CENTER FOR ADJUSTMENT, RESILIENCE & RECOVERY

Mental Health Awareness: A Month of Reflection and Renewed Commitment

Families arriving in the United States after experiencing forced migration often face a mental health system that is ill-equipped to meet their complex needs. Many arrive with deep emotional wounds from trauma, loss, and dislocation—experiences that call for care that is both culturally sensitive and trauma-informed. The existing mental health infrastructure is often inadequate, leaving service providers such as resettlement agencies, community clinics, schools, and nonprofits to bridge systemic gaps. In doing so, they have become both innovators and first responders, developing creative, community-based solutions out of necessity and providing crisis interventions in times of grave need. This approach reveals a deeper issue: as it mirrors the mental health system that remains largely reactive, prioritizing crisis management over prevention and long-term healing. As a result, both families and providers are left in a state of high alert, navigating uncertainty without the consistent support they need.

Turning Awareness into Action

This May marked Mental Health Awareness Month, centered around the theme *'Turning Awareness into Action.'* Since 1949, Mental Health America has led this national effort to increase awareness and reduce stigma related to mental health. Every May, communities come together to learn, share stories, and push for change. Turning awareness into action also means learning from past efforts—both their successes and their shortcomings. While advocacy has led to important advancements, it has also encountered ongoing systemic challenges. For example, early advocacy for deinstitutionalization, or the closing of large psychiatric hospitals, included the promise of community-based care but was ultimately unfulfilled, due to inadequate funding and planning. In reality, these changes increased the homelessness and incarceration of many individuals with severe mental illness. The repercussions are still seen today in our urban areas, along our highways and within our prison systems.

The Mental Health Parity Act, and subsequent Mental Health Parity and Addiction Equity Act (MHPAEA) pledged that insurance providers cover behavioral health treatment the same as a heart disease or diabetes. But just like past laws, ongoing systemic barriers created a different experience for individuals and families. Based on a recent report to congress MHPAEA faced major implementation challenges including inadequate network providers, exclusion of key treatments, and quantity limits on services. A noted limitation was funding and staff to enforce legislation, proposed cuts to the Centers for Medicare & Medicaid Services (CMS) will likely further reduce regulatory oversight. While these policies were rooted in the right intentions—community care and parity in treatment—their impact was limited by poor implementation and lack of funding.

Finally, a more hopeful development, was the passage of the National Suicide Hotline Designation Act of 2020, which established 988 as the universal number for the Suicide &

Crisis Lifeline. This change was rooted in local advocacy, when a father in Utah contacted his senator after his son was turned away from an emergency room. More than a decade later, 988 has supported over 10 million individuals through calls, texts, and chats. In many states, the service now includes mobile crisis response units and specialized support for rural communities, veterans, youth, and other marginalized groups.

Advocating for Forcibly Displaced Families

Forcibly displaced individuals face serious barriers when it comes to accessing mental health care. Many arrive with deep emotional wounds from war, loss, or dangerous journeys, and the trauma doesn't end when they reach safety. Adjusting to a new country, language, and culture while dealing with uncertainty about the future can add layers of stress. Unfortunately, the mental health system isn't always equipped to meet these complex needs. Language barriers, lack of culturally sensitive care, fear of stigma, and limited access to affordable services all make it harder to get help. Understanding this complexity is the first step toward building a system that truly supports healing and recovery for everyone.

To effectively support the mental health of forcibly displaced families in the United States, advocacy efforts should focus on several key areas. First, legal protections are essential to ensure that individuals can access care without fear of discrimination or immigration-related consequences. Second, workforce development should include hiring from within displaced communities and investing in educational opportunities, such as clinical licensure pathways, to build a culturally responsive mental health workforce. Third, integrating mental health services into resettlement agencies, primary care clinics, and schools can help make care more accessible and coordinated. Additionally, expanding insurance coverage and public benefits is critical to removing financial barriers and ensuring long-term access to care, regardless of immigration status. Finally, establishing community advisory boards can help ensure that programs are informed by lived experience and remain responsive to the unique needs of refugee and immigrant populations. At the heart of this work is a simple idea: everyone deserves the chance to heal, thrive, and be heard—and it's up to all of us to help make that possible by *turning awareness into action.*