Rendering Mental Health Services to Undocumented Immigrants

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It is estimated that in 2018, there were approximately 68.5 million forced migrants worldwide (The United Nations High Commissioner for Refugees, 2017). Particularly within the United States, the past year has produced observable changes in the number of persons removed, arrested, and those found inadmissible at national borders. While an increase was observed in the number of individuals removed and found inadmissible at the border, the number of undocumented immigrants arrested has decreased. It is estimated that approximately 143,000 undocumented immigrants were arrested by ICE in 2019, which was 10% less than prior years. Additionally, the average daily population of those detained increased by 19%, reaching approximately 50,000 detainees (United States Immigration and Customs Enforcement, 2019). The criminalization of immigration, and therefore influx in those detained, has led to the privatization of facilities to house detainees. Aside from the physical conditions that detainees are exposed to, it has been found that many immigration detention centers lack adequate mental health services (Mason, 2012).

Mental Health Concerns of Undocumented immigrants

The mental health needs of those involved in immigration proceedings often referred to as undocumented immigrants (i.e. refugees, asylum seekers, undocumented aliens) vary drastically from other populations that mental health providers serve. The abovementioned populations face unique situational concerns, pre-/post-migration adversities, and factors affecting access to care/rendering of services. Undocumented immigrants may present with complex medical concerns, such as psychiatric disorders/injuries sustained from trauma (McColl, McKenzie, & Bhui, 2008), and have been found to be more vulnerable to specific mental health diagnoses including posttraumatic stress disorder (PTSD) and depression (Center for Disease Control and Prevention, 2011; Fazel, Wheeler, & Danesh, 2005; Priebe, Giacco, & El-Nagib, 2016). Additionally, undocumented immigrants, and ethnic minorities in general, are more likely to present psychiatric symptomatology by means of somatization (Bauer, Chen, & Alegría, 2012; Lanzara, Scipioni, & Conti, 2019).

Pre- and Post-Migration Adversities

There are many risk factors, occurring prior to and following migration, that can significantly affect an undocumented immigrant’s mental health status and needs. In general, the process of migration is a risk factor, as undocumented immigrants often face hazardous journeys and separation from their community and family. Pre-migration factors include exposure to war, imprisonment, genocide, physical/sexual abuse, witnessing the abuse of others; traumatic bereavement; starvation; homelessness; and lack of healthcare. Following migration, undocumented immigrants may face additional adversities such as discrimination in their host
country, detention related to immigration proceedings, denial of healthcare, and a lengthy decision process pertaining to their immigration status. These pre- and post-migration adversities, coupled with the abovementioned predisposition to specific mental health concerns, can result in unique factors for mental health providers to navigate.

**Suicidal and Self-Injurious Behaviors**

In addition to rendering patient-centered care addressing factors unique to detained immigrants, a great concern of mental health providers is the prevention of suicide and self-injurious behaviors in detention facilities. Many studies have found that responses to extreme distress, such as migration and detention, often result in self-injurious behaviors (Fiske, 2016; Kendall, Taylor, Bhatti, Chan, & Kapur, 2011; Morrissey, 2015). It has been found that suicidal behaviors are more associated with immigration proceedings, rather than pre-existing mental health conditions (Bursztein Lipsicas, 2012; Fiske, 2016). Extensive research surrounding suicidal/self-harm behaviors in undocumented immigrant populations is lacking in research, however, it has been estimated that self-harm occurred in 12.8% and 22% of detained immigrant populations (von Werthern, Robjant, Chui, Schon, Ottisova, Mason, & Katona, 2018). Although the rate of suicide has increased in the United States since 2000, there is limited empirical research pertaining to the effects of immigration on suicide prevalence (Krivo & Phillips, 2018).

Despite the number of detained immigrants in the United States, few studies exist investigating the impact of immigration on mental health in the United States immigration detention centers. A recent systematic review (von Werthern et al., 2018) gathered data from 26 studies pertaining to the effect of immigration on mental health. Of these 26 studies across eight countries, only five studies were conducted in the United States. Consistent with other research that was reviewed, a majority of the studies (n = 8) originated in Australia. The studies conducted in the United States included samples from various Latin America countries (Barbeck & Xu, 2010; Keller, Rosenfeld, &Trinh-Shervin, 2003; Rojas-Flores, Clements, Hwang Koo, & London, 2017; Rothe, Castillo-Matos, & Busquets, 2002a; Rothe, Lewis, Castillo-Matos, Matinez, Busquets, & Martinez, 2002b). Authors concluded that 6% of detained immigrants initially presented with mental health symptoms; the reason for detention contributed to new mental health concerns while a positive correlation was observed between the length of detention and symptom severity. Based on data obtained in the systemic review, it was found that anxiety, depression, and PTSD are the most frequently endorsed symptoms by detained immigrants. Pre-migration trauma exposure and isolation from family members were found to be associated with higher rates of the abovementioned symptoms. Three studies found that upon release from detention, psychiatric symptoms persisted for an additional 10 months to four years (von Werthern et al., 2018).

**Mental Health Assessment with Detained Undocumented immigrants**

Due to the vast diversity of detained immigrants and situational factors associated with providing mental health services in immigration detention centers, no research has identified standardized guidelines for mental health assessment. At a minimum, a mental health screening should be conducted to obtain information relevant to mental health history, a mental status examination, and screening for depression and PTSD (Center for Disease Control and Prevention, 2015). It is suggested that clinicians ensure that a sufficient amount of time is allotted to reduce a
patient’s anxiety and obtain a detailed history. If possible, collateral data should be obtained, however, this is often difficult in immigration detention facilities. Prior to conducting an evaluation, the patient’s primary language should be identified in order to obtain an interpreter or identify an appropriate clinician to conduct the interview. If offering a formal diagnosis, clinicians should consider pre-migration adversities, as well as cultural factors (e.g. a cultural view of mental illness/treatment, language barriers, somatic expression of mental illness, common risk factors, religion; McColl et al., 2008). It is recommended that within the admission process, vulnerable populations are identified such as those with a history of trauma, women, children, persecuted ethnic groups, those with recent negative immigration decisions, complex health issues, family at risk, previous mental health conditions, and extended periods of time in detention (Booker, Albert, Young, & Steel, 2016). Additional guidelines for mental health assessment in detention centers include expedited psychiatric referrals in urgent situations, clinicians educating themselves on culturally competent practices, use of medically trained interpreters, and routine follow-up services (Center for Disease Control and Prevention, 2015).

Additionally, the use of interpreters is an inevitable topic to address when discussing the provision of mental health services in correctional facilities with undocumented immigrants. It has been that use of qualified mental health interpreters in mental health services ultimately leads to more accurate diagnoses (Bischoff, Bovier, Isah, Francoise, Ariel, & Louis, 2003) and improved access to and higher quality of healthcare (Bloom, Masland, Keeler, Wallace, & Snowden, 2005; Ziguras, Klimidis, Lewis, & Stuart, 2003). It is imperative to use trained and qualified interpreters, which results in improved rendered services (Karliner, Jacobs, Chen, & Mutha, 2007). Trained interpreters are more likely to possess knowledge of clinical terms, reducing errors (Smith, 2008). However, access to trained interpreters is often limited due to sparse resource allocations. To remedy the deficit in translation services, facilities often use untrained professionals who are employed within the facility (Hagan, Swartz, Kilian, Chiliza, Bisongo, & Joska, 2013). Additionally, facilities have begun to train mental health professionals to work as interpreters, however, this remedy is rare (Fung, Lagha, Henderson, & Gomez, 2010). While the use of a qualified interpreter is ideal, there are some potential challenges posed to service delivery. The addition of a third-party could lead to inaccuracy and impact on the client-clinician interaction or therapeutic relationship (Searight & Armock, 2013). In some cases, there is also the potential for vicarious trauma to be inflicted on the interpreter based on the interview content (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Seabright & Searight, 2009). It was found that in the United States, medical consultations that utilized interpreters increased by 18 minutes (Krazitz, Helms, Azar, Antonius, & Melnikow, 2000). The ethical implications should also be considered, such as rights to privacy, patient confidentiality, and standards of competence (Searight & Armock, 2013).

Due to the nature of working with undocumented immigrants in detention facilities, mental health clinicians face unique challenges in this type of setting. Clinicians may experience dual, but incongruent “loyalties” to both the detainees they serve and the detention facility operators (Booker et al., 2016). In these types of situations, clinicians are encouraged to review the Specialty Guidelines for Forensic Psychology to navigate ethical concerns. Particularly, guidelines 7.01 (conflicts with legal authority) and 7.02 (conflicts with organizational demands) are relevant to concerns that may arise for clinicians providing services with undocumented immigrants. It is recommended that providers attempt to resolve conflicts between ethical violations and the law, however, if the conflict persists, clinicians should adhere to the governing authority without
violating human rights. Additionally, if a mental health professional experiences conflict between organizational demands and rendering clinical services, one should attempt to resolve the conflict while maintaining professional obligations and responsibilities (American Psychological Association, 2013). Rendering mental health services in immigration detention centers vary from other types of correctional facilities, as there is often a lack of clear and well-established policies and procedures (Brooker et al., 2016). As immigration policies and procedures continue to evolve, the need to provide mental health services to undocumented immigrants is likely to persist in the future. To ensure quality care, providers should seek education and training concerning cultural competency, factors unique to undocumented immigrants, and barriers to rendering services in immigration detention facilities.
References


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