HIAS

Center for Refugee Policy

Needs Assessment

Wellbeing of Asylum Seekers in New York City and the Washington, D.C. Area

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1 Executive Summary

This assessment aimed to explore the needs of asylum seekers in New York City and the greater Washington, D.C. area, with an emphasis on social services, and particularly mental health and psychosocial support (MHPSS). Through documenting existing services, needs, and opportunities, HIAS aimed to determine whether and how HIAS could add value through programming, partnership, and advocacy. These locations were selected as HIAS currently provides legal and social services to asylum seekers in both locations.

The report includes an analysis of current services offered by the following stakeholders: a cross-section of 46 organizations engaged in serving asylum seekers through a service mapping questionnaire and interviews, as well as 39 asylum seekers and asylees through interviews and focus group discussions between February and March 2024. Unless otherwise specified, "stakeholders" refers to the combined categories of providers and asylum seekers/asylees. These findings build upon a desk review of secondary data conducted prior to the needs assessment.

Key Findings

New York City (NYC) and the Washington, D.C./Maryland/Virginia (DMV) area represent two distinct contexts and two different orders of magnitude in terms of longstanding populations, asylum seeker arrivals, and service provision ecosystems. Nevertheless, this assessment found many parallel needs, gaps, and opportunities with regards to asylum seeker services. Core findings include:

Asylum seekers face significant gaps in access to basic needs, housing, legal services, and healthcare, including mental health services, as providers in both cities are overstretched and under-resourced. Asylum seekers who had sought services, including legal services and mental health services, reported being turned away from multiple providers due to lack of capacity and long waitlists.[1] Providers report operating at or over capacity across multiple areas: housing, legal, social, health, and mental health services. Many shared that they are filling gaps which the government should be addressing through direct assistance or policy changes. Since providers are at capacity, their ability to do needs-based targeting and outreach has been dialed back, so word-of-mouth referrals have increased, particularly in New York. Furthermore, accompaniment and advocacy are often needed to get asylum seekers served. This accompaniment is absent for many asylum seekers given underinvestment in both traditional and alternative forms of case management. These factors raise concerns regarding service coverage for the most vulnerable asylum seekers.

Mental health needs are prevalent and under-addressed among asylum seekers, who face systemic barriers to accessible and culturally relevant care. Addressing mental health challenges requires a variety of approaches. Providers and asylum seekers say that mental health issues are under-reported due to asylum seekers' daily struggle to meet urgent survival needs, as well as stigma many see related to receiving mental health support. Due to so many things being out of their control, including the continued precarity of the asylum process, many asylum seekers are struggling to process trauma. Interviewees noted that isolation, discrimination, and loss are widely felt.

Asylum seekers encounter barriers which are intimately related to systemic issues in mainstream U.S. society. These include a lack of access to culturally responsive or bi-lingual, bi-cultural service providers, which perpetuates distrust and stigma among certain populations. Additional barriers to care include the conceptualization of mental health across cultures, which can lead to mistrust in mental health-focused care even when available.[2] Stakeholders suggest offering a variety of mental health and social supports with multiple inroads to help people adjust, seek culturally relevant care, and engage in therapeutic support. These expressed needs should translate into funding for culturally appropriate mental health service provision.

Marginalized asylum seekers experience continued rejection, discrimination, and exclusionary practices. Asylum interviewees from communities which experience greater marginalization, including ethnic or political minorities within a diaspora group, Black migrants, members of the LGBTQ+ community, and people with low or no literacy, reported experiencing rejection and discrimination in spaces where they had hoped to find solidarity and support, including among service providers and/or within their own diaspora or communities.

Access to reliable, up-to-date information is a gap. Asylum seekers described how difficult it was to

receive accurate information before and after crossing the U.S. border. This difficulty, combined with the fact that most recent arrivals said they have no family or friends in the United States, impedes their ability to access services and make informed decisions. Interviewees reported relying on word-of-mouth information, often through informal channels such as mass WhatsApp groups, to exchange information. News from these sources cannot be easily verified and rumors abound. Reliance on informal peer-to-peer information sharing also poses certain challenges against the backdrop of competition for limited resources.[3]

Inequitable language access exacerbates barriers to information as well as access to crucial health and social services. Language access for Spanish speakers, while far from complete, appears to be considerably more advanced than access for speakers of other languages in both locations. Lack of language access compounds issues around information flows and creates barriers to engaging in mental health support even when care is made available.

Asylum seekers' trust must be earned. Questions about how best to serve asylum seekers prompted substantial feedback about the importance of trust—specifically, how challenging and consequential it is for asylum seekers to decide who is safe to trust, and what information can be shared. As a result, asylum seekers often exercise great caution when engaging with a new stakeholder. The importance of working through contacts who have earned asylum seekers' trust was emphasized by multiple interviewees.

Limited coordination and collaboration among service providers affects the breadth and depth of coverage for asylum seekers. Providers reported instances of strong collaboration in both cities, often driven by either a well-established complementarity of services or personal relationships. At the same time, service organizations reported gaps in coordinating referrals and in maintaining up-to-date mechanisms to ensure functional referral pathways, particularly in New York City. Several highlighted how competition for resources can undermine collective impact. Community-based organizations have some of the strongest relationships with asylum seekers, and often the least access to funding.

Peer support and mutual aid are preferred avenues for asylum seekers. Many asylum seekers interviewed expressed a desire to receive peer support for both mental and social health and wellbeing. Equally, many asylum seekers interviewed expressed a desire to support other newcomers and/or to contribute to organizations that are providing them with assistance. Several of those interviewed were already doing so, including some very recently arrived asylum seekers who were participating in mutual aid efforts — a collaborative approach in which members of a community support one another with a vision of "solidarity, not charity." Policies at shelters and rigid contracts for service provision, often stated to be in the interest of safeguarding, also prevent mutual aid groups from connecting with shelter residents. Existing policies often contribute to continued transience of asylum seekers, and the need for ongoing crisis stabilization, impeding efforts to engage asylum seekers in mutual aid or peer support.

Key Recommendations for Service Providers in NYC and the DMV

1. Invest in **multimodal community-based psychosocial support** to meet the cultural and practical preferences of asylum seekers. This includes provision of psychological first aid, peer support, group support and alternative therapeutic interventions.
2. Promote **greater access to information** among asylum seekers — primarily on navigating available services, and secondarily on cultural orientation.
3. Advance **mutually beneficial partnership development**, meaningful coordination, and enhanced referral pathways.
4. Collaborate on **systems advocacy** among and with diverse coalitions of service providers, mutual aid networks, and city and state entities to procure more funding for asylum services.
5. Leverage comparable **refugee resettlement and integration funding and programmatic service models** for asylum seekers.

The assessment team thanks all the stakeholders who took time from very busy days to share their insights with us. A full list of organizations consulted can be found in Annex A. The team also thanks the dedicated HIAS staff in the New York City and Silver Spring offices who generously shared thoughts, contacts, and guidance; and the equally dedicated volunteers who provided thoughtful interpretation support to interviews and focus groups.

After fleeing Cameroon for her personal safety, Claris sought asylum in the U.S. HIAS helped her win her asylum case and get a green card, but Claris' children were still back in Cameroon. After 6 years, she finally got approval for them to come and join her in the Washington, D.C. area. (Evy Mages for HIAS)

2 Context & Background

Through its Legal and Asylum Department, HIAS provides free legal representation to asylum seekers through HIAS lawyers in the Washington, D.C. and New York City metro areas, and nationwide through a network of pro bono lawyers. Since 2017, HIAS has provided wraparound legal services through a volunteer program designed to support clients. In 2021, wraparound services expanded to include case management for clients in NYC and the D.C./Maryland/Virginia (DMV) area. As the number of asylum seekers arriving in these two regions increased between 2021 and 2023, HIAS sees the need for more comprehensive services for newcomers.

In the fall of 2023, HIAS leadership commissioned a needs assessment to better understand the evolving needs, context, and responses of key stakeholders, with an eye to identifying opportunities to further contribute to this response. Prior to primary data collection, a desk review was conducted to identify key stakeholders and priority areas of inquiry. The desk review focused on population trends and specific vulnerabilities faced by asylum seekers as well as experiences of asylum seekers, best practices for support, multi-level psychosocial support, and mechanisms for referral and coordination.

3 Methodology

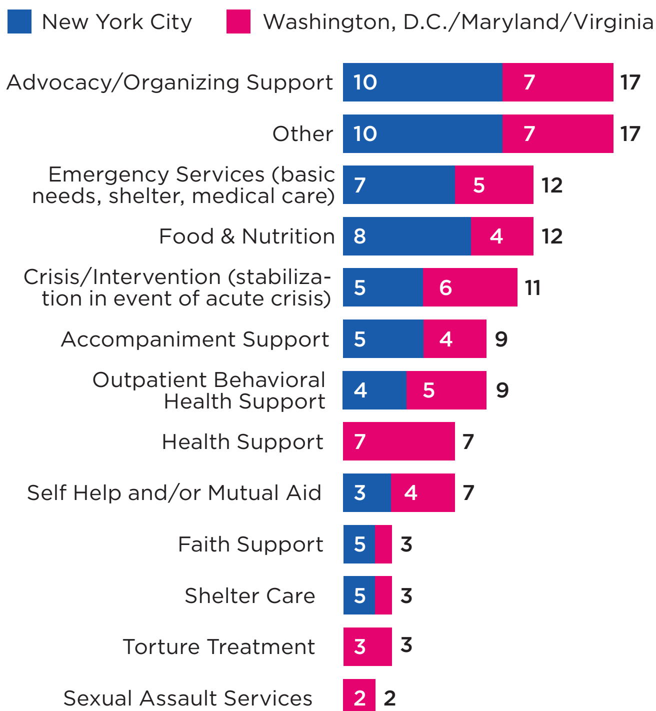
Service Mapping Questionnaire

A service mapping questionnaire was emailed to a cross-section of providers in NYC and the DMV including resettlement agencies, social service providers, legal service providers, physical and behavioral healthcare providers, advocacy organizations, community-based organizations, including mutual aid networks and faith communities, and municipal and state government bodies. The exercise aimed to document types of services provided, geographic service areas, eligibility criteria, provider language capacities, and accessibility.

There were 33 organizations that responded to the questionnaire. In total, there were 15 responses from organizations based in the DMV area and 19 responses from organizations based in NYC, with HIAS completing one response per area. Responding organizations most commonly reported providing advocacy/organizing support as well as emergency and/or crisis intervention services. Food and nutrition support was commonly reported in NYC, and health support reported more frequently in the DMV. Many organizations stated they provided services other than those listed in the questionnaire, often mentioning legal services, resource navigation, and workforce development.

Services Offered by Survey Respondents

Among organizations which responded "other," key types mentioned include legal services, resource navigation, and workforce development.



Data source: HIAS service mapping questionnaire. Based on 19 responses from organizations in NYC and 15 responses from organizations in the DMV. HIAS submitted one response for each location.

Key Informant Interviews — Service Providers

HIAS approached a cross-section of organizations for semi-structured interviews, ultimately conducting interviews with 11 providers in the DMV and 14 providers in New York City, in addition to HIAS staff in these two locations. Many, but not all providers, also completed the questionnaire. In a few cases, providers interviewed were asylum seekers or asylees themselves.

Key Informant Interviews and Focus Group Discussions — Asylum Seekers

The assessment team heard from 39 asylum seekers and asylees over the course of two weeks in February and March 2024. In New York City, 10 people participated in interviews and another 8 in a focus group discussion. In Washington D.C., 6 people participated in interviews and 7 in a focus group discussion. The sample of asylum seekers and asylees included women, men, and non-binary people. Countries of origin represented included: Venezuela, Ecuador, Peru, Guatemala, El Salvador, Haiti, Guinea, Sudan, Mauritania, Myanmar, Indonesia, Russia, and former members of the USSR.

Informed Consent and Ethical Considerations

Asylum seeker interviews were arranged through the mediation of service providers known to the asylum seekers. An informed consent form was provided to any stakeholder who participated in interviews or focus group discussions. For some asylum seekers interviewed, the consent form was translated into Spanish and/or French, and/or explained verbally in

Arabic. The informed consent explained the purpose of the interview, that responses would be anonymized and confidential, and the right to decline participation. Visa gift cards in nominal amounts ($25) were offered to thank participants for their time, as well as Lyft vouchers to offset transportation expenses incurred. The team adhered to trauma-aware practices in the consent procedures; this entailed sharing information about where asylum seekers could receive MHPSS support and other resources.

Limitations

When analyzing the data, key limitations should be considered. Most importantly, the sample of providers and asylum seekers should not be taken as representative of the wider population. HIAS aimed to speak with asylum seekers of diverse nationalities, languages, genders, sexual orientation, and (adult) ages. However, some gaps are noteworthy: these include Chinese asylum seekers (given the significant presence of this population within New York City), asylum seekers with disclosed disabilities, and older asylum seekers. Children were not consulted directly due to a lack of preparedness to ensure child protection safeguarding and state assent law requirements. It should also be noted that all asylum seekers were identified through service providers and interviewed within a service delivery environment.

While HIAS made efforts to engage a diverse cross-section of providers, those consulted should not be seen to represent the totality of providers in these metro areas. The insights are also limited to a narrow timeframe of data collection and willingness of stakeholders to participate. Importantly, requests to access government-funded shelters were denied in both New York City and Washington, D.C. Some stakeholders did not respond to requests for interviews within the timeframe of the assessment. In New York City, the assessment team did not speak with for-profit organizations contracted by the city to provide sheltering services.

4 Findings

Overview of Service Landscapes

In New York City, long a hub for asylum seekers and other immigrants, stakeholders described how politicization and privatization have shaped the environment for asylum seekers since 2022. That year, city authorities outsourced core reception and sheltering services to private for-profit companies. Time limitations on shelters and the shuffling of asylum seekers between shelter locations have kept many in a state of transience which led an INGO representative to compare the context to international humanitarian settings in terms of "people on the move." New York's robust network of community and migrant-serving providers have responded in myriad ways, with some receiving funding from the city and state for limited assistance programs, and others seeking to fill gaps in service delivery. Many organizations have a great deal of experience; most of those surveyed or interviewed have been in operation for over a decade. Some more recently created organizations and initiatives are stepping up in the face of rising numbers of arrivals and a government response they described as inadequate. Several key service providers in New York City are entirely or mostly driven by volunteers, and some of the most momentum appears to lie in voluntary efforts.[4]

The area of Washington, D.C., southern Maryland, and northern Virginia (DMV) has a smaller number of providers and asylum seekers when compared to New York City. As in New York, many of the organizations in the area serving migrants are long-standing, while a few have formed recently. (Of the 17 organizations surveyed or interviewed in the DMV, 13 have been in operation for more than a decade). Arrivals to Washington D.C. slowed in 2023, with the last chartered bus from the border arriving in November 2023. However, stakeholders noted that compared to the initial busing period, the DMV has shifted from being an area of transit to a final destination for many. Some asylum seekers are also arriving on their own from other cities, such as Denver or New York, with the intention of settling in the DMV.[5] This shift has not been accompanied by a sufficient investment in services for asylum seekers who choose to remain in the area, stakeholders reported.[6] Compared to New York City, the DMV is also more fragmented with three distinct legal and regulatory environments in the District of Columbia, Maryland, and Virginia. Within Maryland and Virginia, the context varies further by county. This situation leads to confusion among asylum seekers regarding their rights and options.[7]

Service providers in both New York and the DMV reported that they are overwhelmed and facing significant capacity issues. Many said they are forced to fill gaps left by insufficient government responses. Providers emphasized that due to capacity strains, a reduction in coverage by any organization can put a strain on the wider network. The chronic saturation of providers raised concerns around duty of care toward asylum seekers, with organizations reporting feeling forced to choose between breadth and depth of coverage. Some are providing intensive services to a narrow range of clients who meet specific criteria or curtailing outreach and targeting efforts knowing they will need to turn away new clients due to sheer lack of capacity. Notably, providers suggested that larger NGOs and INGOs are being more cautious about engaging asylum seekers due to fear of raising expectations which cannot be met, and sometimes focusing on advocacy efforts instead.

On the other hand, some organizations — particularly at the grassroots level — reported a different strategy of turning away as few people as possible, which requires limiting the number or depth of services to each client. Some observed that in effect, the caution of larger organizations is leaving smaller, less well-resourced organizations to fill in service gaps. One representative of an INGO reflected that this also means that "so many people are being lost, especially people who aren't already engaged with the system."

Role of U.S. Contacts

It is also important to note the role of the U.S. contacts of asylum seekers and their extended networks, which have historically constituted an important source of support for new immigrant populations. While some of the asylum seekers interviewed reporting having direct U.S. contacts, levels of support from these contacts varied. Many of the asylum seekers interviewed in New York said they had no U.S. contacts. Providers in the DMV, meanwhile, note that a growing number of asylum seekers are arriving to the area with no U.S. contacts. This shift is linked in part to changes in the countries of origin among new arrivals. The DMV has longstanding populations originating from particular countries or regions, including the Northern Triangle, Ethiopia, and Afghanistan. Providers reported that recently arriving asylum seekers from these areas were more likely to have personal contacts in the country. By contrast, a mutual aid organizer estimated that among the primarily Venezuelan population her team engages, 9 in 10 arrive with no U.S. contacts.

For some, an alternative to personal contacts is to connect with diaspora communities. Providers assessed that diaspora networks in these regions are more established for some groups than others. As a result, providers observed that some asylum seekers are moving to parts of the country which have stronger diaspora networks. Providers and asylum seekers also expressed that solidarity from other refugee and asylee communities is not guaranteed. Some asylum seekers interviewed reported facing rejection from members of their national, linguistic, or cultural communities on the basis of political differences, anti-LGBTQ+ prejudice, or anti-migrant prejudice among previous migrants.

Existing Legal Services

Stakeholders reported that legal services for asylum seekers in New York City and the DMV, both paid and pro bono, are under immense pressure. With demand far outstripping supply, providers described making difficult choices weighing quality against coverage. Some focus on full legal representation, taking a smaller number of cases for intensive long-term support to maximize each client's chances for approval. Others have mobilized to deliver a basic level of support to greater numbers of people through legal orientations or pro se assistance to support asylum seekers to file asylum applications, weighing the low likelihood of success for pro se cases where individuals represent themselves against the slim odds of securing representation for each asylum seeker within the one-year window for filing. With limited screening of cases in the context of some pro se clinics or services, some legal providers raised concerns that one consequence will be a high volume of cases which are not ultimately viable.

In June 2023, New York City opened the Asylum Application Help Center, which the city reported had completed over 50,000 applications for asylum, work authorization, and temporary protected status as of May 2024.[8] Nonprofit lawyers voiced some reservations about the quality of support, including that those filling out applications may not be attorneys or have legal experience. The service is also available only to those currently residing in city shelters, limiting access for many newcomers and impeding meaningful follow-through. Service providers and asylum seekers reported that within New York City shelters, access to legal orientation and referrals to the asylum application center is patchy. One provider said, "We have heard through partners about individuals in shelters who haven't spoken to any case managers and have not received any information about their legal rights and responsibilities."

In Washington D.C., where there are several longstanding immigration service organizations, the city increased funding in 2021 for the Immigrant Justice Legal Services Grant program (IJLS).[9] However, stakeholders report that across the DMV, pro bono legal providers are at or over capacity. A few mentioned they are experiencing gaps in staffing due to budget cuts or difficulty recruiting. Organizations which do not offer full legal services are struggling to refer clients due to long waitlists (sometimes 6 months or more per one mutual aid organizer), as well as lengthy intake processes.[10] It was not uncommon to hear providers had stopped giving clients lists of legal providers because they found that people were having little luck in securing representation.

Asylum seekers in New York and the DMV described making strenuous efforts to secure legal support, often without success. One recalled contacting "dozens" of legal providers in New York and hearing back from only one, 6 months later. Another recalled contacting over 15 organizations in the DMV, all of which told her they were at capacity. She was finally connected to an organization one month before her filing deadline. In a focus group discussion with recently arrived Venezuelan and Peruvian asylum seekers, all said that they needed legal services.

Asylum seekers also detailed barriers they had encountered when seeking paid lawyers, including difficulty attending appointments in locations far from shelters, high fees (which often meant running out of money before an asylum application had been submitted), and sometimes poor work quality, which could put an application at risk.

Stakeholders also raised concerns that certain populations, including Black migrants and speakers of languages other than Spanish or English, are being placed at a disadvantage in terms of access to legal information and services. One New York provider which primarily serves African asylum seekers has ramped up its pro se assistance for asylum seekers who are 8-12 months post-arrival, in part because they have found many Black migrants have not been adequately informed of the deadline to file for asylum due to language barriers and systemic exclusion. A provider in Washington, D.C. which primarily serves African asylum seekers raised concerns that these populations are being deprioritized for support by providers. This provider recalled experiencing significant trouble referring clients to recipients of city IJLS grants, with the exception of two who specifically focus on African asylum seekers. "It feels like if you're not part of the Latino community, you're on the back burner...it's an unwritten rule."

Existing Non-Legal Services

Shelter

In both New York City and the DMV, access to shelter is difficult and precarious, while long-term housing solutions remain elusive.

New York City has a unique legal obligation, dating to the 1980s, to provide shelter to anyone in the city who needs it.[11] Since 2022, the city has struggled to uphold this obligation with regards to asylum seekers. City authorities reported that approximately 65,600 asylum seekers were residing in city shelters as of late May 2024, with nearly 200,000 people having passed through the system since April 2022. Over three-quarters of asylum seekers residing in shelters were families with children under 18.[12] This includes populations residing in shelters operated by the Department of Human Services (DHS), and those residing in facilities opened as Humanitarian Emergency Response and Relief Centers (HERRCs) run by other agencies, including Health+Hospital systems. Conditions vary by shelter site and by shelter type—for example, providers note that HERRCs sometimes lack important facilities, including showers.

Volunteerism and Mutual Aid

Volunteers have been critical to the efforts of many grassroots organizations — in the words of one organizer, "volunteers are the backbone of this response." Volunteers include members of the host community and asylum seekers, stakeholders told the assessment team.

Several asylum seekers consulted are contributing to the efforts of providers, particularly grassroots organizations and mutual aid initiatives, lending their time and skills to interpretation, coordination, outreach and information dissemination, logistics, and office administration.

While reciprocity is valued by asylum seekers and the providers they support, they note that they are working against structural barriers. In particular, organizers said, shelter limits and the regular shuffling of people to new locations impedes groups' ability to engage asylum seekers in true mutual aid.

Stakeholders pointed to conditions in NYC shelters which they say are harmful to asylum seekers' well-being and dignity. Many providers and asylum seekers raised concerns around food quality, which they described as unacceptably poor and frequently inedible or frozen. A healthcare provider reported that they directed patients to food pantries but were blocked by shelter staff from bringing outside food into the facility. Other issues raised by both male and female asylum seekers included safety and security concerns and disrespectful treatment by shelter staff.[13] It should be noted that after the period of data collection for this report, New York City announced in April 2024 it would scale back its arrangement with the company which had been

providing shelter and feeding services through an emergency no-bid contract, and in June 2024 issued a competitive request for proposals to source long-term replacements.[14]

The overarching concern stakeholders voiced with regards to sheltering services in New York City is the precarity and instability of access. This instability has grown since 2023 as New York City has introduced successive measures to limit the duration of shelter stays. Families with children under 18—who constitute a majority of shelter residents—face a time limit of 60 days, except those who are eligible for public benefits after applying for asylum or Temporary Protected Status.[15] Adults without children face time limits of 30 to 60 days, and as of May 2024 must demonstrate "extenuating circumstances" to receive an extension.[16] In practice, stakeholders reported to the assessment team that asylum seekers may be pressured to leave even before these deadlines.

When extensions are granted, they commonly require relocation to another site, which may be in a new neighborhood or borough. Stakeholders stressed that this poses serious disruptions for access to service providers with whom asylum seekers may have established trust, as well as for children's school enrollments. LGBTQ+ asylum seekers pointed to a shortage of shelter spaces for LGBTQ+ adults who have aged out of youth-specific shelters, and who are not eligible for housing programs specific to HIV-positive individuals. Asylum seekers told the assessment team that they are sometimes left unhoused while waiting for reassignment, and advocates have raised concerns about rising risk of street homelessness as eviction notices are enforced.[17]

Authorities in Washington, D.C. focused on providing short-term shelter for migrants in local hotels. Faith communities also provided emergency shelter at a smaller scale, but at times struggled with capacity.[18] Since early 2023, the city has made efforts to scale down sheltering operations, citing a lack of funding. As of March 2024, the city's Office of Migrant Services told the Washington Post that 637 people remained in the hotels, and another couple hundred in a short-term city respite center.[19] LGBTQ+ providers noted that the city had experienced a set-back in affirming shelter with the closure in 2022 of low-barrier shelter Casa Ruby.[20]

Solutions for longer-term housing in both areas are elusive. This is due both to broader shortages of affordable housing in NYC and the DMV, and to the unique challenges faced by asylum seekers, such as a lack of access to the formal economy while waiting for work authorization, lack of credit, and ineligibility for many existing housing assistance programs. One provider based in Baltimore said, "we don't even try to refer out for housing because there is nothing there for people." Stakeholders indicated that while some housing slots may be available for specific populations, such as youth or survivors of domestic violence,[21] most see no other recourse beyond the shelter system, or what one provider called "unstable housing situations with weak social ties."

Social Services

Stakeholders in NYC and the DMV reported that case management is not resourced at the needed scale, leaving understaffed and underfunded providers struggling to patch gaps. Long-term case management programs are especially scarce and often limited in eligibility to specific groups, with implications for most asylum seekers' access beyond their initial arrival periods.

New York City's official practice is to provide access to case management for asylum seekers residing within shelters. (New York City manages a reception center for asylum seekers at the Roosevelt Hotel in Manhattan, which serves as a gateway to shelter and other services.[22]) The assessment team found examples of referrals and linkages being made by shelter staff to outside providers. However, the team also heard from numerous stakeholders about inconsistency in the coverage and standards of case management within shelters. Providers flagged a "huge lack of quality in terms of case management" and raised concerns about the city's reliance on for-profit companies for staffing. One organization said, "We heard that some people's only interaction with staff was when they were told to leave."

Government funding for case management to asylum seekers is concentrated in a handful of specifically targeted programs. At the New York state level, providers are contracted to provide limited case management and direct assistance for families residing in New York City through the Assistance to Migrants Program (AMP), and more in-depth services, including case management, for families willing to leave for a participating county in New York State through the Migrant Relocation Assistance Program (MRAP). State authorities acknowledged that these programs, which have struggled to enroll clients at the volume intended, were premised on the assumption that asylum seekers would quickly receive work authorizations. Federal funding includes the Case Management Pilot Program

(CMPP).[23] Providers noted that asylum seekers may be hesitant to enroll in this program, which is limited in scope, geography, and eligibility, because doing so can slow down their legal cases.

Beyond these initiatives, longer-standing case management programs exist for specific populations, including survivors of torture, but access for the general asylum-seeking population remains low due to screening and eligibility criteria. Many organizations say they have the expertise to provide wider case management but lack funding to do so. Others said their teams find it difficult to offer ongoing case management to asylum seekers in New York when this population is kept in a state of forced transience in terms of shelter, often lacking independent mobility, and focused on daily survival needs. As a result, one provider said, they have pivoted to a "rapid response" model over long-term case management.

Social services in the DMV vary by location. In Washington D.C., a nonprofit was contracted to provide basic reception services at the time of data collection, with another nonprofit contracted to provide limited, short-term case management services to residents of the city-operated shelters. Recently arrived asylum seekers staying at city-operated hotel shelters reported receiving support with service enrollment, including obtaining IDs and enrolling in medical insurance, as well as some legal orientation. Importantly, providers noted a "lack of continuity" after the respite period, including limits on "re-entries" in terms of re-enrollment for services, which can reduce access over time for asylum seekers who remain in the region. In areas surrounding Washington, D.C. some county governments have stepped in to offer case management, with asylum seekers and providers noting services are relatively more robust in Montgomery County. Single adults have less access to respite services in Washington, D.C., while providers noted more flexibility in parts of Maryland.

Providers in both locations reported attempting to patch gaps left by city services in various ways. Grassroots organizations and mutual aid operations consulted tended to focus on resource navigation and service enrollment, healthcare navigation, in-kind assistance such as clothing, or a combination of services. Some are working to secure city-level documentation for people, which is critical to facilitate access both to services within the city, and onward travel for asylum seekers who decide to move. A few organizations offered mail services, storage, and safe shower facilities. In the absence of funding to staff sufficient case management roles, organizations sometimes mobilized part-time staff, non-specialist staff, or volunteers. At more than one organization, individual staff described being thrust into a case management role without training, due to client needs.

In this context of limited resources, scale-downs or closures by any actor are a source of real concern for other providers. Several stakeholders in the DMV referred to the reduction of social services at local provider of case management and mental health services, due to funding cuts in 2022, noting the overall toll on service coverage in the wider area. One provider noted that their own grants were written with the assumption of other actors continuing to cover certain populations and locations.

In both cities, providers highlighted that refugee resettlement organizations may be able to step up to play a bridge role in support for asylum care. Refugee resettlement organizations already have some key infrastructure and staffing in place, so asylum seekers may in theory access case management and support comparable to that which is serving refugee newcomers. This type of support is often accessed through in-kind means at existing resettlement agencies.

However, the level of priority given to asylum seekers may vary across teams in the absence of clear organizational mandates. There is limited funding as decision makers seek to stretch a finite pool of resources across different populations of forced migrants. Because there is limited capacity even in federally funded programs to support the needs of asylees (those already granted asylum), asylum seekers must usually obtain services from organizations without similar federal funding.

Cash and In-Kind Assistance

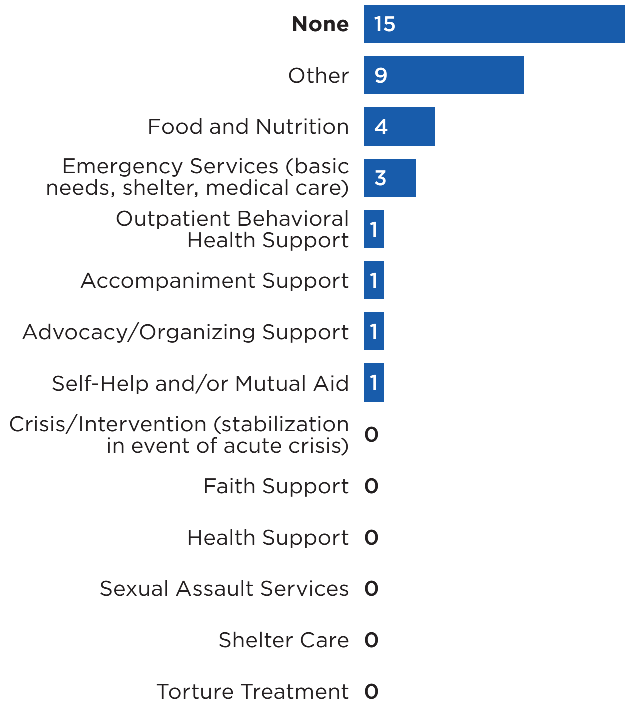
Cash assistance is limited for those not enrolled in specific case management programs, and less common than in-kind assistance.

Among surveyed organizations — largely non-governmental entities — most reported providing no cash assistance, or very limited support in case of emergencies or for small one-off fees, such as USCIS legal processing fees. Some mutual aid organizations distribute nominal amounts of cash in exchange for asylum seekers' contributions to activities.

Exceptions included organizations which focus on intensive case management with a limited number of clients, where more regular financial support was sometimes available. Specific programs include AMP and MRAP in New York, and a pilot program operated

Surveyed organizations reported limited cash assistance

Among those who listed "other" examples of case assistance included local transportation costs, clothing, legal processing fees with USCIS, medical bills, or emergency rental assistance.



Data Source: HIAS service mapping questionnaire. Based on 19 responses from organizations in NYC and 15 responses from organizations in the DMV. HIAS submitted one response for each location.

out of the D.C. respite center by a non-governmental provider.[24] In New York State, asylum seekers may be eligible for cash benefits through the Safety Net Assistance program only after filing for asylum or Temporary Protected Status.[25]

Key types of in-kind assistance include food pantries, clothing, diaper bins, and luggage (a common request in New York as asylum seekers are forced to frequently relocate), and medical items such as eyeglasses or mobility aids.

Training and Education

Providers have stepped in with education and training, including English language instruction, workforce training, computer literacy, and cultural orientation. Libraries were highlighted by some providers as an important no- or low-barrier educational resource for asylum seekers, and partnerships between library branches and local providers were noted. Educational programs can be a way to engage asylum seekers while other services or processes are pending. Stakeholders also reported that some training and education programs may include components of know-your-rights orientations which can be an effective means of sharing information with communities.

Job readiness programs are often restricted to those who have work authorization, with some OSHA workforce trainings cited as an exception. Providers expressed concerns about a lack of orientation for those participating in the informal economy to do so safely, exacerbating risks of exploitation.

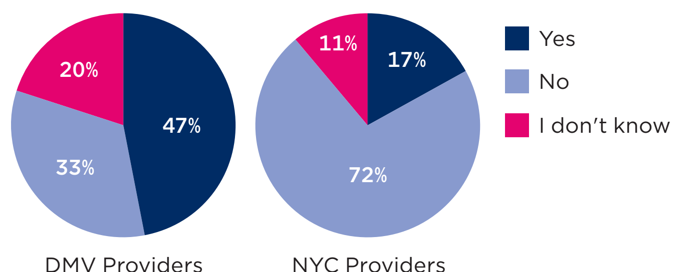
Healthcare

Asylum seekers seeking healthcare in NYC and the DMV face complex and ever-changing access requirements, shortages of affordable providers, and unexpected costs.

Insurance enrollment is a key focus for many of the stakeholders consulted; it was noted that this process can be lengthy and face delays due to documentation requirements. Providers in New York also flagged that the benefits for enrolled individuals have waned. Two providers cited cases in which adult patients faced requests for copays (around $30) for visits which would previously have been fully covered. This change has not been well communicated by the city, one provider said, leading to confusion and complicating providers' efforts to help asylum seekers navigate access.

Community healthcare providers interviewed in both areas stated that they offer holistic services which asylum seekers can access, although programs were

Does your organization have resources to offset costs for people who do not have Medicaid, employer insurance, or other resources to pay for services?



Data Source: HIAS service mapping questionnaire. Based on 19 responses from organizations in NYC and 15 responses from organizations in the DMV. HIAS submitted one response for each location.

not specifically designed for this population. These community healthcare centers, however, regularly have staffing shortages and waitlists for new patients. As a result, providers noted, asylum seekers often end up going without care or running around in circles trying to access care within larger city healthcare systems. The assessment team also heard of asylum seekers receiving care for urgent needs through emergency pathways, ending up with high medical bills. Most providers surveyed said they do not have resources to offset costs for uninsured clients.

Mental Health and Psychosocial Support

Tailored, long-term mental health supports are concentrated around specific populations, including survivors of torture and crime victims, where assessment criteria are met. For other populations, services at both the individual and group levels remain scarce, particularly for long-term services.

Organizations which do not have in-house mental health services reported challenges referring clients out, such as long delays, lack of linguistically appropriate care, and time limitations on services. Authorities in New York City say that behavioral health specialists are available to shelter residents through Health+Hospitals — New York's municipal healthcare system — but providers expressed some skepticism that this is upheld in practice. In the DMV, more than one stakeholder mentioned that the loss of a mental health team at a key entity left "a huge void in the area." To address a lack of linguistically or culturally appropriate providers, some providers and asylum seekers noted that they have engaged remotely with therapists located outside the United States. School-based services for children and youth are also quite stretched, with one provider in the DMV observing that "you might have 1.5 therapists for a whole school."

Several organizations in the DMV and New York operate group programming. All who did said that group programming has been well received, with a few noting that men's voluntary participation in particular was higher than anticipated. However, providers pointed out that issue-specific support groups in asylum seekers' languages to address specialized needs like grief, cancer, or addiction, can be lacking. A number of providers who were not hosting group MHPSS programming expressed an interest in adding this programming, or hosting partners in their space to lead such activities.

To reach new populations who are not actively seeking out mental healthcare, one provider shared that they are experimenting with combining MHPSS interventions with in-kind distribution in spaces where asylum seekers are waiting to receive city services. Groups are also experimenting with unconventional approaches such as "healing spaces" centered around an unrelated activity or craft.

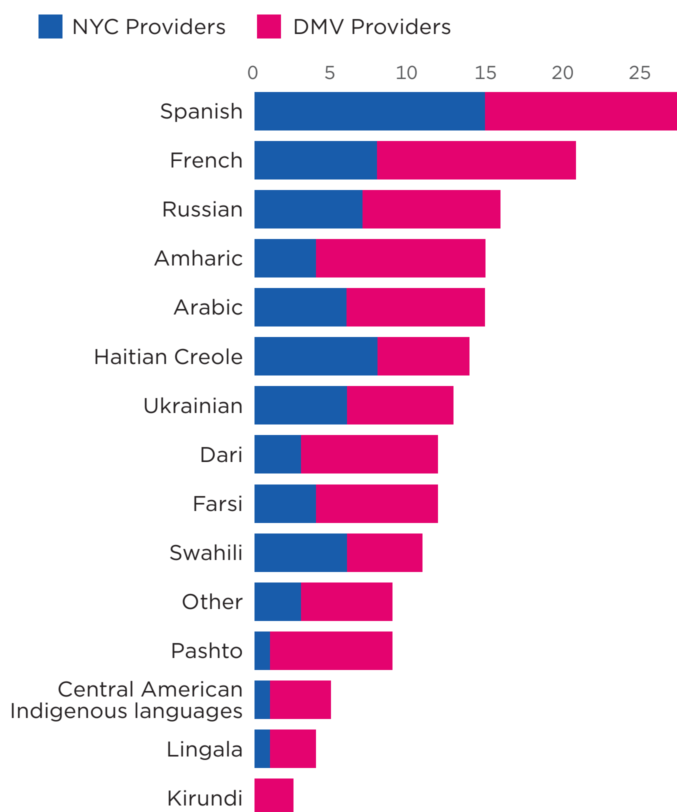
Accessibility

Asylum seekers face numerous barriers in accessing services, including transportation and childcare challenges as well as service providers' scheduling, location, languages accommodated, inclusivity or lack thereof, and the overarching complexity and fragmentation of services.

Language represents a major accessibility challenge, one which is particularly pronounced for non-Spanish speakers.[26] Even for well-established providers, meeting the language needs of a highly diverse asylum-seeking population has been challenging. These gaps were echoed by service providers who responded to the survey. Most reported being able to accommodate Spanish speakers, with a drop-off in the number reporting the ability to accommodate other languages. DMV providers surveyed were more likely to report language capacities beyond Spanish than NYC providers surveyed. A pronounced difference was noted in capacities for Amharic, reflecting a longstanding Ethiopian diaspora population in the DMV; however, DMV providers were also more likely to report capacities for languages which are widely spoken in both areas such as French, Russian, and Arabic. DMV providers were also more likely to be able to accommodate Southwest Asian languages including Dari, Pashto, and Farsi. With the exception of Arabic and Amharic, providers in both cities reported low coverage of African languages.

New York City and Washington D.C. both have language hotlines which can in theory expand providers' in-house capacities. However, while stakeholders in Washington D.C. gave generally positive reports of the language hotline, New York providers said that their city hotline's coverage is less reliably comprehensive than advertised. In some cases, the dialects offered through the New York language line may differ from those spoken by the asylum seekers to the point of impeding communication. For some languages, interpreters may be entirely unavailable.[27]

Which languages can your organization accommodate?



Data Source: HIAS service mapping questionnaire. Based on 19 responses from organizations in NYC and 15 responses from organizations in the DMV. HIAS submitted one response for each location.

Several stakeholders reported challenges with other service providers offering language access. Language access and justice issues also affect access to public benefits, with one provider reporting needing to advocate for clients who had been denied interpretation when seeking public benefits such as social security. One asylum seeker explained how a lack of language access can impede getting support, noting, "People feel very insecure about asking for help when you don't speak the language."

Providers emphasized that low- and no-literacy populations often face additional barriers. The DMV asylum seeker population includes a significant number of people with low- or no-literacy. A Salvadorean asylum seeker from a professional background said, "I think about how difficult [seeking services] was for me as an educated person who is comfortable with technology...how do people who can't read or write do this?" She added, "It doesn't scare me to speak up for myself," whereas people with lower educational levels may experience even greater discrimination. This fear was expressed by a Guatemalan asylee who is not literate, as she recalled being verbally abused by a Medicaid representative over the phone. "The woman asked me to spell my name, and I said I couldn't. She started saying a lot of bad things to me like, 'you're an adult, what is wrong with you?'" This asylee, a single mother, noted that she would like to petition for child support from her child's father, but has refrained from doing so for fear she will face further abuse from government employees in the process.

Interrelated challenges of transportation, scheduling, and childcare impede asylum seekers' ability to access services. While public transportation cards are available in New York shelters, they are provided at the discretion of staff, and typically only on the day when requested, making it difficult to plan ahead. Asylum seekers who are working may not be able to take time off to access services for themselves or their children. It can also be noted that shelter policies prohibit leaving children unattended, which providers find has a disproportionate effect in restricting the mobility of mothers.

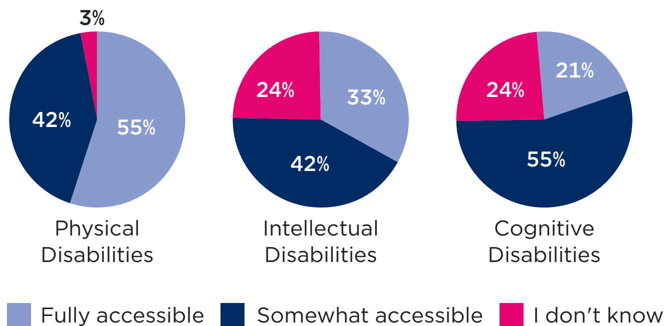
Clearly communicating hours of operation is important, stakeholders said, as is flexibility in scheduling and where possible, remote options. "What's needed is consistent services that fit [asylum seekers'] schedules and needs" one provider said. "What's happening is the opposite — the asylum seekers need to work around the schedules of service providers." Providers also suggested that school-based services, or services located adjacent to community or faith-based facilities, can help to address the gap.

People with disabilities also face accessibility barriers in both cities. Survey responses suggest that accessibility is especially difficult for people with intellectual and/or cognitive disabilities. It should be noted that during interviews, multiple providers highlighted a rise in the number of families traveling with a child with a condition such as Down syndrome, or with neurodivergence in the form of autism and/ or ADHD.

Stakeholders shared feedback on circumstances in which asylum seekers of different groups may not feel welcome or safe. Some Black asylum seekers reported experiencing racism within service environments or information spaces, including from non-Black asylum seekers. Providers noted several "high quality, high confidence" providers for LGBTQ+ affirming services in the DMV and NYC, but also cited examples of environments where LGBTQ+ asylum seekers felt unsafe, including shelters. Stakeholders stressed the importance of taking steps to communicate

Survey responses show gaps in accessibility for people with disabilities, particularly intellectual and cognitive disabilities

How accessible are your services for people with:



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inclusivity to clients — for example, one provider received feedback from clients that they were unsure if LGBTQ+ people were welcome due to the provider's sharing of building space with a church, and the provider responded by incorporating visual markers of inclusivity, such as Pride flags, into their offices.

Stakeholders also called attention to gaps in inclusivity for some populations based on race or nationality. The importance of prioritizing all asylum seekers equally based upon needs was voiced by a service provider who stated, "I am concerned that we put a lot of effort into supporting certain groups of asylum seekers and refugees and less into supporting others. For example, Ukrainians coming to the U.S. received — rightly so — a lot of high-quality attention and services...we need to see through the responsibility to serve other populations in the same way...We need a serious investigation into why this isn't the case."

Above all, the complexity and fragmentation of the systems asylum seekers must navigate represent an overarching accessibility problem. "The interventions that we offer are very fragmented and unstable," a healthcare provider reflected. Oftentimes, this means that legal support can be disjointed from housing, which is separated from health, and so on. Asylum seekers said that the bureaucracy involved in getting support was "just enormous." Accessing services not only requires extensive time and effort while juggling competing survival needs, but stakeholders also underlined how consistent rejection can deter asylum seekers from seeking help. "A really demoralizing part of the asylum process is that you are expected to seek out support constantly and then you are shot down constantly" one provider said. As a result, "we see clients who no longer want to reach out for help because they are being shot down."

Trust

Asylum seekers and service providers both emphasized the importance of trust in addressing asylum seekers' needs. Asylum seekers are protective of their privacy. "We met one woman who refused to tell a caseworker where she lived for over a year," one community-based provider in New York said, "because she was afraid of being targeted." Another provider in D.C. reflected, "People hold onto their secrets because anything can be used against you." Asylum seeker interviewees echoed this concern, with one recalling that the questions he was asked by some providers during intake and screening felt "invasive" and left him "over-paranoid." Cultivating trust is necessary to understand the full extent of needs, providers noted, as well as to make onward referrals.[28]

Cultural navigators can serve a crucial role in bridging asylum seekers with services. As one organizer stated, "You need a trusted person to communicate with people if you don't look like them." At the same time, providers stressed that trust and privacy must be considered when putting asylum seekers in contact with members of their own communities, such as in group activities. Some asylum seekers may still be part of extortion networks or may fear they are being spied upon. Providers also noted that while some asylum seekers express a preference for interpreters from the same cultural group, others are uncomfortable with interpreters who may share their community, network, or cultural background. Offering asylum seekers choices in selecting a group versus individual setting, and which type of interpretation setup will make them most comfortable, can bolster safety and trust. A legal and social services organization that delivers volunteer-run support emphasized that volunteers can also play an important role in building trusting relationships which bridge back to the wider organization.

Referrals

Referral systems in both NYC and the DMV are inconsistent and severely backlogged, with particular challenges in legal, housing, and mental health services. This issue forces a reliance on informal ties between staff and advocacy by referring providers, with no clear consensus among providers on how to improve referral processes and mechanisms.

In New York, providers and asylum seekers alike reported that the most common way asylum seekers are finding services and resources is through word of mouth, rather than referrals. Referral mechanisms are lacking in New York, providers said, and the capacity strains being experienced by many organizations are squeezing even informal referral pathways. "There have been so many instances of failed referrals," one provider for survivors of torture lamented. Referrals for legal, housing, or mental health are especially challenging due to lack of capacity among receiving organizations, another provider noted. Asylum seekers consulted echoed these persistent challenges: "Each place sends you to a different one until you end up back at the first, and the circle closes."

Providers in New York expressed differing views on how to improve referral processes and mechanisms. Some reported using referral platforms such as Unite Us, but limitations were noted. In particular, providers said privacy and confidentiality concerns can conflict with desire for follow-up on referral outcomes. One provider recalling successful applications as a cluster coordinator in international humanitarian operations, suggested a standardized referral form.[29] Staff of a large national provider, on the other hand, were highly skeptical of the suggestion, calling a referral form as a panacea "a fantasy." This provider instead reported relying to a great extent on informal contacts to coordinate and refer clients, emphasizing "everything runs on relationships." Lengthy intake and referral processes can mean losing contact with clients halfway through a handoff to another agency. "This work requires a great deal of informal ingenuity," one said.

In the DMV, worth of mouth also factored in, but organizations reported more frequently than New York providers that referrals were a common way for new clients to find them. Asylum seekers in the DMV echoed this reality, reporting receiving referrals, including in respite facilities for new arrivals, and from one service to another. However, capacity strains mean that waitlists can be anywhere from 6-12 months. When refreshing lists of resources, one provider said, "we might start with a list of 35 organizations, and it gets down to only three that have capacity for new clients." Organizations which offer a wide suite of in-house services tend to rely primarily on internal referrals, but providers shared that current caseload levels are sometimes forcing them to look for external resources.

In both NYC and the DMV, many service providers emphasized the need for more referral partners in key areas, yet at the same time they themselves do not actively promote their services. One said, "in good conscience I can't do that when wait lists are so long." As a result of these constraints, many providers consulted said cold referrals are not effective. Due to providers' limited capacity, warm referral and accompaniment is needed to get people served. Several providers voiced concerns about the implications for the access of asylum seekers who do not have such an advocate.

Coordination

Providers in both cities saw a need for increased coordination and information sharing. They called for more transparent and continuous information sharing from authorities as policies and funding strategies evolve, as well as more mechanisms for peer-to-peer coordination.

Stakeholders in New York described a reality in which the two systems of city-managed services and other work are operating largely in parallel. Humanitarian service providers reported extremely limited access to city-run facilities. While asylum seeker arrivals receive extensive media coverage, providers note that there can be a lack of information around the details of the city's response. One NGO said, "Sadly we find out a lot of information through the New York Post before we hear from Health+Hospitals colleagues." Of particular concern are changes to service requirements or availability, which providers say they sometimes learn of only through failed attempts to refer clients. "The city does not dialogue with us about this" the provider said, and clients may have less trust in the referring provider as a result. City authorities acknowledged to the assessment team that while coordination is part of their mandate, information sharing can be impeded by legal and procedural hurdles. They noted that the city is working on mapping available services for asylum seekers and has encouraged non-governmental providers to coordinate laterally.

Providers consulted in Washington, D.C. also expressed a desire for greater coordination. One provider stated that while the D.C. mayor's office makes some effort to convene providers, this forum is mostly used to share one-directional information about the work of the mayor's office. More lateral information sharing among all providers is needed, some said. Providers in the DMV emphasized the importance of remaining up to date on policy and funding developments in all three parts of the area, as local changes will impact the wider area.

A key challenge is keeping current on what other organizations are offering, providers said. Many had made efforts at resource mapping but noted that static lists are "dead documents" nearly as soon as they are created, as services, capacities, and requirements shift constantly. No stakeholder in the DMV or NYC named a source of reliably updated and comprehensive information on service providers. It should also be noted that entities working directly with government funds are sometimes contractually limited in sharing information related to funded programs. This fact, combined with some stakeholders' concerns about government policies vis-à-vis asylum seekers, can at times have a distancing effect between providers which receive government funding and those which do not.

Providers pointed out some examples of coordination spaces they said had "potential" but stressed the need to go beyond exchanges of information to develop communities of practice. This type of coordination needs to be local, one stressed. "To do more than share resources and methods, it needs to be local," one provider said. "So much of what we do is about helping specific clients."

Partnerships

Stakeholders described scenarios in which productive partnerships had been established: 1) between organizations sharing grants and sometimes clients; 2) between organizations with clear complementarities in their offerings and equally clear division of roles when bringing these offerings together; and 3) volunteer-driven and grassroots providers with strong relationships acting in solidarity in response to surges in need.

It is noteworthy that providers in NYC often reported fruitful informal partnerships, while providers in the DMV reported more formal, contractually defined partnerships. Interviewees in New York pointed to particularly close collaboration among some community-based organizations. Among several grassroots organizations, individual organizers formed relationships first, which led to partnerships between organizations. Grassroots organizations described a current situation in which larger organizations sometimes host programming within the spaces of grassroots groups or engage in specific campaigns. It should be said that these arrangements may not include channeling financial resources to the community-based providers, some of which struggle to maintain baseline operating expenses and/or are not eligible for government funding.

One noted barrier to partnership is competition for limited funding. Providers expressed concern that such competition is affecting coalition building as well as referral coordination. In each location, at least one provider said they felt peers were refraining from referring clients who need additional services to "competitor" organizations, even those well placed to address the needs.

Another barrier can be a lack of clear complementarity — either because of overlapping offerings leading to duplication and confusion for clients, or due to narrow eligibility restrictions or decreased capacity.

Some stakeholders also reported challenges in building broad partnerships due to discrimination or a lack of intersectional perspective among other providers. One group working with LGBTQ+ asylum seekers said, "We feel unwelcomed by some faith-based groups working on immigration. I had gotten connected with [a faith-based group I admired] on WhatsApp, but they blocked me when they found I was with [an LGBTQ+ group]. We face homophobia from other organizations. We go to LGBTQ+ spaces and they aren't tuned into immigrant issues — they aren't paying attention to the growing population of LGBTQ+ immigrants."

One area where many providers expressed an interest in greater partnership is in advocacy. In particular, stakeholders noted the importance of having a platform to allow smaller grassroots organizations to participate in advocacy efforts. One provider with a larger platform described a promising practice of creating an advisory body with grassroots organizations in an effort to reflect their voices and concerns in discussions with authorities.

Outreach and Communication

In the fragmented information environment facing asylum seekers in both New York City and DMV, word of mouth dominates. This includes word of mouth in its physical form and its digital one — social media and group chats.

Providers noted that the popularity of specific platforms varies across populations, though WhatsApp and Facebook were consistently highlighted as leading channels for many nationalities.[30] Voicenote and video features can provide access to no- and low-literacy asylum seekers. While some asylum seekers said they use general Internet search engines, this was less commonly reported than social media.

A number of organizations mentioned that they have come to rely on WhatsApp threads to circulate

information to local asylum seeker populations. While some threads are managed by providers, others are maintained by asylum seekers, with some organized around specific shelters and others around language groups or nationalities. Information from these sources cannot be easily verified, and racist and discriminatory comments against LGBTQ+ people, Black migrants, and other groups of people were reported. With fewer communal threads in languages other than Spanish, several non-Spanish speakers said they sought out other speakers of their language to get information .

Physical handouts can be an important complement to digital information sources, stakeholders indicated, often directing people to digital information through QR codes or links. Some organizations pointed out that the ability to spread information through fliers is limited by lack of access to city facilities.

The importance of maintaining consistent schedules, then clearly communicating services and (if applicable) walk-in hours on websites and social media platforms was emphasized. In-person communication plays a role in building trust, stakeholders noted. To communicate individually with existing clients, some providers used a combination of email and text messages, noting that newly arrived asylum seekers were more likely to communicate primarily via text.

Overall Needs and Gaps

No area was identified as well covered in New York or the DMV. Asylum seekers are juggling multiple urgent survival needs with limited access to information and accompaniment as they navigate overwhelmed systems. Gaps in legal services leave newly arrived asylum seekers racing against the 12-month deadline to file for asylum and with no clear path out of shelters and into stable employment and housing. A lack of case management complicates each step of the journey, including stabilization for new arrivals and meaningful integration for those who have been in the United States for longer periods.

Among New York providers, the top needs identified were legal services, housing, and healthcare.[31] Some providers mentioned case management and access to information as critical to meeting needs. Needs for food and basic items such as diapers are frequently left unmet despite their importance and urgency.[32] In New York, asylum seekers consistently voiced the following primary needs: housing, employment, and legal services. Some also mentioned resource navigation, access to nutritious food, and English language instruction.

Providers in the DMV emphasized housing, legal services, and healthcare as the most urgent needs. They also identified case management, mental health, financial support, job readiness and placement support, and English language instruction as other key needs.[33] Asylum seekers in the DMV listed these priority needs: legal services, job readiness and job placements, English language instruction, and some form of orientation to life in the U.S.

In both cities, stakeholders suggested that asylum seekers would benefit from greater access to information. One type of information needed is information about available services and benefits, and how to navigate accessing them. Another type is information on cultural orientation topics to support societal integration for asylum seekers.

Providers stated that a lack of case management exacerbates the lack of access to information, and that needs of asylum seekers are often under-documented. They drew connections between case management gaps and protection gaps, whereby a lack of case management is leading to gaps in screening for domestic violence, gender-based violence, or exploitation. What support is available is subject to the fragmentation noted by providers. Asylum seekers echoed that much of the support they can access consists of one-offs, such as a legal consultation or food from a food bank, while the solutions they need are longer-term: "What you really need is a place to live, a job, and a lawyer." Given fragmentation and capacity strains, one provider observed, "On the scale needed, services absolutely do not meet the needs… All service providers for asylum seekers are watching asylum seekers live in abject poverty."

Providers mentioned groups which face particular gaps, including speakers of languages other than English and Spanish, Black asylum seekers, LGBTQ+ asylum seekers, and single adults, who are often deprioritized for services including shelter.

Several providers also emphasized the policy context for the needs. One asserted, "A lot of the needs we see are the result of terrible policies." In particular, another provider argued, much of the precarity which asylum seekers are currently experiencing is constructed: "We need a legal status in place so that they're not in fear of being moved around or deported. We need health insurance that's good for a year so you're not in the continual role of recertification, and not something you need to think about until you're settled."

MHPSS Needs and Gaps

Mental health needs of asylum seekers vary by person and at different stages of people's journeys, but providers pointed to clear trends in unaddressed needs.

Providers in both cities noted that many asylum seekers voice similar mental health challenges: "We see a lot of people expressing the same traumas." Traumatic experiences can occur in asylum seekers' countries of origin, during their journeys, and some asylum seekers experience ongoing exploitation and abuse. The struggle for daily survival needs and broader uncertainty around one's prospects in the United States shadow asylum seekers constantly, while family separations and social isolation take a heavy toll on well-being.

Poor conditions in shelters and dehumanizing treatment were cited as a major ongoing stressor by both providers and asylum seekers. Social isolation is a driver, the effects of which can be deepened by awareness of negative media attention and general anti-migrant sentiment. Providers note that some new arrivals travel with an abuser, and many instances of trafficking, domestic violence, or gender-based violence are being missed due to a lack of case management. "There are lots of instances of sexual and physical abuse which people don't want to report."

Participants reported that a lot of mental health issues are connected to subsistence concerns, and with the inability to legally work. One asked, "What do we eat during these six months before we can work?" Others with some access to services expressed uneasiness that they are "a burden on the state." A loss of control and uncertainty at multiple horizons — regarding shelter, family separation, work, and legal cases — leads to a constant state of feeling "extremely stressed and mentally exhausted." Many asylum seekers discussed feeling survivor's guilt, ongoing grief, and ambivalence about their choice to come to the United States.

Asylum seekers and providers described how mental health challenges may evolve through stages of shock, feeling overwhelmed, grief, and isolation. Stakeholders described this evolution in terms summarized by the words of one provider:

"Clients who are recently arrived, who are not far out from their trauma in their home country, show high vigilance, fear, looking over their shoulder. After a while, people have stress keeping up with appointments, missing things, working, seeming exhausted and tired. Clients who have been here for years, who haven't seen their kids in years, seem isolated and distant. They don't talk about making friends, or building community."[34]

Stakeholders also acknowledged that mental health issues can manifest in any number of ways. This includes people who are "anxious, edgy, or who cry at the slightest conflict" one provider said, while for others, "stress shows up as fighting" according to an asylum seeker. Substance abuse was also highlighted as a common negative coping strategy. Providers also shared examples of how complaints, difficulty keeping appointments, or reports of physical ailments such as insomnia or back pain can act as signals of unaddressed mental health issues. Supporting clients through these challenges can work to build trust and identify a potential need for MHPSS interventions. Providers also described screening for MHPSS needs in supporting clients through adjustment-related challenges, such as concerns related to a child's school experience or reunification after a lengthy separation.

Asylum seekers and providers share a deep concern about the wellbeing of children and youth. Minors have even less control over their circumstances than adults, asylum seekers noted, and processing trauma and cultural adjustment can be especially hard at a delicate stage in development. Another observed that newly arrived youth appear "disconnected" and less willing to participate in group activities, including celebrations.

Barriers to Addressing MHPSS Needs

Barriers to addressing MHPSS needs include lack of access to insurance; shortages of culturally responsive, trauma-informed providers; a need to prioritize other urgent survival needs; and lack of familiarity with or stigma surrounding mental health support.

A lack of or inconsistent insurance coverage presents barriers to accessing healthcare in general and therapy or needed medication. Furthermore, many noted how mainstream mental health providers may not deliver accessible or relevant care to asylum seekers and that clinical care is not always what clients seek.[35] The small number of appropriate providers available on a low bono or pro bono basis for uninsured patients tend to have long waitlists. While providers indicated that short-term therapy can be effective for some asylum seekers, there is a dearth of long-term service options for those requiring more extended treatment.

Providers noted many asylum seekers prefer not to access therapy through interpretation — a scenario in which "you lose three-quarters of the information." A lack of providers with lived experience of displacement and opportunities for peer support among asylum seekers was also highlighted. MHPSS interventions which are not trauma-informed can alienate asylum seekers. One asylum seeker described an unsatisfying experience in a workshop at a vocational training center, which included a component on managing stress. "Some fancy [NYC college] girls came and put on some massage music on YouTube and talked to us about breathing exercises. I was so annoyed. She had no idea what I'd been through."[36]

Additional barriers include daily survival needs which are not being met, as well as a lack of case management which could help identify MHPSS needs. Several providers reported that it is common for clients to decline offers of mental health support when offered. "For them it is not a priority," one provider said. "They have to work first, they have to feed their families, they have to send money home." One recently arrived asylum seeker, who is currently on a waiting list for therapy, reflected that seeking mental healthcare could fall by the wayside because "this experience is about survival." The first priority is physical safety, she said, followed by work. As a result, "I feel I am floating because I am not stabilized economically or emotionally." She said that she is currently volunteering at her church as a form of "auto-therapy," highlighting how mutual aid can be a support to well-being for some asylum seekers.

Stigma can also be associated with seeking mental health care. Some asylum seekers may be particularly reluctant to identify with mental health diagnoses. This hesitancy can stem from different understandings of mental health, as well as fears that seeking help could work against them in efforts to receive recognition from the U.S. government and integration into their new communities. "There is a desire to present yourself as the perfect migrant in the U.S." one organizer reflected, "and this is at odds with sharing mental health concerns."

Engagement Strategies for MHPSS

Stakeholders suggested offering a variety of non-invasive inroads to MHPSS support which are culturally appropriate and would include stand-alone interventions at the individual and group levels as well as mainstreaming approaches within other services.

In asylum seeker interviews, interest in MHPSS support was expressed by men, women, and nonbinary people. Asylum seekers saw different needs, including group support, some form of individual therapy, access to medication, and support to couples and families.

Multiple culturally responsive approaches are needed, including one-on-one therapy, such as talk therapy, and psychosocial support. More investment is required to engage culturally competent, trauma-informed clinical providers who can offer care in asylum seekers' languages. In addition to clinical providers, investments in community-based MHPSS supports could mean mobilizing non-clinical mental health supporters, as stakeholders noted that some asylum seekers may prefer to seek emotional support and spiritual care from a faith or community leader.

The theme of peer support was emphasized in several asylum seeker interviews, where many expressed interest in connecting with others who share similar experiences or issues. Several providers reported positive results from psychosocial groups as graduated approaches to mental health promotion among asylum seekers. Stakeholders highlighted gender-specific groups as helpful for both men and women, as well as tailored peer support among specific groups such as single mothers, members of the LGBTQ+ community, or trafficking victims. At the same time, some pointed out that group settings may be challenging for certain people when processing trauma or internalized oppression. Skilled oversight of group programming is critical, providers stressed, and there is a need to invest in appropriate staffing and training.

In addition to these traditional approaches, complementary and alternative approaches such as acupuncture, massage, arts-based approaches, and nature-based approaches were identified as beneficial.

To increase awareness of and acceptance of MHPSS supports, providers also suggest offering basic psychological first aid and psychoeducation. There is a need to help asylum seekers "put language to feelings" one organizer said, but this must be a gradual, culturally sensitive process. Stakeholders saw a use for information, education, and communication materials, such as short videos, on psychoeducation. However, it was noted that trusted people may be the most effective messengers for some asylum seekers. Providers stated that case managers can often play an important role in encouraging asylum seekers to reflect on MHPSS needs and engage with available supports. The first step, providers and asylum seekers told the assessment team again and again, is to break

people out of isolation by providing some connection to community and safe, welcoming places to spend time.

Some stakeholders also mentioned using incentives to encourage clients to engage with unfamiliar services, including MHPSS. One provider said they try to encourage participation in MHPSS and broader social services programming by offering incentives such as a small stipend for people who attend 60% of activities in a given month. This provider recommends an approach that says to asylum seekers "here is the table set for you — nothing is forced." Stakeholders stressed that mental health services should be tailored to address proximal barriers including language, transportation, and location of services.

Where possible, stakeholders noted that main-streaming MHPSS into other service settings — both programming and waiting spaces — can help offer support to those who are focused on other urgent needs. Whether mainstreaming MHPSS into other services or offering stand-alone interventions, a holistic approach is important to ensure that mental health support does not take place in a context where material needs are not being met.

5 Recommendations

Recommendations for Service Providers in NYC and the DMV

Recommendations are derived from stakeholder consultations across the two locations. The following suggestions are offered with sensitivity to variances in local resources, staff capacities, and rapidly changing policy environments. They are intended to serve as a springboard for network providers to adapt efforts considering both short-term and long-term goals.

Key Recommendation 1: Invest in multimodal community-based psychosocial support to meet the cultural and practical preferences of asylum seekers, including provision of psychological first aid, peer support, group support, and alternative therapeutic interventions.

In the short term, the network may strive to:

1. Offer social events, community support groups, and peer support services, alongside long-term clinical services. Consider prioritizing language groups which are currently underserved. Diversify settings, service schedules, and modalities (through mobile, tele-health or partner co-location approaches) to maximize access.
2. Address language barriers in a way that is responsive to asylum seekers' needs by expanding training and credentialing for interpreters in mental health concepts and trauma-informed care.
3. Seek resources to reduce barriers to transportation and childcare through partnerships, sponsorships, and volunteer recruitment.
4. Support service providers who do not offer mental health support with psychological first aid and psychoeducational skill development through partnerships, knowledge sharing, and network opportunities.
5. Deploy trained providers with psychological first aid actions or informational materials alongside other programming and/or while asylum seekers are awaiting other services.

Over the long term:

6. Prioritize funding for stand-alone case management services.
7. Equip mainstream mental health providers with knowledge of cultural competency considerations, case management practices, and how to engage with existing case management resources in order to advance health equity for asylum seekers.

Key Recommendation 2: Promote greater access to information among asylum seekers — primarily on navigating available services, and secondarily on cultural orientation.

In the short term:

1. Develop materials such as resource guides, using "dynamic interactive spaces" to enable updates to each organization's information. As fliers or handouts may be a helpful way to reach some asylum seekers, some stakeholders noted that QR codes could be used to ensure that even paper resources benefit from up-to-date information. Consider organizing meet-and-greet spaces for providers to share available resources and disseminate these resources in asylum seekers' languages (through print, audio, and other means).
2. Develop guidance on what is required to access resources and instructions on how to engage with the relevant provider or stakeholder, and access legal services.
3. Develop and facilitate cultural orientation programming including acculturation information to support asylum seekers in navigating life in the United States akin to what exists as for resettled refugees. Content should include how to navigate systems, laws, institutions, and societal norms.

Over the long term:

4. Work to refine cultural orientation programming engaging asylum seekers through cultural validation among different groups.

Key Recommendation 3: Advance mutually beneficial partnership development, meaningful coordination, and enhanced referral pathways.

In the short term:

1. Contribute to dynamic information spaces regarding resource and capacity mapping. Make information about services, current capacities, and results of past and ongoing programming easily and publicly accessible.

2. In local coordination fora, move beyond information sharing toward a community of practice through peer-to-peer learning, case consultations, and group support. Cultivate participation among all organizations serving these populations, rather than limiting to organizations with existing funding or referral relationships. Expand inclusivity to reach mutual aid and other volunteer-run organizations to ensure engagement in coordination spaces.
3. Alongside investments in systems, invest in nurturing connections between staff. Set standards for knowledge and relationship transfer to promote continuity of organizational coordination in the event of handover or ending of a program.

Over the long term:

1. Consider calling for local coordinator positions to be established to oversee resource and capacity mapping. Potential models could include an independent position funded by one or more providers, or leveraging state migrant health and refugee staff.
2. Ensure that partnerships between larger organizations and grassroots or community-based organizations channel appropriate resources to the latter.
3. Adopt programming and community partnership models including development of comprehensive and complementary support.

Key Recommendation 4: Collaborate on systems advocacy among and with diverse coalitions of service providers, mutual aid networks, and city and state entities to procure more funding for asylum services.

1. Develop shared messaging and advocacy campaigns at the city and state level for increased funding to address needs of asylum seekers, including through public-private partnerships with local philanthropists. In the health sphere, seek opportunities to elevate asylum seekers within state-wide health equity efforts, such as leveraging reimbursement mechanisms as part of state-funded Medicaid.
2. Build skills of providers and asylum seekers to engage in advocacy and empowerment work. Among organizations with larger platforms, amplify voices and visibility of smaller organizations.
3. Ensure representation from asylum seekers and grassroots service providers on advisory bodies or mechanisms.
4. Establish a more coordinated funding approach among local organizations who are on the frontlines of asylum-seeker care across each state. Earmark funds toward a coalition of organizations that can be contracted or sub-contracted to deliver support services such as housing, mental health, livelihood, workforce, and legal assistance.
5. Promote shared evidence-based learning around existing frameworks and approaches and identify opportunities for improvement. Call for funders to evaluate the benefits and gaps of existing programs available to asylum seekers, as well as funding and partnership models in other states. Pilot new models — jointly where possible — and use results to demonstrate proof of concept, advocating where appropriate for state and local health or government systems to take over support.

Key Recommendation 5: Leverage comparable refugee resettlement and integration funding and programmatic service models for asylum seekers.

1. Pursue partnership and knowledge exchange between organizations which specialize in serving asylum seekers and refugee resettlement agencies. Asylum seeker-serving organizations can offer insights on adapting programming designed for refugees to address the unique circumstances of asylum seekers, as well as specific cultural and linguistic needs of various asylum seeker populations. Refugee resettlement organizations can leverage and maximize infrastructure to scale up services to asylum seekers.
2. Advocate to city and state actors for asylum seeker funding comparable to that allocated to refugees, as well as for infrastructural support for asylum care, which includes extended case management and a per-capita amount to asylum seekers comparable to refugee entrants. Use case examples of other state models, in other transit hubs (i.e. Washington State, Oregon, and other states). Network members can mobilize through city and state legislative processes the value of such funding toward resettlement or to assist local organizations to support holistic care for asylum seekers.

A HIAS staffer (right) hugs Juny Araceli Lopez, an asylum seeker from Guatemala, at the Embajadores de Jesus migrant shelter in Tijuana, Baja California state, Mexico, on February 17, 2022. (Guillermo Arias for HIAS)

Conclusion

This needs assessment of two key metropolitan areas documented the urgency of survival needs, the overwhelming need for legal representation, and the importance of holistic care which includes culturally responsive mental health support. As one provider observed, “Legal services allow people to physically be here — but social services allow people to mentally be here.”

Gaps in mental health services have long been noted within systems that serve forcibly displaced populations in the United States, including the U.S. refugee resettlement program. These gaps, coupled with continued mental health disparities within behavioral healthcare, leave many providers struggling to sustain funding for mental health care for racially and ethnically diverse populations.

Service providers and asylum seekers alike described the need for long-term solutions. To achieve such solutions at scale, the asylum services infrastructure must be fundamentally bolstered to ensure needs-based access to housing, food security, healthcare, employment opportunities, and other core integration supports throughout the asylum process. The implementation of policies and programs for people seeking asylum can be met with innovative funding allocations, along with infrastructure support to asylum seekers through in-kind, or directly funded program models.

While policies drive the systemic challenges documented in this assessment, providers need not wait to take action on tactical, operational, and coordination approaches which can improve collective impact while also engaging in systems advocacy. In strengthening social services programming, providers can improve a service delivery system so that it reflects the interconnected nature of asylum seekers’ needs, and the interdependence of the many dedicated providers striving to meet them.

Annex A: Organizations Consulted

Organization	Location	Survey	Interview
1. Afrikana Community Center	NYC	✓	✓
2. African Services Committee	NYC	✓	
3. Asylee Women Enterprise	DMV	✓	✓
4. Asylum Works	DMV	✓	
5. Ayuda	DMV		✓
6. Bellevue Program for Survivors of Torture	NYC		✓
7. Benach Collopy LLP	DMV	✓	✓
8. Black and Arab Migrant Solidarity Alliance (initiative now closed)	NYC		✓
9. Cabrini Immigration Services	NYC		✓
10. CASA Maryland	DMV	✓	
11. Catholic Charities of the Diocese of Arlington	DMV	✓	
12. Catholic Charities of New York	NYC		✓
13. Commonpoint Queens	NYC	✓	✓
14. Community of Hope – Medical	DMV	✓	
15. Community Healthcare Network	NYC		✓
16. D.C. LGBTQ+ Community Center	DMV	✓	✓
17. D.C. Mayor's Office on African Affairs	DMV	✓	✓
18. D.C. Volunteer Lawyers Project	DMV	✓	
19. Family and Youth Peer Support	NYC	✓	
20. Federation of Italian-American Organizations of Brooklyn LTD	NYC	✓	
21. Fundavenyc	NYC	✓	
22. Good Shepherd Services	NYC	✓	
23. HEAL - Refugee Health & Asylum Collaborative	DMV	✓	
24. HIAS Legal and Asylum Department	DMV and NYC	✓	✓
25. Hot Bread Kitchen	NYC	✓	✓
26. Humanitarian Action	DMV	✓	✓
27. Immigration Law & Justice New York	NYC	✓	
28. Intercultural Counseling Connection	DMV		✓
29. International Refugee Commission	DMV and NYC		✓
30. Jewish Family Services of Western New York	NYC		✓
31. Legal Services of the Hudson Valley	NYC	✓	
32. Mary's Center	DMV	✓	✓
33. Mixteca	NYC	✓	✓
34. Network for Victim Recovery of D.C.	DMV		✓
35. New York Office of Temporary and Disability Assistance	NYC		✓
36. Nonprofit Staten Island	NYC	✓	
37. Office of the Mayor of New York City	NYC		✓
38. Project Hospitality	NYC	✓	
39. Prophetic Whirlwind Fellowship	NYC	✓	
40. RUSA LGBTQ+	NYC	✓	✓
41. Sun River's Health Connect Program	NYC	✓	
42. SAMU First Response	DMV	✓	✓
43. TASSC	DMV	✓	✓
44. Team TLC NYC	NYC		✓
45. The Bridge Project	NYC	✓	
46. 86 the Barrier	NYC	✓	

Informal consultations also took place with Floyd Bennett Field Neighbors Mutual Aid in NYC.

Annex B: Service Mapping Questionnaire

1. **Organization Name**
   Response option: Open response
2. **Name of Primary Contact**
   Response option: Open response
3. **Position of Primary Contact**
   Response option: Open response
4. **Phone Number of Primary Contact**
   Response option: Open response
5. **Email Address of Primary Contact**
   Response option: Open response
6. **Which locations does your organization currently serve?**
   Please select all that apply.
   Response options: Dropdown
   O Washington, D.C.
   O Maryland
   O Virgina
   O New York City – Brooklyn
   O New York City – The Bronx
   O New York City – Manhattan
   O New York City – Queens
   O New York City – Staten Island
   O New York State (beyond the five boroughs)
7. **Are there limitations on where you can provide services?**
8. **How long has your organization been in operation?**
   Response options:
   O Less than 1 year
   O 1-2 years
   O 3-5 years
   O 5-10 years
   O 10+ years
9. **At which level(s) do you provide services to asylum seekers?**
   Please select all that apply.
   O Individual
   O Family
   O Community
10. **What services does your organization offer to asylum seekers and migrants?**
   Please select all that apply.
   Response options:
   O Accompaniment Support
   O Advocacy/Organizing Support
   O Legal Support
   O Health Support
   O Outpatient Behavioral Health Support
   O Crisis/Intervention (stabilization in event of acute crisis)
   O Emergency Services (basic needs, shelter, medical care)
   O Shelter Care
   O Sexual Assault Services
   O Torture Treatment
   O Faith Support
   O Self-Help and/or Mutual aid
   O Food and nutrition
   O Other (please specify)
11. **For which services do you provide financial assistance (cash or vouchers)?**
   Please select all that apply.
   Response options:
   O Accompaniment Support
   O Advocacy/Organizing Support
   O Legal Support
   O Health Support
   O Outpatient Behavioral Health Support
   O Crisis/Intervention (stabilization in event of acute crisis)
   O Emergency Services (basic needs, shelter, medical care)
   O Shelter Care
   O Sexual Assault Services
   O Torture Treatment
   O Faith Support
   O Self-Help and/or Mutual aid
   O Food and nutrition
   O Other (please specify)
12. **Which languages do you have the capacity to accommodate, either through staff or interpreters to which you have regular access?**
   Please select all that apply.
   Response options: Dropdown
   O Arabic
   O Amharic
   O Central American Indigenous language(s) (specify)
   O Dari
   O English
   O Farsi
   O French
   O Haitian Creole
   O Kirundi
   O Lingala
   O Pashto
   O Russian

- O Spanish
- O Swahili
- O Ukrainian
- O Other (specify)

13. Does your organization have any eligibility criteria for who it serves (for example, asylees only, unaccompanied children only, families only, etc.)?

- O Yes
- O No
- O I don't know

14. Which types of criteria does your organization use to determine eligibility?

Please select all that apply.

- O Gender or gender identity
- O Age
- O Sexual Orientation
- O Family composition
- O Legal status
- O Vulnerability type (social isolation, survivor or torture, gender-based violence, psychological or trauma, complex health, access barriers, disability, or other vulnerability (write in) etc.)
- O Place of residence/fixed address
- O Other
- O None
- O I don't know

15. How accessible are your organization's services for people with physical disabilities?

- O Not accessible
- O Somewhat accessible
- O Fully accessible
- O I don't know

16. How accessible are your organization's services for people with intellectual disabilities?

- O Not accessible
- O Somewhat accessible
- O Fully accessible
- O I don't know

17. How accessible are your organization's services for people with cognitive disabilities?

- O Not accessible
- O Somewhat accessible
- O Fully accessible
- O I don't know

18. On average, how many people does your organization serve on a monthly basis?

- O 0-25
- O 26-100
- O 101-250
- O 251-500
- O 501-1000
- O 1001 or more
- O I don't know

19. If your organization provides health related services including behavioral healthcare, does your organization accept State-funded Medicaid insurance?

- O Yes
- O No
- O I don't know

20. Does your organization have funds (or pro-bono resources) to offset costs for people who do not have state-funded Medicaid, employer insurance or other resources to pay for costs associated with healthcare?

- O Yes (specify source of funding)
- O No
- O I don't know

Endnotes

1. While not the focus of this assessment, it can be noted that most interviewees who entered the United States through the southern border reported receiving no services or humanitarian assistance during their journeys from their countries of origin. This trend was more pronounced among asylum seekers who did not speak Spanish. Of those who said they did receive assistance, a number mentioned HIAS. The assessment team met two asylum seekers in New York and two in Washington D.C. — all originally from Venezuela — who engaged with HIAS in Colombia or Ecuador. One volunteered with HIAS. Two noted that in later stages of their journeys, they searched online to see if HIAS was present along their route.
2. Importantly, a limited number of persons who have experienced forced migration that are suffering from mental health distress will seek clinical services. Annamalai, A., & Prabhu, M. (2014). Treatment of Mental Illness. *Refugee Health Care* (pp. 173-180). Springer, New York, NY. and Kashyap, S., Keegan, D., Liddell, B. J. Thomson, T., & Nickerson, A. (2021). An interaction model of environmental and psychological factors influencing refugee mental health. *Journal of Traumatic Stress*, 34(1), 257-266.
3. For example, Spanish-speaking asylum seekers in Washington, D.C. complained that some people hoard information about services due to a scarcity mindset.
4. This includes organizations run by volunteers, and staff of larger NGOs, who are engaging with mutual aid and volunteer mobilization efforts outside of their paid work.
5. https://www.washingtonpost.com/dc-md-va/2024/03/12/migrants-dc-border-crossings-lull/
6. In addition to stakeholders interviewed, this situation was highlighted by Migrant Solidarity Mutual Aid Network (MSMAN) in a 2023 policy brief: https://www.dcmigrantmutualaid.org/press-releases/5-25-23
7. In a focus group discussion, one family described their dilemma as they faced the expiration of their stay at a D.C. shelter. The mother noted that she is wary of moving outside D.C. for fear it could threaten their children's health insurance. However, she and her husband are concerned they will not be able to afford rent prices in D.C.
8. https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-celebrates-one-year-anniversary-of-the-arrival-center-for-newly-arriving-asylum-seekers/
9. https://mayor.DC.gov/release/mayor-bowser-celebrates-national-citizenship-day-awarding-funds-organizations-committed; https://mayor.DC.gov/release/mayor-bowser-celebrates-national-citizenship-day-awarding-funds-organizations-committed-protect
10. Some organizations which had established MOUs for legal referrals noted they were better able to place clients.
11. https://www.nytimes.com/2023/05/23/nyregion/right-to-shelter-nyc.html
12. https://comptroller.nyc.gov/services/for-the-public/accounting-for-asylum-seeker-services/asylum-seeker-census/. The city has not released data on the demographics of shelter residents, but authorities said that a "plurality" of residents included nationals of Venezuela, Peru, and Colombia, with growing arrivals from Ecuador, Senegal, and Mauritania. City representatives said that groups which they do see not moving through the city shelter system in large numbers include asylum seekers from China moving through the system, and they speculated that many may be leaving New York by tapping into diaspora networks.
13. https://www.politico.com/news/2024/04/09/new-york-city-drops-troubled-migrant-services-provider-00151073
14. https://apnews.com/article/new-york-city-migrants-docgo-048c1cb735d881ef9fecb0c2ed1aad77; https://www.nyc.gov/office-of-the-mayor/news/482-24/adams-administration-releases-competitive-rfp-reduce-asylum-seeker-costs
15. https://www.thecity.nyc/2024/08/20/mgrant-family-shelter-eviction-temporary-disability-assisstance-homeless-services/
16. https://citylimits.org/2024/08/23/for-migrants-in-shelter-an-asylum-application-can-mean-the-difference-between-30-or-60-more-days/
17. https://www.nytimes.com/2024/08/09/nyregion/migrants-homeless-encampment-nyc.html
18. One provider noted that a mosque had been offering shelter to whoever needed it, but its Silver Spring location closed due to lack of capacity.
19. https://www.washingtonpost.com/dc-md-va/2024/03/12/migrants-dc-border-crossings-lull/
20. https://www.washingtonpost.com/dc-md-va/2022/07/17/casa-ruby-programs-close/

21. One asylum seeker who is a Russian trans woman noted that, at 32 years old, she is unable to access LGBTQ+ shelters. Meanwhile, when she tried to follow up on housing leads through Russian diaspora networks, she was unwelcome due to her gender identity.
22. Between fall 2022 and spring 2023, the city operated a resource navigation center at a Red Cross facility with involvement of a number of non-governmental providers. One reflected on the challenges of that period, noting it was "incredibly challenging" to work with city providers on this effort, because "we didn't have control over the tone and tenor of interaction with clients."
23. https://www.dhs.gov/dhs-cmpp
24. https://www.washingtonpost.com/dc-md-va/2024/03/12/migrants-dc-border-crossings-lull/
25. https://otda.ny.gov/policy/gis/2023/23DC039.pdf
26. In terms of barriers to accessing information, providers told the assessment team that non-Spanish speakers are at times less aware of critical information related to the U.S. asylum process, including that they must apply for it, or the one-year deadline to do so. The team encountered a Haitian family staying in a New York City shelter who crossed with the CBP One app and were unaware they had to do anything further to get asylum. Non-Spanish speakers may also be left without information about how their families are being processed at the border. A New York provider spoke of one Pulaar-speaking client from West Africa who was put on a bus from the border to New York under the impression her child was being put on the next bus, only to arrive in New York and realize they had been separated.
27. One provider said, "We theoretically have access to interpretation services for 190 languages, but I still can't find a Fulani interpreter."
28. This provider noted that some asylum seekers have experiences of being "chased continuously." One provider cited an example of a man who was a member of the LGBTQ+ community, was cast out of his family in Senegal, and fled to Morocco. He then had to flee Morocco when his brother came "chasing" him and made his way to the United States. He was staying with friends who were unaware of his sexual orientation, but he felt they were using increasingly hostile language toward members of the LBGTQ+ community and felt unsafe remaining there. When he found this particular provider, he was sleeping at Union Station, the train station in D.C. The provider helped him to enroll in therapy.
29. An example of this approach would be the IASC Inter-Agency Referral Guidance Note for Mental Health and Pyschosocial Support in Emergency Settings. https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-inter-agency-referral-guidance-note-mental-health-and-pyschosocial-support-emergency-settings
30. Popular platforms among different groups include Telegram among Russian-speaking asylum seekers, Viber among Eastern European populations, and WeChat among Chinese-speaking asylum seekers. YouTube and Instagram are also popular with some groups.
31. Maternal healthcare was highlighted as a particular gap.
32. One healthcare provider said, "We know that there are moms who are trading food for diapers, because that's all they can do."
33. These include related concerns such as dental needs and specialty medical needs.
34. Some asylum seekers who are particularly isolated may feel unable to socialize due to past trauma. One provider recalled a client "unable to go out anywhere, learn how to navigate the system. She was granted asylum but is having a lot of difficulty navigating the system. She cannot read or write in her language. When asked, she 'overstates her wellbeing.' She is not reaching out to anyone, not building trust with anyone. She is matched to a volunteer but doesn't seem to be getting other support."
35. Disparities in mental health care exist in countries of asylum due to structural oppression of foreign-born populations, a lack of culturally responsive providers, applicable interventions for stigma reduction, and culturally congruent approaches to psychosocial well-being. These social determinants of health, in addition to lack of legal support, are risk factors for developing mental health impacts.
36. In addition to being trauma-informed, providers also noted that any programming which was designed for non-asylum seeking populations needs to be contextualized. One provider said: "We have to integrate immigration issues with domestic violence and parenting workshops, because this can't be separated."

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