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The Role of Cultural Psychiatry in Improving the Policy Response to Central America's Unaccompanied Minors at the American Border: Local and Global Implications

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Abstract

Since 2014, children from El Salvador, Guatemala, and Honduras unaccompanied by their parents have fled in large numbers to the United States to escape violent crime and social disadvantage. Current mental health policies in the U.S. government's response can be improved based on guidelines from professional psychiatric and psychological organizations. These guidelines emphasize the importance of immigration and culture, raising questions into how the field of cultural psychiatry can offer conceptual frameworks and methods to research unaccompanied minor migration as a humanitarian problem. This paper conducts a policy analysis by reviewing shortcomings in the U.S. response and explores the potential contributions of cultural psychiatrists in optimizing services to address the needs of these children in the U.S. and their countries of origin.

Keywords

Cultural psychiatry; mental health policy; child and adolescent psychiatry; Central America

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In 2014, nearly 69,000 unaccompanied children were detained at the United States border, of whom 75% were fleeing poverty and gang and drug-related violence in El Salvador, Guatemala, and Honduras (United States Government Accountability Office, 2015). This statistic does not include those sold to smugglers or into sexual slavery along the way (Ahmed, 2015), suggesting that even more may be attempting to reach the United States. In July 2015, a Department of Homeland Security (D.H.S.) official testified on the treatment of children at the border: U.S. Customs and Border Protection agents (1) interview the child, (2) screen for human trafficking indicators that necessitate a separate investigation, and (3) transfer the child to the Department of Health and Human Services (D.H.H.S.) within 72 hours for care and placement in a least restrictive setting after assessing for suicidality, homicidality, and flight risk in parallel with asylum proceedings (United States Department of Homeland Security, 2015a). Based on a social work assessment, children are placed with a sponsor who accepts legal custody from a D.H.H.S.-appointed shelter if resettlement is granted (United States Department of Homeland Security, 2015b). Clinicians must conduct mental health evaluations and treatment within 72 hours of learning about minor-to-minor sexual abuse while in D.H.S. custody (United States Department of Health and Human Services, 2016a). All clinicians must also provide culturally competent services by making on-site interpreters available, letting minors communicate in preferred languages, translating all documents, permitting minors to practice their faith, and allowing minors access to religious leaders in government detention facilities (United States Department of Health and Human Services, 2016b).

The U.S. government has integrated components of mental health evaluations to process unaccompanied children. Due to the policy's evolution, future announcements may expand on these components. However, the current response could be improved by adopting guidelines from mental health organizations for evaluating and treating immigrants and refugees. This raises larger questions into how the field of cultural psychiatry could be integrated in future responses to build service capacity for unaccompanied minors in the U.S. and their countries of origin. The paper identifies shortcomings in the U.S.'s mental health response by analyzing extant policies against professional guidelines from psychological and psychiatric organizations and explores potential contributions from cultural psychiatry in improving service capacity. This topic assumes heightened importance given that the number of families stopped at the U.S.-Mexican border jumped 122% between October 2015 and April 2016 from the same period a year earlier and immigration from Central America to the U.S. has become an issue in the 2016 American presidential elections (Stargardter & Edwards, 2016). Our proposals have international relevance since unaccompanied minors exhibit significantly higher rates of depressive, affective, and traumatic disorders compared to native minors or migrants accompanied by caregivers in Belgium (Vervliet, Lammertyn, Broekaert, & Derluyn, 2014), Denmark (Barghadouch, Carlsson, & Norredam, 2016), and the United Kingdom (Michelson & Sclare, 2009).

The U.S. Response and Professional Guidelines

Mental health evaluations are required only for D.H.S.'s limited purposes of risk assessment to determine least restrictive settings and upon the discovery of potential minor-to-minor sexual misconduct when minors are in D.H.S. custody. However, professional guidelines

from mental health organizations support a broader scope for evaluations to include preventive screening. The World Psychiatric Association (W.P.A.) recommends cultural competence training for all service providers as well as public mental health campaigns for immigrants and refugees (Bhugra et al., 2011). Current U.S. government policies fulfill recommendations for cultural competence training, but not for public mental health campaigns. The National Latina/o Psychological Association (N.L.P.A.) suggests screening all minors for symptoms of grief, loss, depression, suicidality, and trauma exposure within cultural and linguistic contexts, with special attention to family members such as siblings who may be detained in the same facility (Fernández, Chaves-Dueñas, & Consoli, 2015). U.S. policies appear to use mental health screening to determine placement, but not for diagnostic assessment or treatment. Finally, the American Psychological Association (A.P.A.) (2012) names unaccompanied minors as a pressing issue and recommends the use of qualitative, quantitative, and mixed methods to evaluate the validity and cultural significance of existing practices. The U.S. government has not publicized any evaluations of its existing practices from internal or independent experts.

All three guidelines underscore the importance of immigration and culture in mental health evaluations for unaccompanied children, raising questions into a potential role of cultural psychiatrists toward service improvement. Cultural psychiatry's chief research aims have been to illuminate variations in risk, presentation, course, and response to mental distress across social contexts (Kirmayer, 2007; Kleinman & Kleinman, 1991). Cultural psychiatrists have shown that providers in community vs. clinical sectors may respond to mental illnesses differently, and that referrals between these sectors can improve overall mental health and service delivery (Kleinman, 1998). When applied to unaccompanied minor migration, these frameworks reveal opportunities to improve services in all affected countries. For example, each country's public health system could bring together affected communities, practitioners, and researchers along the migration pathways of unaccompanied minors. According to the World Health Organization (2011), Honduras has four times the number of psychiatrists as El Salvador, but all three countries have fewer psychiatrists than Latin America's regional mean of 2.1 psychiatrists per 100,000 people. All three countries also demonstrate comparable neuropsychiatric burdens of disease that exceed 16% of all disability-adjusted life years (World Health Organization, 2011). These countries are unlikely to expand care through existing mental health service models in time to accommodate demand from unaccompanied children who have returned home or to decrease factors towards migration, highlighting the utility of expanding community-based interventions. Cultural psychiatrists can contribute by investigating the organization of mental health services across clinical and community settings based on local understandings of health.

How Cultural Psychiatry Can Improve Services

The following recommendations can generate an evidence base for program evaluations and models for interventions. This evidence can also be tested in other regions with unaccompanied minor migration. Recommendations can be introduced at the U.S. border, the countries of origin for unaccompanied minors, and along paths of migration.

At the U.S. border

The number of unaccompanied minors travelling with relatives such as siblings or cousins has not been publicized. D.H.S. is mandated to collect this data (United States Department of Health and Human Services, 2016b), which can be used to improve services based on research evidence. For example, cultural psychiatrists who have conducted semi-structured interviews and participant-observation with Canadian immigrant children applying for asylum have shown that uniting families in the same detention facility can ease fear and isolation (Kronic, Rousseau, & Cleveland, 2015). This finding may apply to unaccompanied minors at the U.S. border and concords with N.L.P.A. guidelines. In addition, although D.H.S. mandates mental health screenings in shelters, this likely does not occur since processing times have shortened based on increased migration (Bishop & Ramirez, 2014). Cultural psychiatry's methodology of person-centered ethnography (Hollan, 1997) could improve services by interviewing local officials, clinicians, and minors on the D.H.S.-D.H.H.S. transfer and mental health screening processes. For example, ethnographic interviews with staff from the federal government's Office of Refugee Resettlement and community partners in St. Louis demonstrated that clinicians prioritized screenings for specific disorders when given limited resources (Morland, Duncan, Hoebing, Kirschke, & Schmidt, 2005). Participant-observations of everyday staff life revealed ways to organize best practices in training clinicians to conduct mental health screenings and audit the numbers actually screened (Morland et al., 2005). This type of program evaluation could be applied to unaccompanied minors in accordance with A.P.A. guidelines.

At the countries of origin

Interventions only at the U.S. border may miss opportunities to treat migrants before they leave home. As members of the Pan-American Health Organization (P.A.H.O.), El Salvador, Guatemala, and Honduras have committed to community-based mental health research and training programs for minors (Pan American Health Organization, 2014). P.A.H.O. could act as a regional center of excellence for medical diplomacy that funds epidemiological teams to track disorders across all three countries and focuses best practices on the most prevalent disorders (Aggarwal & Kohrt, 2013). This information could be used to initiate public education and health campaigns as suggested by W.P.A. guidelines. Teams could also share this information across borders so that D.H.S. and D.H.H.S. officials hone mental health screening procedures. P.A.H.O. could encourage cross-border care by instituting new visas for mental health professionals across the Americas with cultural and linguistic expertise.

Along paths of migration

Little is known about social and geographical networks that unaccompanied children use to reach the border. Here, research in cultural psychiatry can expand our knowledge on the migration patterns of minors and their impacts on mental health through multi-sited ethnography. For example, interviews with unaccompanied minors could identify local institutions that could be enlisted along paths of migration to respond to signs of mental illness. Non-governmental organizations could deploy personnel to deliver brief interventions that impart coping skills and create referral networks to the formal biomedical

system through models of stepped care. This advances cultural psychiatry's agenda of improving referral systems between community and clinical settings.

We have focused on Central America, but our proposals may apply to other conflicts, such as Syrian unaccompanied minors in Europe and the Middle East. Establishing mental health services in Syria may not be feasible due to civil war, but opportunities exist at various borders and along paths of migration. For example, Turkish researchers have demonstrated the efficacy of eye movement desensitization and reprocessing (EMDR) for post-traumatic stress disorder and depression at the Kilis Refugee Camp on the Turkish-Syrian border (Acaturk et al, 2016). This raises questions as to whether EMDR can be implemented elsewhere, especially since clinicians in countries such as Greece that are along paths of migration have called for treatment in refugee camps due to urgent mental health needs (Kousoulis, Ioakeim-Ioannidou, & Economopoulos, 2016). Most Syrian refugees have fled to Jordan and Turkey (Abou-Saleh & Hughes, 2015), and the Organization of the Islamic Conference could act a center of excellence to foster medical diplomacy throughout the Middle East. In 2015, Germany received asylum applications from 413,000 people of whom 25% arrived in a single month, and physicians have expressed concerns that European clinicians may not possess the cultural and linguistic competence to treat Syrians (Nicolai, Fuchs, & von Mutius, 2015). Fortunately, cultural psychiatrists have published systematic reviews on the cultural and linguistic needs of displaced Syrians (Hassan et al., 2015) as well as on the process of culturally adapting psychotherapies for practical clinical use (Aggarwal, 2015), providing models for future work. The European Union has already signed an action plan with Turkey to support refugee and migration management through visa liberalization and financial assistance (European Commission, 2015), and provisions for mental health care could be considered in this and other diplomatic agreements.

In conclusion, the U.S .response to unaccompanied minor migration is commendable for incorporating components of mental health screenings throughout the D.H.S.-D.H.H.S. transfer process, but does not fulfill all standards in professional guidelines. Each guideline acknowledges the importance of culture, raising questions around how cultural psychiatrists can improve the validity of treatment interventions and the organization of mental health services based on local understandings of health. We call on all mental health professionals interested in culture to undertake policy-pertinent research on unaccompanied minor migration whose prevalence worldwide is only unfortunately increasing.

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