PSYCHIATRIC CARE FOR UNDOCUMENTED IMMIGRANTS AND THEIR FAMILIES: ETHICAL FRAMEWORKS AND CLINICAL APPROACHES

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ABSTRACT

The U.S. has a complex history with immigration, currently marked by shifting policies. Despite the polarized climate, undocumented immigrants remain vital to American society contributing to the United States demographics, economy, and culture.

This paper explores the ethical frameworks and clinical approaches relevant to providing ethical psychiatric care for undocumented individuals and their families. This exploration includes examining the application of core principles of bioethics—autonomy, beneficence, non-maleficence, and justice—in the context of undocumented immigration status. Finally, this thesis provides practical methods by which psychiatrists and other physicians can provide ethical care to undocumented immigrants in the clinical setting.

Keywords: urban bioethics, psychiatric care, undocumented immigrants, immigration policy, healthcare access,

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TABLE OF CONTENTS

Page

CHAPTER 1

INTRODUCTION

Although frequently referred to as a nation of immigrants, the United States has a complex and contentious history with immigrants and immigration policy. In recent times, undocumented immigration in the U.S., marked by increased xenophobic rhetoric and shifts in public policy, has become increasingly polarizing and political (Lauret, 2016). Contrary to the rise of this anti-immigration rhetoric, undocumented immigrants remain an integral group in American society.

Demographics of Undocumented Immigrants in the U.S.

As of 2022, approximately 11 million unauthorized or undocumented immigrants live in the U.S. according to data from the Pew Research Center (Passel & Krogstad, 2024). Undocumented immigrants comprise 3.3% of the total population and 23% of the foreign-born population in the U.S. (Passel & Krogstad, 2024). They migrate from diverse regions, with the majority from North and South America, while a quarter are from Asia, Africa, and Europe (Passel & Krogstad, 2024). Although 54% of undocumented immigrants live in just six states, their distribution is becoming more geographically diverse within the U.S. compared to previous decades (Passel & Krogstad, 2024). Undocumented immigrants span various occupational sectors and are 4.7% of the workforce despite comprising only 3.3% of the total population (Passel & Krogstad, 2024). In the U.S. economy, they make significant contributions to federal, state, and local tax revenues. In 2022 alone, they contributed $59.4 billion in federal taxes plus $37.3 billion in state and local taxes, increasing government budgets to support essential services and programs (Davis et al., 2024).

Deferred Action for Childhood Arrivals & Mixed-Status Families

In addition to undocumented immigrants, two other notable populations are further explored in this thesis: recipients of the Deferred Action for Childhood Arrivals (DACA) and children in mixed-status families.

In June 2012, President Obama issued an executive order establishing DACA. Eligible undocumented immigrants, who arrived in the U.S. before age 16 and before June 2012, are protected from potential deportation and provided temporary work authorization through DACA (U.S. Department of Homeland Security, 2012; Moslimani, 2024). Approximately 600,000 DACA recipients live in the US and 1.1 million individuals are currently eligible for DACA status (Moslimani, 2024).

Mixed-status families are families with at least one unauthorized adult living with a child or spouse, who is a U.S. citizen or lawful resident. Approximately 84% of children in mixed-status families were born in the United States and are therefore U.S. citizens (Passel & Krogstad, 2024; Capps et al., 2017). These children often face challenges related to their family's immigration status and with 10%, or 4.4 million children, living in mixed-status families, the impact is far-reaching (Passel & Krogstad, 2024; Capps et al., 2017).

Federal Legislation Impacting Healthcare Access

Two federal laws significantly influenced access to healthcare for undocumented immigrants over the past 40 years: the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 and the Emergency Medical Treatment and Labor Act (EMTALA) (Parmet & Fischer, 2013). PRWORA imposed restrictions on federal, state, and local public services, including health benefits, for undocumented

immigrants (Personal Responsibility and Work Opportunity Reconciliation Act, 1996; Kolker, 2022; Parmet & Fischer, 2013). As a result of PRWORA, undocumented immigrants are ineligible for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Affordable Care Act (ACA) Marketplace plans. In contrast, EMTALA mandates that emergency medical treatment must be provided to any individual who seeks it, ensuring that undocumented immigrants and other vulnerable populations receive necessary emergency care (Emergency Medical Treatment and Labor Act, 1986; Parmet & Fischer, 2013). While Medicare-participating hospitals are required to provide stabilizing medical care, they may still bill for these services (Parmet & Fischer, 2013). Besides emergency care, undocumented immigrants can obtain routine healthcare through safety net providers and private health insurance, which can be obtained through employer-purchased or individual plans (2023b). These plans are not subsidized and are often unaffordable for undocumented immigrants who are predominantly employed in low-wage jobs (2023b).

Health Insurance Coverage for Undocumented Immigrants & Families

As of 2023, 50% of undocumented immigrants lack health insurance, compared to 8% of U.S.-born citizens and 6% of naturalized citizens (2023b). Health insurance coverage is a well-documented socioeconomic determinant of health, and the lack of coverage directly contributes to the healthcare disparities seen in undocumented immigrant populations (Majerol et al., 2015; Siddiqi et al., 2009). State-level variations significantly impact the availability of healthcare services, with some states implementing more inclusive policies that expand coverage for undocumented individuals, while others maintain restrictive measures (Pillai et al., 2024). Besides

policy-related challenges, undocumented immigrants face several barriers to accessing healthcare. Fear of deportation often deters individuals from seeking medical care, language barriers can hinder effective communication with healthcare providers, and lack of transportation can further restrict access to necessary services (Pillai et al., 2023).

While DACA offers relief from deportation and provides recipients with work authorization, it does not grant a path to permanent residency or citizenship (U.S. Department of Homeland Security, 2012). Additionally, DACA recipients face unique stress, such as periodic renewals of their status in a tumultuous political climate, where immigration policy is fast-changing, which can lead to uncertainty about their future (Torres et al., 2021). The lack of access to federal financial aid and certain public benefits limits their educational and economic opportunities (Macías, 2018). They are not eligible for federally funded health insurance as they are not considered lawful permanent residents or citizens and are uninsured at a rate of 47% compared to 10% of their citizen counterparts (2023a). The Biden administration recently announced that DACA recipients will be considered lawfully present for ACA Marketplace coverage eligibility, effective November 1, 2024, for the 2025 Open Enrollment Period. Although this does not extend to Medicaid and CHIP eligibility, this policy development represents a significant improvement in access to healthcare coverage for DACA recipients (Pillai & Artiga, 2024).

Children in mixed-status families face unique challenges as evidenced by their higher uninsured rates, linguistic isolation, and limited English proficiency, which can hinder educational and social integration (Capps et al., 2017). Mixed-status families often struggle with poverty due to barriers to accessing employment and financial services

(Capps et al., 2017). Forced separations can destabilize housing and food security and potential separations can have severe psychiatric ramifications in children, including anxiety, depression, and disruptions in sleep and eating patterns (Brabeck et al., 2014). Eighty-four percent of children in mixed-status families are U.S. citizens and therefore eligible for Medicaid and other medical and social programs, such as food stamps and the Special Supplemental Nutrition Program for Women, Infants, and Children (Passel & Krogstad, 2024; Capps et al., 2017). Even with available social programs, 19% of lawfully present immigrant children and 7% of U.S. citizen children with undocumented parents are uninsured, compared to just 4% of children born to U.S. citizen parents (Capps et al., 2017). This is often due to undocumented parents being hesitant to apply for public assistance or seek medical care for their children out of fear that their immigration status might be revealed, leading to potential deportation (Ku & Jewers, 2014). Sadly, undocumented immigrant children fare significantly worse, with a 31% uninsured rate. (Capps et al., 2017). Certain states, such as California, Illinois, and New York, provide state-funded coverage to income-eligible children, notwithstanding immigration status (2023b). These realities underscore the impact of immigration policies and societal fears on the well-being of undocumented children and children in mixed-status families. Policy and support systems need to improve to ensure that every child has access to necessary care.

CHAPTER 2

PRINCIPLES OF BIOETHICS

The principles of bioethics provide a framework for addressing the complex ethical issues that arise when providing psychiatric care to undocumented immigrants and their families. These principles include autonomy, beneficence, nonmaleficence, and justice (Beauchamp, 2016).

Principle of Autonomy

Autonomy refers to an individual's right to make rational decisions regarding their medical care without undue influence by others (Beauchamp, 2016). Assessing and supporting decision-making capacity and ensuring informed consent is vital, requiring clear communication about medical procedures and options. In patients with limited English proficiency, appropriate language access and communication are required for informed consent and a legal right, protected by Title VI of the Civil Rights Act of 1964, enforced by Executive Order 12166 “Improving access to services for persons with limited English proficiency.” This requires medical interpreters or bilingual staff to facilitate clear dissemination of information for patients with limited English proficiency (Clinton 2000; 42 U.S.C. § 2000d; Joint Commission, 2016).

Principle of Beneficence

Beneficence emphasizes the duty to act in the best interest of the patient (Beauchamp, 2016). The American Medical Association (AMA) notes that although immigration status is a socioeconomic determinant of health, it is a medically irrelevant detail that does not justify withholding appropriate medical care (Harbut, 2019). This is reflected in the AMA Code of Medical Ethics's numerous policy recommendations,

specifically addressing healthcare for undocumented immigrants. The AMA has issued comprehensive policy recommendations aimed at safeguarding access to essential medical services for these vulnerable populations through policies such as H-440.876, titled "Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients," which vehemently opposes any measures that would penalize healthcare providers for offering necessary medical treatment to undocumented immigrants (American Medical Association, 2019a). This policy also advocates against using proof of citizenship status as a determinant for receiving healthcare, recognizing that such practices can exacerbate health disparities and decrease access to essential services. In addition, the AMA supports legislative efforts to expand federal funding for emergency services for undocumented immigrants, as outlined in policy H-160.917, which recommends ensuring that emergency medical care is accessible to all individuals, regardless of their immigration status (American Medical Association, 2019b).

Principle of Non-Maleficence

Non-maleficence centers on the obligation to "do no harm" (Beauchamp, 2016). The principle of non-maleficence is central to the debate over whether to include patients' immigration status in medical records. Recording immigration status can aid in continuity of care and communication among clinicians, especially since undocumented status can be linked to specific health risks. However, such documentation can also expose patients and their families to potential harm via stigmatization and discrimination by healthcare providers who may not be supportive of immigrants, as well as the possibility of exposure to immigration enforcement if this information is shared with authorities (Kim et al., 2019; Garcini et al., 2017). The AMA denounces reporting undocumented patients

to immigration officials, aligning with the principle of non-maleficence. This information is protected under the Health Insurance Portability and Accountability Act of 1996 (Office for Civil Rights, 2003). The AMA Code of Medical Ethics emphasizes that safeguarding patient information and respecting privacy are crucial for maintaining trust and ensuring open communication between patients and healthcare providers (Kim et al., 2019). Additionally, the AMA Journal of Ethics advises against documenting immigration status in patient records when the risks outweigh the benefits and when such risks are influenced by shifting political and cultural contexts (Schweikart, 2019).

Principle of Justice

The principle of justice most often encompasses the framework of distributive justice, which focuses on the equitable, fair, and appropriate distribution of resources (Beauchamp, 2016). Urban bioethicists, prioritize the framework of social justice and argue that health disparities are inevitably linked to historical patterns of power imbalances, social hierarchy, and systemic injustice (Fabi & Goldberg, 2021). When considering the provision of healthcare to undocumented immigrants both frameworks are relevant. In regards to the allocation of healthcare, it is often erroneously believed that undocumented immigrants impose a higher financial burden than their citizen counterparts due to their utilization of costlier emergency care services. In actuality, undocumented immigrant healthcare spending is significantly lower than that of US citizens per capita, and undocumented immigrants paid more in taxes to the Medicare Trust fund than they utilized. Citizens generate a $30.9 billion dollar deficit in Medicare revenue in contrast to the approximately $11.1-$17.2 billion surplus generated by undocumented immigrants (Brenner et al., 2021; Zallman et al., 2013). In 2022,

undocumented immigrants contributed significantly to U.S. tax revenues, with $25.7 billion in Social Security taxes, $6.4 billion in Medicare taxes, and $1.8 billion in unemployment insurance taxes, thus helping fund programs from which they are excluded (Davis et al., 2024). Undocumented immigrants contribute more than they receive to the systems from which they are excluded, highlighting a lack of equitable distribution of resources. This disparity not only undermines the principle of fairness but also perpetuates health inequities, as undocumented immigrants face greater health risks due to limited access to care while still bearing a substantial financial burden. This inequity reflects broader issues of social justice, where marginalized groups are denied their basic needs and face substantial health risks, despite their contributions to society and the economy.

CHAPTER 3

CASE STUDIES

Case 1: Undocumented Pediatric Patient

Lucia is a 13-year-old girl from Guatemala, who arrived in the United States as an unaccompanied minor after feeling gang violence. She speaks only Spanish. Her mother passed away when she was 10 years old. Her father lives in a remote village, making him inaccessible to the team in their attempts to obtain parental consent. She is living with her aunt in a large city. Lucia was hospitalized for an infection and psychiatry was consulted for concerns of major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. She has been experiencing symptoms including nightmares, flashbacks, tearfulness, and severe anxiety.

Case Formulation 1

The pediatric and psychiatry teams face a difficult situation in providing Lucia with healthcare. In regards to autonomy and decision-making capacity, given her age and the absence of her parents, obtaining informed consent for treatment is complex. The healthcare team must evaluate her ability to understand and consent to her treatment and will need to potentially involve her aunt as a guardian. This may require a discussion with the hospital ethics committee or legal counsel. If Spanish-speaking providers are unavailable, trained interpreters should be utilized when speaking to her. In addition, the team must protect Lucia's sensitive information. Her legal status should not be documented explicitly in the electronic medical record to prevent harm from this disclosure. In addition, if appropriate, she should be started on medication for her infection and mental health conditions and should be connected to appropriate outpatient

follow-up after discharge. The teams should provide trauma-informed care by creating a safe environment, respecting Lucia's readiness to discuss trauma, using culturally sensitive practices, and avoiding pressure for her to talk about her trauma if she is not ready. Lastly, Lucia should receive the same quality of care as other patients and her team should advocate for her health needs.

Case 2: Pediatric Patient in a Mixed-Status Family

Fatima is a 9-year-old girl born in the United States. However, her parents and older siblings are undocumented. She has been showing signs of severe anxiety and panic attacks after her best friend's father was deported. She fears for her family's safety and potential separation. She is referred to an outpatient psychiatrist due to her anxiety and school avoidance. Despite her lawful status, she does not have health insurance.

Case Formulation 2

Given her age, informed consent involves ensuring that her parents understand her treatment plan while considering Fatima's age-appropriate participation in decisions about her care. If her parents do not speak English, the team must use a trained interpreter when speaking with them. Utilizing social workers, physicians should connect Fatima and her family with community resources, such as legal aid and support groups. When connecting Fatima to public programs, if forms require parental insurance/legal status, "ineligible for insurance" can be used to prevent disclosure of legal status. The staff should provide care that does not re-traumatize the patient or cause undue harm, by following the principles of trauma-informed care. In addition, she should be treated with culturally sensitive care, that respects her family's background. The physician should consider leaving her family members' legal status out of the electronic medical records

and protect Fatima's privacy and confidentiality. The psychiatrist can elicit the parent's perspective when making this decision. Despite her lack of health insurance, Fatima should be given equitable care by advocating for her access to necessary health services and exploring options such as sliding scale fees, community health programs, or charity care.

Case 3: Undocumented Adult Patient

Rhea, a 35-year-old undocumented immigrant from India, was involuntarily hospitalized due to severe schizophrenia, which has been exacerbated by her isolation and lack of support in the area. She continues to hear auditory hallucinations telling her to kill herself. Despite an extended hospitalization, her condition has not improved significantly, and she continues to be at increased risk of harm to herself. She has been in the acute inpatient unit for 8 months and the team anticipates that she will need to be transferred to a long-term care facility for continued treatment and support.

Case Formulation 3

Rhea's autonomy is compromised by her severe schizophrenia. She may struggle with decision-making capacity given her severe psychiatric illness. Due to her lack of capacity, the next of kin should be her medical decision-maker. Given the lack of family and support in the community, no next of kin is available to make decisions in her best interest. Given that emergent care is required due to her active suicidality, the treatment providers are to make medical decisions in her respecting her rights and best interests. Involving a legal guardian or representative could help advocate for her needs and preferences, given her condition. Medical repatriation, or the process of deporting undocumented patients to their home countries for further care. Given Rhea's lack of

capacity due to severe psychiatric illness, she cannot consent to medical repatriation at this time. Medical repatriation raises significant ethical issues, particularly regarding the quality and continuity of psychiatric care Rhea would receive in India and the potential risks to her health. Utilizing ethical frameworks such as principle-based ethics, care ethics, and narrative ethics, the psychiatric team must advocate for Rhea's right to comprehensive mental health care, strive to provide culturally sensitive and trauma-informed treatment, and consider the broader socio-political context of her fears and experiences. Collaboration with legal advocates is essential to navigate these complex ethical challenges and to protect Rhea’s well-being during her hospitalization and beyond.

CHAPTER 4

CLINICAL APPROACHES

Trauma-Informed Care

Immigrants may experience a range of unique stressors throughout their journey. They may experience pre-migration stress, including war, torture, separation from family members, gang violence, extreme hunger/poverty, natural disasters, and discrimination. During their journey, they may experience migration stressors, including violence, the arduous and often dangerous journey itself, trafficking, loss of loved ones, and extreme hunger, Finally, upon arriving at the intended destination, they may experience post-migration stressors related to acculturation, including discrimination, racism, social isolation, language barriers, poverty, suboptimal living conditions, and unstable housing (Dow, 2011).

Trauma-informed care (TIC) is a philosophical approach applicable to all medical professionals, interacting with patients who may have experienced trauma. The goal of TIC is to apply the understanding of trauma and its consequences and intentionally practice medicine in a way that does not cause undue re-traumatization to the patient. Its implementation is limited as it is a framework, not specific and actionable directives (Rudolph, 2021). Nonetheless, various professional organizations, including the American Academy of Pediatrics, consider it the standard of care for immigrant and refugee youth (Miller, Brown, Shramko, & Svetaz, 2019). The principles of TIC encourage clinicians to promote a safe environment, that supports patient choice/autonomy, shared decision-making, cultural humility, integrated care, and healing relationships (Miller, Brown, Shramko, & Svetaz, 2019; Reeves, 2015). Treatment of

patients should include an appropriately timed screening of trauma in a culturally sensitive way. Exploration of experienced traumas should not cause harm to the patient, in line with the principle of non-maleficence. The physical environment in which the patient is evaluated should feel physically and emotionally safe and nonjudgemental. There should be adequate lighting inside and outside the building and signs should be friendly with inclusive language. Pamphlets describing what to expect during the visit and after can be provided to patients. In addition to the clinicians, the front desk staff, security, and custodial staff should have training on identifying and addressing signs of trauma and de-escalation. During the encounter, patients' boundaries should be respected by asking permission before broaching sensitive topics or physical exam maneuvers. In addition, hiring practices should reflect the diverse population of the community being served (Yatchmenoff, Sundborg, & Davis, 2017; Miller, Brown, Shramko, & Svetaz, 2019).

Emergency Care Considerations

The undocumented immigrant population may find themselves seeking care in emergency departments (EDs). Emergency medicine and emergency psychiatry physicians have an ethical and legal responsibility to care for this population (Brenner et al., 2021). The American Civil Liberties Union, Physicians for Human Rights, and National Immigration Law Center have published, *Health Care Providers: Preserve Access to Care and Protect Your Patients from Border Patrol and ICE Interference A Guide to Best Practices for Protecting Your Rights and Your Patient's Rights,* that provides information on best practices when working with undocumented immigrants. A summary of their recommendations is provided here. First, all healthcare providers need

to be knowledgeable about the legal rights of healthcare providers and patients when interacting with Immigration and Customs Enforcement (ICE) officers. The U.S. Department of Homeland Security, including its agencies ICE and Customs and Border Protection (CBP), deems that immigration enforcement actions should be restricted to "sensitive locations." Hospitals and other medical facilities, such as doctors' offices, accredited health clinics, and urgent care centers, are designated as "sensitive locations" where enforcement requires prior approval from a designated official. When ICE presents to the hospital, healthcare providers can decline to provide information about patients unless a warrant or court order is provided. Healthcare workers interacting with ICE agents should direct them to a hospital-designated staff member who is well-versed in the facility's policies regarding law and immigration enforcement. The designated staff member should review the warrant to ensure it is valid and authorized, signed by a judge, and executed within the listed timeframe and address. If the warrant covers only certain areas, staff should not allow officers to exceed these boundaries.

Hospitals should establish written policies that define private areas within the facility, such as exam rooms and administrative offices, restricting access to these areas to essential medical staff only to ensure patient privacy and safety and reduce the risk of unauthorized access. It is important to note that ICE officers can enter public areas (such as a waiting room or lobby) without a warrant and can see and hear anything that is in "plain view" and "plain hearing," respectively. Staff must be trained not to discuss confidential patient information in areas accessible to ICE officers. Patients can be provided with appropriate language educational materials, including posters and know-your-rights cards that explain that they can refuse to answer questions from immigration

agents and request legal representation. Hospitals can establish a relationship with a local immigration attorney who can offer guidance and support if enforcement actions occur. Lastly, it can help build trust between healthcare providers and patients, by informing them that their health information is protected under federal and state laws and that the facility is committed to maintaining a safe and confidential caring and healing environment. This approach helps ensure that patients feel secure seeking medical care despite the potential presence of immigration enforcement.

In addition, undocumented immigrants may seek primary care services in the Emergency Department (ED). Primary care is not often addressed in the emergency setting, and, when discharged, referrals to primary care or specialty care are made to address non-emergent medical conditions that are evident during the evaluation. As EDs may be the only providers of health care to undocumented immigrants, it may be beneficial to provide primary care in the ED setting. The provision of suboptimal primary care has to be balanced with practicing within the scope of training of the physician and provision of care without appropriate outpatient follow-up for routine monitoring and continued prescribing (Brenner et al., 2021). When discharging patients who are undocumented, ED providers should facilitate referrals to community-based organizations (Brenner et al., 2021). At an institutional level, EDs can hire social workers and partner with medical-legal partnerships (MLPs) to facilitate connection to services for this population (Brenner et al., 2021). Lastly, medical and psychiatric ED physicians can educate themselves on signs of violence or human trafficking and learn how to intervene appropriately. Undocumented immigrants who are victims of crime and willing to assist law enforcement in the identification of the perpetrators/traffickers may be

eligible for a U Visa, for victims of crime, and a T Visa, for victims of trafficking. Connecting undocumented immigrants to MLPs can facilitate this process and application (Brenner et al., 2021).

Cultural Sensitivity and Humility

The Diagnostic and Statistical Manual (DSM)-IV published the Outline for Cultural Formulation, a framework of core themes to include in a psychiatric evaluation to enhance diagnostic clarity and patient participation by eliciting a patient's cultural context (Lewis-Fernández et al., 2016). This led to the development of the Cultural Formulation Interview (CFI) in the DSM-5, a 16-item questionnaire to aid psychiatrists in providing culturally sensitive care. The CFI questions are divided into three domains: how the individual culturally defines the chief complaint, their views on the cause, context, and support, and the cultural factors influencing their coping strategies and help-seeking (Lewis-Fernández et al., 2016). A scoping review by Jones-Lavallée et al. showed that utilization of the CFI enhanced the therapeutic relationship and communication between patient and clinician, facilitated deeper exploration of a patient illness story, and improved diagnostic clarity and treatment planning (Jones-Lavallée et al., 2022). In a small multi-site study conducted by Mills et al., CFI training improved self-reported cultural competency among general psychiatry residents. Despite unclear implications for clinical practice, this may be an area of intervention for psychiatry training programs (2016). Although further research is needed, current data suggest that utilization of the CFI is an actionable step in improving culturally sensitive psychiatry care.

Training and Education

Cultural competence is a valuable concept commonly taught in medical education, that involves acquiring specific knowledge, skills, and attitudes to understand and provide effective care to people of different cultural backgrounds, including immigrants. The term or concept implies a normal group must learn about an abnormal or different group, which can problematically reinforce stereotypes and biases leading to implicit or explicit bias and discrimination. Cultural humility, on the other hand, is a lifelong process of self-reflection and self-critique focusing on the power differential between patient and physician. It emphasizes recognizing one's cultural biases and limitations and understanding every patient will have their own cultural experiences and needs. Understanding structural competence, the systemic barriers that lead to health disparities, is a part of cultural humility (Fisher-Borne et al., 2014; How et al., 2021; Metzl & Hansen, 2014).

There are multiple avenues in psychiatry training where cultural humility and structural competence can be incorporated into the curricula, including, but not limited to, supervision, clinical work, and didactics (How et al., 2021). In clinical supervision, faculty supervisors can acknowledge the power dynamics and personal limitations trainees may experience when working with immigrants. Supervisors can model self-reflection and humility and encourage trainees to include structures and systems producing health disparities affecting vulnerable patients, including Undocumented immigrants, directly and indirectly into the case formulations discussed during supervision. In addition, supervisors should encourage trainees to utilize the resources available at their institution including social workers and MLPs (How et al., 2021).

Didactic curricula focusing on immigrant populations should not be relegated to "cultural seminars" or cultural competency lectures, as this furthers the experiences of immigrants. Instead, lecturers can be asked to incorporate how the mental health of immigrants and other vulnerable populations can be incorporated into their lectures and didactics on a variety of psychiatric topics (How et al., 2021). In didactics, lecturers can be asked to review the research presented to see if it was conducted with diverse groups and whether different subgroups respond differently to treatments and to explore what might be driving these differences, such as access to healthcare, discrimination, or economic oppression. In addition, they can be asked how to reflect on how implicit bias might affect the presented research questions, framing of results, and conclusions. Programs can work to ensure diverse voices are highlighted in the didactic curriculum and that the required reading literature includes authors from varied backgrounds. Additionally, didactics taught by other professionals with unique skill sets including attorneys can be invaluable to trainees.

Physician Advocacy

Urban bioethicists assert that when health inequities are ethically unjustifiable, advocacy becomes a moral imperative (Rocco & Tuohy, 2021). This perspective is increasingly embraced within the medical community, where advocacy is recognized as a fundamental aspect of medical professionalism. The American Board of Internal Medicine has incorporated public advocacy to address systemic issues that impact patient care as a core part of a physician's role (2002). The American Medical Association's Declaration of Professional Responsibility states explicitly that physicians should alleviate suffering and promote well-being by actively engaging in "social, economic,

educational, and political reforms" (2002). The American Psychiatric Association endorsed the AMA's Declaration of Professional Responsibility advocates for increased access to mental health care, and also supports increased funding for training psychiatrists in primary care skills to increase access to physical healthcare (2015). These organizations recognize that physicians have a responsibility to champion policies that address health inequities and improve access to care. This commitment, to advocacy, by numerous organizations, reflects a broader understanding of the physician's role, not just as a provider of care, but as an agent of social justice.

CHAPTER 5

CONCLUSION

Undocumented individuals, DACA recipients, and children of mixed-status families face consequential barriers to accessing healthcare that contribute to broader health disparities. Providing care is complicated by language barriers, cultural barriers, and fear of deportation, all of which impact their ability to receive appropriate medical care. Steadfast application of the principles of autonomy, beneficence, non-maleficence, and justice are essential in providing appropriate and equitable care to these vulnerable populations.

Psychiatric and medical professional must integrate trauma-informed and culturally sensitive care into their training and practice. Physicians who work with these populations and bear witness to their suffering should advocate for policies that expand healthcare access and insurance coverage at the state and national. Physicians can work within their hospital systems to provide trauma-informed care and enhance the availability of multilingual services and legal support. Training future physicians should include a strong emphasis on advocacy, social justice, and cultural sensitivity. By implementing these measures, we can work towards reducing health disparities and ensuring that all individuals, regardless of their immigration status, receive compassionate and equitable care.

REFERENCES

American Medical Association. (2002, July 19). *AMA declaration of professional responsibility*. https://www.ama-assn.org. https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility

American Medical Association. (2019). Federation payment for emergency services for undocumented immigrants H-160.917.

American Medical Association. (2019). Opposition to criminalization of medical care provided to undocumented immigrant patients H-440.876.

American Psychiatric Association. (2015). Position statement on the role of psychiatrists in reducing physical health disparities in patients with mental illness.

Beauchamp, T. L. (2016). Principlism in bioethics. *International Library of Ethics, Law, and the New Medicine*, 1–16. https://doi.org/10.1007/978-3-319-43419-3_1

Brabeck, K. M., Lykes, M. B., & Hunter, C. (2014). The psychosocial impact of detention and deportation on U.S. migrant children and families. *American Journal of Orthopsychiatry*, *84*(5), 496–505. https://doi.org/10.1037/ort0000011

Homes, B. H., & Centers, H. (2015). APA official actions position statement on the role of psychiatrists in reducing physical health disparities in patients with mental illness.

Brenner, J. M., Blutinger, E., Ricke, B., Vearrier, L., Kluesner, N. H., & Moskop, J. C. (2021). Ethical issues in the access to emergency care for undocumented immigrants. *Journal of the American College of Emergency Physicians Open*, *2*(3). https://doi.org/10.1002/emp2.12461

Capps, R., Fix, M., & Zong, J. (2017, April 7). *A profile of U.S. children with unauthorized immigrant parents*. migrationpolicy.org. https://www.migrationpolicy.org/research/profile-us-children-unauthorized-immigrant-parents

Congressional Research Service, & Kolker, A. F. [Report], Unauthorized immigrants' eligibility for federal and state benefits: Overview and resources (2022). Washington, D.C; Congressional Research Service.

Davis, C., Guzman, M., & Sifre, E. (2024, July 30). *Tax payments by undocumented immigrants*. ITEP. https://itep.org/undocumented-immigrants-taxes-2024/

Dow, H. D. (2011). An Overview of Stressors Faced by Immigrants and Refugees: A Guide for Mental Health Practitioners. *Home Health Care Management & Practice*, *23*(3), 210–217. https://doi.org/10.1177/1084822310390878

Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (1986).

Fabi, R., & Goldberg, D. S. (2021). Bioethics, (funding) priorities, and the perpetuation of injustice. *The American Journal of Bioethics*, *22*(1), 6–13. https://doi.org/10.1080/15265161.2020.1867934

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2014). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

42 U.S.C. § 2000d (2016).

Garcini, L. M., Peña, J. M., Galvan, T., Fagundes, C. P., Malcarne, V., & Klonoff, E. A. (2017). Mental disorders among undocumented Mexican immigrants in high-risk neighborhoods: Prevalence, comorbidity, and vulnerabilities. *Journal of Consulting and Clinical Psychology*, *85*(10), 927–936. https://doi.org/10.1037/ccp0000237

Harbut, R. (2019). AMA policies and code of medical ethics' opinions related to health care for patients who are immigrants, refugees, or asylees. *AMA Journal of Ethics*, *21*(1), E73-77. https://doi.org/10.1001/amajethics.2019.73

Health Care Providers: Preserve Access to Care and Protect Your Patients from Border Patrol and ICE Interference A Guide to Best Practices for Protecting Your Rights and Your Patient's Rights. Physicians for Human Rights. (n.d.). https://phr.org/wp-content/uploads/2020/08/NILC_ACLU_HealthcareProvidersGuide-FINAL_8_10_20.pdf

How, P. C., Kho, C., Rodríguez, R., & Shim, R. S. (2021). Immigration as a social determinant of mental health: Implications for training and education in psychiatry. *Academic Psychiatry*, *45*(1), 93–99. https://doi.org/10.1007/s40596-020-01362-2

Joint Commission. (2016). Language access and the law: Title VI of the US Civil Rights Act (1964). *Accessed August, 8 2024*.

Jones-Lavallée, A., Bernard, G., Taing, J., & Leanza, Y. (2022). The state of current knowledge on the cultural formulation interview: A scoping review. *Journal of Psychopathology and Behavioral Assessment*, *45*(1), 265–276. https://doi.org/10.1007/s10862-022-10009-5

Key facts on deferred action for childhood arrivals (DACA). KFF. (2023a, April 13). https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

Key facts on health coverage of immigrants. KFF. (2023b, September 17). https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/

Kim, G., Molina, U. S., & Saadi, A. (2019). Should immigration status information be included in a patient's health record? *AMA Journal of Ethics*, *21*(1), E8-16. https://doi.org/10.1001/amajethics.2019.8

Ku, L., & Jewers, M. (2014). Health care for immigrant families: current policies and issues. Washington DC: Migration Policy Institute.

Lauret, M. (2016). Americanization now and then: The "nation of immigrants" in the early twentieth and twenty-first centuries. *Journal of American Studies*, *50*(2), 419–447. https://doi.org/10.1017/s0021875816000487

Lewis-Fernández, R., Aggarwal, N. K., Hinton, L., & Kirmayer, L. J. (Eds.). (2016). *DSM-5 ® handbook on the Cultural Formulation Interview*. Lippincott Williams & Wilkins.

Macías, L. F. (2018). The scheme game: How DACA recipients navigate barriers to higher education. *Educational Studies*, *54*(6), 609–628. https://doi.org/10.1080/00131946.2018.1530236

Majerol, M., Newkirk, V., & Garfield, R. (2015). The uninsured: A primer. Key facts about health insurance and the uninsured in the era of health reform. Washington, DC: The Henry J Kaiser Family Foundation Commission on the Uninsured.

Martin, S. F. (2021). *A nation of immigrants*. Cambridge University Press.

Medical Professionalism Project. (2002). Medical professionalism in the new millennium: A physician charter. *Annals of Internal Medicine*, *136*(3), 243. https://doi.org/10.7326/0003-4819-136-3-200202050-00012

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Miller, K. K., Brown, C. R., Shramko, M., & Svetaz, M. V. (2019). Applying trauma-informed practices to the care of refugee and immigrant youth: 10 clinical pearls. *Children*, *6*(8), 94. https://doi.org/10.3390/children6080094

Mills, S., Wolitzky-Taylor, K., Xiao, A. Q., Bourque, M. C., Rojas, S. M., Bhattacharya, D., Simpson, A. K., Maye, A., Lo, P., Clark, A., Lim, R., & Lu, F. G. (2016). Training on the DSM-5 cultural formulation interview improves cultural competence in general psychiatry residents: A multi-site study. *Academic Psychiatry*, *40*(5), 829–834. https://doi.org/10.1007/s40596-016-0551-x

Moslimani, M. (2024, July 22). *What the data says about immigrants in the U.S.* Pew Research Center. https://www.pewresearch.org/short-reads/2024/07/22/key-findings-about-us-immigrants/

Office for Civil Rights. (2003). *Summary of the HIPAA privacy rule*. U.S. Department of Health and Human Services.

Parmet, W., & Fischer, S. (2013). Human rights and immigrants' access to care. *Salud Pública de México*, *55*(6), 631. https://doi.org/10.21149/spm.v55i6.7309

Passel, J. S., & Krogstad, J. M. (2024, July 22). *What we know about unauthorized immigrants living in the U.S.* Pew Research Center. https://www.pewresearch.org/short-reads/2024/07/22/what-we-know-about-unauthorized-immigrants-living-in-the-us/

Pillai, A., Pillai, D., & Artiga, S. (2024, May 1). *State health coverage for immigrants and implications for health coverage and care*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/

Pillai, D., & Artiga, S. (2024, May 15). *New Regulations Extend Health Coverage to Deferred Action for Childhood Arrivals (DACA) recipients*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/new-regulations-extend-health-coverage-to-deferred-action-for-childhood-arrivals-daca-recipients/

Pillai, D., Artiga, S., Hamel, L., Schumacher, S., Kirzinger, A., Presiado, M., & Kearney, A. (2023, September 17). *Health and health care experiences of immigrants: The 2023 KFF/LA Times Survey of immigrants*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996).

Reeves, E. (2015). A synthesis of the literature on trauma-informed care. *Issues in Mental Health Nursing*, *36*(9), 698–709. https://doi.org/10.3109/01612840.2015.1025319

Rocco, P., & Tuohy, B. (2021). A new dawn of bioethics: Advocacy and social justice. *The American Journal of Bioethics*, *22*(1), 23–25. https://doi.org/10.1080/15265161.2021.2001105

Rudolph, K. (2021). Ethical considerations in trauma-informed care. *Psychiatric Clinics of North America*, *44*(4), 521–535. https://doi.org/10.1016/j.psc.2021.07.001

Schweikart, S. (2019). Should immigration status information be considered protected health information? *AMA Journal of Ethics*, *21*(1), E32-37. https://doi.org/10.1001/amajethics.2019.32

Siddiqi, A., Zuberi, D., & Nguyen, Q. C. (2009). The role of health insurance in explaining immigrant versus non-immigrant disparities in access to health care: Comparing the United States to Canada. *Social Science & Medicine*, *69*(10), 1452–1459. https://doi.org/10.1016/j.socscimed.2009.08.030

United States. (1986). *Emergency Medical Treatment and Labor Act*. 42 U.S.C. § 1395dd. https://www.govinfo.gov/content/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap7-subchapXVIII-partE-sec1395dd.pdf

United States. (1996). *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*. Pub. L. No. 104-193, 110 Stat. 2105. https://www.govinfo.gov/content/pkg/PLAW-104publ193/pdf/PLAW-104publ193.pdf

U.S. Department of Homeland Security. (2012, June 15). Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children. U.S. Department of Homeland Security. https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf

Varkey, B. (2020). Principles of clinical ethics and their application to practice. *Medical Principles and Practice*, *30*(1), 17–28. https://doi.org/10.1159/000509119

Yatchmenoff, D. K., Sundborg, S. A., & Davis, M. A. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work*, *18*(1), 167–185. https://doi.org/10.18060/21311

Yin, J. C. (2022, September 21). *Fact sheet: Undocumented immigrants and Federal Health Care Benefits*. National Immigration Forum. https://immigrationforum.org/article/fact-sheet-undocumented-immigrants-and-federal-health-care-benefits/

Zallman, L., Woolhandler, S., Himmelstein, D., Bor, D., & McCormick, D. (2013). Immigrants contributed an estimated $115.2 billion more to the Medicare Trust Fund than they took out in 2002–09. *Health Affairs*, *32*(6), 1153–1160. https://doi.org/10.1377/hlthaff.2012.1223