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REVIEW ARTICLE

Diversity, Equity and Inclusion

Asylum seekers and the role of the acute care physician

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Abstract

There has been a recent influx of migrants and asylum seekers to the United States. They often arrive with poor social support and an inability to access reliable health care. This can lead to overutilization of emergency departments (ED) while awaiting legal proceedings. With asylum seekers in all 50 states, it is important for emergency physicians (EP) to understand the barriers to care and difficulties asylum seekers face, and to gain tools to improve both migrants' and community health. Migration and experiences within the United States can worsen pre-existing health conditions. EPs are uniquely positioned to screen for acute pathology and link people to care. Psychiatric illnesses may present differently in asylum seekers. EPs must understand the sequalae of trauma to address it. EPs must also be aware of legal protections for asylum seekers to care for these patients, and recognize challenges faced by the population to mitigate health disparities.

KEYWORDS
asylee, asylum seeker, detention, health disparities, immigration, interpreter, PRUCOL, southern border, unaccompanied minors

1 | WHY ARE MIGRANTS COMING AND FROM WHERE ARE THEY ARRIVING?

At the end of 2022, there were an estimated 108.4 million forcibly displaced people and 5.4 million asylum seekers worldwide.[1] There are many drivers for migration, including climate change, political persecution, state-sponsored and gang violence, gender-based violence, and LGBTQ+ discrimination. As violence has risen, so too has the number of asylum seekers pursuing protection in the United States, with 331,761 asylum applications in 2022 compared with 60,850 applications in 2012.[2]

Although the United States receives asylum seekers from across the globe at many ports of entry, there has been a recent increase of asylum seekers crossing the US southern border and an increase in asylum applications among migrants from Venezuela (21.2% of asylum applications in 2023), El Salvador (6.2%), Guatemala (9.2%), and Honduras (9.4%), Haiti (7.1%), and Cuba (23.1%). Migrants from the Caribbean have also grown and Chinese nationals seeking asylum at the US–Mexico border have increased by over 1000%.[3,4]

2 | US–MEXICO BORDER

At the US–Mexico border, asylum seekers face resistance from the US government and growing anti-immigration sentiments. While waiting to enter the United States, asylum seekers in Mexico have been subjected to violence, extortion, kidnappings, and sexual assault.[5,6] They have minimal access to health care because of administrative barriers and lack the ability to pay for care. Subsequently, most care is provided pro bono by nongovernmental organizations and volunteers.[7] Due to

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the limited access to potable water and poor sanitation at the border, dehydration and infections are common.[8] Asylum seekers may spend days, months, or years at the border before crossing and requesting asylum in the United States.

3 | THE US ASYLUM PROCESS

Asylum seekers pursue admission either at a port of entry or from within the United States[9] They have federal protection from *refoulement*, or forcible return to the country in which they faced persecution. Increasingly frequently, asylum seekers are apprehended at the border and placed in immigration detention. Here, an interview is conducted to determine if there is a credible fear of persecution or torture if the asylum seekers returned to their country of origin.

If this fear is deemed present, US Citizenship & Immigration Services (USCIS) may conduct a second "Asylum Merits" interview to determine asylum eligibility or refer the case to an immigration judge.[10] If asylum is granted, asylum seekers may remain in the United States. If asylum is denied, they may seek other forms of relief from removal. If no relief is granted, they are deported to their countries of origin.[10]

Affirmative asylum can be applied for by persons not in removal proceedings within 1 year of the date of last arrival in the United States, regardless of how they arrived or their current immigration status.[10] Defensive asylum is requested after removal proceedings have begun.[10] In 2022, 331,761 new asylum applications were received. Note that 14,134 cases were granted asylum affirmatively and 22,481 were granted protection defensively.[11]

Nearly 1.6 million asylum seekers are currently waiting for legal hearings in the United States, which may take years to occur.[12,13] The asylum process is stress inducing, and longer timeframes exacerbate the mental health sequelae of trauma.[14] With higher numbers of asylum seekers waiting longer periods of time for their decisions, the mental health impacts of the process grow. Where asylum seekers await the asylum decision varies. At the end of January 2024, there were nearly 40,000 asylum seekers in Immigration and Customs Enforcement (ICE) detention facilities waiting for outcomes of their cases.[15] Approximately 190,000 asylum seekers are enrolled in the Alternatives to Detention program, where they are paroled into the community and live with sponsors while awaiting their court dates.[12,16] They are given follow-up appointments with ICE within 60 days in the cities where they reside, and ICE follows them throughout the process. When seeking healthcare, asylum seekers may be in any stage in this asylum process, in immigration detention facilities, or the community. An outline of the asylum process is included in Figure 1.

4 | GENERAL HEALTH CONCERNS OF ASYLUM SEEKERS AND THOSE IN IMMIGRATION DETENTION

Asylum seekers may have declining health or new health needs after difficult migrations. One study compared asylum seekers to resettled refugees. The latter are granted secure escape routes and receive government medical care upon arrival to the host country, while asylum seekers lack such a safety net. Behavioral disorders were nine times more common in asylum seekers and infectious diseases and parasitic infections twice as prevalent as in resettled refugees.[17]

Confinement in immigration detention is also associated with unfavorable health outcomes.[18] Migrants report having medications confiscated by ICE during detention and being denied medications including anti-epileptics, cardiac and HIV medications, antipsychotics, and insulin.[19] When asylum seekers present to EDs from detention centers for care, physicians must recognize that individuals may arrive with exacerbations of chronic diseases, mental health sequalae of trauma, and untreated new conditions.

Additionally, asylum seekers are often unfamiliar with the US health care system and face cultural, language, and community-based challenges in navigating their care. With few social supports, they frequently present to EDs across the United States seeking health care. Among first-generation immigrants, perceived discrimination in health care is negatively associated with physical and mental health, while social supports mitigate the negative impacts of this perception.[20] Therefore, it is important for EPs to understand the asylum process, conditions in asylum seekers' countries of origin, and health barriers migrants experience to effectively treat the individual patient and narrow health equity gaps. EPs can improve individual clinical care, public health outcomes, and impact systemic inequalities via in-person contact, telemedicine, and pre-hospital supervisory roles.

4.1 | Unaddressed, undiagnosed, and neglected medical comorbidities

Asylum seekers may be unable to obtain health care prior to emigration in their countries of origin.[21] EPs should ask about both past medical history and last visit to a health care professional, as individuals may deny medical problems but lack care for decades. Given the prolonged course of migration, asylum seekers may commonly face dehydration and musculoskeletal problems, and children may have missed routine vaccinations. EPs should inquire about and screen for communicable diseases such as tuberculosis (active and latent), HIV, and hepatitis B and C, as the prevalence of these illnesses is higher among asylum seekers, and identifying these diseases in newly arrived migrants is important for individual health and for population disease control strategies.[22,23] Asylum seekers should not be routinely isolated without clinical suspicion for transmissible disease.

Approximately 87% of torture survivors who resettle in other countries suffer from chronic pain, which often goes undiagnosed due to a lack of culturally sensitive diagnostic tools and confounding psychiatric illness.[24] EPs need to be aware of long-term sequalae of physical abuse and pain that asylum seekers may experience and inquire about both the quality and duration of pain during an ED visit in order to make accurate diagnoses.

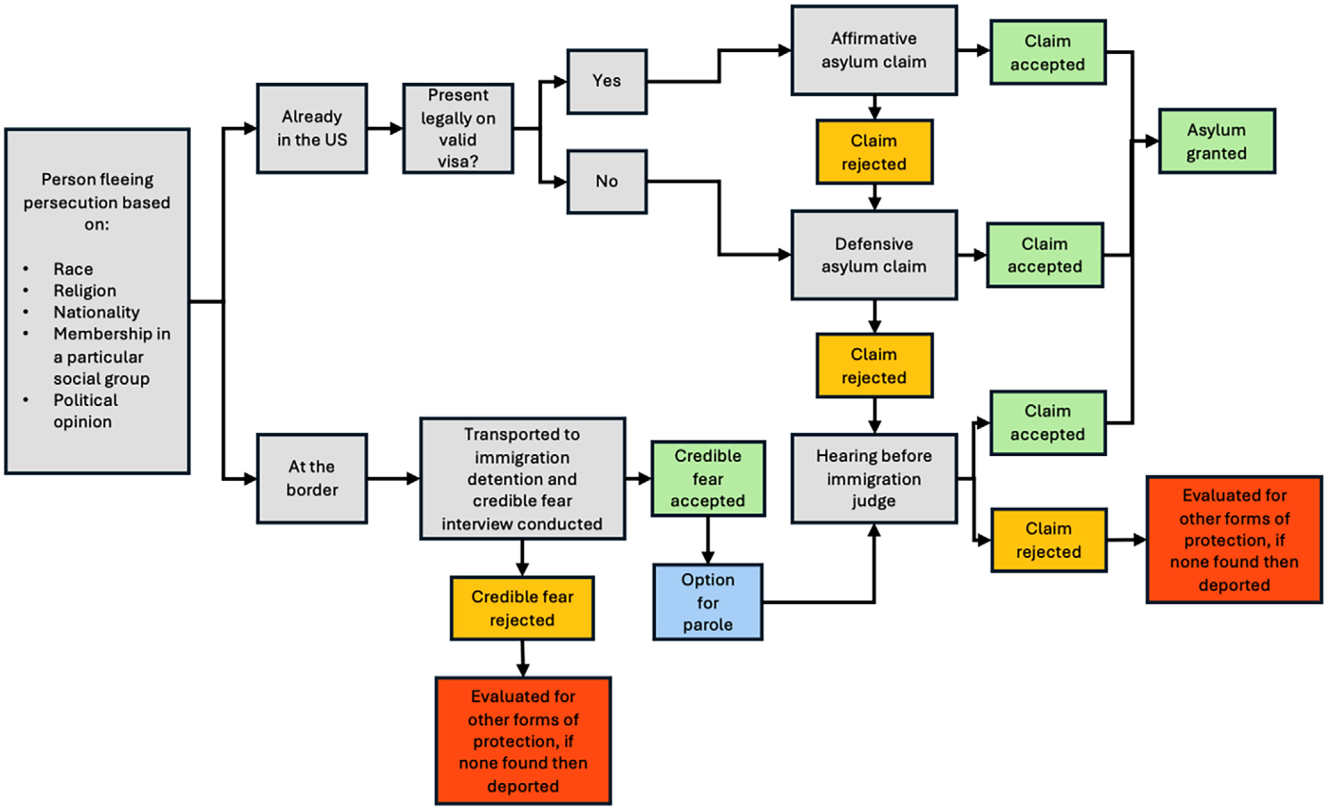

FIGURE 1 The US asylum process.

4.2 | Mental health

Pre-migration trauma and the impact of witnessing violence have high impacts on mental health. In one study, 69% of refugees were diagnosed with posttraumatic stress disorder (PTSD) and 55% with depression.[25] Adverse mental health impacts of ICE detention have been well documented, with higher levels of anxiety, depression, and PTSD in this population of asylum seekers, all of which worsen with longer detentions.[26] Transgender asylum seekers detained in ICE facilities report psychological trauma secondary to abusive treatment by authorities and a culture of transphobia. Some reported placement in solitary confinement as punishment for requesting housing based on gender identity instead of birth sex. Some were refused access to medical care and hormone treatment despite ICE's requirement to provide such treatment to those who are already receiving this therapy when brought into custody.[27]

Less attention has been paid to post-migration stressors including acculturation, adjusting to a new language, lack of social support, family separation, fear of deportation, and the asylum-seeking process itself.[28,29] Asylum seekers and refugees are less likely to report mental health complaints to health professionals because of cultural differences in symptomatology and stigma surrounding mental illness.[30] Yet, one study demonstrated that when asylum seekers sought mental health support during a crisis, they came to EDs more often than non-immigrants.[31] Thus, EPs need to be aware of asylum seekers who are more likely to present to the ED for mental health care but may not be as forthcoming about their emotional struggles as other patients. Emotional challenges may present in myriad ways including physical manifestations, sleep disturbances, and memory impairments.

It is reassuring that mental health symptoms are significantly impacted by interventions. PTSD symptoms among asylum seekers decreased after mental health care, with the number needed to treat as low as two to three patients.[32] Therefore, EPs can consider referrals for mental health care upon ED discharge in patients with symptoms. Validated screening tools for behavioral issues in children (Strength and Difficulty Questionnaire [SDQ]), anxiety (Generalized Anxiety Disorder 7-item [GAD-7]), depression (Patient Health Questionnaire [PHQ-9]), and PTSD (Harvard Trauma Questionnaire) are readily available. The Harvard Trauma Questionnaire is a cross-cultural screening instrument that was specifically validated in refugees.[33]

Children asylum seekers are at higher risk of psychological sequelae of trauma than adults. They are susceptible to detrimental mental health effects from forced parental separation, as was seen under the zero tolerance policies of the Trump Administration.[34] However, children asylum seekers are also remarkably resilient. Embracing a holistic approach to their care that harnesses their strengths is crucial to support them. Resilience-promoting factors such as enrollment and engagement in education should be encouraged.[35]

5 | HEALTH PROTECTIONS

5.1 | PRUCOL

Asylum seekers frequently rely on EDs for health needs, noting a lack of affordable health care as a deterrent to seeking preventive care.[36] However, many may be unaware that they fall under Permanent Residence Under Color of Law (PRUCOL), a public benefit eligibility status that entitles them to full Medicaid coverage once they obtain confirmation of receipt of their asylum application by USCIS. Educating asylum seekers about their eligibility for this program so that they can enroll at home or referring them to ED or community social workers to assist them with enrollment can have a profound impact on their ability to obtain affordable medical care. Once granted asylum, asylees continue to be eligible for Medicaid. Prior to submitting their asylum application, individuals may also be eligible for Emergency Medicaid, a more limited form of assistance that covers services needed to treat acute conditions.

5.2 | EMTALA

Asylum seekers are covered under the Emergency Medical Treatment and Labor Act (EMTALA), which requires that hospitals participating in Medicare provide emergency services and stabilization to patients in the United States, regardless of legal status.[37] Hospitals are considered safe spaces for asylum seekers, and ICE has directed agents to avoid making arrests or carrying out searches in these spaces.[38] However, to best protect migrants, physicians should document a patient's immigration status only if it is absolutely necessary for care.

5.3 | Health care barriers and needs of asylum seekers in the ED

5.3.1 | Unaccompanied minors and trafficking recognition

Most unaccompanied minors are boys between 13 and 17 years old, although unaccompanied elementary school-aged children are increasingly arriving.[39] It was previously estimated that 75%–80% of newly arriving unauthorized unaccompanied children were brought across the border by paid smugglers (*coyotes*).[40] Coyotes have occasionally been reported to sell migrants into forced labor or sex work to recover their costs. One study found that 68% of trafficked persons presented to a healthcare professional at least once, and 56% of the time they presented to emergency and urgent care.[41] Unfortunately, just 4.8% of EPs report feeling confident in their ability to identify human trafficking victims.[42] Thus, EPs must maintain a high index of suspicion for trafficking, screen regularly for both labor and sex trafficking in adults and children, and rely on guidelines to identify and treat potential trafficking victims in the ED.[42] For comprehensive guidelines on the evaluation and documentation of torture, which is beyond the scope of the typical EP, we recommend the United Nations' Istanbul Protocol.[43]

5.3.2 | Language interpreters

EPs must use professional language interpreters when evaluating patients with limited English proficiency. Language is a barrier for newly arrived immigrants seeking care; many expect to be misunderstood and not have their native language available via an interpretation service.[36,44] The use of professional interpreters is associated with improved quality of clinical care compared to ad hoc interpreters, and it is also associated with equal follow-up adherence, equal visit lengths, decreased ED returns, and fewer disparities in ED admissions when compared to English-speaking patients.[45]

5.3.3 | Follow-up, medication access, and social needs

Patients seeking asylum often lack primary care access and financial resources, and many are unaware of their Medicaid eligibility. Where possible, EPs should employ resources including GoodRx and other affordable medication programs and seek social work assistance to guide asylum seekers to continuity social service programs. Asylum Seeker Resource Navigation Centers assist new arrivals to obtain free and confidential help accessing health insurance and school enrollment, mental health counseling, child services, and legal services.[46] Finally, the American College of Physicians published a toolkit of healthcare resources for refugees, asylees, and non-detained asylum seekers to help clinicians better understand healthcare coverage options and health considerations for these populations.[47]

Asylum seekers have limited financial resources and social networks in the United States and are more likely to be unhoused, live in overcrowded residences, or seek shelters than US-born patients.[48] Housing instability is an independent risk factor for poor health status and delayed doctor visits.[49] Unhoused asylum seekers who present to EDs should be navigated to shelters or other housing options while awaiting more permanent housing, as they may lack the language capabilities to do so themselves.

6 | CLINICAL BEST PRACTICES

Although asylum seekers with unique physical and emotional issues have increased in the United States, medical professionals may be unfamiliar with their plight and health conditions. EPs have a unique window into the health of migrants, and ED visits may be the only time asylum seekers encounter health care. Currently, many migrants come to the United States after crossing through the jungles of Colombia and Panama before arriving in Mexico. Therefore, EPs need to consider not

TABLE 1 Medical consideration in those seeking asylum.[32,50,56–58]

Organ system	Symptom, injury, disease process	Diagnostic and treatment considerations
Dermatologic	Snake and animal bites; scabies, lice, and parasitic insects; acute or chronic wounds	Antibiotics for animal bites. Have a high index of suspicion for parasites in those recently arrived or released from crowded detention facilities—treat bacterial superinfections
Gastrointestinal	Diarrheal illnesses	Consider with a history of a lack of potable water and limited sanitation; supportive care or antibiotics; consider nutritional deficiencies and prescribe iron or vitamin supplements
Genitourinary/ gynecologic	Pregnancy, sexually transmitted infection (STI), and urinary tract infections (UTI)—consider acute or chronic sequalae of sexual violence	Provide pregnancy, STI, and UTI screening and treatment
Hepatic	Hepatitis B and C	Often asymptomatic; screening labs
Immune system/ infectious disease	HIV/AIDS, varicella, mumps, measles, influenza, leishmaniasis, malaria, dengue fever, leptospirosis, yellow fever, typhoid fever, Chagas disease	Health care for HIV/AIDS may be unavailable or inaccessible in country of origin. Screening labs (CD4 count and Viral Load) and refer to infectious disease specialist Screen for rashes and offer catch up vaccinations for all newly arrived children, adolescents, and adults to align with the host nation's schedule; work up fever and have a high index of suspicion for diseases that are atypical in the United States
Musculoskeletal	Myalgias, arthralgias, subacute or healed fractures	Often presents as chronic pain; may result from torture and persecution
Psychiatric	Mental health issues as sequelae of persecution or stressors of migration; anxiety, depression, and PTSD are common as well as somatic complaints	Short validated screening tools; referrals for mental health care upon ED discharge in patients with symptoms
Pulmonary	Tuberculosis (TB) and upper respiratory illnesses	Screen for active/latent TB; viral respiratory disease is common in recently arrived migrants and those recently released from crowded detention centers—consider respiratory panel in young children or older adults
Renal	"Border-crossers' nephropathy"	In recently arrived migrants crossing the border, check serum creatine kinase, electrolytes, and urine for myoglobinuria; consider if muscle pain, weakness, or swelling present
Social determinants of health	Health care access	Provide follow-up care, medication access through affordable programs (GoodRx), and referral to hospital social work for assistance with housing and enrollment in entitlement programs

only the individual's country of origin but also their migration route, along which diseases may be acquired.

Asylum seekers may be predisposed to various medical conditions (Table 1). For patients with infectious symptoms, a high index of suspicion is maintained for diseases that are atypical in the United States but may have been acquired during migration. A new phenomenon termed "border-crossers' nephropathy" presents as rhabdomyolysis complicated by myoglobinuric acute kidney injury due to the arduous journeys many asylum seekers face to cross the US southern border.[50] Hospitals as far as New York City have seen such cases in recently arrived migrants who quickly move north.[51]

EPs should use a trauma-informed approach to the interview and examination to help prevent retraumatization and encourage an open dialogue. However, they do not need to be afraid to directly ask migrants about prior threats, harm, or persecution as this is an opportunity to intervene and refer survivors of abuse to existing community resources.[52]

EPs can offer sexually transmitted infection and pregnancy screening, and influenza and tetanus vaccines to migrants, which can profoundly impact the individual and their community's health. They should ensure adequate, attainable follow up through linkages to local asylum clinics for forensic evaluations, affordable general clinics, or Federally Qualified Health Centers. Social workers, where feasible, can help address the social determinants of health impacting this population. EPs should assist patients in getting supplies like at home sphygmomanometers for patients with hypertension, thermometers for those with infectious symptoms, wound care supplies for chronic or acute wounds, and canes or supports for those with walking difficulties to help bridge gaps to follow-up care.

For patients previously on medication, EPs can consider restarting these prescriptions where clinically appropriate. While this should ideally be the role of primary care, asylum seekers may face delays getting continuity care appointments and the ED visit is frequently the only encounter with healthcare for an extended period.

For interested clinicians, opportunities exist to engage in ethical care at the US–Mexico border and to counter the stigmatization many migrants face. This may involve providing in-person or telehealth care to migrants with limited access to services or challenging harmful immigration policies.[53] Physicians may also become involved in providing pro bono forensic medical evaluations and writing medical-legal

affidavits to objectively document human rights abuses for an asylum seeker's legal case. Completing a medical-legal affidavit as part of the legal proceedings may significantly impact asylum seekers. In one study, 81.6% of applicants who received forensic medical evaluations were granted relief, compared to the national asylum grant rate of 42.4%.[54] Physicians without asylum medicine or forensic expertise can still assist patients by referring them to immigration lawyers and expert physicians.[55]

7 | CONCLUSION

Asylum seekers have diverse and complex medical needs. EPs must consider their routes of migration and countries of origin when assessing their potential for locally acquired diseases. Many asylum seekers who have unmet health needs rely on the ED to receive care and may be unaware of entitlements. ED interventions can have a profound impact on those who lacked medical care for years. Harnessing the internal resilience of asylum seekers and providing holistic, trauma-informed care are essential to them and their communities. Beyond improving individual well-being, such care amplifies the voices of asylum seekers and helps address health disparities and policies that disproportionately impact their health.

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REFERENCES

1. UNHCR. *Global Trends: forced displacement in 2022*. UNHCR; 2023.
2. United States Citizenship and Immigration Services. *Asylum application processing fiscal year (FY) 2022*. United States Citizenship and Immigration Services; 2023.
3. Baugh R. *Refugees and Asylees: 2021*. Department of Homeland Security Office of Immigration Statistics; 2021.
4. Gibson I. *Refugees and asylees: 2022*. Annual Flow Report. Office of Homeland Security Statistics; 2023.
5. Ramage K, Stirling-Cameron E, Ramos NE, et al. "When you leave your country, this is what you're in for": experiences of structural, legal, and gender-based violence among asylum-seeking women at the Mexico-U.S. border. *BMC Public Health*. 2023;23:1699.
6. Human Rights Watch. *Mexico: abuses against asylum seekers at US border*. Human Rights Watch; 2021.
7. Infante C, Vieitez-Martinez I, Rodriguez-Chavez C, et al. Access to health care for migrants along the Mexico-United States border: applying a framework to assess barriers to care in Mexico. *Front Public Health*. 2022;10:921417.
8. Reynolds CW, Ramanathan V, Das PJ, et al. Public health challenges and barriers to health care access for asylum seekers at the U.S.-Mexico border in Matamoros, Mexico. *J Health Care Poor Underserved*. 2022;33:1519-1542.
9. United States Citizenship and Immigration Services. *Refugees and asylum*. United States Citizenship and Immigration Services; 2022.
10. United States Citizenship and Immigration Services. *Obtaining asylum in the United States*. USCIS; 2022.
11. United States Department of Homeland Security. *2022 Yearbook of Immigration Statistics*. United States Department of Homeland Security; 2023.
12. TRAC. *A sober assessment of the growing U.S. asylum backlog*. Transactional Records Access Clearinghouse (TRAC); 2022.
13. Walden J. Caring for the forcibly displaced. *Prim Care*. 2021;48:1-7.
14. Robjant K, Hassan R, Katona C. Mental health implications of detaining asylum seekers: systematic review. *Br J Psychiatry*. 2009;194:306-312.
15. TRAC. *First immigrant detention numbers of 2024 show new norm*. TRAC; 2024.
16. United States Department of Homeland Security. *Privacy impact assessment for the Alternatives to Detention (ATD) program*. United States Department of Homeland Security; 2023.
17. Kleinert E, Müller F, Furaijat G, et al. Does refugee status matter? Medical needs of newly arrived asylum seekers and resettlement refugees—a retrospective observational study of diagnoses in a primary care setting. *Conflict Health*. 2019;11:39.
18. Saadi A, Patler C, De Trinidad Young ME. Cumulative risk of immigration prison conditions on health outcomes among detained immigrants in California. *J Racial Ethn Health Disparities*. 2022;9:2518-2532.
19. Hampton K, Mishori R, Griffin M, et al. Clinicians' perceptions of the health status of formerly detained immigrants. *BMC Public Health*. 2022;22:575.
20. Szaflarski M, Bauldry S. The effects of perceived discrimination on immigrant and refugee physical and mental health. *Adv Med Sociol*. 2019;19:173-204.
21. Alberto C, Chilton M. Transnational violence against asylum-seeking women and children: honduras and the United States-Mexico border. *Human Rights Review*. 2019;20:205-227.
22. Proença R, Souza FM, Bastos ML, et al. Active and latent tuberculosis in refugees and asylum seekers: a systematic review and meta-analysis. *BMC Public Health*. 2020;20:838.
23. Taha H, Durham J, Reid S. Communicable diseases prevalence among refugees and asylum seekers: systematic review and meta-analysis. *Infect Dis Rep*. 2023;15:188-203.
24. Kaur G, Weinberg R, Milewski AR, et al. Chronic pain diagnosis in refugee torture survivors: a prospective, blinded diagnostic accuracy study. *PLoS Med*. 2020;17:e1003108.
25. Saadi A, Hampton K, de Assis MV, et al. Associations between memory loss and trauma in US asylum seekers: a retrospective review of medico-legal affidavits. *PLoS One*. 2021;16:e0247033.
26. Keller AS, Rosenfeld B, Trinh-Shevrin C, et al. Mental health of detained asylum seekers. *Lancet*. 2003;362:1721-1723.
27. Minero LP, Dominguez S Jr, Budge SL, et al. Latinx trans immigrants' survival of torture in U.S. detention: a qualitative investigation of the psychological impact of abuse and mistreatment. *Int J Transgend Health*. 2022;23:36-59.
28. Haas BM. "Asylum is the most powerful medicine": navigating therapeutic interventions in Limbo. *Cult Med Psychiatry*. 2021;45:193-217.
29. Miller KE, Rasmussen A. War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Soc Sci Med*. 2010;70:7-16.
30. Brown CM, Swaminathan L, Saif NT, et al. Health care for refugee and immigrant adolescents. *Prim Care*. 2020;47:291-306.
31. Saunders NR, Gill PJ, Holder L, et al. Use of the emergency department as a first point of contact for mental health care by immigrant youth in Canada: a population-based study. *CMAJ*. 2018;190:E1183-E1191.
32. Turrini G, Purgato M, Acarturk C, et al. Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: systematic review and meta-analysis. *Epidemiol Psychiatr Sci*. 2019;28:376-388.
33. Berthold S, Mollica R, Silove D, et al. The HTQ-5: revision of the Harvard Trauma Questionnaire for measuring torture, trauma and DSM-5 PTSD symptoms in refugee populations. *Eur J Public Health*. 2019;29:468-474.

34. MacLean SA, Agyeman PO, Walther J, et al. Mental health of children held at a United States immigration detention center. *Soc Sci Med*. 2019;230:303-308.
35. Sangmo L, DiRisio AC, D'Andrea MR, et al. The experiences of minors seeking asylum in the United States: a modified consensual qualitative research analysis. *J Trauma Stress*. 2020;33:882-893.
36. Asgary R, Segar N. Barriers to health care access among refugee asylum seekers. *J Health Care Poor Underserved*. 2011;22:506-522.
37. Brenner JM, Blutinger E, Ricke B, et al. Ethical issues in the access to emergency care for undocumented immigrants. *J Am Coll Emerg Physicians Open*. 2021;2:e12461.
38. United States Immigration and Customs Enforcement. *Protected areas and courthouse arrests*. ICE; 2023.
39. Ataiants J, Cohen C, Riley AH, et al. Unaccompanied children at the United States border, a human rights crisis that can be addressed with policy change. *J Immigr Minor Health*. 2018;20:1000-1010.
40. Kandel WA, Bruno A, Meyer PJ, et al. *Unaccompanied Alien Children: Potential Factors Contributing to Recent Immigration*. Service CR; 2014.
41. Chisolm-Straker M, Baldwin S, Gaïgbé-Togbé B, et al. Health care and human trafficking: we are seeing the unseen. *J Health Care Poor Underserved*. 2016;27:1220-1233.
42. Shandro J, Chisolm-Straker M, Duber HC, et al. Human trafficking: a guide to identification and approach for the emergency physician. *Ann Emerg Med*. 2016;68:501-508.
43. Office of the United Nations High Commissioner for Human Rights. *Istanbul Protocol*. United Nations; 2004.
44. Lopez-Murray E. Health of asylum-seeking immigrants: providing medical care from a volunteer's perspective. *JAAPA*. 2019;32:13-14.
45. Karliner LS, Jacobs EA, Chen AH, et al. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res*. 2007;42:727-754.
46. New York City Mayor's Office of Immigrant Affairs. *Asylum seeker resources*. New York City Mayor's Office of Immigrant Affairs; 2023.
47. American College of Physicians. *Healthcare resources for refugees, asylees, and non-detained asylum seekers living in the US*. ACP. 2024
48. Newman A. *A record 100000 people in New York homeless shelters*. The New York Times; 2023.
49. Stahre M, VanEenwyk J, Siegel P, et al. Housing insecurity and the association with health outcomes and unhealthy behaviors, Washington State, 2011. *Prev Chronic Dis*. 2015;12:140511.
50. Ossai NO, Hour BT, Szerlip HM. Border-crossers' nephropathy: the risk of coming to America. *Renal Failure*. 2013;35:483-486.
51. McVane BA, Andreae MC, Fernando DB, et al. Exertional rhabdomyolysis in a long-distance migrant. *Journal of Emergency Medicine*. 2019;56:551-553.
52. Hexom B, Fernando D, Manini A, et al. Survivors of torture: prevalence in an urban emergency department. *Academic Emergency Medicine*. 2012;19:1158–1165.
53. Martinez C, Carruth L, Janeway H, et al. How should clinicians express solidarity with asylum seekers at the US-Mexico border? *AMA J Ethics*. 2022;24:e275-e282.
54. Atkinson HG, Wyka K, Hampton K. Impact of forensic medical evaluations on immigration relief grant rates and correlates of outcomes in the United States. *J Forensic Leg Med*. 2021;84:102272.
55. McKenzie KC, Bauer J, Reynolds PP. Asylum seekers in a time of record forced global displacement: the role of physicians. *J Gen Intern Med*. 2019;34:137-143.
56. Beaudry G, Zhong S, Whiting D, et al. Managing outbreaks of highly contagious diseases in prisons: a systematic review. *BMJ Glob Health*. 2020;5:e003201.
57. Higuita NA, Suarez JA, Millender E, et al. U.S. bound journey of migrant peoples InTransit across Dante's Inferno and Purgatory in the Americas. *Travel Med Infect Dis*. 2022;47:102317.
58. Lo NC, Nyathi S, Chapman LAC, et al. Influenza, varicella, and mumps outbreaks in US migrant detention centers. *JAMA*. 2021;325:180-182.

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