Behavioral Health Service Delivery with Immigrants

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Introduction

The United States is home to more immigrants than any other country in the world (Pew Research Center, 2016). According to the Pew Research Center (2016), there were also 43.7 million immigrants in the USA in 2016, accounting for approximately 13% of the population in the country. There are several definitions used by the government to differentiate among immigrant groups (e.g., refugee, asylum-seeker[1]). For the purposes of this chapter, we will be using the term immigrant to indicate someone that was not born in the USA and has moved to with the purpose to settle in the country permanently. We would like to also distinguish this process from emigration which refers to leaving one's country to settle somewhere else.

It is important to note that there are significant differences in the experiences between immigrant groups. For example, the diversity in immigration is reflected on the different locations that are the most common birthplaces for US immigrants: Mexico (11.6%), China (2.7%), followed by India (2.4%), the Philippines (1.9%), and El Salvador (1.4%) (Pew Research Center, 2018). These countries have vastly different sociopolitical histories of immigration to the USA. Altogether, the diversity of the groups immigrating to the USA, along with the complexities and intricacies of the US immigration system, must be considered as they might impact the experiences and stressors to which these groups are exposed to during post-migration.

Adapting to life in the USA can be a challenging experience accompanied by high levels of stress (Berry, 2006a). Learning a new language, isolation, loss of social support, and experiences of discrimination, are examples of the stressors frequently experienced by immigrants. In addition to post-migration stressors, immigrants sometimes have also experienced difficult experiences in their countries of origin. These circumstances can amplify the impact of present stressors that result from their adaptation to life in the USA. Available evidence suggests that these stressors, both at the pre- and post-migration stages, are linked to negative mental health out-

[1]According to the Department of Homeland Security (2019), (1) a refugee is a person that is not living in their country of origin and cannot return due to fear of persecution, and (2) asylee refers to a person that meets the criteria for refugee and is either at a port of entry to the USA or already in the country.

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comes such as depression, anxiety, and suicidal thoughts (Cho & Haslam, 2010; Hovey, 2000; Rasmussen et al., 2012; Sirin, Ryce, Gupta, & Rogers-Sirin, 2013).

The evidence presented above indicates that this population is at risk for experiencing high levels of stress, which highlights the need to access mental health services. Mental health treatment can be helpful in preventing negative outcomes and strengthening the use of effective coping strategies. Unfortunately, despite the evidence that immigrants may face a greater need for mental health services after settling in the USA, we see overall lower mental health service utilization, in comparison with non-immigrants (Bridges, Andrews, & Deen, 2012; Chen & Vargas-Bustamante, 2011). Disparities in utilization of mental health services are exacerbated by structural barriers. Existing interventions for mental health have been designed based in studies with a majority of non-immigrant, English-speaking, white sample; therefore, they might not address the needs of the immigrant population in the USA.

Although some researchers have called for the adaptation of existing treatments in order to be able to provide treatments that are culturally responsive to immigrant communities (Griner & Smith, 2006), there continues to be a significant gap in the delivery of mental health services for and with immigrant communities. Additionally, the current sociopolitical climate in the USA creates a significant barrier for reducing health disparities among immigrants. More specifically, the anti-immigration policies in the past two decades and exacerbation of current anti-immigrant sentiment in the country impose not only additional stressors for immigrant groups, but interfere with the access to health services by instilling fear in these communities (Amuedo-Dorantes, Puttitanun, & Martinez-Donate, 2013; Garcini et al., 2017; Paat & Green, 2017; Salas, Ayón, & Gurrola, 2013). In this chapter, we aim to identify the barriers to the delivery of mental health services for immigrants, discuss the current sociopolitical context of immigrant populations in the USA, and review the considerations and the guidelines that have been developed to address the needs of the immigrant population in clinical settings. Our main goal is to identify areas of need for this group and provide recommendations to be used in the day-to-day delivery of mental health services that are culturally responsive to immigrant individuals.

Barriers to Behavioral Health Service Delivery

As mentioned above, significant disparities exist in service access and utilization among immigrant groups. Those individuals with mental disorders may be significantly more likely to have sought medical care, but not psychiatric services (Bridges et al., 2012). Those with college degrees or higher are also more likely to seek services (Fortuna, Porche, & Alegria, 2008). Among immigrant communities, lower rates of use are pronounced among men, those with no health insurance, and those without documentation in the USA, as well as among younger immigrants (Derr, 2015). Interestingly, as age at the time of immigration increases, the likelihood of service use decreases (Lee & Matejkowski, 2012).

Behavioral healthcare needs may be recognized, but not necessarily prioritized, among immigrant families, depending on the host of other immediate and basic needs and/or risk of deportation faced by some (Zayas et al., 2017). As mentioned above, immigrant families face a myriad of stressors that impact behavioral health and decisions to seek help or support for mental health needs. These include challenges related to economic stability, discrimination, socio-cultural and linguistic adjustment, parenting and family dynamics, employment, and immigration status (Saechao et al., 2012). This section addresses barriers to access to behavioral health services among immigrant communities—structural barriers, cultural barriers/perceived need for services, social support and stigma, immigration-related barriers, and prior exposure to abuse or violence.

Structural Barriers Several structural barriers contribute to the disproportionately lower use of behavioral health services among immigrants. First, immigrant communities are negatively

impacted by the high cost of services, coupled with limited access to health insurance coverage (Bridges et al., 2012; Chen & Vargas-Bustamante, 2011; Fortuna et al., 2008; Lee & Matejkowski, 2012). Among non-citizen immigrants, those with health insurance are more likely to use mental health services than those without; however, those without citizenship are less likely than their citizen counterparts to have health insurance (Lee & Matejkowski, 2012). In addition to lack of health insurance, limited and inadequate linguistic access to mental health services serves as a structural barrier to care (Falgas et al., 2017; Fortuna et al., 2008; Saechao et al., 2012). Importantly, systemic racism and anti-immigrant or xenophobic sentiments also serve as barriers to help-seeking and access to services (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000).

Immigration-related barriers represent an important consideration in understanding help-seeking and service use among immigrant communities. Immigration status influences access to and use of behavioral health care among immigrants, and individuals' legal immigration status, fear of being denied services due to status, fear of deportation, anxiety about being asked for documentation, and experiences of discrimination from health care providers negatively contribute to behavioral health care utilization (Bridges et al., 2012; Derr, 2015; Falgas et al., 2017; Fortuna et al., 2008).

In addition to the enduring and negative impacts of historical anti-immigrant policies, several recent practices and policies are important to consider in understanding the current political landscape faced by immigrant communities in need of behavioral health services. Current immigration policies and practices may serve as barriers to meeting the mental health needs of some immigrant communities (Zayas et al., 2017). It is critical to examine, for example, restricted access to immigration legal remedies such as U Visas, expanded use of immigrant detention, immigrant family separation, changes to domestic violence-based asylum, delays in processing immigration-related applications, and proposed strengthening of public charge rules. Those who have migrated to the USA for a variety of complex and interrelated reasons may be detained, sometimes with their young children, in large, locked facilities without access to legal representation, adequate mental health services, or other services and supports. Negative bio-psycho-social impacts of detention compound the stress, violence, and/or trauma immigrants may have experienced before, during, and after migration (Coffey, Kaplan, Sampson, & Tucci, 2010; Robjant, Hassan, & Katona, 2009). The negative psychological impacts of detention, in addition to the increased need for mental health services after release from detention, are well documented in the literature (Coffey et al., 2010; Davis, 2014; Fazel & Stein, 2002; Keller et al., 2003; Robjant et al., 2009; Silove, Austin, & Steel, 2007; Steel et al., 2006).

In addition, this context is complicated by recent reports of human rights violations, such as acts of harassment and violence within detention, as well as, limited access to mental health services within detention settings (Cantor, 2015; Cook Heffron, 2019; Cook Heffron, Serrata, & Hurtado, 2018; UT Immigration Law Clinic, 2018; Women's Refugee Commission, 2017). An additional factor in considering access to and use of services, is the recently published changes to the "public charge" policies in October 2018. Proposed changes could result in the use of social welfare programs such as Medicaid, SNAP (food stamps), and some housing assistance programs counting against immigrants seeking to adjust their status. Advocates fear that immigrants may forego needed public benefits, in addition to more wide-ranging medical and mental health services, in order to protect future immigration remedies (www.childrensdefense.org).

In particular, refugee and asylum-seeking immigrants show increased need and higher service use rate than other immigrant and non-immigrant groups (Derr, 2015). Help-seeking and access to family violence services is an important consideration for immigrants, asylum-seekers, and refugees who experience violence before, during, or after migrating to and settling in the USA. In fact, immigrants often live in,

and/or are exposed to high levels of poverty, community violence, and discrimination, and while some immigrants may migrate to find protection or relief from political violence (and/or a host of other pre-migration conditions, stressors, persecution, or trauma), they may encounter additional exposure during immigration and after settling in the USA (Fortuna et al., 2008). Those previously exposed to abuse or violence (such as political violence or intimate partner violence) may have limited access to and may be less likely to seek behavioral health services and other services that aim to respond to survivors of abuse and violence (Menjívar & Salcido, 2002; Raj & Silverman, 2002; Warrier & Rose, 2009). Similar to the broader immigrant community, barriers to help-seeking and access to services among survivors of violence include language barriers, lack of awareness or information, fear of immigration consequences, pressure to maintain traditional gender role expectations, discrimination, the impact of migration-related trauma, and contemporary immigration policies and practices (Bauer et al., 2000; Dutton, Orloff, & Hass, 2000; Reina, Lohman, & Maldonado, 2014). While immigrant survivors may have extensive knowledge of formal and informal supports in their countries of origin, they may lack awareness of the service context in the USA (Wachter & Dalpe, 2018). Similar to the broader immigrant community, undocumented or precarious immigration status negatively impacts survivors' likelihood of seeking formal help (Frías & Angel, 2005; Guruge & Humphreys, 2009; Levine & Peffer, 2012; Zadnik, Sabina, & Cuevas, 2016).

Cultural Barriers In addition to structural barriers, a number of cultural factors also influence access to and use of behavioral healthcare. First, newcomers' lack of knowledge of the mental health service delivery system in the USA—where and how to seek treatment—serves as a barrier to immigrants in need of treatment (Chen & Vargas-Bustamante, 2011; Saechao et al., 2012). Research finds that service utilization among immigrants increases as knowledge about mental health services in the USA increases and among those who know someone who has utilized mental health services (Bridges et al., 2012). Even given knowledge and information about the US system, immigrant communities may have little trust in the effectiveness of treatment options, further contributing to lower rates of service use (Falgas et al., 2017). In addition, stigma about mental health and mental health services in the country of origin contributes to lower use of mental health services (Saechao et al., 2012). In particular, gender norms and expectations related to masculinity and emotional vulnerability may serve as an additional barrier for immigrant men (Fortuna et al., 2008).

It is important to note that the formal service delivery system is not the only source of potential care or support, and immigrants may be more likely to turn to alternative service providers, religious or spiritual leaders and healers, and/or social support networks as sources of behavioral healthcare (Bridges et al., 2012). Social support may be particularly important, as immigrants are more likely to seek help first from family, friends, or religious/spiritual leaders. These networks impact help-seeking behaviors and influence immigrants' identification of the need for treatment, as well as the initiation of treatment (Falgas et al., 2017). Help-seeking from social support networks and alternative treatment providers (such as homeopathy, acupuncture, and traditional healers) are not necessarily connected with lower formal service use, though they may be related to delayed treatment by medical and mental health professionals (Derr, 2015). Unfortunately, social support networks often shift and may temporarily weaken during or following migration (Ayón, 2018).

Understanding the Sociopolitical Context of Immigrant Populations

Ecological Framework The original ecological model proposes that an individual's experience is shaped by the interactions between themselves and their environment (Bronfenbrenner

1979). This framework was then expanded to also include home, school, community, values, and society at large as well as the interactions of these systems with one another as contextual factors that impact individual behavior (Bronfenbrenner, 1989).

This model has been used to understand the acculturative process given that this is a multilevel model that accounts for proximal and distal factors that affect immigrants' mental health outcomes. Acculturation refers to the process in which individuals change and adapt as a result from interacting with a different cultural context (Berry, 2006b; Gibson, 2001). For example, Serdarevic and Chronister (2005) explain that the ecological framework accounts for the complex bidirectionality of factors that are part of the immigration and acculturative processes (see Fig. 15.1). In clinical practice, using this model allows providers to understand an individual's chronosystem, which refers to the transitions or changes that occur through time (Neal & Neal, 2013). This system will include the historical context and sociopolitical climate of immigrant communities. Clinicians can then ask questions about the experiences that individuals might be having outside the therapeutic room that might exacerbate their mental health outcomes, make it difficult for them to engage in services, and/or interfere with treatment adherence. Moreover, it provides clinicians a lens to contextualize some of the symptoms that immigrant individuals might be reporting during the initial assessment stage and throughout treatment, in addition to helping clinicians formulate treatment plans that account for their sociopolitical environments.

Jensen (2007) also provides a description of how this model can be used to gain a more in-depth understanding of the experiences of immigrants in the USA (see Fig. 15.2). More specifically, he highlights those factors that can promote well-being at different environmental levels. This information can be integrated in the delivery of mental health treatment to promote effective coping strategies and bolstering cultural factors that already contribute to resiliency in this group.

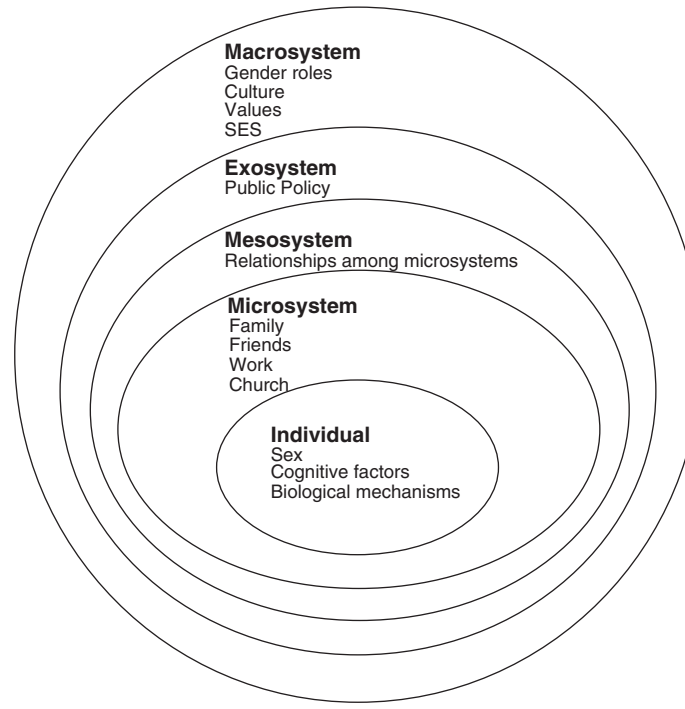

Fig. 15.1 Theoretical conceptualization of the role of context of immigration processes. (From Serdarevic & Chronister, 2005)

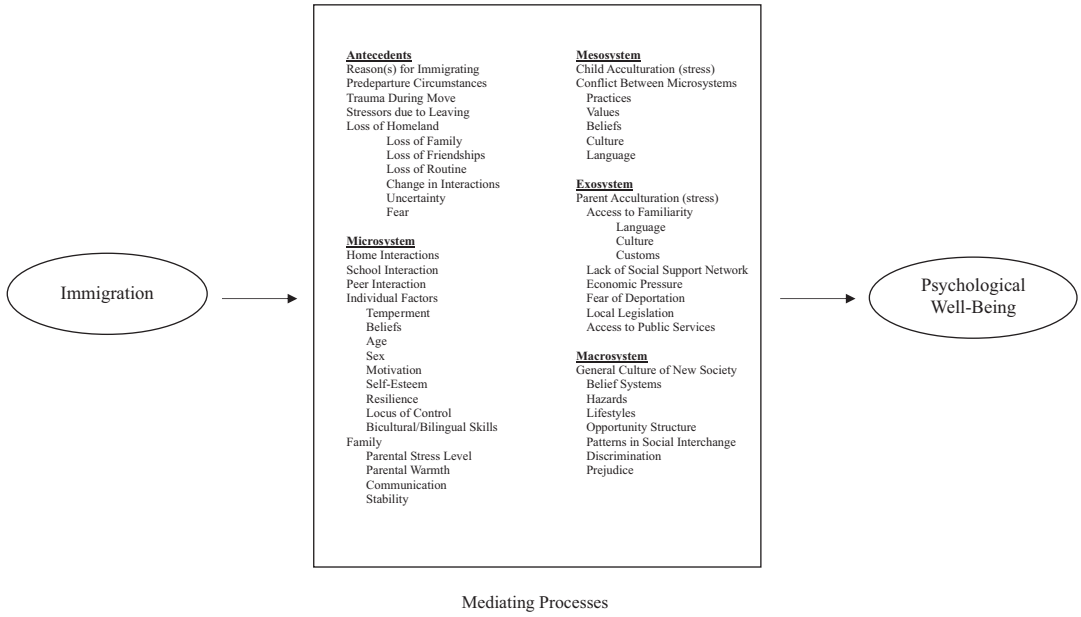

Fig. 15.2 Multilevel model of mediator factors of immigration and well-being. (From Jensen, 2007)

Ethnoracial Trauma An important element of the ecological framework that is particularly salient for immigrant communities seeking mental health services is that of ethnoracial trauma. The immigration process consists of different stages, the pre-migration experience in an individual's country of origin, the journey to the USA, and the post-migration experience once the individual has arrived in the USA (Perez Foster, 2001). It is important to note that the migration process is often fluid; therefore, individuals might go through these stages in a way that is non-linear with continued mobility across space. There are multiple reasons why people might choose to migrate to the USA. Some people experience poverty or violence (e.g., persecution, domestic violence, interpersonal violence) in their country of origin. Others have opportunities for work and education, or they might have family members that have already migrated.

Available studies suggest that immigrants are at a high risk for undergoing traumatic experiences throughout the migration process (Casillas, 2006; Infante, Idrovo, Sanchez-Dominguez, Vinhas, & Gonzalez-Vazquez, 2012; Rasmussen et al., 2012). As mentioned above, the exposure to traumatic events can result in a negative impact to the mental, physical, and overall well-being of immigrant individuals. Exposure to traumatic events can also exacerbate pre-existing mental and physical health symptoms, especially for those that have experienced violence previous to their immigration experience. In addition, when individuals arrive to the USA, they can experience threatening conditions, including detention in centers where their physical and psychological needs are not met, human trafficking, exploitation and forced labor, isolation, and poverty (Chavez-Dueñas, Adames, Perez-Chavez, & Salas, 2019; Cook Heffron et al., 2018).

Since the 2016 election, when President Trump bolstered nativist views throughout his campaign, including making demoralizing statements about ethnoracial minorities and promoted the construction of a wall at the border with Mexico, there has been a rise in a broader anti-immigrant climate and increased fear among immigrant communities (Chavez-Dueñas et al., 2019). Chavez-Dueñas et al. (2019) also note that

this environment can lead to ethnoracial trauma, a response characterized by increased distress and fear due to experiences of systemic oppression, that can take place at the individual level but also has a significant effect on families and communities.

Families and communities might worry about its members being victims of hate crimes and other instances of abuse and racism. The increased fear from immigrant communities is not unfounded as hate crimes rates have continued to increase since 2016 (U.S. Department of Justice, 2017). In addition, there is also great fear of community members being arrested, detained, and/or deported. In 2017, there was a 30% increase in administrative arrests by Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) (U.S. Immigration and Customs Enforcement, 2016, 2017), and an 11% increase between 2017 and 2018 (Zong, Batalova, & Burrows, 2019). Moreover, major changes to immigration policies include the entry ban to individuals from majority-Muslim countries, reducing the number of allowed refugee admissions, attempts to cancel the Deferred Action for Childhood Arrivals (DACA) program, and ending the Temporary Protected Status for several groups (Zong, Batalova, & Burrows, 2019). There has also been an expansion in the authority of ICE and the number of agents for immigration enforcement, as well as changes to the prioritization for deportation policies (National Immigration Law Center, 2017). This climate of fear can place immigrant communities at a heightened vulnerability for other crimes as it will be less likely for them to seek help from local authorities, such as reporting crimes (e.g., domestic violence, sexual abuse, exploitation) and seeking services for physical and mental health.

Considerations in Behavioral Health Service Delivery with Immigrant Populations

Language Accessibility and Justice Language is an integral part of who we are and how we experience the world. Extensive evidence suggests a connection between the words that we use to describe our emotions and affective experiences (Brooks et al., 2017). In fact, research findings suggest that mental health interventions provided in an individual's preferred language are more effective than those delivered in English (Griner & Smith, 2006). Thus, being able to use our native language to describe our experiences, thoughts, and perspectives and understand those of others is imperative in the delivery of mental health interventions.

In the USA approximately 22% of people report that they speak a language other than English at home (Migration Policy Institute, 2018); therefore, the recommendations regarding the reduction of health barriers with immigrant groups have emphasized language accessibility. This concept typically refers to having services available in such a way that an individual can understand and communicate effectively (e.g., translation or interpretation in their preferred language) (Antena, 2012). However, when providers do not take into consideration literacy level, cultural views, and cultural context, they are not yet providing culturally relevant services. Therefore, we turn to a language justice framework that applies social justice principles to language accessibility.

Language justice focuses on ensuring that the level of reading and translation should be accessible to individuals of most socioeconomic and educational backgrounds, as well as those with special needs (Antena, 2012). This can be complicated as this might differ per country of origin. Hiring qualified interpreters, involving individuals that can connect with clients to explain the materials, and use of cultural references and customs, can all be helpful in closing the gap of linguistic differences and creating an inclusive environment (Antena, 2012).

Cultural Responsiveness Cultural responsiveness refers to the ability to provide mental health services that are adequate for multicultural populations. This means that the needs of these populations regarding mental health can be fulfilled within an appropriate cultural context. The

American Psychological Association (APA) has released updated guidelines to provide culturally competent services to multicultural groups. In these guidelines, they outline the importance of the therapist' understanding of different cultural groups and their values, as well as their use of skills and practices that are culturally centered (American Psychological Association, 2017).

In addition to the guidelines to providing care to multicultural groups, APA has also released an additional update for clinicians based on their Taskforce on Immigration (American Psychological Association, 2012). The update highlights important considerations in the provision of mental health services to immigrant individuals. These considerations include the different stages of the migration experience, language accessibility, symptom expression, gender and intergenerational roles, economic stressors, marginalization and oppression, resilience, and intersectionality (American Psychological Association, 2012).

In addition to the consideration of the factors outlined above that reflect the experience of immigrants in the USA, it is important that therapists examine their own knowledge, attitudes, and biases about different immigrant groups, as well as their own privilege and blind spots regarding issues of marginalization and oppression. The process of introspection is key in the provision of culturally responsive services as it will allow the clinician to understand the impact of their own experience in the conceptualization of clients and barriers that might arise in the implementation of different therapeutic strategies. It should be noted that cultural responsiveness is an ongoing process that requires significant effort on the part of the clinician.

Evidence-Based Practices Evidence-based practices are defined as those that integrate the available research evidence and clinical judgment while taking into consideration the individual's context (e.g., preferences and traits) (American Psychological Association, 2005). Evidence-based interventions have also been determined to be effective through clinical trials.

Cultural adaptation of evidence-based practices is done to adjust the intervention to the context of the individual (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009). This can be achieved through the use of principles that emphasize flexibility, openness, and culturally meaningful strategies (e.g., use of metaphors or content that is relevant to the client's experiences) (Bernal & Saez-Santiago, 2006; Smith, Domenech-Rodriguez, & Bernal, 2011).

There has been some debate about the adaptation of available evidence-based practices in order to meet the needs of diverse groups, such as ethnoracial minorities and immigrants. Concerns about this process center on the balance between cultural-specificity and treatment fidelity. The consensus now is to create culturally responsive modifications while maintaining the treatment factors that have been identified as mechanisms of change in an existing intervention (Smith et al., 2011).

Several studies have found cultural adaptations of evidence-based treatments to be effective (Koslofsky & Domenech Rodríguez, 2017; Griner & Smith, 2006). Some research groups have examined the effectiveness of adapted interventions for immigrant populations. Through their research they have identified meaningful culturally responsive strategies for this group. Some examples include, using group sessions to increase social support in a cognitive behavioral intervention designed for PTSD and depression with low-income Latina immigrants in primary care clinics (Kaltman, Hurtado de Mendoza, Serrano, & Gonzales, 2016), or increased flexibility around time and duration of sessions for the treatment of oppositional defiant disorder within the context of intimate partner abuse with undocumented individuals (Maríñez-Lora & Cruz, 2017). In short, using culturally adapted practices and strategies when implementing evidence-based interventions can be one strategy to increase access to mental health services and meet the needs of immigrant individuals.

Another approach to EBP includes working with immigrant communities themselves to develop and/or adapt approaches that might work best for them. As noted in the ecological model,

services directed at the individual level are one approach to supporting immigrant communities; however, interventions at the community level can also be effective at creating environments of support that can buffer the sociopolitical stressors experienced by this community. The Community-Centered Evidence Based Practice model (Serrata, Macias, Rosales, Hernandez, & Perilla, 2017) is an approach that offers tangible recommendations on how to center specific community members in developing, adapting, and improving interventions. Mental health practitioners should be connected with and aware of immigrant-servicing community-based organizations in their communities as the stressors experienced by immigrant communities are multi-layered and require multi-layered tactics (see Fig. 15.3).

While the training many mental health practitioners receive may not serve as adequate preparation for community-based practice, practitioners may struggle with how to initiate these connections. In building relationships with community organizations, it is critical that practitioners approach community organizations with the authentic purpose of listening and learning and seek to build relationships that are based on shared power and reciprocity. Practitioners may first simply identify local immigrant-serving organizations, particularly immigrant-led initiatives, attend and support community events, volunteer time and skill to existing efforts, and inquire where and how one's expertise can be of use to the community. As relationships develop, practitioners may begin to ensure that members of community-based organizations are included in decision-making opportunities that impact the design, implementation, and evaluation of future mental health interventions. This may involve prioritizing immigrant perspectives in staff and consultant positions and on task forces, advisory boards and boards of directors. Finally, it is important for mental health professionals to consider the ways that immigrant-serving organizations may be under-resourced and experience exhaustion or secondary traumatic stress. Practitioners are often well-positioned to address the impact of the work on communities and community-based organizations, for example, by offering support to address secondary trauma and burnout (e.g., offering healing sessions for staff).

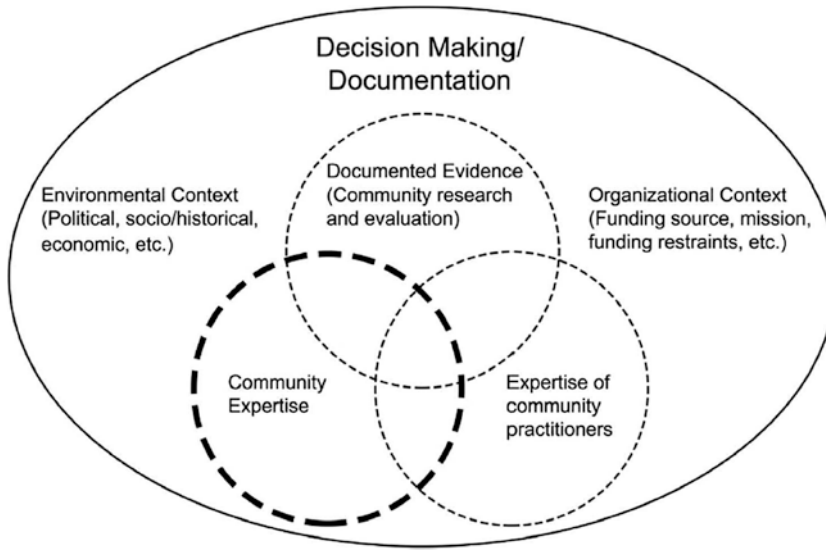

Fig. 15.3 Community-centered evidence based practice model. (From Serrata et al. 2017)

Conclusion

Recent statistics show that one in five US residents is born outside of the USA (Pew Research Center, 2016). In addition, 28% of the US population is comprised by immigrants and their children (Migration Policy Institute, 2017). It is expected that this population increases to become 36% of the US population by 2065 (Pew Research Center, 2018). Altogether, these statistics note that immigrant communities are a significant portion of the overall US population and this group will continue to grow in the years to come.

Immigration has become a more salient discussion in the current sociopolitical climate in the USA within the past couple of years. As mentioned above, nativist and ethnocentric views continue to be enforced by changes in laws and policy creating an anti-immigrant climate around the country. The present state of affairs poses a significant challenge for those providing mental health services to these communities as it amplifies the already-existing structural and cultural barriers that contribute to significant health disparities in this group.

We aimed throughout this chapter to provide an overview of the immigrant community in the USA, as well as some of the challenges that this group might experience throughout their immigration experience. In addition, we hope to highlight the considerations that providers must have in their day-to-day service delivery in order for intervention and strategies to be culturally responsive.

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