evidence-based and practical guidance is available regarding the proper actions to be taken to recognize and respond to trauma-related stress in

migrant/refugee patients and families.[35,41,43,87,88] This often takes the form of a detailed protocol with suggested screening questions and/or universal education materials on traumatic stress and stress management, potential indicators of traumatic stress, and a flow diagram outlining the responsibilities of each staff member involved in the process of assessment and follow up. A directory of relevant community and national/international resources should be created and periodically updated so staff can easily access and share referral information with patients.[88] Every effort should be made to locate culturally responsive mental health professionals who are able to provide in-person or telemental health services for patients experiencing severe distress, with or without co-morbidities. Ideally these professionals are trained in trauma and migration issues. All HCPs should receive training on the protocol and know where they can seek help when questions arise (e.g., social work, legal counsel; hospital administrator).

Migrant and refugee patients often experience significant barriers to seeking medical and mental health care as they face transportation challenges, work hours that conflict with clinic hours, language barriers, lack of knowledge of the health and mental health service systems, and social stigma associated with seeking mental health care. Healthcare organizations providing primary medical care to newcomers should consider creating an integrated service model[88] with health, reproductive health, dental, and behavioral health services available at a single site, or within a single campus.[89] Social workers and mental health providers may then work directly with pediatricians, internists, and obstetrician/gynecologists to screen patients for traumatic stress and provide psychoeducation and/or formal psychological assessment and treatment. On-site, integrated behavioral health services help minimize stigma and shame that patients may feel or anticipate,[53] and improve engagement in counseling services. HCPs may also rely on social workers and mental health professionals to provide advice and guidance regarding particular patient/family encounters.

Central to optimizing care for patients and families who have experienced significant adversity is the establishment of a trauma-informed healthcare facility.[71,72,77,90] This involves incorporating trauma-informed concepts into policies and practices throughout the institution, addressing each of the 6 pillars of TIC: safety (physical and emotional); trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality, empowerment, voice and choice; and cultural, historical and gender issues.[62] A trauma-informed organization may improve staff confidence and satisfaction, as well as patient and family satisfaction, with increased recognition of trauma-related patient needs and connection with critical resources.[77]

Healthcare facilities may encourage newcomer patronage by prominently displaying welcoming signage and conveying the message that the facility is a safe place for migrant and refugee patients to obtain culturally responsive care. Bilingual staff and staff that are from the cultures commonly encountered in the patient population increase a newcomer's sense of belonging and safety and help to ensure accurate

language interpretation during the medical visit. Posts on social media or other platforms can further the reach of the welcoming message to newcomers throughout the area served by the facility. Written and digital patient information should be available in all relevant languages, and designed with input from cultural brokers, patients and/or families.

Conclusion

Cross-border migration of forcibly displaced populations is an increasing global public health crisis. HCPs in the European Union are very likely to encounter migrant children and adults and need to recognize signs and symptoms of traumatic stress that may be interfering with patient health and daily functioning. To do this, they need training on migrant health, cultural responsivity, traumatic stress and the trauma-informed approach to care. They need clinical protocols to guide recognition of significant traumatic stress and facilitate an effective response. Guidance should outline basic strategies to screen for traumatic stress, using validated clinical tools if available, or open-ended questions about migration experiences and current stressors. The protocol should describe the process for HCPs to provide psychoeducation and guidance on simple stress management strategies. The use of a relatively large work force (healthcare personnel) to screen and counsel newcomer patients, and refer a limited number to a small work force (mental health specialists) optimizes available resources and expands the patient population receiving services. Healthcare organizations can support their providers by facilitating training and protocol development, identifying community and national resources for migrant patients, and creating a trauma-informed facility.

Conflicts of Interest:

The authors have no conflicts of interest to declare.

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